

## Research Article

# Capitalism and Health Care: A Critique

Julian Ungar-Sargon MD PhD

Dept Health Sciences, Dominican University IL

**Corresponding author**

Julian Ungar-Sargon, Dept Health Sciences, Dominican University IL

**Received:** 11 Sep 2024**Accepted :** 15 Sep 2024**Published:** 18 Sep 2024**Copyright**

©2024 Julian Ungar-Sargon

OPEN ACCESS

## INTRODUCTION

In our ongoing attempt to create a new model and healing space for the future of healthcare, we need to revisit the prior systems that failed the poor and the responsibility of the state to care for its citizens with affordable care.

In this essay I review the literature including proposals that revisit Marxist theory in an effort to suggest an alternative model for affordable healthcare.



## Summary

Capitalism has had significant impacts on medical care and healthcare systems in several ways:

### Profit-Driven Healthcare

Capitalism has led to a profit-driven model of healthcare in many countries:

- Healthcare services and products are often treated as commodities to be bought and sold.
- Pharmaceutical companies and healthcare providers prioritize profitable treatments and procedures.
- There is pressure to increase productivity and reduce costs, sometimes at the expense of quality care.

### Inequality in Access

The capitalist system has exacerbated inequalities in healthcare access:

- Those with more financial resources can afford better quality care and insurance.
- Low-income populations often have limited access to healthcare services.
- Profit motives can lead to neglect of less profitable areas of medicine that may serve vulnerable populations.

### Technological Innovation

Capitalism has driven significant medical and technological innovations:

- Profit incentives spur research and development of new drugs and medical devices.
- Competition between companies can accelerate innovation.
- However, research is often directed towards profitable areas rather than greatest medical need.

### Marketization of Healthcare

There has been an increasing marketization of healthcare services:

- Growth of private insurance markets and for-profit hospital chains.
- Emphasis on consumer choice and market competition.
- Shift towards viewing patients as customers.

### Financialization

The financialization of healthcare has impacted how services are delivered:

- Increasing role of financial markets and institutions in healthcare.
- Focus on shareholder value and financial metrics in healthcare organizations.
- Complex financial instruments used to fund and profit from healthcare services.

### Challenges to Universal Healthcare

Capitalist interests often oppose universal public healthcare systems:

- Resistance from private insurers and healthcare companies that profit from the current system.
- Ideological opposition to government-run healthcare programs.
- Lobbying efforts to maintain market-based approaches.

While capitalism has driven innovation and efficiency in some areas of healthcare, it has also led to inequalities in access and a prioritization of profit over public health in many cases. Balancing the profit motive with equitable access to quality healthcare remains an ongoing challenge in

capitalist systems.

## The Unfolding Crisis

Economics has revealed a system that is managed not for the benefit of the people but rather for the corporations and the small elite who lead them, and which is clearly unsustainable in its present form [1].

Yet, there is a hidden consequence of this system: an unfolding crisis in health care, driven by the greed of corporations whose profit-seeking model is also failing.

Proponents of commodifying healthcare simultaneously argue that the cost of providing care for ageing populations is unaffordable while working to create demand for their health care products among those who are essentially healthy.

Will healthcare be the next profit-fuelled investor bubble?



We look for inspiration to the Prussian physician Rudolph Virchow who, while fully aware of the key role played by lice, drew attention to the social and economic circumstances in Silesia in the nineteenth century that allowed typhus epidemics to occur [2].

Yet, in recent years, too many public health professionals have left the big decisions to politicians and economists, assuming they must know what they are doing. But now we know that they do not.

A different solution is needed that prioritizes health and social wellbeing. Public health professionals are as well-equipped as anyone to propose it.



Today, in the world's economic centres such as Wall Street and the City of London, regulations that had once held the financial markets in check are viewed as obsolete. Advances in computing now allow billions of dollars of shares to be traded in milliseconds. In the 1980s, new types of traders were recruited, with degrees in maths, physics and engineering, all trained in the more obscure areas of mathematical theory.

The financial markets changed profoundly. The original rationale for a stock market was to raise money to enable companies to grow. Investors looked for people with clever ideas who they could turn into a sustained profit stream. They invested for the long term. The same was true of banks. Local bank managers knew the businesspeople who lived in their town or city. They were willing to take risks and, in doing so, provided the capital that allowed large numbers of small and medium companies to start up and grow, providing local employment and benefitting everyone. But this was to be swept away. Long-term investments were discarded as those in the financial sector realised that they could make billions of dollars in an afternoon using ever more complex derivatives; in reality just a form of gambling, albeit for very high stakes and with other people's money [3].

Bank chief executives asked themselves: "Why waste money on local branches when we could improve efficiency by centralizing banking and making decisions on which companies to support based on computerized algorithms rather than detailed local knowledge?"

Slowly, the financial system stopped being something that was there to support ordinary people, as investors, manufacturers, pensioners and savers, but rather a means by which a tiny percentage of the population could become fabulously rich at other's expense, using their money [4].

Once, the companies they ran would return most of their profits to shareholders. No more. Now most of it would go on bonuses to senior staff. And in many cases these profits were greatly inflated by outsourcing as much of their workforce as possible, ideally to developing countries such as India. The heads of these companies had lobbied hard to ensure the free global movement of goods, services and capital, but were determined not to extend that to people. After all, if the highly trained workers in developing countries could come to Europe or America, then they would demand higher wages, something they considered totally unacceptable.



## The lessons for health care

The corporate greed that underpinned the financial crisis has implications for health policy that are too easy to overlook. Some years ago, major corporations realised that they needed to move beyond the traditional means of making money, the production of goods that people would buy, to the provision of services. The problem was that many of the key services that people depended on, such as health, education, and social care, were being provided by the state, at least in Western Europe. The challenge they faced was to transform these services, which for 50 years had been funded by taxes, based on the ability of citizens to pay, and received on the basis of need. They were owned collectively by the people through the interme-

diary of the state, and people remained safe in the knowledge that they would be there when needed. They were not seen as an opportunity for private profit.

