

Politics and Political Economy of Health

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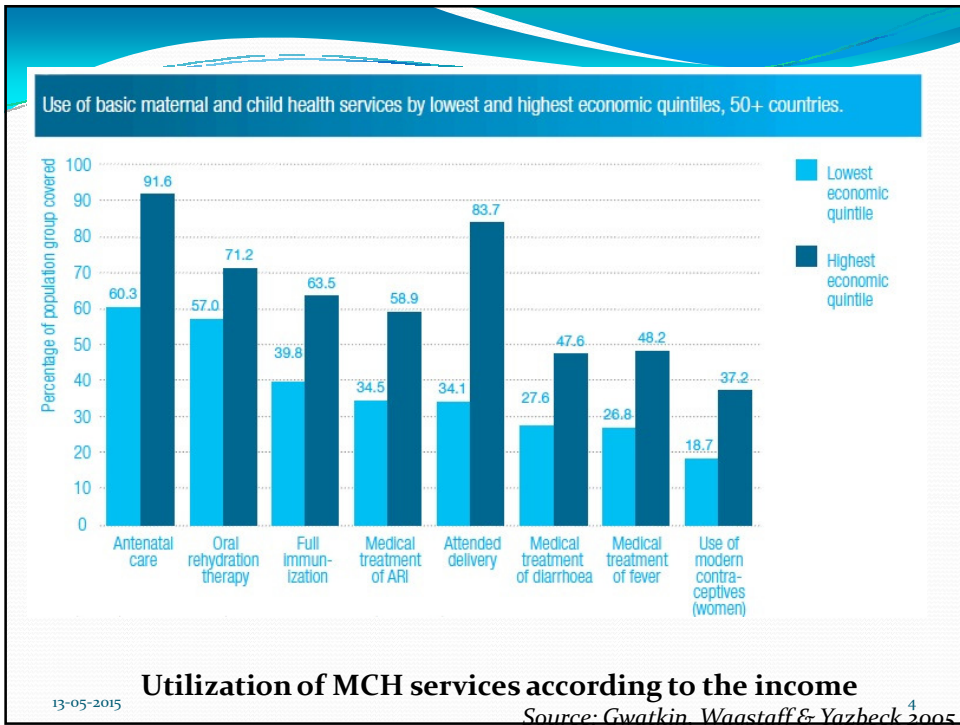
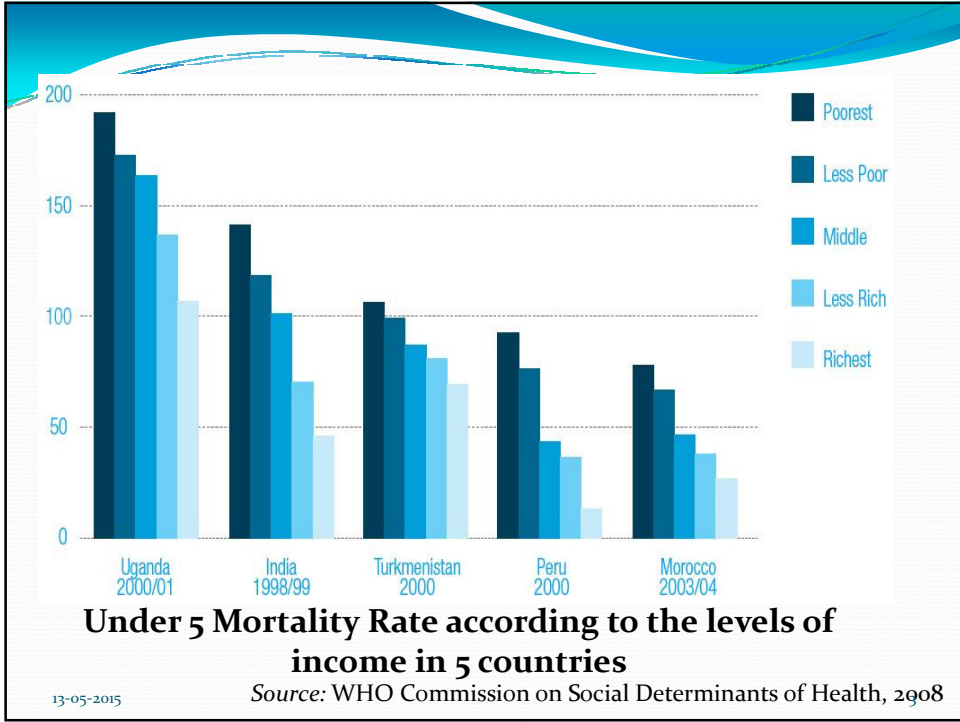
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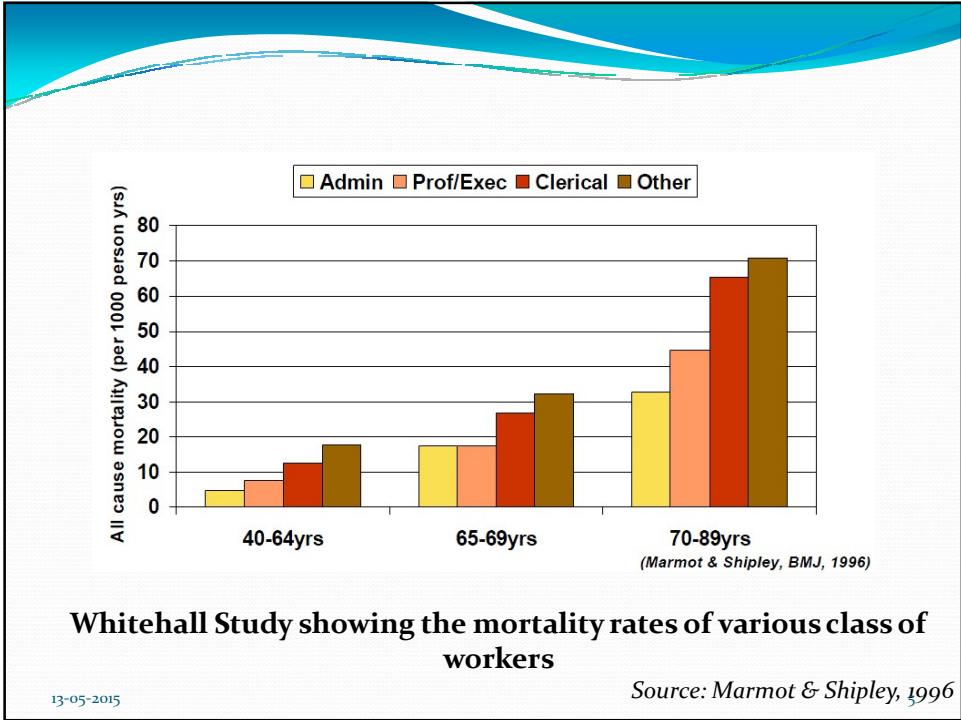
Place	Life expectancy at birth
United Kingdom, Scotland, Glasgow (Calton) ^b	54
India ^a	62
United States, Washington DC (black) ^c	63
Philippines ^a	64
Lithuania ^a	65
Poland ^a	71
Mexico ^a	72
United States ^a	75
Cuba ^a	75
United Kingdom ^a	77
Japan ^a	79
Iceland ^a	79
United States, Montgomery County (white) ^c	80
United Kingdom, Scotland, Glasgow (Lenzie N.) ^b	82

