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The Political Economy of Health: Bringing Political Science In

Julia Lynch

Department of Political Science and Leonard Davis Institute for Health Economics, University of Pennsylvania, Philadelphia, Pennsylvania, USA; email: jflynch@sas.upenn.edu

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Abstract

The public's health is intimately linked to politics and policy. But political science has yet to make a major contribution to understanding the political economy of health (as distinct from medical care). In order to advance understanding of the drivers of health in an era of emerging infectious disease and global pandemics, more political scientists must begin to do what we are uniquely well situated to do: analyze in a contextualized way the pathways and mechanisms through which power configurations cause illness and inequity. This article reviews key findings from recent literature about the policy, political, and structural contributors to population health and health equity and sketches what a political economy of health more deeply rooted in political science could look like.

INTRODUCTION

"Medicine is a social science, and politics is nothing else but medicine on a large scale" (Virchow, quoted by Taylor & Rieger 1984). Each year in the first lecture of my undergraduate course on comparative health politics, I ask my students what they think this quotation could mean. I am not alone; these words from the nineteenth-century Prussian pathologist-turned-Member-of-Parliament Rudolph Virchow, who penned them after investigating an outbreak of typhoid in Upper Silesia in 1848, are used frequently as an epigraph to encapsulate "public health's biggest idea" (Mackenbach 2009): that the public's health is intimately linked to politics and policy. With so much teaching and research in social epidemiology, public health, and social medicine devoted to this idea, why do we need, as I shall argue that we do, political science to enter the fray?

One justification might be that a decade on, there is still truth in Carpenter's (2012, p. 289) observation: "Compared to the study of politics in many other realms (e.g., labor, environmental), the study of health politics is in its infancy." Yet as we have just seen, the study of health politics dates back at least to the middle of the nineteenth century. This review will show that, far from being un- or even understudied, the politics of health has been taken up vigorously, but most often in disciplines outside of political science. In order to advance understanding of the drivers of health in an era of emerging infectious disease and global pandemics, more political scientists must begin to do what we are uniquely well situated to do: analyze in a contextualized way the pathways and mechanisms through which power configurations "get under the skin" (Green & Darity 2010) to cause illness and inequity.

In the past, political science as a discipline has tended to view health through the narrow aperture of medical care policy. For example, three previous reviews in the *Annual Review of Political Science* (*ARPS*) have related at least in part to health politics, focused mainly on the politics of healthcare spending, the regulation of markets for medical good and services, and access to medical care and insurance (Campbell 2012, Carpenter 2012, Wilkerson 2003). The one *ARPS* article that has addressed health outcomes rather than medical care centered on the need for "[m]ore intensive dialogue with sociology" in order to understand variations in population health across societies (Hall & Lamont 2013, p. 49).

ARPS articles reflect a tiny slice of the discipline as a whole, of course—but scholarship on the politics of medical care policy has dominated much of political science and policy studies. This is particularly true of work focused on rich, industrialized democracies in the Global North, where scholars have built typologies of healthcare systems and examined their political determinants (e.g., Montanari & Nelson 2013; Toth 2013, 2016; Wendt 2014). Further discussion has focused on possible policy feedback effects linking the structure of healthcare systems, public opinion, and political behavior (e.g., Cammett et al. 2015, Clinton & Sances 2018, Gollust & Haselswerdt 2019, Immergut & Schneider 2020, Michener 2018). In lower-income settings, political scientists and policy scholars have generated important insights into the politics surrounding access to healthcare services and pharmaceuticals, particularly (though not only) in the context of the HIV/AIDS epidemic (e.g., Dionne 2011, Ho et al. 2022, Lieberman 2009, Nam 2015, Roemer-Mahler & Elbe 2016, Youde 2010).

Access to medical care is important for health, and the state's involvement in the provision and regulation of health services delivery has impacts that go far beyond individual or even population health. Moran's (1995) work delineating the "three faces of the health care state"—the state's role in patient care, production of medical goods and services, and allocating resources such as jobs and financing associated with health care—helped to orient a generation of comparative health policy researchers toward the politics of medical care policy. But health status matters too: for people (Sen 2002, Walzer 1984), for states and societies (Hall & Lamont 2013, Murray et al. 2000, Wilkinson &

Pickett 2011), and for particular phenomena in which political scientists are often interested, such as economic growth (e.g., Bhargava et al. 2001) or political engagement (e.g., Anderson et al. 2021).

