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Chapter 1

REVITALIZING THE POLITICAL ECONOMY OF HEALTH AND HEALTHCARE IN A CONTEXT OF CRISIS

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Exasperated by the teleological assumption of neoclassical economics that, free from government 'intervention', markets will *eventually* return to equilibrium, John Maynard Keynes (2013 [1923]: 65) sardonically quipped: 'in the long run we are all dead'. The ongoing Global Coronavirus Crisis (GCC) – the most pervasive and lethal epidemiological calamity since the 1918–19 Spanish Influenza pandemic – has recently reinforced a parallel, if more morbid, precept. As recurrently demonstrated throughout the history of capitalism (Szreter 2005; Leys 2009; Chernomas and Hudson 2013), the GCC grimly confirmed that restructuring socio-ecological life around market processes increases the likelihood of illness and death in the *short run*, too. Put differently, contrary to the assumption of both mainstream political discourse and media outlets, the pernicious health impacts of the Crisis are not merely biological in character – the deadly result of an easily transmissible pathogen run rampant. Nor are they simply the inadvertent product of collective individual irrationality and recklessness in flouting government directives to wear masks and isolate. Rather, the global health disaster engendered by the spread of the SARS-CoV-2 virus cannot be understood removed from the wide-reaching institutionalization and deepening of pro-market *neoliberal* programs in place since the 1970s (Primrose *et al.* 2020; Luisetti 2022; Sparke and Williams 2022; Wamsley and Benatar 2023).

Four decades of neoliberal efforts to restructure socio-ecological spheres through a narrowly economistic lens have, ultimately, intensified the scope of the pandemic in at least three ways. First, the *commodification of healthcare systems* – reorienting them from public goods to profit-making domains – lessened both the accessibility and quality of healthcare services. States have been left ill-equipped to handle a public health crisis on the scale of COVID-19, with hospital capacity scaled back, essential healthcare components privatized or outsourced, and austerity imposed on health budgeting, particularly following the Global Financial Crisis of 2007/08 (Schrecker and Bambra 2015; Labonté and Stuckler 2016; Fouskas and Gokay 2020; Navarro 2020).

Second, diminished public investment in infrastructure, equipment, vaccine research and development, and medicines has occasioned states to cede ground on *preventative medicine*, instead relying on pharmaceutical companies to devise strategies for a pathogenic response. Typically, the for-profit imperatives of the pharmaceutical sector have made it less inclined to invest in non-remunerative research and development on infectious diseases or preventive medicine in general. Unless the state has been willing to bestow guaranteed revenues (such as those available under

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so-called 'Operation Warp Speed' in the United States), the development of more profitable *post facto* treatments remained the focus of industry (Harvey 2020; Anderson 2023). Third, neoliberalism has left populations broadly vulnerable to the epidemic, by negatively influencing the *social determinants* of human health. By aggravating economic inequality, making work increasingly precarious, and undermining the quality and affordability of public services (such as public housing, childcare, and aged care), significant portions of the population faced higher risk in relation to the pathogen and possessed fewer resources to cope with its consequences (Navarro 2020; Bambra *et al.* 2021; Davy and Dickinson 2023).[1]

These outcomes correspond with the longer-term structural dynamics of global capitalism, which are marked by systemic contradictions. In particular, sustained capital accumulation depends on the conditions of social reproduction, such as birthing and raising children, caring for friends and family, and preserving household and community networks. These very same necessities, however, tend to be undermined by the systemic compulsion of capitalism toward perpetual accumulation (Fraser 2016, 2022). Accordingly, while health and healthcare might be use values *par excellence*, they are of limited interest to capital unless they can be converted into exchange value, or otherwise configured to the pursuit of expanding accumulation (Doyal 1979; Baer 1982; Leys 2009). Indeed, prior to the outbreak of the GCC, the rapid globalization of the corporate agri-food regime clearly contributed to the precipitous emergence and rapid dissemination of pathogens through its ongoing disruption and commodification of local socio-ecological processes (Wallace 2016, 2020; Akram-Lodhi 2021; Waitzkin 2021). Similarly, in the midst of the pandemic, capitalist states were frequently willing to risk the spread of infection and heightened mortality rates as a means to maintain a minimum level of accumulation. Advice from public health officials around quarantine measures was often rebuffed to keep the non-essential economy open and/or enable resumption of regular production and consumption practices (Knott 2020; Leake *et al.* 2020).

