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The COVID-19 Pandemic Exposes Fatal Health Inequities

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"Health for All in the Year 2000!" In 1978, this was the defiant rallying cry of UNICEF and the World Health Organization. Embedded in the Declaration of Alma-Ata, the challenge affirmed health as a human right, promised access to health based on socioeconomic development promoted in the New International Economic Order, sanctioned government provision of universally accessible primary health care, and condemned as unacceptable the existing gross inequality in people's health statuses.[1]

It took just two years for the wealthy countries to marshal their opposition. In 1980, the World Bank published its first health sector policy paper, which reduced primary health care to a selection of limited preventive strategies—the few diseases to be treated were those for which interventions of proved efficacy existed.[2] This "selective strategies" approach marked the abandonment of Alma-Ata's primary health care principles and the start of rampant privatization of health services and medical and pharmaceutical supply.[3] Inevitably, the policy would come to widen social inequalities, both in terms of living and working conditions, as well as access to health care.

Now it is 2020 and we are in the midst of the COVID-19 pandemic with a shortage of both human and material health resources, most of which must be sourced from the private sector. Some of the wealthiest countries—France, Italy, Spain, the United Kingdom, and the United States—have proved unable to respond rapidly. How we came to this impasse is the subject of this article, which analyzes the evolution of public health over the past forty years, leading to the current crisis.

As stated in the United Nations Universal Declaration of Human Rights, health is a fundamental human right.[4] Over the past four decades, however, government health policies have reduced health services to commodities and objects of speculative investment. As the World Bank became involved in lending to health projects, it subjected the public health bud-

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gets of even the poorest countries to austerity policies, hastening the turn to the private sector to meet people's needs for health care.

From Privatization to Commercialization to Financialization

Since the 1990s, the global health industry has undergone dramatic changes. With the introduction of neoliberal economic policies and structural adjustment programs mandated by the World Bank, health care shifted from government-run and funded public health services to private hospitals, private pharmacies, and private medical practices. This move to privatization away from the goals of comprehensive, universal, primary health care withered public health infrastructure and siphoned off talented personnel. It is difficult to describe fully the degree to which privatization resulted in the fragmentation of health systems—some would say the cannibalization of health care—as more and more public functions were outsourced to private firms. The current COVID-19 pandemic has exposed the folly of austerity, a central neoliberal policy, in cutting government health budgets.[5]

Added to privatized delivery of health care was the scrapping of government negotiation of bulk purchase of medical supplies and equipment, which enabled large multinational corporations to marketize the provision of medical products and pharmaceuticals. Cardinal Health is an example of a global, integrated health care services company: operating in forty-six countries, it sells medical products and pharmaceuticals to hospitals, health systems, pharmacies, ambulatory surgery centers, clinical laboratories, and physician offices. Claiming it improves the cost effectiveness of health care, Cardinal Health, worth $136.8 billion in 2019, is the fourteenth-highest revenue-generating company in the United States.

With the drastic reduction of tax-based services, privatization opened the door to transnational health insurance companies like Cigna, a global health insurance company with revenues of $155 billion that currently employs seventy-four thousand people in more than thirty countries. People who bought private insurance policies had enough money to avoid the increasingly underfunded and understaffed public facilities that still served the poor. The shift in decision-making away from legitimate public policy processes is one of the detrimental effects of private health insurance; another is governments' lost ability to advance disease prevention and public health programs.

Manipulating concerns about cost effectiveness and efficiency, nongovernmental, philanthropic, and international development organizations led the way to the second phase—commercialization—by focusing on targeted health interventions. Called variously *vertical programs* or *selective health strategies*, targeted health interventions narrowly limited projects

to individual diseases that could be eliminated or controlled with commercial products – immunization or medication.[6] Once again, the organizations sidestepped the goals of comprehensive, universal, primary health care. It is amazing how these failed strategies persist – the same approach is being applied today to COVID-19.

With an ideology of individual responsibility and self-reliance, these organizations introduced fee-for-service plans in public services, which had the intended effect of reducing demand and the consequence – intentional or not – of raising death rates among those who could not pay the fees. Commercialization, this second phase of health care transformation, saw public hospitals descend into marketplaces, where patients had to supply their own services and equipment – everything from food and nursing to drugs and surgical sutures, all purchased on the commercial market at prices vastly inflated from what public hospitals could normally negotiate. The consequences were disastrous for the poor, who in effect were made to pay for care that was initially designed to be, and should be, free.

