Global Labour Column
http://column.global-labour-university.org/
Number 268, April 2017

Capital, Labour and the Politics of Inequality in Global Public Health

Bridget O'Laughlin

The impasse: what to do about global health inequalities?

Inequalities of health are recognised as one of the most problematic aspects of the sharpening global divide between rich and poor (Deaton, 2013). There are, however, major differences as to what the causes of health inequalities are and hence on what can and should be done to address them. Some argue for the expansion of commercial healthcare and a greater role for private capital in public health provisioning as a direct investor, as a partner of the state and non-governmental organisations or as a philanthropic funder of business-like interventions. Others argue that redressing global health inequalities is a redistributive project incompatible with commercial logic and private profit. They privilege the role of the state as regulator of public health, as provider of health services and as taxer of wealth.

The expanded role for capital in global public health

In the World Development Report of 1993, *Investing in Health*, the World Bank both legitimised increased development assistance for international health and extended its critique of the intrusive developmental state to the area of health. This move was significant since even in neo-classical terms, health has long been recognised as a domain of imperfect markets. Institutionalist economists have argued that capitalist enterprises typically do not cover the social costs of their production, either the health of their labour force or the non-commodified environmental resources they consumed unless they were forced to do so through aggressive state regulation.

In recent years, however, the involvement of capital in global public health has gone far beyond the rather tentative references to encouraging private involvement in insurance markets and service supply suggested in *Investing in Health*. Direct corporate investment has increased in private hospitals and clinics and in brokerage of private insurance schemes. Some of this investment is by 'social enterprises', profit-making companies that have social objectives in which their profits should be invested. Corporate enterprises investing in health in developing countries often leverage subsidies such as advance profit guarantees, tax-breaks or direct investment grants from the development budgets of OECD countries (McGoey, 2014). So also do the corporate philanthropies, such as the Bill and Melinda Gates Foundation, whose funding priorities have been become influential in shaping global health policies (Birn, 2014).

Private/public partnerships tie governments to private companies and/or non-profit health Non-Governmental Organisations (NGOs) or both. In social franchising, for example, international NGOs (INGOs) or social enterprises advise private clinics on how to strengthen their business practices. There is also pressure for new forms of involvement of civil society groups in care – patient groups, associations of traditional healers and religious communities – while some of what is labelled as partnership with civil society resembles the outsourcing that has made wage-work precarious in other domains. Government, international agencies, INGOs and some private firms contract local NGOs as service providers for particular healthcare tasks. They rely on local NGOs, for example, for drug distribution, supplanting state-run public health programmes.

Commercial management has been extended to public healthcare and to medical research. Universal primary health care systems are being displaced by universal access to health insurance schemes organised by private financial agents. Funding conditionalities require governments and NGOs involved in health provisioning to use the same systems of management and assessment that are employed by corporations. The functioning of public facilities on a non-commercial basis can be cross-subsidised by establishing clinics within their premises where the same staff provide both everyday care and specialised procedures on a priority basis to those who can afford market rates. In the corporate university much medical research is both funded by and oriented to the private sector, privileging the development of profitable pharmaceutical cures over research on the causes of disease.

Commercial discourse has been extended to the broad field of health promotion. Healthcare provisioning is conceptualised as a market where patients are clients, choosing among competitive options and individually responsible for their own health choices. The emphasis in health promotion has accordingly shifted from education to persuasion. Social marketers employ the techniques of commercial advertising: branding, attractive packaging, tailoring messages to particular market segments and using private market channels for distribution of products.

Consequences for the politics of inequality in global public health

The ascendency of corporate capital in global health has restricted the political terrain where inequalities in public health can be contested. Redistributive healthcare reform is focused on the market while existing public health services are increasingly overburdened. This shift reflects both the explicit preference for the private sector amongst the major health donors and dependence on donor contributions for government health expenditure in many developing countries. These changes weaken both decommodification as a strategy of redistribution and the collective basis of alliance around health justice. The regulatory powers and responsibilities of the state in public health have been narrowed. This is partially because of the reduction in budgets and marginalisation of public health in government ministries, but also because the importance of public/private partnerships means that states now act as facilitators rather than regulators of corporate involvement in health. Cor-

Nicolas Pons-Vignon, E-mail: Nicolas.Pons-Vignon@wits.ac.za
Mbuso Nkosi, E-mail: Mbuso.Nkosi@global-labour-university.org

porate social responsibility (CSR) initiatives can also be a way for companies to avoid regulation by negotiating their own norms and making compliance voluntary.

