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ORIGINAL ARTICLE

Universal health coverage and capital accumulation: a relationship unveiled by the critical political economy approach

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Abstract

Objectives To analyze the fundamentals of the global health agenda from 1944 to 2018, especially regarding Universal Health Coverage, in order to unveil its relations with capital accumulation in health services and to contribute to world social mobilization to change this tendency.

Methods A historical study was carried out based on a purposeful selection of primary sources on the global health agenda from multilateral organizations and secondary sources about the changes of capitalism from the study period.

Results The global health agenda changed from the state responsibility for health to an insurance healthcare system based on markets. The medical–industrial complex pressured national economies, broke postwar pacts, and urged economic globalization. The neoliberal, neoclassical, and neo-institutional discourse that promoted a new state–market relationship eased the new capital accumulation in healthcare into financial and cognitive capitalism.

Conclusions Understanding these relationships allows us to provide elements for social mobilization geared to transform the healthcare sector toward a new vision of health with a nature–society relationship that contributes to socially constructing human and environmental health, rather than gaining profits based on illness and chronic suffering.

Keywords Universal health coverage · Healthcare systems · Medical–industrial complex · Healthcare financialization · Cognitive capitalism · Global health agenda

Introduction

In Kazakhstan 2018, the Global Conference on Primary Health Care promulgated the Declaration of Astana in commemoration of the 40 years since the Declaration of Alma-Ata. There the global health agenda was exposed, and its title, "From Alma-Ata towards universal health coverage and the Sustainable Development Goals," evidences the centrality of the proposal of Universal Health Coverage (UHC). UHC was introduced at the joint meeting of the World Bank (WB) and the World Health Organization (WHO) in 2000, by Joseph Kutzin (2000). Fifteen years later, the UHC was included in objective three of the Sustainable Development Goals (SDG). It was thus proposed to guarantee access to health services, technologies, and medicines through the "providing protection against financial risk" (WHO 2005, p. 124) that involves paying

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for them and assuming that they are indispensable, effective, and costly.

This discourse on Primary Health Care (PHC) has a fundamental difference compared to that of the Alma-Ata Declaration of 1978: It is presented as a cornerstone of UHC and the sustainability of health systems. What are the theoretical and ethical–political foundations of this change in the discourse, and what is its place in the dynamics of health in contemporary capitalism? These are the questions that the investigation conducted by the research group sought to answer between 2016 and 2019.

In summary, the global health agenda has gone from a logic of state responsibility for the health of populations and direct provision of goods and services (Esping-Andersen 1990), to a logic of financial protection of individuals through public and private insurance systems and service provision by competing markets (Laurell and López-Arellano 2002). This transformation of the agenda is based on a neoclassical perspective of the economy, and on a neoliberal, individualistic, and utilitarian vision from the ethical–political point of view (Hernández 2017). This shift has been functional to the demands of capital accumulation in the field of healthcare services since the formation of the medical–industrial complex in the 1960 s, amid a change in the accumulation regime of contemporary capitalism: from one of the Fordist industrial type (Jessop 2008), to that of financialization and cognitive capitalism (Burlage and Anderson 2018; Zukerfeld 2008). The consequences of this transformation are evident in the most advanced cases of the implementation of the agenda (Chile and Colombia), where market expansion has hindered access to services. To understand the process in which this takes place, it is useful to think about the construction of sociopolitical alternatives in health.

Methods

A historical investigation was conducted. Using an approach of critical political economy and the resource of documentary analysis, articulations between the interests of the bureaucracies of international organizations and the dynamics of healthcare in contemporary capitalism were identified. For this, the scientific–technical and ethical–political discourse of the actors that make up the international health scenario was analyzed.