Male Life Expectancy at Birth according to the place of birth

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Source: WHO Commission on Social Determinants of Health, 2008²

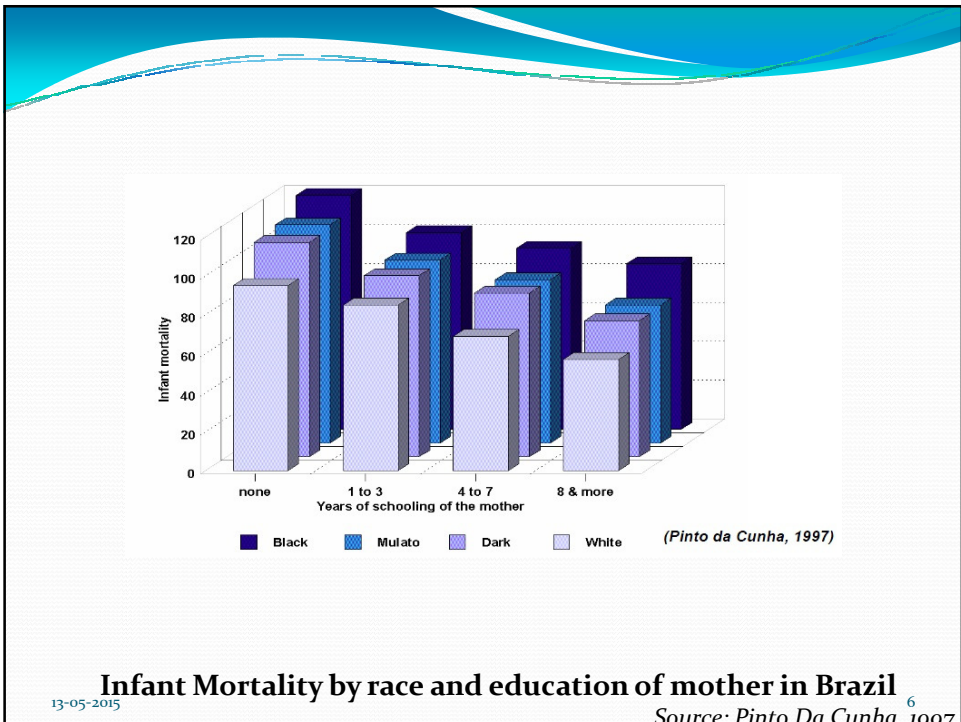




Whitehall Study showing the mortality rates of various class of workers

Source: Marmot & Shipley, 1996

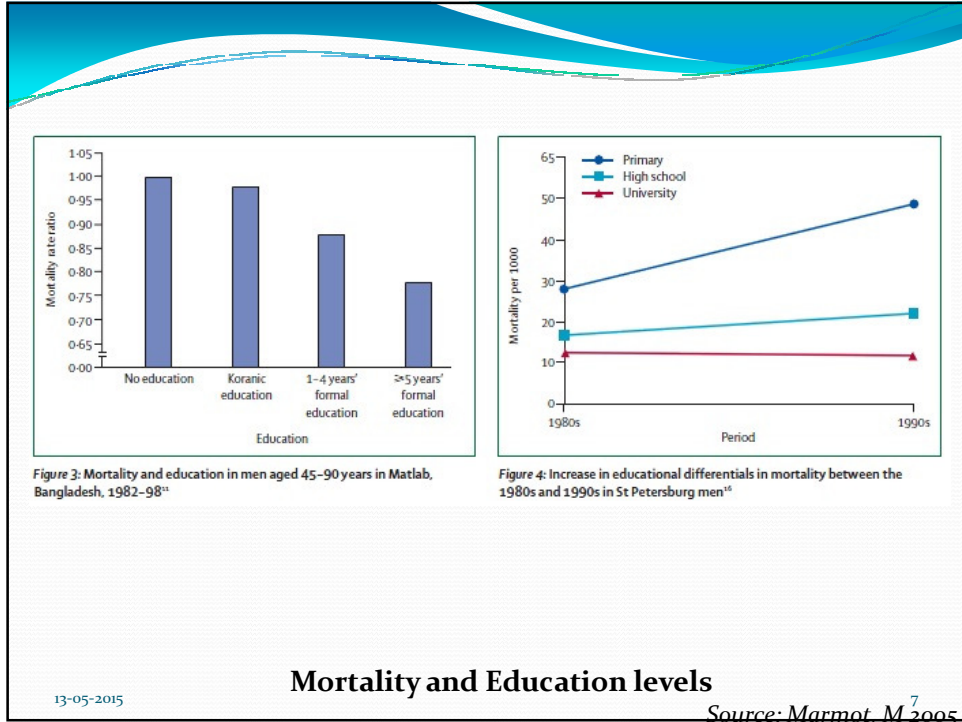
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Infant Mortality by race and education of mother in Brazil

