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Publisher: Routledge

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## Critical Public Health

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/ccph20>

### The global financial crisis and health equity: toward a conceptual framework

Arne Ruckert<sup>a</sup> & Ronald Labonté<sup>a</sup>

<sup>a</sup> Department of Epidemiology and Community Medicine, Institute of Population Health, University of Ottawa, Ontario, Canada

Available online: 14 May 2012

To cite this article: Arne Ruckert & Ronald Labonté (2012): The global financial crisis and health equity: toward a conceptual framework, *Critical Public Health*, DOI:10.1080/09581596.2012.685053

To link to this article: <http://dx.doi.org/10.1080/09581596.2012.685053>



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## The global financial crisis and health equity: toward a conceptual framework

Arne Ruckert\* and Ronald Labonté

*Department of Epidemiology and Community Medicine, Institute of Population Health, University of Ottawa, Ontario, Canada*

*(Received 5 April 2012; final version received 7 April 2012)*

In this article, we identify pathways that link the global financial crisis to health equity. We distinguish between direct and indirect channels of influence, and develop a conceptual model that builds on the literature analyzing the impacts of globalization on social determinants of health. The most pertinent direct pathways discussed are economic contraction, health budget cutbacks, rise in unemployment, and qualitative transformations of health systems. We also outline how other indirect channels of influence are likely to affect health equity, including cutbacks to welfare programs, labor market transformations, the emergence of an ideological climate conducive to austerity politics, and reductions in official development assistance. We conclude by suggesting that the current intensification of neoliberal policy implementation is likely to undermine health equity, and that a different path toward economic recovery is required to ensure equitable access to health care.

**Keywords:** health equity; global financial crisis; population health; social determinants of health; health governance

### Introduction

Health equity is becoming a central concern in health research (Östlin *et al.* 2011), with the tenacity of health disparities in countries around the world identified as one of the most serious public health threats of the twenty-first century (Edwards and Di Ruggiero 2011). The WHO defines health equity as the absence of systematic differences in health, between and within countries, that are avoidable by reasonable action (CSDH 2008, p. 1). Health equity research starts from the assumption that many of the differences in health outcomes between different segments of the population are directly traceable to inequalities in the underlying social and economic conditions that are essential for health, or what recently came to be called ‘social determinants of health’ (SDH) (Labonté *et al.* 2009). A rapidly growing body of literature on SDH surfaced in the 1990, and has gained momentum with the WHO Commission on Social Determinants of Health (CSDH 2008) and subsequent national and regional reviews (for a good overview, see Navarro 2009, Raphael 2011).

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\*Corresponding author. Email: aruckert@uottawa.ca

As a part of this literature, a small branch is focusing on how global factors and forces are shaping SDH domestically (e.g. Labonte and Torgerson 2005, Labonte and Schrecker 2007a, b, c, Edwards and Di Ruggiero 2011). However, recent global developments, in particular the on-going global financial crisis and the concomitant austerity drive that it unleashed, present a new set of challenges for understanding the links between global macro-structural developments and health equity that remain largely unaddressed in the literature. There have been multiple warnings that the financial crisis will negatively impact on health outcomes (e.g. Banoob 2009, Blakey and McLeod 2009, Labonté 2009, Marmot and Bell 2009, WHO 2009; Gill and Baker 2011, Kentikelenis *et al.* 2011), with a Lancet commentary calling the financial crisis an ‘acute threat’ to population health (Horton 2009). Some studies have started to analyze the ways in which the financial crisis is percolating down to the level of health policy making (e.g. Mladovsky *et al.* 2011, WHO 2011). But there has been little effort to explicitly assess the health equity implications of the global financial crisis and subsequent changes to health policy and governance, and little emphasis placed in the literature on the indirect health equity effects of financial crises. This article attempts to fill this research gap.

