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The dominance of finance in healthcare: political action of unlimited capital in the 21st century

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Abstract *This article gives, first, a historical account of the action of capital in healthcare in contemporary Brazil and then introduces a debate on the dominance of finance ('financial dominance') in healthcare based on one case to examine: the hypertrophy of the structure for intermediation in private healthcare existing in Brazil, using the theses of José Carlos de Souza Braga as its principal reference. The article highlights the nebulous nature of what happens at the interface between the public and private elements of the Brazilian health system, and the limits inherent to the use of reductionary, or dichotomic, models to explain details and factors in this interaction.*

Key words *Public policy, Health policy, Socioeconomic factors*

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Introduction

The advent of the bourgeois revolutions in the central countries, and the addition of new industrial technologies to the process of capitalist accumulation on a global scale, have established a standard of intensive exploration of salaried human work, and of natural resources, for manufacture of merchandize on an unprecedented scale.

The contradictions intrinsic to the relationship between capital and work have, in modern societies, come to be mediated also by the social policies of states, which are wide-ranging, and directed to maintaining minimum levels of reproduction of the populations of workers, including the aspects of healthcare, social security and social assistance.

A feature of the second half of the twentieth century was a global expansion in the supply of industrial products, including those used as inputs for the provision of medical/hospital services. The new dimension acquired by the structure of the various health service systems, worldwide, made it possible for various transaction spaces to be incorporated into the process of sectorial capitalist accumulation, transforming the field of healthcare, itself, into a privileged locus of 'capital in action'[1].

The political and institutional arrangement established between the central countries in 1945 was, after a brief period of stability, marked by increase in the average wage of workers and reconstruction of the infrastructure that had been destroyed in the years of conflict, updated in the three last decades of the twentieth century. In Brazil, the post-war period was marked by an accelerated process of urbanization and industrialization, which brought to the poorer areas of the great cities social tensions related to the persistent inequalities of income that the population had historically suffered.

Neoliberalism, *globalization* and, more recently, *financialization* are new coinages, which began to be used by the press and academe to describe major lines of force which had a clearly regressive bias in relation to the income earned by work.

The new reality imposed on various populations now involves: forces that make work relations more precarious; structural unemployment; budget restrictions on social policies; increases in the levels of inequality of income[2]; and restrictions on people's ability to cross national frontiers. At the same time, the lowering of territorial barriers to transit of capital, potentialized by information processing technologies and the strengthening of organized economic groups as a global accumulation machine, with corporate strategies that are virtually immune to the traditional mechanisms of social control, are elements that have been consolidated as a 'new normal', which is present in the daily life of the people and governments of the twenty-first century.

The decline of the institutional mechanisms for containment of the socially regressive action of capital, including in relation to the State's social policies, runs side-by-side with an insufficiency of theoretical and conceptual elements adjusted to the fluidity and nebulosity associated with the new accumulation strategies developed under the present logic of 'financial dominance'.

This article takes as its starting point two fundamental arguments developed separately in the following sections, which seek, firstly, to reconstitute, in a historical perspective, although not an exhaustive one, the trajectory of 'capital in process' in contemporary Brazilian healthcare, and subsequently, to introduce the discussion on *financial dominance* in healthcare based on the specific case of the hypertrophy of the structure for private healthcare intermediation that exists in the country.

The concluding considerations highlight the nebulous nature of the phenomena at the interface between public and private articulation of the Brazilian health system and the inherent limits of the use of reductionist/dichotomic explanatory models in dealing with this subject area.

Healthcare as a *locus* for accumulation of capital

Industrial development in Brazil took place late, and has specific characteristics. The exhaustion of the first republican political cycle in 1930 marked the start of an acceleration of the process of industrialization/urbanization and the development of a modern State bureaucracy endowed with a stronger degree of centralization and a widened scope of activity.