To change this, market elites first had to rewrite the rules in their favor, getting their client governments in North America and Europe to shape the General Agreement on Trade in Services to their advantage [5].

Within the European Union, similar measures were adopted in relation to the provision of services [6]. To get their hands on health and education services, seen as the main growth areas, the corporations needed to prise them away from government control. The anticipated rewards of privatization were enormous, as they had realised in the United States where returns on investment in the health sector had been huge (now accounting for one-fifth of GDP, the highest worldwide). And health had another benefit. The demand was potentially unlimited, not least because those who supplied it could themselves stimulate demand.

Second, the market elites had to overcome resistance from a universal public system that had enduring popularity and public support. This involved creating popular discontent, drawing attention to any failings in the public system, and promoting choice as a value in itself, alongside effectiveness, efficiency, humanity and equity.

However, in seeking to unleash a market in health care they faced some fundamental problems. Some fifty years ago, the Nobel Laureate Kenneth Arrow described why the market in health care fails [7].

The reasons include the presence of externalities, whereby one person benefits from another receiving health care, especially if they have a contagious disease or a psychosis that may cause them to be violent. There is also information asymmetry, where the health professional offering care knows more about what the patient needs than they do themselves. But above all there is the problem that those who are in most need of care are the least able to afford it. In contrast, those who need care least have plenty of money.

This was recognised in the 1920s in the United States when the insurers Blue Cross and Blue Shield were created by associations of doctors and hospitals, not because they were concerned about the ability of people to obtain care, but rather to ensure that they themselves would be paid for providing it. Given these well-known market failures, how can the private sector make the profits it sought from health care? The answer is to redefi-  
ne health care.



A British general practitioner, Margaret McCartney has recently described

what she terms the Patient Paradox. She describes her difficulties, even in the National Health Service in the United Kingdom, in getting appropriate care for her patients who really do have illnesses, and especially the most difficult group, those with mental illness, while at the same time being cajoled, encouraged, and incentivized to deliver services, such as ever increasing varieties of unevaluated screening, to those who are well. Put simply, those with real illnesses offer little scope for profit by those who have been contracted, in the British internal health care market, to provide care [8].



## Big Pharma

The pharmaceutical industry now realizes that it is running out of ideas that will make it the massive profits it was once used to. These profits were based on a model that found a common disease, ideally with its onset about middle age, which would require regular treatment for years. It found them. They included, among others, high blood pressure, chronic airways disease, diabetes, Parkinson's Disease, and depression. But the problem now is that there are no more of these diseases to be found. There are perfectly good treatments for them and any new treatments can make, at most, a marginal contribution, and even that is frequently exaggerated by selective reporting and manipulation of clinical trial data [9].

These firms could develop antibiotics, but the problem there is that resistance emerges before expiry of patent protection, so there is no money to be made.<sup>21</sup> Then there is cancer, but it is not a single disease. The more scientists learn about it, the more they divide the market into smaller and smaller parts.<sup>22</sup> Any new drug will be effective against tumours in a relatively small number of people. They will only take it for a short while. The cost per dose will be astronomical. Publicly funded health systems will be reluctant to pay, knowing that they will have to reduce existing care for others as a result.

And the individual patient will, with rare exceptions, be able to pay. The same is true of drugs for children. Who will pay for the necessary testing knowing that the market will be tiny? Instead, the industry has focused on so-called lifestyle drugs. Anyone watching American television could be forgiven for thinking that the entire male population must have erectile dysfunction. The system of drug production, based on the free market, is as broken as the financial system and, just like it, it is far from clear how to fix it.

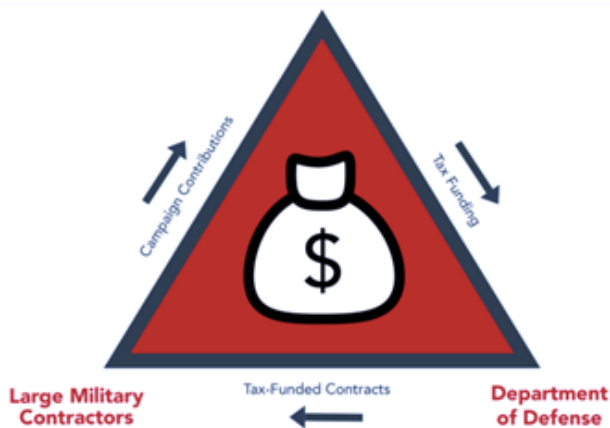
## Corporate Practice of Medicine

Those corporations moving into the delivery of health care have equal blame. Their problems are illustrated by the ageing of populations. Older people can be very difficult to treat. They do not fit into convenient boxes with a single disease. They have multiple disorders, necessitating a complex combination of drugs, many of which may interact with each other [10].

They may have varying degrees of organ failure, with their liver or kidney function influencing how those drugs are metabolized. They may have cognitive decline, so that they forget to take their tablets when they should, leading to unanticipated and potentially unnecessary admissions to hospital.

Fundamentally, they are unpredictable and, as we are constantly told, markets hate uncertainty. Anyone running a health system for profit will see them as the last people they want to deal with. Instead, they want to design simple, protocol-driven packages for young people with single diseases, such as uncomplicated diabetes or asthma, that can be delivered by health workers with minimum training, or even better, by computerized systems that take the human touch out of care delivery altogether.

To respond, just as the financial sector did when it realised that its traditional sources of profit were no longer sufficiently lucrative, they must redefine the rules of the game.



### The medical-industrial complex

Back in the 1950s, Eisenhower warned about what he called the military industrial complex, whereby a powerful coalition of generals and chief executives conspired to talk up the threat from the Soviet Union, exaggerating the so-called ‘missile gap’ and seeing threats where none existed [11]. The goal was not to protect the United States, but instead to transfer vast sums of money from the federal budget to the coffers of the corporations, and ultimately to those generals who would move seamlessly into their employment on retirement.