It is hard, in this context, to avoid the conclusion that death, disease, and ill-health are inexorably interrelated with their *political-economic* context (Bambra 2011; Chernomas and Hudson 2013). Both individual and population health are structured by the complex interactions between ideas, interests, and institutions that are, in turn, inexorably interrelated with the material conditions in which societies produce, distribute, exchange, consume, and reproduce. These political-economic processes shape the capacity of the human body to reach its full potential, and the ability of society to prevent disease and cure illness. Accordingly, they influence all elements of human health – from food consumption and occupational health and safety, to inequality, healthcare, and housing, and even the biophysical conditions in which humans live (Doyal 1979; Leys 2009; Marya and Patel 2021).

Indeed, it was precisely this premise with which we hoped to engage when originally proposing the present book to Routledge in June 2019 – less than six months before the initial outbreak of SARS-CoV-2 in Wuhan. Prior to the crisis, a suite of complex challenges already confronted the enduring health and well-being of humanity: persistent occupational health and safety disasters; declining mental health standards in myriad social spheres; uneven access to quality healthcare services; and ongoing concerns with the spread of HIV/AIDS in sub-Saharan Africa, to name but a few. As with the pandemic, these 'health' or 'healthcare' matters cannot be understood outside of their political-economic context. Rather, contemporary capitalism, particularly the extension of its neoliberal form, has proven to be a pivotal factor in constituting these phenomena (Schrecker and Bambra 2015; Sell and Williams 2020; Sparke 2020). Accordingly, while scholarly and political attention to the efficacy of healthcare systems has burgeoned over the course of the pandemic, our purpose in preparing this volume was to compile a series of critical reflections on these abiding political-economic determinants and their health-related implications.

Among the explosion of valuable politically-minded health studies that have arisen in the last decade or so, there are simply no extensive samplings of the critical political economy of health and healthcare that might be of wide service to academics and practitioners alike. The *Handbook* aims to redress this lacuna by taking stock of established and cutting-edge theoretical approaches to the field; the political-economic dimensions of key contemporary issue-areas and their manifestation in geographically varied settings; and a plethora of alternative health and healthcare configurations for a post-neoliberal (even post-capitalist) world. All of this has been done with an open – somewhat agnostic – view of the boundaries of political economy, as a means to open the volume as much as possible to the diverse perspectives and empirical foci comprising the field. In doing so, our intention is to revitalize scholarly interest in the political economy of health and healthcare by demonstrating its epistemological pertinence for comprehending a range of pressing social concerns. Equally, we aspire to exhibit the strategic relevance of political economy as a field of study for scholars and activists committed to transforming the world in more progressive, even radical, directions. Most obviously, this is manifest in multiple chapters establishing healthcare as a site of political contestation: between commercial forces seeking to commodify it further, and other movements striving to retain it as a public good and reduce extant gross inequalities of access. In both respects – as an invitation to intellectual controversy and stimulus for political activity – we hope that the book contributes to 'illuminat[ing] the world in which we live so that we may act in it intelligently and effectively' (Baran and Sweezy 1966: 27–8).

The contours of political economy

Before reflecting on its novel contribution to critical accounts of matters relating to health and healthcare, it is first necessary to delineate briefly the contours of political economy as a field of social inquiry. Political economy constitutes a critical social science, examining the complex constellation of interrelated factors that determine the material basis of human societies, both individually and collectively. Pertinently, this use of the term distinguishes it from its common deployment to refer to the normative study of government policies, as distinct from the study of 'economics' as the study of market functions (*e.g.* Little 2002). It also remains distinct from the 'economics imperialism' of particular traditions of neoclassical economics – such as the 'public choice' theories of James M. Buchanan and others at the Virginia School (see: Candela 2018) – which use these principles to examine public policy processes (Fine and Milonakis 2009; Madra and Adaman 2010). Accordingly, as understood in this book, political economy is not concerned with broadening the topics to which neoclassical economic tools are applied – in this case, to the study of health and healthcare (*e.g.* Furton *et al.* 2022). Rather, it constitutes a more complex approach to understand real-world economic issues. In this endeavor, it builds on a rich historical legacy, stretching back at least to the Physiocrats and Adam Smith in the Eighteenth Century, through scholars such as David Ricardo, Karl Marx, Thorstein Veblen, John Maynard Keynes, Joan Robinson, and John Kenneth Galbraith. While diverging in their conceptual and ideological orientations, these figures commonly sought to comprehend the progress and dynamics of society through the study of accumulation, growth, and distribution processes (Stilwell 2002, 2023; Stilwell *et al.* 2022b).