Selected theoretical and political documents published from 1944 until 2018 by the principal multilateral organizations in the field of health and social protection with a special focus on the Pan American Health Organization (PAHO), the WHO, the United Nations Children's Fund (UNICEF), the WB, the International Monetary Fund (IMF), and the Inter-American Development Bank (IDB) were analyzed as primary sources. Published studies that critique the place of healthcare in the dynamics of capitalism after the Second World War were used as secondary sources. A critical political economy analysis of the documents was carried out, which involved the delineating the political agenda and identifying the interests of the actors, their relationships, and the States arrangements, within capitalist societies (Jessop 2008). This takes into consideration both the structure of States and geopolitical relations, as well as the contemporary networks of power (Hernández 2004).

For the primary sources, the selection was made by the assessment of the theoretical and political importance of the global agenda, and its plausibility, in terms of the time–place–person–content coherence and the text–context relationship (Bergquist 1989). For the context analysis, secondary sources were analyzed to account for the social, economic, political, and cultural conditions which is required by a conjuncture-structural historical analysis (Braudel 1985).

Being a study based on documentary analysis, basic techniques of documentary review and content analysis were used. These include the consultation of databases and institutional archives as well as the coding and categorization of data. In the case of the former, the work resorted to database consultation through several universities. In the case of the latter, a semantic and pragmatic analysis of the discourse was carried out, focusing on the meaning of the statements and the context in which they are produced (Molero de Cabeza 2003).

Results

The theoretical and ethical–political foundations of the international health agenda of the postwar period were strongly tied to a Fordist regime of accumulation and a Keynesian economy that enabled its development. In this context, the healthcare services sector grew more and more into a profitable medical–industrial complex. In the 1970s, this sector was part of the capital overaccumulation crisis that drove the change of the accumulation regime toward financialization and, a little later, toward cognitive capitalism. Thus, the UHC discourse appears to sustain and reproduce the new accumulation regime from the health field.

The discourse of the global health agenda in the Fordist and developmentalist regime

World War II led to a strategic alliance between the liberal capitalist and planned socialist projects that ended in the Cold War. From this, alliance emerged the international

institutions that displayed their worldwide presence in the postwar period. In 1944, the Bretton Woods agreement shaped the multilateral financial organizations (WB and IMF), while establishing the dollar-gold standard for world trade, as a sign of US hegemony based on the vertical integration of its transnational corporations. Between 1946 and 1948, the United Nations (UN) was configured with its different agencies and the support of the expansion of the human rights charter, which was ratified in 1966 by the International Covenant on Economic, Social, and Cultural Rights (ICESCR). In this way, the responsibility of the States for their citizens broadened.

In 1946, the constitution of the WHO defined the well-known idea of health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, and that the enjoyment of health is one of the fundamental rights of every human being without discrimination. The ethical–political foundation was the "equal dignity" of people as supreme value, a deontological position based on the ethics of Kant (Gracia 1990). No human being should be discriminated against when it comes to requiring attention for an illness, and everyone should have living conditions that would allow them to reach the highest attainable standard of health. Soon, this "highest attainable standard of health" was assimilated to the best healthcare, and an enormous expansion took place in biomedicine with its technologies and medications (Clarke et al. 2003).

In this framework, the social-democratic proposal of the "welfare state" was consolidated, which meant a pact between capital and labor to guarantee the expansion of social citizenship rights through a solid and stable wage relationship (Esping-Andersen 1990). With this vision, the Keynesian perspective of planned economy broadened, and in a way was inspired by socialist countries, following the inertia of interventionism from the interwar period (Polanyi 1997 [1944]). This pact allowed for the consolidation of the Fordist accumulation regime that was being configured since the First World War (Jessop 2008).

The agenda was divided between the institutions that should boost economic development through the multilateral financial sector and trade between countries, and those that should promote the guarantee of new rights by way of the UN member States. The idea of development/underdevelopment that sustained programs like those of the World Bank's fight against poverty, on the one hand, and the import substitution industrialization model of the United Nations Economic Commission for Latin America and the Caribbean (ECLAC), on the other, guided the economic political agenda between the 1950s and the 1980s. Loans would flow from developed countries to underdeveloped countries, according to Walt Whitman Rostow, who assumed that the injection of financial resources should be sufficient for "traditional" (underdeveloped) societies to achieve the conditions for "takeoff" toward mass consumption (developed) societies (Rostow 1961). Meanwhile, the UN specialized agencies for social rights promoted technical cooperation processes to strengthen the national States in their responsibility to guarantee the rights agreed upon in the ICESCR, including health and social security.

