
REVIEW ARTICLE

HEALTH INEQUITIES IN CONTEMPORARY CAPITALISM

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Arnel M. Borras

Health and Health Care Inequities: A Critical Political Economy Perspective

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During a conversation in Oscar Wilde's *The Importance of Being Earnest* (2005 [1899]:15), the character of Algernon rejects his colleagues' claim to have revealed 'the whole truth pure and simple' by quipping that '[t]he truth is rarely pure and never simple.' This adage is exemplified in Arnel Borras' timely and important new book. Herein, he convincingly demonstrates that health inequities cannot be effectively comprehended, nor tackled, as a purely 'health-related' problem. Instead, they are inexorably interrelated with the dense configuration of socially determined inequalities and power relations marking global capitalism

To wit, on the one hand, the volume makes a conceptual case for introducing greater complexity into explanations of health inequities than is commonly found in extant accounts of the phenomenon. The latter often remain grounded in methodological individualism or, at best, articulate thin social ontologies abstracting from 'big picture' considerations to focus on social processes proximal to individuals. Departing from such

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circumscribed representations, Borras deploys insights from critical political economy – alongside interdisciplinary acumen from political science, history and social epidemiology – to investigate the historically-specific implications of capitalism for health and the pursuit of health equity. On the other hand, building on this formulation, Borras (2025:100) contends that ‘achieving health for all’ requires a multifaceted political transformation beyond tinkering at the margins of this system. Instead, *socialism* is advanced ‘as a social system and way of life’ that may contribute to ‘improv[ing] health equity within and beyond capitalism.’

While these dual themes are certainly far from ‘pure’ and ‘simple’, it is to Borras’ credit that he articulates them in generally clear and crisp prose across a mere 163 pages. Each of the book’s eight chapters effectively combines conceptual reflections from (predominantly Marxist) political economy and theories of policy analysis, alongside a wide range of empirical data and original qualitative research drawn from around the world – with particular emphasis placed on case-studies (e.g. housing and healthcare policies) and interviews (with activists, workers and academics) from Borras’ adopted home of Canada. Although the book progresses rapidly through this material and may have benefitted from elaborating a little more on some themes (see below), it provides an accessible, yet provocative, invitation for scholar-activists concerned with health inequity to explicitly confront capitalism in their research and political activities.

Accordingly, this review reflects on the two key leitmotifs arising from Borras’ contribution – namely, its explicit engagement with the political economy of capitalism and associated praxiological reflections on the need for a socialist alternative – to prompt further debate and discussion on health and healthcare inequities.

Bringing capitalism ‘back in’

Borras’ book presents an unequivocal challenge to conventional representations of health and morbidity within public health research and policy discourse that primarily revolve around *biomedical* and *behaviouralist* explanations (see Chernomas and Hudson 2013:4-5; Birn *et al.* 2017:90-2; Primrose and Loepky 2024:5-6). Within biomedical accounts, ‘health’ is formulated in largely individualised and biological terms as akin to a struggle between individual human bodies and disease, thereby reducing it to an absence of the latter from the former (Engel

2012). Conversely, the body itself is designated as the locus of poor health, whereby risk factors ranging from genetics (e.g. Lakhani *et al.* 2019) to environmental pollution (e.g. Kravitz-Wirtz *et al.* 2018) engender aberrations from its standard biological functioning (cf. Clarke *et al.* 2003; Yuill *et al.* 2011:7-10; Rocca and Anjum 2020; Acolin and Fishman 2023). Interpreting the body as amenable to manipulation via pharmaceutical, surgical, or genetic interventions targeting individual biology, proponents then favour policies to mitigate the threat of risk factors or alleviate their effects, such as distributing public health funding toward hospitals or research centred on developing novel medical techniques and tools (cf. Humber 2019; Rahman *et al.* 2024).

On the other hand, behaviouralist interpretations present health as arising from individual (or household) decision-making and mental models. Ill-health is, accordingly, deemed a product of actors' unhealthy lifestyle choices – such as smoking or eating excessive junk-food – and continuing to pursue such erroneous decision-making in spite of contrary medical advice (e.g. Rippe 2018; Deslippe *et al.* 2023). Securing better health outcomes, in turn, necessitates remedial measures that facilitate individuals to make healthier choices via levers such as education, counselling or incentive-based devices (cf. Korp 2010; Baum and Fisher 2014; Primrose 2024).

