

Book Review

Robert Chernomas and Ian Hudson

To Live and Die in America: Class, Power, Health and Healthcare

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Reviewed by Howard A. Doughty

Every contemporary liberal democracy from Austria to Australia has some form of publically supported universal health insurance system. These advanced nations take some pride and their citizens take some solace in the fact that principles of equity, excellence and accessibility are claimed as essential to the care and treatment of the ill and infirm. No doubt some healthcare systems perform their duties better than others. No doubt improvements could be made in all of them. Only in the United States of America, however, is there significant opposition to the foundational premise that it is duty of the state to ensure that everyone is given the best care possible without regard to individual economic circumstances. Like education, healthcare is regarded as a right and not a commodity to be sold to the highest bidder and to be denied to the poor and the indigent.

Yet, in the United States, even President Obama's *Affordable Care Act*, which leaves millions of Americans uninsured and allows for-profit insurance companies to dominate the healthcare "industry," is regularly denounced in state legislatures and by state governors, condemned in the United States Congress, and challenged in the courts—including the Supreme Court of the United States. Bitterly fought cases have not been abandoned despite the failure of the critics to succeed (so far) in overturning what is contemptuously called "Obamacare" by its rancorous critics.

The strength of corporate interests and the relative weakness of unions have given the United States a bloated and inefficient health care system. The result is a system that at great cost provides people with a level of care that is often worse than countries which spend half as much."

- Dean Baker, Center for Economic and Policy Research, Washington DC

To many outsiders, with the exception of intransigent, doctrinaire neoliberals, Americans' hatred and/or fear of "socialized medicine" are unfathomable. To be fair, prior to the crafting and passing of Mr. Obama's reforms, public opinion polls commonly found that ordinary citizens favoured some form of single-payer system akin to the one that has been available in Canada since the 1960s and that has been common in part of Europe for a considerably longer time (Brohinsky & Schulman, 2009, July 29). Moreover, in one way or another, both Republican and Democratic presidents at least since Teddy Roosevelt have sought to introduce and expand the people's right to medical care.

Thanks, however, to immense pressure from health insurance providers, pharmaceutical companies, private hospitals and also to inflammatory rhetoric and recklessly implausible fear-mongering by politicians affiliated with the far-right faction called the “Tea Party,” hopes and expectations for a measure of change that would bring the USA significantly closer to other OECD countries have been foiled.

Of course, also to be fair, it must be recognized that President Obama himself displayed timidity from the outset and hastily took the concept of a single-payer, universal insurance program off the negotiating table before discussions with the opposing party and the private-sector healthcare providers had even begun. By doing so, he left some of his supporters disconsolate, confused and wondering if the “progressive” new president wasn’t a defender of the *status quo* rather than the vehicle for “hope” and “change” that he had claimed to be on the campaign trail of 2008—an uncertainty that has remained throughout his presidency. Moreover, the vitriolic objection to “Obamacare” was also at least partially the result of gross administrative incompetence when the program was “rolled out.” For whatever combination of reasons, however, this allegedly historic and legacy-defining legislative reform has had the double effect of harshly disappointing authentic healthcare reformers and of further infuriating those who preternaturally resent “government interference” in the lives of taxpayers (formerly known as citizens). The healthcare industrialists, of course, are laughing all the way to the banks (with which they share ideologies and practices dedicated to private profit and not the common weal).

“This book should become a classic. It should be read by everyone who feels that power in the United States is very unevenly distributed, not only by gender and race, but primarily by class.” – Vicente Navarro

Outsiders, of course, are astonished not merely by the reluctance of contemporary American leaders to contemplate a system that is so widespread and welcomed in other parts of the world (and that is envied by countries not yet wealthy enough to afford it), but also by the fact that, by most measures, the United States has a relatively poor healthcare record. Americans pay about twice as much for healthcare (17.7% of GDP versus an average of 9.3% for OECD countries), but receive only about half the service as other developed countries.

Moreover, the US is falling further behind other countries, especially in northern Europe, where “socialist” tendencies are the strongest. Moreover, by most measures of both physical and mental well-being and by evidence of equitable distribution of health services, the United States compares unfavourably even with countries that have far less prosperous economies. No one doubts, of course, that American innovation in medical practices and technologies are among the finest in the world, but it is also plain that the power of health-related corporations and the ideological message of their political supporters have convinced a large portion of the American electorate to vote against its obvious material self-interest, to say nothing of values of social responsibility and community solidarity.

