to examine in depth, Staupers turned her disillusionment into a powerful political movement among Black nurses, the Black press and clergy, and prominent White supporters waiting for the next inevitable wartime shortage of White nurses. When President Franklin Roosevelt stood ready to draft White nurses, Staupers launched a powerful media campaign challenging such draconian measures when thousands of fully qualified Black nurses stood willing and ready to serve in the military. Almost overnight, the Army Nurse Corps desegregated. A few year later, the American Nurses Association became the first professional health care organization to admit Black nurses as members.

MORE QUESTIONS

Real issues remained within American nursing—not the least being the different meanings attached to the implications of such words as "integration" and "desegregation." In Jones and Saines' words, these changes in meaning were incremental and, if not ephemeral, then at least constantly contested. But to return to the idea of nurses and nursing as a broader case study, we can see the illustrative power of how this group of clinicians, and the discipline they represent, allow us to more fully understand the nature of social and political change. Should agendas around change in public health policy and practice strive for changes in attitudes and beliefs that are small but steady, or sweeping and transformative? How does self-interest or group interest intersect with broader issues of social justice? Are harm reduction policies appropriate steps when ultimate goals are nothing short of broad-based prevention? These are not easy questions. But we can thank Jones and Saines for allowing us to cast the history of nurses and nursing as an exemplar of a discipline that might provide answers. AJPH

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CONFLICTS OF INTEREST

The author declares no conflicts of interest.

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The Political Economy of the United States and the People's Health

See also McCartney et al., p. 942.

The political economy approach argues that the behavioral and social determinants of health are themselves shaped by macro-level structural determinants: politics, the economy, and the state.[1] Population health is thereby politically determined with patterns of health and disease produced by the structures, values, and priorities of political and economic systems.[2] The 2007–2008 global financial crisis, austerity, and the rise of populism (e.g., President Trump, Brexit) has led to a widening awareness in the international public health community of the important influence of political and economic structures on public health.[3]

This issue of *AJPH* engages with this political "public health reawakening" by featuring an important and timely evidence review by McCartney et al. (p. 942) on the impact of political economy on population health. Reviewing a sizeable international literature of more than 50 systematic reviews conducted over the past 25 years, the authors concluded that social democratic welfare states, higher public spending, fair trade policies, compulsory education, microfinance initiatives, health and safety regulation, universal access to health care, and high-quality affordable housing have positive impacts on health while the retrenchment of the public sphere associated with neoliberalism has negative effects.

Nowhere exemplifies the findings of the McCartney et al. review and the importance of political economy for health more than the United States. The United States has a significant health disadvantage relative to other wealthy countries—it punches well below its economic weight.[4,5] For example, infant mortality rates in the United States are almost three times that of Iceland and 50% higher than the Organization for Economic Cooperation and Development average. Likewise, at 79 years, average life expectancy in the United States is three years lower than in Sweden and Costa Rica.[6] This disadvantage became particularly prominent from around 1980—and mortality and morbidity rates are now increasing—particularly among middle-aged, low-income Whites.

Traditional analysis has pointed to the role of differences in health behaviors between the United States and other high-income countries. For example, around 20% of the US health disadvantage is attributable to historical differences in smoking rates, and there are significant differences in diet—the United States has the highest average calorie intake in the world.[4] Health systems researchers have focused on the lack of universal health care in the United States where the market-based system means that around 10% of Americans are without health insurance and millions of others remain underinsured[4]. Given the well-established association between poverty and health,

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advocates of the social determinants of health perspective have highlighted the higher rates of relative poverty in the United States (17%) compared with other high-income countries (e.g., 7% in Denmark).[6]

However, the traditional, the health systems, and the social determinants approaches are not able to explain *why* Americans have a higher calorie intake, *why* the United States does not have universal health care, or *why* the United States has worse poverty rates.[6] To really understand why the United States has a health disadvantage, the full chain of causality ("the causes of the causes") needs to be examined and, to do this, as the McCartney et al. review shows, requires an examination of the political economy of health in the United States.

KEY FACTORS

There are significant political and institutional arrangements that differentiate the United States from other rich democracies, setting the wider rules of the game, and shaping the environment within which the other behavioral, health care, and social determinants of health play out.[6] There are three key factors associated with the American ultraliberal political economy model that has led to the US health disadvantage.[6]

Low Public Health Regulation

Perhaps the most direct way in which the US political economy explains the US health disadvantage is through the limited regulation of unhealthy products, such as cigarettes, alcohol, and ultraprocessed food and drinks, and the industries that produce and market these products, arguably leading to the relatively worse health behaviors of US citizens.[6] Regulating the formulation of these products (e.g., by limiting levels of saturated fat, salt, and refined sugar in food and drinks), their availability (e.g., via age and opening hours restrictions), marketing (e.g., restricting advertising), and price (reducing affordability) are known to be effective means of reducing consumption and, therefore, their negative public health impact. Yet, the United States remains one of the least-regulated high-income countries.

Minimal Welfare Provision

As the McCartney et al. review highlights, higher levels of public spending on welfare, health care, and the provision of services such as high-quality public housing has positive impacts on population health. The public (federal or state) provision of social welfare, though, is minimal in the United States compared with other high-income democracies, with modest social insurance benefits subject to strict entitlement criteria, means testing, and receipt, accordingly, being stigmatized.[6] A stark division exists between those, largely the poor, who rely on public aid and those who are able to afford private provision. The United States now provides the lowest level of public welfare generosity and the lowest level of health care access of high-income democracies.[6] Indeed, with declining jobs in manufacturing and traditional industries over the past few decades—alongside an increase in "flexible" service sector work—there has also been a steep erosion in the proportion of the workforce covered by private and occupational welfare schemes (e.g., pensions).[7]

Low Levels of Political Incorporation

Countries with higher rates of trade union membership have more extensive welfare systems, better health care provision, and higher levels of income redistribution—and correspondingly have lower rates of income inequality and better health outcomes.[6] The United States has always had the lowest rate of trade union membership among wealthy democracies—and it has declined even further in recent decades to around 12% of the workforce today (compared with 68% in Sweden).[6] This has restricted the representation of working-class interests in policy and politics. Furthermore, the United States was a historical laggard in terms of the incorporation of minority groups—with equal civil rights for African Americans only achieved in the 1960s. The United States is also the most unequal of wealthy countries in terms of income inequality, which is associated with higher infant mortality rates, lower life expectancy, higher rates of obesity, excess risk of premature mortality, higher homicide rates, and higher levels of mental ill health.

CONCLUSIONS

A political economy analysis can also help explain why the US mortality disadvantage become more pronounced since 1980. As the McCartney et al. review shows, neoliberalism is associated with worse population health outcomes as a result of the deregulation of the market, the scaling back of public welfare, lower political incorporation, and the resulting higher income inequalities. Neoliberalism had an impact on all high-income countries, but it was most actively pursued by successive US governments following the election of Reagan in 1980.

So, to paraphrase Bill Clinton's 1992 election catchphrase, in the case of the US health disadvantage, "it's the [political] economy, stupid!" and the McCartney et al. review in this issue of *AJPH* provides further evidence of the importance of looking to the "causes of the causes" of population health outcomes. AJPH

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