In the late 1990s, the international financial institutions persuaded a weakened World Health Organization to embrace public–private alliances, understood as "partnerships," that bring private sector efficiency and innovation to public facilities and programs. For example, a typical public-private partnership might involve contracting a private company to finance, construct, and maintain a hospital in exchange for an annual payment from the public authority. Public-private partnerships range from product-development partnerships (new drugs or vaccines) to regulation and quality-assurance partnerships to "improve" the regulatory environment and product quality.

Public-private partnerships foreshadowed a larger role for private financial markets in public service provision and financing. The critical shift was from direct public ownership in which governments paid for and provided utilities (such as water) and services (such as education and health care) to a system of indirect public provision in which governments partnered with private, for-profit providers (like Suez Water, Bridge International Academies, Johnson & Johnson). As participants began to accept the necessity of private finance for these ventures, the priority and purpose of public services changed and the path to financialization was paved.

Financialization is the third and most confounding phase, and the one in which we currently find ourselves. It leverages private sources of capital and turns exchanges of goods and services into financial instruments.[7] Benjamin Hunter and Susan Murray claim that public funds are used to facilitate private investment in health care companies through equity investments and loans, thereby transforming health care into salable and tradable assets for global investors.[8] Investment banks like Goldman Sachs,

Merrill Lynch, and Credit Suisse, which stand at the apex of global finance, all have health investment departments to cobble these financial instruments for client companies. In France, as Ana Carolina Cordilha shows, financialization had a major influence in the direction taken by the post-1990 health care reforms, with new strategies allowing the increased participation of financial capital in the system's long-term, short-term, and investment financing.[9] Ipek Vural describes the impact of global private equity investments in the Turkish private hospital sector as intensifying and broadening the processes of marketization in health care services.[10] In Turkey, financialization advanced the process of chain formation by large hospital groups, spread financial imperatives into the operations of private hospitals, fostered the internationalization of capital, and augmented inequities in access to health care services and standards.

To be clear, the primary purpose of corporations is not to further common prosperity but to produce profit. Financialization is known to increase inequality, slow investment in production, exacerbate the pressures of indebtedness, and quicken a decline in democratic accountability. Thanks in part to new technology (for example, computerized trading), global financial assets (as opposed to real assets in land, property, or commodities) grew from $12 trillion in 1980 to $379 trillion in 2018. Despite these alarming trends, the United Nations promotes financialization under the banner of sustainable development as the solution to the provision of universal health coverage.[11]

The Effects of Globalization and Financialization on Health Services

The aspect of globalization most relevant to this discussion is offshoring—the relocation of production processes abroad in order to lower labor costs. Offshoring shrinks the scope of productive activities in the country where the parent firms are based; for example, an estimated eight million U.S. manufacturing jobs were moved overseas between 1980 and 2017.[12] Offshoring is an economic class issue because it forces former U.S. factory workers to take low-paid, nonunion service jobs or face unemployment, while workers in finance see their earnings and company profits rise.[13] Since offshoring results in the loss of manufacturing skills and capabilities, as well as networks of suppliers, it is not easily reversed. The COVID-19 pandemic has revealed the perils of dependence on external suppliers for critical medical supplies, as well as the inability of countries to reproduce quickly the equipment needed at home.

Financialization furthers the restructuring of production both vertically and internationally, creating global production networks and enabling firms to raise prices (cost mark-ups), increase profits, and boost share-

holder values. At the same time, financialization reduces investment to sanction higher dividend payments, share buybacks, mergers, and acquisitions, and other purchases of financial assets.[14] The process of financializing firms supplying the health sector results in higher costs, as illustrated by trends in the U.S. pharmaceutical industry. Firms extract profit by accumulating excessive returns on assets (rent-generating intangibles like patents and trademarks), rather than by earning realistic revenues for socially useful products.[15] This trend harms public health by raising the prices of drugs and reducing investment in medicine research and development. Financialization of the major U.S. pharmaceutical companies has evolved at the expense of drug innovation.[16]

Victor Roy investigates financialization in relation to a single drug—sofosbuvir—a cure for hepatitis C, which Gilead Sciences priced at $90,000 for a three-month regimen. Gilead's investment was limited to the acquisition of Pharmasset for $11 billion in 2011. A small biotechnology company, Pharmasset emerged from public investments to develop sofosbuvir. In other words, the price of sofosbuvir did not represent the tangible costs of innovation or the health value for the seventy-one million people who suffer from hepatitis C worldwide. Instead, Gilead's strategy was to benefit shareholders by pursuing capitalization and control of intangible assets in financial markets. Gilead is also the company that charges $3,000 for a five-day regimen of remdesivir, which is used to treat severe cases of COVID-19. Remdesivir, which has still not been demonstrated to confer statistically significant benefits, was developed and financed with U.S. government funds, and experts say it costs less than $10 to produce.[17]

