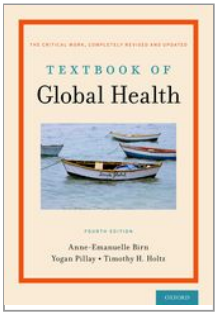

Textbook of Global Health
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Political Economy of Health and Development

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Abstract and Keywords

This chapter introduces a critical political economy of health approach (and its social medicine underpinnings), which is used as the textbook's guiding framework, contrasting it to dominant biomedical and behavioral understandings of health and disease. The chapter provides a historical analysis of regional and global increases in life expectancy together with case studies that demonstrate the limitations of bio-behavioral and economic growth explanations. The chapter then discusses health and development in the foreign policy and aid milieu, highlighting donor-recipient tensions and contradictions around development aid for health. It also discusses contemporary development strategies, discourses, and approaches that are closely intertwined with current global health practices, including capabilities and human rights approaches and the Sustainable Development Goals, introduced in 2015. It argues that the potential of global governance for health to improve the effectiveness and fairness of the global health and development architecture has been marred by corporate penetration.

Keywords: political economy, biomedical approach, behavioral approaches, mortality trends, social medicine, foreign policy, debt-aid paradox, development strategies, sustainable development, global governance for health

Suppose you are a middle-aged minibus driver working for a medium-sized company in a highly populated city. Transport, like most industries in your country, is largely unregulated. Vehicle emissions contribute to dangerously high

pollution levels throughout the year, and road collisions take an enormous toll on the lives of young adults. The pay is low and in order to earn enough to provide for your family, you work upwards of 12 hours per day, 6 days a week, in fierce competition with other minibus drivers. Throughout the day you barely get to rest or even take a toilet break. You buy food from street vendors, eating meals as you drive.

Despite your long work hours, you are chronically behind on bills and can only afford an apartment in a dilapidated building that you know is structurally unsound, and lacks potable water and reliable electricity. Your wages must also cover school fees for your children, as the government only partly subsidizes education. There is no labor union for transit workers, your employer offers no benefits, and the government offers meager social welfare provisions—a worthless pension and inadequate health insurance, requiring high out-of-pocket payments. Although business is booming throughout your country, with new buildings and companies appearing almost every month, you have not enjoyed the benefits of this economic growth.

One morning, while driving your bus, you experience a brief but frightening episode of shortness of breath and tightness in your chest. You try to ignore it but feel weak after finishing your route and decide to see a doctor on your way home. After conducting an ECG and other tests, the doctor diagnoses you with high blood pressure, symptoms of angina, and possible early coronary heart disease. She recommends blood tests to assess cholesterol levels, as these may be elevated given your sedentary and stressful occupation and excess weight. After advising you to make dietary and physical activity changes, and prescribing an expensive medication that might lower your risk of a heart attack, the doctor charges you the equivalent of a day's wages for the consultation.

How can we understand and address your (the driver's) health problems?

Political Economy of Health (and Development)

Key Questions:

- What are the underlying causes of health and illness?
- Do, or how do, the main models of understanding health and disease incorporate these factors?
- How have political economy approaches developed over time?
- What do these approaches tell us about how good or ill health and particular patterns of disease and death are produced and how they might be addressed?

This chapter begins with three sets of explanations for health and disease patterns, comparing and contrasting the dominant biomedical and **(p.90)** behavioral/lifestyle approaches with a political economy understanding, which is

used as a framework for this textbook. We explore various historical dimensions of a critical political economy of health framing and apply it to case examples of tuberculosis in South Africa and the post-Soviet mortality crisis to illustrate how political economy differs from prevailing approaches to understanding health. In the second part of the chapter we focus on political economy of development as related to global health, covering mainstream development discourses and strategies—foreign policy, aid, and financing arrangements—and highlighting several current development approaches, including human capabilities and rights, and the Millennium and Sustainable Development Goals. We conclude with an analysis of global governance issues, discussing the constraints to global health governance under the contemporary political economy order.

Approaches to Understanding Health and Disease

Determining and addressing the factors that produce (or lead to) health and disease are central concerns of the global health arena, its institutions, ideologies, and practices. However, there is no universally accepted approach to understanding health and illness. Here we examine two dominant models (biomedical and behavioral/lifestyle) that are mostly taken for granted by global health actors and one alternative (a critical political economy approach). We present them separately, though in practice there is overlap among them. To be sure, these models are not exhaustive. For example, they do not encompass various Indigenous paradigms, such as Andean *Buen Vivir*, stressing the role of ecological harmony—the balance of community needs and preservation of the natural environment—in shaping health and the quality of life (see chapter 13).

