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Debate

Pragmatism, Structural Reform and the Politics of Inequality in Global Public Health

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ABSTRACT

Despite broad international agreement on the importance of addressing global health inequalities on grounds of both social justice and health security, there is little accord on how this should be done. The Debate that follows interrogates the role that capital and corporate institutions have assumed in defining and implementing global healthcare reforms. The contributors to the Debate do not agree on the legitimacy of the classic oppositions in design of healthcare — state vs market or public vs private. Nor do they concur on the (in)compatibility between pragmatic collaboration with corporate institutions and realization of norms of social justice in health. Yet all do agree that unequal access to healthcare is only one of the structural determinants of inequalities in global health. Global capital is implicated in structural patterns of investment that have made jobs, wages and land-based livelihoods insecure and unhealthy, fouled air and water and profited from spiralling costs of drugs and treatment. On such an economically and politically conflictual terrain, it is unlikely that collaboration with corporate institutions is consistent with structural assault on the social determinants of global inequalities in health.

THE UNSTABLE CONSENSUS OVER GLOBAL INEQUALITIES IN HEALTH

There is now broad concern among scholars and within the institutions of development about the need to address inequalities of global health. Angus Deaton's (2013) *Great Escape* is a reflection on what we can learn from the past about how global economic growth might avoid creating new inequalities of wealth and health both between and within countries. Jeffrey Sachs (2012) argued in *The Lancet* for achieving universal health

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coverage in low-income settings. From within the World Bank itself has come a call for 'attacking inequality' in the health sector (Yazbeck, 2009) and recognition that improved public health may be a condition for economic development rather than just its outcome (Leon, 2015: 97–104). Thus mainstream development authorities have joined the company of those such as Farmer (1996), Krieger (2014), Marmot (2005), Navarro (2007) and Wilkinson (1996) whose work has long dealt critically with the relation between inequality and health. What was once the rather marginal specialized field of international health development has been transformed into a new field — global health — in which inequality is a central issue.

The shift in development discourse from poverty to inequality recognizes that the issue is not just creation of wealth but its control and distribution. A rapid rise in donor spending on global health over the last three decades would indeed seem to indicate that there is a consensual commitment to global redistributive public health based on transfers of wealth through government grants, World Bank loans and contributions from private foundations. Using OECD data, Leon (2015: 11) calculates that health's share of world aid rose from 6.8 per cent in 1977–1981 to 13.7 per cent in 2002–2006. The 1993 World Development Report, *Investing in Health* (World Bank, 1993), thus appeared to signal a distancing from the structural adjustment policies that weakened many public health systems, particularly in Africa, in the 1980s (Leon, 2015). The World Bank, a distributor of largesse as well as a lender, has displaced the World Health Organization (WHO) as the major influence behind health policies in poor countries (Abassi, 1999).

When one probes more closely, however, the apparent redistributive consensus on addressing global inequalities of health falls apart. There are major differences as to why global health inequalities are considered to be important, on what the causes of health inequalities are, on what can and should be done to address them and who should do it. For some, such a massive redistributive project demands an active role of the state as regulator of public health, as provider of health services and as taxer of wealth. For others redistribution on this scale will only be possible if the state facilitates private initiative, including the creative involvement of capital as investor in global public health, as partner of the state and non-governmental organizations and as philanthropic funder of business-like interventions. Both sides recognize that the terrain of public health includes individuals, households and organizations of civil society, but the normative roles they are assigned vary with these two fundamentally different versions of the relation between capital, state and society. This deeply political question of the private/public divide in redistributive global health reform is inevitably embedded in considerations of ethics and values as well as economics and politics. It is the subject of this Forum Debate. Debates around inequality and the public/private divide are not a novelty in development studies, so it is useful first to establish what is distinctive about current discussions of inequality and its causes in the field of global health.

INEQUALITY AND THE DIVIDED CONCEPTUAL TERRAIN OF GLOBAL HEALTH

This Debate is concerned with the politics of public health, which customarily focuses on the health of populations, as distinct from medicine, which addresses individual health. As Farmer et al. (2013: 9) recognize there is a risk in reifying the distinction: both have to do with social processes as well as biological ones and are shaped by the same relations of inequality. Population is an abstraction from the everyday experience of individuals. Foucault (2000b: 94) considered this abstraction to be an instrument of governance, and managing the health of populations to be a technique of political domination. The distinction is maintained here, however, because medicine and public health ask different questions: medicine asks why particular individuals become ill; public health tries to understand patterns of health and disease across society (Rose, 2008; Wilkinson, 1996). The reasons for each are not the same. Failure to distinguish the two questions has led, for example, to the tragic denialism of early HIV/AIDS policy in South Africa in that the question of how the infection was transmitted, sexually or not, became confused with the explanation of the skewed racial distribution of the incidence of the disease. This latter question, inherently political, had to do with the profound and historically rooted inequalities of race, class and gender in South African society (Fassin, 2007).

A second conceptual division relates to the meaning of global health. Lakoff (2010: 59) argues that although global health appears to have a shared moral and technical project, it is not really a unified field. He identifies two different regimes for envisioning and intervening in the field of global health, each with different political orientations: health security and humanitarian biomedicine. The approach of the former is exemplified by international organizations of health surveillance such as the WHO, and the latter by international NGOs such as Médecins Sans Frontières or Partners in Health, concerned with remedying the suffering of individuals who are deprived of the health services that others enjoy. Each regime construes inequalities of health in different ways.