This article unfolds as follows: First, we review the existing literature on the impact of global forces, in general, and the financial crisis, in particular, on health equity, linking the financial crisis conceptually back to the macro-structural process of neoliberal globalization. We next develop a generic framework of the linkages between the current financial crisis and health equity, distinguishing between direct and indirect channels of influence (Figure 1). We then discuss the most pertinent direct channels of influence, with a focus on economic contraction with its associated decline in the tax base, health budget cutbacks, rise in unemployment, and qualitative transformations of health systems. We then outline how other indirect channels of influence are likely to affect health equity, including cutbacks to welfare programs, labor market transformations, the emergence of an ideological climate conducive to austerity politics, and reductions in official development

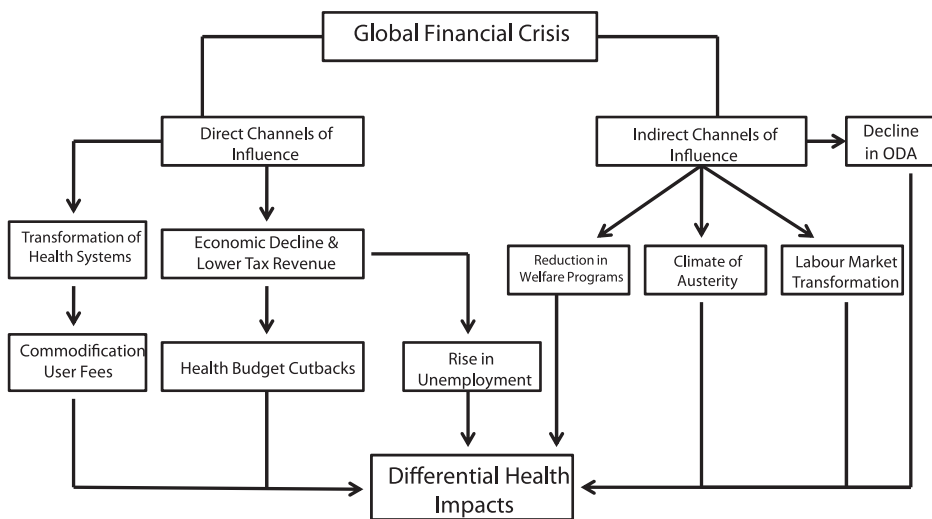


Figure 1. Health equity-relevant pathways of global financial crisis.

assistance (ODA). This article selectively draws on some of the early experiences with and effects of the financial crisis on SDH in a range of different countries representing developed, transition, and developing economies. The article concludes by suggesting that a different path to that of deep austerity is required to insure that health equity goals will not be undermined further in the policy response to the global financial crisis.

### **Globalization, the global financial crisis, and health equity**

Financial crises have been a central characteristic of neoliberal globalization since the beginning of the deregulation of finance in the early 1980s, with more than 20 financial crises occurring annually since 1986 (Mohindra *et al.* 2011). Most of these financial crises have been contained domestically, with the exception of the Asian financial crisis (in the late 1990s) and the global financial crisis (2007/2008 and ongoing). All have strongly affected health and wider social living conditions in the countries in which they transpired. The wider health equity impacts of the current global financial crisis must be situated within the context of the globalization of production and finance that has been a key feature of the world economy over the past three decades. The liberalization of financial markets has been identified as one of the key pillars of neoliberal globalization, with strong implications for health equity and SDH (Labonté and Schrecker 2007b). Financial liberalization refers to the global integration of financial markets and predominantly consists of the deregulation of the foreign sector capital account, the domestic financial sector, and the stock market (Arestis 2004). A central element of financial liberalization since the early 2000s has been the self-regulation of banking entities, with risk assessments performed internally through models developed and controlled by banks themselves. The loosening of financial capital from the regulatory constraints of the nation state has ushered in a new era of market discipline with concomitant loss of policy space in the health domain (Bakker and Gill 2006).<sup>1</sup> Loss of policy space is related to the ways in which investor decisions can influence the policy making process. Under globally integrated financial markets, governments require the confidence of large international institutional investors to fund their operations through sovereign debt markets (borrowing). In the realm of health, this implies that even governments committed to improving access to better and more equitable health care are reluctant to risk the effects of displeasing financial markets. Governments may also be reluctant to implement policies that might be viewed negatively by sources of foreign direct investment or foreign sovereign bond investors (Labonte *et al.* 2009, p. 118). This tendency has been intensified with the onset of the global financial crisis, as rating agencies have become private actors whose embrace or rejection of government policies can have far-reaching consequences. Any downgrading of a country's public (government) bond issues can dramatically increase the cost of borrowing in international markets. The higher interest rates governments pay on their bonds decrease revenues available for public service spending and potentially increase debt, risking a cycle of further bond-rating downgrades and higher borrowing costs.