More concretely, political-economic inquiry may be understood – somewhat taxonomically – as grounded in at least four methodological commitments (Stilwell 2019). First, political economy entails *critical engagement with mainstream economic thought*, centered on a neoclassical theory of hyper-rational individuals each seeking to maximize their utility and interacting in self-equilibrating markets. Such abstract and unrealistic accounts are devoid of social and historical

analysis, particularly due to their methodological individualism and implied separation between politics and economics (Hodgson 2001; Lawson 2015). As such, they provide little explanatory insight into the complexity and unpredictability of real-world economic systems, especially that of capitalism (Arnsperger and Varoufakis 2008; Fine 2015; Westra 2021). Second, political economists make the case for adopting *alternative theoretical traditions* that articulate more realistic and holistic accounts of economic processes as a means to comprehend their real-world complexity. Various 'schools' have developed in this regard, ranging from Marxism and institutionalism, to feminism and ecological economics (see: Lee 2009; Stilwell *et al.* 2022a).

Third, political economy embarks from the ontological proposition that real-world phenomena do not fit neatly into boxes labeled 'economy', 'society', 'politics', and so forth. In turn, practitioners seek to foster constructive *transdisciplinary* interchanges with other social scientific disciplines – such as geography, psychology, and sociology – and utilize insights from them in order to foster an *interdisciplinary* approach to the study of economic issues (Fine and Milonakis 2009; Crespo 2017). Fourth, and finally, because it recognizes that economic issues are inexorably entwined with socio-ecological concerns and political judgments, political economy recognizes that questions of *ideology* inevitably pervade the study of these matters (Myrdal 1969; Fine 1980; Heilbroner 1989; Jo 2022). Accordingly, contrary to the positive-normative distinction commonly deployed within neoclassical economics (see: Grivaux and Badiei 2022), it is futile to present the discipline as somehow 'value-free' (Davis 2022). Instead, the objective is to make these ideologies explicit and subject to scrutiny.

In practice, because political economy has been extended in distinct directions by different schools, its commitments have commonly engendered a broader scope of inquiry than that found in neoclassical economics. The latter attempts to replicate the formalism and universalism of the natural sciences, such that it narrowly focuses on questions of allocative efficiency and stability in markets (Mirowski 1991). Conversely, political economy adopts a more critical and social scientific epistemology, thereby opening up more complex lines of research that analyses the interrelations between economic, political, social, cultural, historical, and ecological dynamics.

Two interrelated lines of substantive investigation may be identified in this regard (Munro 2004: 146–7). First, political economy explores the complex provisioning processes through which goods, services, income, and wealth are *produced*, *distributed*, *exchanged*, and *consumed* within historically specific socio-economic systems, such as capitalism or communism (Lee 2009; Jo and Todorova 2017; Stilwell *et al.* 2022b). It also examines the manner in which this provisioning process occurs within both commodified and non-commodified social spheres (for instance, within the home, family, or community), thereby highlighting the necessary nexus between *reproduction* of human life and preservation of socio-economic existence (Bhattacharya 2017; Mezzadri *et al.* 2022). Political economy addresses how the organization of these processes is structured by constellations of ideas, interests, and institutions, and the resulting winners and losers engendered by this formation – particularly through exploring the operation of power therein (Stilwell 2002; Spies-Butcher *et al.* 2012). Second, political economy simultaneously explores the systemic implications of such provisioning processes. It considers how their specific societal configurations, along with the imperatives arising from them, generate (often-contradictory) dynamics and power relations (such as those of class). These, in turn, influence the direction of virtually all other socio-ecological structures – from family life and institutions of governance, to our collective functioning within extant biophysical arrangements (Moore 2015; Ferguson 2020). Thereby, it deliberates on the broader repercussions of these processes for the material reproduction of both humanity and the ecological systems we inhabit (Jo and Todorova 2017).