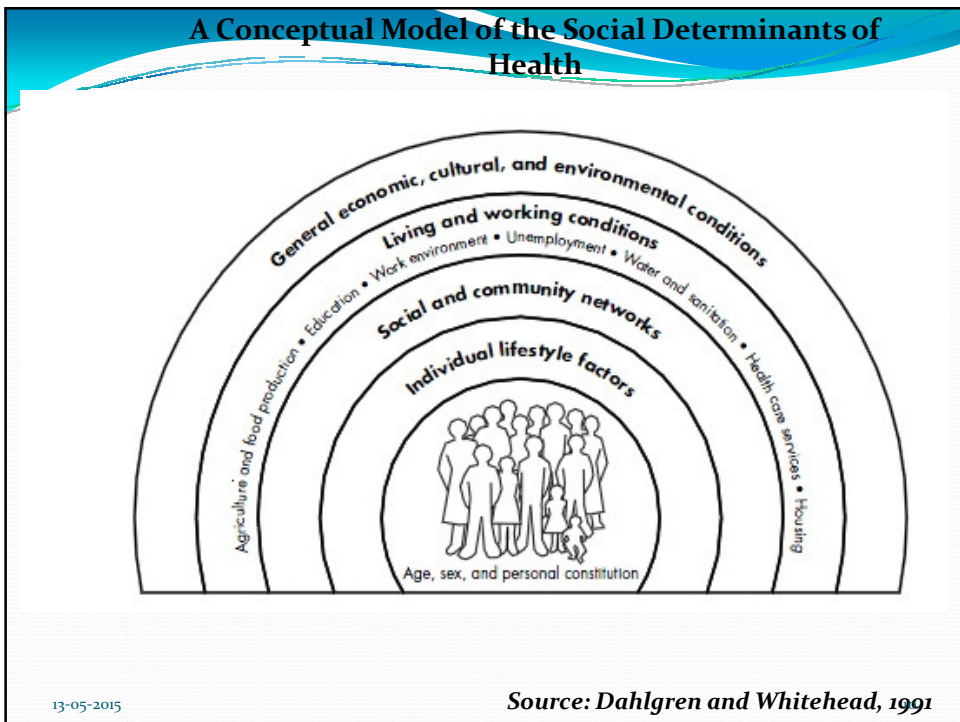
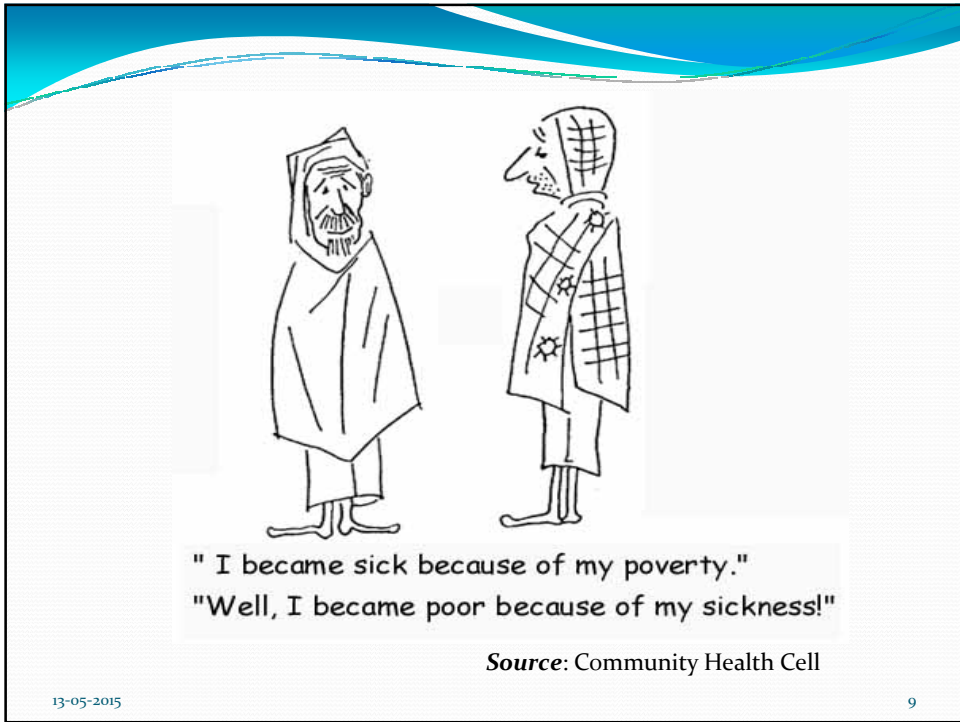
Source: Pinto Da Cunha, 1997

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Background characteristic	Neonatal mortality (NN)	Postneonatal mortality ^a (PNN)	Infant mortality (₁ q ₀)	Child mortality (₅ q ₁)	Under-five mortality (₅ q ₀)
Education					
No education	45.7	24.0	69.7	26.9	94.7
<5 years complete	48.4	17.6	66.0	13.8	78.8
5-7 years complete	34.5	15.1	49.5	11.5	60.5
8-9 years complete	32.0	9.5	41.5	5.6	46.9
10-11 years complete	26.9	9.6	36.5	3.6	40.0
12 or more years complete	19.6	6.3	25.9	3.9	29.7
Religion					
Hindu	40.3	18.2	58.5	18.5	76.0
Muslim	34.1	18.2	52.4	18.6	70.0
Christian	31.5	10.1	41.7	11.6	52.8
Sikh	35.9	9.7	45.6	6.8	52.1
Buddhist/Neo-Buddhist	43.0	9.8	52.8	17.1	69.0
Other	43.3	41.4	84.6	50.4	130.7
Caste/tribe					
Scheduled caste	46.3	20.1	66.4	23.2	88.1
Scheduled tribe	39.9	22.3	62.1	35.8	95.7
Other backward class	38.3	18.3	56.6	17.3	72.8
Other	34.5	14.5	48.9	10.8	59.2
Wealth index					
Lowest	48.4	22.0	70.4	32.3	100.5
Second	44.6	24.0	68.5	22.6	89.6
Middle	39.3	19.1	58.3	14.4	71.9
Fourth	31.9	12.1	44.0	7.5	51.2
Highest	22.0	7.2	29.2	4.8	33.8