Despite the conceptual challenge of connecting the macro-structural phenomena of globalization to individual health outcomes, a body of scholarship has developed that assesses the health equity implications of globalization. A comprehensive

conceptual framework linking globalization to health equity was presented by Labonté and Schrecker (2007a, b, c) in their work funded through the WHO Globalization Knowledge Network of the CSDH. They propose seven clusters of pathways that link various aspects of globalization with SDH and health equity: trade liberalization, reorganization of labor markets, debt crises, financial liberalization, restructuring of cities, environmental impacts of globalization, and marketization of health systems (Labonté and Schrecker 2007b). Building on this framework, the financial crisis could be considered a novel health equity-relevant pathway, which is linked to previous financial liberalization efforts, and which directly impacts the SDH and health equity through the channels specified below.

### **The global financial crisis and health equity: direct channels of influence**

#### ***Economic decline and health budget cuts***

The most direct link between financial crises and health equity is the steep decline in overall economic activity that financial crises induce. The opportunity costs of financial crises, understood in terms of lost or forgone output, are much higher than those for normal economic recessions (Gill and Bakker 2011), as financial crises produce more significant declines in overall economic activity than 'normal' recessions (Reinhart and Rogoff 2009). This puts constraints on the government's ability to maintain social spending, notably but not exclusively in public health. The International Monetary Fund (IMF) recently estimated that after a financially induced recession, output is about 10% below its previous trend in the medium term, which it defines as seven years (Gill and Bakker 2011). This implies a deeper and longer economic contraction with more pronounced challenges to government budgeting. Such a steep decline in economic activity leads to a decline in the tax base and associated cuts in government spending, as the crisis response thus far has focused on spending cuts and tax increases, mostly by way of socially regressive taxes (such as value added and sales taxes), which have the potential to significantly undermine SDH. However, if revenues from such taxes are used to finance universally accessible health and social programs, they can function in a redistributive way; but not in the absence of progressivity in other tax measures. At the same time, previous experiences with the impact of financial crises on health suggest that health equity impacts can materialize more rapidly than during a mild recession (Marmot and Bell 2009).

A WHO commissioned study on the health policy response to the financial crisis provides a preliminary picture of how the crisis has affected health care spending in a wide range of European countries (Mladovsky *et al.* 2011). Although the response has varied across health systems in Europe, some of the findings are disturbing and suggest that health equity impacts of the financial crisis will not only be felt widely but will also likely persist over time in many countries. Several countries reported that steep health budget cuts, in some cases by over 20%, including in Bulgaria, Romania, the Czech Republic, Estonia, Ireland, Latvia, Spain, and Portugal. The most dramatic case is clearly Greece, where the hospital budget has been cut by more than 40%, while demand (partly due to the health hardships induced by austerity measures) increased by approximately 25% (Kentikelenis *et al.* 2011), leading to a comeback of diseases such as HIV and malaria (Henlay 2012). It increasingly looks

like Greece will represent a blue-print for steep austerity measure to come in other parts of Europe, especially the Southern periphery.