To Live and Die in America is written by two University of Manitoba economists. Robert Chernomas is a Professor with special interests in Health Economics, the History of Economic Theory and the role of the academic as a social activist. Ian Hudson is an Associate Professor whose main interests are in Fair Trade, Ethical Consumption and Sustainable Development. The two previously collaborated on *The Gatekeeper: Sixty Years of Economics According to the New*

York Times (2010). Often excoriated by right-wing American politicians and pundits as being irredeemably “liberal,” the paper has nonetheless been an enthusiastic supporter of American adventurism and argued strongly in support of the Vietnam debacle, gave unapologetic enthusiasm to President Bush’s spectacularly wrong-headed attack on Iraq in 2003, and continues to endorse the seemingly unwinnable but nonetheless permanent “war on terror.”

The authors correctly claimed, in the alternative, that “the usual liberal-conservative dichotomy that has been used as the previous spectrum of media bias, while accurate, overlooks a more profound bias”; namely, that American conceptions of ideological difference are remarkably narrow and that any opinion that violates the boundaries of permissible debate is to be rudely predissmissed. So, they say, “an economic debate that limits itself to options pursued by these two camps would be similarly limited.” The available range of tolerable economic, political and social choices in the United States are all based on common eighteenth-century liberal conceptions—held in amber by Republicans and allowed to evolve by Democrats but, at the root, identical. In the case of *The New York Times*, they say its support is given to “the long-term interests of U.S. business, not a range of opinion that demonstrates ideological diversity in European, much less more exotic societies.” They are right.

America’s healthcare system is neither healthy,
nor caring, nor a system.” – Walter Cronkite

A similar awareness and sensitivity is brought to their treatment of healthcare reform. The authors set themselves the difficult task of explaining how this prime example of “American Exceptionalism” came into being, and why it remains a matter of venomous controversy and conflict at this historical moment. They meet their challenge commendably. Instead of focusing on the propaganda and passionate protestations from healthcare reform’s vociferous opponents in and out of government, they concentrate on American capitalism as a system that has created both the institutions and the enabling attitudes that sustain the fundamental elements of healthcare service delivery despite widespread dissatisfaction about its efficiency, efficacy, equity and accessibility.

Chernomas and Hudson argue effectively that the dominant North American models of disease are not unlike the commonplace distinction between “liberal” and “conservative” policy preferences; to wit, there’s much less to them than meets the eye. Firstly, the biomedical approach urges us to spend money on acute care directed to solving existing problems through advanced technology, surgery and medicines. The treatments, of course, are often highly invasive. Secondly, the behavioural approach encourages us to eat healthy foods and do exercise. This preventative approach mainly affects individual “lifestyle” and is morally virtuous, but of uncertain value in a deathly epidemic. *To Live and Die in America* finds fault with both. Although it is incontestable that innovation leads to good “repairs” to a damaged body (I am pleased that modern techniques to deal with a ruptured appendix were in place at the time, or I would not have been alive for my seventeenth birthday), and although there is little doubt that health benefits accrue to people who keep fit, eat nutritious foods, and refrain from smoking cigarettes (I congratulate myself daily on quitting tobacco in August, 1974). Chernomas and Hudson, however, point to a third explanatory model.

Social class—not merely disparity of income as measurable in commonly accepted factors of “social stratification,” but the deeper structural social connections defined by relations

to the mode of production and distribution of goods and services—is the primary cause (or the “cause of the causes”) of inadequate healthcare. The authors explain that the foundational healthcare problems in the United States are a product of the unique brand of capitalism that has developed in the US, but that is not absent, just less dominant and less immediately visible elsewhere. It is this particular form of capitalism that creates both the social and economic conditions that largely influence health outcomes and the inefficient, unpopular and inaccessible healthcare system that is incapable of dealing with them optimally or, in many cases, even minimally. Their explanation, therefore, is not only relevant to people seeking to understand the current state of American healthcare, but also to identifying and assessing the influence that the American debate threatens to have in countries with existing universal health insurance systems, but that are finding themselves under increasing assault both by US-based ideological messages and by US institutions trying to affect policies and practices in other countries.

The Harper strategy will increase health expenditures and reduce access while a more complete public healthcare sector would have billions more to spend on real problems without increasing costs to the taxpayer.
– Robert Chernomas

A fact that Chernomas and Hudson make clear is that, although the US model pushes the mantra of deregulation and privatization, it is unwise to oversimplify matters. On the one hand, Chernomas quotes the Vice-President of the Ford Motor Company saying that his company would support a Canadian-style system in the USA “in a heartbeat,” but that Ford was a member of corporate advocacy groups that would not tolerate any of their members suggesting that public sector solutions were better than those proffered by profit-centred, private sector and, increasingly, P-3 (Public-Private Partnership) arrangements in which the public assumes the risk and the private partners win the profits.

