

# ST.GALLEN SYMPOSIUM

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## THOUGHT PROVOKING IDEAS OF THE GLOBAL ESSAY COMPETITION 2022

### Health equity in an intergenerational contract

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“But tell me, this physician of whom you were just speaking, is he a money-maker, an earner of fees or a healer of the sick?” (Plato & Bloom, 1968). Ahead of his time, Plato points to a tension between the right to health and the commodification of healthcare. For most of the world's population, universal health coverage (UHC) defined as where “all individuals and communities receive the health services they need without suffering financial hardship” (WHO, 2021) is a chimera far from being realized. In 2021, more than 150 million individuals in 44 million households were pushed into poverty as a result of catastrophic health expenditure (ibid). Given that poor health is a major determinant of poverty by limiting individual freedoms and capabilities, reducing this statistic is of vital importance in global efforts to eradicate poverty and improve livelihoods. In what is likely to become a pandemic era, there is a moral duty to ensure people who fall ill should not have to choose between poverty or death. It is to this end that I believe health equity should be written into a new intergenerational contract.

Only when we value people over profit will we progress towards intergenerational justice in access to healthcare.

According to the World Bank and World Health Organization 2021 estimates, 70 million people were pushed into extreme poverty, 435 million people were pushed further into poverty and at least 1.4 billion people incurred financial hardship, all as a result of out-of-pocket (OOP) health expenditure. OOP health expenditure is defined as any payment incurred by a household when a member of the household must pay for a health treatment. When the OOP expenditure exceeds 10% of a household's total income or budget, it is categorized as a catastrophic health expenditure. Universal Health Coverage (UHC) can limit these incidences by ensuring the availability of financial protection services such as insurance schemes or general taxation systems designed to protect all members of a population. Yet, many countries including the US and most low-and-middle income countries are a long way from achieving UHC. This leaves millions of people around the world vulnerable to financial catastrophe and subsequent poverty.

Breaking this cycle of intergenerational poverty through catastrophic health expenditure relies upon a normative shift in conceptions of justice and what is fair in health systems.

Countries such as Germany, Canada, Sweden and New Zealand each have UHC, but this has been achieved through their own idiosyncratic financing mechanisms (Silberhorn, 2015). As such, we lack a universally applicable blueprint for UHC as its implementation is contingent upon the context of each country. The difficulty in achieving UHC is frequently attributed to limited resources and logistical challenges. While this can be true in some cases, I will evidence how in others, it is a lack of political will and administrative integrity that pose as bigger barriers to health equity. This is not to imply that real practical challenges do not exist in the implementation of UHC, or that its implementation rests strictly on a change in discourse. Rather, I aim to give greater credence to the normative underpinning of equity in health systems following the line of reasoning that the ideational and the material are highly interconnected and to a significant extent, mutually reinforcing. This implies that when health equity as a norm is advanced in an intergenerational contract, that it will be complimented by shifts in health policy in the direction of increasing access to healthcare for vulnerable populations. Though UHC is addressed at a national level, health equity in an intergenerational contract should similarly pose as a framework for tackling the uneven political economy of pharmaceuticals on a global level as well.

Neoliberal governmentality in the 80s institutionalized the commodification of healthcare by big pharma that we presently witness. I believe that the commodification of healthcare in practice is a result of the institutionalization of norms of profit-seeking in neoliberal ideology. This prescriptive, economized, state-centric mentality governed the way development was executed in policy and practice.

Its failures were recognized by Amartya Sen and others who advocated for the inclusion of human development through health and education, beyond economic growth (1999). This paradigm shift in development practice thus started with a normative shift at the start of the century and was practically complimented by being institutionalized in the Human Development Index. To this end, a new intergenerational contract requires a normative shift to health equity in access to healthcare for there to be an actionable equivalent in health and development policy. This is largely discursive and relies on a discourse shift that emphasizes mutual care, accountability and prioritizing human lives over profit.

Thus, the first tenet of a new intergenerational contract on health equity needs to prioritize mutual care for one another. In our increasingly interconnected world, there is a moral responsibility we each have, to care for one another (Davies, 2012). Consider how the climate change movement gained momentum in recent decades through narratives that centre around interconnectedness, universality, and the mutual risk that a dying planet poses to us all. Similar discourses should be propagated around health equity, as poor health is a global concern in the context of globalization which increases the risk of pandemics. However, speaking about health equity in this way comes with the risk of only prioritizing communicable, infectious diseases, to the detriment of those non-communicable diseases such as cancer or diabetes that do not have pandemic potential (Davies, 2010). A new intergenerational contract should therefore emphasize efforts to ensure equity as moral duties done in the name of justice and care for other human lives, rather than due to shared risk, as this may divert attention from non-communicable diseases which do not infect others.

