The Political Economy of Health and Healthcare:

Unhealthy Distribution

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Cambridge
Scholars
Publishing

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This book first published 2020

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN (10): 1-5275-4259-9
ISBN (13): 978-1-5275-4259-4

To Mojegan, Samim, Saba, and Yalda

For their unwavering support and encouragement

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PREFACE

About three centuries ago, Adam Smith of Scotland published his inquiry into the *Wealth of Nations* in which he argued that productive labour creates the wealth of nations, and not the amount of gold and other precious metals stored by a nation as the so-called *Mercantilists* believed. In our time, a more pressing question has been, what determines the *Health of Nations*? Over the years, numerous researchers have investigated the health of individuals and populations from various disciplinary approaches in attempts to answer this question. Not surprisingly, however, there is little consensus on what determines health. The diversity of opinion on what determines health may in part be related to the fact that health is a complex phenomenon whose mechanisms are not fully understood. But, perhaps more importantly, the diversity of opinion arises from the interests of diverse groups. Since the health economy is huge, the stakes for the parties involved are huge too. In this regard, the examination of health and healthcare from a political economy perspective is critically important. Such a perspective becomes even more relevant as the evolving paradigm of *social determinants of health* identifies socioeconomic position and command over economic resources as the key upstream determinants of health, and relates health inequities to economic inequities and social injustice in general.

We live in an era of unprecedented wealth and prosperity in many parts of the world, have access to advanced technology, and are pretty well informed about most of the issues and problems surrounding us. At the same time, poverty and hunger are widespread in most of Africa, South Asia, and Latin America. The gap between the rich and the poor is as wide and widening as fast as ever, not just in poor countries but also in those that are quite rich. What is striking is that, aside from the general fact that people in the richer countries are healthier that those in the poorer ones, ill health and health inequities are prevalent in all countries, rich and poor. We have not been able to translate our great wealth, technology, and scientific knowledge into high levels of health and wellbeing for all the members in our societies. Why is this?

The main purpose of this book is to show that health inequities both between and within nations are, to a significant degree, the consequence of income and wealth inequities. In other words, I seek to demonstrate that

the distribution of health within a nation or across nations is critically tied to the distribution of income and wealth in the respective jurisdictions. To this end, I draw upon published work and empirical evidence to support the argument that a grossly unequal distribution of resources is *unhealthy* for all, as it undermines the health of nations and creates enormous health divides, with consequent substantial economic and social costs.

A second, but equally important, purpose of this book is to emphasize the rapid acceleration in the concentration of wealth and income in fewer and fewer hands starting in the early 1980s with an ideological shift in economic views to what is now widely known as neoliberalism. As will be discussed in the book, the neoliberal ideology has brought about unprecedented economic inequalities that have deepened the existing health inequalities. Worse yet, it has undermined the capacity of governments in their attempts to rectify the situation, which is only getting worse in the absence of a major shift in the prevailing political economy.

Scholarship on the political economy of health and healthcare from different disciplinary perspectives is growing, and some seminal work in this area is available. Nevertheless, the intention in writing this book is to provide a coherent and vivid picture of how economic resources (income and wealth) are distributed through the markets as the main distributing mechanisms in our capitalist societies, and why markets have no regard for equity and social justice. It also takes issue with the current belief of many that markets are impersonal mechanisms following their own logic, and are impervious to our societal values and community aspirations. It argues that markets are what we make them to be, through regulation, codes of behaviour, and rules of fair play. Moreover, it draws on the literature and current data to show how the distribution of health and healthcare reflect the distribution and redistribution of power, wealth, and income in our capitalist societies.

This book consists of five parts. Part I looks at the health of the nations in broad strokes to pin the idea that health outcomes are varied both across and within nations. It starts, in chapter one, with definitions of health as conceived by different researchers and international institutions, before moving into a discussion of various health measures, which is ultimately what we use to compare the health of populations or nations in chapter two. Chapter one emphasizes how important is health in itself, and in its contribution to the economy, and makes the obvious, but necessary, distinction between health and healthcare. The dominant biomedical view of health has successfully managed to impart on many the idea that health is equal to healthcare. The reality, of course, is far from that. The comparative study of the health of nations in chapter two leads to a

discussion of the various healthcare systems and the amounts they spend on healthcare. This provides a good segue into discussion of the evolving paradigm of social determinants of health, which offers a direct challenge to the prevailing biomedical view of health.