Medical care is, counterintuitively to many, one of the less important drivers of health (House 2016, McGinnis et al. 2002, McKeown 1979). This is because illness and early death result from a combination of exposure to health threats, vulnerability to those threats, and treatment of their effects. Access to medical care can determine if, when, and how an illness is treated (if it is treatable)—but, with the partial exception of vaccines, medical interventions do not protect against either exposure or vulnerability to a risk factor (see Lynch 2020). This means that a wide variety of factors beyond medical care—for example, nutrition, the prevalence of pathogens, social and physical environments, health behaviors, and occupational safety—all have major impacts on health, as do the numerous public policies and economic forces that influence the distribution of these factors. These nonmedical determinants of health are often called "social determinants of health" (WHO 2008). The farthest upstream (i.e., most distal but also most broadly influential) causal factors, those rooted in politics and the economy, are labeled "structural," "fundamental causes," or "macrosocial determinants" (Link & Phelan 1995, McGrail et al. 2022, McKinlay 2019, Putnam & Galea 2008).

Understanding how the organization of politics, society, and the economy influences the distribution of the upstream, nonmedical determinants of health is the task of a political economy approach to health and health equity. Such an approach analyzes how political and economic structures shape the allocation of social determinants of health through mechanisms such as the articulation and representation of interests, government (in)action to shape the economy, the translation of economic power into political and health resources, and communities' actions to reshape the institutions that govern society and the economy. A political economy approach to health and health equity is essential for creating "structural competency": the trained ability of scholars, practitioners, and citizens/subjects to recognize and respond to community health as an outcome of laws, policies, systems, and institutions (Westbrook & Harvey 2023).

This article outlines the key contributions political scientists and researchers from other disciplines have made in recent years to our understanding of policy, political, and structural contributors to population health and health equity, with a focus on systematic reviews and research from the last five years. It then sketches what a political economy of health more deeply rooted in political science could look like, and why it is worth pursuing.

RESEARCH ON THE UPSTREAM DRIVERS OF POPULATION HEALTH AND HEALTH EQUITY

There is virtually complete agreement among health scholars and policy makers about the importance of the downstream social determinants of health for individual health status, the health of populations, or inequalities in health between population groups. The World Health Organization (WHO), leading textbooks in epidemiology and public health, and thousands of research articles published in the last decade all document how factors largely outside of individuals' control—e.g., discrimination, access to green space, occupational hazards, social connectedness, food availability, unemployment, and access to medical care—have an immediate impact on individual and community health and well-being (e.g., Berkman et al. 2014, Marmot & Wilkinson 2005, WHO 2008).

Moving upstream from these social determinants of health to examine the political and economic, structural, or "fundamental" (Link & Phelan 1995) causes of health and health equity invites more controversy in public health policy and research. This controversy arises for several reasons. First, many of the interventions that would be required to interrupt the links between upstream drivers of ill health and health inequity are the subject of intense political and ideological debate. Second, some disciplines represented in the field of health equity research require

experimental or quasi-experimental evidence to claim a causal connection between, for example, income inequality and health inequalities, while other disciplines see triangulation of data, causal process observations, and qualitative evidence as sufficient to establish causation (for discussion of this methodological issue, see Collyer & Smith 2020, Kelly-Irving et al. 2022). Third, because of political scientists' lack of engagement with health, the details of how upstream drivers are translated via politics and policy into influences on health are understudied, an issue to which I return below. The next three sections lay out what we currently know about the likely policy, political, and structural determinants of health.

POLICY DETERMINANTS OF HEALTH

Public Health Policy

We can begin with health policy. We have already discussed the limited (albeit important) role of medical care policy on population health in general terms. However, as the COVID-19 pandemic has brought sharply into focus, health systems[1] concern more than the organization and delivery of curative medicine and can have a profound influence on public health and health equity. Indeed, Chriqui et al. (2011) note that the ten top achievements in public health in the twentieth century were all influenced by changes in policy outside of the medical care system.

Public health systems are organized and financed differently in different countries (as well as, often, different substate polities). But there has been little attention to the sources of variation in public health systems (as distinct from the literature on medical care systems), or indeed to their impact on population health. In a 2012 systematic review of the literature on public health systems in the United States, Hyde & Shortell (2012) found that most studies evaluated the organizational characteristics related to provision of ten Essential Public Services laid out by the WHO (WHO Europe 2012) but only rarely studied how these organizational characteristics were related to the systems' performance in terms of service delivery or public health outcomes. More recent research in public health (e.g., Aluttis et al. 2014, Besnier et al. 2019, Hassan et al. 2021, Lyn et al. 2019, McPherson et al. 2016, Salter et al. 2017, Stamatakis et al. 2020, Wallace et al. 2020) has given more attention to various elements of public health system practice and performance. However, until the arrival of COVID-19, analysis of the sources of variation in organization or performance of public health systems was rare. Going forward, analysis of public health systems—including aspects beyond surveillance and control of infectious diseases—should be a priority for further research in political science and health policy.