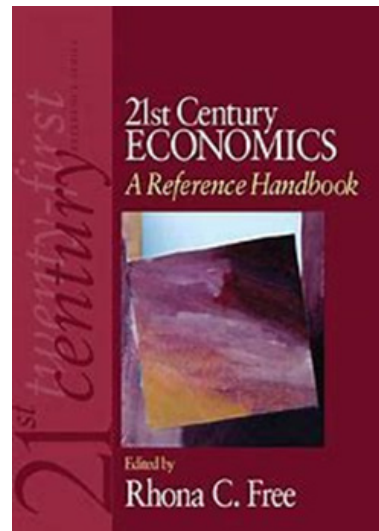
This has resulted in countless people having their cosmetics, nail files and the like confiscated while the few people who actually had bombs sailed straight through, even when they have done everything possible to draw attention to themselves [12].

But it is now the medical industrial complex that is setting the rules of the game, by redefining the goals of health care away from those in most need, such as those with tropical diseases or ageing populations with chronic disorders and towards those who are essentially well. If the general practitioner is unwilling to respond to these pressures and incentives, many others will.

In particular, those who do respond are the many private providers who offer so-called screening services using ever more complex imaging technology to visualize every part of one’s body to find entirely harmless anomalies for which they can extract money for giving what they call ‘treatment’. McCartney catalogues many examples, such as the treatment of surrogate markers, such as cholesterol, even at levels far below where it might do any harm, the creation of new so-called diseases, such as pre-diabetes, and treatment of raised levels of prostate-specific antigen, even at the cost of

often appalling side effects while giving no overall benefit [13].

Yet at the same time as people are being encouraged to spend ever greater sums of money on interventions that are useless, corporations are telling everyone that the rise in health care expenditure is unaffordable and must be rationed. Moreover, those same corporations are funding lobby groups, often in a manner that is far from transparent, to persuade governments and the public that the European welfare state is unsustainable, using highly selective and frequently misleading evidence. In some cases, where governments view the economic crisis as a once in a lifetime opportunity to roll back the welfare state, they are pushing at an open door [14].



### Twenty-first-century capitalism: What’s new?

Susan K. Sell has asked the question posed 10 years earlier by McKee and Stuckler [15].

US economic and political power vis-à-vis other states in the international system has propelled the spread of financialization, trade liberalization, and global supply chains (GSCs) throughout the global economy [16].

At the macro-level, three features of twenty-first-century financialized capitalism and trade stand out. First, financialized capitalism has introduced a system of economic volatility, with repeated banking crises that threaten the real economy and households alike. Second, economic power has shifted from the mainstays of the real economy (commodity producers and traders) to the controllers of global value chains (GVCs) who own intangibles such as intellectual property and financial instruments. According to de Medeiros and Trebat [17], “the ‘core business’ of every TNC [transnational corporation], irrespective of its particular branch, is to control and capitalize on these intangible assets” in order to maximize shareholder value and generate large rents. Third, economic concentration among TNCs fosters their oligopoly and oligopsony power vis-à-vis consumers and suppliers .

As a macro-regime of capital accumulation it combines “flexible labor markets with the expansion of credit ... to sustain consumption in the face of stagnating real wages” This results in low wages for the many and increased economic inequality. I will discuss each in turn [18].

What we talk about in discussing “trade” these days is really the control of intangibles such as financial services and intellectual property. Trade agreements now have little to do with trade, and everything to do with deep economic integration and domestic regulation.

According to Durand and Milberg [19], “lead firms engaged in GVC trade are interested in stricter IPRs in trade agreements to contain the risk of IP appropriation resulting from the international fragmentation of production.” Today, “profitability is a function of a firm’s ability to extract monopoly rents from complex value chains using their control over IPRs”

Big Pharma routinely blocks pro-health initiatives aimed at promoting the use of TRIPs flexibilities to make essential medicines affordable, because these would threaten their profits and reduce shareholder value [20].

Commercial returns mean “a mismatch between health research priorities and the burden of disease outside the industrialized world” [21].

Patent protection increases the prices of drugs and reduces access to medicines and vaccines. Strategic behavior aimed at blocking generic competition contributes to rising drug prices: “companies create serial barriers to hold off competition” “When more than 70% of best-selling drugs had their protection extended, it is clearly the go-to approach for profitability”

Trade agreement provisions that extend patent life and impose clinical test data exclusivity all serve to suppress price competition for drugs and medical devices, thereby reducing access to them, and support high rents for Pharma. According to Feldman, “our incentive structure is badly misaligned with societal goals”

The economic and political power of IP-rich global firms has enabled them to shape trade and investment agreements to further entrench their power and increase their profits. According to Missoni, “trade and investment treaties limit the policy space for public regulatory interventions to protect public health”.



Trade and investment agreements routinely contain intellectual property provisions that extend protection beyond the TRIPs obligations of the World Trade Organization. Intellectual property has come to be treated as an “investment asset” in Investor-State Dispute Settlement (ISDS) agreements under which private firms can sue states for regulations that they claim reduce the “expected value” of their initial investment.

The Philip Morris tobacco cases against Uruguay and Australia over plain packaging (thus reduced value of the trademark) and the Eli Lilly case against Canada over its pro-health patent policies are three recent examples of intellectual property-based challenges to public health regulations. Even though Philip Morris and Eli Lilly lost these ISDS challenges, we can expect to see more IP-based ISDS challenges in the future [22].



# PHILIP MORRIS

## Reform Opportunities

Twenty-First-century capitalism seems to be driving us further away from the goal of Universal Health Coverage, shifting obligations from the public provision of basic services to private households and individuals to borrow money to “invest” in their health and wellbeing [23].

Nolke et al. hold: “for financialization to be sustained, it invariably needs to incorporate new areas in terms of other economic sectors, the public sector, social security systems, the housing markets or other spheres of social reproduction—and reorganize them according to the rationality of financial markets” [24].

As this brief review has highlighted, twenty-first-century trade and financialized capitalism have not served the masses particularly well. A very small percentage of people have benefited enormously, while sharpening income inequality has left the vast majority behind. This is not to detract from the notable and spectacular gains in incomes in China and India, which have lifted many millions of people out of grinding poverty.

