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Bringing (domestic) politics back in: global and local influences on health equity

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ABSTRACT

The *Lancet*-University of Oslo Commission on Global Governance for health correctly concluded that: 'with globalization, health inequity increasingly results from transnational activities that involve actors with different interests and degrees of power'. At the same time, taking up that Commission's focus on political determinants of health and 'power asymmetries' requires recognizing the interplay of globalization with domestic politics, and the limits of global influences as explanations for policies that affect health inequalities. I make this case using three examples – trade policy, climate change policy, and the domestic politics of poverty reduction and social policy – and a concluding observation about the 2015 UK election.

Introduction

The conference where the original version of this analysis was presented took place against the backdrop of the Ebola outbreak in Sub-Saharan Africa. The outbreak dramatized the weaknesses of the region's national health systems, and threatened to exacerbate those weaknesses as 'secondary health crises' emerge in such areas as malaria, nutrition and maternal care.[1] The weaknesses reflect international influences. Rowden has argued that 'the conspicuous unpreparedness of countries like Guinea, Liberia, and Sierra Leone is a direct consequence of years of insufficient public investment in the underlying public health infrastructure' – and, further, that the International Monetary Fund (IMF)'s obsession with fiscal restraint is partly to blame.[1] Other authors have similarly pointed to the connections between the region's extreme poverty and its integration into the global economy on highly exploitative terms, through such processes as land grabbing by foreign actors.[2]

This example shows the importance of one of the conclusions reached by the *Lancet*-University of Oslo Commission on

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Global Governance for Health: 'with globalization, health inequity increasingly results from transnational activities that involve actors with different interests and degrees of power'.[3] (p. 630) The Commission also foregrounded the concepts of 'power asymmetries' and 'political determinants of health', which introduce a further level of complexity to the analysis. While the Commission was primarily concerned with power asymmetries on a global scale, in fact they operate on multiple scales, often involving the effects of globalization and global (or at least transnational) economic and political actors on domestic economic opportunity structures, resource distributions, and politics. Further, there are situations in which domestic political choices are crucial enablers, facilitators or promoters of globalization. In still other cases, globalization plays only a minor role in shaping political preferences and policy choices that affect health and health inequalities. An adequate understanding of the political determinants of health must include and recognize all these possibilities, paying special attention to interactions between the global and the domestic or the local. Here I present three examples – all that space constraints permit, but enough to demonstrate the importance of such interactions for understanding the politics of health and to suggest the value of a larger research program, as part of what has been called a 'political science of health'.[4]

Example 1: trade policy

In a world where production is routinely organized across multiple national borders in complex commodity and value chains, trade policy is not only about tariffs and non-tariff limitations on trade, but also about investment and various 'behind-the-border' policies including standards related to public health. A key characteristic of the post-1995 World Trade Organization (WTO) regime, and an accompanying proliferation of bilateral and plurilateral agreements some of which actually predate the WTO, is that they restrict governments' policy space: 'the freedom, scope, and mechanisms that governments have to choose, design, and implement public policies to fulfil their aims'.[5] (p. 105) Notably, harmonization of intellectual property protection under provisions of the Agreement on Trade-Related Aspects of Intellectual Property (TRIPs), which were driven by the economic interests of US pharmaceutical and information technology corporations,[6] has restricted governments' ability to provide access to essential medicines. This impact has been magnified by so-called TRIPS-plus provisions in bilateral and plurilateral agreements.[3] (p. 642),[7] More recently, intellectual property protection under trade agreements has been invoked by the tobacco industry as a basis for opposing plain packaging requirements.[3] (p. 643–4)

Other health impacts are less conspicuous. For example, an expanding body of research indicates that trade and investment liberalization have facilitated the unhealthy transformation of diets in low- and middle-income countries (LMICs) by fast food chains, supermarkets, and producers of ultra-processed foods.[8–10] Mexico, where such trends are especially conspicuous, now has obesity rates comparable to those in the United States. When countries lower trade barriers and make labour markets more 'flexible' in order to attract foreign investment, the result is often destruction of livelihoods by imports that may be heavily subsidized.[11] The health consequences that result[12] are much more difficult to document to an epidemiological standard of proof, at least until long after the window of opportunity for policies to protect employment and health has closed.

In some cases, trade and investment liberalization has been a response to IMF and World Bank conditionalities, a key aim of which was to restructure national economies around competitive export sectors in order to protect countries' ability to repay foreign debts. Even when such conditionalities are not an issue, large economies (like the United States) or economic blocs (like the European Union) have a formidable bargaining advantage in bilateral or plurilateral negotiations with smaller economies, meaning they are able to demand major concessions (in areas like intellectual property protection, which can drive up the costs of medicines) in exchange for limited increases in access to their markets.[13] The negotiation of trade and investment agreements thus exemplifies global power asymmetries. However, such asymmetries exist within countries as well as among them. When governments enter into trade and investment agreements or make other kinds of commitments involving the global marketplace, they may be accepting risks on behalf of vulnerable groups with limited political voice, in the interests of securing gains to domestic constituencies such as export industries or property investors. This helps to explain why governments accept provisions that may expand market access for attract foreign investment even as they limit access to essential medicines by raising their cost, or create new constraints on policy space through investor-state dispute settlement (ISDS) mechanisms that are beyond effective democratic control.[14,15]

In such cases, the role of external influences on trade policy is limited; they may function primarily as a way of adding credibility to domestic elite agendas. Policy elites led Mexico unilaterally to liberalize trade and expose domestic producers to foreign competition well before it agreed to do so within the North American market under the North American Free Trade Agreement (NAFTA);[16] it has been argued that NAFTA itself was adopted in order to lock in neoliberal domestic economic policies by restricting future governments' policy space,[17] for example through its ISDS provisions. Thus, although global inequalities clearly play a role in explaining the health consequences of the contemporary trade policy regime, at least some trade policy commitments confirm Halperin's view that: 'globalization is a matter of deliberate organization and collective effort on the part of elites concerned to maintain a specific distribution of resources that subordinates labour and preserves elite privileges. The discourse of globalization emphasizes the necessity of governments to adapt to newness and difference, a necessity that forecloses choice. But government policies are designed, not to adapt to new circumstances, but to promote them'.[18] (p. 224)

Example 2: climate change

Climate change was identified by a 2009 *Lancet* Commission as 'the biggest global health threat of the 21st century'.[19] The

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