The Inequities of Financialized Health Care

Health is evaluated in a context of inequality between men and women and among social classes. Health data register divisive social categories such as race and ethnicity, and health is compared across nations in such terms as life expectancy and infant mortality. *Inequality* is an empirical concept documented in terms of income or consumption, and the relationship between income and health is well established: the higher individuals' income, the better their health. The United Nations touts the drop in global poverty rates as measured by income since 2000 while conceding that 10 percent of the world's population (734 million in 2015) live on less than $1.90 a day. That inequality is rising with the transformation of the occupational and wage structure of national economies as a result of the globalization of production is not taken into consideration in these calculations.

Nevertheless, extreme poverty is no longer the exclusive burden of less developed nations. Neoliberal economic globalization beginning in the

1980s created a complex map of wealth and poverty. About three-quarters of the world's poor now live in middle-income countries, making inequality a major issue everywhere. India, for example, is classified by the World Bank as a lower middle-income country. Its expanding billionaire class, which counts more than one hundred members with a collective worth of over $300 billion, lives alongside some 176 million people who subsist on less than $1.90 a day. Philip Alston, former United Nations Special Rapporteur on extreme poverty and human rights, calls this "a scandalously unambitious benchmark, which aims to ensure a mere miserable subsistence."[18]

To appreciate the gravity of the state of global health and health care as the COVID-19 pandemic spreads, it is insufficient to expose health inequalities. Single policies like raising the wages of the poor cannot solve the problems of extreme poverty (though they would help), nor can single programs like mass vaccination campaigns to lower mortality rates from specific diseases make lasting improvements to health status (though, again, they help). The manifestations of poverty and poor health include hunger, malnutrition, limited access to public services and utilities, social discrimination, and political exclusion.

Equity, unlike equality, is normative, a question of values associated with the idea of social justice. To reduce inequity is to undo unfair and unjust discrimination. Whereas health inequalities are defined as disparities in health status (for example, variations in mortality rates between people of different income groups), health inequities are systemic: they are produced by social norms, policies, and practices that tolerate and even promote unfair access to power, wealth. and social resources. A strong public health system – both within and among nations – is essential to health equity.

Financialization works against income equality by eliminating unionized jobs, lowering workers' wages, and inflating executive compensation. Financialization also aggravates health inequities. It introduces a new level of transnational corporate power, which facilitates tax evasion, shifts revenue to tax havens, and reduces the tax base available for comprehensive, universal, primary health care. The pharmaceutical industry is highly financialized, and Big Pharma routinely blocks initiatives to promote health through the flexible use of the Trade-Related Aspects of Intellectual Property Rights agreement.[19] Under pressure from the economic South, the World Trade Organization adopted the language of flexibility to make essential medicines affordable; but because its use would threaten their profits and reduce shareholder value, drug companies oppose it.[20] Exemplifying these trends is Gilead Sciences, which gave its new CEO, Daniel O'Day, a $31 million compensation package in 2018, his first year on the job. For its 2018 fiscal year, Gilead listed the CEO pay ratio as 158 to 1, with the firm's employee median

pay figure at $163,963.[21] Gilead had $34 billion on hand in 2017, 86 percent of which was held overseas where the company could avoid paying U.S. taxes.

The Financialization of U.S. Health Care

COVID-19 in the United States: over 207,000 deaths as of early October, more than seven million people infected, and many who have recovered complain of severe and ongoing health problems. Several analysts have written about what went wrong.[22] From the earliest days of the pandemic, the inability of public health and private services to respond effectively was evident. One problem is unique among wealthy nations: the United States fails to provide national health insurance or a national health service, relying instead on a complex public/private health care system that comprises six layers. People, employers, and the government (through Affordable Care Act subsidies, Medicare, Medicaid, and Tricare) pay health insurance companies, which pay aggregators (pharmacy benefit managers and preferred provider organizers). These intermediaries in turn pay doctors, hospitals, and pharmacies, which in turn pay wholesalers, who pay the manufacturers of equipment and drugs.[23] Some conglomerates span several layers: through mergers, health insurance companies have acquired related facilities and services. For example, UnitedHealth owns surgery centers, doctors' offices, and data analysis services. Mergers dampen competition and allow insurers to raise prices, buy influence in Congress, and redistribute cost savings to shareholders.

