Neoliberalism Redux: The Global Health Policy Agenda and the Politics of Cooptation in Latin America and Beyond .pdf

Anne E Birn, University of Toronto
Laura Nervi, University of New Mexico
Carlos Eduardo Siqueira
Debate

Neoliberalism Redux: The Global Health Policy Agenda and the Politics of Cooptation in Latin America and Beyond

Anne-Emanuelle Birn, Laura Nervi and Eduardo Siqueira

ABSTRACT

This article explores the neoliberal cooptation of social justice-oriented global health policies over the last three decades, from primary health care and ‘health for all’ to various contemporary so-called ‘health equity’ initiatives, such as Universal Health Coverage and ‘health convergence’. The authors illustrate and contextualize the different periods and approaches with examples from a range of Latin American countries, drawing on diverse political experiences and social struggles in the health arena. The analysis concludes with reflections about the region’s experiences of resisting and challenging the neoliberal health agenda, in spite of domestic and global environments that have constrained these efforts, past and present. In this sense, the struggle for bona fide equity in health and health policy remains an important and ongoing priority.

INTRODUCTION

In the space of just a few years, the goal of Universal Health Coverage (UHC) has risen to the top of the global health agenda, even becoming one of the pillars of the UN’s new Sustainable Development Goals (SDGs). On one level this appears to represent the successful fruition of decades-long struggles by progressive forces around the world for public, universal health systems in the context of health and development equity. Yet on another level, as witnessed across the Americas, the rise of UHC as a global priority does not portend the creation of comprehensive, unified and single-tier health systems, but rather a cooptation of such approaches by privatized or semi-privatized, segmented and fragmented, ‘pluralistic’, profiteering, and...

Our thanks go to Mariajóse Aguilera, Esperanza Krementsova, Ramya Kumar, Devaki Nambiar, the anonymous reviewers and the editors of Development and Change.

ultimately inequitable arrangements for universalizing partial and insufficient health insurance coverage.

While perhaps seeming to outsiders an arcane or semantic debate relevant solely to global health specialists, the UHC cooptation story is illustrative of the fate of many progressive international and global health policy efforts in the context of neoliberal globalization over the past three decades. Further, given that the health sector (or the medical industrial complex) constitutes around 10 per cent of world GDP or US$ 6.5 trillion, including both public and private spending (WHO, 2012; World Bank, 2016), what happens in the massive health arena has enormous repercussions for society writ large.

Cooptation, a word coined in the seventeenth century to refer to the self-selection of new members by an existing committee or group, came to mean ‘the process of absorbing new elements into the leadership or policy-determining structure of an organization as a means of averting threats to its stability or existence’ (Selznick, 1949/1966: 13) in the mid-twentieth century. More recently, the concept has been taken to connote the assimilation of political movements and/or their ideas and leaders into dominant agendas that contradict the project or mission of these movements or organizations. Here we refer to cooptation as the process of decontextualized and selective appropriation of the progressive health justice agenda and discourse by re-emergent neoliberal ideologies and actors.

This article examines the cooptation of social justice-oriented global health policies over the last three decades, from primary health care and ‘health for all’ to various so-called ‘health equity’ initiatives, drawing from a range of Latin American examples. Our analysis concludes with reflections about the region’s experiences of resisting and challenging the neoliberal health agenda, in spite of domestic and global environments that have constrained these efforts, past and present. In this sense, the struggle for bona fide equity in health and health policy remains an important and ongoing priority, even as proponents of highly visible initiatives (such as the SDGs) claim that equity, universality and other health justice concerns are being amply addressed through mainstream approaches.

THE DEEP ROOTS OF LATIN AMERICAN STRUGGLES FOR HEALTH JUSTICE

Latin America is a particularly useful vantage point from which to analyse health and social justice efforts and their cooptation, due to the century-long experience of popular mobilization for improved working and living conditions — including health services — as well as the perennial quashing of these movements and the sometime appropriation of their aims. Moreover, as we shall see, Latin America has served as a key experimental venue for several waves of neoliberal reforms in recent decades (Robinson, 2014).
Although most of the region attained independence in the nineteenth century (Cuba and Puerto Rico being notable exceptions), it was long characterized by weak and unstable states, US/European economic dominance and political interference, marginalization of indigenous and rural populations, late industrialization, and concentration of land in the hands of elites. Yet once countries in the region embarked upon concerted state-building efforts in the late nineteenth and early twentieth centuries, these were accompanied by a range of (initially mostly urban) highly vocal labour and social movements. Building on burgeoning friendly societies of workers, these movements incorporated demands for health care into struggles for better working and living conditions, which at times were parlayed into concrete victories (García, 1981–2).

An early hallmark was Chile’s 1924 passage of statutory social insurance for industrial workers, among the first outside of Europe, enabled by intense working class and socialist struggles for a more just and equitable society. After the leftist Popular Front coalition won the 1938 national elections, the health minister at the time, Salvador Allende, a socialist physician, set the wheels in motion for Chile’s Servicio Nacional de Salud (SNS), which was ultimately enacted into law in 1952 under a more centrist administration seeking to court the support of unions/militant labourites. Comparable to the UK’s National Health Service launched in 1948, the SNS was one of the world’s most comprehensive health care policies with significantly expanded access to care for workers, dependants and the indigent; it was the culmination of decades of mobilization by unions, social movements and progressive health professionals, working with and through leftist political parties (Illanes, 1993; Waitzkin, 2011).

Unlike other Latin American health care legislation at the time, Chile’s SNS sought to integrate financing and provision of health services into an umbrella public system that unified and centralized a variety of welfare institutions and medical insurance for industrial workers, although, like Britain, Chile was not able to abolish private practice. On the cusp of Allende’s election as President in 1970, the project to unify the health system under a single, public payer met such fierce opposition among powerful physician groups and private sector elites that it was not explicitly included in his Popular Unity party’s platform of nationalization and redistribution. Then, following the 1973 CIA-backed military coup that deposed Allende, Chile’s landmark SNS achievement was brusquely overturned, just twenty-one years after it was launched. The privatization reforms that followed under Augusto Pinochet’s military dictatorship are considered by many to have been an incubator for neoliberal policies in the health and social security sectors (De Vos and Van der Stuyft, 2015).