However, even in those countries, the gaps between those at the top and those at the bottom are widening sharply and rapidly. Twenty-First-century trade and financialized capitalism have played a prominent role in exacerbating income inequality. Given the recent spread of right-wing populism and the increasing incidence of “deaths of despair,” we need to ask whether “the inequality of contemporary capitalism is reaching levels that may threaten the social conditions required for the existence of democratic societies” [25].

## HEALTH CARE UNDER THE KNIFE



Moving Beyond Capitalism for Our Health



HOWARD WAITZKIN  
and the Working Group on Health Beyond Capitalism

In Howard Waitzkin's collaborative book, *Health Care Under the Knife: Moving Beyond Capitalism for Our Health*, he argues that the struggle toward viable national health programs now must become part of a struggle to move beyond capitalism [26].

Table 1 presents the book's table of contents and provides an overview of the key themes and the working group of scholars and activists who created the book.

**Table 1.** Table of Contents, *Health Care Under the Knife: Moving Beyond Capitalism for Our Health*.

---

Introduction, Howard Waitzkin

**PART ONE. Social Class and Medical Work**

1. Disobedience: Doctor Workers Unite!, Howard Waitzkin
2. Becoming Employees: The Deprofessionalization and Emerging Social Class Position of Health Professionals, Matt Anderson
3. The Degradation of Medical Labor and the Meaning of Quality in Health Care, Gordon Schiff and Sarah Winch
4. The Political Economy of Health Reform, David Himmelstein and Steffie Woolhandler

**PART TWO. The Medical Industrial Complex in the Age of Financialization**

5. The Transformation of the Medical Industrial Complex: Financialization, the Corporate Sector, and Monopoly Capital, Matt Anderson and Robb Burlage
6. The Pharmaceutical Industry in the Context of Contemporary Capitalism, Joel Lexchin

**PART THREE. Neoliberalism and Health Reform**

7. Obamacare: The Neoliberal Model Comes Home to Roost in the United States – If We Let It, Howard Waitzkin and Ida Hellander
8. Austerity and Health, Adam Gaffney and Carles Muntaner

**PART FOUR. The Trajectory of Imperialism's Health Component**

9. Imperialism's Health Component, Howard Waitzkin and Rebeca Jasso-Aguilar
10. U.S. Philanthrocapitalism and the Global Health Agenda: The Rockefeller and Gates Foundations, Past and Present, Anne-Emanuelle Birn and Judith Richter

**PART FIVE. The Road Ahead**

11. Resisting the Imperial Order and Building an Alternative Future in Medicine and Public Health, Rebeca Jasso-Aguilar and Howard Waitzkin
12. The Failure of Obamacare and a Revision of the Single Payer Proposal after a Quarter Century of Struggle, Adam Gaffney, David Himmelstein, and Steffie Woolhandler
13. Overcoming Pathological Normalcy: Mental Health Challenges in the Coming Transformation, Carl Ratner
14. Successful Health Care Reform Requires Changing Social and Environmental Determinants of Health, Carles Muntaner and Rob Wallace
15. Conclusion: Moving Beyond Capitalism for Our Health, Adam Gaffney and Howard Waitzkin

---

In addition to these financial changes related to neoliberalism, those struggling for just and accessible health systems now need to confront the shifting social class position of health professionals. As described in our book, the social-class position of physicians and other health professionals has changed drastically in the United States and most other capitalist countries.

Neoliberal policies have led to privatization, cutbacks in public-sector services and institutions, and public subsidization of private profit-making through transfer of tax revenues into private insurance corporations. The growing financialization of capitalist economies includes the increasingly oligopolistic and financialized character of the health insurance, both public and private. The financial flows of both public and private health insurance programs increasingly merge with those of the broader finance capital and real estate industries (the so-called FIRE sector: finance, insurance, and real estate).

In addition to these financial changes related to neo-liberalism, those struggling for just and accessible health systems now need to confront the shifting social class position of health professionals. As described in his book, the social-class position of physicians and other health professionals has changed drastically in the United States and most other capitalist countries.

Previously, the majority of physicians worked in individual or group practices. Although some were employees receiving relatively high salaries and

benefits, most were small entrepreneurs. In the “fee-for-service” system, they seldom accumulated capital on the scale of industrialists or financiers, but they still saw themselves – and others saw them – as members of an “upper class.” Some Marxist-oriented theorists of class viewed them as members of a “professional managerial class” [27].

Physicians increasingly have become employees of hospitals or practices at least partially owned by large health systems. In a large 2015 survey, 63% of all U.S. physicians reported being employed, including 72% of women physicians [28].

These changes primarily reflected the increased costs of owning a private practice due to billing and other administrative requirements. A study in 2019 showed that administrative costs of interacting with public and private payers in the United States averaged about \$169,300 (all dollar amounts in U.S. dollars) annually for physicians' practices, or 21.8% of gross receipts, versus \$36,825 and 10.8%, respectively, in Canada.

As a result, most U.S. doctors have become employees of hospital and health system corporations, where relatively high salaries tend to mask the reality of employee status.

With loss of control over the work process and a reduced ability to generate high incomes compared to other professional workers, the medical profession has become proletarianized.



physicians usually do not realize that their malaise reflects their changing social-class position. In a way, they have joined that highest stratum of workers to which V.I. Lenin and others referred as the “aristocracy of labor” [29].

From Samir Amin’s perspective of political economy, the current wave of “generalized proletarianization” has engulfed the medical profession [30].

“A rapidly growing proportion of workers are no more than sellers of their labor power to capital . . . a reality that should not be obscured by the apparent autonomy conferred on them by their legal status.”<sup>10</sup>

Beyond the changing class position of health professionals, the coming transformation will need to address the oligopolistic character of the insurance industry, the consolidation of large health systems, and the financialization of health services within global capitalism. In the United States, Obamacare has increased the flow of capitated public and private funds into the insurance industry. Through this process, Obamacare has extended the overall financialization of the global capitalist economy.

This process has occurred in the context of financialization in the national health programs of other countries, especially in Europe, that previously served as models in proposals for change in the United States. In this sense, the financial flows of health insurance cohere with John Bellamy Foster’s comment [31].