While research in public health on the relationship between public health systems and health outcomes has been rare, there has been much greater attention to the effects of policies outside of the health system. At the same time, within political science, we know more about the upstream political, institutional, and economic determinants of policies that lie outside of the health arena than we know about the politics of health policy (Carpenter 2012). This means that reconstructing the pathways linking policy making to health outcomes outside of the health policy arena should be relatively straightforward, especially if venues for ongoing collaboration between scholars in public health, epidemiology, and political science can be created. The following areas of policy have been particularly important for health researchers, with varying levels of input by political scientists into the connections between politics, policy, and health.

[1]The WHO (2011, p. vi) defines a health system as "all the organizations, institutions, resources and people whose primary purpose is to improve health. The health system delivers preventive, promotive, curative and rehabilitative interventions through a combination of public health actions and the pyramid of health care facilities that deliver personal health care—by both State and non-State actors."

Foreign Policy

In the area of global health (and reflecting a North-centric bias in the literature on global health), the impact of foreign policies has been particularly widely studied (for recent overviews, see Feldbaum et al. 2010, Fidler 2009, Youde 2018). This area can be disaggregated into several strains of research: on the health impacts of policies related to diplomacy (e.g., Almeida 2020, Kickbusch & Liu 2022),[2] national security (e.g., D'Arcangelis 2020, McInnes & Lee 2006), foreign aid (e.g., Banchani & Swiss 2019, Youde 2010), and trade (e.g., Burns et al. 2016, Madureira Lima & Galea 2018). Trade policy, in particular, has captured the attention of international health policy makers, who have taken up the label "commercial determinants of health" to indicate the potentially deleterious effects of global trade practices related to, e.g., food, alcohol, tobacco, and pharmaceuticals. In the last decade, a robust literature in public health and health policy has developed around conceptualization and measurement of commercial determinants of health (e.g., de Lacy-Vawdon & Livingstone 2020, Gómez 2022, Lee et al. 2022, Mialon 2020).

In each of these areas, political scientists working in the fields of international relations (IR), international political economy (IPE), and health policy have been active contributors to the literature, resulting in both conceptual and empirical advancements to the understanding of the global system's relationship to health. Of particular note are contributions by Benton & Dionne (2015) on IPE and infectious disease, Eckhardt & Lee (2019) on the IPE of health, and Paxton & Youde (2019) on IR theory and global health.

Social Policy

Due to their obvious connection with many of the downstream social determinants of health, social policy interventions have been evaluated extensively for their impact on population health and health equity. At the most macroscopic level, and primarily but not exclusively in the Global North, scholars have examined how welfare "regimes" or "worlds" (Esping-Andersen 1990) are associated with a variety of health outcomes including mortality, self-rated health, mental health, oral health, and the like (Abdul Karim et al. 2010, Bambra 2006, Bergqvist et al. 2013, Guarnizo-Herreno et al. 2017, Muntaner et al. 2011, Witvliet et al. 2012). A core finding of this literature is that the social democratic welfare states of northwestern Europe are associated with the best overall health outcomes and the lowest relative inequality in health status between groups with higher and lower socioeconomic status. Several studies also note that welfare regime type can moderate the relationship between other factors (e.g., unemployment, disability, gender) and health outcomes (e.g., Bambra & Eikemo 2009, Hadjar & Kotitschke 2021, Van de Velde et al. 2019, Widding-Havneraas & Pedersen 2020).

Studies of individual nonhealth social policies, such as policies affecting education, unemployment insurance, and old-age pensions, have also found robust relationships with health outcomes (e.g., Arno et al. 2011, Balaj et al. 2021, Chriqui et al. 2011, Etile 2014, Kuhn et al. 2020, Lundberg et al. 2008, Meghir et al. 2018, Shahidi & Parnia 2021, Sjöberg 2014). One noteworthy finding is that, in causally well-identified studies, the generosity of individual policies other than education and basic old-age pensions tend to have mixed effects on health outcomes. In the few studies to examine the impact on health of social investment policy orientations,[3] as distinct from traditional compensatory welfare regimes, the effects have been either negative (Harvie & Ogman 2019) or negligibly positive (Morris et al. 2019).

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[2] Fazal (2020) discusses the distinction between analysis of "global health diplomacy" and the health effects of diplomacy more broadly.

[3] Social investment policy orientations aim to bolster welfare state sustainability and economic competitiveness through investments in human capital, including health, training, and gender equity.

Some of the scholarship on welfare regimes has emphasized that welfare regimes as classically conceptualized are distinct from health policy regimes and have an independent effect on health outcomes (see, e.g., Bambra 2006, Kam 2012). Fewer scholars, however, have worked to disentangle the effects of policy configurations associated with welfare regimes from the effects of political, partisan, or ideological factors that are responsible for creating these configurations. Further research into these distinctions and into the overall impact of social policy on health outcomes would be helpful in clarifying the pathways through which the farthest upstream factors affect population health and health equity.