Chile’s experience, though more dramatic — in both the SNS’s early and far-reaching coverage and its abrupt toppling — was consistent with efforts elsewhere. Through the mid-twentieth century, urban (and parts of agrarian) Latin America became heavily unionized, with workers actively pressing
for a range of social benefits. There were major advances towards health justice in Argentina in the late 1940s and early 1950s, Mexico in the 1930s and 1940s, and various other countries, particularly those in the first wave to establish social security for industrial workers (including Brazil, Costa Rica, Cuba and Uruguay) (Mesa-Lago, 2012). However, as with Argentina’s labour movement, among the pioneering and most militant on the continent, unions were at times divided, and governments coopted some unions, played favourites to dissipate power, and subjected organized labour to severe repression during periods of authoritarianism. Despite these obstacles, many workers’ organizations and social movements continued demanding access to health care services and other social policies for all (Birn and Nervi, 2015).

In addition to domestic political and social dynamics, an important factor in understanding the impulse for universal and equitable health and social welfare systems in Latin America is the role of international exemplars, including Bismarck’s compulsory social insurance scheme (part of his carrot and stick policy of tempering working class unrest), based on regional, sector- and occupation-specific ‘sickness funds’ launched in Germany in 1883, and the Soviet Union’s nationalized health system deriving from the citizen right to health care, developed in the 1920s under Health Commissar Nikolai Semashko. In Latin America just one country, Cuba, ultimately adopted a fully publicly funded and delivered health system that transcended the inequities of fragmentation and segmentation, though it differed from the Soviet model. As we shall see, it remains the only country and health system that has not been penetrated by neoliberalism and that has avoided the cooptation of its health reforms.

FROM THE COLD WAR TO THE RISE OF NEOLIBERALISM: THE BEGINNINGS OF COOPTATION IN INTERNATIONAL HEALTH

Although the struggles portrayed above unfolded in national contexts, Latin American developments in health (as in other fields) were increasingly tied to international actors and the now dominant capitalist order. The Americas served as a testing ground for the possibilities of early international health organizations, including the first multilateral health agency, the Washington DC-based Pan American Sanitary Bureau (founded in 1902; today the Pan American Health Organization, WHO’s regional office), which was initially focused on sanitary agreements to stave off epidemics that might disrupt commerce. The Rockefeller Foundation, the influential private US philanthropic organization that in the early twentieth century developed an enduring model of international health based on technical disease campaigns and asymmetrical agenda-setting, also pioneered its approaches in the region (Birn, 2006; Palmer, 2010).

In the mid-twentieth century, health multilateralism secured a broader institutional footing, one that would be shaped by a new set of priorities.
Following short-lived utopian aspirations for post-World War II health cooperation to build on the League of Nations’ interrupted progressive efforts to address the social and political context of health, international health became swept up in Cold War concerns. International health — including the flagship targeted campaigns of the World Health Organization against yaws, malaria and smallpox, among other diseases (Cueto, 2007; Manela, 2014; Packard, 1998; Stepan, 2011), and US-led population control activities (Necochea López, 2014) — became a pawn in the Soviet–American competition for power and influence.

The two major blocs were not always in control of the agenda, however. In the 1970s, the WHO’s disease-focused, donor-driven approach began to be challenged both by member countries — especially the non-aligned movement and Group of 77 countries (G-77), which were advocating cooperative efforts consistent with a New International Economic Order (NIEO), seeking national sovereignty and fair terms of trade and aid (Benjamin, 2015) — and from within its own headquarters, under the visionary leadership of its Danish Director-General Halfdan Mahler (first elected in 1973, and re-elected until 1988). The primary health care (PHC) movement, enshrined in the seminal 1978 WHO-UNICEF Conference and Declaration of Alma-Ata (WHO, 1978), in which over 130 governments were represented, held that health should be addressed as a fundamental human right through integrated social and public health measures that recognized the economic, political and social context of health, rather than through top-down, techno-biological campaigns (Mahler, 1976). Entailing complex political negotiations at all levels, this call for ‘urgent and effective national and international action to develop and implement [PHC] throughout the world’ (WHO, 1978: 6) in order to achieve ‘health for all . . . by the year 2000’ (ibid.: 5) represented an explicit ideological (NIEO-framed) alternative to the existing disease-control modus operandi.

The heart of the Alma-Ata strategy — a commitment to addressing the roots of leading health problems, including inadequate nutrition, poor sanitation, and social and economic inequality, from an intersectoral and community-based PHC approach — generated enormous discursive currency and receptivity from numerous governments. But it was quickly coopted. In the wake of Alma-Ata, the Rockefeller Foundation sponsored a meeting and study promoting ‘selective primary health care’ (SPHC) — a reductionist technical approach based on vaccines and vector control — to replace the broad view of PHC, which it deemed ‘above reproach’ but overly ambitious and insufficiently cost-effective (Walsh and Warren, 1979). Pressure by the US government, especially, to adopt SPHC’s utilitarian promise of visible results led UNICEF, the WHO and various bilateral agencies to work for several decades on a far narrower agenda than that envisioned by the Alma-Ata declaration (Cueto, 2004; Taylor and Jolly, 1988).

Meanwhile, ideological tensions over PHC and other WHO initiatives and resolutions (including a formulary of generic essential medicines and
a code to prevent the unethical corporate marketing of breast-milk substitutes) led WHO’s largest donor, the USA, to withdraw considerable support. Formally, the excuse was that the WHO was inefficient, autocratic and poorly managed (an accusation that might be levelled at many bureaucracies). In reality, the opposite was true, at least in regards to PHC. PHC’s call for the public provision of primary care, together with social and economic measures, was efficient, redistributive and participatory; however, it threatened the emerging, soon-to-be dominant ideological paradigm of neoliberalism.