Through devising explanatory frameworks and corrective interventions centred on the individual human body and/or mind, both the biomedical and behaviourist approaches decontextualise health from its broader socio-political milieu (Primrose and Loeppky 2024). Conversely, Borras (2025: esp. Chs 1-3 and 6) presents a more holistic conception to argue that individuals' and societies' ability to enjoy a healthy life cannot be reduced to biomedical factors or individual lifestyles alone. Rather, these elements are themselves configured by a multiplicity of social determinants – such as food, housing, employment and working conditions, income and wealth, welfare, education and healthcare – the unequal distribution of which perpetuates health inequities (see also: Bryant 2025).

In making this case, however, the volume transcends much of the extant 'social determinants of health' literature (e.g. Marmot and Wilkinson 2005; WHO 2008) which, while valuably comprehending health as interrelated with such drivers, predominantly overlooks how the latter are themselves determined by 'upstream' structural factors and social relations (Coburn 2004; Primrose and Loeppky 2024). To redress this lacuna,

Borras introduces critical political economy to examine how ‘human beings are inherently social, with lives *shaped by the social relations of production*’ which underprop ‘structures such as the economy, politics, and law, influencing social consciousness which *emerges from material and social conditions of life*’ (Borras 2025:82, emphases added; see also: Mooney 2012; Bryant 2025). This, in turn, renders a research agenda *viz.* health inequities centred on investigating ‘how ideology, interests, and power determine who gets healthy and who does not’, such as via consideration of ‘how integrally imbricated social relations like class, race, and gender affect resource production, distribution and consumption’ (Borras 2025:82). In short, ‘health inequities [are understood to] mainly result from unequal social relations of power shaping the distribution of the social determinants of health among social classes and groups’ (Borras 2025:4).

The conceptual utility of this approach may be understood as twofold. First, the deployment of critical political economy enables Borras to direct his critical gaze toward the perennially ignored elephant-in-the-room in studies of health inequities: namely, global capitalism. Despite abundant historical and contemporary evidence to the contrary (e.g. Sreter 2005; Case and Deaton 2021; Freudenberg 2021; Sullivan and Hickel 2023), mainstream scholarship and policy discourse continue to lionise the latter and its orientation toward perpetual economic growth as having chiefly propelled the substantial improvements in human health materialising since the ‘mortality revolution’ in England during the late-Nineteenth Century (see also: Leys 2009).

Yet, notwithstanding some notable exceptions (e.g. Chernomas and Hudson 2013; Waitzkin *et al.* 2018; Sell and Williams 2020; Cordilha 2023; Fox 2024; Batifoulier *et al.* 2025), recent reflections on the social character of health have tended to displace the contradictory systemic dynamics overdetermining them or, at best, confronted them in disavowed form as pernicious ‘commercial determinants of health’ (CDH). Accounts centred on the latter – constituting the business or industrial strategies, products, and activities that impact public health processes (e.g. Maani *et al.* 2023) – tend to remain steeped in historicist narratives. Specifically, individual opportunistic, greedy corporate actors are framed as contributing to the proliferation of preventable health problems via production and distribution of profitable, yet socially harmful commodities (e.g. tobacco and ultra-processed foods). However, while usefully highlighting the exercise of corporate power and its impact on

public health, this focus on contingent ‘bad apples’ largely eschews examining of how the integral logic of capitalism enabling and compelling their activities is itself ‘rotten to the core’ – that is, the perennial reproduction of capital as ‘value-in-motion’ (Harvey 2017:1), necessitating expanding exploitation and expropriation of human-beings and socio-ecological processes (Fraser 2023).

Instead, Borras (2025:85) places the system and its constitutive social relations front-and-centre of his account: pugnaciously suggesting that ‘Big Capital kills on a massive scale’ due to the orientation of capitalism around ‘profit maximisation and capital accumulation, often at the expense of lives.’ More specifically, the book proffers that ‘[a]t the heart of capitalism is the drive for profit and continual wealth accumulation’, which ‘pushes capitalists toward an endless loop: maximising profit, gathering wealth, and reinvesting capital for further financial gains’ that, in turn, undercuts the socioeconomic foundations of health (Borras 2025:85). On this basis, Borras proceeds to muster a combination of historical and contemporary research to demonstrate the myriad ways in which, within the context of the antagonistic class relations informing the system, capital utilises its structurally advantageous position to effect political and organisational outcomes engendering or underpropping inequalities in the social determinants of health. That is, short of affording causal priority to largely apolitical representations of the latter, emphasis is placed on investigating the embodied structures, ideologies (especially neoliberalism), power, and political struggles that constitute the form and asymmetries marking these social determinants in the first place (see also: Coburn 2010; Primrose and Loepky 2024).