Part II of the book is on resource distribution and health, which is central to the theme of this book. Chapter three introduces the market mechanism and the logic of market distribution as it is currently practiced almost everywhere, and explains why such a distribution is inherently neither equal nor fair. The chapter documents the links between economic inequities (arising from market-driven distribution) to health inequities. Chapter four then discusses the redistributive measures taken by governments to mitigate if not rectify some of the inequities originating in the market's allocations. In doing so, the chapter explores the rise of the welfare states in various advanced countries, and examines their clustering based on certain common features. The final chapter in this part describes the retrenchment of the welfare states under the influence of the neoliberal idea of austerity, and shows how the resultant fiscal constraints that were augmented by the financial crisis of a decade ago are undermining the ability of the states in their redistributive efforts.

Part III of the book is devoted to health inequalities as related to economic distributions. It shows how inequities have skyrocketed in the wake of neoliberalism over roughly the past four decades. To this end, chapter six explores poverty and growing inequities in the midst of plenty in the advanced capitalist countries. It shows the persistence of poverty, and child poverty in particular, and examines the welfare state efforts in fighting poverty across these nations to document some of the successes and failures in this regard. The chapter identifies several key factors that are believed to have contributed to poverty and economic inequities. More specifically, it examines the shrinking share of the labour income, rising precarious employment, and job insecurity, as well as the adverse impacts of the more recent phenomena of *financialization* and *digitization* in our economies. It also highlights the enormous economic power and political clout vested in multinational corporations, offering a view into their negative effects on poverty and inequity. Chapter seven focuses on the consequences of poverty and inequality for population health, and, drawing on the available data, shows clear relationships between poverty and inequality and the inferior health outcomes across several countries. It also examines some of the negative consequences of austerity on the health of people who were particularly affected by it. The final chapter in this part is an empirical investigation of the effects of fair distribution on good health. It provides a conceptual model of resource distribution and

health, and distinguishes between primary and secondary distributions to identify the distributional orientations of different advanced countries. It maps out such orientations, along with the welfare state regimes, and estimates the relationships between the countries' distributional tendencies and their health outcomes, to show that the countries with the more egalitarian distributions enjoy better health outcomes.

The political economy of healthcare is discussed in part IV of the book. Chapter nine begins with a tour of the healthcare industry, or the *health economy*, in the major developed countries to highlight its significance in the overall economy, and its superior profitability compared to other sectors of the economy. It examines the role of aging as a potential contributor to rising healthcare costs, and shows in the light of the existing evidence, and contrary to popular belief, that aging is only a minor contributor. It also explains why such a myth persists in the face of the contrary evidence. Chapter nine also discusses some of the key factors for the thriving health economy including medicalization, advancement in medical technology, and greed. It argues that lax regulations and healthcare commodification in the wake of neoliberalism has encouraged the key players in the industry – namely, healthcare providers and insurance and pharmaceutical companies – to take advantage of people's vulnerabilities for massive profit opportunities. Chapter ten looks at the inadequacies and inequities in access to healthcare. It argues that the lack of insurance or inadequate insurance essentially limit access to adequate care or care of any kind, once again reminding us of the inequities in the distribution of resources and privileges. When healthcare is commoditized, access to care becomes inequitable. Chapter ten also compares private versus public insurance to document the advantages of the latter both in terms of equity and administration costs. It reviews the global push for universal healthcare coverage under the direction of the WHO, and the likelihood of success for such an initiative in the light of past disappointments and failures. The chapter ends with a discussion of the rising costs of healthcare and the challenges of containing such costs. This challenge is argued to be a major one, as it requires the balancing of the interests of providers, insurers, patients, and politicians. The final chapter in this part poses the question, do we care about our health and the health of others, or not? It reviews the arguments on the sustainability of healthcare, and critiques the push towards personalized medicine, away from population health, and calls for a shift towards prevention with a focus on the upstream determinants of health rather than treatment.