The case for the public sector is obvious. Perhaps counterintuitively, it relies on the classical distinction between “productive” and “unproductive” labour. The bulk of the healthcare industry (that part not involved with actually rendering service) is compromised by the predominance of finance, marketing, risk assessment, actuarial calculations, and, of course, profit. Absent these elements (never mind the multiple corporate redundancies in executive, clerical and sales functions), the gap between US and, for example, Canadian expenditure would be significantly reduced or eliminated, and more and better care would be provided.

What’s more, a public takeover of enterprises such as pharmaceutical production could make them immensely more efficient and publically accountable. The advertising-to-research ratio in massive private sector firms and the almost unlimited private corporate access to public research in universities or coordinated by entities such as the American National Institutes of Health maximizes profits while achieving limited medical benefits. So, Chernomas and Hudson support the building of Canada’s own drug sector on the model of already successful Crown Corporations. Such obviously beneficial changes, however, are anathema to the capitalist sector

and rejected out of hand by political leaders such as Mr. Obama and Mr. Harper (to say nothing of Sarah Palin and the Koch brothers).

By approaching the issue of healthcare through the lens of political economy, the authors are able to look beyond existing arrangements and explore their origins. They write cogently about the rise and fall of infectious diseases in nineteenth-century America and about the relationship between class and chronic disease in our own. They attribute many of the improvements in healthcare to political militancy especially among British trade unions that were largely responsible for the National Health Service and among the working and middle classes in the USA, Canada and elsewhere who have, with varying degrees of success, followed suit. It was these organizations that agitated for higher wages (hence better nutrition and better housing), public health programs, public hygiene, sanitation and immunization. Although American programs such as “Medicare” and “Medicaid” are deemed essential, especially by many of the Tea Party persuasion who attack Obama for wanting to “steal” their funding to finance “Obamacare” (neither logical consistency nor evidence-based argument have ever been among their greatest strengths), the strident opposition to these “socialist” programs intended to assist the elderly and the indigent was once carried on using the same arguments that are now used to savage the single-payer system. The opponents, however, were not merely to be found on the fringe of the Republican Party, but also among liberal Republicans and mainstream Democrats whose commitment to the “American Way of Life” made them sceptical of government intervention in general and to regulation of giant corporations in particular.

Chernomas and Hudson make a case for a political-economy approach by examining living and working conditions as a cause of disease and poor health. They point out that health and politics cannot be separated, and they emphasize the positive correlation between working-class power and health outcomes across nations.

– Steven Pressman (2013)

Chernomas and Hudson describe and eloquently defend the quest for reform from the bottom up. They also provide an excellent assessment of the reaffirmation of corporate power in the last thirty years of the previous century. Unions were devastated by a shift in North American investment away from manufacturing and into the tertiary sector where laws governing union organization made unionization of service industries from commercial and financial enterprises to mass distributors such as Walmart next to impossible. Now, of course, neoliberal ideologues with visions of “right-to-work” laws and unfettered attacks on public sector employees have undermined the strongest supporters of equitable healthcare and threaten to undo the projects that took a century to accomplish.

Healthcare is partly a matter of providing excellent quality services. It is also partly a matter of health promotion intended to alter individual behaviour. *To Live and Die in America*, however, puts both of these partial explanations under the larger umbrella of political economy. Writing from Canada and watching a federal election unfold in which the national government has effectively abandoned its mandated role in healthcare and in which the newly appointed Minister of Employment and Social Development is an anti-union ideologue who viscerally despises most credible social programs, I may occasionally look south of the border and be saddened by the state of the American health and healthcare. When, however, I look around my

own country (once considered a more humane North American alternative, albeit within the capitalist framework), I no longer look south with compassion, but with trepidation.

The wretched betrayal of First Nations peoples and the degradation of the health and healthcare of the aboriginal peoples can hardly be worse in the USA and is just one of the ways in which Canadians have lost any pretense of the moral authority needed to reproach the United States for its failures. By the light of Chernomas and Hudson's analysis, we can see that the troubles experienced by healthcare reformers in the USA are as likely to infect the Canadian body politic as any example we provide is apt to teach our friends some helpful lessons about how to manage healthcare—if not well, then at least better than before.

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