This, then, points to the second pertinent epistemological contribution of Borras’ study: its expansive account of how capitalism drives and augments the social determinants of health inequities. Borras skilfully builds on, and contributes to, a burgeoning Marxist scholarship (e.g. Federici 2004; Fraser 2014, 2023; Moore 2017; Patel and Moore 2017; Bieler and Morton 2024) conceptualising the system as historically dependent on creating devalued and disposable peoples and places – above all, women, nature, and colonies (Mies 2014) – to demonstrate how, ‘infused with colonialism, racism and sexism, [capitalism] shapes unequal health outcomes’ (Borras 2025:83). In particular, the book investigates how the logic of capital manifests through interrelated social structures co-constituting capitalism itself – especially class, imperialism, colonialism, racism, sexism – to produce a complex system in which certain population

segments are actively marginalised, or outright excluded, from accessing elements such as quality and stable housing, healthy food, affordable and effective healthcare, and secure jobs. This, in turn, results in and entrenches ill-health, high morbidity and deprivation amongst these groups, while others are enabled to thrive (Borras 2025:Ch. 6).

Notwithstanding Borras explicitly confronting the causal power of capitalism in producing such health inequities, one significant component of his conceptual framework might have been elaborated more fully. Namely, the book would have benefitted from a more methodical articulation of the *systemic logic* of capitalism itself and *why* this, in turn, promulgates the pernicious consequences for health inequities that Borras details meticulously. The analysis presented in the volume is strongest when detailing the historical and contemporary *impact* of global capitalism on the social determinants of health and its lop-sided implications for different population groups. Herein, when discussing the intricate politics of health policy, for example, the interrelated exercise of power, promulgation of ideology, and struggles arising from the antagonistic social relations constitutive of the system are held aloft as enabling ‘Big Capital’ to disproportionately influence the direction of health policies (Chapter Four), and also disseminate ideas and evidence to inform them in accordance with their interests (Chapter Five). That is, ‘[t]he vast wealth and power of dominant groups [...] sustain health inequities’ (Borras 2025:65).

A cursory glance at the modern political economy of health in light of the global COVID-19 crisis confirms the value of such reflections (e.g. Bambra *et al.* 2021; Di Muzio and Dow 2022; Primrose *et al.* 2024; Bryant 2025). Yet, where do the contradictory *systemic drivers* of capitalism itself – those that both compel and enable the institutionalised exercise of power discussed above – fit into this story? As Marxists such as Postone (2013 [1993]) and Smith (2018) have argued in differing ways, within capitalism the logic of capital as value-in-motion operates as a quasi-autonomous and contradictory form of social domination: binding material reproduction of individuals and social processes to the systemic imperative of intensifying capital accumulation as the self-expansion of value. This dynamic, in turn, proffers the abstract foundations upon which more complex social relations are inscribed, such that its proliferation is predicated on myriad immanent forms of exploitation, extraction and subordination – most obviously, class struggle (within and across countries), grounded in appropriation of produced surplus value (Taylor 2003, 2004). More

concretely, subjugation of use-value to the socially antagonistic logic of generating and circulating exchange value underpins the integral irrationalities of capitalism – in this case, health inequities and ill-health more generally.

Largely absent such considerations, Borras sometimes relies on voluntaristic explanations of phenomena. Consider, for instance, his statements such that ‘the state and its apparatuses care more about making money and keeping the system thriving than using evidence’ to produce health policy (p. 80), and ‘[p]owerful interest groups, like political and business leaders, control much of the lawmaking process to benefit themselves, not the public. Less powerful groups dealing with social and health inequities often lose out’ (p. 66). Following the CDH literature discussed above, such articulations stress the agency and profit-making myopia of ‘bad apples’ in abstraction from the compulsive drive toward capital accumulation, exploitation and inequality generated by the system. As noted earlier, Borras certainly *begins* to touch on such complex questions of agency and structure within the system (especially in Chapter 6), though they might usefully have been elaborated more fully and earlier in the book to frame subsequent discussions about the politics and policy of health inequities.