International health security in a world of national inequalities is not really a new preoccupation. The negotiation of quarantine, balancing liberal interest in open trade and investment versus the dangers of contagious diseases transmitted by infected cargo, passengers and crews, have been arbitrated by international treaties since the early nineteenth century (Harrison, 2006). Imperial powers were concerned with limiting the impact of contagious disease on the productivity of their labour forces and the protection and treatment of settler communities in both Africa and Asia (Feierman, 1985; Peckham and Pomfret, 2013). The question is whether present patterns of globalization have spawned new inequalities of health that pose new threats and with them new kinds of politics.

Dodgson et al. (2002) have argued that, given current patterns of globalization, relations between states cannot be treated as the sole medium of intervention in public health. Globalization has intensified cross- and transborder flows of people, good, services and ideas. It has increased the importance of determinants of health that lie outside the health sector: trade and investment flows, collective violence and conflict, illicit and criminal activity, environmental change and communication technologies. As Koivusalo (2006: 13) observes, globalization has also altered normative institutions and ideologies; global economic integration and legal agreements have redefined regulation, rights, risks and responsibilities and privileged neoliberalism in both international and national health policies.

Porous international boundaries have upset earlier assumptions about international health security. It no longer seems certain that developed countries have passed through an epidemiological transition that renders communicable diseases much less dangerous to them than the chronic diseases associated with ageing and life-style. With globalization have emerged new threats from infectious diseases such as HIV/AIDS, SARS and Ebola. Fears of contagion have led to calls for the barriers of quarantine to be strengthened. From a health security point of view, addressing inequalities of health has an instrumental rationale. Not only does rapid and frequent movement of people mean that infections also move quickly between rich and poor, but systems of control based on exclusion hinder trade, make the monitoring of diseases difficult (those at risk evade identification), and undercut the public health capacity for rapid intervention.

For the contrasting regime of humanitarian biomedicine, inequalities of health are a problem in themselves, regardless of the health security threats they pose to developed countries. The task of global health is to alleviate the suffering of individuals regardless of national boundaries or social grouping, particularly in places where public health infrastructure is poor or non-existent (Lakoff, 2010: 60). For some, global health is best viewed as part of a global social justice movement, not simply as humanitarian medicine: 'Global health is an attitude. It is a way of looking at the world. It is about the universal nature of our human predicament. It is a statement about our commitment to health as a fundamental quality of liberty and equity' (Richard Horton, editor of *The Lancet*, quoted by Farmer et al., 2013: xv). The stress on health inequalities and human rights in humanitarian intervention has energized concern with social justice across the field of global health.

Lakoff (2010: 75) suggests that the two regimes might be politically complementary rather than contradictory, that 'humanitarian biomedicine could be seen as offering a philanthropic palliative to nation-states lacking public health infrastructure in exchange for the right of international health organizations to monitor their populations for outbreaks that might threaten wealthy nations'. Lakoff's conceptual distinction between two different global health regimes can be politically deceptive since both health security and

humanitarian intervention are structured by the same cross-cutting relations of inequality (Fassin and Rechtman, 2009; Nguyen and Peschard, 2003; Wald, 2013).

The same point has been more forcefully made by Levich (2015) in relation to the ascendency of global capital in the institutions of global health. He draws attention to Bill Gates's recent post-Ebola call to set up a global institution modelled on NATO to coordinate warning and response to epidemics (Gates, 2015) and suggests that such proposals for 'global health governance' actually constitute 'global health imperialism'. The pluralist political institutions of global health — its inter-state organizations, courts, humanitarian organizations and social movements — currently have less impact than the shadowy institutions of global capitalism — the World Bank, the G7, health-oriented transnational corporations, major foundations and associated networks of NGOs (Levich, 2015: 732–3). This radically limits democratic participation in control of healthcare (ibid.: 733). As Latour (2009: 141), one of the great prophets of globalization, has said, we have a tendency to exaggerate the extent to which we as individuals access the global sphere — we mainly live in narrow local corridors.

THE STRUCTURAL CAUSES OF INEQUALITIES IN GLOBAL HEALTH

The HIV/AIDS crisis, or more precisely its persistence, has made a political space for the fractious meeting between international health security, global capital and social justice movements in health. Paul Farmer (1996, 1999, 2003, 2004) has had an important role in describing this space, particularly with his rhetorical power (e.g. *Infections and Inequalities, Pathologies of Power*) and his concept of 'structural violence'. Farmer uses the concept loosely to establish linkages between his moving accounts of individual suffering and analysis of mediating structural processes (Janes and Corbett, 2009), in ways often saturated, as Wacquant (2004) pointed out, by moral judgements that are not analytically based. To condemn can be easier than to find ways of intervening to eliminate the causes of structural inequalities of health. The title chosen for a recent collection by Farmer et al. (2013), *Reimagining Global Health*, is promising, but the editors' stress on finding pragmatic possibilities for public health practitioners leads them to be somewhat conventional in their choice of allies and modes of intervention. The collection falls short particularly in its discussion of the political barriers, both in discourse and practice, to be confronted in building a 'global movement for health equity' that would address the structural causes of inequalities in health.[1]

1. See Janes (2014) for a good review of both the strengths and lacunae of the collection. See also Birn and Brown (2013) for alternative approaches to linking politics to humanitarian health intervention.

Farmer does not, however, write in a vacuum. Concern with the social and environmental causes of health, inequalities of health and the need for better public health were important themes of reform movements in nineteenth century Europe — for example Engels' research on the living conditions of the English working class (Engels, 2009) and Virchow's study of the causes of typhus epidemics in Germany (Mackenbach, 2009). In North America, John Griscom, the Quaker health inspector of the city of New York, exposed in 1845 the miserable health conditions of the labouring poor (Rosenberg, 1997). The development of the germ theory of disease, which suggested that any infectious disease that arises under the same biological conditions will respond to the same biomedical treatment everywhere, revolutionized clinical medicine, but gradually marginalized the importance given to the causal importance of the social contexts in which infection and treatment took place (Kunitz, 2007; Terris, 1985).