By 1980, amidst right-wing power-mongering and Cold War fears that Cuba’s revolutionary turn would sweep through the continent, many Latin American countries were ruled by US-backed military dictatorships and other authoritarian governments. These regimes repressed opposition movements (including but not exclusively those that called for socialism, ethical governance and radical economic redistribution) and also facilitated the return of earlier neoclassical economic models (Veblen, 1900) emphasizing individual rational actors and de-emphasizing state protections. Most Latin American governments rejected, or in some cases coopted, the Alma-Ata approach, instead favouring SPHC, which fitted the ascendant strategies of targeted short-term programmes in the absence of rights, fragmentation of social policy, and increased community responsibility for health services delivery — fallaciously dubbed participation, again appropriating PHC’s ideal of local decision making (Nervi, 2008; Testa, 1985; Ugalde, 1985). One short-lived exception was Nicaragua, which made impressive strides for PHC for several years following the 1979 Sandinista revolution (Garfield and Williams, 1992) — an effort ultimately aborted when the Frente Sandinista lost the elections in 1990 after a US-backed destabilization war involving mercenary fighters.

The turn to neoliberal capitalism up-ended public sector investment priorities, instead promoting policies aimed at reducing social spending, privatizing state-led industries and activities, and reorienting regulations to favour business at the expense of protecting the public. The Soviet Union, facing its own political and economic crises, no longer provided a counterbalance to this ‘Washington Consensus’. By the mid-1980s, the WHO’s role as an intergovernmental entity at the fulcrum of international health agenda setting and activities had fundamentally changed. Its dues from member countries plummeted, and it was displaced by agencies not subject to democratic policy-making processes — UNICEF in the area of SPHC implementation, then the World Bank in health financing and reform, and, eventually, UNAIDS in HIV control. A wholesale shift occurred, with a plethora of alliances, partnerships and initiatives seeking to exercise private influence over the WHO agenda and activities. Since then, these entities have shrewdly drawn on the WHO for legitimacy, while maintaining a stranglehold over its decision-making capacity; many are controlled by actors who cannot be regarded as appropriate or ethical global health authorities and who have
no public accountability (Adams and Martens, 2015; Birn, 2014; Nambiar et al., 2013; Richter, 2012).

**PHASES OF NEOLIBERAL GLOBALIZATION AND HEALTH IN LATIN AMERICA: CONTEXTUALIZING COOPTATION**

While the debates over primary health care and the NIEO were unfolding, the global political economy was undergoing turbulent change, caused by a combination of the breakdown of the currency stability system forged in Bretton Woods in 1944 and spikes in oil prices linked to turmoil in the Middle East. While all but oil-exporting countries faced inflation and economic stagnation, low- and middle-income countries (LMICs) were particularly hard hit by rising oil prices and soaring interest rates.

By the early 1980s, a full-blown ‘debt crisis’ had materialized. Total LMIC debt increased from US$ 70.2 billion in 1970 to US$ 579.6 billion in 1980. Hastened by a 1979 rise in US interest rates to combat inflation, Latin America’s debt, alone, more than doubled to US$ 327 billion in three years.¹ This led a band of countries across the continent to default on private loans in rapid succession, beginning with Mexico in 1982. Mexico’s default spread a financial shockwave across the continent (ECLAC, 1996; Prashad, 2012). As of October 1983, 27 LMICs, many in the Americas, had defaulted on their loans or were in the process of rescheduling debts.

The International Monetary Fund (IMF) and World Bank began to furnish loans to debtor countries to relieve balance-of-payments deficits and the burden of servicing debt — as well as to bail out the private banking sector in high-income countries. But the strings attached to these loans (conditionalties) came at a high price: the implementation of structural adjustment programmes (SAPs). SAPs, and subsequent loan programmes, compelled major economic reforms designed to open domestic markets to foreign penetration and stimulate low-cost exports. Reforms included: drastic cuts to government spending (particularly in health and other social sectors) and agricultural subsidies; removal of restrictions on foreign investments in industry and financial services; currency devaluation; and privatization of state enterprises. While policies aiming to dismantle the welfare state and privilege and globalize the interests of capital first took hold in the Britain of Margaret Thatcher and the USA of Ronald Reagan, the debt crisis provoked an even more rapid transformation in Third World economies, with Latin America as a laboratory. The economic crisis and reforms led to annual inflation rates of up to 1500 per cent, poverty levels close to 50 per cent, and large-scale capital flight from Latin America, all resulting in worsening social indicators, such as infant mortality and school attendance (Musgrove, 1987). The 1980s became known as ‘The Lost Decade’, but since Latin

America’s poverty rates did not come back down to 1970s levels until 2004, it might be better to refer to the ‘lost quarter century’ (Ocampo, 2013).

While the debt crisis was the immediate impetus for interference by the international financial sector, the termination of Latin America’s post-war economic model — based on internal economic development and import substitution policies — was an accompanying rationale. Political protests against the concentration of power and wealth and demands for greater redistribution provoked a brutal reaction from elite interests and conservative sectors (backed by military forces and the USA) in a wave of dictatorships from the mid-1950s to the 1980s; however, efforts to privatize the economy and reduce the welfare state were incompletely realized (Pinochet’s Chile serving as the ‘successful’ exception to this). The debt crisis thus offered the opportunity for the neoliberal paradigm to penetrate deeply into Latin America.

With huge cuts in public spending starting in the neoliberal onslaught of the 1980s, compounded by existing fragmentation and extreme inequities, huge swathes of the population had little or no access to healthcare. By 1990, most Latin American countries had embarked on extensive health sector reforms, many of which entailed privatization of both health and social security systems, as advised by the World Bank and other financial agencies (Armada et al., 2001). Specifically, these measures have included: increasing penetration of financial capital in the health sector through growing private health insurance coverage for those who can afford it, namely the healthy and wealthy (exclusion of ‘high-risk’ individuals is a long-standing private insurance practice throughout the Americas); and increasing the market share of Big Pharma, as opposed to generic and public drug manufacturers and distributors. Privatization within public health systems has taken on different forms: the contracting of private hospitals and providers using public funds; outsourcing of public system management; subcontracting of the most profitable aspects of service delivery (for example, laboratories and pharmacies); subcontracting of support services such as cleaning, food services and patient transportation; outsourcing of public sector human resources recruitment and management (including payroll); and other forms of publicly subsidizing private providers and managers. In addition to the private sector’s growing share of health insurance coverage, most policy makers and administrators in Latin America agreed to charge user fees for services provided by state-funded health institutions in order to increase revenues and decrease demand. The proponents of these measures touted their efficiency and transparency, even as they have produced opposite effects: waste, unnecessary expenses, growing inequities and corruption.