Economic Policy

In the minds of public health scholars and professionals, public health outcomes have long been associated with economic conditions. As we have seen, scholars of public health and epidemiology have recognized since the mid-nineteenth century that poverty is strongly associated with poor health. One of the reasons for the interest in social policies as potential causes of population health is their hypothesized ability to break the link between deleterious economic conditions and health by supporting incomes even when employment opportunities are weak (for an explicit statement of this logic, see McFarland et al. 2023). But public health scholars have also shown considerable interest in the health effects of economic policies and the economic conditions that they help to engender. Beyond trade policies and the commercial determinants of health discussed above, redistribution and inequality, fiscal and macroeconomic policies, labor market policies, workplace regulation, and policies leading to long-term economic decline or reorganization have all been subjects of studies examining health outcomes (and, in some cases, health inputs).

Recessions and unemployment have a mixed relationship to health. Short economic downturns tend to improve health at the population level by increasing leisure time and by reducing deaths and illness due to commuting by car, consuming restaurant meals, and experiencing unemployment as a solitary event. Longer downturns and longer periods of unemployment, however, tend to have uniformly negative health effects (Avendano & Berkman 2014). It is no surprise, then, that macroeconomic policies and industrial policies that result in extended periods of economic decline and unemployment (e.g., shock therapy–induced structural adjustment, deindustrialization, austerity, urban "renewal") have all been linked to adverse public health outcomes—including "deaths of despair" (e.g., Burgard & Kalousova 2015, Case & Deaton 2020, Diderichsen et al. 2021, Forster et al. 2020, King et al. 2022, Mehdipanah et al. 2018, Nosrati et al. 2022, Rajmil & Fernández de Sanmamed 2019).

One of the more contentious issues in the study of health equity involves the relationship between income or wealth inequality and the size of health inequalities between socioeconomic groups. While some scholars continue to regard this debate as unsettled given the scarcity of well-identified studies demonstrating a causal impact (see, e.g., Mackenbach 2019), many others argue that the preponderance of evidence points to a causal link between overall inequality and health inequality (see, e.g., Kelly-Irving et al. 2022, Pickett & Wilkinson 2015). The possible mechanisms connecting economic to health inequalities (summarized by Lynch 2020) include the direct effects of low income (e.g., inability to afford health-promoting goods, lack of sanitation, chronic stress), the harmful health consequences of being on a lower rung of a social hierarchy, and the political effects of inequality (e.g., opportunity hoarding and exclusion from policy influence). Economic policies that reduce inequalities in wages, earnings, and wealth should thus be associated with increases in population health and reductions in health inequality (Venkataramani et al. 2020). Indeed, many studies have found associations or causal effects linking improved health outcomes with the introduction of a minimum wage (Reeves & Stuckler 2016, Reeves et al. 2017, Sigaud et al. 2022, Wehby et al. 2022) and other labor market and fiscal policies that bolster earnings and

wealth for lower-wage workers and families (Barling & Kelloway 1996, Baughman 2012, Jones et al. 2022, Kim 2018, Minkler et al. 2014).

The regulation of unions and collective bargaining, which are central topics in the political science literatures on comparative political economy and American political development, are also critical for public health. The rights of workers to unionize and to bargain collectively over wages and working conditions have important implications not only for the level of wages but also for workers' experience of occupational risks that contribute to illness, and for the patients who come into contact with workers in healthcare settings. Greer (2018), Leigh & Chakalov (2021), Reeves & Stuckler (2016), and Venkataramani et al. (2020) provide helpful reviews of the relationship between labor policy and health.

Other Policy Determinants of Health

Several other policy areas of high or increasing interest to political scientists are also noteworthy for their close connections to health. Extensive recent research has linked restrictive immigration policy to poor health outcomes among migrants (e.g., Ayón 2020, Bruch et al. 2021, Moyce & Schenker 2018, Ortiz et al. 2021, Perreira & Pedroza 2019) and to the supply of healthcare workers in sending and receiving countries (Shah 2010, Walton-Roberts 2015). Similarly, restricting gender and sexual equality by enacting laws that impinge on civil, political, or social rights creates health inequity and is hence detrimental to population health (Bagade et al. 2020, Du Bois et al. 2018, Kavakli & Rotondi 2022, Kennedy et al. 2021, Latt et al. 2019, Pearson et al. 2021). Policies related to the criminal-legal system also cause a variety of ills for individuals and communities who come into contact with its institutions (Boen et al. 2022, Bor et al. 2018, Hawks et al. 2020, Klein & Lima 2021). Environmental and climate policies, too, are significant contributors to population health (Ebi et al. 2017, Majeed & Ozturk 2020).