In relation to the social policies for social security and healthcare for the expanding mass of urban workers, whether one establishes its starting point in the regulation of mutual saving institutions as from 1923[3], or in its later incorporation by the more centralized structure of the institutes, starting in the 1930s[4], it can be stated that, with the structural changes of the first half of the twentieth century, a new level was established in the relationship between capital and work, and

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healthcare became an important mediator in the resolution of this distributive conflict.

The pattern of peripheral introduction of Brazilian industrial production, colored by the persistence of the structure of exportation of primary products, and the advent of war in the 1930s and 1940s, limited, for a certain time, the overall supply of products and services to the urban populations, but as from 1945 an expansionist dynamic began to determine the configuration of more complex economic and political structures[5].

A detailed look at urban workers' healthcare reveals that the expenses on this area declined as a percentage of total spending by the social security system in the period after 1930, with the creation of the institutes, as Oliveira & Teixeira[3] and Cordeiro[6] have highlighted. In other words, the movement of incorporation, by the state, of the previously finely-spread-out private mutual assistance structures resulted in the consolidation of resources on a considerable scale, but their centralized management began to obey, in general, a strict actuarial vision, leaving expenses on healthcare in the background.

The political and economic viability of this distributive arrangement was guaranteed, for some time, by the *Estado Novo,* but as from 1945 a new configuration determined by the overall expansion of economic activity began to pressure for creation of stable purchasing demand for health products and services, based on the expanded mass of urban workers, establishing two vectors, pressing in opposite directions, incident upon healthcare expenses financed by the institutes. These were the precursors of the structural crisis which became more evident after 1964: on the one hand the historic budget restrictions on healthcare spending, and on the other, the thirst of capital seeking new niches for accumulation. The political solution made possible by the military government was to be provided through the route of privatization.

As from the 1950s there already was a large material base of hospital beds under private control. In 1962, according to Cordeiro[6], the first table of remuneration for medical services emerged, along with the first plan of classification of hospitals, prepared by the Social Security Institute Medical Council, a body that advised the National Social Security Department, serving as a basis for other rules which would subsequently regulate the provision of contracted medical services.

In general lines, the 10 years from 1956 to 1966, when the previous institutes were unified, saw movements that resulted in wider articulation between the State, healthcare service companies and industrial companies, under an increasing process of accumulation of capital in healthcare with higher growth rates than the rest of the economy. Thus, if with the establishment of a military government in 1964 this process assumed characteristics that were increasingly convergent with the interests of capital anchored in healthcare, the material bases on which this process would take place were already, largely, under the control of private interests since the previous period[1].

The bureaucracy of the institute of industrial employees commanded the process of unification of the social security system, arranging for the influence of unions to be purged from the political management of its funds, and expanding its interconnections with medical companies operating under contract working agreements.

A new direction for capital accumulation in healthcare opened with the conjugation of provision of low-complexity health services with the administrative activity of intermediation, which was made practicable by the *medical entrepreneurs,* which were de-capitalized at that time, by policies of financial and credit stimulus operated within the logic, practiced by the military government, of economic growth with concentration of income.

The segregation of the supply of healthcare packages by social/occupational type and the inclusion of demand for health plans in the corporate agendas of the main groups of workers of the dynamic centers of economic activity in the 1980s enshrined the models of intermediation practiced by the medical companies and raised their level of capital to the level of the commercial insurance companies originally linked to the financial sector.

The commercial interests of the insurers, and the denunciation of the recurring episodes of negation of cover by medical companies, came together to cause the creation, in the 1990s, of a hybrid space for transactions, that brought together in a single sector the traditional financial activity of sale of health insurance with the neophytes of healthcare intermediation, now capitalized and linked politically to the structure of government, the employer companies, and workers' unions.

The debate in the 1990s led to prognostications of a serious standoff between the interests of health plan/health insurance companies and those of wider organized sectors of society[7], and, given the more robust economic base of the in-

surance companies, expansion of their control over the sale of health plans and insurance, to the detriment of (i) medical cooperatives and (ii) group medicine organizations.