In Latin America, with a larger middle class than many other LMIC settings, another feature of neoliberalism flourished: the foreign penetration of domestic insurance and pension markets that served formal sector workers covered by social security systems. In the 1990s, US private pension and health insurance investment soared in Latin America (Iriart et al., 2001);
in Colombia in 1994, a regulated health insurance market reform involving both domestic and US insurance companies increased obstacles to access and exacerbated inequities (Vargas et al., 2010); this famed, ‘exemplary’ (according to the World Bank) competition-oriented reform resulted in a virtual collapse of the social security-based health system (Franco, 2013).

By the 2000s, the global implementation of neoliberal policies was leading to widespread resistance, in particular across a significant number of Central and South American countries (as well as Mexico City), where social democratic or ‘pink’ governments invested in a series of initiatives to expand health coverage, and in a number of policies to improve living and working conditions, among other determinants of health, through publicly-funded programmes under the principle of the right to health (ISAGS, 2012) (discussed below). Yet many of the gains stemming from the redistributive policies implemented within this counter-offensive are once again under attack: neoliberal policies have clawed back ground, especially following the Great Recession starting in 2008, which has ongoing (economic, political and ideological) consequences (Borges et al., 2012).

INVESTING AND CONVERGING: EXAMINING COOPTATION THROUGH TWO REPORTS, A GENERATION APART

While the contours of health reforms were set by financial directives, mainstream development actors did not wish to leave the exact form of neoliberalization of LMIC health sector policies to chance. In the case of Latin American countries returning to democracy, this meant circumscribing government responses to domestic constituencies which had pent-up, legitimate claims on the state, for instance by re-infusing public financing into drained public health systems. In 1993 the World Bank coopted the demand for health sector investment by issuing its first health-oriented World Development Report (WDR), entitled *Investing in Health*. Ironically and tragically, the deterioration of health systems and the dire need for health investment were products of the very loan conditionalities imposed by the International Financial Institutions (IFIs) (Waitzkin et al., 2007). Moreover, the report twisted popular demands for public investment in health into a policy prescription encouraging private investment.

The WDR 1993 recommended that LMICs adopt a ‘basket’ of cost-effective interventions — valued at US$ 12 per capita per year for the lowest-income and US$ 21.50 for middle-income countries — as a top public health priority. The basic basket theoretically covered immunization, sick-child care, family planning, prenatal care and childbirth, treatment for TB and sexually transmitted infections, and HIV prevention. Not included in the recommended basket were treatments for chronic needs, such as diabetes and mental illness, emergency treatment for many injuries, or broader public health measures such as sanitation, many of which, the report argued, ought
Debate: The Cooptation of Global Health in Latin America

The report based its recommendations on the unsubstantiated assertion that in LMICs, private practitioners and service providers for sanitation, housing and garbage collection are ‘often more technically efficient than the public sector and offer a service that is perceived to be of higher quality’ and more accountable (World Bank, 1993: 4).

Almost immediately, activists, advocates and many policy makers denounced the prescriptions in the WDR 1993 for their narrow assessment of health and health interventions, based almost exclusively on in-house studies; for defining health care as a private good; for failing to recognize the ongoing deleterious effects of SAPs on health care systems; and for disregarding government responsibility for protecting health as a human right (Laurell and López Arellano, 1996; Pfeiffer and Chapman, 2010). These critiques, perhaps most forcefully from Latin American quarters, proved prescient.

Although the report claimed ‘The main problem with universal government financing is that it subsidizes the wealthy, who could afford to pay for their own services, and thus leaves fewer government resources for the poor’ (World Bank, 1993: 11), the reverse has been shown to be true, as society-wide financing via progressive taxation helps ensure adequate resources and broad public support for universal public systems (Hoddie and Hartzell, 2014). Indeed, the 1990s privatization reforms drastically weakened health systems, contributing to increasing gender, class and other social inequities. In spite of overwhelming evidence that private health service delivery reduces access to care, especially among the marginalized (Jasso-Aguilar and Waitzkin, 2015), the World Bank has actively encouraged and promoted private health insurance marketplaces (Preker et al., 2010), as per a key publication, Establishing Private Health Care Facilities in Developing Countries: A Guide for Medical Entrepreneurs (World Bank, 2007).

As previously noted, IFI-recommended user fees provided another mode of promoting private financing for health, which the WHO and many health ministers were gradually compelled to accept. Having been introduced with particular intensity in Africa in the late 1980s as a cost-recovery/cost-sharing mechanism for health systems jeopardized by SAPs, user fees became widespread across LMICs. World Bank economists argued that market-level user fees would generate health system revenues, improving access, efficiency and quality of care. In addition, resources would shift from expensive in-patient treatment to more affordable primary health care services. In sum, if patients paid for services, according to this sophistry, they would use health resources more rationally.

It turned out that the Bank’s recommendations were based on ideology rather than evidence, even though abundant research from Canada and other settings had by then demonstrated that user fees reduced both access to and utilization of care (e.g. Beck, 1974). Underscoring this, the World Bank’s own in-house and external reviews have shown that fees resulted in
significant barriers to care (Lagarde and Palmer, 2011; Russell and Gilson, 1997), harming the very people they aimed to support — poor, rural populations. For example, when El Salvador eliminated user fees for the services provided by the Ministry of Health through its network, both utilization and equity improved markedly (MSPAS, 2009–2010). For years, numerous governments, NGOs and advocacy groups called for abolition of user fees in LMICs (PHM et al., 2005; Robert and Ridde, 2013). Only after more than two decades has the World Bank finally recanted its position on user fees (Rowden, 2013).