In sum, public health research has shed light on the relationship between health and foreign policies, welfare regimes or varieties of capitalism (on the latter, see McLeod et al. 2012), economic policies, and a range of other types of policies—but is less successful at illuminating where these policies come from. Political science research, on the other hand, excels at unpicking the relationship between politics and policies, but understands little about the mechanisms linking policies and health. Making the connection between these two literatures is essential to understanding the policy pathways through which politics influences health—an avowed goal of much population health research.

POLITICAL DETERMINANTS OF HEALTH

Regime Types and Legal Institutions

Beyond policies, various political and institutional factors likely have independent effects on health. One of the oldest areas of research at the intersection of political science and health is the effect of democracy and other regime types on population health and mortality. Muntaner et al. (2011) reviewed this literature more than a decade ago and concluded that there was ample evidence for a positive effect of democracy on health outcomes, even after controlling for national income, education, and individual income. This effect worked either directly or via the impact of democracy on growth, individual income, or collective goods provision. A 2018 update replicated the main results of this review (Barnish et al. 2018). The subsequent literature has generally confirmed these findings, while expanding the array of mediating or moderating variables intervening between income and health, the range of health outcomes, or the types of polities considered (e.g., Annaka & Higashijima 2021, Batinti & Costa-Font 2022, Bollyky et al. 2019, Ramos et al. 2020, Rosenberg et al. 2018, Son & Bellinger 2022).

Social scientists have also helpfully turned their attention to how the component parts of political and legal regimes might affect health. For example, Kavanagh (2016) and Matsuura (2015, 2019) both found that constitutional rights to health are associated with better health outcomes, the former worldwide, the latter in US states. Other studies have examined the relationship between health and civil rights laws (McGowan et al. 2016), women's suffrage (Batinti et al. 2022, Bhalotra & Clots-Figueras 2014, Miller 2008), gender-based representation quotas (Bhalotra et al. 2019), proportional representation (Wigley & Akkoyunlu-Wigley 2011), and the strength of political parties (Bellinger 2021), finding positive associations or causal effects on health. Work that concretizes abstract phenomena such as "democracy" and investigates empirically the mechanisms through which they influence health—which political and other social scientists are ideally situated to carry out—is an important contribution to public health research.

Government Partisanship and Ideology

As encouraging as the literature on democratic institutions and health may be, democracy alone is likely not enough to promote population health improvements or health equity. Political scientists could also add a great deal to our understanding of how political regimes achieve their characteristic associations with health via intervening mechanisms of representation and policy making. It matters not only that (some) people are able to vote, but also who they vote for, whose interests their representatives promote in policy, and whether politicians can in fact achieve their policy goals.

Scholars of public health and political science have in fact attended for decades to the possibility that partisan or ideological differences at the level of governments could cause differences in health outcomes. In one of the earliest contributions to this genre, Moon & Dixon (1985) found that the ability of states to meet basic human needs, including health, varied by the ideological orientation of ruling elites (left, center, or right), but that this relationship was moderated in opposite directions by state capacities. Subsequent studies concerning richer democracies have not interacted ideologies by state size or strength, and generally (though not exclusively) have found a strong association between leftist government, better population health, and smaller relative health inequalities by social class (for reviews of this literature, see Barnish et al. 2018, Falkenbach et al. 2020, Muntaner et al. 2011).

Studies in the last decade have examined, in addition to the standard left–right dimension, the implications for population health and health equity of populist governments (e.g., Falkenbach & Greer 2021, Kavanagh et al. 2021, Rinaldi & Bekker 2019). The core finding of this literature (leaving aside COVID-19, which we consider below) is that having populists in office tends to lead to the loosening of tobacco regulations, restriction of reproductive rights, an increase in the number of uninsured people, the privatization of health care, a reduction in healthcare funding, etc. It is too early to know if the current wave of populist governments around the globe will have the predicted negative effects on health, but researchers will surely want to investigate in the near future.

Political Behavior

There is some evidence that poor health has recently led voters to be more likely to vote for right-wing parties in the United States and Europe (e.g., Koltai et al. 2019, Wasfy et al. 2020). However, in the 1990s, left voting was associated with higher mortality at the level of constituencies in Great Britain (Smith & Dorling 1997). Until health status variables are regularly included in election surveys, we will likely have to guess about the true relationship between health and party selection—and in any case it is likely to vary across time and place, depending on party positioning with respect to policies that affect health and on the association of health with other

factors predicting vote choice. However, regardless of vote choice, there does seem to be a close connection between good health and political participation. Numerous studies have found that a range of illnesses lead to depressed likelihood of voting at the individual and aggregate levels, with the magnitude of effects often similar to or greater than that of traditional predictors (e.g., Burden et al. 2017, Landwehr & Ojeda 2021, Mattila et al. 2013, Pacheco & Fletcher 2015).