Reconsidering the prevailing study of health and healthcare

The chapters in this book elaborate on this agenda as a means to comprehend, and revitalize scholarly interest in, the complex drivers and social implications of contemporary issues of health and healthcare. Over the course of recent decades, health and healthcare have been subject to intellectual curiosity, scrutiny, and political contestation (*e.g.* People's Health Movement *et al.* 2022). Such discussions have provoked their fair share of ethical and political conundrums, and it is an understatement to say that very little has been academically or practically settled in this broad arena (Birn *et al.* 2017; Parker and García 2018). How should 'health' and 'healthcare' be defined? Who should be the primary focus of analysis when dealing with human health? How much health is enough? What kinds of social mechanisms help generate healthy societies? Which social actors and institutions should be involved in delivering healthcare, and which should not? These are but a few of the questions that immediately spring to mind when reflecting on the intricate domains of health and healthcare, and a wealth of corollary and subsidiary issues could easily accompany them.

Of course, it is possible to approach these matters from multiple conceptual and disciplinary perspectives, all of which contribute to our understanding of certain elements of them (Collyer 2015). In this respect, health and healthcare are prisms through which concerns relating to identity, economics, politics, sociology, science, and philosophy are refracted, rendering them rich and perplexing fields of study. Nevertheless, conventional explanations for health and morbidity within scholarly and policy discourse have, until recently, largely fallen into one of two broad traditions: *biomedical* and *behavioral* (for critical surveys, see: Chernomas and Hudson 2013: 4–5; Birn *et al.* 2017: 90–2).

The former approach conceives of health as a primarily individual and biological phenomenon, in which the human body is the locus and source of ill-health, subject to biomedical manipulation and/or interventions. From this perspective, health is comprehended predominantly as the lack of disease, rather than as a more holistic (social, psychological, cultural) state of well-being. Concretely, illness and disease are deemed the product of a combination of 'natural' factors – genes and germs – and treatment focuses on restructuring individual biology, largely through pharmaceuticals, surgery, or genetic intervention (Clarke *et al.* 2003; Yuill *et al.* 2011: 7–10). Conversely, behavioral approaches examine health and illness as a function of individual or household behavior and beliefs, such that poor health is typically imputed to poor decisions or lack of volition. Accordingly, normative recommendations center on utilizing a combination of education, counseling or incentive-based measures to eliminate, regulate, or circumvent self-destructive activities, as a means to engender desirable health outcomes (Cockerham 2005; Baum and Fisher 2014). In different ways, both the biomedical and behavioral approaches decontextualize health from its broader socio-political environment, instead attributing poor health to the individual human body and/or mind while formulating corresponding remedial measures targeting these spheres (Birn *et al.* 2017: 90–4; Rocca and Anjum 2020).

More recently, however, an alternative approach has sought to transcend this methodological individualism and, in doing so, has become increasingly popular within mainstream public health scholarship and political discourse. The *social determinants of health* (SDH) approach (*e.g.* Marmot and Wilkinson 2005; WHO 2008) recognizes that health outcomes stem from myriad social factors beyond healthcare alone, and are not reducible to the products of economically organized medical science. Alternatively, in seeking to discern the complex determinants of human health, this tradition highlights the importance of indicators of socio-economic status (SES), such

as income, wealth, and education (Braveman *et al.* 2011; Braveman and Gottlieb 2014). The now extensive literature in this area predominantly isolates such indicators as a means to demonstrate their causal association with negative and/or positive health outcomes, thereby implying that securing the correct balance of SES indicators would precipitate more favorable societal and/or global health consequences (Birn *et al.* 2017: Chapter 7).

Undoubtedly, SDH approaches have heightened our analytical and public awareness of injustices surrounding health and health delivery – a fact that was plainly evident during successive COVID waves, as the relations between inequality and ill-health became increasingly stark (Bambra *et al.* 2021). Without pre-existing, broad institutional acceptance of the association of SES with health status among public health institutions, researchers, hospitals, and international organizations, discussions concerning inequality and COVID would not have occurred with such potency within media and governmental circles (WHO 2021; Bonner 2023). Nevertheless, despite this important contribution in identifying a broad nexus of social factors shaping health outcomes, the SDH literature tends to disregard the 'upstream' social conditions and power structures that adversely affect health (Navarro 2009; Schofield 2015). That is, the tradition largely fails to progress further up the causal chain to address how the social determinants of poor health (such as inequality) are, themselves, determined by structural factors, such as class or the systemic imperative of capitalism toward perpetual capital accumulation. As David Coburn (2004: 44) saliently notes with regard to SDH, 'inequality or [socioeconomic status] simply refer to individuals or families who are higher or lower on some characteristic without any real social relationships between these, and without any necessary antagonism between those lower or higher'.