Biomedical Approach

According to a biomedical approach, health and illness are viewed at an individual level and in predominantly biological terms, with the body conceptualized as a machine with constituent processes and parts (i.e., genes, organ systems, and so on) that can be manipulated or repaired through technical interventions (Clarke et al. 2003). Health is understood primarily in terms of the absence of disease, rather than as an integrated (social, psychological, cultural) sense of well-being. This reductionist understanding decontextualizes health, illness, and healing from the social and political environment and from subjective human experience (Fee and Krieger 1993).

While the biomedical approach is largely curative, it also rests on a preventive armamentarium (e.g., vaccines, diagnostic screening, and genetic testing) and incorporates the role of behavioral determinants of health insofar as they affect so-called “risk factors”—personal characteristics related to heredity, biology, and “lifestyle” that are believed to predispose individuals to disease (Krieger 1994; Pearce 1996; Susser 1998). Much of the appeal of a biomedical approach stems from the dramatic technological advances in medical treatment over the last century or two, as in surgery (anesthesia and asepsis) and pharmacotherapy (Bell and Figert 2015), but it is also closely connected to the commodification of

health (i.e. treating health as a good or service that can be bought and sold), and, as we will discuss, biomedicine has become a massive business enterprise in itself.

The search for and application of so-called “magic bullets”—quick-fix tools including medical technologies, drugs, and devices—most vividly characterizes this model. For example, the biomedical model has helped spur technical approaches to addressing child malnutrition, such as “Ready-to-Use Therapeutic Foods” (RUTF)—energy-dense and enriched food products to treat severe acute malnutrition. RUTF and similar techno-fixes (e.g., food fortification and nutritional supplements to treat micronutrient deficiencies) are often linked to vested commercial interests, and they are typically implemented without addressing the root economic and social causes of chronic malnutrition (see chapter 7).

Although RUTF was developed as a short-term emergency response to severe malnutrition in crisis or conflict situations, UNICEF has promoted its use on a wider scale, even where not requested. In 2009, the Indian government asked UNICEF to take back a batch of RUTF, judging it an inappropriate form of assistance and of dealing with child malnutrition (PHM et al. 2011). Indeed, RUTF, especially when **(p.91)** used beyond emergency scenarios, treats malnutrition as a bio-technical problem, divorced from malnutrition’s underlying causes. In rural India these include farm and employment losses due to land-grabbing, costly farm inputs and prohibitive credits, inadequate government support for rural infrastructure, and high rates of poverty, among other factors (Desai et al. 2016).

In sum, though it is tempting (and convenient) to attribute health improvements largely or exclusively to narrow interventions, as examined ahead, without concomitant societal changes most biomedical developments have played a limited role in increasing life expectancy historically and to the present.

Per a biomedical approach, as the bus driver in the earlier example you need to take blood pressure and cholesterol-lowering prescription drugs, antiplatelet therapy, and continue to be monitored by a physician. You should also heed medical advice on lifestyle modification (see next model) for secondary prevention of coronary heart disease.

Behavioral/Lifestyle Approach

A behavioral/lifestyle approach views health and illness primarily as a consequence of individual or household comportment and beliefs (Kahan et al. 2014). This approach focuses on the regulation or modification of personal conduct and attitudes through education, counseling, and incentives aimed at achieving desirable health outcomes. Although the social environment and policy measures can be considered mediating factors, for the most part behavioral

approaches deem the individual (and sometimes the household or community) to be responsible for health and typically ascribe poor health to poor decisions or lack of volition.

Behavioral approaches to health are often nested within medicalization, which has the effect of "pathologising normal behaviour, disempowering individuals when subject to control by medical professionals or models of care, decontextualising experience, and depoliticising social problems" (Clark 2014, p. 2). (Biomedicalization is discussed in chapter 11.)

Of course, healers have long proffered advice to the infirm on routines of sleep, work, and diet, commonly filtered through spiritual or supernatural beliefs. The moralizing dimensions of such approaches—with rewards for healthy living or punishment for the (inevitable) outcome of poor "lifestyle" choices and personal deficiencies—continue to the present.

In recent decades behavior has taken on renewed scientific pretense as a primary determinant of health. Its modern rebirth was most vividly articulated by Marc Lalonde, then Canada's Minister of National Health and Welfare, who issued a report arguing that the country's recently universalized health care system was "only one of many ways of maintaining and improving health" (Lalonde 1974, p. 5). Even more important, he proposed:

> [O]minous counter-forces have been at work to undo progress in raising the health status … They include environmental pollution, city living, habits of indolence, the abuse of alcohol, tobacco and drugs, and eating patterns which put the pleasing of the senses above the needs of the human body (ibid).

