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DIALOGUE

Struggles for Health: An Emancipatory Approach in the Era of Neoliberal Globalization

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Abstract Capitalism is experiencing a prolonged crisis and is forcing structural changes in the global economic system to perpetuate its hegemony. Increasing financialization of the global economy is producing ever increasing concentration of wealth and inequity. These changes are devastating livelihoods of people across continents with many consequences on people's health. This article analyzes the global governance for health, the social determination of health and, finally, its commodification. It highlights the need of a global mobilization of civil society to build a transnational movement able to defend health in all its aspects.

Keywords Health · Global governance · Privatization · Social determinants · Healthcare

Global Governance for Health

The global architecture of governance, trade and economics has come to be informed by neoliberal globalization and consequently national decision making and national policies are often subject to global influences. This is true in the health sector as well (Woodward et al. 2001) and the advent of globalization marks a shift in institutions and structures that govern health at a global level. Several new developments have had an impact on the structures and processes of global governance for health. The first is the emergence of the World Bank as a major player in the arena of health governance in the 1980s. Second, the growing importance of global trade in international relations, and its impact on health in different situations across countries, has led to a major role for the World Trade Organization (WTO) and regional and bilateral trade agreements. Third, private foundations (such as the Bill and Melinda Gates Foundation) entering through public private partnerships and other avenues, have become big players in global health issues. Finally, the erosion of the legitimacy of the World Health Organization (WHO) as the premier organization on global health, has shifted mechanisms related to global governance for health away from intergovernmental forums.

Intergovernmental mechanisms are giving way to Global Public Private Initiatives (GPPIs). Several hundred such initiatives have been launched, with over 100 in the health sector alone (including mega initiatives such as Gavi, the vaccine alliance, and the Global Fund). GPPIs came to be developed based on an understanding that multilateral co-operation in the present globalized world could no longer adhere to the older principle of multilateralism which primarily involved nation states. Global partnerships were, thus, imbued with a new meaning, that involved not just nation states, but also other entities, including, prominently, commercial organizations such as pharmaceutical companies.

These new partnerships are also increasingly supported by private philanthropic foundations. Partnerships with the private sector and civil society are thus held up as the way to achieve what governments and the United Nations cannot manage alone (Martens 2007). GPPIs address what

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neoliberal economists describe as 'market failures', but at the same time do not question the fundamental faith in the ability of the market to regulate the global flow of goods and services.

The WHO's legitimacy has been seriously compromised because of its inability to secure compliance of its own decisions, which are reflected in the various resolutions passed at the World Health Assembly (WHA). Developed countries which contribute the major share of finances for the functioning of the WHO have today a cynical disregard for the ability of the WHO to shape the global governance of health. They see the member state-driven process in the WHO (where each country has one vote) as a hindrance to their attempts to shape global health governance, and prefer to rely on institutions such as the World Bank and the WTO, where they can exercise their clout with greater ease. As with many other UN organizations, the WHO's core funding has remained static because of a virtual freeze in the contributions of member states. Its budget amounts to a tiny fraction of the health spending of high-income member states. In addition, a large proportion of the WHO's expenditure (above 80%) comes in the form of conditional, extra-budgetary funds that are earmarked for specific projects by contributing countries (Global Health Watch 2014).

An analysis of structures and dynamics of global decision-making reveals the dominance of entrenched power structures—through the agency of more powerful nations, the Bretton Woods institutions, private philanthropy and large transnational corporations—and a democratic deficit in the structures and dynamics of global health governance. These power structures also operate directly through bilateral and regional trade agreements; through the operations of bilateral health-related assistance; and through direct advice and influence. In many respects the regulatory, financing and policy outcomes of this system reflect an imbalance between the interests of a limited number of country governments and global institutions, many of them private, and the needs and priorities of a majority of the globe's population.

In the case of medicines, the structures of global governance for health currently promote strong Intellectual Property (IP) protection. Advocacy of strong IP protection (that is higher standards of patenting) is designed to secure the monopoly power and thereby financial interests of Multinational corporations (MNCs) in the pharmaceutical sector located in North America and Europe. The Agreement on Trade-related Intellectual Property Rights (TRIPS) under the World Trade Organization in 1995 was pushed by countries of the North to benefit their pharmaceutical companies. The TRIPS agreement harmonized IP laws across the world and prevented countries such as India from pursuing independent policies that were designed to curb the monopoly power of pharmaceutical MNCs. In recent years bilateral and plurilateral trade agreements that involve the powerful economic powers—EU, US and Japan—attempt to go beyond the remit of the TRIPS agreement to further ratchet up standards of IP protection.