Critical social medicine, with an emphasis on the social determinants of health, continued to be important, however, in the first half of the twentieth century, including in League of Nations interventions in the inter-war period (Borowy, 2007). Even in 1930s South Africa, where medical officers working in the mines skewed results to reflect racialized stereotypes (McCulloch, 2013; Packard, 2009), the National Health Services Commission proposed the establishment of a unified national health system based on the principles of social medicine: concern with the social causes of disease, the importance of prevention and community-based primary care (Marks, 2014).[2] Progressive social medicine also became an important tradition in Latin America (with Allende as an iconic figure). It has produced a large body of work on the social determinants of health, including on the relation between health outcomes and work, environment, violence and policies of healthcare (Waitzkin et al., 2001). This is an approach that has been carried beyond Latin America in the work of Navarro (Navarro and Shi, 2001), Mutaner (Benach et al., 2007; Muntaner et al., 2010) and others.

There have also been heterodox voices in anglophone and francophone epidemiology and sociology of health attending to the impact of the social environment, including inequalities of race, gender, class and region, on health. McKeown and Brown (1955) argued that improvements in living conditions were more important than specific medical therapy in the decline of mortality from infectious disease in early nineteenth century England. Susser (1962) brought his concern with inequalities between race and class, and from South Africa to Britain and the United States, an approach carried forward in the work of Krieger (2014) and critical medical anthropology (Singer and Baer, 1995). In the United Kingdom, the work of Marmot and Wilkinson has been focused on the impact on health of inequality in living and working conditions (Marmot, 1994; Marmot and Wilkinson, 2006;

2. The proposal was rejected.

Wilkinson, 2005; Wilkinson and Pickett, 2006). Marmot emphasizes the relation between social inequality and differences in the quality of life not just in differential mortality rates. He has looked, for example, at the impact of the psychosocial environment on mental health in Western industrialized countries (Siegrist and Marmot, 2004). Castel (2003) revealed the ways in which precarity of jobs exposes the working poor to extreme health risks even within the domain of European welfare states. There are also critics of social medicine. Foucault's body of work on the history of bio-science (Foucault, 1997, 2000a) challenged the assumption that intervention in the health of collectivities by the modern liberal state was necessarily driven by egalitarianism. Rather he saw redistribution as a technique of governance embodying and reproducing inequalities of power.

The renewed legitimacy of the concepts of structural causes and structural intervention in global health has been important because structure, like inequality, is a relational concept that makes it possible to think of states of health not as the properties of individuals but as the outcome of socially defined relations of hierarchy and domination. At the turn of this century, the World Health Organization, whose main brief is international health security, began to look seriously at the social causes of disease.

The WHO Commission on the Social Determinants of Health (CSDH), set up in 2005, had Michael Marmot as its chair. The Commission followed a consultative process, integrating states, international organizations and academics from both North and South. The process represented an alternative to both discourses of global health policy then dominant in the WHO: biomedical health security and the efficiency calculations of assessment of neoclassical health economics. The 2008 report of the Commission (CSDH, 2008: ii) declared that social justice was a matter of life and death and made inequalities of health its focus: 'These inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces'.

The report focuses on daily living conditions, within which access to healthcare is only one. It ends with a long list of recommendations for governments and international institutions but groups them in three overarching conclusions: improve daily living conditions; tackle inequitable distribution of power, money and resources; measure and understand the problem and assess the impact of action.

The CSDH challenged many of the habitual boundaries of global health in the WHO. In insisting on looking at the impact of social inequalities within countries and not just between them, it took global health beyond states and international organizations to the ways in which local struggles articulate with global processes. By linking individual suffering to structural patterns of inequality within populations, it blurred the boundary between healthcare and public health. By moving beyond demands for a just distribution

of healthcare to inequalities of daily life rooted in conditions of work and residence, it provided political grounds for linking environmental, labour, trade and health struggles. By pointing out that most health research funding remains biomedically focused and that randomized controlled trials and laboratory experiments generally do not work for research on the social determinants of health (CSDH, 2008: 20), it opened the meaning of 'evidence-based global public health' to critical scrutiny (Adams, 2013). By drawing attention to the universal importance of the quality of life in developing as well as developed countries, it recognized the growing body of research that shows that mental health, environmental safety and chronic disease are universal issues, and not limited to industrialized countries (Becker et al., 2013).

The CSDH report has drawn criticism from different quarters. Writing as health economists, Epstein et al. (2009: 495) argued that social justice is a 'legitimate perspective', as indeed it is from a liberal point of view (cf. Reid-Henry in the following Debate). They found, however, that the report had three failings: it didn't explain how to assess the causal impact of the determinants of health and health inequalities or of policies to address them; it didn't prioritize a long set of possibly competing policies and objectives; and it did not explain the appropriate role of government in influencing behaviour. These critical queries appear to be technical but they are in fact political. Each refers to unsettled areas of debate within the CSDH process, between the WHO and the World Bank and more broadly in the field of global health, as to the respective roles of state and capital in redistributive and regulated global health.

From the left, Navarro (2009) launched a more strident critique of the ambiguous consensual politics of the WHO, arguing that the report avoided confronting neoliberal public policies that were promoted worldwide in the period 1980–2008, including by the WHO — policies that actually contributed to global inequalities of health. Within the health sector, Navarro argued, these policies have meant: reduced public responsibility for the health of populations; the transformation of national health services into insurance-based healthcare systems and privatized medical care; a discourse in which patients are referred to as clients, planning is replaced by markets, individuals have become personally responsible for improving their health, and health promotion has become behavioural change (Navarro, 2009: 425).