These prognostications were not in fact confirmed, but it is undeniable that the logic of *financial dominance* found expression in the corporate strategies of all the companies in the sector, whatever their nomenclature.

Financial dominance in healthcare

Financial dominance and *financialization* are concepts that have been used as an explanatory key for understanding of various phenomena, processes and achievement of wealth in contemporary capitalism, and also the growing centrality of financial operations in the process of global accumulation. They are, thus, expressions that refer to the relation of subordination of the group of society as a whole to a mechanism of dominance and control that operates through processes that are typically financial.

The thesis of financialization, according to Van der Zwan[8], gradually widened its scope of approaches in multiple disciplines, while moving from the periphery to the mainstream of the body of social sciences, and from the geographical limits of the central countries to the periphery of the global economic sphere.

One of the theoretical frameworks most used to talk about *financialization* is in the macroeconomic approach, and can be transcribed in few words in the generic definition currently used, formulated by Gerald Epstein[9]: *The growing role of financial motivation, of the financial markets, of financial agents and financial institutions in the functioning of domestic and international economics.*

Guttmann[10] refers to three fundamental aspects in the definition of financialization: (i) maximization of value to the stockholder as a norm in management of companies; (ii) breaking of the links between profits and investments; and (iii) a process of redistribution of income in which income from capital assumes greater weight than income from work (included for example interest, dividends and commissions).

The removal of barriers between financial compartments that were previously separated; the deregulation of the financial markets and the formation of an integrated, hierarchialized worldwide space, without any instances of regulation and control, marked by financial innovations and unified by its operators, with a highlight for institutional investors: according to Chesnais[11], these things form a group of decided changes normally associated with neoliberalism. More recently, the same author[12] has postulated that *capitalism has succeeded, up to a certain point, varying from one country to the other, in erecting forms of domination that result in work being subsumed, as a matter of fact, to finance.*

The developments arising from this group of changes for various aspects of economic activity has been accompanied by a debate on the position of non-financial entities (NFEs) in this process. There are authors who emphasize the interpretation that financialization has been imposed from the outside inward, *submitting* companies to itself, and *making them more fragile*[13] – which, they argue, would lead to the weakening of the real component of investment and of growth[14-16]. Others emphasize the *active* participation of NFEs in this process[17], through incorporation of financial activities into the list of activities comprising the *objective function* of their corporations. On this point, the transnational companies (TNCs) can be seen as economic categories *per se,* characteristic of this period, in which financial groups simultaneously assume productive, commercial and service activities[18] – a development which is materialized in the form of the *holding company* and in the use of various strategies for downsizing, increase of value, and growth, through mergers and acquisitions, outsourcing and operations in tax havens to avoid taxes.

The thesis of Braga[19] was the pioneering study on this area, arguing that *financial dominance* is a new systemic pattern of *definition* of wealth by means of the three-part mechanism currency/credit/property and a new pattern of *management* of wealth produced, using for this the financial macro structure comprising the principal central banks, the private financial system and the treasuries of the large industrial and commercial companies. Further, *financial dominance,* he argues, defines the forms of *realization* of this wealth through money and through the predominance of financial over operational assets in a growing number of countries and private economic agents.

Braga[20] criticizes the current use of the idea of financialization as if it were a *deformation* of capitalism, or a supposed barrier to the development of production and of industrial technical progress. At the limit, he says, this would lead to a dichotomic vision which separates, ideologically, *bad* capital, which is moved around the world of monetary and financial assets, and *good* capital, which relates to the world of production of

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merchandise using natural resources and salaried human work.

He also criticizes the emphasis that certain analysts of financialization attribute to the concept of *corporate governance* as if there was a sort of dictatorship of the investors-stockholders over the management of companies with the aim of giving predominance to increase in value of shares, to the detriment of management oriented by investment and by organizational and economic success in the context of production of merchandize conducted by the owner-manager of an industrial company. Here, once more, with variations, the reductionist dichotomy of financial versus productive capital may be present.