13-05-2015 **IMR and Social Determinants of health** *Source: NEHS, 2006*



MARKET LOGIC

- › Entitlements to people to what they have acquired
- › Emphasis on Individual responsibility – primary duty to avert death and disability is with the individual ignoring the pre-conditions for such a behaviour.
- › Victim blaming and moves the debate away from the “structural violence”
- › Fatalism and a weakening of the collective endeavour
- › Minimal obligations to protect the common good
- › Over reliance on Biomedicine - technological fix for a painful social change
- › ‘Winner takes all’. Does not recognize the social / societal inequalities.

Source: Beauchamp, D 1976

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JUSTICE

- › Justice
- › Justice as fairness and reasonableness
- › Justice means each person receives his /her due
- › Burdens and benefits are equally shared and distributed
- › The powerful minority accepts their fair share of burden and needs to protect the powerless majority threatened with death, disease and disability

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SOCIAL JUSTICE

- Under Social Justice all persons are entitled to all the ends equally such as health protection or minimum standards of income.
 - Importantly burdens are collectively accepted otherwise powerful forces will obstruct fair distribution
 - ***'The dream of public health is of minimizing preventable death and disability which is also the dream of Social Justice'***.
 - Social Justice framework is a powerful critique of the market justice of the unjust protection of powerful from collective burden and to the extravagant faith on the efficacy of medical care
 - Public health is not just about a technical activity but is to be seen as a way of doing justice, as a way of asserting the value of human life
- Source: Beauchamp, D 1976*
- What are the benefits worth if they have been purchased at human cost?

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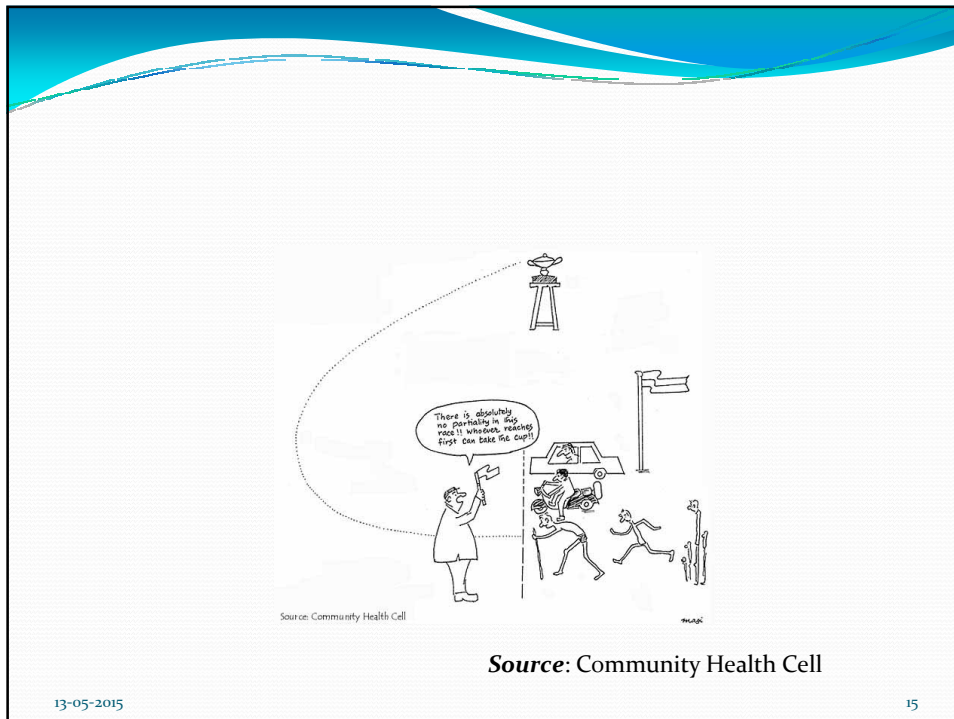
SOCIAL JUSTICE