The CSDH was a process of political negotiation. Given the diversity of positions involved, Marmot et al. were probably pleased to have produced a report that brought a social justice perspective to an institution dominated by neoclassical health economists and Lakoff's health security regime. For Navarro, however, the consensual compromises of the CSDH report papered over the ways the renegotiation of the private/public divide in health had created new inequalities of access to health services and reduced the capacity of the state to either regulate or reduce them redistributively. Looked

at in this way, the World Bank's commitment to 'investing in health' was not really 'changing sides'. Like other major global health funders such as the Gates Foundation or USAID, the World Bank has retained its strategic commitment to reducing the role of the state as health provider relative to non-governmental organizations and weakened the state's power to regulate public health programmes (Pfeiffer and Chapman, 2010). It is worth remembering that *Investing in Health* was released in the wake of the dramatic demise of the Soviet Union in 1990, an event that gave the term global capitalism a whole new meaning.

Consensual ambiguity extends beyond the CSDH; it is inherent in the social justice approach to global health. Beneath a shared rhetoric of commitment to equity and fairness and recognition of the legitimacy of some form of redistribution lies an unresolved debate around the private/public divide. Current discussion tends to focus on the role of the state versus the market in healthcare provisioning, but this is a misleading image of the private/public divide. It abstracts from the underlying structural relations of inequality that shape both provision of healthcare and the causes of illness, including the unmanaged outbreaks of disease and violence with which institutions of health security are concerned. Deconstructing the private is particularly important because of corporate capital's growing involvement in global public health projects, as both funder and provider, and its new legitimacy — if not hegemony — in shaping global health policies.

CAPITAL, INEQUALITY AND REDISTRIBUTIONAL REMEDIES IN GLOBAL HEALTH

Investing in Health (World Bank, 1993) put its argument for privatization and competition in health services in neoclassical terms. Competition would improve efficiency and allow governments to reduce their spending on health while at the same time reducing health inequalities by providing coverage to more people. The state would also continue to be accountable for general public health and provide health services to the very poor.

On theoretical grounds it once seemed ridiculous to expect capital to resolve extreme health inequalities both within and between countries. Marx argued that the historical specificity of capitalism's law of population was that capital was not obliged to assure that wages covered the costs of reproduction of its labour force as long as there were people obliged to sell their labour power (Coontz, 1998). The institutionalist economist F.W. Kapp, whose work is discussed by J.-F. Gerber in the Legacies section of this issue, extended this point, arguing that capitalist enterprises did not cover the social costs of their production, neither the health of their labour force nor the non-commodified environmental resources they consumed (Kapp, 1969). Neither Kapp nor his like-minded friend Polanyi thought capital could be left to regulate itself.

Feminist theory, which emphasized that the social costs of production were gendered (Moore, 1994), suggested that the withdrawal of the state from health provisioning under structural adjustment programmes would exacerbate gender inequalities. If privatization meant households were obliged to take upon themselves greater burdens of care, the costs would be disproportionately borne by women. Even in neoclassical terms, health seemed to be a domain of imperfect markets. It is hard to see how profit can be made by providing services to those who have minimal purchasing power. Those who have money do not wish to be taxed to pay for services from which they themselves receive no direct benefit or for which the benefits are enjoyed by all (Colclough, 1997). It was once assumed that where markets failed to ensure the public good, aggressive regulation was needed to make private agents follow health standards and that there were strong grounds for state-organized redistributive public health services.

Yet, since 1993, 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*. This expansion has various tentacles, some more obvious than others.

First, in developing and developed countries direct corporate investment has increased in private hospitals and clinics, in service provision 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 surplus revenue should be invested (Roy et al., 2014). 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 OCED countries (McGoey, 2014). As part of its 'Beyond Aid' initiative, the UK government, for example, is investing in commercial hospital chains in emerging economies. Two-thirds of this investment went to companies in Turkey or the BRICS (Brazil, Russia, India, China, South Africa) where profit-taking could reasonably be expected (Hunter and Murray, 2015).

A second area of expansion of corporate involvement in health is private–public partnership: governments are tied to private companies and/or non-profit health NGOs or both. In social franchising, for example, a large international NGO or social enterprise provides services to private clinics in strengthening their business practices, branding themselves and purchasing drugs in bulk at wholesale prices (Schlein et al., 2013). There is also government support for new forms of involvement of civil society groups in care: patient groups, associations of traditional healers and religious communities. However, some of what is labelled as partnership with civil society resembles the kind of 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. The very large INGOs such as

Oxfam have a great deal of influence in international health platforms and could justifiably be called partners, but small local NGOs may work on a non-profit basis and have a social mission, while they must pay their staff, maintain offices, fund programmes and justify the results of their activities. They have little possibility of challenging the terms of reference under which they are contracted.

A third area of expansion is 'philanthrocapitalism'. Corporate philanthropy is not new in global health. The Rockefeller foundation funded a hookworm eradication programme in Java in the 1920s (Engel and Susilo, 2014) and a malaria eradication programme in Brazil (Packard, 2007), but as McGoey (2014) emphasizes, the question is scale and the amount of influence that philanthrocapitalism — and the Bill and Melinda Gates Foundation in particular — now has on global health policy. The purchase of the Gates Foundation extends beyond what it actually funds since it leverages funds from governments and other institutional donors and receives substantial tax breaks for philanthropic giving. The model of corporate philanthropy is applied by smaller multinational and regional corporations as well. Land concessions in Africa often include the promise to build a health post (with staffing usually left to the public health service) and important companies are invited to participate in health 'platforms' similar to international health policy meetings.