At the more stratospheric level represented by contemporary finance, the general formula for capital, or M-C-M’ [money-commodity-more money], is being increasingly supplanted by the circuit of speculative capital, M-M’, in which the production of use values disappears altogether and money simply begets more money.<sup>11</sup>

Waitskin clarified 4 main priorities for action in the United States and in other countries affected by the neoliberal, corporatized, and commodified model of health care.

(1) a sustained, broad-based movement for a single-payer national health program that ensures universal access to care but drastically reduces the role of corporations and private profit, as a step toward moving beyond

capitalism and beyond the inevitable contradictions that capitalism generates for national health programs;

(2) an activated labor movement that this time includes a well-organized sub-movement of health professionals such as physicians, whose deteriorated social class position and proletarianized conditions of medical practice have made them ripe for activism and change;

(3) more emphasis on local and regional organizing at the level of communal organizations as envisioned by Istvan Metszaros [ ], and attempted in multiple countries as a central component in the revolutionary process of moving “beyond capital;”

(4) carefully confronting the role of political parties while recognizing the importance of labor or otherwise leftist parties in every country that has constructed a national health program, and understanding that the importance of party building goes far beyond electoral campaigns to more fundamental social transformation. All these priorities emphasize the urgency of creating bridges that link health activism with social movements that focus on social-class oppression, including poverty and inequality, racism, sexism, environmental degradation, militarism and imperialism, and the dominant ideologies that lead women and men to accept pathological social conditions as normal.



Our reluctance to look at capitalism when we investigate global patterns of health and disease has a cost, writes Nicholas Freudenberg [33].

*A cascade of health crises—from the covid-19 pandemic, to our climate emergency, and a rise in “deaths of despair”—are contributing to growing global health burdens, making this the time for health professionals to seek the common causes of these catastrophes. Mounting evidence suggests that key features of 21st century capitalism add to the global burden of disease and to health inequities within and among nations. Corporate managed globalization spreads viruses, unhealthy products, and pollution across borders. Financialization leads to privatization of healthcare, reductions in worker compensation, and less attention to product safety and pollution controls. Corporate appropriation of science and technology leads to the use of discoveries in pharmaceuticals, food, and transportation not to improve wellbeing, but to increase profits.*

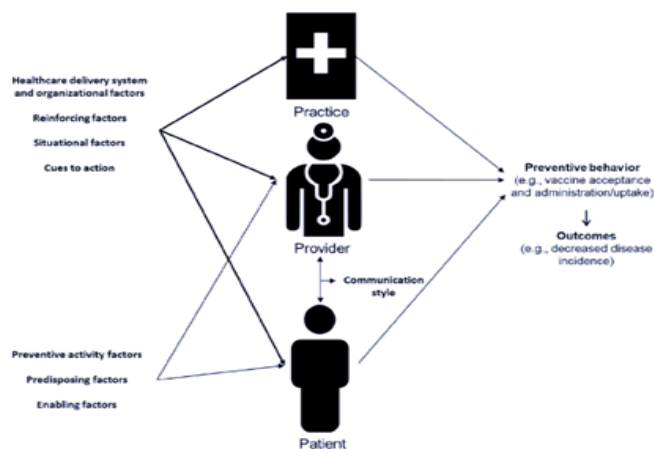
*Despite these links between dominant political and economic structures and health, health professionals are often reluctant to use the word capitalism when analyzing the world’s current health problems and proposing solutions. Some fear that use of the word will brand them as relics caught up in the conflicts of another century or immature rebels, or make them targets for career damaging reprisals. Leading scientific paradigms, from the reductionist biomedical model to the behavioral focus of public health practice, can further discourage use of complex terms like capitalism.*

*But this reluctance to look through the prism of capitalism to investigate global patterns of health and disease and identify more effective approaches for preventing global health crises has a cost. First, it ignores growing evidence that, for example, the global food and agriculture system contributes to a suboptimal diet, now the leading risk factor for premature death and preventable illness. The fossil fuel industry is a driving force for the world's climate emergency and the pollution that now sickens so many.*

*The marketing practices of the food, alcohol, tobacco, pharmaceutical, and firearms industries play key roles in exacerbating the rise of deaths of despair and from non-communicable diseases. The growing concentration of wealth in the world's largest corporations and richest individuals worsens the living conditions, health, and family lives of an increasing proportion of the world's workers. Ignoring the system that has led to these declines would be like physicians seeking to treat illnesses without considering the human body.*

*Second, reluctance to make capitalism itself a subject of investigation reinforces the siloization of health problems and our responses to it. Do researchers have to study separately for decades the business and political practices of the food, tobacco, financial, and Big Tech sectors before they can identify common causes of health problems and recommend changes to ameliorate these harmful influences? Do health professionals have to examine separately the disease process in each organ system when these conditions share common pathways and solutions? Do health organizations need to confront each disinformation campaign designed to discredit relevant science by the fossil fuel, tobacco, alcohol, food, and other industries, or can they devise new governance mechanisms that de-normalize corporate practices that undermine public health?*

In previous centuries, the efforts of health professionals, reformers, and social movements led to advances that improved human and planetary health. By focusing on reducing the costs of 21st century capitalism, we can contribute to the next chapter of improving human and planetary health.



## Medical Ideology

Howard Waitzkin writes [34].

*Ideology is an interlocking set of ideas and doctrines that form the distinctive perspective of a social group. Along with other institutions like the educational system, family, mass media, and organized religion, medicine promulgates an ideology that helps maintain and reproduce class structure and patterns of domination. Medicine's ideologic features in no way diminish the efforts of individuals who use currently accepted methods in their clinical work and research. Nevertheless, medical ideology, when analyzed as part of the broad social superstructure, has major social ramifications beyond medicine itself.*

*Recent studies have identified several components of modern medical ideology [35].*

1) Disturbances of biological homeostasis are equivalent to breakdowns of machines. Modern medical science views the human organism mechanistically. The health professional's advanced training permits the recognition of specific causes and treatments for physical disorders. The mechanistic view of the human body deflects attention from environmental causes of disease, including work processes or social stress. It also reinforces a general ideology that favors industrial technology under specialized control.