Similarly, while most developing countries did not immediately contract health spending in response to the global financial crisis, by now, they have started to follow the path toward austerity. A comprehensive review of IMF agreements with low-income countries commissioned by UNICEF has fueled criticisms of excessive austerity in recent IMF programming with low-income countries, especially programs agreed upon since 2010 (Ortiz *et al.* 2011). Although the IMF initially showed some flexibility in its crisis response, and allowed marginally higher fiscal deficits than in past episodes of financial upheaval, by 2010 it has been back on its austerity path. The above-mentioned study found that most governments initially introduced small fiscal stimuli to buffer their populations from the impacts of the crisis during 2008–2009; but that expenditure contraction became widespread beginning in 2010 despite vulnerable populations' urgent and significant need of public assistance. The scope of austerity is becoming severe and widening quickly, with 70 developing countries (or 55% of the study's sample) reducing total expenditures by nearly 3% of GDP, on average, during 2010, and 91 developing countries (or more than 70% of the sample) expected to reduce annual expenditures in 2012. The biggest cuts are anticipated in North Africa, the Middle East, and sub-Saharan Africa. What is particularly disconcerting is that, comparing the 2010–2012 and 2005–2007 periods, nearly one-quarter of developing countries appear to be undergoing excessive contraction, defined in the study as cutting expenditures below pre-crisis levels in terms of GDP (Ortiz *et al.* 2011, p. v).

In a World Bank analysis of global social spending trends since the onset of the financial crisis, Lewis and Verhoeven (2010) confirm that in developing and transition economies, social spending levels have declined in aggregate terms, with both education and health spending impacted equally. This is not surprising as developing countries generally display a proclivity toward procyclical macro-economic management, especially in the area of public expenditures for health (Calvo 2010). This is largely an outcome of the misguided policy prescriptions and conditionalities enforced by international financial institutions. Lewis and Verhoeven (2010) note that the impacts of the financial crisis on social spending in developing and transition economies 'have generated concern about continuity of services when citizens need them most' (p. 84). However, there is a notable exception to this decline as social spending has actually increased in Latin America (Barcena 2012). Latin American economies have largely been able to avoid having to rely on IMF and World Bank lending in the aftermath of the global financial crisis, which partly explains the expansionary crisis response compared to financially dependent European and African countries.

### ***Rise in unemployment***

Another direct health equity pathway is the effect of the financial crisis on employment levels, which is itself an after-effect of the steep decline in economic output following the rapid (and still ongoing in many countries) contraction of credit. The relationship between employment and health outcomes is well-established. Employment and working conditions are the origin of many SDH, as work in its optimal form can provide financial security, social status, self-esteem,



personal development, and many other health promoting attributes (CSDH 2008, p. 72). Being unemployed is directly associated with various adverse health outcomes, as unemployment has been associated with increased self-harm, suicide, decreased mental health status, and psycho-social stress (Moser *et al.* 1986, Blakely *et al.* 2003). Developed and particularly European countries have seen the steepest increase in unemployment levels, with some countries reaching depression-like unemployment rates exceeding 20%, while most low- and middle-income economies were hit less hard. Nevertheless, the International Labor Organization (ILO 2011a) has recently noted that unemployment globally has reached unprecedented proportions, with more than 200 million workers entering the reserve army of unemployed workers, putting global unemployment at the highest level on record. In many countries, a rise in the level of unemployment also has direct repercussions on the government's ability to fund health care expenditure, especially when government revenue is generated through social insurance contributions. Finally, the nature of the relationship between job loss and health equity is straight-forward: the health of people who lose jobs and have poor employment prospects is affected disproportionately compared with other population groups in society (Marmot and Bell 2009, Suhrcke and Stuckler 2010). Previous experiences with economic recessions confirm that the negative distribution of employment impacts is concentrated amongst those who are already socioeconomically deprived, and who are part of ethnic, racial or other socially disadvantaged minority groups (Blakely and McLeod 2009, Phua 2011).