A fourth area is commercial management of public health. Through the conditionalities imposed by the principal health donors and the guiding hand of the World Bank, governments and NGOs are supposed to use the same systems of management and assessment that are employed by corporations; they should act like businesses even if they are not. Where governments continue to operate public clinics and hospitals, they should apply user fees. The functioning of public facilities on a non-commercial basis can be cross-subsidized by establishing clinics within their premises where the same staff provide both everyday care and specialized procedures on a priority basis to those who can afford market rates. When interventions are planned (and funded by donors) they should be based on a business plan that calculates long-term costs and benefits as measured by DALYs (disability adjusted life years) or QALYs (quality adjusted life years). The best 'gold standard' interventions are those that can be experimentally verified by RCTs (random control trials) (Adams, 2013).

Fifth, commercial discourse is extended to the broad field of health promotion. Healthcare provisioning is conceptualized as a market where patients are clients, choosing among competitive options and individually responsible for their own health choices (Ayo, 2012; Crawshaw, 2014). The emphasis in health promotion has accordingly shifted from education to persuasion. Social marketing began with anti-smoking campaigns in North America (Rutherford, 2000), but was institutionalized by the big international family planning organizations, such as Marie Stopes and PSI, who moved easily into HIV/AIDS prevention. 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.

THE OUTCOMES OF THE RETURN TO CAPITAL

Has the multiplicity of new forms of entry of capital reduced inequality by improving access, reducing costs and improving quality or have they exacerbated inequality by increasing exclusion? Oxfam (2009) has scathingly characterized the turn to private healthcare as 'blind optimism' and identified various dimensions where privatization has increased exclusion (or would be expected to do so): attracting private providers to low-income high-risk areas requires state subsidy; privatized care increases and polarizes health expenditure without increasing coverage; privatized care drives out the less profitable preventative healthcare. In truth, confounding variables make it very difficult to establish the case statistically one way or the other, even in developed countries. Epidemiological reviews are rare and focus principally on quality of care rather than coverage, but have not shown any evidence of superiority of private care facilities over those operated by the state (Basu et al., 2012).

There are, however, abundant case studies suggesting that the shrinking of public health systems has intensified inequalities of health. Many are from Africa, where the Structural Adjustment Programmes of the World Bank in the 1980s initiated cutbacks in government health spending. In the Sahel, for example, Ridde (2015) argues that it has long been clear that imposition of user fees excludes some of those that government health facilities should be treating while not assuring a reliable income stream either. Others show that NGOs and corporate social responsibility (CSR) do not provide the kind of consistent care, monitoring and coordination that public health systems can provide. In one province of post-war Mozambique, Pfeiffer (2003) described how the sudden influx of INGOs and international health workers fragmented local primary healthcare and increased social inequality in the 1990s. The problem has recurred with vertically-funded programmes, particularly HIV treatment, where INGOs are again important intermediaries (Pfeiffer, 2013). In accounting for the slowness of the response to Ebola in Sierra Leone, Wilkinson and Leach (2015) observe that the problem was 'structural violence', long-term processes that led to multiple inequalities, not just the weakness of the local public health system. They also note the incapacitation of rapid response that resulted from restructuring within the WHO itself and the derisory amounts donated by international mining and energy companies operating in Sierra Leone in the name of CSR for emergency healthcare.

It should not be surprising that neither cross-country panel data nor case studies entirely resolve the question of what works best — state or

private — to reduce inequalities of health. The consequences of the turn to capital on inequalities of health vary by context and content of the reforms. There are no universal prescriptions to be deduced on how best to reduce health inequalities. At a structural level, however, we can identify general processes resulting from the ascendency of corporate capital in global health that have consequences for the politics of social justice in global health.

First, the terrain of redistributive healthcare reform is now much more tightly restricted to the market. Existing public health systems have been weakened. This shift reflects both the explicit preference for the private sector in the World Bank, the Gates Foundation and its compatriot, USAID, and dependence on donor contributions for government health expenditure in many developing countries. Donor funding focuses on vertical programmes such as GAVI and the Global Fund that target particular diseases but only indirectly and haphazardly provide funding for everyday functioning of public health systems. Furthermore the struggle for universal access to healthcare has been redefined as the struggle for universal access to health insurance, the right to purchase healthcare in health markets. These changes weaken both decommodification as a strategy of redistribution and the collective basis of alliance around health justice.

Second, the regulatory powers and responsibilities of the state in public health have been restricted. This is partially because of the reduction in budgets and marginalization of public health in government ministries, but also because the importance of private–public partnerships means that states now act as facilitators rather than regulators of corporate involvement in health. For this reason McGoey (2014) finds the private/public dichotomy politically misleading and refers rather to state/market hybrids. Further, as Mackintosh and Tibandebage (2007) pointed out, liberalization of clinical provision in many developing countries, such as Tanzania, has not meant extensive corporate involvement but rather expansion of small-scale unlicensed private provision that is very difficult to register let alone monitor.

CSR initiatives can also be a way for companies to avoid regulation by negotiating their own norms and making compliance voluntary. Seidman (2008) noted that some under-funded NGOs monitoring working conditions received contributions from the enterprises they inspected to subsidize their activities. Fooks et al. (2011) argued that CSR provided the justification for the tobacco industry in the UK to expand its number of access points across government, providing more opportunities to lobby. Gilmore et al. (2011) found that both the WHO and the UK government were very delicate in their regulation of the food and alcohol industries that have voluntary adherence to corporate social responsibility codes to oppose effective binding regulation and to promote self-regulation via voluntary codes.

Third, the focus on corporate entry into healthcare has displaced critical attention from the everyday, long-term presence of capital in public health; it shapes patterns of disease and disability through its normal activity of making a profit in trade and production. As the CSDH (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.