From despair to hope...and back again?

Building on the preceding discussion, it is prudent to reflect on how Borras frames the *praxiological lessons* arising from his critical political economic analysis. Throughout, he consistently and passionately implores readers to consider the normative implications of adopting the latter. In particular, having primarily attributed the generation and exacerbation of health inequities to capitalism and its constitutive social relations, Borras calls for systemic transformation toward a more equitable and democratic system in the form of socialism. This appeal is developed most methodically in Chapters 7 and 8. In the former, Borras demonstrates how countries with institutionalised welfare systems leaning towards broadly socialist (or social democratic) policies have enjoyed favourable socioeconomic outcomes and greater health equity *within* capitalism, especially relative to those grounded in less egalitarian principles. The chapter then draws on Erik Olin Wright’s (2021) typography of anti-capitalist strategies to proffer that a socialist approach to health equity is

both achievable and necessitates multiple, overlapping political movements within and beyond the state. The latter chapter, then, builds on these insights to reflect on the practical lessons of the preceding pages for health activists. To this end, it combines a broad-ranging political ‘call-to-arms’ toward socialism via ‘informing, educating, advocating, organising and mobilising for social justice and health equity’ within capitalism (Borras 2025:121), with a more concrete list of socialist-informed policy recommendations designed to facilitate systemic transformation (*e.g.* provision of socialised housing and expanding social support systems).

Such sustained reflections on the political need, strategic options and possibilities (and challenges) for socialism are a welcome addition to the volume. This is especially so given the relative dearth of attention accorded to post-capitalist alternatives in the extant literature on health inequity, wherein considerations of praxis (where included at all) tend to be confined to small-scale reforms tinkering at the margins of capitalism, or a few throwaway lines tucked-away safely after the ‘serious’ analysis is complete (*cf.* Waitzkin *et al.* 2018; Adler-Bolton and Vierkant 2022; Thomas 2022; Raphael and Bryant 2023; Primrose *et al.* 2024; Bryant 2025). In this respect, Borras’ book is firmly placed in the fine tradition of institutional Marxist scholarship arising from York University and elsewhere in Canada – exemplified by the late Leo Panitch, Greg Albo, Sam Gindin and, more latterly, Stephen Maher (*e.g.* Panitch 2001; Albo *et al.* 2021). As articulated by its proponents, political economy extends beyond abstract theorisation of universal economic laws or hollow utopianism. Instead, researchers must dive headlong into investigating the political and institutional dynamics of capitalism, the social relations, movements and power struggles therein that configure its direction, and the strategic opportunities for progressive reform and systemic transformation that then arise. Accordingly, history is seen as ‘a process of open-ended eventuation, shaped by human beings and the institutions they create, albeit within conditions not of their own choosing’ (Maher and Aquanno 2022:247).

This formulation, accordingly, takes to heart Romain Rolland’s (1920) maxim of the need to balance ‘pessimism of the intellect’ with ‘optimism of the will’ (see also: Gramsci 1977 [1920]; Panitch 2016). Optimism is fruitless unless it is grounded in reality; yet, to avoid merely wallowing in despair, the intellect must be directed towards pursuing a broader human purpose (Antonini 2019). Analogously, for Borras, making an intelligent, productive contribution to a socialist alternative must commence from a

warts-and-all investigation of health inequities grounded in contemporary neoliberalism and capitalism to determine what needs to change. This, though, must be infused with a belief that such transformations are possible, thereby precipitating efforts by social movements to ‘continually educate, organise and rally workers and the masses for real social change’ (Borras 2025:113) and, thus, search for strategic ruptures in the present to cultivate institutional capacities and creative energies to realise the latter. That is, ‘realising health equity means fighting against capitalism – within and outside the state – to establish socialism’, demanding ‘a combination of information, education, advocacy, organisation and mobilisation for systemic change that will free workers, women, racialized groups and other exploited/oppressed populations from the grips of the capital-state alliance’ (Borras 2025:134).