- John Rawls theory of 'Justice as fairness' advocated for fair distribution of primary goods and equality of opportunity as necessary for the development of the individual
- Daniels and colleagues explained this further by mentioning that the governments must formulate policies in such a way that the following primary goods are allocated in a fair manner :
 - Investment in early childhood development
 - Nutrition programs
 - Improvements in quality of work environments
 - Reductions in income inequality
 - Political fairness
- But Amartya Sen argued that the primary goods do not have an intrinsic value in themselves to foster development of the individual.
- For eg. A disabled person's lived experience with access to all the primary goods, is different than a fully abled person and hence advocated for a 'Capability theory'
- Moving from a 'resources orientation' of Rawls' theory to 'results orientation' of the Amartya Sen's capability theory
- Capabilities are enhanced through public action to create 'pre-endowments'.

Source: Braveman and Gruskin 2003

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Equity in Health

- Health inequities are differences in health which are unnecessary, avoidable, unfair and unjust
- Health equity is absence of avoidable, unnecessary, unfair and unjust health differences
- Absence of systematic disparities in health between social groups due to their underlying social advantage / disadvantage. Eg of social advantage is Power, resources/wealth and prestige
- Equity is not the same as Equality
- Equity is equalising of opportunities in an unequal world
- Health Equity is equalising the health outcomes of disadvantaged
- Equity is different from targeting

(Whitehead 1991; Braveman & Gruskin 2003)

Politics and Political Economy of Health

- › Politics – As acts of governments – very narrow definition
- › *Politics as power – Politics is the process through which desired outcomes are achieved in the production, distribution and use of scarce resources in all areas of social existence – Most commonly understood*
- › Politics also means autonomy over one's own health and one's own bodies
Bambra et al 2005
- › Politics - to search for the common good and just society
Beauchamp, D 1976
- › Rudolf Virchow's famous statement – '*medicine is a social science, and politics is nothing but medicine on a grand scale*'
- › Social determinants of health are amenable to political actions – Political parties have shaped the reduction of inequalities and thereby health outcomes
Navarro 2006

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Political Economy of Health

- › Political Economy is the relationship between State, Economics and Civil Society. It links the subject areas of Political Science, Sociology and Economics
- › Issues considered under Political Economy are:
 - Production and distribution of wealth
 - Political Power of the Social Classes
 - Extent of society's reliance on state control of distribution of resources Vs. reliance on Market
(Raphael 2006)
- › Political Economy of Health looks at how different types of state structures, political and economic systems and institutions affect population health inequalities
(Beckfield and Krieger 2009)

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Welfare State

Definition

"A system that allows the government of country to provide social services such as healthcare, unemployment benefit, etc. to people who need them, paid for by taxes"
(Cambridge Dictionary)

"... a capitalist society in which the state has intervened in the form of social policies, programs, standards, and regulations in order to mitigate class conflict and to provide for, answer, or accommodate certain social needs for which the capitalist mode of production in itself has no solution or makes no provision" (Teple, 2000, p.15).

Types of Welfare State

1. Social Democratic (Norway, Sweden etc.,) – Benefits dependent on citizenship
2. Conservative, Christian Democratic (Germany, France) – Benefits dependent on workers' rights
3. Liberal (US and UK) – Benefits based on financial need
4. Ex- Fascist (Spain, Portugal)

The health inequalities increase as we move from 1-4 !!

(Navarro & Shi 2001)

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Neo - Liberalism

Definition

"...a theory of political, economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade"
(Harvey, 2005, p.2)

Typical Prescriptions:

- › Structural Adjustment Programs (SAP) – Reduce fiscal deficit, devalue currencies, open up markets
- › Governments as taboo, as barriers
- › Reduced Government Spending on Social sectors, reduce subsidy etc.,
- › Increased privatization and commercialization (market based)
- › User Fees
- › Vertical Programs
- › Targeted rather than Universal Systems (eg. BPL / APL)
- › Purchaser – Provider Split (PPP)

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Evidence

The WHO Commission on Social Determinants of Health (CSDH) commented that:

- Economic and political reforms resulted in increased commercialization, undermining the PHC approach
- Higher public and social insurance spending on health correlates with better health-adjusted life years
- The Commission also considered health care as a common good and not a market commodity

(WHO CSDH, 2008)

Thank you !!