This official articulation of the "lifestyle model" brought legitimacy to the notion that health is a personal responsibility and that individuals (can) choose to be either healthy or unhealthy (Knowles 1977). The report helped ignite the health promotion movement (see chapter 13), which, though framed broadly in terms of societal influences on health, has been interpreted in an increasingly narrow behavioral fashion (Baum and Fisher 2014).

The key argument underpinning this model—applied in countless superficial studies and problematic public health policies—is that "human behavior is the single most important determinant of variations in health outcomes" (Satcher and Higginbotham 2008, p. 401). Accordingly, changing harmful behaviors is portrayed as essential to improving health, leading to victim blaming, that is, culpabilizing individuals for their unhealthy behavior (Crawford 1977). Despite abundant and consistent evidence that decisions are shaped by far more than individual will and that behavior alone cannot explain patterns of health and health inequities, the narrow behavioral model persists (Skalická, Ringdal, and

Witvliet 2015), leaving the structural determinants that undergird health comportment virtually untouched (Baum and Fisher 2014).

(p.92) Lifestyle approaches have particular resonance in mainstream policies and initiatives that place the onus on individuals to eat and exercise right, wear seatbelts, avoid alcohol, tobacco, or drug use, practice safe sex, and so on, without addressing the context and constraints in which behaviors unfold, or the many other (often more) important determinants of health (Carey et al. 2016). Moreover, behaviorally oriented programs deflect attention away from governmental responsibility for ensuring that public policies (including regulation of the private sector) enhance health and health equity. Such deflections are not innocent but politically-framed decisions and approaches.

According to a behavioral/lifestyle approach to health, you must make better choices regarding the food you eat, avoid stressful situations, take more breaks on the job, work fewer hours, and engage in exercise in order to improve your health status.

Political Economy Approach

A political economy approach to understanding health and disease integrates the political, social, cultural, historical, and economic contexts in which ill health arises. This text uses political economy of health as shorthand for *critical political economy of health*: the idea that health and disease are produced via societal structures (i.e., political and economic practices, policies, and institutions [systems of production, social protection, and governance], and class/gender/race interrelations). These structures and relations, in turn, interact with the particular conditions that lead to good or poor health.

A growing body of scientific knowledge shows that social interactions affect (human) biology in heretofore little recognized ways (Lewontin 2000), making context and life experiences central to producing good or ill health at individual and collective levels. The societal order sustaining the distribution of power and resources within and across societies (and the material conditions thereby experienced) is reflected in a range of linked factors that operate at multiple levels and junctures—individual, household, community, social relations, workplace, nation, and global political and economic conditions—to shape health. (Attempts to understand the environmental or ecological pathways through which such determinants operate are also termed *political ecology of health* approaches, explored further in chapter 10.)

Political economy of health perspectives consider the role of, for example, public policies around transportation and housing conditions, medical care and public health, environmental contamination and resource depletion, as well as social justice strategies (gender and racial equity, unionization), and social-class-mediated political involvement aimed at bettering redistribution and overall

societal welfare across all social groups (see Box 3-1 for political economy definitions). These efforts include, but go far beyond, biomedical interventions and behavior/lifestyle change.

According to a political economy approach, your health reflects/derives from social, political, and economic structures and relations that constrain your control over stressful situations and the work environment, and limit your access to health care, recreation, decent housing, education, and good nutrition (Hervik and Thurston 2016). As such, notwithstanding awareness of the importance of making better choices around diet, exercise, and stress and heeding your doctor's advice, your actions and personal agency are limited by the power dynamics produced by the conditions described above. That said, mobilizing collectively for better living and working conditions together with other bus drivers, workers, and social movements—depending on conditions of oppression in your setting/country and political and economic pressures globally—may lead to partial or wholesale transformation of the circumstances that negatively affect your health.

Box 3-1 Key Political Economy Definitions

• *Capitalism* is an economic system in which: the means of production are predominantly privately owned; production is operated on a for-profit basis; and the "free market" (representing the sum of rational individual decisions) governs levels and patterns of wages, production, distribution, investment, and prices and availability of goods and services. For more on capitalism's emergence and phases, see chapters 1 and 9.

• *Social classes* are broad social groupings indicating societal stratification and hierarchies. Social class may be understood in terms of: one or more measures of socioeconomic status (education, occupation, income); a combination of wealth, power, and prestige (Max Weber's classification); relation to the means of production (as per Karl Marx)—either the class of owners (exploiters) or workers (the exploited) or in an intermediate (contradictory) position as both worker and owner (e.g., administrator, manager, overseer); or caste (social position and occupation determined through heredity and/or racial/ethnic heritage).