Hence, while recognizing the significance of SDH studies in refocusing scholarly and political attention on social factors as the fulcrum of health and healthcare studies, the *political-economic* orientation of this collection seeks to shift how we comprehend associations between SES and health. It places the locus of causality not so much on socio-economic *status*, but rather on the embodied *structural forces*, *power*, and *political struggles* that bring about the proximate status of SES indicators in the first place (Labonté and Ruckert 2019; Sell and Williams 2020; Waitzkin *et al.* 2020). As formulated across this volume, the *political economy of health* is concerned with critically analyzing the historically specific nexus of political-economic structures, processes, and social relations that constitute conditions in which people live and work, and thereby engender particular individual and societal patterns of health, illness, and well-being (Krieger 2011; Chernomas and Hudson 2013). Concomitant to this, the *political economy of healthcare* addresses the impact of these political-economic forces on the production, distribution, and consumption of health services, and the manner in which the latter reflects the power relations of the societies within which medical institutions operate (Waitzkin 1978; Baer 1982).

In short, the capacity of individuals and societies to enjoy a healthy life is not solely attributable to biomedical factors, individual lifestyles, or the presence of particular socio-economic indicators. Rather, all of these are shaped by systemic political-economic dynamics and social relations that determine the environment in which we function (Mooney 2012; Marya and Patel 2021). In the context of antagonistic class relations within capitalism, political economy stresses the degree to which capital utilizes its structurally advantageous position to effect political and organizational outcomes that bring about or maintain the inequalities taxonomized by SDH researchers (Navarro 2002; Navarro and Muntaner 2004). While the latter appositely points to the social nature of health injustice – for example as arising from factors such as uneven access to affordable social housing, poor education, income and wealth inequality, or inadequate welfare systems – political economy insists that the latter is neither incidental nor accidental. Rather, class power and class struggle – however subtly arranged, regulated, or reinforced – are largely

responsible for the inequalities we now recognize more broadly as affecting health and well-being (Coburn 2010).

To illustrate, many recent studies of mental health have usefully avoided biologically deterministic explanations of problems such as anxiety and depression, by instead locating their social determinants in factors such as employment instability, discrimination, inequality, adverse life experiences, poor education, familial instability, and isolated or destitute residential and working conditions (*e.g.* Compton and Shim 2015; Alegría *et al.* 2018). Yet, as Jana Fey's contribution to this volume reveals, the proliferation of such factors must be comprehended as, at least partly, having been propelled by efforts from capital and capitalist state institutions to neoliberalize the governance of multiple spheres of social life over recent decades. As a means to secure ongoing capital accumulation, however, these endeavors have undermined the social conditions for mental health – whether through the commodification of desire and leisure, codifying increasingly precarious working conditions and homeownership, or introducing multiple rounds of fiscal austerity (Matthews 2019). Thus, as Vicente Navarro (2009: 423) pithily quips: '[i]t is not *inequalities* that kill people […] it is *those responsible for these inequalities* that kill people'.

In idiosyncratically developing this agenda across their respective chapters, the contributions to this *Handbook* stand on the shoulders of giants in the field – from Louis-René Villermé, Rudolf Virchow, and Friedrich Engels, to Lesley Doyal, Howard Waitzkin, Vicente Navarro, Julian Tudor-Hart, and Gavin Mooney – to analyze the complex political-economic determinants of myriad contemporary health and healthcare issues. In doing so, as with political-economic analysis more broadly, there is also a strong tendency among chapters to develop their accounts through eschewing the traditional division of labor erected between disciplines within the social sciences (see also: Navarro 1976: viii). Instead, the volume brings together an array of authors seeking to demonstrate the saliency of political economy for comprehending contemporary health and healthcare practices by embracing interdisciplinary insights from diverse scholarly domains, such as history, epidemiology, political science, anthropology, and sociology. The resulting studies present wide-ranging and critical reflections on the pernicious effects of neoliberalism and capitalism on health, while also demonstrating the need to rethink the political means to redress these concerns.

