Commentary

Political Economy of Non-Communicable Diseases: From Unconventional to Essential

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INTRODUCTION

In January 2019, the Prince Mahidol Award Conference organized an international meeting on “the political economy of non-communicable diseases”—the first major global health symposium to include political economy in its title and as its frame for discussion. This commentary is based on a plenary presentation made at the start of the conference. The overall goal of PMAC 2019 was “to foster and enhance global momentum for NCD prevention and control,” using a political economy perspective. The organizers called this “an unconventional outlook.” This commentary argues that political economy should become viewed as a conventional, indeed, an essential outlook for NCDs, and more broadly for global health. Political economy factors are integral to the problems of NCDs and therefore must also be integral to the policy responses.

I have often argued in my career for more attention to political economy in public health—for more attention to the political dimensions of health policy, especially for low- and middle-income countries. This undoubtedly reflects my training as a political scientist. Political scientists constitute a tiny disciplinary club in global health. Just as health economists have a significant organization and a global meeting every two years in the International Health Economics Association, so too should political scientists engaged in health policy issues. The study of politics remains on the margins in the global health community, despite decades of scholarship on this topic, while economics and economic analysis are squarely situated at the center. PMAC 2019 contributed to placing political economy analysis more visibly at the core of debates on global health policy.

While a prolonged discussion of the definition of political economy is not appropriate here, some consideration of definitions is necessary to ensure clarity. In general, most definitions of political economy focus on how the distributions of political and economic resources affect something we care about: inequality, economic growth, some specific policy, who controls a country, or health. The analysis of political economy typically involves consideration of power,
along with interests, ideas, ideologies, and institutions. This article, in particular, focuses on the role of stakeholders in the political economy of NCDs, and is consistent with the approach presented by Campos and Reich in their article on implementation politics in this issue.6 For this commentary, let me suggest a definition of political economy, based on my favorite definition of “politics.” This definition comes from Harold Lasswell, who used it as the title of his 1936 book: Politics: Who Gets What, When, How.7 I like this definition because the words are short and concrete; they focus on actors, consequences, timing, and processes. Lasswell reminds us that any process affecting the allocation of resources in society inevitably involves politics. The same principle holds for NCD policies—since NCD policies seek to change who gets what in the health system and in society. This commentary thus concerns “how the allocations of political resources and economic resources affect who gets what, when, and how in relation to NCDs.”

**USING POLITICAL ECONOMY TO ANALYZE NCDS**

To illustrate the important role of political economy analysis for NCDs, I focus on the three themes used to organize PMAC 2019, and one key actor for each theme.

For the theme on seeking to change the determinants of NCDs, I consider commercial enterprises, and their role as drivers of NCDs.

For the theme on examining NCDs within social systems, I look at patient organizations, and their role in creating solutions to NCDs.

For the theme on addressing governance challenges for NCDs, I examine government agencies, and their role in changing the institutions and actions for NCDs.

This approach proposes that any effort to discuss the political economy of NCDs should examine these three actors—commercial enterprises, civil society, and government agencies—and how they shape both the problems and the solutions for NCDs. This is not the only possible approach to political economy analysis for NCDs, but I believe it is both a good and useful approach.

This approach disaggregates society into specific actors and their different political economy roles. This disaggregation is necessary because there are so many actors that can obstruct and facilitate change for NCDs. With this approach, political economy analysis can help us learn from the past to design strategies that facilitate the changes we seek in health systems.

This approach to political economy analysis for NCDs highlights the main point of PMAC 2019: that scientific evidence about NCDs is not enough to improve health. Political economy analysis and strategies are also needed to make progress.6

**Theme #1: Political Economy of Changing the Determinants of NCDs**

In global health today, the promotion of targeted taxes on harmful products—“sin taxes”—ranks high on the global health policy agenda for addressing the determinants of NCDs. The taxes focus on particular products—especially tobacco, sugary beverages, and alcohol. These commercial products have health impacts on NCDs: cancer, cardiovascular diseases, respiratory diseases, and diabetes. The new taxes promise a seemingly magical policy solution similar to the old phrase of “two birds with one stone”: increased flows of new revenues for the government budget and reduced disease burden and related health expenditure for the targeted NCDs.