• *Redistribution policies* aim to even out the spread of wealth (income, property, assets) across a society. Redistribution can be realized through a mix of progressive taxation (higher taxes on the rich), minimum wages and maximum compensation levels, and targeted or universal social programs in a capitalist system or, in a socialist system, through collective ownership and equitable distribution of societal assets. Redistribution is just one element of battling oppression (see chapter 14).

While ideologically distinct, in practice the three models at times intersect. In a more conducive environment, bus drivers might be able to exercise greater control over some of the factors affecting health. This could take the form of establishing/joining a union and bargaining for higher wages and better working conditions, or participating in a political process that results in an improved welfare state. Stress levels would be lessened if housing quality were regulated and education provided free of charge, potentially enabling shorter work hours and improved health habits. Under a tax-payer-funded national health care system, medical practitioners could be consulted free of charge before the onset of severe symptoms; in less pressured work circumstances and a more favorable **(p.93)** physical environment, it would be easier to change behavior to exercise and eat more nutritious meals.

A political economy of health model is often associated with a critique of capitalism, yet it is not enough to assert that capitalism causes ill health or to demonstrate without elaboration that poverty is correlated with high rates of disease and premature death. As Lesley Doyal (1979) argues cogently, every form of societal organization has corresponding patterns of death and disease, and careful delineation of how the societal political and economic structure affects these patterns is needed in order to comprehend and tackle them.

Certainly communist bloc countries, which all but eradicated poverty, unemployment, and homelessness by the mid-20th century, nonetheless had high rates of heart disease, cancer, lung diseases, and other causes of premature death, albeit having experienced notable health and health equity improvements after World War II. This may be explained by the industrial model pursued by the Soviet bloc to compete against the capitalist bloc that led to enormous pollution and continued workplace stress, which, combined with varying levels of political repression, deeply influenced the prevalence of chronic diseases.

Another illustration of why the capitalism-induced-poverty-causes-disease formulation is insufficient arises from the conundrum of why HIV infection rates are higher among many urban, better-off sub-Saharan African populations than their rural counterparts. Part of the answer, as discussed in chapter 6, is differential exposure to HIV, even as urban, wealthier populations benefit more from prevention and have greater access to treatment (Doyal 2013). And of course, neither of these examples touches upon the complex array of other social factors, including race-ethnicity/racism and sex-gender/patriarchy, that shape health and disease processes. Without identifying and tracing the patterns and mechanisms (and causal pathways), truisms about the links among capitalism, poverty, and health offer little by way of understanding and addressing them, both in the short term, through specific policies, and in the longer transformative processes needed to create healthier, more equitable societies. We begin this endeavor ahead, and then build upon it in chapter 7, where we

explore two additional lenses on health and disease patterns and health inequity: psychosocial and ecosocial models.

A further caveat: by no means does employing a critical political economy framing discount the role and place of public health and medical care in global, national, and local policies and efforts. To the contrary, they remain salient: integrated into a political economy approach, biomedical and behavior change measures can improve well-being and provide much-needed care **(p.94)** and relief from suffering. However in isolation, even if efficacious in driving down certain disease rates, they do not in and of themselves produce health.

Case Study: Working Conditions, Poverty, and Tuberculosis in South African Mines and Beyond

The rate of pulmonary tuberculosis (TB)—a chronic lung ailment—is one of the most sensitive indicators of social and political conditions in a society. The relationship among working and living conditions, poverty, and TB in Black miners in South Africa in the 20th century was comparable to the situation of 19th-century British factory workers and coal miners (Packard 1989). In both countries and eras, TB epidemics surged in conjunction with industrialization. Migration to urban industrial centers in Britain and mining towns in South Africa brought many workers in contact with TB for the first time. In both settings, once workers and their families were exposed to TB, their immunological systems were ill-equipped to resist the disease due to crowded and unhygienic living conditions, deficient nutrition, long hours of exhausting and unsafe labor, inadequate wages to redress these circumstances, and for the miners, poorly ventilated mines filled with toxic mineral dust. The powerful economic and political interests of the state and industry in maximizing production relied on exploitation of the working class, in South Africa especially Black Africans: vested interests were opposed to social and labor reforms to improve social conditions.

