



TO LIVE AND DIE IN AMERICA

Class, Power, Health and Healthcare

Robert Chernomas and Ian Hudson

THE FUTURE OF WORLD CAPITALISM

TO LIVE AND DIE IN AMERICA



The Future of World Capitalism

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For my brother Fred. He would have understood;
he always did.

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For Brett and Mark, best brothers ever.

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1

CLASS, POWER, HEALTH, AND HEALTHCARE

INTRODUCTION

In a 1974 speech to the First Conservative Political Action Conference, then Governor (and President to be) Ronald Reagan told a predictably receptive crowd that the United States was the greatest nation in the world. “Pope Pius XII said, ‘Into the hands of America God has placed the destinies of an afflicted mankind.’ We are indeed, and we are today, the last best hope of man on earth” (Reagan, 1974). This is one of the stronger statements of what is often called US exceptionalism—the idea that the United States is a unique and superior country. Unfortunately, in terms of the health of its people, the United States may be unique, at least among wealthy nations, but it is decidedly not superior.

This book is about how class and power in the United States have determined its health outcomes and healthcare system. The core argument is that disease and death in all nations, including the United States, are predominately structured and influenced by social and economic imperatives, not by irresistible laws of nature that are independent of socially determined political and economic factors (Cairns, 1971; Cassel, 1976; Chernomas, 1999; Chernomas and Donner, 2004; Dubos, 1959; 1965; Galdston, 1954; Navarro et al., 2003; Poland et al., 1998; Wilkinson, 1996). The specific evolution of US capitalism has shaped these social conditions and the healthcare system that evolved to deal with them. If class and power are the two most important determinants of everyday life in the United States, it follows that improving health in the United States will require a change in the system of power, and in turn the conditions in which people live and work, as well as a restructured healthcare system.

The United States has by far the most expensive healthcare system in the world, the worst health among wealthy industrialized nations by almost all measures, and is the only industrialized nation without some form of universal healthcare. US life expectancy is 79.6 years. According to the 2010 United Nations Human Development Index this places it behind 28 other countries, following Greece and Lichtenstein and just above Costa Rica, Portugal and Cuba. In terms of mortality rates for children under five, it ranks a worrying 46th just behind the UAE and above Chile (United Nations, 2011).

These results are not because of underfunding of the US healthcare system. The United States spends more in absolute and relative terms than any other industrial economy. In 2008, the United States spent 16 percent of its GDP on healthcare. This is the highest of the 31 countries in the Organisation for Economic Co-operation and Development (OECD) by a considerable margin. The second ranked country, France, spent 11 percent and the OECD average was a much more modest 9 percent. The combined level of public and private healthcare spending per person is also much higher in the United States than any other country. The United States spent \$7,500 per person, while the second highest nation, Norway, spent only \$5,000 (OECD, 2010). The disparity between healthcare spending and health outcomes suggests that the United States has a particularly inefficient healthcare system, but this divergence is also driven by social and economic conditions that create a less healthy US population.

In the context of these discouraging health indicators, the United States has recently been through a national debate on the future of its healthcare system. President Obama made universal access to healthcare an important plank in his 2008 election campaign. As we will show in Chapter 5, while Obama did manage to expand access, this was accomplished in a manner that maintained many of the features of the US system that contribute to its higher costs and poorer outcomes.

It is critical to point out, however, that not all capitalist nations have the same class and power relations, and therefore we should expect them to have different health outcomes and qualitatively different healthcare systems. One famous typology of capitalist nations groups countries into four categories (extended from Esping-Anderson's (1990) original three groups). Social democratic welfare states (like Sweden), are egalitarian (including more equal access to healthcare), and have strong protective regulations like environmental laws. In these nations, historically strong labor

movements and other civil actors have been able to challenge the power of business and successfully develop a broad network of policies that alleviate, to a certain extent, many of the conditions that give rise to poor health outcomes in modern capitalism (Olsen, 2011: 4–6). The second group of nations is conservative-corporatist welfare states, which tend to provide relatively generous health and social services based on union membership or religious affiliation (like Italy). The third category—wage earner welfare states—provide limited benefits based on employment rather than being universal (like Australia). Finally, liberal welfare states contain a minimum safety net, offering basic social and health services to the poorest and elderly (like the United States). These countries have a history of relatively weak labor organizations and other social movements relative to the power wielded by the business community. This has resulted in a political and economic system with greater inequality and less regulatory intervention (Olsen, 2011: 4–6).

In an international health context, the liberal welfare state embraced by the United States should be viewed as a cautionary tale. As a result of the ability of social democratic countries to win redistributive policies, including an egalitarian healthcare system, and regulatory checks on business activities, people in these countries have superior health results (like lower infant mortality) than other nations (Navarro et al., 2003; Raphael and Bryant, 2004; Birn, Pillay, and Holtz, 2009). The wide variation of political and economic structures that exist between the social democratic and liberal nations suggests that, while the capitalist system does have inherent trends, there is still considerable scope for class politics—the conflict and collaboration of classes and groups—in each country to alter the conditions that create health problems, the health systems that deal with them and their outcomes.

COMPETING THEORIES OF HEALTH OUTCOMES

The emphasis in the preceding section on economic and social factors might come as something of a surprise to readers. Probably the dominant approach to understanding illness is the biomedical approach, in which the causes of disease stem from germs and genes. These illnesses are governed by natural and medical “laws.” The treatment strategy that follows from this theory of disease is preoccupied with the search for bad genes, viruses, and bacteria. Treatments are focused on restructuring the biology of the individual through surgery, genetic intervention, or pharmaceuticals. To use an

analogy, the biomedical approach views human health in much the same way that a mechanic would view a car. Individual components that are not working correctly need to be repaired or replaced. The biomedical approach can certainly boast an impressive list of scientific innovations that cure a very wide swath of illnesses. Medical innovations have also resulted in preventive measures like vaccinations. Yet, as we shall explain in Chapter 2, the biomedical approach cannot claim the credit for diagnosing the principal causes of, or providing the solution for, the major diseases of the nineteenth and twentieth centuries.

A second popular model explains health outcomes through individual lifestyle choices. According to the behavioral approach, the solution is to eliminate these self-destructive preferences. There is an important element of truth in this claim. If people don't smoke, there is less chance that they will get lung cancer. If people eat their vegetables and exercise regularly, they have less chance of heart disease. As we will show later in the chapter, however, there are several important shortcomings with this emphasis on the individual. The first is that people in different social situations but with identical lifestyle choices have different health results. The second is that it fails to explain why individuals make these choices. This is especially important since many supposedly individual choices appear to be heavily influenced by social position. If choices are genuinely individual, they should be evenly distributed across different groups in society, but they are not. People from lower socio-economic status have less nutritious diets, smoke more, and exercise less than do those from higher up the social ladder (Lantz et al., 1998; Nettle, 2010). In fact, many health problems are less a result of individual choice than they are a product of social circumstance rooted in the class-based circumstances and opportunities described throughout this book.

In stressing the importance of the political and economic environment in determining human health, we are advocating a political economy approach. According to this view, the way in which the economy operates, an individual's place in it, and in the social and political systems that go with it, have a strong influence on health outcomes. Of particular importance, in this view, are the power relationships that exist in a society. In our society power is largely conferred through ownership (especially, as Karl Marx famously noted, of the productive capacity). So the people who own firms have more power than their employees. Economic, political and social systems play an important role in determining