2) Disease is a problem of the individual human being. The unifactorial model of disease has always focused on the individual rather than the illness-generating conditions of society. More recently, attempts have been made to blame disease on an individual's "lifestyle" (smoking, overeating, etc.). In both cases, the responsibility for disease and cure rests at the individual rather than the collective level. In this sense medical science offers no basic critical appraisal of class structure and relations of production, even in their implications for health and illness.

3) Science permits the rational control of human beings. The natural sciences have led to a greater control over nature. Similarly, it is often assumed that modern medicine, by correcting defects of individuals, can enhance their controllability. The quest for a reliable work force has been one motivation for the support of modern medicine by capitalist economic interests.<sup>38</sup> Physicians' certification of illness historically has expanded or contracted to meet industry's need for labor.<sup>39</sup> Thus, medicine is seen as contributing to the rational governance of society, and managerial principles increasingly are applied to the organization of the health system [36].

4) Many spheres of life are appropriate for medical management. This ideologic assumption has led to an expansion of medicine's social control function. Many behaviors that do not adhere to society's norms have become appropriate for management by health professionals. The "medicalization of deviance" and health workers' role as agents of social control have received critical attention. The medical management of behavioral difficulties, such as hyperactivity, and aggression, often coincides with attempts to find specific biological lesions associated with these behaviors.<sup>42</sup> Historically, medicine's social control function has expanded in periods of intense social protest or rapid social change [37].

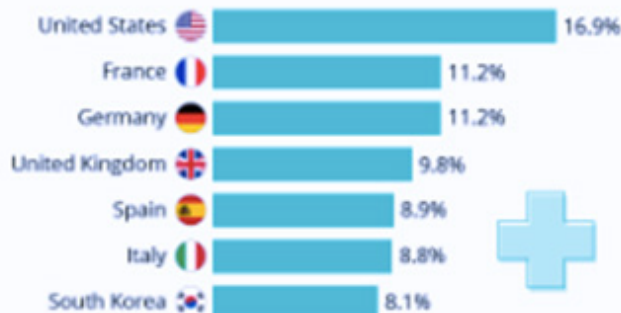
5) Medical science is both esoteric and excellent. According to this ideologic principle, medical science involves a body of advanced knowledge and standards of excellence in both research and practice. Because scientific knowledge is esoteric, a group of professionals tend to hold elite positions. Lacking this knowledge, ordinary people are dependent on professionals for interpretation of medical data. The health system therefore reproduces patterns of domination by "expert" decision makers in the workplace, government, and many other areas of social life. The ideology of excellence helps justify these patterns, although the quality of much medical research and practice is far from excellent; this contradiction recently has been characterized as "the excellence deception" in medicine.<sup>43</sup> Ironically, a similar ideology of excellence has justified the emergence of new class hierarchies based on expertise in some countries, like the Soviet Union, that have undergone socialist revolutions. Other countries, such as the People's Republic of China, have tried to overcome these ideologic assumptions and to develop a less esoteric "people's medicine."

Studies of medical ideology have focused on public statements by leaders of the profession (in professional journals or the mass media), as well as state and corporate officials whose organizations regulate or sponsor medical activities. However, health professionals also express ideologic messages in their face-to-face interaction with patients.<sup>44</sup> The transmission of ideologic messages within doctor-patient interaction currently is the

manufactured in dominant nations and sold in the Third World. This process is nowhere clearer than in the pharmaceutical and medical equipment industries. The penetration of these multinationals, with its stultifying impact on local medical research and development, has led to the advocacy of nationalized drug and equipment formularies in several Third World countries.

## How Much Do Countries Spend On Their Health Systems?

Health expenditure as a percentage of GDP in 2018



RYAN TORRENCE writes [39].

### Comparative International Health Systems

Health care and imperialism. Imperialism may be defined as capital's expansion beyond national boundaries, as well as the social, political, and economic effects of this expansion. One basic feature of imperialism is the extraction of raw materials and human resources which move from Third World nations to economically dominant countries. Navarro has analyzed how the "underdevelopment of health" in the Third World follows inevitably from this depletion of natural and human resources. The extraction of wealth limits underdeveloped countries' ability to construct effective health systems. Many Third World countries face a net loss of health workers who migrate to economically dominant nations after expensive training at home.

Through imperialism, corporations also seek a cheap labor force. Workers' efficiency was one important goal of public health programs sponsored abroad, especially in Latin America and Asia, by philanthropies closely tied to expanding industries in the United States.<sup>47</sup> Moreover, population control programs initiated by the United States and other dominant countries have sought a more reliable participation by women in the labor force. At the same time, workers abroad who are employed by multinational corporations also face high risks of occupational disease.

Another thrust of imperialism is the creation of new markets for products

*Critical health policy researchers have, over the past few decades, shown beyond doubt the connection between socioeconomic inequalities and disparities in health and disease outcomes. The evidence is strong enough that mainstream outlets like the World Health Organization now acknowledge the centrality of the social determinants of health. However, researchers and activists have largely been frustrated in their attempts to mobilize this knowledge into practice. By most accounts, social health inequalities are increasing on intranational and global scales, especially following the 2008 economic crisis [40]. The present Covid-19 pandemic – which has caused unemployment levels to rise to historic heights in most advanced economies – has made understanding the connection between socioeconomics and individual health even more urgent.*

The below chart (Figure 1) summarizes the differences between orthodox Marxist economics, mainstream economics, and mainstream left/post-Marxist economics with respect to the key points outlined above. It is worth noting again here that the summary of mainstream economics is by necessity extremely generalized and overlooks the nuance that would be found in the field itself. The purpose of this paper is not to relate economic theory at a high level of sophistication, only to show how the field of critical health policy has been influenced by the assumptions of mainstream economic thought, and how it might be different if it were to take Marxist assumptions as foundational [41].