The last part of the book, part V, is on *healthy* politics. If politics, or more broadly political ideology, has a significant bearing on the

distribution of power and economic resources, which in turn affects the distribution of health, then health equity requires an equitable or healthy polity where collective interests and the common good supersede individual self-interest. Accordingly, chapter twelve reviews some of the arguments in favour of considering health and access to healthcare as social rights or common goods, which benefit everybody. It also discusses some of the efforts at the national and global levels to promote health equity and identifies a number of barriers in this regard. The next chapter in this part reflects on a classic health report by a prominent pathologist who was commissioned to study and report on the typhus epidemic in Upper Silesia (Prussia) in 1848, to make the point both that attention to living conditions and the social determinants of health has very early origins and, more importantly, that politics matters for health. Chapter thirteen continues with a discussion on the historical evolution of the notion of *social medicine*, a view of health deeply rooted in the recognition that the social and economic conditions in which people live and work are the primary causes of ill health and disease, needing a collective approach focused on prevention and primary care, and less so on medical and reactive care. It also advocates for a politics that is inclusive and has the wellbeing of *all* the members of society as its core value, which may be termed *social politics*. Finally, chapter fourteen highlights some of the key arguments of the book, and ends with some concluding remarks.

Let me finish with a few words of acknowledgement. This book is a reflection on some of what I have learnt about political economy, health, and healthcare policy from numerous scholars, researchers, and commentators over the years. As such, my intellectual debt is heavy, although it is rather anonymous. However, in my learning journey, a few scholars have been my guideposts whom I cannot thank enough for their guidance, insights, and impressive characters. At the risk of missing some, I would like to acknowledge Professor John Loxley at the University of Manitoba, for his significant role in developing my critical political economy approach towards the global socioeconomic problems of our time, and the unfortunate fate of those in the developing world. Equally so, I am honoured to have known Professor Robert Evans of the University of British Columbia, whose incredible knowledge and wisdom both in economics and health, as reflected in his vast seminal scholarship in critical health economics and policy, has been a constant source of inspiration and support in my teaching and research. I would also like to acknowledge Professor Dennis Raphael at the University of York, for his steadfast scholarship in political economy of health, promoting the social

determinants of health discourse through his generous sharing of ideas, and his activism for the promotion of health. Further to the south, it is my pleasure to acknowledge Professor Vicente Navarro at the John Hopkins University, for an enduring critical scholarship on the relationship between politics and health, and for carrying forward the torch of social medicine through his chief-editorship of the International Journal of Health Services, from which I have immensely benefitted. As well, I am indebted to Dr Mathew Anderson at the Albert Einstein College of Medicine, for his dedication to scholarship on social medicine and his co-editorship of a journal with the same name, which provides a bilingual forum for exploring the legacy of social medicine in Latin America and beyond.

Although this book reflects many of the seminal insights of the scholars in the field, any errors of omission or commission remain the sole responsibility of the author.

PART I

THE HEALTH OF NATIONS

CHAPTER ONE

INTRODUCTION

Any inquiry into the health of nations, and any comparative study of population health for that matter, presumes an agreed upon understanding or conception of health. Although, generally speaking, there is a common sense of what health is and is not, any critical study of health that recognizes alternative approaches to health and health policy must grapple with the complex issue of what health really is. Therefore, for clarity of argument as well as meaningful comparison across boundaries, it is very helpful to define what is meant by health. Even if there is no generally accepted definition of health, one needs to be clear and consistent about the particular definition of health one goes by. The better elaboration of various conceptions of health not only enhances our understanding of it, but also helps in the design of appropriate measures of health, which are so critical in any empirical or evidential examination of the health of populations. As the saying goes, *what is counted, counts*. Thus, to attend to health matters and bring them to the attention of those that are in a position to affect health, we need to be able to measure health in as many ways as we can. This is not to advocate for blind quantification of everything related to health. Clearly, certain aspects of health do not lend themselves easily to measurement. Our feelings and emotions are inseparable from our health, and yet there is no meaningful way of measuring them. But it is important to improve our measures of health beyond simple aggregates that obscure the true distribution of health, which is the key concern in health equity discourse.