Finally, and most importantly for the global labour movement, corporate entry into healthcare has displaced critical attention away from the everyday, long-term influence of capital in the causation of ill-health; it shapes patterns of disease and disability while carrying on its normal activity of making a profit in production and trade. Chronic kidney disease among agricultural workers in Nicaragua, for example, is related to unprotected exposure to pesticides while at work (Raines et al., 2014). As the WHO Commission on Social Determinants of Health (CDSH, 2008: ii) put it, public health has to do not just with the systems put in place to deal with illness but fundamentally with the circumstances in which people grow, live, work and age. Capital accumulation much predates private/public partnerships, corporate philanthropy and corporate social responsibility and arguably has much more impact than any of them on global patterns of inequality in the conditions of life and death.

Conclusion

From the class-based perspective of global labour movements certain questions immediately arise. How has capital been able to restrict the political terrain on which global inequalities in health are contested? Why has it been so difficult to defend the principles of state-organised redistributive public health and state regulation? How can voluntary corporate largesse be presented as an alternative form of redistribution and regulation? Why have fundamentalist neo-liberal models of free competition and corporate philanthropy been dug up from the past and applied to global health policy when it is abundantly clear that the real markets in which it functions are not, will not and should not become freely competitive?

Part of the answer lies in the patterns of inequality – of gender and race as well as class – that have characterised some state-organised public health systems, including in colonial and post-colonial contexts. Medical officers in South Africa in the 1930s, for example, blurred the association between mine dust and silicosis by pretending there were two distinct diseases: simple silicosis, a white disease and silico-tuberculosis, a black disease (McCulloch, 2012). But how was capital able to pre-empt the class critique of the welfare state and to commodify the space of reform? One can blame the hegemony of neo-liberal globalisation but that only restates the problem. Another part of the answer must be that working class-based labour movements have often defined very narrowly the terrain of political struggles around health inequality. They have focused on the wage-demands, occupational health and medical coverage of their members, but marginalised the health concerns of non-unionised casual workers. They have not built political alliances around health issues to confront the inequalities of gender, race and class that underlie the causes of disease and ill-health that workers carry with them beyond the workplace as well as within it.

Since access to health care has been one of the defining features of formal sector jobs, it is strategically correct that trade unions concerned with breaking down the formal/informal divide emphasise universal access to health care. There is one caution, however. Universalising access to health *insurance* without expanding decommodified public health care will leave inequality intact.

Bridget O'Laughlin is an anthropologist whose interests are in the political economy of work and health, which can be attributed to her teaching and conducting research at Eduardo Mondlane University in Mozambique. She has retired from the Institute of Social Studies (ISS) at the Hague and is currently a research associate of the Institute of Social and Economic Studies (IESE) in Mozambique.

References

Birn, A.-E. (2014) 'Philanthrocapitalism, past and present: the Rockefeller Foundation, the Gates Foundation, and the (s) of the international/global health agenda', *Hypothesis,* 12(1)**:** e8.

CSDH (2008) 'Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. Final Report of the Commission on Social Determinants of Health'. Geneva: World Health Organisation.

McCulloch, J. (2012) *South Africa's Gold Mines & the Politics of Silicosis.* Johannesburg: Jakana Media.

McGoey, L. (2014) 'The philanthropic state: market-state hybrids in the philanthrocapitalist turn', *Third World Quarterly*, 35(1): 109-125.

O'Laughlin, B. (2016) 'Pragmatism, Structural Reform and the Politics of Inequality in Global Public Health', *Development and Change*, 47(4): 686-711.

Raines, N., González, M., Wyatt, C., Kurzrok, M., Pool, C., Lemma, T., Marín, C., Prado, V., Marcas, E. & Mayorga, K. (2014) 'Risk factors for reduced glomerular filtration rate in a Nicaraguan community affected by Mesoamerican nephropathy', *MEDICC review*, 16 (2): 16-22.

*Adapted from O'Laughlin (2016); 'Pragmatism, Structural Reform and the Politics of Inequality in Global Public Health'.