### ***Qualitative transformation of health systems***

The global financial crisis is also putting pressure on governments to qualitatively transform the delivery channels within health systems, arguably to enhance efficiency. Such transformations, however, can risk undermining health equity goals. Improved efficiency can help reduce the severity of budget cuts and thus allow governments to maintain critical health services (WHO 2011). For example, the introduction of health technology assessments in several countries and the renegotiation of drug prices through public tendering, especially for generic medicines, have led to cost savings in a wide range of countries around the world (Mladovsky *et al.* 2011). However, certain qualitative transformations of health systems represent formidable challenges for health equity. For example, several countries have instituted user charges for specific health services to address revenue shortfalls in response to the global financial crisis, including the Czech Republic, Denmark, Estonia, Finland, France, Greece, Ireland, Latvia, the Netherlands, Portugal, Romania, and Turkey (Mladovsky *et al.* 2011, p. 20). User charges are widely known to have negative health equity effects, as low income groups are disproportionately affected by them (Gemmill *et al.* 2008). At the same time, the introduction of user charges is likely to worsen overall health outcomes and can lead to increased health spending in other areas, such as emergency care. As the WHO (2011, p. 34) notes, the poor and less educated population groups are most likely to make decisions in response to the introduction of user fees that lead to delays in seeking care, which may eventually result in higher costs for the health system and worse health outcomes for the individual.

## Indirect channels of influence

### *Reductions in welfare spending and programs*

As is widely acknowledged, individual health, and especially health equity, is not solely affected by the prevailing levels of health spending. Two recent studies have found a direct link between welfare program expenditure and health outcomes (e.g. Stuckler *et al.* 2010, Bradley *et al.* 2011). Both studies show that lower levels of social expenditure in other areas than health are associated with deteriorating population health. Stuckler *et al.*'s (2010) statistical model demonstrates that each additional US\$100 in welfare spending is associated with a 1.19% drop in all cause mortality. They conclude 'that the maintenance of social welfare systems seems to be a key determinant of future population health' (p. 77). Similarly, Bradley *et al.* (2011) argue that higher levels of social spending are associated with improved overall population health, as the ratio of social expenditure to health expenditure may influence health outcomes beyond that which results from health spending alone. This implies that cutbacks to welfare programs, even if health spending is maintained at pre-crisis levels, are likely to undermine population health. Given the importance of social programs for the most vulnerable populations, cutbacks in social spending will directly undermine health equity goals.

A recent analysis of the impact of the global financial crisis on welfare spending globally documents the pressure that the financial crisis has been exerting over the welfare state (Busch 2010). In Europe, cuts in services, as well as tax and contribution increases, are speeding up the process of recommodification and state retrenchment which has been under way for years. This process is more extreme in countries with high levels of public debt, such as Greece, Ireland, and Portugal. Nevertheless, even countries in a solid fiscal position, such as Germany and Canada, have started to further downsize the welfare state, generally by freezing social assistance rates. In the realm of pension policy, this rolling back of the welfare state finds expression in the introduction of the three-pillar model, through the transition from defined-benefit schemes to defined-contribution schemes, cutbacks in pension payments, and increases to the retirement age (Busch 2010, p. 7). As Busch (2010) concludes, 'reforms of the welfare state in the EU exhibit considerable convergence in the East and the West. Given the common objective and the common socio-political ideal-model (i.e., neoliberalism), this is not surprising' (p. 8). A similar tendency is noted in the revamping of unemployment insurance schemes. In both West and East Europe, entitlement conditions have been tightened up, entitlement periods cut and wage replacement ratios reduced. While most developing countries do not generally have comprehensive welfare states in place, targeted transfer schemes have come under pressure as well in the aftermath of the global financial crisis (Busch 2010, p. 9, Ortitz *et al.* 2011). Given the precarious situation of people relying on such transfers, any cutback will have direct health consequences for the most vulnerable populations in developing countries, further undermining the equitable delivery of health care.