We now fast forward to 2013, when the world’s leading medical journal, *The Lancet*, published ‘Global Health 2035: A World Converging within a Generation’, produced by a Commission chaired by economists Lawrence Summers and Dean Jamison, both intimately involved in the WDR 1993 and invited to build on its legacy (Jamison et al., 2013). The Commission’s objective was to re-examine the case for investing in health and to develop a global roadmap towards a ‘grand convergence’ in health: reducing the worldwide burden of infectious diseases and reproductive, maternal, newborn and child health disorders down to the current rates of Chile, China, Costa Rica and Cuba, the lowest among LMICs (and lower than some HICs). Despite presenting a potentially unifying rallying cry (and taking up the progressive agenda’s concerns around mounting inequality along the way), the Commission’s report is devoid of any understanding of how the historical trajectory or political economy and social justice struggles of these countries shaped their health systems and health outcomes. Indeed, three of four highlighted countries were part of the first era of welfare state building in Latin America in the early to mid-twentieth century, and Cuba and Costa Rica have long enjoyed publicly financed and delivered health care, with full and largely equitable access — not to mention strong social investments in education, housing and employment — and both have been at least partially effective at staving off neoliberalism. Even Chile, which saw its efforts at building an egalitarian welfare state torn asunder four decades ago, had by then among the best indicators in the Third World.

Global Health 2035 proposes three goals to be achieved within two decades: under-5 mortality of less than 16/1,000 live births; AIDS deaths of below 8/100,000 population; and TB deaths of below 4/100,000 population. It also advocates UHC under ‘progressive universalism’. This means providing the poor with an essential package of services, graduating later to a ‘larger benefit package’. These prescriptions are uncannily similar to the failed IFI approaches of the 1980s and 1990s, and raise the same problems regarding equity (which population-wide goals overlook): who decides what is essential, and why there should be separate, scaled-down policies for the poor instead of equal and comprehensive services for all based on the right to health.

Similar to other such reports, Global Health 2035 ignores or underplays a number of critical issues, including the role of intellectual property and
the patent regime in access to medicines and other goods (Dionisio, 2014). Broader determinants of health are only broached in terms of taxing tobacco, alcohol and sugar (regressive measures against the poor). The report also assumes that technology-oriented medical interventions alone will address the health consequences of poverty, unemployment, poor housing, environmental degradation, social and domestic violence, land grabs and displacement, weak states and inequitable development and social policies, among other determinants.

Crucially, recognizing the existence of inequality, and understanding its roots and particularly its remedies, are very different things. Even as orthodox economists are touting a ‘grand convergence’ of mortality rates across the world, with infant mortality halved in the last quarter century and the differences in life expectancy between HICs and some LMICs lessening (Jamison et al., 2013), it is convergence of another sort that should be decried rather than celebrated. First, the ‘grand convergence in health’ overlooks continued divergences in health and mortality within countries. Second, the grandest convergences are in economic and social inequality (Schrecker and Bambra, 2015) and precarious work (Benach et al., 2014), both of which now characterize all societies, even if many LMICs have fared the worst. This trend derives in large part from how most LMICs fit into the capitalist world order and the cumulative effects of neoliberalism since the 1980s, in turn built on mostly incomplete or weak social welfare states. In sum, Global Health 2035 pays lip service to inequality, essentially coopting the aim of equity. Like the Millennium Development Goals that also aimed to reduce mortality without discussing how this would be achieved, ‘convergence’ has broad appeal because it appears to transcend the problem of inequality without addressing its causes or effects at all.

UNIVERSAL HEALTH COVERAGE: THE PINNACLE OF COOPTATION OF PROGRESSIVE GLOBAL EFFORTS

The most remarkable contemporary cooptation of the global health equity agenda involves UHC. On the surface, this latest global health policy trend seems unobjectionable (Reich et al., 2015), albeit, as evidenced in Latin America, not substantiated by solid evidence (González-Guzmán and Cortes Hernández, 2015; Laurell, 2015a). Who could oppose the attractive goal of extending health coverage to entire populations? But the very ambiguity of the term ‘coverage’ (deriving from language used in the private insurance sector) and the imprecision of the definition mask an approach that departs from public universal health care or health care for all. Indeed, the Rockefeller Foundation, a key backer of the UHC goal, has recommended ‘models that harness the private health sector in the financing and provision of health services for poor people’ (Rockefeller Foundation, 2009: 2; Rodin and de Ferranti, 2012).
WHO has also offered a ringing endorsement of UHC even though its concurrent support for a renewed and equitable PHC has been muted. WHO’s backing of universalism in health care without equity began with a 2005 World Health Assembly resolution regarding prepaid pooling of resources to prevent catastrophic health expenditures and impoverishment (PHM et al., 2014; Sengupta, 2013). This was itself an outcome of the report of the 2000–01 WHO Commission on Macroeconomics and Health (see WHO, 2001), which revived the WDR 1993’s discredited formula that poverty is chiefly a result of ill health rather than the other way around (Waitzkin, 2003). By 2010, after the onset of the Great Recession, with health care costs continuing to rise and many LMIC health systems in disarray following decades of neglect and downsizing, the WHO’s World Health Report conveyed its full commitment to UHC, defined as ensuring that ‘all people have access to services and do not suffer financial hardship paying for them’ (WHO, 2010: 7). The World Bank has clarified UHC to mean: ‘access to the health care they need’ (World Bank, 2014) — that is, health services that are ‘essential’ or ‘vital’ rather than comprehensive — and featuring equity in access, good quality services, and financial risk protection (see WHO, 2014b). WHO Director-General Dr Margaret Chan has amplified this grand claim by arguing that:

Universal health coverage is one of the most powerful social equalizers among all policy options. It is the ultimate expression of fairness. If public health has something that can help our troubled, out-of-balance world, it is this: growing evidence that well-functioning and inclusive health systems contribute to social cohesion, equity, and stability. They hold societies together and help reduce social tensions. (Chan, 2015)

In making governments responsible for ‘ensur[ing] that all providers, public and private, operate appropriately and attend to patients’ needs cost effectively and efficiently’ (WHO, 2010: xviii), UHC portends a departure from PHC’s call for public, unified, comprehensive financing and delivery of care.