Therefore, the first two sections of this chapter review various definitions or conceptions of health, and the popular health measures or indicators that are being used in health studies, respectively. The next two sections of the chapter discuss the importance of health, and the need for distinguishing between health and healthcare, in that order. Health, in essence, defines our lives. Our sense of being, capabilities, view on life, contributions to and achievements in the society, and joy are critically defined or confined by our health or lack thereof. Health is necessary for self-realization and flourishing both as individuals and communities. A

particularly narrow view of health has succeeded to magnify the relationship between health and healthcare such as provided in healthcare centres, so much so that a good number of people tend to equalize health with access to healthcare. For the purposes of this book, it is critically important to debunk this false parity. Health, as defined in this chapter, is about far more than access to healthcare.

1.1 Defining Health

The World Health Organization (WHO) has been the key international institution facilitating and coordinating worldwide efforts at defining, measuring, tracking and reporting health outcomes for its member states since its inception. No wonder that the first widely known definition of health, albeit a very broad one, was articulated by the WHO – in 1947 – and incorporated into its Constitution as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1948).

This laudable definition of health recognizes many requisite elements of what constitutes wholesome health and wellbeing, and can be used as a compass preventing us from drifting towards very narrow conceptions of health such as the absence of disease. At the same time, however, the WHO definition is too broad to be effectively measured for individuals or populations. As Evans and Stoddart have aptly pointed out, the WHO definition "has accordingly been honoured in repetition, but rarely in application" (Evans and Stoddart 1994, 28). Nonetheless, as pointed out, this definition of health in terms of an ideal provided the first building block for an operational definition of health (Murray and Evans 2003). Given the broad WHO conception of health, efforts have continued over the years to develop conceptualizations of health that better lend themselves to operational measures of health. These conceptualizations vary in a number of ways. They vary in terms of the scope of what constitutes health. Some, still following the WHO broad or holistic definition, consider health as part of an individual's overall wellbeing. As a result, health is embedded within the broader contextual factors that may well vary from individual to individual and more so from population to population. For example, a discussion document by the WHO defines health as "the extent to which an individual or group is able to realize aspirations and satisfy needs, and to change or cope with the environment". It goes on to say that "health is a *resource for everyday life*, not the objective of living; it is a positive concept, emphasizing social and personal resources, as well as physical capacities" (WHO 1984). Others

prefer to separate health as a distinct category or component of wellbeing or welfare. This approach sharpens the focus on health, and distinguishes between health and its determinants and consequences (Murray and Evans 2003). It also allows for inter-personal as well as inter-population comparability, and makes measurements of change in health more operational. Conceptions of health also vary as to whether health is considered positively or *objectively* measurable, or to be *subjectively* perceived by individuals within specific contexts. Those in favour of objective measures rely on biomedical markers and diagnostic results as obtained in clinical settings. Whereas, those oriented towards a subjective conception of health, prefer to use survey instruments in which individuals' self-reported experiences of health or illness within specific environments are captured.

A key challenge throughout the efforts at conceptualization of health has been that any conceptualization must be comparable across boundaries and capture the multiple dimensions of health (Hansluwka 1985). Although there is a common understanding that health is both intrinsically and instrumentally valuable, more recent efforts are inclined towards developing conceptions of health in which a person's health state can be defined in terms of a number of mostly functional health domains, which may then be combined into an overall health state valuation for measurement purposes (WHO 1980; WHO 2001; Murray and Evans 2003). Consequently, self-report health assessment instruments of various kinds have been developed and are being used along with clinical measures to determine performance levels in various health domains. At the aggregate level, information from such instruments has been incorporated into summary measures of population health that capture both *fatal* and *non-fatal* health outcomes as described in the following section.