The Social Dimensions of Health

Too often, even among groups and organizations active in the struggle for health, the dominant vision is that health care services are primarily responsible for improvements in the health of individuals and communities. However, there is powerful evidence that the main factors affecting our health are the socioeconomic conditions in which we are born, grow, live, work and age. Founding epidemiological studies showed that the mortality rates for the majority of deadly diseases in the past century declined steeply long before modern medicine was able to detect the responsible pathogen, or to discover a vaccine or a treatment (McKeown and Record 1962; McKinlay and McKinlay 1977).

In more recent years, the World Health Organization's Commission on the Social Determinants of Health (CSDH) documented the impact of resource distribution and living conditions on health inequalities, both within and between countries. The final report, 'Closing the gap in a generation', states that health and disease are not distributed equally in society, and that disease disproportionately affects those who have less access to resources such as food, clean water and environment, education, safe and stable job, solidarity-based welfare systems. While being aware of the necessity to make available adequate access to comprehensive health care services for those who fall ill, we should also be concerned about the means to reduce the unnecessary disease burden linked to social injustice.

If we look at the issue from the perspective of social movements, there are two important alternate visions that can help forge a broader unity in our struggles. Both are rooted in a vision of health that is deeply linked with the political, economic, cultural and social aspects that frame our societies.

The first vision focuses not only on the factors that impact on health, but on the processes that determine their unequal distribution within society. In other words, the emphasis is not on the 'determinants' of health, but on health 'determination'. While developing the concept of health 'determination', scholars and activists from the Latin American Social Medicine movement argue that specific socioeconomic and political systems (and people/groups that have interests and/or make profit in maintaining them) are responsible for generating inequality in society, that also translates into health inequalities (Da Rocha and David 2015). The very way in which our

societies are organized, and the power dynamics that are at play in shaping them, have to be questioned and addressed. We need to ask why we have inequalities in health, and not only how different 'determinants' promote health inequality.

Besides generating inequality, the economic and political system in place has detrimental effects on a number of health determinants, including the environment (increasing pollution, climate change, accumulation of toxic waste, etc.), water, land and public services (through increasing privatization and dismantling of public and/or solidarity-based systems). In all these sectors, the social gradient between those who have more resources and those who have less is constantly at play. For example, the concept of 'environmental racism' is used to describe the unequal consequences of climate change and environmental degradation on poorer and marginalized communities. Similarly, the so-called 'inverse care law' documents the inverse relation between health needs and health resources in society. Importantly, power relations operate in the domains of several societal divisions, such as class, gender and race. And, quite problematically, technology intensive healthcare—which we increasingly rely on—is deeply embedded in this system of power dynamics and is one of the most profit-making sectors of our times (investments in pharmaceuticals and medical products are constantly on the rise).

A second important contribution to a social vision of health comes from the indigenous movements of Latin America, and their (cosmo)vision of Buen Vivir or Sumak Kawsay. This idea is rooted in the interdependence of human life and the life of all beings on earth, including earth itself. This interconnected perspective helps us to build a strong and unitary vision of the processes that harm our health while at the same time threatening the very possibility of life on and of the planet. Moreover, this perspective helps us to reconnect to the land and territory in which we live, decreasing our mental and physical dependence on a harmful system of production. Such a vision appears utopian and unrealistic in the light, for example, of the growing urbanization of the world's population. However, the increase in forms of self-organization for organic food production and distribution, and the survival of solidarity-based systems that run in parallel with the market society, show that alternatives are not only possible but also already in place.

In summary, there are important benefits in adopting a perspective on health that is rooted in its social dimensions:

1. We are more able to understand why ill-health disproportionately affects some population groups and individuals, the so called 'root causes' of disease. Naming the processes in place, and who is taking advantage of this situation, helps us connect our struggle with all those who fight for a socioeconomic and political system rooted in social justice and environmental sustainability;
2. By emphasizing on the 'causes of the causes', we can concentrate on what is needed to keep people healthy before (and in addition to) worrying about how to care for them once they are ill. There is much to be done in terms of health promotion and disease prevention, both in terms of research (e.g. on the environmental causes of disease) and of application of existing knowledge (for example, epidemiologists in the UK have advocated for more progressive taxation, as the one measure that could be most cost-effective in reducing health inequalities); and,
3. By framing the problem as a societal problem, we can start to reflect on the interconnections between the current production system and the current paradigm of modern medicine, which relies almost entirely on biomedical solutions. This is in turn linked to the commodification of health. While it is beyond doubt that medical technology has improved living conditions and increased life expectancy, there is also evidence that shows that profit—more than health and social justice—is what drives health research and development. Popular movements need to address the issue of how to disentangle health research and healthcare delivery from profit-making. Both health research and healthcare services need to be seen as public goods that are clearly under people's control.