Without seeking to quash the necessity of such hopeful prescriptions for progressive and radical scholar-activists, Borras’ account begets two interrelated praxiological challenges that might usefully be addressed in future research. First, as noted above, Borras goes to great lengths to discuss myriad strategies and opportunities to mobilise social movements to challenge and transcend the system. Herein, ‘[t]he key to [realising socialism] is harnessing the power of regular people’, given ‘[r]eal change transpires when people unite and decide they have had enough of capitalism’s flaws and harms. Ultimately, it is up to us to push for a better societal system’ (Borras 2025:119).

Yet, this reasoning augers the question: why assume that those whose health and material well-being are most adversely affected by capitalism would seek to *challenge* this status quo at all? Critical political economy often assumes a linear relation between actors’ experience of the contradictions or failures of capitalism and desire for transformative change, such that the objective of (health) activism is framed as enabling political subjects to ‘awaken’ from their ‘false consciousness’ and discern the ‘true’ reality of the system (e.g. Lukacs 1972; Marx and Engels’ 1987 [1845]). For instance, in opining that ‘many workers are *unaware* that the underlying cause of their unfavourable working, living, and health conditions is the system they depend on – capitalism’, Borras (2025:125) reflects that greater ‘class awareness’ is required to ‘address this *flaw in thinking* and *inspire* workers and the masses to envision and strive for a healthier, more equitable world’ [emphasis added].

Somewhat underplayed in this articulation of class consciousness, though, is the *affective* appeal of capitalism itself and, thus, its ongoing capacity to *grip* those encountering its pernicious effects. As highlighted by research from the burgeoning field of libidinal political economy (e.g. Kapoor *et al.* 2023; Kapoor and Fridell 2024), part of the tremendous obstinacy of capitalism, *despite its manifest failings and contradictions*, is that subjects unconsciously *enjoy* the system (e.g. McGowan 2016; Fletcher 2023). Subjects remain libidinally bound to capitalism due to its capacity to exploit our entrenched sense of loss or lack: soliciting and activating our desire for ontological fulfillment via, for example, consumerism and materialism – from cars and smartphones to cheap food and stylish clothes – while never allowing this yearning to be completely satisfied through such means. This partial gratification and *promise* of complete enjoyment in the future (e.g. through irrational consumption of ever-greater material excesses), in turn, provides the subjective foundations for perpetual capital accumulation (Kapoor 2020: Chs 1 and 4; Johnston 2024). Hence, merely speaking truth to power is insufficient to counteract the grip of capitalism on subjects, who may be critically aware of its faults yet – being libidinally enmeshed within the system – continue to *act as if* they did not know *viz.* their consumption habits, political activities and so forth. That is, subjects follow a logic of wilful ignorance Žižek (2007:253) terms ‘fetishistic disavowal’ (see also: Zupančič 2024): “‘I know, but I don’t want to know that I know, so I don’t know.’ I know it, but I refuse to fully assume the consequences of this knowledge, so that I can continue acting as if I don’t know’ (Lacan 1977:230).

Accordingly, it would be prudent for future scholarship to address how health activists might effectively challenge this psycho-social attachment in pursuit of a socialist alternative. Borras implicitly makes an important contribution in conceptualising how this logic may be challenged in one important respect: promulgating a political universalism that cuts across the particularised demands of different social movements via recognising and confronting the antagonistic logic of global capitalism as a common adversary (see also Kapoor and Zalloua 2021; Primrose 2025). Nevertheless, further attention is required to deliberate on how popular disaffection with the system and its underlying antagonisms might be harnessed less toward devising novel techno-managerial means to ‘fix’ it but, rather, toward engendering systemic transformation (see: Kapoor *et al.* 2023:160-4).

This consideration, in turn, points to a second, related praxiological question: why should scholar-activists assume that those disillusioned with the capacity of capitalism to deliver greater health equity will favour *progressive*, let alone *radical* alternatives? Notwithstanding important global trends in social movements pushing the latter over the preceding two decades (see: Bailey *et al.* 2022; Chibber 2025), this same period has witnessed burgeoning political influence and power exercised by Far-Right movements appealing to populations disgruntled with, and feeling marginalised from, extant political economic configurations – including institutions oriented toward provision of public health (Falkenbach and Heiss 2021; Menon *et al.* 2025). Specifically, the pervasive post-political abrogation of responsibility by centre-left political parties for introducing transformative social policies prioritising human well-being (see: Fischer 2020; Conley 2025), and concomitant unwillingness of public health institutions to confront the structural drivers of ill-health and morbidity (Wallace 2023; Primrose and Loeppky 2024; Joppke 2025: Ch. 6), has opened space for *critical* engagement with the health status quo to be increasingly monopolised by Far-Right movements – buttressed by conspiracy theorists such as anti-vaxxers (Stoeckel *et al.* 2022; Backhaus *et al.* 2023; Primrose 2025; Wallis 2025).