Recently global policy attention has increased on sin taxes and NCDs—but that attention has focused on the technical economic aspects of policy solutions, and overlooked the political economy challenges of introducing sin taxes.8,9

Introducing sin taxes requires political economy analysis—because there are huge commercial interests that benefit from the production, sale, and consumption of those products. Introducing sin taxes inevitably triggers a political struggle with commercial organizations. These industries have much greater economic and political resources than perpetually under-resourced public health advocates. Understanding when and how public health can win—despite powerful commercial forces—requires political economy analysis.

Even for tobacco control, which has a long history of policy struggle, the literature on political economy related to low- and middle-income countries is limited. A systematic literature review published in 2013 by Jesse Bump and colleague found 2500 potentially relevant citations but only eight papers had used political economy analysis to examine tobacco control in low- and middle-income countries.10 These papers showed that the primary opposition to taxation is transnational tobacco companies and their economically interested allies.10

One important contribution to understanding the political economy of tobacco taxes examined Thailand’s successful
introduction of strong anti-tobacco measures in the 1990s, by political scientists Sombat Chantornwong and Duncan McCargo. Those legislative achievements at the time were described as “something just short of a miracle.” Important contributions have been made on the international political economy of tobacco control by Kelley Lee and Jappe Eckhardt, but much more needs to be done, at both the national and global levels.

What does this look like in practice? One example of this kind of analysis is research on the successful passage of a soda tax in Mexico. In examining this topic, Erin James and colleagues show how advocates achieved legislative success with this politically difficult proposal, using political economy analysis, as one important factor, to decide on strategies to promote the tax in Mexican society and push the tax through the Mexican Congress.

It is equally important to understand how industry interests overpower public health. Anthropologist Susan Greenhalgh recently demonstrated how the Coca-Cola Company created a non-governmental organization in China to shape scientific research and public policy over a 15-year period, as she put it, “making China safe for Coke” — “through a complex web of institutional, financial, and personal linkages.” The group operated within China’s CDC, shaping government policy on obesity with the company’s corporate message “that it is activity, not diet, that matters—a claim that few public health scholars accept.”

We thus need a better understanding of the political economy of the commercial determinants of health, including actions that can advance sin taxes—along with other effective interventions—to promote public health.

Theme #2: Political Economy of Using a Systems Approach to Address NCDs

Changing a health system’s orientation often requires a political struggle. Technical evidence is usually useful, and frequently necessary, but evidence alone rarely produces sufficient system change. One key force for change comes from the people directly harmed by the existing system.

One lesson from the world’s experiences with HIV and AIDS is the critical role of affected people in organizing social movements to change public policies. We can draw lessons about the political economy of NCDs from past experiences with HIV/AIDS. Social movements of people living with HIV/AIDS have played catalytic roles in changing government rules, regulatory policies, health care delivery, accountability structures, public perceptions, and corporate decisions—through direct action, public protest, political lobbying, and strategic negotiation.

I am not suggesting that the social mobilization of people who are directly affected by a disease alone can achieve these policy changes. But I do believe that civil society’s political pressure (related to their creative use of symbolic politics, to increase political power) is often a catalytic factor to change institutions. The question is how do less powerful groups in society go about changing the policies and the narratives related to NCDs?

Perhaps the world needs mobilizations of those living with NCDs, in order to change the political economy of NCDs and change resistant government and corporate policies.

Think about breast cancer. Women with breast cancer and their families have been a major force worldwide in putting the issue on national policy agendas and compelling governments to devote more resources to screening, diagnosis, and treatment. One striking example is how Nancy Goodman Brinker, after the death of her sister from breast cancer in 1982, created a global non-profit organization, called the Susan G. Komen Breast Cancer Foundation.