Underlying this structure is the nefarious role of private equity, which pumped $30 billion into U.S. health care in 2018. Low interest rates, leverage, and lax antitrust enforcement have enabled conglomerates to take control of health care. Health insurance companies generate abnormally high returns, as do the wholesalers, benefit managers, and pharmacies. An August 2020 headline reads, "Major U.S. Health Insurers Report Big Profits, Benefiting from the Pandemic."[24]

The most controversial source of excess spending on health care (now 18 percent of U.S. gross domestic product) is rent seeking by health care firms. Rent is generated as companies extract outsized profits relative to the capital they deploy and risks they take. CVS Health, which owns Aetna, Caremark (a pharmacy benefit manager), and a drugstore chain, posted revenues of $65 billion in the second quarter of 2020. Anthem's net income soared to $2.3 billion, from $1.1 billion in 2019, while UnitedHealth reported net earnings of $6.7 billion, compared to $3.4 billion for the same three months last year. Jacob Appel calls private health insurance a large-scale criminal endeavor—part Ponzi scheme, part extortion racket.[25]

The consequences for health care are pernicious. Take the example of Hahnemann University Hospital, a 171-year-old institution in Philadel-

phia that served low-income patients of color, which went bankrupt and closed in September 2019. In an egregious case of private equity wealth extraction, Hahnemann was purchased in 2018 by Paladin Healthcare and closed eighteen months later, the land beneath the hospital to be sold for its real estate value (it is located in a gateway for gentrification).[26] Hahnemann could have served five hundred COVID-19 patients: Philadelphia had 37,226 cases and 1,811 deaths by early October.

Consolidation and mega-mergers within the health care industry also affect what consumers pay for health care. Robb Burlage and M. Anderson, who describe the privatization of the Blue Cross and Blue Shield Association, detail the merger of two Harvard University teaching hospitals to create a new entity called Partners HealthCare. After complicated negotiations with Partners HealthCare, Massachusetts Blue Cross increased insurance premiums by 78 percent between 2001 and 2009.[27]

Private equity firms extract value rather than creating it by imposing crippling debt on the companies it buys, stripping their assets, and transferring their resources.[28] In addition to hollowing out health facilities and medical supply companies, financialization has complicated attempts to arrest the COVID-19 pandemic by undermining two sectors vital to public health—water and food.

The Financialization of the Privatized Water Sector

Potable water is vital to public health: access to clean water and modern sanitation has increased lifespans and improved world health more than any other advancement in the field of medicine. Water availability is increasingly threatened by the climate crisis, which intensifies and prolongs droughts. According to the World Health Organization, droughts afflict some fifty-five million people globally every year and affect health, agriculture, economies, energy, and the environment.

Health experts advise that handwashing is the single most important protection from COVID-19. But according to UNICEF, 40 percent of the world's population, or three billion people, do not have a handwashing facility with water and soap at home. The disparities between rich and poor households is extreme—in Sub-Saharan Africa and Central and Southern Asia, only 20 percent of poor households, compared to 80 percent of the rich, can wash their hands at home.[29] Cape Town, South Africa, reveals stark disparities in water consumption: residents in impoverished informal settlements used only 4.7 percent of the city's water in 2018, while middle-class Capetonians in the suburbs used over 70 percent.[30]

The financialization of water services provided by transnational corporations is hampering efforts to slow the spread of COVID-19. The history of

this latest development in water provision can be traced to cost-recovery programs funded by the World Bank in the 1980s. A prelude to privatization, these programs required governments to raise water tariffs. Unlike general taxation, a system in which everyone shares social costs, tariffs fall unequally on the poor. Government tariffs, in turn, motivated private companies to take over systems that charged consumers enough to meet the expenses of maintenance and accrue profits. These private water companies have since taken the easy money that private equity offered.

The financialization of water companies transformed a public service into a commodity with economic value, to be bought and sold.[31] By converting water infrastructure—fixed and stable installations such as pipes, water treatment plants, and sewers—into liquid assets, financialization has created a new mechanism for wealth extraction.[32] The nature and scale of financialization make it a deeply undemocratic process, and its impact on society, ecology, and public health has been highly uneven.[33]

The crises of lead-contaminated water in Flint, Michigan, and Pittsburgh, Pennsylvania, share a connection to Veolia, a French private water company that is the world's largest supplier of water services. Veolia had contracts with both Flint and Pittsburgh at the time lead levels rose in their drinking water.[34] Though the initial elevation of lead levels in Flint's water was traced to the city's decision to switch its water source from Lake Huron to the Flint River, which occurred before Veolia was hired, the city is suing the company for professional negligence and fraud, which it says caused the lead-poisoning problem to continue and worsen. Veolia issued a report in 2015 certifying that Flint's water system met the standards of the Environmental Protection Agency, but neglected to mention high lead concentrations. In the case of Pittsburgh, lead levels shot up after Veolia instituted cost-cutting measures and laid off key employees and experts, including safety and water-quality managers and half of the laboratory staff responsible for water testing.