> "… 200,000 subterranean heroes who, by day and by night, for a mere pittance, lay down their lives to the familiar "fall of rock" and who, at deep levels ranging from 1,000 to 3,000 feet in the bowels of the earth, sacrifice their lungs to the rock dust which develops miner's phthisis [tuberculosis] and pneumonia.
>
> "—Solomon Tshekisho Plaatje, Journalist, Political Activist, and Linguist, 1916

In Europe, struggles to improve housing, working conditions, and nutrition (often met with violent repression) in conjunction with public health efforts to isolate the sick in sanatoria, had gradually enabled declines in TB rates starting

in the late 19th century. But in mid-20th century South Africa under the brutal, racist apartheid regime, the African working class was unable to gain comparable broad-based improvements in labor or social conditions. To the contrary, white workers colluded with the political regime in order to preserve white settler privilege against an organized multiracial labor force.

As a result, while white South African miners experienced modest improvements in conditions, Black workers continued to live in abject poverty. To explain the high mortality rates of TB among the Black working class, white administrators and medical officers relied on biomedical and behavioral frames, attributing TB increases to poor hygiene, supposed racial susceptibility, and an inadequate diet. This sidestepped the underlying conditions that fueled the disease. Administration of effective antituberculosis drugs in the 1950s eventually led to a sharp drop in TB deaths among Black South Africans, but as new laborers continued to migrate to mining and industrial areas with poor working and living conditions, the incidence of TB cases remained extremely high (Packard 1989).

By the 1990s, after South Africa's apartheid regime was dismantled, the mining sector remained an important source of jobs for over half a million migrant workers. Under continued substandard social and working conditions, hundreds of thousands of miners have become sick not only with TB but also with HIV, partially via sex workers unknowingly exposed to and spreading the disease. Both TB and HIV rates have soared in mining areas over the past two decades, with the more than 40,000 cases of active TB in miners each year exacerbated by the HIV epidemic. Meanwhile, understaffed and poorly coordinated health services have dispensed TB drugs in an unregulated fashion (and until recently without HIV drugs), leading to the emergence of extensively drug-resistant TB strains (see chapter 6).

When miners have returned to their homes, their families, too, have become infected with TB and HIV, multiplying the crisis across the country and elsewhere in Southern Africa, given the large proportion of migrant workers (e.g., from Lesotho, Mozambique, and Swaziland) who have long been employed in the mines (Corno and de Walque 2012).

All told, the intractable legacy of apartheid-era labor practices and working conditions remains **(p.95)** difficult to resolve; even after legalized racial apartheid ended, a form of economic apartheid that goes beyond South Africa's borders persists.

Over the past few decades, a similar phenomenon has taken place in societies as diverse as Peru and the United States, where increased homelessness, malnutrition, marginalization, and problems of health care access have caused TB, once close to elimination, to reemerge as the leading global infectious disease killer, surpassing HIV (WHO 2015a). Inadequate health care is certainly part of the story, but TB's resurgence cannot be understood without considering larger structural issues, from poor housing and nutrition to unemployment and undemocratic governance, all framed by poverty and growing inequality (Neely 2015).

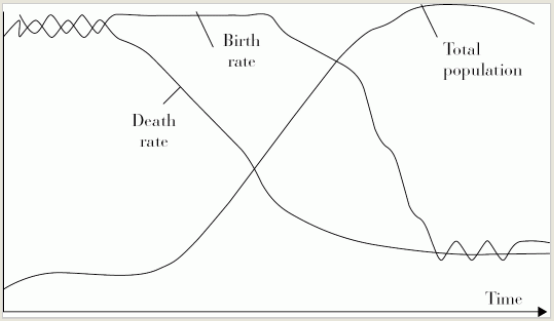

Figure 3-1: Demographic transition.

Source: Based on Notestein (1945).

In sum, an ailment that by the late 19th century was largely preventable through improved housing, nutrition, and other infrastructural factors, and curable by the mid-20th century through antibiotics, has returned as a significant problem while its political economy dimensions have been largely disregarded.

Tying the Past to the Present

Transition Intransigencies

A background motif of global health is identifying historical patterns of mortality, fertility, and disease and gleaning what factors have driven these changes. This enables determination of past paths of progress, informs decisions on current actions and activities, and even helps predict future patterns. The "demographic transition" concept is credited to Princeton University professor F.W. Notestein (though parallel ideas were articulated by others). As illustrated in Figure 3-1, the concept outlines changes in birth and death rates that historically accompanied the shift from "traditional" to "modern" society based on the experience of Western European countries. In Notestein's classic description, a stage of high birth and death rates and little or no population growth gives way to a transitional stage of falling mortality, foremost infant mortality, during industrialization (as food supplies and living conditions improve), sustained high birth rates, and population growth. This is followed, after a lag, by a reduction in fertility, and then to a new stationary stage in which birth and death rates and population growth are relatively low. Such transitions can dramatically alter a population's age structure, featuring proportionately fewer children, more older people, and a substantial increase in median age and life expectancy.