Think about lung cancer, emphysema, and COPD. In social movements to promote tobacco control, people suffering from smoking-related illnesses have played important symbolic roles. In the United States, a former “Marlboro Man” (a rugged cowboy pitchman for that product) with lung cancer testified at the annual meetings of Phillip Morris and became a potent symbol of the damage caused by cigarettes. Individual sufferers put personal faces on public health statistics regarding the harm caused by tobacco companies; this helped mobilize social movements for tobacco and smoking control. Patients and families helped change the power dynamics related to NCD policies, helped change the social narrative about responsibility for NCDs, and influenced who gets what, when, and how for NCDs.

Social movements of victims have played critical political roles for major reform efforts in many domains beyond public health, such as the civil rights movement in the United States in the 1960s, and the anti-pollution movement in Japan in the 1970s. Social movements of patients may not be necessary for the advancement of each NCD: for diabetes, for each type of cancer, for different cardiovascular diseases, for mental illness. But I do believe that social movements can play a catalytic role in changing social values and narratives and in transforming government and corporate policies, in ways that can advance efforts to address NCDs.

These social movements also play a critical role in changing the stigma associated with NCDs, making it more acceptable to discuss what were once considered “private” or “family” matters such as mental illness, cancer, and other NCDs—as public issues.
It is not easy, however, to take personal troubles into the public realm, to create a group of common sufferers and transform a health issue into an effective political mobilization. The process has personal costs, often producing a kind of double victimization, once from the disease process itself and then from the social process of mobilization. This occurred for people living with HIV/AIDS, and it occurs for sufferers of other public health tragedies (including gun violence and traffic accidents) who transform their personal troubles into political issues.

An additional factor that creates challenges for addressing NCDs is the lack of connections across different diseases. Social mobilization on breast cancer or lung cancer, for example, does not transfer into activism on other NCDs, such as diabetes or mental health.

In sum, we need a better understanding of the political economy of social movements of NCDs in diverse national settings, especially understanding how social movements can put specific illnesses on national policy agendas and can compel changes in policies and resource allocations.

**Theme #3: Political Economy of Reforming Governance of NCDs**

We know from social science that institutions tend to resist change. Every established social system is biased and resists reform. As political scientist E.E. Schattschneider wrote, every system has a “mobilization of bias” that promotes attention to certain issues and avoids attention to others. Thus, changing built-in systemic bias is not easy. This resistance to reform is related to the concept of “path dependency.” Once a system adopts a particular policy, it is difficult to change that policy because the system develops positive feedback loops and stakeholders develop strong interests in maintaining that particular organization of benefits.

At the global level, Richard Horton, editor of the *Lancet*, asked a pointed question, “Why has global health forgotten cancer?” Horton draws a direct parallel to the history of AIDS, writing, “The NCD community has become trapped in an ideology that privileges prevention over treatment. A similar mistake disfigured the early response to AIDS.” I hope that discussions at PMAC 2019 can help clarify how and why global health has forgotten cancer, through political economy analysis—and how that can be changed.

The gap in global governance for NCDs is striking for international agencies. We have many declarations about giving higher priority to NCDs. But development assistance still provides very limited resources for NCDs in low- and middle-income countries, as shown in Figure 1.

How are development agencies, such as the World Health Organization, the US Agency for International Development, and the World Bank, being held accountable for their calls to increase attention to NCDs? The political economy of holding multilateral organizations accountable for supporting health system transitions to NCDs is a critical topic for research and action.

At the national level, the governance of NCDs is weak and confused. Many health systems—particularly in low- and middle-income countries—are not oriented toward providing NCD-related services, and remain focused on infectious diseases. Research by Corrina Moucheraud on five resource-limited health systems (Bangladesh, Haiti, Malawi, Nepal, and Tanzania) found very low NCD service availability and readiness. They all lacked trained health workers and essential medicines for NCDs, and these situations were distinctly worse in rural areas.

In short, huge gaps exist between what is needed for NCDs and what is provided. The core challenge is how to transform existing health systems, with a continuing focus on infectious diseases, to meet changed patterns of disease. The NCD tsunami is no longer something to expect; the tsunami has arrived and most nations’ health systems are not ready. In short, the epidemiological transition is happening faster than the governmental transition.