Many UHC efforts, such as reforms in the USA and Mexico, involve multifaceted financing reforms that add coverage to previously uninsured populations for some services (‘packages of benefits’), but not necessarily for all needed services (even as well-insured populations retain comprehensive coverage). In UHC plans, the public sector either withdraws from the provision of care altogether, to become a manager and purveyor of funds, or enters into a competitive relationship with an expanded, often for-profit private sector, leading to further fragmentation. Through UHC, insurance corporations gain access to public revenue streams (social security contributions and taxes) that finance contracts to provide a set of services to the previously uninsured (Sengupta, 2015). For their part, the newly insured, who are overwhelmingly economically precarious, are required by law in some settings to contribute taxes, premiums and user fees for their own coverage; at the same time the most vulnerable — who are employed in the
informal sector — may be excluded from ‘universality’ (Oxfam International, 2013) by virtue of being outside social security protections. Additionally, most UHC approaches do not call for funding via higher and more equitable taxes — through which the rich would be contributing to risk pools directly or indirectly — but rather rely on cross-subsidies among uninsured populations and requirements that providers offer charity or ‘free care’ for ‘community benefit’ (Birn et al., forthcoming 2016).

To be sure, universality is a key principle of health systems, important to ensuring equity, social inclusion and efficiency. It was certainly central to the Alma-Ata declaration, which called for ‘health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible’ (WHO, 1978: 3). The Canada Health Act of 1984, for example, codified that country’s national health insurance system by defining universality as coverage to all residents and a single level of care for all. Universality has also been at the heart of most European health systems. But WHO’s focus on universal coverage, without the guarantee of a unified, solidarity-oriented, single-tiered and comprehensive set of services as the heart of its return to PHC, is highly disconcerting. Stated differently, ‘if everyone has access to some health care benefits, but only a few have their cancer treatment covered, there is no universalism to speak of’ (Martínez Franzoni and Sánchez-Ancochea, forthcoming 2016). Nor can a health system be considered universal when some people enjoy higher quality care or more resources than others, or where co-payments impede access. Any policy that fragments more than it unifies or results in segmented financing or pools of beneficiaries inherently goes against universalism, even if it is called universal.

If implemented based on unifying principles — having the state play a ‘central role’ in assuring funding for and access to a unified set of health care services and regulating quality — UHC could be helpful (Cotlear et al., 2015). There remains a possibility that ‘progressive governments can try to privilege public systems’ and equity (PHM et al., 2014: 81), but the thrust of UHC, adding new patient demand and a new revenue stream to profit-seeking insurance companies in a context of further fragmentation, makes such a possibility remote. A 2014 Lancet series on UHC in Latin America reiterates such understandings of technocratic exigencies driving reforms without considering their political basis (Waitzkin, 2015).

Another deficiency is that UHC does not adequately incorporate a social determinants of health perspective (Clark, 2015; Marmot, 2013). For WHO’s Director-General to assert that: ‘universal coverage is the single most powerful concept that public health has to offer’ (Chan, 2013) belies WHO’s articulated commitment to the societal determinants of health and ignores WHO’s own ample evidence that social injustice, that is, political, economic and other societal inequities (among which lack of access to health care is but one aspect), ‘is killing people on a grand scale’ (WHO, 2008: 26; see also Navarro, 2009).
In sum, aspirational language notwithstanding, decontextualized UHC is a misguided approach, justified by certain legitimate concerns around catastrophic health spending, but offering the likelihood of large-scale, rapacious health system penetration by, and channelling of resources to, private interests that entrench health system inequity and income-based stratification. Unified and integrated national health systems, which are based on health as a right rather than as a commodity, pool resources across entire populations, and prevent impoverishment due to catastrophic illness, offer the best hope for equity and efficiency, even as quality has been threatened by resource starvation and privatization in recent decades (Chiriboga, 2014; Heredia et al., 2015). Why such systems are not at the heart of WHO’s push for universality is puzzling indeed.

One answer comes from Mexico, whose troubled health system has become the ironic poster child for UHC, bolstered by a concerted advocacy campaign by its proponents. While touted as the culmination of three stages of advances in health care organization and access (Frenk et al., 2003), Mexico’s situation might be better understood as the result of a regression of once promising efforts towards health policy equity. The vicissitudes of Mexico’s century-long effort to meet the demands of its 1910–20 revolution and its 1917 Constitution include the creation of mandatory rural service for graduating doctors, nurses and other health personnel, as well as a system of health services for agrarian cooperatives established by the 1930s government of President Lázaro Cárdenas. Unable to meet citizen social welfare claims on the state in a unitary or equitable fashion, due to the power of domestic elites and foreign investors, the Cárdenas administration responded to the enormous mobilization of both agrarian and industrial unions with universal education and increased health care access (Carrillo, 2005). However, health insurance and social security measures for various segments of the formal labour force were piecemeal, exclusionary and fragmented. A solid social security system for industrial workers (IMSS, realized in 1943), and for civil servants (ISSSTTE, initiated in 1959), were on their way to extending the same level of coverage to agricultural workers and the informal sector when neoliberal reforms started tearing the system apart (Laurell, 2015b).

As such, Mexico’s 2004 Seguro Popular (SP) marks more of a failure than a success in the country’s quest for health equity justice. Exacerbating Mexico’s infamously fragmented system, the SP was established not to universalize existing programmes (themselves under assault), but to cover the country’s 50 million uninsured individuals (almost half of its 2004 population of 105 million people) through voluntary health insurance coverage for a defined package of interventions (Laurell, 2007). Instead of merging coverage for the uninsured population with the social security system, as Brazil did (discussed below), Mexico’s legislation — so-called structured pluralism — created a new separate system, financed by premiums from the state and federal governments and participating families (with exemptions for the poorest 20 per cent) and contracting with public and private providers.
In 2012, the Ministry of Health and its allies claimed that UHC had been reached through incorporation of the 50 million previously uninsured (Knaul et al., 2012), but census and national survey data contradict this claim, indicating that between 25 and 30 million people remain uninsured, including over one-third of the poorest income quintile (PHM et al., 2014). Not only has private expenditure on health remained near its pre-reform level (48 per cent of the total, according to WHO, 2014a) but SP affiliates continue to pay proportionately more out-of-pocket than those covered by social security (Knaul et al., 2012), with out-of-pocket expenditures for the poorest groups barely declining (Laurell, 2015a). Meanwhile, SP’s benefits are less comprehensive than the social security scheme. SP’s defined set of interventions (not diseases) exclude common causes of mortality and morbidity, such as complications related to diabetes (Mexico’s leading cause of death), cerebrovascular diseases, many types of cancer, and trauma or burns due to accidents. Moreover, because SP expansion has not been supplemented by concomitant investments in infrastructure and human resources, many of the previous barriers to quality and access persist, especially in rural areas. Regional disparities and inequitable and fragmented financing and coverage remain entrenched, and the populations who have historically benefited from, or been disadvantaged by, a segmented system remain the same as before the reform (Laurell, 2015a). As Professor Cristina Laurell, a perspicacious analyst of health care privatization in Mexico and other Latin American countries, has cogently argued, UHC — euphemized as structured pluralism — is regressive rather than progressive, retaining the vast inequalities of fragmented systems (unequal pluralism, structured or otherwise, enables this) and opening the door to ever further privatization, contradicting the very aims of universal and equitable health systems.2