1.2 Measuring Health

Regardless of its particular conception, health is usually measured at the individual level. But as needed, we can aggregate individual measures of health into population health measures using appropriate methods. Since our focus in this book is on population health, we review some of the popular measures of population health in this section.

Simple and crude measures of population health such as mortality and life expectancy have been historically provided in conventional life tables and are still in use. However, starting in the mid 1960s, persistent efforts have been made to combine both *mortality* and *morbidity* into composite

indices of health (Sanders 1964; Sullivan 1971; Bone 1992; Mathers and Robine 1993; Murray et al. 2000; Murray and Evans 2003). This has been done by incorporating morbidity information extracted from representative sample surveys into mortality data from life tables using various weighting techniques. It has been noted that over time declines in mortality rates have been accompanied by increases in morbidity rates as reflected in the greater prevalence of chronic diseases (Sanders 1964; Gruenberg 1977; Kramer 1980; Olshansky 1991; Robine et al. 1999). Therefore, adjusting expected life years for declines in health due to increased morbidity or disability is a sensible approach.

The summary measures of population health are divided into two classes: *health expectancies* and *health gaps*. The former is a positive measure of health capturing the average expected years of life in good or full health, whereas the latter is a negative measure of health that quantifies premature mortality in reference to a normative goal as expressed in *years of life lost* measures (Mathers et al. 2003). Health expectancies are further divided into two categories: one in which health state weights are dichotomous (e.g. the presence or absence of a certain condition), and the other where weights are used for a more disaggregated set of health states (e.g. low, moderate and high severity of a condition). Examples of the former category include measures such as *disability-free life expectancy*, *life expectancy with disability*, *handicap expectancy*, *unhealthy life expectancy* and so on. Better-known examples of the second category include *health-adjusted life expectancy*, *disability-adjusted life expectancy*, and *healthy life expectancy* (Mathers et al. 2003). Mathers and colleagues articulate a set of criteria for assessing the desirability of particular population health summary measures, based upon which *health-adjusted life expectancy* is recommended as a preferred measure. This health measure was adopted by the WHO in its World Health Report in 2001.

Efforts to refine and standardize the summary measures of population health continue. What is important to consider is that the availability of more informative measures of population health gives us better pictures of cross-country population health and, one would hope, better ways of linking health to its determinants for appropriate policy formulation and implementation.

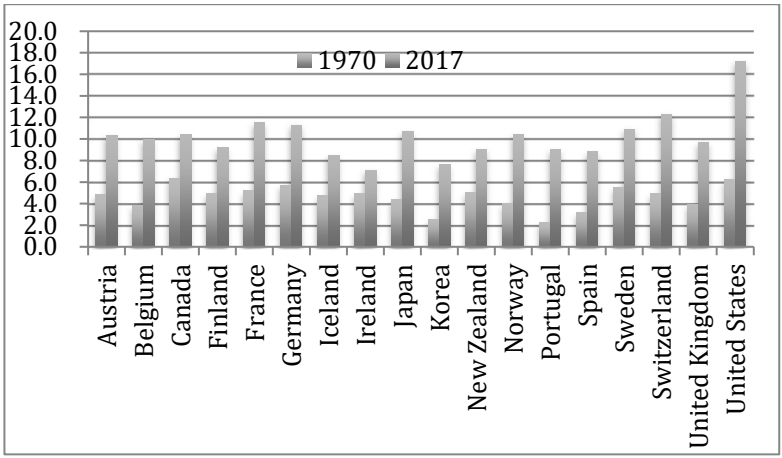
1.3 The Significance of Health

Since the dawn of human history, health has been a key concern for individuals and populations. As our knowledge of health and its

underlying factors has improved over the centuries, if not millennia, our attention and preoccupation with health and health related matters has grown accordingly, so much so that health and healthcare issues are front and centre in the media on a daily basis. It is very obvious that health is essential to human identity and function, and allows the flourishing of human capabilities for the living of fruitful and productive lives. It is also no wonder that a vast number of players in a fast-growing industry have significant stakes in promoting and propagating health concerns, bringing it to the forefront of markets, policy debates, political campaigns, and national and international conferences. In what follows, a broad picture of the health sector or the *health economy* in several advanced countries is portrayed to emphasize the importance of health and healthcare in modern societies.