For example, Mexico, through reforms to its health system, has made significant progress in financing treatment for high-cost illnesses, including many NCDs. But many problems remain in the delivery of those services, as illustrated by the case of breast cancer in Mexico. The system confronts:

- inadequate mammographic equipment for testing;
- low rates of screening coverage for Mexican women;
- scarcity of personnel trained to provide screening and read tests; and
- concentration of treatment facilities in Mexico City.

As a result, many women with breast cancer in Mexico enter treatment with late-stage disease, with lower probabilities of success and higher costs of treatment. In short, breast cancer in Mexico is still more lethal than it should be. Changing the political economy of government systems and making them work effectively is not easy.

Many low- and middle-income countries confront similar challenges for cancer. Lack of resources, lack of equipment, lack of personnel, lack of priority, and lack of data all add up to late detection, limited capacity to treat, and large numbers of cancer deaths. Julie Livingston’s ethnography of Botswana’s main cancer ward tells this story in searing detail. Botswana
has scaled up access to AIDS medicines and taken control of that epidemic in many ways; but “Clearing away the cloud of AIDS revealed the landscape of cancer”—with its own patterns of “suffering, illness, and death.”

Deciding how to organize the ministry of health for NCDs is not easy. One high government official recently asked me: Should there be a separate government “center” for each NCD? Or a single NCD center, with individual directors for each NCD? If international aid is not available for NCDs, how much domestic resources should be used for NCDs, and where can those funds come from? Should the government introduce a separate sin-tax for each NCD? How should the government decide how much to allocate each of the major diseases? According to the burden of disease, or according to the effectiveness of interventions, or according to the pressures of different provider or patient groups?

An additional political economy challenge for national action on NCDs is that interventions are often needed outside the health sector, for example, on food and agriculture regulation, or in changing the curriculum of schools. These actions require cross-ministry collaboration or conversations that can create significant bureaucratic and budgetary obstacles to effective action.

Setting national priorities and organizing government agencies for NCDs are political economy processes that we need to understand better in order to address the governance challenges for NCDs.

CONCLUDING COMMENTS

In concluding, I would like to focus on this message: Let’s move political economy from unconventional to essential in global health, starting with NCDs. Here are three suggestions.

First, Development Agencies and Foundations Need to Move from Slogans and Lip Service to Actions and Financial Support on Political Economy

Donors need to make funding available for political economy analyses in health reform loans and grants, and make these analyses a required part of health policy development.
This will help create a demand for new and improved methods of analysis and for people trained in political economy. This will also highlight political economy methods and tools that offer greater success to address NCDS both globally and nationally.

Second, Global Health Researchers Need to Direct More Attention to the Political Economy of NCDs

There is significant room for expansion in relation to academic theory, data collection, case study analysis, focused comparisons, and documentation of real-world practices. Researchers can help explain how effective NCD policies overcome obstacles of corporate and bureaucratic resistance and how social movements successfully pursue reforms. We need better insight into how to change government structures and policies to provide effective prevention, treatment, and palliative care for NCDs.

Third, We Need an Accountability Mechanism for Assessing Political Economy Analyses in Practice and in Research

In effect, we need a mechanism that will improve the quality and effectiveness of political economy. This accountability mechanism could include a clearinghouse of political economy studies and researchers, a review process to assure high-quality political economy analyses, and an evaluation process to assess the impacts of different kinds of political economy methods and strategies to assure effective action.

These are do-able efforts. In the short term, I urge focusing attention on the political economy of NCDs for the three actors I have discussed: on commercial companies; on patient organizations; and on government agencies. Focused attention will help us advance the place of political economy in global health. This, in turn, will help us support people working at the frontlines in health systems to effectively address NCDs. Policy makers and policy analysts need to give more attention to the role of political economy factors in understanding the determinants of NCDs in their countries and designing effective policy responses for NCDs, as argued in this article. In the future, I hope we will point to PMAC 2019 as a global turning point in promoting political economy as an essential contributor to global health and in identifying successful strategies to prevent and manage NCDs.

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