Lyon (2021) and Engelman et al. (2022) find, however, that the effect of poor health on voting is conditioned by income, with higher-income voters less easily deterred by illness. Meanwhile, Pacheco (2019) uses anchoring vignettes to show that the correlation between health and voting is explained away by interpersonal variability in optimism, a characteristic that influences both self-assessed health and the likelihood of participating in politics. Both of these findings suggest that more complex modeling strategies based on a strong underlying theoretical model of participatory behavior are needed to fully explore the relationship between political participation and health.

If health may or may not cause people to participate at different rates, or to have different political preferences (see, e.g., Rodriguez 2018), it is nevertheless undeniable that people who are not alive cannot vote. This means that differential mortality across groups on its own can help to shape the electorate. For example, Rodriguez et al. (2015) estimate that excess mortality reduced the number of voting-age Black citizens in the United States by 1.4 million in 2004—enough to reverse 7 Senate and 11 gubernatorial races in that year's general election. Deaths from HIV/AIDS have reshaped electorates in African countries as well (Chirambo 2008), and it seems likely that socioeconomic, racial, and gender inequalities in death rates and severe disablement from COVID-19 will have similar effects across the globe. Political scientists have long been attuned to the outputs of politics when other forces—such as suffrage extension, migration, voter suppression, or mass incarceration—have constituted electorates in new ways. The impact of health on the electorate is a potentially important way that health policies feed back into politics, and it should be a priority area for future research on health policy for political scientists.

STRUCTURAL DETERMINANTS OF HEALTH

Political determinants of health range from the relatively concrete (e.g., "voting behavior") to the almost hopelessly abstract (e.g., "power"). However, public health scholars—especially those who work in a critical vein (Schrecker 2022)—have identified other, structural determinants of health that are intertwined with and/or upstream of even the most abstract political factors. These include a variety of "-isms": structural racism and sexism, colonialism, capitalism, and neoliberalism, all of which are manifestations of power relations within or across societies.

Structural discrimination has been recognized as a cause of health inequalities by race, ethnicity, nationality, color, gender, and the like for decades (Krieger et al. 1993, Williams & Collins 2001). However, it is only in recent years that health researchers and political scientists have begun explicitly and regularly to call out structural or systemic racism and sexism, as opposed to interpersonal experiences of discrimination (often in the healthcare system), as causes of poor health. Some notable recent examples include McClure et al. (2019) on the health effects of redlining in Detroit; Homan (2019) on structural sexism and health in the United States; Shonkoff et al. (2021) on the effects of toxic stress from racism in early childhood; a review of studies using the concept of "structural violence" to explain adverse health outcomes in Europe (Macassa et al. 2021); and a special issue on structural racism in the journal *Health Affairs*, the most widely read health policy publication among US health policy professionals (Weil 2022). Of note, a number of recent health publications have also been devoted to the proper conceptualization and measurement of structural discrimination—often in an explicitly intersectional framework (Adkins-Jackson et al. 2022, Graetz et al. 2022, Groos et al. 2018, Krieger 2020).

Colonialism, too, has been identified as a source of adverse health outcomes and health inequalities that negatively affect (racialized) colonial and former colonial subjects and Indigenous peoples across the globe (Bashford 2003, Czyzewski 2011, Ramos et al. 2022). An older line of research, but with recent additions relevant to a political economy understanding of health, concerns the adverse impact of dependency relations and globalization on health in the Global South, and on health inequities between populations in the Global North and South (Barnish et al. 2021, Forster et al. 2020, Labonté et al. 2011). Neoliberal policies, policy paradigms, power relations, and ideas have also been identified as sources of health inequalities, both in a global context and within rich democracies (Friel et al. 2021, Lynch 2020, Schrecker 2016, Sparke 2017).

Finally, recent public health scholarship has hypothesized a deleterious effect of capitalism itself on health and health equity (Flynn 2021, Harvey 2021, Sell & Williams 2020, Taiwo et al. 2021). Class position and class relations, too, have been examined as causes of health (Eisenberg-Guyot & Prins 2020, Kokkinen et al. 2020, Muntaner et al. 2010). In all of this research, capitalism is conceptualized as an upstream determinant that influences health through a combination of political, economic, and cultural mechanisms that influence policy making, commercial practices, employment relations, consumption, social hierarchies, and the like, all of which in turn affect health outcomes. The focus on power and power relations in the health critique of capitalism obviously implicates political science. If we wish to contribute to a political economy of health, political scientists will need to overcome our tendency to avoid explicit discussion of the relationship between capitalism and political power.

