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Editorial

The welfare state and global health: Latin America, the Arab world and the politics of social class

El estado de bienestar y la salud global: América Latina, el mundo árabe y la política de la clase social

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The term "welfare state" has been used in the second half of the 20th century to refer broadly to a series of state-financed social services and transfers[1]. In contemporary public health and social epidemiology, however, the term has a broader meaning and often includes social transfers, social and health services, consumer, environmental and workplace protection, labor market policies and reduction of social inequalities[2]. Global health has been defined as "the area of study, research and practice that places a priority on improving health and achieving equity in health for all people worldwide"[3]. Because welfare states have been associated with different levels of population health in wealthy countries[4,5], our attempt here is to point to their relevance to the contemporary broader global health context.

Why we should avoid "Eurocentrism"

The development of European welfare states in other world regions has been plagued with difficulties almost from the start. Already in the early 20th century Werner Sombart famously talked about "American Exceptionalism" referring to the hypothesis that unique factors such as racial divisions, lack of feudalism and migration accounted for lack of socialist institutions (and thus lack of welfare state) in the US as opposed to Europe[6]. It has also been argued that among middle and low income countries, the burden of imperialism, that is "the creation and/or maintenance of an unequal economic, cultural, and territorial relationship, usually between states and often in the form of an empire, based on domination and subordination"[7], limits the degree of autonomy that these countries have in developing their own welfare states, including public health systems[8].

During the 1980s and 1990s, high level of indebtedness in impoverished countries led to the implementation of Structural Adjustment Policies (SAPs) conducted by the International Monetary Fund with the support of the World Bank. These policies involve conditions for getting new loans or lower the interest rates of current loans[9]. These "conditionalities" are applied to debtor countries requesting assistance to confront the difficulties for external debt repayment, which typically involve deregulation and privatization to make countries more market oriented[10,11]. Little concern has been given to the social and public health impact that these conditions might have on the poor[12] and on human rights, including health[13]. One of the main consequences of the SAPs in highly indebted countries has been the weakness of the state and, consequently, the difficulties to build welfare states, including their public health and health services infrastructures[14]. In recent years, the World Bank has tended to give more attention to social welfare policies, but without reviewing the impacts of the neoliberal policies still attached to its lending and debt relief policies[12].

Real change in Latin America and the Arab world

Current developments in the expansion of the welfare state in Latin America, propelled by social democratic governments, such as in Argentina, Bolivia, Brazil, Chile, Ecuador, Paraguay, Uruguay, and Venezuela, have challenged previous hegemonic notions of Washington Consensus that there is no alternative to reduction of welfare state interventions and deregulation of labor markets, finance and trade[15]. The mix of equity-oriented inter-sectoral policies (polices by sectors other than the health sector that have an impact on population health, such as environmental, transportation, labor market, workplace, housing, or educational policies)[16] implemented by Latin American governments (e.g., Brazil's Bolsa da Famila, Chile's Progresa, Venezuela's Barrio Adentro and other Misiones) is hard to characterize in term of European Social Democratic Welfare Regimes[17]. Their political instrument is different from the "labor-farmer" alliance that characterizes the Nordic regimes of the 20th century in the establishment of their welfare states: for example, in Bolivia the transformation was led by an indigenous movement with its own cosmology of harmonious relations between humans and nature[18] while in Venezuela it was led by the urban poor[14]. Another distinctive feature of Latin American intersectoral policies is their emphasis on direct democracy and community control of programs. The Barrio Adentro primary health care program in Venezuela is overseen by community councils and operates in conjunction with a number of social programs including education, pharmacy, food, employment, sports, among others[19]. These participatory intersectoral programs represent a come back to the 1970s public health equity oriented intersectoral developmental policies described by the World Health Organization (e.g., Cuba, Sri Lanka) and that had been replaced by human capital oriented policies in the 1980s[20]. Recently, a number of Arab countries such as Tunis, Egypt, Bahrain, Morocco, Syria, Yemen, have witnessed the emergence of political movements aimed at reaching greater

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political and economic equality. Popular demands include elements of established welfare states such as increase in the state provision of social and public health services and regulation of labor markets[21], although the shape of these reformed states remains uncertain.

The endurance of class coalitions

Yet, in spite historical specificity, some commonalities also emerge, most notably the establishment of class alliances in the development of newly egalitarian-minded welfare state reforms, including publicly funded universal national health systems[17,22]. Thus, small farmers, rural and urban working class and urban middle classes configure the MAS movement in Bolivia[18], while the urban working class, allied with some elements of the middle class, is the backbone of the Bolivarian movement in Venezuela that supports the Bolivarian health care reform[14]. In Tunis, the pro-democracy movement that ousted Ben Ali was propelled by an alliance of labor unions and urban middle class youth[23] while in Egypt the labor movement, active since early 2000s joined urban middle classes to replace Mubarak's dictatorship with a more egalitarian regime[21].

Why we need realist global health theory

Surprisingly, the emerging field of global health would have none of that. Its approach could be divided into three "worlds of global health" research: the governance/civil society[24], the global risk factor epidemiology[25] and the Human Rights[26] approaches. Explaining the population health consequences of welfare state reforms, their regional characteristics, the intersectoral policies and political alliances that bring them about are all absent. Rather, focus seems to be "governance", a depoliticized area that deals with the process of government while ignoring power, "civic society", a term that skews social stratification and its underlying conflicts, and the private sector, the later treated as independent and bearing apparently no influence on government policies. Common to this approach is the aim at reforming the United Nations, creating or reforming existing UN institutions with global "civil society", "government" and "private sector" to meliorate global governance and public health. Yet such views of UN that ignore the power imbalances and conflicts between member nations (e.g., war resolutions, pharmaceutical policy, food security, water) are naïve. The mere creation of a new UN agency for global health governance is likely to reproduce existing power imbalances.

In the second view, that of traditional risk factor epidemiology, individual attributes such as education are related to health using many national surveys[25]. We know that persons with high credentials in many labor markets, a small proportion of the population, tend to enjoy better health than those whose credentials are less in demand, who earn lower wages and enjoy fewer benefits. But expecting that a high proportion of the population might obtain high credentials and their health enhancing consequences is unrealistic since no society can accommodate a large proportion of jobs requiring high education. And once their credentials became more common their labor market value would decrease anyway. Even more crucial, we know from Rose's seminal work that individual risk factors do not explain much variation in major causes of mortality across societies[27]. The answer is more likely to be provided by individual risk factors but in the economic, political and cultural structure of societies[27].

The third approach to global health is that of the Human Rights (although human rights also appear as moral background of other approaches) and Non Governmental Organization (NGOs)[28]. Here the efforts are typically partial and cannot substitute for national public health systems (e.g., Haiti as an extreme modern colonial case). NGOs are mostly accountable to donors and outside the democratic control of the populations they serve[29]. Even when useful and well meaning, they risk reinforcing the inequalities between donor and recipient countries (e.g., championing the moral superiority of "good doctors" and the wealthy country institutions they represent).

Conclusion

In the last two decades, new attempts at building equitable welfare states, including public health systems, have begun in medium and low income countries, most notably in Latin America and, more recently, in the Arab world. These should be met with realistic global health models that deal with the imbalances of power in the world system between rich and low and middle income countries, as well as with the class dynamics that bring about change or lack thereof at the national and international levels[30]. Current approaches to global health seem vested in ignoring international and class conflicts to the detriment of the field of global public health.

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