Framework	Theory of Value	Concept of Profit	Existence of Exploitation	Class Relations	Tendencies to Crisis
<i>Orthodox Marxist</i>	Marx's labour theory of value ("law of value")	Origin of all profit is surplus labour; originates in <b>production</b>	Exploitation defined as appropriation of surplus labour; necessary to the existence of profit	Class relates to relationship to production, i.e. ownership of the means of production (proletariat & bourgeoisie)	Crisis tendencies present in the internal logic of capitalism; focus on the tendency of the rate of profit to fall
<i>Mainstream Economics</i>	Subjective theory of value (marginal utility theory)	Profit originates in <b>exchange</b> ; is created whenever something is exchanged for something of greater (subjective) value; "buy low, sell high"	Impossible by definition, providing exchange is free and non-coercive between equals	Class as "socioeconomic status"; correlated <i>post hoc</i> with empirical measures such as income, education level, etc.	A free market left to its own devices tends toward equilibrium; source of crisis is usually exogenous to the market itself (i.e. too much government intervention)
<i>Post-Marxist/Neo-Marxist Economics</i>	Rejects the law of value; skeptical of the assumptions of marginal utility, but generally assumes a subjective theory of value	Similar to mainstream economics	Topic of contention; redefined in the analytic Marxist tradition as essentially an unfair distribution of resources leading to unequal power relations in exchange	Necessity to update Marxist concept of class due to rejection of the labour theory of value; various influential interpretations such as Erik Olin Wright's elaboration of class	Various tendencies toward crisis that do not require a labour theory of value; dominant are "underconsumptionist" theories about loss of consumer purchasing power (similar to Keynes' focus on aggregate demand)

This paper proceeds from the premise that the basics of Marxist economics, which had been thought to be obsolete and disproven in academia for most of the 20th century, may be overdue for a reappraisal, and may be a useful foundation for critical health policy research. This notion is inspired by the work of a group of Marxist economists who since the 1980's have been advocating for a "return to Marx", and doing research that calls into question the validity of the "debunking" of Marx's critique of political economy.



## The Influence of “neo-Marxism” in the Field of Critical Health Policy

It may not be clear how the project of reasserting Marxian economics is relevant to critical health policy research. However, the various schools that emerged from the debate over the tenability of Marxism – neo-Marxists, post-Marxists, and others – have had a great deal of influence in the field. Much of the theoretical foundation of progressive comparative health policy originates in this tradition. In this section I will explore the influence of neo-Marxist thought in health policy research through the example of Gosta Esping-Andersen, whose *Three Worlds of Welfare Capitalism* [42], has been described as “the most influential piece of comparative welfare state research in the contemporary period” and is a seminal contribution to the comparative health policy field.

Until then, welfare states were generally categorized along a single continuum ranging from less spending to more spending. Esping-Andersen's contribution was to add multi-dimensional and qualitative aspects to the analysis, categorizing welfare states not only according to the amount of provision, but also the ideological justification for the spending, the primary recipients of the spending, and other factors.

He arrived at a typology consisting of three main types of welfare state: liberal, which are minimal and tied to private and market-based solutions (e.g. Anglo nations like Canada and Australia); conservative, which prioritize family values and solidarity (e.g. Germany and the Netherlands, also known as Christian welfare states); and social-democratic, which promote equality and are more generous in provision (e.g. the Scandinavian countries).

One of the central issues in critical health policy is the stubborn persistence of health inequalities correlated to social class, despite constant attempts to address proximal factors that are thought to be the mediating variables between social status and health. For example, in the 19th century it was thought that lack of sanitation and housing conditions were the primary causes of poor people's health problems; by the mid 20th century, lack of access to medical services was thought to be the main driver of

poor people's health outcomes. However, despite huge progress in much of the world in addressing these (for example by indoor plumbing and publicly funded health care, respectively), health inequalities persisted. Studies have shown an “enduring or even increasing association between socioeconomic status and disease outcome” When one mediating risk factor disappears, another one invariably replaces it, the fundamental relationship stays the same.

To explain this, Link & Phelan [43], have proposed a “fundamental cause theory” (or “fundamental social cause”) that is meant to explain this connection. However, they link the fundamental cause to imbalanced distribution of “knowledge, money, power, and prestige” among other factors, demonstrating an essentially Weberian understanding of social class. This has allowed right-wing researchers to seize on the idea of fundamental cause, claiming for instance that intelligence (IQ level) might be the fundamental cause of persistent health inequity [44].

I think that the “fundamental social cause” under capitalism is better explained with reference to exploitation and Marxian class dynamics. The notion of a fundamental social cause maps well onto Marx's understanding of private ownership of the means of production as the fundamental social contradiction of capitalism, as it is the social relationship of domination lying at the core of capitalist reproduction.

## References

1. Martin McKee<sup>1</sup> and David Stuckler<sup>2</sup> (2012). The Crisis of Capitalism and the Marketisation of Health, *J Public Health Res.* 1: 236–239.
2. Reilly RG, McKee M. (2012) ‘Decipio’: examining Virchow in the context of modern ‘democracy’. *Public Health.* 126: 303-7.
3. Ferguson N. (2008) *The ascent of money: a financial history of the world.* Allen Lane; London.
4. Elliott L, Atkinson D. (2008) *The gods that failed: how blind faith in markets has cost us our future.* Bodley Head; London.
5. Pollock AM, Price D. (2003) The public health implications of world trade negotiations on the general agreement on trade in services and public services. *Lancet.* 362: 1072-5.
6. Mossialos E, McKee M. (2002) *EU law and the social character of health care.* Peter Lang; Brussels.
7. Coulter A. (2010) Do patients want a choice and does it work? *BMJ.* 341: c4989.
8. McCartney M. (2012) *The Patient Paradox: Why sexed-up medicine is bad for your health.* Pinter & Martin, London.
9. Goldacre B. (2012) *Bad pharma.* Fourth Estate; London.
10. Nolte E, McKee M. (2008) *Caring for people with chronic conditions: a health system perspective.* Open University Press; Maidenhead.
11. Pursell CW. (1972) *The military-industrial complex.* Harper & Row, New York, USA, 342.
12. Harris P. (2011) How private firms have cashed in on the climate of fear since 9/11. *Guardian.* Available from: <http://www.guardian.co.uk/world/2011/sep/05/private-firms-fear-9-11>
13. McCartney M. (2012) *The Patient Paradox: Why sexed-up medicine is bad for your health.* Pinter & Martin, London.
14. Klein N. (2007) *The shock doctrine: the rise of disaster capitalism.* 1st ed. Metropolitan Books/Henry Holt; New York USA.
15. Sell, S.K. (2019) 21st-century capitalism: structural challenges for universal health care. *Global Health* 15: 1-76. <https://doi.org/10.1186/s12992-019-0517-3>.
16. Fuchs D, Meyer-Eppler R, Hamenstadt U. (2013) Food for thought: the politics of financialization in the agrifood system. *Compet Chang.* 17: 219–33.
17. de Medeiros CA, Trebat N. (2017) Inequality and income distribution in global value chains. *J Econ Issues.* 51: 401–8. P407.
18. van der Zwan N. (2014) Making sense of financialization. *Soc Econ Rev.* 12: 99–129. P102.