Structure of the volume

In articulating this agenda, the chapters in this volume are apportioned across five distinct sections. *Part one* features chapters reflecting on the political economy of health and healthcare from different theoretical traditions. The objective of this section is not to provide a meta-theoretical framework for the *Handbook* as a whole. Indeed, the volume interprets political economy as an irreducibly pluralist endeavor, characterized by multiple, overlapping schools of thought. Accordingly, as a means to enable readers to engage with and juxtapose ideas from each, this opening section introduces and critically reflects on the contribution of multiple contemporary schools – both mainstream and more critical – within the political economy of health and healthcare (see also: Mooney 2009; Davis and McMaster 2017). Each chapter focuses on an individual theoretical approach: (neoclassical) health economics, the economics of conventions, Marxism, post-Keynesianism, feminism, new materialism, and behavioral economics.

Building on these conceptual insights, *parts two and three* examine the political-economic character of a variety of long-standing health and healthcare issues from around the globe. Each chapter reflects critically on the form and implications of these issues, by investigating their relation to developments in contemporary capitalism and, in particular, the contemporary extension of neoliberalism. The *Constitution of the World Health Organization* (WHO 1948: 1) proclaims that

'[t]he enjoyment of the highest attainable standard of health is one of the most fundamental rights of every human being'. Moreover, '[g]overnments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures'. From this perspective, by means of their capacity to influence both the social determinants of health and prevailing healthcare system, states should play a key role in securing the health and well-being of its citizens as a basic right. Nevertheless, as demonstrated by the chapters in these sections, the increasingly pervasive influence of neoliberalism as a rationality of governance over the preceding four decades has seen states largely abrogate this obligation. Instead, widespread neoliberal policies and governance mentalities have undermined the socio-ecological conditions determining health, while cultivating and institutionalizing commodified healthcare primarily as a site of capital accumulation (see also: Sparke 2020). Put simply, the present political-economic context has generated many noxious consequences for human health and well-being.

Part four is organized around exploring the interplay of these dynamics in determining health trends and the direction of healthcare systems in geographically specific environments. Concentrating on a diversity of countries and regions – from sub-Saharan Africa and post-Soviet Eastern Europe, to the European Union and Australia – chapters critically investigate how the vicissitudes of health and healthcare delivery are intertwined with contextually specific historical and contemporary political-economic processes, as well as the broader dynamics of global capitalism. As grimly revealed by the GCC, the interplay of these factors engenders substantial divergences in population health and well-being, as well as the capacity of healthcare systems to prevent and treat illness and disease (Sheehan and Fox 2020; Serikbayeva *et al.* 2021; Jones and Hameiri 2022). Consistent with the preceding two sections, these chapters also collectively reveal a common 'red-thread' running through their case-studies: neoliberalism has fostered a shift from healthcare as a public good to a novel site of capital accumulation *via* its commodification, while simultaneously producing deleterious consequences for the broader social determinants of population health.

Given the multifaceted malaise afflicting health and healthcare outlined over the preceding four sections, it remains prudent to ask: what political-economic conditions are necessary to secure a more positive, equitable course in global population health and well-being, and how can healthcare systems be geared toward this end? Can such outcomes be engendered through reconfiguring capitalism in more progressive directions, or are broader, revolutionary socio-ecological transformations required? In addressing these complex normative questions, *part five* concludes the volume by surveying the opportunities and challenges associated with constructing alternative political economies of health and healthcare that transcend their extant neoliberal, or even capitalist, forms (see also: Deppe 2010; Waitzkin *et al.* 2018; Adler-Bolton and Vierkant 2022). To this end, contributions analyze a range of existing systems that diverge from prevailing institutions and ideologies – such as those of Cuban internationalism and commons-based healthcare arrangements – and the more general lessons for political economy that can be extrapolated from their operation in practice. This final section also includes more speculative accounts of how alternative health and healthcare processes may be restructured – for instance, according to principles of degrowth or post-capitalism – to foster more socially just, inclusive, and effective outcomes. In both cases, chapters unanimously favor extending practices of decommodification and reinstitutionalizing more democratic political practices, upon which fundamentally different health systems might be constructed.

Across each section, in keeping with our commitment to foster renewed interest in the political economy of health and healthcare as a valuable field of study, we have sought to include a diversity of germane perspectives and issues. Nevertheless, some apposite theoretical approaches and

topics did not 'make the cut', or only receive brief mention within existing chapters. For instance, the traditions of *institutional economics* (Champlin and Knoedler 2008; Hodgson 2008; Josifidis and Supic 2022) and *social economics* (Davis 2001; Davis and McMaster 2017) present powerful theoretical alternatives to the prevailing neoclassical school informing mainstream 'health economics' and, thus, warrant further elaboration in future research. Moreover, the particular implications of capitalism for the health and healthcare needs of *Indigenous groups* (Saggers and Walter 2007; Ullah 2016) and *queer communities* (Padilla *et al.* 2007; Bell 2020) are germane issues that remain comparatively underexplored within extant political-economic literature.