Corporate capital is heavily represented in health research, innovation and product development on a profit-making basis in a global biomedical industry. Pharmaceutical companies scour forest and savannah in developing countries procuring new genetic varieties and patenting these genes. They also sell these new health products across the world. Individuals can purchase a mapping of their genome, with attention drawn to health risks. New and very expensive treatments are being found for previously untreatable illnesses. Biehl and Petryna (2011: 359–60), for example, describe a hospital ward in Porto Alegre, Brazil where children are receiving enzyme replacement therapy that can cost up to US$ 200,000 per patient a year for a rare congenital condition. There are global markets in organs and surrogate child-bearing with the poor in developing countries as the main sellers and service providers. Multinational pharmaceutical companies have lobbied in their home countries to assure market dominance in drugs. The WTO TRIPS agreement on protection of intellectual property rights has been used to impede the import or manufacturing of cheap generics in developing countries (McGoey et al., 2011). The cost–benefit DALY/QALY analysis recommended by the World Bank for determining the feasibility of a health intervention is calculated on the basis of such oligopolistic pricing. The success of the South African treatment action campaign (TAC) in reducing the price of anti-retroviral treatment was a reflection both of its remarkable building of political alliances but also of the existence of generous flexible profit margins in the pharmaceutical industry.

Developing countries often have poor infrastructures of transport and energy that limit productivity, but corporations can nonetheless make a profit by, as Kapp (1969) would predict, driving down wages, externalizing health and environmental costs and evading regulatory control. Multinational forestry companies in southern Africa, for example, subscribe to voluntary international certification schemes that in theory monitor their labour, health and environmental standards; Forestry Council certification has itself now become a tradable asset. Yet companies outsource key parts of the labour process to contractors who hire casual workers, pay low task-based wages and employ techniques of production that are health-threatening and difficult to regulate (Cousins, 2014; Pons-Vignon, 2014). The social distances between the labour unions focusing on wages, environmental groups focusing on the long-time impact of climate change and the health justice movement focusing on access to healthcare are politically disabling.

Finally, as Waitzkin and Jasso-Aguilar (2015) have recently pointed out, corporatization of medicine has changed the class structure of medical

practice and public health with implications for the agenda of progressive health movements. This effect may not be so striking in the United States, from whence have come many of the conventional edicts of global public health policy and which has never had a national health system. It has, however, been important in many developing countries where national health systems have over the last generation been dismantled or enfeebled. Many doctors are now themselves owners of clinics and public health services are harder to staff.

DEFINING REFORM

Why has it been so difficult to defend the principles of state-organized redistributive public health and state regulation? Why is corporate largesse accepted as an acceptable form of redistribution and regulation? Why have fundamentalist neoliberal 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 and will not become freely competitive?

One possible answer is disillusionment with what states accomplished in reducing inequalities of health in the past. They have provided too little care, unevenly distributed and skewed in the quality of provision — many people have been excluded or marginalized on grounds of race, gender, ethnicity or citizenship; as have those who are unemployed, have casual jobs, are self-employed or live in rural areas. Foucault argued that the liberal state used social health to embed domination through surveillance and control without recourse to the exercise of explicit violence. Marxists, including those in the Latin American social health movement, continually denounced the class basis of entitlement in state health provision and feminists the state's willingness to assume a hierarchical gendered division of labour that made women's unpaid labour available for everyday care.

Many countries in the developing world are former colonies where the government-run public health systems inherited at independence reproduced divisions of race, class and region in access and quality of healthcare. We have a rich body of historical work on colonial health that documents discrimination in research, diagnosis of illness, monitoring of work processes and environmental pollution resulting from privileges extended to corporate and settler lobbies. To provide only two of many examples, Hunt (1999) showed how Belgian population policies in the Congo shifted from pronatalist, when labour shortages prompted concern with high mortality rates on the mines, to fertility control once Belgian families began to settle. Medical officers in South Africa blurred the association between mine dust and silicosis by constructing two diseases: simple silicosis, a white disease and silico-tuberculosis, a black disease (McCulloch, 2012: 72). Such divisions are not so easily effaced from the landscape of public health. In *When Bodies*

Remember, Fassin (2007) dissects the political basis for popular insistence in South Africa that AIDS was the outcome of persistent inequalities rather than a sexually transmitted disease; he shows distrust of biological explanations of the epidemic to be not just Mbeki's tic but an historical precipitate of the experience of apartheid.

The real question then is not whether state-organized public health should be continuously open to political critique but how it is that capital, based in a fundamental inequality of our times, has come to appropriate the right of critique and to dominate the space of reform. How it is that public health reform has come to be defined as recommodification of healthcare, imposition of a market calculus on health and environmental public goods, redistribution through voluntary gifts rather than taxation and self-regulation of capitalist enterprises. The answer often given to this question is to point to the hegemony of neoliberalism, but that is only to restate the question. Neoliberalism as we know it is not a miasma emerging from the ground to infect us. Since we have made it, its deconstruction means understanding how we have done so and finding alternatives.

The contributors to this Forum Debate were therefore asked to include political processes in their thinking about new visions for global public health. The politics of social justice in global public health has become the central concern of the Debate.

CONTRIBUTORS: THE POLITICS OF SOCIAL JUSTICE IN GLOBAL PUBLIC HEALTH

As editor of the 2016 Forum, I was allowed to set the question for debate. I put on the table what seemed to me to be a paradox in current public health policy: how could wide concern with global inequalities in health be reconciled with assigning such an important role in addressing them to corporate and financial capital, the dominating pole of one of the core global inequalities of our times — namely class? How it is that capital has come to appropriate the right of critique and to dominate the space of reform? This is a political question so contributors were asked to focus on the politics of inequality in global public health.