A clear indicator of the significance of health and healthcare in a society is the proportion of its total production that is devoted to the provision of healthcare services of all kinds. For accounting convenience, this is typically expressed as the proportion of a country's Gross Domestic Product (GDP) that is spent on healthcare. Figure 1-1 provides this information for a number of countries of the Organization for Economic Cooperation and Development (OECD) for two selected years, almost half a century apart.[1]

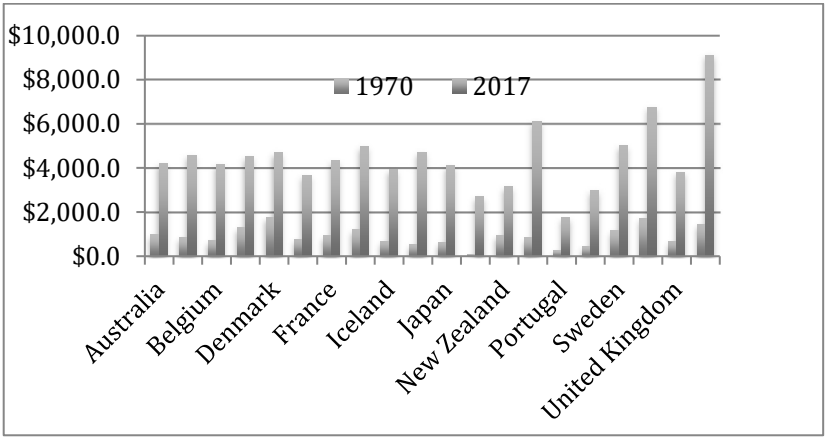
Figure 1-1 Total health expenditures as a proportion of GDP



[1] All the figures in this chapter are produced by the author, and are based on data obtained from the OECD database.

The above figure shows that a sizable proportion of each country's GDP is spent on healthcare. More noticeable is the fact that this proportion has roughly doubled – generally from around 5% or less in 1970 to around 10% in 2017 – for all but four countries, for which the proportion has roughly tripled, among which the United States clearly stands out: whilst Korea's, Portugal's, and Spain's expenditures have grown from relatively modest 1970 levels to now sit well within the norms of their OECD co-members, the US, already one of the two highest spenders in 1970, has shot out well above the rest. These proportions hide the fact that the GDPs in those countries have grown almost four-fold in real terms, on average, during this time period. Therefore, in absolute terms, the amounts spent on healthcare have increased more rapidly than is shown in figure 1-1. (See figure 1-2 below.)

Figure 1-2 Total per capita health spending*



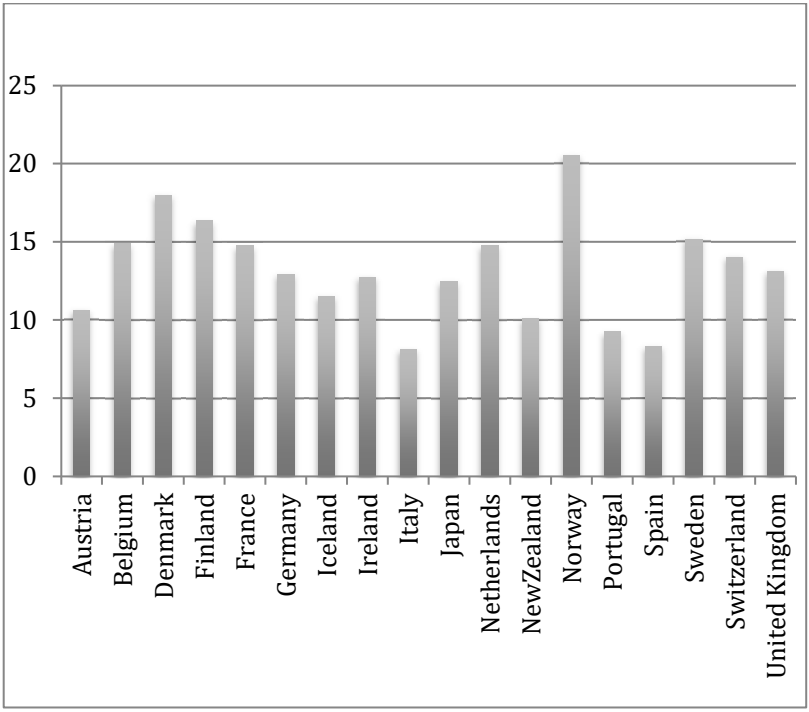
* The amounts are in constant (2010) US dollars adjusted for Purchasing Power Parity (PPP).