A close political analysis of capitalism promises to reveal mechanisms through which power influences policy, including how ideas and language frame political choices. Two observations in particular—that policy making is not a neutral, technocratic, or evidence-based enterprise but rather infused with power and politics; and that how political and societal actors frame public problems impacts both what policies get made and what outputs they produce—are central to political science, but they have been less thoroughly explored in the public health literature. Scholars trained in political science and social and health policy have, however, made important contributions to the public health literature on how politics influences health policy (e.g., Béland & Katapally 2018, Greer et al. 2017, Smith 2013) and on the impact of framing on health policy (Gollust & Lynch 2011, Gollust et al. 2019, Lynch 2020, Namugumya et al. 2021, Shiffman & Shawar 2022).

Health is both a desired good and, as we have seen, an outcome of structured power relations that influence well-being through their impact on public policy, economic life, and social relations. Moreover, the distribution of health in society affects the distribution of power and influence. For all of these reasons, public health and health equity are eminently appropriate topics of study for political scientists. And to the extent that we as a discipline wish to side with the forces determined to bring about a more just society, we have a responsibility to contribute to understanding how current political, policy, and economic arrangements have led to the further marginalization of disempowered communities by stripping them of their most basic right: to well-being.

HOW POLITICAL SCIENCE CAN CONTRIBUTE TO A RICHER POLITICAL ECONOMY OF HEALTH

I have argued, here and elsewhere (Lynch 2019, Lynch et al. 2022), for a deeper and more productive engagement between political science and public health. I am far from the first to do so. In the world of public health policy, the *Lancet*–University of Oslo Commission on Global Governance for Health (Ottersen et al. 2014, p. 659) explicitly identified political determinants of health and recommended that an international body analogous to the Intergovernmental Panel on Climate

Change be established to focus on "a political analysis of the social and political determinants of health." Public health and medical journals, too, have called for more integration of political science and public policy research (Bernier & Clavier 2011, de Leeuw et al. 2014, Fafard & Cassola 2020, Gagnon et al. 2017, Gómez et al. 2022). But what is the best way to achieve this?

Political scientists have finally entered the study of health politics en masse with the arrival of the COVID-19 pandemic. New pandemic-related work by political scientists, including special issues published by *Perspectives on Politics*, *International Organization*, and the *Journal of Health Politics, Policy and Law*, has touched on many of the policy, political, and structural forces affecting health discussed in the preceding sections. This stands to reason: While some researchers continue to characterize the pandemic as an exogenous shock or natural experiment and to use its onset to gain causal leverage, variation in the management and impact of the pandemic has important links to earlier political and economic choices and longstanding policy orientations (Bailey & Moon 2020, Bambra et al. 2021, Drezner 2020, Hancké et al. 2022, Jones & Hameiri 2022, McNamara & Newman 2020, Rovny et al. 2022).

Political scientists have also identified important impacts on health, during the pandemic, of recent, prepandemic phenomena such as intensifying partisan polarization and politicization of health policy, ongoing economic changes linked to the global financial crisis of 2008–2010, massive international migration, and the rise of populist governments (e.g., Adolph et al. 2022, Bojorquez et al. 2021, Bozorgmehr et al. 2020, Gadarian et al. 2021, Pevehouse 2020, Ringe & Rennó 2022). In addition, political scientists have contributed important insights into the process of politicization of previously neutral topics such as mask wearing and vaccination that are likely to affect population health (e.g., Hegland et al. 2022, Touchton et al. 2021, Walter et al. 2020).

Some political science research, though, has suffered from a tendency to use public health simply as case material, or what some have termed the "add COVID and stir"[4] phenomenon: treating COVID-19—or indeed other health issues—as conveniently quantifiable inputs to or outputs of political processes in which we are already interested, without examining in much depth whether the intervening causal mechanisms are useful to study or even, in some cases, present. Public health, to be sure, can suffer from a similar problem: incorporating political variables such as welfare regimes, ideologies, or indeed power into causal models predicting health variables, without an in-depth analysis of how these highly aggregated and sometimes abstract entities might concretely work to influence health.

Integrating Science and Politics for Public Health (Fafard et al. 2022), edited by and including contributions from authors who have been researching the politics of public health for many years, lays out a compelling path toward a "public health political science" (p. 5). This volume helpfully identifies sources of what the editors describe as an "intellectual stalemate" (p. 6) between public health and political science and offers lessons that are generalizable to political science as a whole. However, the scope of the book is restricted to the parts of political science most focused on public health policy making, primarily in the Global North, rather than, e.g., IPE or comparative political economy, IR, or electoral studies.