### *Changes to aid flows*

Another major concern related to the long-term health consequences of the global financial crisis is the impact that the crisis will have ODA flows to low-income countries. The fact that international assistance in health already accounts for



roughly 50% of all public health expenditure in low-income countries reveals how crucial the role of international assistance has become (Taskforce on Innovative International Financing 2008). In the case of Rwanda, donor funding represent almost 100% of the total public health budget (Calvo 2010). In the period 2008–2010, overall donor funding in the form of ODA has not been cut. Organization for Economic Cooperation and Development (2011) notes that ODA flows have continued to rise in line with promises made by the international community, with aid flows from Development Assistance Committee donor countries totaling USD 129 billion in 2010, an increase of 6.3% over 2009. However, given a string of recent announcements in a wide range of countries to cut back on ODA, this trend is likely to be reversed. Previous experiences with financial crises also suggest that in countries struggling with budget deficits ODA will likely plateau and then decline as countries start addressing large fiscal deficits (World Bank 2009). For example, Canada just announced a 10% cut to its international assistance envelope in order to rein in its budget deficit.

At the same time, a preliminary estimate of health aid flows by Leach-Kemon *et al.* (2012) notes that while development assistance for health continued to grow in the aftermath of the financial crisis, growth has slowed down significantly to around 4% from 2009 to 2011 (p. 228), compared to double digit growth rates before the financial crisis, with a growth rate of 17% between 2007 and 2008. Disconcertingly, this limited growth in international assistance for health was largely driven by the World Bank's increased disbursements to middle income countries, while World Bank health funding to low-income countries through the International Development Association actually decreased since the onset of the global financial crisis (Leach-Kemon *et al.* 2012, p. 231). From a health equity perspective, this reallocation of health funding away from low income to middle countries raises significant concerns.

In addition, some multilateral disbursements have already been negatively affected by the global financial crisis, with a high-profile victim: the Global Fund to Fight AIDS, Tuberculosis, and Malaria. International donors have started to drastically reduce contributions to the Fund, despite a recent infusion of \$750 million by Bill Gates. As a result, in November 2011, the Global Fund announced that it would make no new grants until 2014, in large part because of depressed donations attributed to the global financial crisis. More than 70% of life-saving AIDS medicine in the developing world, and about 85% of TB programs in Africa, are financed by the Global Fund (York 2011). Consequently, the cancelation of the next round of grants will negatively impact on tens of thousands of impoverished people living with HIV who depend on foreign financing for their medicine. Finally, development assistance for health from UN agencies has become stagnant. Stagnation in UN funding may pose a challenge to several health focus areas in which these channels play an important role, including the areas of maternal and child health (the United Nations provided 37% of total development assistance for health for this area in 2009), noncommunicable diseases (25%), and tuberculosis (16%; Leach-Kemon *et al.* 2012, p. 232).

### ***Labor market transformation***

Another indirect pathway by which the global financial crisis has already affected health equity is through a qualitative transformation of the labor market.

Current policy responses to the global financial crisis emphasize the importance of 'modernizing' labor markets, especially in developed economies struggling with large budget deficits. In most cases, this means a dismantling of the protective measures that have insulated workers from the vagaries of unregulated labor markets. These qualitative transformations of the labor market are not entirely novel as even before the financial crisis neoliberal reforms noticeably transformed working conditions, with deep implications for SDH (Labonté and Schrecker 2007b). Increased 'flexibility' in the labor market has been a corner stone of neoliberal globalization which has lastingly transformed the global landscape for workers (Vosko 2006). In this context, flexibility can best be defined as 'reducing the constraints on the movement of workers into and out of jobs previously constrained by labour laws, union agreements, training systems, or labour markets that protect workers income and job security' (Hadden *et al.* 2007, p. 6). This flexibilization resulted in an increase in various contractual forms, such as temporary, part-time, and self-employed work.