In Western Europe, sociopolitical arrangements led to models oriented toward social security based on full employment and salary, or toward the formation of single public funds based on progressive taxes. The USA continued its liberal protection project based on property rights, free market, employer social security, and public assistance for the poor through Medicare and Medicaid programs. Meanwhile, the periphery countries of Fordist industrial capitalism had fragmented institutional responses with large inequalities based on the family's ability to pay, not on the condition of the citizen (social citizenship). But these arrangements could not be seen as a technical issue of finance modeling. It was seen as a correlation between the sociopolitical forces, more or less articulated in organized social classes and political parties, which configured institutions amid complex relationships between the economy, politics, and domestic life, as several studies have shown (Fleury 1997; Hernández 2004).

For periphery countries, the health agenda advanced in the logic of increasing the capacity of the States through the integration of health services, either through social security or through the single health service. When the correlation of forces within each country resisted integration, it was proposed to speak about "national health systems" with institutional components segmented by social classes, although always with the States' obligation to advance on the guarantee of universal access (Hernández et al. 2002). In this regard, and in the midst of the world crisis of the 1970s, the World Health Assemblies of 1975 and 1977 agreed to set the goal of "Health for All by the Year 2000" (Mahler 1977), and in 1978, the WHO and the UNICEF convened the International Conference on Primary Health Care, making the Alma-Ata PHC the best strategy to achieve that goal.

However, it generated great tension to assume the idea of "primary" as the "essential" and, at the same time, as a low-cost priority package to expand care coverage, as it was understood by the UNICEF and the Rockefeller Foundation in selective PHC (Cueto 2006). And the pressures of the so-called New International Economic Order were felt as much as the critical economic situation that, in the end, affected the stability of welfare states and opened the way for neoliberalism (Harvey 2007). This situation led Halfdan Mahler, director of the WHO, to think that in order to achieve "Health for All by the Year 2000," and to

defend a broad vision of PHC, more cost-effective strategies were required, especially in poor countries (Mahler 1975). This way, PHC would serve as an economic strategy for expanding access to health services in times of crisis, but by means of public investment and state provision, as the markets did not seem interested in reaching the poor. Hence, PHC became considered as the central core of the countries' health system and economic development.

The change and the fundamentals of the global health agenda in the 1990s

The world crisis perspective of the 1970s was projected in the 1980s as a financial crisis in Latin America. It was called the "lost decade," but also that of the "structural adjustment" (Burgos 2009). This adjustment, tested in Chile during the Pinochet dictatorship, with the support of the Chicago School led by Milton Friedman, resulted from the political decision of the US Federal Reserve to increase interest rates more than four times between 1979 and 1980 and raise the price of the external debt service for periphery countries (Harvey 2007). In response to the declaration of inability to pay by debtor countries, the IMF prepared the structural adjustment programs according to which each country should implement an agenda of progressive decrease in public spending, privatization of service provision and state-owned enterprises, labor market flexibility, and economic openness for foreign direct investment (Burgos 2009).

In this context, the first transformation of the agenda took place, led by John Akin, an economist from the World Bank's Department of Population, Health, and Nutrition in 1987. The proposal was entitled "Financing health services in developing countries: an agenda for reform" and consisted of getting everyone who could pay for healthcare to do so. The best payment mechanism would be health insurance. For the poor, it would be possible to take advantage of all kinds of philanthropic or self-managed private initiatives and increasingly decentralized programs or service packages run by subnational governments (Akin 1987).

The argument, based on the rational choice theory of economics and political science (Amadae 2003), asserts that healthcare behaves as a "private good" to the extent that it is consumed by each individual and meets the principles of rivalry and exclusion; therefore, people are willing to pay for it. In these kinds of goods, competition in the market operates with efficiency, obtaining better quality at a lower price. Only situations with high externalities, such as epidemics or disasters, could be considered "public goods" in health and should be assumed by the States. Thus, financing should fall on individual payment mechanisms in the form of health insurance.