What, then, can political science offer to a reinvigorated political economy of public health? A useful starting point for answering this question is to observe the current state of the public health literature on political economy. In a recent review, McCartney et al. (2019) define political economy in relation to public health as societies' "historical contingencies as well as their contemporary economics, production and consumption activities, power relations, governance,

[4]I have heard this phrase in private conversations, including as a grant reviewer and journal editor. Notably, I have also heard "Add politics and stir" in discussions of public health research.

policies, polities (or institutions), legal rules, culture, values, and ecology" (p. e2), as well as the "interrelationships and power dynamics" (p. e2) characteristic of these aspects of society. They operationalize exposure to political economy as "a difference or change in policy, law, or rules; economic conditions; institutions or social structures; or politics, power, or conflict" (p. e3). The authors conclude that, using this definition of political economy of health, "there remain substantial gaps in the available evidence base" (p. e9). In particular, they note a lack of sustained research on "the interrelationship among governance, polities, power, macroeconomic policy, public policy, and population health, including how these aspects of political economy generate social class processes and forms of discrimination that have a differential impact across social groups. This includes the influence of patterns of ownership (of land and capital) and tax policies" (McCartney et al. 2019, p. e9).

Political scientists could contribute to filling some of these gaps. Our substantive interest in and expertise in power lead us to see politics, including but not limited to its influence on policy, as endemic to social relations—and not, as some public health researchers and practitioners wish it might be, as an aberration or a deviation from an apolitical norm (on this point, see Fafard et al. 2022). One exemplary analysis of how power relations affect public health is Kentikelenis & Rochford's (2019) article "Power Asymmetries in Global Governance for Health: A Conceptual Framework for Analyzing the Political-Economic Determinants of Health Inequities." The authors not only recognize that there are "no level playing fields" in global health governance; they go on to provide examples of how actors' political, economic, epistemic, and symbolic power resources take root in institutions and differentially empower organizations and individuals in the global health field, and how these multiple types of power and levels of analysis interact to influence health.

While they may seem elementary to anyone who has taken or taught an introductory-level political science class, the "three I's"—interests, institutions, and ideas—provide a powerful framework for thinking about how and why power manifests in the world and what impact it has on health. Walls et al. (2018) use this mnemonic device to good effect in their brief article "Addressing Trade Policy as a Macro-Structural Determinant of Health: The Role of Institutions and Ideas." They show that identifying how the global trading system enforces ideas such as neoliberalism concretizes and gives teeth to our understanding of trade as a "structural" determinant of health. Similarly, Smith (2013) shows how the structure of health and policy-making institutions in the United Kingdom inhibited the uptake of the most potentially radical parts of the social determinants of health paradigm. My own work on the failed promise of government strategies to reduce health inequalities (Lynch 2020) traces how politicians' beliefs about what was politically possible during a period of neoliberal ideational hegemony led to a change in how they framed the problem of inequality. I find that this ideational shift, in turn, prompted a change in the policy instruments that could be used to address inequality, a change that stymied efforts to reduce health inequalities (Lynch 2020).

All of these examples show that a political economy approach to understanding how interests, institutions, and ideas connect to health at the population level relies on both concretizing and contextualizing what might otherwise be nebulous assertions about the nefarious influence of capitalism, neoliberalism, racism, and the like. Concretizing requires disaggregating larger systems and institutions into their component parts and showing how those parts influence health. For example, if we say social democracy reduces health inequalities, what do we really mean by social democracy? We might mean social democracy as an ideology. (If so, what part of it—its egalitarianism? its collectivism? its focus on full employment?) Or perhaps we mean social democratic parties (their links to unions? their platforms? their party discipline?) or social democratic politicians (their social backgrounds? their norms?). Concretizing also requires identifying mechanisms

that join successive links from what may be distal causes (e.g., whichever aspect of social democracy we take to be causative) to specific health outcomes (e.g., reduced gaps in relative mortality by education level among men). Finally, these assertions must be contextualized. Do we mean center-left parties writ large, or only those in Nordic countries? Norway or Denmark? During what time period? And with respect to what areas of policy making?

Bringing this level of concreteness and specificity to the study of how large-scale political and economic institutions affect health outcomes will require real collaboration between political scientists, who are trained to pick politics apart in this way, and public health scholars, who are trained to understand how more proximate causes of health get under the skin. One benefit of such collaboration will be a stronger understanding of the links between politics and health at the macro level. But there are others, too. First, many public health researchers are also involved in attempting to influence policy makers and in the implementation and evaluation of health policies. They have micro-level knowledge about politics and policy, and they have access to policy makers and communities that many political scientists would envy. Second, public health scholars have in-depth knowledge about types of data and data sources that political scientists are only beginning to tap into. We would do well to learn from these scholars' experiences with, e.g., cause-of-death data, given their notorious lack of consistency across reporting units and given the politicization of COVID-19. Third, public health has developed an arsenal of causal concepts that political scientists who work on diffusion, or on causal processes with varying etiologic periods, might find useful (Lynch 2019).

Politics is not a game or a puzzle. Even in the richest societies, and even during "normal" times, power has the potential to kill, or to allow people to thrive. We have the expertise and the inclination to make power's channels visible in a way that few other disciplines do. Keeping a close eye on how the organization of politics and policy choices affects health would also be good, dare I say it, for the soul of political science.

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