LATIN AMERICAN COUNTER-EXAMPLES TO GLOBAL HEALTH COOPTATION

Notwithstanding the troubling tales of UHC in some Latin American countries, struggles for health justice in resistance to neoliberal hegemony have enjoyed a revival of sorts in recent years (González-Guzmán and Cortes Hernández, 2015), albeit with caveats. Virtually all Latin American countries have tried to tackle healthcare inequities — Uruguay moved towards an integrated national health system in 2008, Bolivia has increased access with a paradigm of multiculturalism and the elimination of user fees — but the challenges of confronting problems produced by costly private systems and fragmented public ones loom large.

2. See Cristina Laurell’s website: http://asacristinalaurell.com.mx
The example of Cuba, of course, long pre-dates the rise of neoliberalism. Even before the 1959 Cuban Revolution, the main political parties supported certain public health services as a lure for voters. But its transformation into Latin America’s sole equitable, fully public, universal health care system took place in the context of a socialist state forged through decades of political struggle. In the thick of the Cold War, the revolution spurred nationalization of productive assets and universal provision of social services — sanitation, housing, education, and so on. Starting with rural health services in the country’s most remote and underserved areas, within a decade Cuba’s health services were integrated into a regionalized network of polyclinics at the primary level with corresponding secondary and tertiary care facilities, together comprising free, high quality, participatory health care reaching the entire population. Although half the physicians fled the country after the revolution, a large-scale medical training effort ensured sufficient staff by the 1970s; the subsequent development of a respected biotech/pharmaceutical sector enabled near self-sufficiency (Farber, 2011; Feinsilver, 1993). Despite the major economic belt-tightening that accompanied the breakup of the USSR and the end of Soviet subsidies, the Cuban health care system has not only persisted but thrived. It is also significant that, more than any other country, Cuba has, since the revolution, addressed the larger societal forces influencing health through policies of committed egalitarianism in education, housing, transport and other areas (Pagliccia and Álvarez Pérez, 2012).

Costa Rica’s experience also represents a long struggle for the right to health. As a fruit- and coffee-exporting ‘banana republic’ coming out of a divisive civil war, in the 1940s it launched the foundations of what in just three decades would become a comprehensive welfare state (partially financed by the abolition of the military). In 2012 the country had the highest scope of universal protections and government services of the region, outside of Cuba (Martínez Franzoni and Sánchez-Ancochea, 2013). Although the crisis of the 1980s led to severe recession, the government continued to invest in social services, including public health, thus maintaining gains in infant mortality and overall health status (Mesa-Lago, 1985; Morgan, 1987). Today, Costa Ricans enjoy the second-longest life expectancy in the Americas, after Canadians.

To what can one ascribe these health gains? First, Costa Rica’s mandatory social insurance system, launched in 1941, began with the lowest paid blue-collar workers, over time incorporating higher paid workers until universality was reached from the bottom up. A single fund was created so that, unlike in other countries, there was no segmentation by industry. The expansion of coverage thus enjoyed wide public support. By the 1970s, when the wealthy were mandated to contribute payroll taxes into social insurance, a unified set of high-quality benefits covered the entire population, although since doctors were not prohibited from practising privately, elites paid for privileged medical access without going through the social security
system (Martínez Franzoni and Sánchez-Ancochea, 2013). At the level of organization of health services, several features of the system stand out: publicly provided services (rather than services contracted out to the private sector); a single public insurer; no purchaser–provider split or autonomy for hospital managers; integration into a single system; and user involvement in the management of services (Unger et al., 2007).

Other factors are also key. In the 1970s, a special fund was created for the poorest populations previously excluded from social policies. Wide backing for social entitlements helped Costa Rica to partially resist neoliberal reforms when its economy faltered (i.e., fending off privatization of social service provision), although the quality and funding for some services deteriorated markedly at this time (Seligson and Martínez Franzoni, 2009). Emphasis on principles of collectivism and worker solidarity, and the state’s prioritization of human development (with high levels of literacy, employment generation and women’s insertion into the paid labour force) — all part of Costa Rica’s long tradition of social protection — helped cushion it against the worst hardships of recent economic crises (Martínez Franzoni and Sánchez-Ancochea, 2013). Still, since the 1990s the health and education systems have faced a deterioration of both quality and equity, with creeping privatization and out-of-pocket spending and the entry of for-profit insurance corporations.

Neoliberalism in the 1980s and 1990s also failed to stop Brazil’s re-democratization movement from trying to build universal social policies and a universal, public and unified health system, as opposed to UHC (Cohn, 2008). Drawing from the post-dictatorship 1988 Constitution’s enshrining of health care as a universal right under the principles of universality, equality and community participation, Brazil’s reform has attempted to rectify inequities in health care access and financing, based on a publicly funded, integrated universal system (D’Avila Viana et al., 2015; Lima et al., 2005). It operates a tax-funded Unified Health System (SUS), free at the point of service for the entire population (Paim et al., 2011). The decentralized system, involving federal, state and municipal governments in both management and financing, has sought to improve equity in part by creating local decision-making councils and regional management roles to align health system planning with needs (Fleury, 2011). Today PHC is delivered across most of the country through over 32,000 community-based family health teams, each consisting of a doctor, nurse, nurse technicians and up to a dozen full-time community health workers, serving over 120 million people across the country. Yet even with SUS, problems and inequities persist. Provision of most tertiary care is contracted out to an increasingly expensive, although substantially not-for-profit, private sector. Private insurance covers 25 per cent of the population, but represents over half of health expenditures. The shortage of primary care doctors in the poorest and most rural areas recently obligated the Brazilian government to contract almost 15,000 doctors, mostly from Cuba, through the Mais Médicos programme, stirring
Anne-Emanuelle Birn, Laura Nervi and Eduardo Siqueira

counter controversy and garnering welcome support among the almost one quarter of the population lacking physicians (Kirk et al., 2015).