Shortly thereafter, in 1993, neoclassical economists from the WB developed a new conception of service provision for insurance market agents, in the "Investing in health" report. In this report, the "burden of disease" was measured from a utilitarian perspective that would allow for prioritizing more cost-effective interventions and building "essential health services packages" for each country. Thus, the agents of the transnational health insurance market were called upon to invest, especially in poor countries, and, at the same time, to define service packages that could be subsidized with public resources in order to incorporate the poor into the insurance model (Laurell and López-Arellano 2002).

The foundation of health insurance was built on the principal–agent theory promoted by Kenneth Arrow since the 1960s (Arrow 1963), according to which medical care constitutes a private good as having many uncertainties, both for the complexity of the good, as for the information asymmetries between the consumer/patient and the service provider. Under these circumstances, an "intelligent buyer" is required: an agent who represents the patient in front of the provider or the health professional, as it has been done in the USA since the 1930s (Starr 1991).

Once these kinds of health systems reforms were promoted in Colombia and Mexico, economist Juan Luis Londoño and the physician Julio Frenk prepared the document entitled, "Pluralismo Estructurado: Hacia un Modelo Innovador para la Reforma de los Sistemas de Salud en América Latina" (Structured Pluralism: Towards an Innovative Model for the Reform of Health Systems in Latin America), which became the clearest synthesis of the health systems reform agenda (Londoño and Frenk 1997). This pluralism involves a new arrangement between the State and the markets, according to which, by means of a compulsory insurance mechanism linked to income and a demand-side subsidy paid for by taxes to incorporate the poor into insurance, a public financing model is established and resources are delivered to agents, "articulators" in "regulated competition," in charge of organizing the service networks for their affiliates. This delivery of resources to the insurers is through a unified per capita payment in exchange for a package of services. In this way, the "articulators" do not compete for the price of a policy, but for economy of scale and control of expenditure. This is precisely the model closest to the proposal of the economist Alain Enthoven, Arrow's disciple, called "managed competition" (Enthoven 1988). The proposal also incorporates the guidelines of neo-institutionalism in economics promoted by Douglas North on the need for institutions that reduce transaction costs between agents and facilitate the accumulation with the resources of "governance" and "good governance," which grant legal certainty to market agents (North 1993).

From these focal points, the concept of "financial protection" arises through insurance as the best way to achieve access to the expensive private good of healthcare (Kutzin 2000). In 2005, the World Health Assembly formally adopted the UHC proposal (WHO 2005), and in 2010, it dedicated the World Health Report to promoting the proposal as a financing model for health systems. With "financial protection," it was sought to raise more resources for healthcare, without questioning its high costs (WHO 2010).

From then on, the agenda focused on articulating resources to increase the population covered by some insurance, expand the services included in the package, and reduce direct family spending. This has involved the development of different health insurances: public, in the form of compulsory or subsidized, and private. In this frame of reference, PHC is assumed as a "gatekeeper" to the system that guarantees its financial viability and is based on public resources that are delivered to insurers in competition, now with managed competition and demand-side subsidy for the insurance of the poor.

The medical–industrial complex and the functionality of the global health agenda

In the Fordist accumulation regime, one of the sectors in expansion since the 1920s was that of healthcare. The development of the university hospital, together with the expansion of the pharmaceutical industry, configured an articulation front between research, innovation, training, and the offer of services in the factory hospital that assimilated to the production chain of the Fordist model (White 1994; Goodman 2003). With the development of health insurance in the USA in the 1930s and 1940s, the healthcare sector was strengthened (Starr 1991). In the 1950s and 1960s, war and postwar technology was also incorporated into healthcare, especially in the USA (Waitzkin 2013). When the subsidy called Medicare, designed for older adults without payment capacity, was approved in 1966, the sector expanded to the point of being called the medical–industrial complex to assimilate it to the military–industrial complex (Ehrenreich and Ehrenreich 1971).