19. Durand C, Milberg W. (2018) Intellectual monopoly in global value chains. Working Papers 1807, New School for Social Research, Department of Economics 21-22.
20. Correa C. (2006) Implications of bilateral free trade agreements on access to medicines. *Bull World Health Organ.* 84: 399–404.
21. Missoni E. (2013) Understanding the impact of global trade liberalization on health systems pursuing universal coverage. *Value Health.* 16: S14–8.
22. Diependaele L, Cockbain J, Sterckx S. *Eli Lilly v. (2017) Canada: the uncomfortable liaison between intellectual property and international investment law.* *Queen Mary J Intellect Property.* 7: 283–305.
23. Lavinias L. (2018) The collateralization of social policy under financialized capitalism. *Dev Chang.* 49: 502–17.
24. Nolke A, Heire M, Bieling H-J. (2013) Editorial: the politics of financialization. *Compet Chang.* 17: 209–18.
25. Case, A, Deaton A. (2017) Mortality and morbidity in the 21st century. *Brookings Papers on Economic Activity.* (Spring): 397–476. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5640267/>.
26. Waitzkin H. (2018) and the Working Group on Health Beyond Capitalism. *Health Care Under the Knife: Moving Beyond Capitalism for Our Health.* New York, NY: Monthly Review Press.
27. Ehrenreich B, Ehrenreich J. (1977) The real story behind the crash and burn of America's managerial class. *Alternet.* February 13, 2013. <http://www.alternet.org/economy/barbara-and-john-ehrenreich-real-story-behind-crash-and-burn-americas-managerial-class>. Ehrenreich B, Ehrenreich J. The professional-managerial class. *Radical America.* March–April 11: 7–31.
28. Rosenthal E. (2020) Apprehensive, many doctors shift to jobs with salaries. *New York Times.* February 13, 2014. <http://www.nytimes.com/2014/02/14/us/salaried-doctors-may-not-lead-to-cheaper-health-care.html>.
29. Hobsbawm E. (2012) Lenin and the 'aristocracy of labor'. *Mon Rev.* 64: 26–34.
30. Amin S. (2014) Contra Hardt and Negri: Multitude or generalized proletarianization? *Mon Rev.* 66: 25–36.
31. Foster JB. (2013) The epochal crisis. *Mon Rev.* 65: 1–12.
32. Istvan Metszaros I. (1995) *Beyond Capital.* New York, NY: Monthly Review Press.
33. <https://blogs.bmj.com/bmj/2021/05/06/why-do-we-ignore-capitalism-when-we-examine-the-health-crises-of-our-time/>
34. <https://archive.scienceforthepeople.org/vol-10/v10n6/a-marxist-view-of-medical-care/> Reprinted, (1978) with modifications, from *Annals of Internal Medicine.* 89: 2.
35. Navarro, V. (1977) *Medicine Under Capitalism.* New York, Prodist, 1976; Berliner, H., "Emerging Ideologies in Medicine." *Rev. Radical Polit. Econ.* 8: 116-124.
36. Krause, E. (1973) "Health Planning as a Managerial Ideology." *Int. J. Health Serv.* 3: 445-463.
37. Poulantzas, N. (1977) *Classes in Contemporary Capitalism.* London: New Left Books, 1975; Waitzkin, H., and B. Waterman, *The Exploitation of Illness in Capitalist Society.* Indianapolis, Bobbs-Merrill, 1974; Zola, I. K., "In the Name of Health and Illness: On Some Socio-political Consequences of Medical Influence. *Soc. Sci. Med.* 9: 83-87, 1975; Pfohl, S. J. "The Discovery of Child Abuse." *Soc. Problems* 24: 310-323.
38. Waitzkin, H., and J. D. Stoeckle. (1972) "The Communication of Information About Illness: Clinical, Sociological, and Methodological Considerations." *Adv. Psychosom. Med.* 8: 180-215.
39. <https://yorkspace.library.yorku.ca/server/api/core/bitstreams/4dd75270-89a4-4a27-80d8-241a8376c9b8/content>
40. Cash-Gibson, L., Rojas-Gualdrón, D. F., Pericàs, J. M., & Benach, J. (2018). Inequalities in global health inequalities research: A 50-year bibliometric analysis (1966-2015). *PLoS One*, 13: e0191901.
41. <https://www.library.yorku.ca/web/collections/yorkspace/>
42. Princeton University (1990) Press February 12.
43. Link, B. G., Phelan, J. C, & Tehranifar, P. (2010). Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. *Journal of health and social behaviour.* 51: S28-S40.
44. Batty, G. D., & Deary, I. J. (2005). Health communication, intelligence, and health differentials. *American journal of public health.* 95: 1088-1088.

**Cite this article:** Julian Ungar-Sargon. (2024) Capitalism and Health Care: A Critiques. *Japan Journal of Medical Science* 5 (1): 174-184.

**Copyright:** ©2024 **Julian Ungar-Sargon.** This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.