The provision of water to low-income communities must be seen in the broader context of water management for all uses as the climate crisis tightens availability of this vital resource. Although water covers over 70 percent of Earth's surface, 97.5 percent is saltwater and only 2.5 percent is fresh water; nearly 70 percent of that fresh water is frozen in the icecaps of Antarctica and Greenland, leaving less than 1 percent of fresh water (around 0.007 percent of all water) accessible for direct human use. Three economic sectors consume freshwater: agriculture, 70 percent (mostly irrigation); industry and energy, 19 percent; and municipal (domestic), 11 percent.

Water is one element of the energy-food-climate nexus. Global financial networks have been central in articulating the nexus, using it to

effect the transition from state-oriented development models to financialized approaches.[35]

The Financialization of the Food Supply Chain

COVID-19 is spreading in the midst of a hunger crisis affecting 822 million people, with 113 million facing acute hunger, a figure that could rise to 270 million before the end of 2020 because lockdowns are affecting access to food. The pandemic is worsening food insecurity in hunger zones and creating new centers of hunger. According to Oxfam, twelve thousand people could die daily from hunger linked to COVID-19 by the end of 2020, potentially more than will die from the disease itself.[36] Although conflict, climate crisis, mass unemployment, and inequality contribute to this crisis, also implicated is the highly profitable and financialized food and beverage industry (eight of the biggest companies paid over $18 billion to shareholders between January and July 2020).[37]

Consumer food prices are rising in many countries as the pandemic disrupts local production, supply chains, transport, and distribution. The less visible reasons are found in the ongoing process of financialization. Financial actors play an increasingly active role in food retailing, food processing, grain trading, food-price setting, distribution of agricultural risk, provision of agricultural inputs, and ownership and control of farmland. Reinforcing the position of food retailers, which are the dominant actors within the agriculture and food system, financialization has intensified the exploitation of food workers, increased their workload, reduced their real wages, and heightened precarity for everyone involved.[38]

The World Food Programme is calling urgently for $4.9 billion in funding to reach as many as 138 million people with food assistance by the end of 2020. This would be life-saving support, but it will do nothing to mitigate the underlying problems of a highly financialized agriculture and food system.

Conclusion

Governments like those of Brazil and the United States chose to protect the financial interests of conglomerates, leading to an inequitably experienced health disaster that could have been avoided. The same logic prevailed in Europe, where the European Commission decided to classify the SARS-CoV-2 virus as a level three (rather than four) infectious agent despite the lack of a vaccine or cure, allowing employers to avoid deploying the most stringent measures to protect workers.[39]

The COVID-19 pandemic is not yet under control and many unknowns remain about its evolution. We need to learn the lessons of what happened and why, because in some countries those in power are already trying to

erase memories of the pandemic. In the United States, the administration speaks of the virus in the past tense while trying to suppress statistical reporting on cases and deaths. The failure of governments to organize coherent care to meet this crisis has aroused awareness and protest.

In France, for example, caregivers have resumed demonstrations with Tuesdays of Wrath. They have turned down offers of rewards like medals or bonuses, knowing that the real need is massive investment in training and recruitment, an overhaul of working conditions, and the creation of a health democracy to oppose an inhuman bureaucracy. Health professionals must build a common front with users of health services to demand that the health and human needs of patients, as well as the working and living conditions of caregivers, be placed at the heart of a reorganized public health system. Prevention cannot depend solely on a vaccine; it also requires reducing social inequities in health and health care.

Our responsibilities extend beyond a reorganization of health care systems. The global pandemic we are experiencing confirms the extremely serious threats to the immediate and long-term future of all humankind. It is the model itself that we have to question—and this requires, above all, the necessary recognition of the fundamental right to life, health, and dignity of all. Workers, now more than ever, must resist the dangers of profits over people.

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In sum, the Critics' analytical method is to separate out the various parts of the U.S. and world economy and to sever economics from politics. They arrive at the conclusion that, by tinkering with some of the parts through political pressure, capitalism can be reformed so that it can live and grow without imperialism. Our point of view is that the separate parts must be understood in the context of their interrelations with the social organism of world monopoly capitalism. Further, it is important to recognize the essential unity of the economics, politics, militarism, and culture of this social organism. We reach the conclusion that *imperialism is the way of life of capitalism. Therefore, the elimination of imperialism requires the overthrow of capitalism.*

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