Doing Just Health Pragmatically

Reid-Henry's paper 'Just Global Health' invokes Norman Daniels' aphorism, 'Public health should be a way of doing justice'. He thus problematizes the Debate's focus on inequality to ask what is just in a world of inequalities of health. If we pursue not equality but more equitable health outcomes, then what are our standards of fairness? He recognizes that market justice and social justice are not the same but argues that the familiar opposition

between state and market is a false question: what matters is the social justice of outcomes. Using three examples related to the pharmaceutical industry, including one showing how socialist Cuba negotiates in international drug markets to secure better domestic access to drugs, Reid-Henry argues that achieving more socially just forms of global health does not require returning to what there was before the 'neoliberal onslaught'. More socially just outcomes can be achieved through mixed economy approaches involving both state and markets, as long as market justice does not predominate. There are two questions here. In pragmatic politics, who defines the boundaries of the doable? Why, for example, should universal public healthcare once have been considered a pragmatic option whereas universal access to health insurance is held to be what is doable today? Second, how does social justice predominate in a world structured by relations of power?

The Politics of Change in Global Health Policy

Birn, Nervi and Siqueira take on these questions in their paper 'Neoliberalism Redux: The Global Health Policy Agenda and the Politics of Co-optation in Latin America and Beyond'. They trace the historical trajectories of political economy and social justice struggles that have over the last thirty years reduced calls for 'health to all' to the tolerance of inequality manifest in Universal Health Coverage and proposals for gradual progression to health 'convergence'. They focus particularly on healthcare reforms in Latin America where the tradition of social medicine has long linked struggles for more equitable healthcare to those for better working and living conditions by confronting and capturing the policies of states. They show how the institutions of international capital, particularly the United States government, international financial agencies and philanthropic foundations, have funded a neoliberal pro-privatization agenda focused on healthcare while seeking to appropriate and co-opt, often artfully, the agenda, values and activities of health groups working for social justice. What explains this process of co-optation that reduces critique to neoliberal common sense? Once privatization is on course, the shifts in the class structure of medical practice observed by Waitzkin and Jasso-Aguilar (2015) may be part of the answer, but Latin America shows that retreat from progressive agendas is not inevitable. There have been robust defences of progressive health agenda, including public health services, in Latin America and elsewhere. What makes the difference?

The Political Framing of Struggles for Universal Health

This question is addressed by Qadeer and Rama in their paper 'Shrinking Spaces for the "Public" in Contemporary Public Health'. As their title

indicates, they continue to think that the state is the critical terrain of struggle in health reform. Like Birn, Nervi and Siqueira, they ask how progressive health movements, in India and elsewhere, have celebrated the restriction of public healthcare in their endorsement of Universal Health Coverage (UHC) as an alternative to the universal coverage envisioned by Primary Health Care (PHC) policies. UHC provides only weakly redistributive market-based insurance schemes as a substitute for public healthcare. UHC also undercuts the basis for the strong preventive public health system needed to address social causes of health inequalities. Qadeer and Rama argue that these changes in policy are happening because globalization and the financial crisis have given global debates more weight in domestic public health policy, debates which increasingly take place in institutions that are not democratically accountable. The narrow defensive focus on health coverage has also deprived progressive health movements of the political support that could be enlisted through labour movements and other struggles for social justice.

NGOS, Market Justice and the Politics of Partnership

The rise of NGOs as service providers, doing things that states once did, can politically marginalize the social justice critique. In their paper 'Challenging Gendered Inequalities in Global Health: Dilemmas for NGOs', based on a study of UK NGOs working in the health sector, Gideon and Porter show how the demands of funders can compromise complex approaches to gender inequalities when NGOs work in private–public partnerships with the corporate sector. There is no reason why double entry book-keeping should violate norms of social justice but business-based standards of assessment of results and current global standards of evidence-based medicine make it difficult to recognize the weight of long-term interdependent social determinants of health, such as gender, or to recognize the specificities of local contexts. In the strain of finding ways to construct indicators of what Polanyi (1957) would call 'fictitious commodities', a kind of depoliticization through numbers can occur. The particular moral agendas of donors and their commitment to particular medical technologies can also skew the definition of what is pragmatically possible. Donors have come into conflict, for example, with gender NGOs' commitment to reproductive rights.

The Politics of Depoliticization in Global Public Health

The influence of social justice movements on the terrain of health reform hinges on their involvement in democratic processes. In his paper, 'Pushing "Global Health" out of its Comfort Zone: Lessons from the Depoliticization of AIDS Control', Hunsmann takes the interrogation of the politics of global public health beyond the realms of NGOs and progressive health justice

movements to the more fundamental question of democratic public action. He focuses on vertical HIV/AIDS programmes, which account for a large proportion of the increased spending on global health since the 1990s and have contributed to the fragmentation of public health systems. He shows how policy processes make the grounds for political action and the space of decision politically inaccessible to democratic debate. The framing of the disease abstracts from the structural relations of inequality in which the disease is embedded, implicit rationing hides inequalities in access to treatment and vertically organized programmes bypass representative political structures. Confronting inequalities and making them actionable would mean recognizing that making health policy is necessarily a process of political struggle.

The Historical Subordination of Nutrition to Capital's Market Justice

One of the clearest markers of social inequality is not having access to enough food. Yet, as Sathyamala shows in her paper, 'Nutritionalizing Food: A Framework for Capital Accumulation', nutritional failure has come to be medicalized and construed as the result of individuals' risky behaviour, their failure to eat or feed children properly. Dietary supplements and special diets have entered the realm of corporate profit, along with personalized genetic medicine, organ replacement, fertility treatment, cosmetic surgery, even blood. Sathyamala suggests that it has been possible to build very broad political coalitions around lowering the prices of particular drugs and nutritional supplements since the main opposition tends to be limited to the pharmaceutical industry. It is more politically contentious to address the underlying relations of inequality that determine why some people have an income that allows them to eat abundantly and well and others live with persistent undernutrition and a diet that lacks variety and quality. There is also the possibility, raised by Qadeer and Rama's discussion, that progressive health groups have been so absorbed by the market versus state question in healthcare provisioning in the terrain of reform that they have neglected alliances addressing the broader structural determinants of health.