As figure 1-2 shows, health spending per capita has grown manifold over the period 1970–2017. In fact, the average spending for this group of countries increased from an amount under $900 to over $4500, a roughly five-fold expansion in real terms. The expansion of healthcare spending varies across different countries. Korea, Norway, Spain, Ireland, Japan, and the United States show above average rates of increase in their health spending.

Another indicator of the importance of health and healthcare in the economy is the share of employment in this sector. As figure 1-3 shows, a

sizable proportion of employment, ranging from 8 to roughly 20 per cent, belongs to the health sector. For the countries considered, this proportion averages out to 13.2 per cent. That is, out of seven jobs, one is in the health sector. Overall, the Scandinavian countries, led by Norway, show a higher share of employment in the health sector.

Figure 1-3 Share of healthcare in total employment (percentage, 2017)*

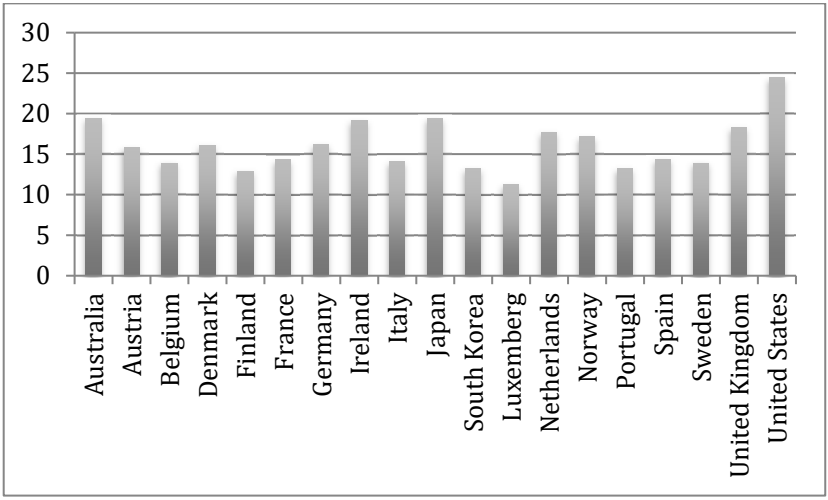


* The employment share includes health and social work activities.

The governments of many countries have been heavily involved in the healthcare sector, either by way of direct provision of services, or by providing health insurance for certain groups in the population or universally for the entire population. As a result, a significant portion of public budgets has been spent on health and healthcare. This portion varies among the countries, depending on the nature and extent of the government involvement in the health economy. Figure 1-4 reports the percentage of public health expenditures out of total public or government expenditures.

A glance at figure 1-4 reveals that these governments spend a good portion of their budgets on healthcare services. This portion ranges from 11.3 per cent to 24.4 per cent, with an average of 16 per cent for the group of OECD countries depicted in the figure. Interestingly, some governments – namely the United States, Australia, Japan, and Ireland – which are perceived to be more market driven and pro private interests, are spending a higher proportion of their budgets on healthcare compared to others. This counterintuitive result arises from the fact that the governments in those countries have smaller budgets compared to their GDPs.

Figure 1-4 Public health expenditure as a proportion of total public expenditure (2016)*



*The underlying data for this graph have been calculated using data on the public expenditure on health as a percentage of GDP, and total government expenditure as a percentage of GDP.