The overaccumulation of capital in this sector became evident in the 1970s, right at the time of the crisis of the Fordist regime, and it was articulated with the financialization process that began in the 1980s (Burlage and Anderson 2018), thanks to the incorporation of technologies such as information technology, telematics, and telecommunications in the financial sector. The crisis of the welfare states and of the socialist bloc, along with the neoliberal privatization policies, opened up opportunities for the expansion of insurance corporations by means of a managed care model and the recent strategies of the pharmaceutical industry for producing consumers (Iriart and Merhy 2017). In the 1990s, the articulation between the agenda and the expansion of transnational health corporations became evident (Armada et al. 2001).

With the United States' decision to transform the rules of copyright and industrial property in terms of "intellectual property" in 1976 (Zukerfeld 2008), the technology and drug industry maintained deep ties to the process of production, distribution, consumption, and capital accumulation in the framework of cognitive capitalism (Míguez 2013). Intellectual property rights, together with the financialization of patents through share transaction, explains the exorbitant costs of healthcare and manifests itself in the development of biotechnological medicines.

As the international health agenda articulates UHC with PHC and assumes it as a way to guarantee the "highest attainable standard of health," it fosters the capital accumulation processes that are taking place in the health's medical–industrial and financial complex. Thus, it becomes increasingly functional to the new financialization and cognitive capitalism accumulation regime, which consolidates the sectors that are promising for capital accumulation. At the same time, the agenda promotes the search for funding from different sources, especially from families, to achieve UHC, and assumes PHC as "gatekeeper" to guarantee the sustainability of insurance-based healthcare investments.

Discussion

It is necessary to understand the nexus between technocratic discourses and the place of health in the dynamics of capitalism. Otherwise, the analysis may be insufficient. For example, after presenting the tension between Alma-Ata PHC and selective PHC, Cueto suggests that these are two ideas about the response to health problems: a social and economic perspective that requires "a political response," and a naturalist perspective that requires "adequate technological solutions" (Cueto 2006, p. 57). It may be so, but it is not advisable to reduce the explanation to an abstract matter. Both positions are inserted in the transformation of the place occupied by health services during the crisis of the Fordist accumulation regime, as it has been shown. Furthermore, David Sanders, leader of the People's Health Movement, criticizes the way in which the Astana Declaration assumes PHC as a means to achieve UHC, because it "confines the health sector to a much more restricted role" (Sanders 2019: p. 621). But it is not a question of the order of the factors, but of the profitability that PHC can offer to the accumulation of capital in a system dominated by

insurance, given that it can improve health, reduce expenses, and increase profits.

The agenda proves to be functional because it does not doubt the costs of care, the dynamics of exploitation, or the predatory development model that generates illness. On the contrary, the agenda assumes that the regulation of conflicts of interest by States would be sufficient to avoid the outrages of the private sector (Sanders 2019). It is necessary to recognize that the principal support of the expansion of the medical–industrial complex is the cultural incorporation of the idea of health as an individual biological balance whose restoration depends on biomedical technology. In this, cultural hegemony, life sciences, and economic and political sciences have made a deep alliance (Cooper 2008). Even though drug regulation, as a result of the Thalidomide tragedy in 1961, demanded demonstration of safety and efficacy through controlled clinical trials, the regulatory agreements established by the International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use (ICH) have not affected the profits of the private sector, and on the contrary, the industry has found mechanisms for adapting and co-opting the rules to increase profits (Goldacre 2013).

It is clear that insurance increases access to health services and decreases out-of-pocket expenses, as shown by the SDG tracking indicators of target 3.8 (WHO and WB 2017). But the increase in inequities derived from access to differentiated packages according to payment capacity, in addition to the neglect of living conditions that generate illness, is also evident (Hernández 2017; Birn and Kumar 2018). It is necessary to study the debate in depth, understand the mechanisms that lead to capital accumulation at the expense of the health of the populations, and move forward in the world construction of alternatives that allow us to think of health as the care of life, human and non-human, and life and knowledge as part of the "common" of the human species, not as fictitious commodities with which it is possible to accumulate capital.

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