Most perniciously, in the crisis-ridden conjuncture of contemporary capitalism, the effects of neoliberalism in eviscerating the socio-ecological conditions of health have been recognised and weaponised by these movements (Stuckler 2017; Falkenbach and Heiss 2021; Labonté and Baum 2021). Draping themselves in populist rhetoric, the Far-Right has increasingly claimed the mantle of offering the *only* political option to redress the systemic inequities and deficiencies infusing extant health systems ignored by ‘establishment’ political figures. This has manifest, most conspicuously, in a strategy of ‘welfare chauvinism’: promising maintenance or augmentation of welfare benefits for core constituencies (‘the people’), while disregarding minorities – most notably, migrants (Greer 2017; Falkenbach and Greer 2018, 2021; Rinaldi and Bekker 2021). Of course, in practice, this has largely led to the expansion and deepening of neoliberalism: cutting healthcare budgets, emasculating health regulations, and undercutting the broader social determinants of health (e.g. reducing public housing programs or welfare provision) (Moise *et al.* 2021; Zabdyr-Jamróz *et al.* 2021).

Simultaneously, despite invoking the need for prioritising transformative measures to bolster human health, Far-Right political figures have frequently translated this into the escalation of, and reallocation of resources toward, redressing alternative political priorities framed as necessary to buttress population health – such as defence and migration (Falkenbach and Heiss 2021). Consider, for example, J.D. Vance's (see Weaver 2023) claim that 'illegal immigrants' are responsible for the opioid crisis in the US. Building on Donald Trump's prior remark that this group was 'poisoning the blood of our country', Vance fallaciously posited that immigrants were trafficking fentanyl into the US across the border from Mexico. Such scapegoating affords the Trump regime a political rationale for bolstering spending on border defences between the two countries. It also allows the Government to assiduously avoid confronting the political economic origins of the crisis: most notably, the corporate operations of Purdue Pharma (who aggressively marketed the highly-addictive narcotic, OxyContin, to GPs and within impoverished regions of the country), compounded by the US' lack of a universal public healthcare system or expansive welfare program (Case and Deaton 2021:esp. Ch. 9; Morefield 2025).

Of course, it is not possible nor necessary for Borras to have considered the nuances of all such phenomena within his deliberately slim and accessible book. Rather, the more general point arising from the preceding two reflections is that health activism oriented around channelling popular disaffection with neoliberal and capitalist health systems cannot *assume* that this will necessarily and spontaneously lead subjects toward pursuit of substantive change, let alone socialist alternatives. In the contemporary context, it is just as likely that the declining living standards and social status of many individuals and communities will continue to be harnessed by the Far-Right toward a politics of *resentment* – less toward global capitalism and its dominant classes than alleged 'external threats' (e.g. foreign governments, immigrants and asylum-seekers) and the 'enemy within' (the political Left, academics, environmentalists, feminists, LGBTI+ communities, religious and ethnic minorities), alongside 'the liberal establishment' accused of according both special treatment (Damhuis and Rashlova 2024; Bortun 2025; Slobodian 2025). Presenting such 'threats' as engendering a burgeoning existential crisis, the Far-Right has articulated an affectively seductive pledge to eradicate them to return society to 'normality' and its former glory: a 'violent reset which restores the traditional consolations of family, race, religion and nationhood,

including the chance to humiliate others' (Seymour 2024:21). For health scholar-activists, then, the challenge becomes how to direct disaffection with neoliberalism and capitalism toward a transformative post-capitalist alternative, while resisting the temptation to assume that the experience of such dynamics will *inevitably* lead to a spontaneous awakening of class consciousness and pursuit of progressive, even revolutionary, praxis (Žižek 2017, 2025; Primrose 2025).

Conclusion

In *Health and Health Care Inequities*, Borras has penned a much needed and important intervention into the often-staid field of studies health policy and politics. It is a fine contribution, both in its own right and as an 'opening salvo' for future research. Accordingly, it deserves to be widely read for its contribution to the nascent, albeit growing literature on the critical political economy of health and health inequities.

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