Previously, standard arrangements generally provided social benefits, security, modest income, and various other entitlements. However, the standard employment relationship is shifting, so that employers are reducing their 'commitments' and entitlements offered to their workers. The responsibility and costs for benefits such as training, extended health care, and pensions are being shifted away from employees to workers, creating new burdens for them and their families, and undermining SDH in the process. Such changes are under way in a wide range of European countries, most prominently Greece, Spain, Italy, and Portugal. Various studies show that economic recessions, especially when they are steep, tend to exacerbate the deviation from the standard employment relationship (Vosko 2006, Perry *et al.* 2007). Workers in precarious arrangements often share similar characteristics with the unemployed, with some evidence suggesting that chronic job insecurity may be more damaging to health than actual job loss. In fact, dimensions which are typically, but not exclusively, related to precarious work arrangements, such as job insecurity, have long been linked to adverse health outcomes such as psychosocial morbidity (Ferrie *et al.* 2002, Virtanen *et al.* 2005). Studies suggest that workers that are involuntarily involved in temporary work contracts are at an increased risk for mortality (Natti *et al.* 2009), and that unsecure employment relationships (where future employment is unknown) are associated with overall poorer health indicators.

## Conclusion

It has been widely acknowledged that the global financial crisis of 2008 will have lasting effects on the health of populations (Horton 2009, Labonté 2009, Marmot and Bell 2009). These health effects, however, will not be felt equally or even similarly by different population segments, as different socio-economic positions in the societal hierarchy will lead to different health outcomes (Blakey and McLeod 2009, Phua 2011). This article attempted to conceptually sharpen our understanding of the transmission channels by which the (ongoing) global financial crisis will undermine SDH and challenge health equity goals. We proposed a number of direct and indirect channels of influence by which the global financial crisis has already begun impacting health equity outcomes. Yet, it likely will take some time until the full impact of the crisis on health equity can be comprehensively assessed, especially

in relation to the indirect channels of influence. In this context, it is important to highlight that the most challenging years are still ahead. In many countries, the initial response to the financial crisis was counter-cyclical and expansionary, as few countries engaged in cutbacks to health budgets and welfare programs in the immediate aftermath of the crisis. However, the current ideological climate of austerity will make it more likely that further cuts to health and other social expenditure will be enacted. This can already be seen in a wide range of European countries that have started to make draconian cuts to health and welfare budgets (Houston *et al.* 2011, Mladovsky *et al.* 2011). But even fiscally sound countries, such as Canada, have recently started to wield the axe to cut government programs in order to close budget deficits. If access to health and other social services continues to decrease, this will more strongly affect those that rely on such services for maintaining their basic health, i.e., groups within society living in vulnerable conditions.

However, there are alternatives to the currently hegemonic neoliberal austerity agenda as cracks in its consensus are already appearing. As can be observed in Greece, deep cutbacks in government spending can actually be self-defeating as budget deficits are likely to remain large due to the economic decline and associated revenue contraction that are the logical outcomes of austerity measures. In contradistinction to the austerity agenda, the global financial crisis could be seen as an opportunity to reinforce commitments to equity, solidarity, and protection (WHO 2011); this would require a significant redistribution of power and wealth, for example, through more progressive systems of taxation that would ensure that those at the top of the income spectrum, currently benefiting from generous bail-outs of the banking system, at least contribute a fair share to burden-sharing within society. Alternate agendas (e.g. enhanced social protection, expanded universal social protection, new systems of global taxation) are all part of global discourse at the moment (e.g. ILO 2011b), if not yet with the national political or financial institution traction needed to move from page to policy. Assuming they do, even if only because states will need to accommodate such demands to alleviate increased domestic strife, there may still need to be some budgetary cuts in the near- to mid-term. If budget cuts in certain areas turn out to be unavoidable, health equity impact assessments should be given a priority to determine how cuts can be implemented in such a manner that health equity will not be undermined further in the policy response to the global financial crisis.

### **Acknowledgments**

Arne Ruckert was supported in this study through the Emerging Researcher Award by the Population Health Improvement Research Network (PHIRN), funded through the Ministry of Health and Long-Term Care, Province of Ontario. Ronald Labonté is supported through the Canada Research Chair Program of the Government of Canada.

### **Note**

1. Policy space can be defined as the freedom, scope, and mechanisms governments have to choose, design, and implement public policies to fulfill their aims (Koivusalo *et al.* 2008).

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