Commodification of Health: The Challenge Facing Health Systems

One characteristic of most health systems is the large number of actors and interest groups: political authorities and national, regional or local public institutions; users/patients; citizen taxpayers; health professionals (doctors, nurses, other health workers, chemists, technicians, and administrative staff); enterprises and insurance companies; and charities or non-profit-making organizations.

Despite variations—mainly due to differences in how they have evolved—health systems in most countries are today confronted with similar problems closely linked with the increasing commodification of health.

While health has been converted into a commodity that is transacted through the medium of the market, this has also led to an increase in human and financial resources dedicated to healthcare. Expenditure on health represents around 10% of the global GDP—more than 7000 billion

dollars. The proportion of public expenditure on health is about 60% of this amount.[1]

There are several powerful actors that benefit from the commodification of health, including big pharmaceutical corporations, private facilities providing medical care (private hospitals, clinics and laboratories), and even investment funds and banks. Those who benefit have pushed forwards local, national and international policies and legislations that promote the commoditization of health.

The strategy employed to push for further commodification of health works at two levels:

1. Through the commodification of various dimensions of health and social needs, influencing both health and healthcare.
2. Through the capture of public or socialized resources by for-profit care providers, commercial insurance companies and private investors.

Commodification and Privatization

Today, sustained propaganda by the votaries of neoliberalism seeks to promote a vision of the human body and of health which is rooted in the principle that all human activities can be converted into market-based contractual relations of a commercial nature. The process of commodification extends beyond healthcare to include other social aspects which determine health.[2] By such a strategy, working at the cultural and ideological planes, institutional processes and healthcare practices are being transformed.

Consequently, new practices and concepts that help convert health and healthcare into a commodity, have taken shape. These include, for example, 'standardization' of medical interventions (through hospital 'reform' policies, 'pay-as-you-go' principle, etc.); promotion of the notion that ill health and disease are merely individual conditions and influenced only by medical factors; and management techniques (human resources management, training, creation of indicators). These are transforming care into a commercial relationship between a supplier (health professional, care institution) and a buyer (patient or 'client').[3]

Private capital, as a result, is continuously increasing its 'market share' in activities related to provision of healthcare. This is happening, for example, through the promotion of private insurance (basic cover or complementary insurances), through the supply of care by commercial enterprises (by outsourcing activities in hospitals such as cleaning, catering or imaging services), through the encouragement of private investments in healthcare services (public–private partnerships), and by aggressively creating markets for different medical products. Above all, in order to establish complete control over the 'market' for health, fundamental changes in health systems are being instituted through legislative changes, which are designed to minimize the role of the State and of not-for-profit healthcare providers.[4]

'Shock Therapy'

There is evidence that private capital stands to gain when social and health systems are in crisis and there is increased economic hardship.

In such situations, the State and public institutions find it difficult to maintain necessary financial support for comprehensive healthcare services. Neither are they able to increase support necessary for addressing new pathologies, needs of an ageing population, life style related conditions, or for the use of new medical and pharmaceutical technologies.

As a result, commercial, for-profit entities move into areas that are now not supported by the State. Private enterprises thus 'compete' in providing services with public providers in a 'market' for healthcare services. In the market, private providers have several advantages as they are able to curtail costs borne by providers by reducing wages and by resorting to unscrupulous practices such as compromising on quality of care. They also push unnecessary interventions and medical products, and thus actually increase the cost of care to be borne by patients. Patients often lack the knowledge and the information to be able to make a choice between private and public interventions and are lured by the (often unethical) marketing

[1] These figures may differ significantly from one country to another. They enable us, however, to get an idea of the size of the health sector and consequently a measure of its strategic relevance. It should be noted that there are large inequalities in health between countries and within countries.

[2] While quality and accessibility to a care system are essential, the latter contributes only a quarter to health. Social aspects (income, education, food, housing) and environmental factors determine the other three quarters.

[3] These trends are more marked in hospitals given the size of these institutions, the diversity of health professions, the specialism of practices and the sizeable financing needed to access expensive medical and pharmaceutical technologies.