Despite the significant increase in public coverage, recent privatization trends undermine SUS and undergird a two-tiered health care system: a public SUS for the poor, and subsidized private health insurance for those who can afford it — and yet who often return to SUS coverage for catastrophic expenses, depleting its resources, even as they resist paying higher taxes (de Almeida Rodrigues, 2014). In sum, the main problems impeding SUS from fulfilling its mandate of universality, quality and equality are federal underfunding, increased public financing for private sector insurance, rigidity of the bureaucratic-administrative structure of the state, and privatization of SUS management (dos Santos, 2013). These problems have persisted if not grown, even under three successive progressive (in the social policy arena) Workers’ Party administrations: the SUS has seen defunding and a greater role for and power of the private sector, despite a strong resistance movement that has increasingly denounced its denationalization (ABRASCO, 2015).

The arrival of the new millennium brought further efforts to build universal and public health systems in several other countries of the region. Among these, the case of Venezuela stands out: in the space of less than a decade, through the Barrio Adentro programme (‘Inside the Neighborhood’, founded in 2003) and thanks to the work of some 14,000 Cuban doctors, Venezuela doubled access to primary health care (reaching near universality), with 3,200 health clinics built in the country’s poorest neighbourhoods — places that had never before enjoyed such local infrastructure or attention to human need (Muntaner et al., 2013). This initiative drew on Venezuela’s 1999 Constitution that declared health to be a human right guaranteed by the state, coupled with ‘bottom-up’ political demands for health and social services, nutrition, housing, education and improved employment (Walker, 2015). Undoubtedly the considerable resources invested in this effort (including the exchange of Venezuelan oil for the services of thousands of Cuban doctors, organized between Fidel Castro and Hugo Chávez) go beyond what some other countries might manage, but re-orienting existing health care spending would go a long way in any setting. The enormously popular Barrio Adentro programme has also improved health care infrastructure, and in 2010 Venezuela’s Bolivarian government began an ambitious programme to train its own community physicians and reduce dependence on foreign doctors. By March 2015, almost 19,000 Venezuelan physicians had graduated with degrees in Integral Community Medicine and had begun working with Barrio Adentro (MPPS, 2015). A remaining challenge is to fully integrate Barrio Adentro with the existing state public health system, since they currently operate in parallel.

The lack of interest on the part of most mainstream development actors (whose ideological agendas reject these kinds of redistributive measures) in supporting, highlighting or even considering Venezuela’s integrated approaches as a legitimate and effective (though not flawless) route to global
health equity speaks volumes (although non-interference by the USA and IFIs may have also been protective).  

THE STRUGGLES AND NEED FOR A NEW GLOBAL HEALTH (INTERNATIONAL ECONOMIC) ORDER

The preceding analysis shows the extent to which the global health agenda of the last three decades has been captured by neoliberal exigencies via two avenues. The first is a concerted effort at privatization of health services (including in settings where there has been historical progress at addressing equity issues) and global health activities, through pro-privatization policy-making channels in major multilateral, bilateral and philanthropic agencies. The other avenue comprises indirect efforts by these same actors, together with domestic counterparts, to appropriate the agendas, values and activities of social movements, unions, advocacy groups, grassroots NGOs, and other solidarity efforts that represent bona fide social justice and equity-oriented public health approaches. This cooptation has sought to reframe key categories and principles elaborated and long employed by progressive sectors into the lexicon and policies of public and private players engaged in health policy making at national and international levels. The latter form of cooptation is especially nefarious because appropriated language around universality, convergence and shared agendas can be deceptive — eliciting support from many audiences who are unaware that progressive agendas might have been taken over and distorted (Armada et al., 2001).

Alongside the task of unmasking and debunking the modus operandi of two generations of a dominant neoliberal agenda in health, it is also important to recognize the experiences of resistance to this onslaught. Such experiences demonstrate that there are viable progressive and dynamic alternatives to the hegemonic model that go well beyond the labour base of yore. They also reveal the weaknesses and fragility of these alternatives, reinforcing the need for ongoing struggle towards the building of a new global health order. While Latin America is by no means the only region in which alternative models have emerged, perhaps no other part of the world has undergone such long-term and dramatic struggles in the health and political arenas, at times yielding extraordinary moves towards social justice, and at times seeing these overturned — a poignant reminder that without continuous mobilization, even the most profound health and social justice achievements may be reversible.

In an era in which the WHO itself is being coopted by private and philanthrocapitalist interests (Velásquez, 2015), vigilance and broad participation by scholars, activists and the (critical) development community at large will

3. It is extraordinary, for example, that global health philanthropic efforts pay no attention to these promising, if Sisyphean, developments.
be essential in staving off the neoliberal cooptation of progressive global health equity policies and in helping to build a counter-cooptation movement for genuine health justice.

REFERENCES


Anne-Emanuelle Birn, Laura Nervi and Eduardo Siqueira


Debate: The Cooptation of Global Health in Latin America


Anne-Emanuelle Birn (corresponding author; e-mail: ae.birn@utoronto.ca) is Professor of Critical Development Studies at the University of Toronto, Canada. Her books include Oxford University Press’s Textbook of Global Health (4th edition forthcoming) and Comrades in Health: US Health Internationalists, Abroad and at Home (Rutgers, 2013). In 2014 she was recognized among the top 100 Women Leaders in Global Health.

Laura Nervi (e-mail: lnervi@salud.unm.edu) is a global health and international cooperation scholar currently based at the University of New Mexico, USA. Her research interests include analysis of international cooperation policies, global health and national systems reforms in Latin America, and health and trade agreements in the Americas.

Eduardo Siqueira (e-mail: carlos.siqueira@umb.edu) is an Associate Professor at the College of Public and Community Service and Coordinator of the Brazilian Transnational Project at the University of Massachusetts, Boston, USA. He has written articles on work environment policy, environmental justice for Brazilian immigrants, Brazilian health policy, and health and safety disparities at work.