States of Exception: Citizenship, Migration and the Politics of Global Health

Social justice movements have used international conventions to defend the health rights of international migrants against accounts that define them as agents of disease, but in their essay 'Migration, Health and Inequality in Asia', M. Amrith and S. Amrith argue that there has not been enough attention to the social determinants of migrant health. They argue that migrants confront peculiar inequalities in health risks in the course of their journey, in fears about the threat to their security and in their search for better health as

part of better lives. At the same time, they show that these conditions are also confronted by domestic migrants living in sub-standard housing and barred from urban health services. On the other hand, their precarious living and working conditions may be very similar to those of non-migrants dependent on casual jobs, or through into unemployment in the latest round of restructuring of capital. Their essay shows the political limitations of citizenship as the discourse of health justice reform. Layered rights to health in Asia as elsewhere are in part the result of diverse migrant experiences. Addressing them means addressing the broader grounds of political disenfranchisement and discrimination.

CONCLUSION: PRAGMATISM AND TRANSFORMATIVE POLITICS IN GLOBAL PUBLIC HEALTH

Despite divergences of position between them, all the participants in this Debate are advocates for greater social justice in global public health. They have certainly taken back the right of critique, showing how the bias towards inequality is embedded in the redefinition of universal access to healthcare as universal access to insurance coverage; in the channelling of scientific medical research towards commodifiable innovations that will attract wealthy consumers; in the limitation of public healthcare to residual provider for the poor and deprived; and in the dismantling of public health systems that linked care to prevention. They have shown how relations of inequality permeate the terrain of global health reform politically: in relations of clientage between corporate funders and NGOs, health professionals, government departments and even communities; in the power over global health policy of informal coalitions of corporate institutions of governance that are not democratically accountable anywhere.

Yet the Debate has offered more in critique than in providing an alternative transformative vision of how to reclaim politically the space of reform. To a certain extent, this reticence is representative of the current state of the field of social justice approaches to global public health. Paul Farmer is known for his work on the structural causes of disease, but *Reimagining Global Health* (Farmer et al., 2013) is rather a compendium of practical ways to provide more equitable outcomes within the current institutional structures. Reid-Henry has provided a reasoned philosophical basis for such an approach in this Debate: a contribution to greater equity of outcomes is better than no contribution at all.

Related to this modest pragmatic approach to structural transformation in global health is, I think, a certain discomfort among some participants with the importance I assign to class, and in particular to the role of global corporate capital, as an underlying cause of inequalities in health. All emphasized that doing social justice in health is a contentious political process, not a technical exercise in planning and design. They pointed out quite correctly

that contentious politics of class, gender, race, ethnicity and migrant/non-migrant health outcomes are historically formed and contextually specific, not processes that can be reduced to the logic of capital.

Nonetheless, it is important to recognize that class is not a relationship of inequality between income groups, the rich and the poor, whose health outcomes will gradually converge as the poor become richer at some future point in time. The politics of social justice in global health works itself out today in a global class structure grounded in the contradiction between global corporate capital that controls patterns of accumulation on a global scale and politically fragmented classes of working people. It is not that capital is omnipotent or infallible, but in recent recurrent crises it has continually restructured itself to externalize more costs of production, including the provision of decent working conditions and environmental security, enormously expanding the context of health risk. At the same time it has reconstituted healthcare as an area of profitable investment and innovation, pushing outwards the boundaries of healthcare cost, including in developing countries. Corporate capital has been able to bracket its involvement in expanding pathologies and health costs and has made the reduction of access to health to access to insurance against risk both common-sensical and profitable.

But as Birn (2009) pointed out in her review of the WHO's call to close the gap in global health in a generation, we must look to history for perspective. This is just one moment in a long-term, recurrent and unsettled struggle over how to frame and what to do about inequalities of health. The alternative to the neoliberal consensus begins with the social causes of health and illness. It takes both wants and scarcity as inseparable social constructions and biological processes. If prevention — including clean water, clean air and regulation of working conditions and housing — is given greater importance, the incidence and distribution of health and disease can be changed. If communities and civil society groups play a greater role in the functioning of a unified national public health system, social accountability can be greater. The costs of universality could be reduced even with increasing population and life expectancy if the incidence of disease changes. If the priorities of medical research prioritize questions of social need and not corporate profitability, then increasing demand for expensive treatments and drugs can be reduced. The pioneering research of Navarro (1972) on Cuba's exceptional public health system inspired a tradition of radical interest in how to practise social health, but experiences in socializing public health exist in many places in different forms and social contexts, reflecting different histories and different political outcomes.

Contributions to this Debate have shown that addressing the social causes of health requires broadening the political basis of coalitions beyond health professionals to find common ground with groups working against gender and racial discrimination or for migrant rights, land rights, better working conditions and wages and accountable government. Collective power built

through struggles waged by local and national coalitions pushing for change in national health policies can affect the public health agenda of multilateral institutions such as the WHO.

The politics of social justice should not, therefore, be limited to narrow comparison of equity in individual outcomes. They must challenge the structural premises of the current health consensus. If corporate capital and social justice activists sit down in common fora and pragmatically agree, then there is something terribly wrong since structural struggle should always displace the boundaries of the possible.

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