[4] For more details on process and forms of privatisation, see: https://healthcampaignstogether.com/pdf/Kondilis%20(2016%20Brussels)%20Healthcare%20privatization.pdf. We also invite you to complete the privatisations database at http://www.health-is-not-for-sale.org/?lang=en.

tactics employed by private institutions. Over time, private providers garner larger and larger proportion of the 'market share' and in many situations end up by becoming the dominant provider of services.

It needs to be emphasized that the under-financing of healthcare services by the State, which opens up opportunities for private enterprises, is often a deliberate ploy employed by States under the influence of neoliberal policies. Neoliberal polices encourage decrease in social contributions and taxes paid by corporations and the rich, and are lenient towards fiscal fraud and tax evasion by the richest strata. Corruption in public services and poor management practices also undermine their efficiency. The sum total of these influences is a reduction in State budget for public services. This opens up opportunities for institutionalization of a system that converts health into a commodity, encourages commercialization of healthcare and benefits private health management organizations, insurance companies and pharmaceutical companies.[5]

Experiences from the Ground

The multiplicity of operators in the health system, brought about by privatization, fragments care systems, making it even more difficult to manage and plan in a coherent and integrated manner. New costs are generated: running costs, advertising and promotion costs, profits to distributors and proprietors, etc.

Commercial dynamics modify the distribution of resources in favour of the needs for profit-maximization and to the detriment of the true social needs of health (thus, for example, the pharmaceutical industry would rather not invest in finding solutions for malaria which affects mainly poor and debt-ridden populations). This pattern fosters the development of skewed priorities, and the poor, the aged, the most vulnerable, migrants, etc. are denied care as it is more expensive (and not profitable) to have systems in place that can reach out to them.

Commodification and its contractual view of care challenge the aspirations and principles of health professionals for whom caring with dignity (and efficiently) for a human being is a prime objective. Besides, a Taylorist approach (designed to improve economic efficiency, in other words to maximize profits) to care compromises the ability of staff in the health sector to apply rational and scientific principles of care, and to show solidarity and initiative when confronted with difficult situations.

In the health sector, working conditions are deteriorating. In its frantic attempts to abolish 'superfluous' costs, the sector is putting pressure on wages, working hours, social benefits, etc. Poor and insecure working conditions have an obvious negative impact on the quality of care.

Most patients are unable to afford comprehensive healthcare services—they are available to only those who can pay. This leads to the creation of a multi-tiered health system, which caters selectively to patients based on their capacity to pay cost of treatment.[6]

Finally, commodification of healthcare is changing the relationship between users (patients) and health professionals. A shift towards a dehumanized relationship is leading to a feeling of unease at work for health professionals (with increasing incidence of depression, suicides, etc.). The changed relationship also alienates the user(patient) from his or her health, since it is now a product, mediated through a commercial relationship.

Our analysis and local experiences show that commercial interests run contrary to public health interests and more generally to the right to health. This is true at a practical level as regards efficient management of a health system in relation to the fair allocation of financial resources, and also at a philosophical, cultural and political level given how dehumanizing the commercial approach to health is.

It is thus essential and urgent to reject the commercial and mercantile logic being pursued in most regions as regards the health sector. It is no mere coincidence that several struggles across the world are making this demand.

Building a Global Movement for Health

Health is a powerful call to mobilize. What else could it be? How could we ignore the vital importance of the right to health, the right to access healthcare services, the right that everyone of us has to well-being? Not to be subjected to degrading situations or conditions which undermine this right?

This is the very force for mobilization that lies at the core of our struggles, which helps them surmount the harshest difficulties and obstacles, which enables or forces alliances, and which can lead to victories, this force is our strength!

Our analysis leads us to state that a profound social, economic and cultural change is needed and it requires building a mass movement sufficiently powerful to threaten the interests of the global elite. This will not happen

[5] For a discussion on the strategy of 'shock', refer to Klein (2007).

[6] It has been noted that nowadays, even in the most 'advanced' health systems a considerable number of people postpone or abandon treatment. At least 400 millions people in the world do not have access to one or several essential health services. Each year, 100 million people are thrown into poverty and 150 million people are in financial difficulties due to personal expenses incurred while accessing health care.

overnight. A medium- and long-term strategy is therefore necessary to build: (1) a shared political vision; (2) a social and political alliance that will flesh out the vision; and (3) the organization(s) that will coordinate our actions. It will be necessary to take into account the different spatial (local, national, international) and temporal dimensions (as every region and locality has its own rhythm and pace).