Michael Marmot introduced the concept of social determinants in global health discourse (2006). By this he refers to broader, non-health related factors which impact health in a less direct way. For instance, carbon emissions may release harmful toxins into the air which can cause lung disease, making corporations significant actors in global health. Social determinants need to be more strongly incorporated into global health discourse and more ostensible in an intergenerational contract to counter how frequently individuals are blamed for their poor health outcomes. Since obesity, diabetes and high-blood pressure for some examples, are all acquired diseases and often a result of poor lifestyles, they are misconstrued as self-inflicted. A common contention against UHC is that people face these illnesses because they choose to eat unhealthily and live sedentary lifestyles, and to provide free healthcare to all can present a free-rider problem and further encourage these lifestyle choices.

A new intergenerational contract needs to shift away from this victim-blaming discourse and adopt a social determinants lens to understand the causes behind people's choices. For instance, people may eat unhealthily because they do not earn above minimum wage and healthier alternatives are more expensive. Or unhealthy fast foods are easier to access and closer to people's homes. In the same vein, people may not exercise because they live in unsafe neighbourhoods and cannot do so after working hours. Or people live sedentary lifestyles because their jobs are computer-based. To what extent then, can we blame individuals for their poor health outcomes without considering the broader structures of poverty which limit their agency over particular aspects of their lives.

The second tenet of a new intergenerational contract on health equity needs to stress accountability. A frequent counterargument to health equity approaches is the resource constraint argument (Krennerich, 2017). Many states, the argument goes, lack the logistical structures necessary for an equitable health system that can uphold UHC. It is certainly true that there are many poor countries in the world that are resource deprived and lack funds for a strengthened health system that can uphold UHC. However, there are also countries that either a) have the funds but mismanage them b) have the funds but choose not to allocate them into health equity efforts or c) have the funds but claim not to. This is not merely my suspicion but is manifested in the nearly 455 billion dollars lost to health corruption on an annual basis, making healthcare one of the most corrupt sectors globally (Hong, 2017; Vian and Crable, 2017). To this end, a new intergenerational contract must not simply accept the resource constraint argument without pushing for accountability and transparency in the allocation of funds to ensure there is truth to the claim. Governments must ensure accountability and transparency mechanisms are available on every level of health service delivery. Receipt systems for instance, should be introduced to ensure the proper and precise monitoring of drugs through stringent record-keeping. Monitoring by the government needs to occur at regular intervals, and reprisals must be implemented when health practitioners fail to account for funds. If a new intergenerational contract advocates for these measures, it will give teeth to the movement for health equity as malpractice and corruption would not be overlooked the way they presently are today.

Finally, the last tenet of an intergenerational contract is an interrogation of the systems and structures that govern global health, particularly the pharmaceutical industry. Pharma oligopolies that restrict the entry of generics into the market to drive down prices should be held accountable as obstructing the realization of a human right to health. Patent extensions that last over 20 years and are continually renewed to protect exclusive ownership should be held accountable for obstructing the realization of a human right to health. Exortionately high prices for medical treatments so that those who are ill and poor opt for death or are further driven into poverty by catastrophic health expenditures should be held accountable for obstructing the realization of a human right to health. Ultimately, these mechanisms of inequity that are persistent in the global health architecture should not be complacently accepted as the way of the world, but challenged, reformed, and forcibly be made more equitable.

Yet to do so is often considered an overly ambitious ideal of revolution that cannot be practically implemented. However, the reality is that this narrative of impossibility is the biggest barrier to equity across various sectors. Take for instance the BLM movement which brought to light the systemic racism innate in the US justice system. For decades, black people felt hopeless against systemic racism that was simply considered a way of their world. But BLM was able to challenge this structural inequality having an impact on legislative levels. In this same vein, we need to hold confident and hold strong the belief that we as a generation of leaders of tomorrow can hold big pharma accountable for its prioritization of profit over people. Pogge's idea that the pharmaceutical industry has an obligation to limit or remove patents to increase accessibility of medication for the vulnerable should not be disregarded as an unattainable ideal but should be a norm that we press for until we witness its manifestation in legislation (2008).

We are not victim to these grand structures, and we must remember that we created them, so we can change them.

In conclusion, enhancing health equity in access to medicines for vulnerable populations is not a far-reached illusion. To believe it is, is to undermine the power of the leaders of tomorrow to press for change. Youth activists through social media discourses and normative shifts have already picked up the pen and started rewriting the new intergenerational contract. In the chapter on health systems, they must write into it a normative shift in our conception of justice. Firstly, the dialogue around victim-blaming needs to shift to one of social determinants so that we can understand the broader causes of disease and recognize that poor health is not always a choice. Secondly, governments must do their part to ensure regular monitoring and regulation systems on a national and local level to ensure health equity for their populations. Finally, as we have targeted corporations in the climate change movement, and legal systems in the BLM movement, we similarly need to tackle the inequitable underpinnings of the pharmaceutical industry which pose significant barriers to accessing medicine.

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