Moreover, as acutely highlighted during the GCC, capitalism also engenders contradictory political-economic processes that have deleteriously affected population health by perpetuating *racialized* (Laster Pirtle 2020; McClure *et al.* 2020) and *developmental inequalities* (Birn *et al.* 2017; Labonté and Ruckert 2019) within and between countries. Such inequalities have also fed into contemporary problems of *addiction* (Young and Markham 2017; Courtwright 2019), which have been especially pronounced in the ongoing *opioid epidemic* sweeping across the Americas (Pereira 2021; Hansen *et al.* 2023). Finally, as the ecological rhythms of the Earth continue to be detrimentally affected by climate change, the complex interrelations between these and capitalism in determining global *planetary health* (Gill and Benatar 2020; Baer and Singer *forthcoming*) promise to become an increasingly prominent topic in coming decades. Readers interested in further exploring these important themes should consult the illustrative sources for each listed above, in conjunction with the broader reflections on the political economy of health and healthcare explored in this volume.

Looking forward

This *Handbook* was prepared in the midst of yet another capitalist crisis that menaced the continued well-being of societies. In turn, it was submitted in early 2023 when COVID-19 remained a virulent – if less politically deliberated – threat to population health, especially in the context of the continued obstinacy of neoliberalism (Šumonja 2021; Wood *et al.* 2023). The volume, thereby, emerges in a context in which the importance of health for politics, as well as the political-economic character of health, could not be more prescient. Since early 2020, the world has been in the grips of the novel coronavirus, its variants, and now subvariants. With close to 610 million reported cases and 6.5 million deaths at the time of writing, COVID-19 has demonstrated not only the critical importance of public health, but also the general centrality of political-economic issues to health and well-being. Whether considering geographical disparities and resource-poor healthcare settings; unequal access to care; deep relationships between inequality, race, and poor health outcomes; North-South disparities in access to medicines; or the extraordinarily ageist results of austerity, long-term care, and residential outbreaks, the ongoing pandemic has thrust the political-economic character of health and healthcare heavily into the spotlight.

By subjecting the latter to scrutiny with regard to a wide range of issues and within diverse geographical contexts, we hope that this volume facilitates a rejuvenation of debate over the complex social determinants of health. Indeed, we consider the book less a 'handbook' in the conventional sense – as an introductory reference to various topics – and more a 'reader' compiling a range of argumentative pieces, deliberately designed to provoke critical discussion and future scholarly work. That is, we wish for the chapters contained herein to contribute to shifting the epistemological locus of deliberations on health and healthcare from the confines of neoclassical economics and neoliberal policies, toward more capacious formulations of their political-economic character. In the present conjuncture, this task is more salient than ever.

Nevertheless, while necessary, this step alone remains insufficient as a means to achieve more amenable conditions for human health. Renewed scholarly concern with the political economy of health and healthcare as a field of study must be complemented by the involvement of social movements capable of struggling for progressive or radical political alternatives across this terrain (Panitch and Leys 2009; Waitzkin *et al.* 2018). We do not, in this regard, predict any sudden regression of the current neoliberal orientation of health and healthcare due to the publication of this volume. Instead, for scholars and activists seeking to secure transformative health outcomes in a post-GCC era, we tender this *Handbook* as a kind of clarion call for political strategy. As the following chapters demonstrate, the quality of health and healthcare systems remain products of material and ideological determinants that, *themselves*, must be contested and reoriented in order to effect alternative outcomes.

For instance, as Patrick Neveling's contribution reveals, the appalling occupational health and safety (OH&S) conditions confronting workers in the global garment industry have not simply arisen from the actions of negligent individual employers. Rather, they stem from numerous historical institutions, policies, and laws codified by capitalist states that prioritize accumulation over worker safety, as well as globalized commodity chains that both minimize capital investment in technology and circumvent expenditure on OH&S for 'undeserving' workers. Effectively redressing such concerns necessitates locating the capitalist state, the garment industry, and the exploitative dynamics of global capitalism as sites of political contestation (see also: Heino 2013; Lax 2020). The broader implication here is that, while illness and death are an inevitable part of human life, the dynamics of neoliberalism and capitalism accelerate and magnify this reality in avoidable ways. As such, 'the demand for a healthier society is, in itself, the demand for a radically different socio-economic order' (Doyal 1979: 296–7).