Our demands, our proposals and our vision must be articulated in a clear, coherent and radical narrative and will have to be widely communicated. Counterpoised to the right to private property we shall propose common good, social justice and ecology; against client satisfaction, respect and dignity; against individual responsibility for illness, its social determination. Against the mainstream paradigm, that of an individual anthropocentric and biomedical approach to health, a new paradigm: a collective awareness of social determination and a bio-centric approach to health (which links humans to their ecosystem).

Our Collective Processes

Thanks to our broad and popular struggles we are ideally placed to sense the felt needs of people. This can be further strengthened through popular education.

Collective processes addressing specific issues or popular demands build awareness: illness is no longer individual, collective solutions exist, the right to health asserts itself, authorities opposing it are exposed.

Because our struggles are also the place for individual and collective reappropriation of health, our struggles democratize health. In doing so, they contribute to freeing health and body from the function of reproduction of a labour force essential to the economic system.

The current, financialized form of capitalism is systematically consuming our capacities to sustain social bonds. The gendered separation of social reproduction from economic production constitutes the principal institutional basis for women's subordination in capitalist societies. Our struggles must contribute to liberate social reproduction of its submission to capitalist processes. In this regard, feminist struggles would be a natural ally.[7]

Towards a Global Organization

Struggles for health have the double advantage of being, on the one hand, anchored locally and on the other capable of carrying a simple message which is globally understood. While doing so, they can illustrate in a concrete manner the fundamental link which today connects the local to the global dimension.

These two dimensions are now more intertwined than ever before: decisions that modify our local realities are often taken as a response to global processes (trade agreements, G7, G20, WTO, etc.). Conversely, local practices can have a global impact: consider the signing of the free trade agreement between the European Union and Canada, which was blocked because of local resistance in Wallonia (Belgium). In the same way, it is possible, through coordinated action, to destabilize a multinational company by challenging its local operations in different locations. Not taking into account either of these two dimensions would be a handicap for our struggles.

Conclusion

The struggle for health has multiple facets and variations. It has left its mark over centuries. Struggles have mushroomed in the current epoch and still mobilize millions of people, communities, groups and organizations throughout the world. Their shape reflects the issues and practices of a society and its times.

The urgency of the health, economic and social situation of millions of people throughout the world, and associated challenges ranging from wars, climate and environment changes to poverty and forced migration must not prevent us from conceiving our mid and long-term struggles.

Day after day mobilization gathers impetus, fuelled by the increasingly evident contradictions embedded in a harmful and oppressive economic system. The awareness that for the realization of the right to health, it is necessary to multiply actions at all levels, is growing. The globalized nature of the forces that threaten us makes it necessary to organize our struggles at the global level as well.

It is a major challenge that we must and can take up thanks to our awareness of the real situation, our desire to confront it collectively, our experience on the ground and the new tools at our disposal.

Our struggles are designed to bring about social change and collective empowerment. Our struggles are premised on the respect for all efforts that are directed at improving the conditions of living of all the people who live on this planet, as well as respect for the planet's ecology.

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[7] https://www.dissentmagazine.org/article/nancy-fraser-interview-capitalism-crisis-of-care.

References

Rocha, Da, Patrícia Rodrigues, and Helena Maria Scherlowski Leal David. 2015. Determination or determinants? A debate based on the Theory on the Social Production of Health. *Revista da Escola de Enfermagem da USP* 49(1): 129–135.

Global Health Watch. 2014. WHO Reforms: For What Purpose. Global Health Watch 4: 247–266. London: Zed Books. http://www.ghwatch.org/sites/www.ghwatch.org/files/D1_1.pdf.

Klein, Naomi. 2007. *The Shock Doctrine: The Rise of Disaster Capitalism*. New York: Picador.

Martens, Jens. 2007. Multistakeholder Partnerships—Future Models of Multilateralism? Dialogue on Globalization, Occasional Papers, No. 29, January, Berlin: Friedrich Ebert Stiftung.

McKeown, Thomas, and R.G. Record. 1962. Reasons for the Decline of Mortality in England and Wales during the Nineteenth Century. *Population Studies* 16(2): 94–122.

McKinlay, John B., and Sonja M. McKinlay. 1977. The Questionable Contribution of Medical Measures to the Decline of Mortality in the United States in the Twentieth Century. *The Milbank Memorial Fund Quarterly Health and Society* 55(3): 405–428.

Woodward, David, Nick Drager, Robert Beaglehole, and Debra Lipson. 2001. Globalization and Health: A Framework for Analysis and Action. *Bull WHO* 79: 875–881.