Whether the amounts spent on healthcare services provide countries with commensurate gains in their population health outcomes is an important argument to which we return in chapter two. Nevertheless, the data presented in this chapter make it abundantly clear that spending on healthcare is a top priority for both governments and the private sector. This all happens within a frame of mind that recognizes healthcare as an important, if not the most important, determinant of health. As we will discuss throughout the book, there are significant vested interests in

maintaining and promoting this narrow frame of mind. But the general public, who suffers from an informational disadvantage, has learnt to respect people in positions of authority, without ever thinking about challenging such a frame of mind. The next section will distinguish between health and healthcare to effectively challenge the narrow biomedical view of health and its agenda of selling healthcare as health.

1.4 Health vs Healthcare

Health and healthcare are obviously two different things. Health − whether defined narrowly as the absence of disease or injury, or widely as complete physical, mental, and social wellbeing − is a desirable state in which individuals and populations would like to live their lives. Deviations from the healthy state are, therefore, undesirable and trigger efforts on the part of individuals or groups of individuals to seek remedies or healthcare. In modern societies, the immediate remedies are an array of goods and services that are offered by various providers through hospitals, clinical labs, medical offices, pharmacies, long-term care facilities, home care, and so on as healthcare. As such, healthcare is not desired due to any intrinsic value, if it has any, but because of the expectation that it will restore health, which is desirable. Therefore, healthcare is sought on the presumption that it restores health, or at least ameliorates discomfort or pain. The immediacy and availability of healthcare, especially in critical situations, in combination with those instances when it actually is effective in restoring health convinces healthcare recipients that health is restored or determined by healthcare. For those suffering from chronic conditions, who are often frustrated with an inability or ineffectiveness of healthcare to improve their conditions materially, the experience might be different. The fact that ill health often leads to the use of healthcare, to the extent that is available and accessible, links ill health and healthcare unavoidably, so much so that some would rather refer to the healthcare system as the "sickness care" system. We need not to be negative about the healthcare system, as it does a good job of restoring health in many respects. The concern is that the coupling of health and healthcare stops people from asking why they got sick or unhealthy in the first place. In other words, the question of what determines health or ill health beyond healthcare is left unanswered. There is now ample evidence that the health of individuals and populations is fundamentally determined by the *social determinants of health.* I discuss this further in chapter two.

In the chapters that follow, I try to depict a vivid picture of who is who in the health and healthcare arena by looking into the distribution of economic resources, which underpins the distribution of power, both of which affect the distribution of health as well as healthcare. In preparation for this journey, the following chapter explores the health of nations around the world to give us a better sense of how populations in various countries are doing as far as their health is concerned.

CHAPTER TWO

HEALTH AROUND THE WORLD

Comparing social phenomena across boundaries is always an exciting expedition. It not only caters to our sense of curiosity as to the potentially unknown beyond our boundaries, it also deepens our knowledge of what is already known within our own boundaries. As such, comparing the health of populations around the world is rewarding in terms of learning about the health both of other nations and our own. We cannot possibly visit each and every nation on this journey, but, it is hoped, the ones we do visit will give us a good sense of the overall distribution of health throughout the world. We do expect to see significant variation in the health of populations in a world that is increasingly polarized between the two camps of those who have and those who do not. But we will perhaps be intrigued to find out that there are substantial differences among the wealthy nations, as well as within those nations individually in terms of population health outcomes.

As will be seen in the pages that follow, the differences in population health appear to follow well established and persistent patterns that speak to the historical experiences, foundational social values, institutional structures, and political climates that have shaped the nations over time. When comparing health across the wealthy advanced nations, we realize that their differences cannot be attributed to their healthcare systems per se. These countries all have modern healthcare systems equipped with the latest medical technology and well-staffed with armies of professional providers. Also, despite some exceptions, access to the healthcare services in those countries is relatively universal. Therefore, to explain the observed variations in population health across the nations we need to look beyond the healthcare systems into broader determinants of health that have much to do with the socioeconomic positions of individuals and populations, both within their nations and relative to other nations.