In this respect, while its constitutive chapters adopt multiple, sometimes incommensurable political angles on issues of health, the volume as a whole should contribute to the formulation of political strategies centered on what Slavoj Žižek (2017) has called the 'courage of hopelessness'. For Žižek, it is self-defeating to trust in the deceptive optimism of a promised progressive future when confronted by breakdowns in the existing political-economic order. Indeed, 'the light at the end of the tunnel is probably the headlight of another train approaching us from the opposite direction' (Žižek 2017: xii). Conversely, *despairing* at the perpetual failure of techno-managerial and neoliberal reforms within the status quo and, thus, *acknowledging* the gravity of the current conjuncture may foster decisive political action and the pursuit of more radical transformation (see also: Žižek 2023). To paraphrase Romain Rolland's (1920) famous maxim, the necessary optimism of the will for emancipatory political action must first be nourished by a substantial pessimism of the intellect.

The chapters of the *Handbook* contribute to this orientation by explicating (i) the scope and scale of contemporary health and healthcare challenges, *and* (ii) their intimate relation to the routine operation of neoliberal policies and the structural dynamics of capitalism. Hence, the volume challenges critical scholars and activists hoping to address (i) to confront the inherent limitations – the 'hopelessness' – of acquiescing to (ii) as the ultimate horizon for action and, thus, of pursuing incremental political solutions to eventually render the status quo more palatable. In the crisis-ridden conjuncture of contemporary capitalism, the effects of neoliberalism in eviscerating the socio-ecological conditions of health have been recognized and weaponized by Far-Right movements (Stuckler 2017; Falkenbach and Heiss 2021; Labonté and Baum 2021). For instance, the latter have promulgated forms of 'welfare chauvinism' – promising maintenance or augmentation of welfare benefits for core constituencies, while disregarding minorities (Greer 2017). This was notoriously exemplified in 2016 by placards adorning the 'Brexit bus' undertaking to remedy UK

health concerns upon leaving the EU by reallocating an additional £350 million each week to the NHS. Analogously, we hope that the contents of the book may prompt progressive and radical social forces to reflect on the need to *embrace* the inescapably dire consequences for health and healthcare propagated by neoliberalism and capitalism. The associated 'despair' arising from recognizing the hopelessness of attempting to 'fix' the status quo via perennial techno-managerial tinkering may, in turn, prompt these movements to channel their efforts toward systemic political-economic change to secure more efficacious and equitable health outcomes.

On this semi-sanguine note, we would like to take the opportunity to acknowledge and express our appreciation to those who have helped bring this undertaking to fruition. Despite the demanding, often gloomy context in which it was conceived and organized over the past few years, it has been a pleasure to work together to prepare the *Handbook*. In this respect, we first wish to thank each other, as co-editors, for the opportunity to develop a project collectively in a research area of substantial social import. We are also sincerely grateful to all chapter authors for their excellent contributions and ongoing commitment to the project, especially when many divided their expertise between academia and working as medical professionals during the GCC. Our heartfelt thanks go out to Andy Humphries at Routledge for his patience, enthusiasm, and sage advice on the volume during its extended compilation and gestation. Thank you, too, to the team at Routledge for their fine work in helping to ensure the book's production was a straightforward and positive experience. Finally, to our families and loved ones, we must extend our warm appreciation for your enduring support while the book was completed – especially given two new additions were born during its production! We hope that this volume will contribute in some small way to revitalizing debate over the complex political economy of health and healthcare so that they and future generations may contribute to a world in which capital accumulation is subordinated to the health and welfare of humanity and the planet.

Note

1 Similarly, despite the GCC manifestly demonstrating the pernicious repercussions of neoliberalism for both population health and healthcare systems, the latter continues to delimit the ideological horizon for public health discourse (Primrose *et al.* 2020). Since the outbreak of the pandemic, mainstream political deliberations have largely disregarded the potential for introducing alternative measures designed to restructure the neoliberal subsumption of social reproduction to capital through reconfiguring existing health systems. Instead, public policy aspirations have remained been oriented toward facilitating the prompt resumption of economic activity *within* extant neoliberal structures (Šumonja 2021; Wallace 2023; Wood *et al.* 2023) – that is within 'the partition of the sensible' (Rancière 1998).

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