According to Braga[20], there are also the formulations that explain the global phenomenon of financialization as a direct consequence of the exhaustion of the capacity for productive accumulation in the central economies after the end of the *Fordist* regulatory environment and the collapse of the Bretton-Woods accord signed immediately after the Second World War. Such formulations appear to be frequently linked to proposals for reform of the present financial systems, as if either a return to the Keynesian standard established in the 1930s or a reduction of the size and the scope of the present financial institutions were possible.

Braga[20] situates the sense of financial dominance in today's capitalism in a perspective different from those that consider the predominance of finances as a matter of crisis or as a consequence of *dysfunctional* behavior of economic agents and their institutional mechanisms of control and regulation.

As a new *mode of being* of global wealth and of *capital in process,* financialization involved at the same the major productive corporations and the instances of regulation of the State. The financial power of the major global corporations handles money and the quasi-currency, both in industrial circulation and in financial circulation, which become highly connected domains, in contrast to the previous pattern of wealth in which industrial circulation was restricted to industrial companies, and financial to the banks. Braga[20] argues that through the financial macro structure there is an interaction of money and assets between both circulations.

Financialization, thus, is, according to this author, part of the global movements of *property interdependence* between the most significant economic agents of all the sectors and not only a reversible articulation of commerce and credit as it was previously. At the same time, Braga[20] identified, in this new scenario, the capture of the finances of the National States through financialization of the public debt which, in this way, sanctions private financial gains and expands the general process of *financial dominance* over society as a whole. The significance of the concept of *financial dominance* here is not to be confused with the concept of privatization or of marketization. Although in some specific cases privatization and marketization are a prerequisite for the development of new strategies of financialized accumulation, in other cases it is the subsistence of the public institutional structure that will sanction *financial dominance* in various aspects of social life.

The place of mediation in the relationships between capital and work occupied by healthcare in the industrial societies, and the potential for universalization of the healthcare processes, taken as a privileged locus of accumulation, confer importance and strategic value upon empirical analysis of specific cases of financialization situated at the limits of the health system.

In Brazil, in spite of the general progress in distribution of healthcare resources achieved on the basis of the institutionalization of the Unified Health System (SUS), the process of private accumulation in healthcare, already well-established, has expanded and assumed new forms of convenience always based on the ideology of socio-occupational segmentation of demand and on the organization of supply according to the user's payment capacity.

The private commercial Schemes for healthcare intermediation and other modalities of segmentation reached, in 2012, the level of coverage of approximately 25% of the population[21], and in 2014 had discretionary control over approximately R$ 124.5 billion in funds coming from financial installments, an amount higher than that employed by Brazil's federal government for the public system in the same period[22].

The principal structural change that took place in the period, though, was not the change of level of capitalization of the medical companies, but the incorporation, by the non-financial companies established in the sector, of the logic of financialized relationships determined by the manner of operating of capital in the twenty-first century.

Updated figures from empirical research on companies[23] reveal important aspects on the characteristics of the new configuration established in the field of healthcare: (i) movements

of entry and exit of global investment funds in equity holdings; (ii) public offerings of shares on stock exchanges; (iii) composition of multisector, multifunction and multinational holding companies; (iv) hypertrophy of the financial departments in non-financial companies; (v) establishment of multisector value chains, articulated in such a way as to ensure global positive results that cannot be reached by the inspection activity of government bodies; (vi) production of important financial results based on stable non-financial operational bases; (vii) growing political influence in the formulation of sector agendas and ad hoc legal frameworks; (viii) growing ideological influence of corporate think tanks financed by companies' funds.

In other words, when one looks at the specific case of the Brazilian scheme of healthcare intermediation one can see the incidence of various elements characteristic of *financial dominance* with potential for repercussions on the health system as a whole, imprinting a bias of increasing regressiveness on the modulation of the relationships between capital and work in the field of healthcare.

Final considerations: the challenge of approach to and treatment of the interface phenomena

The accumulation of critical knowledge on healthcare in the field of Collective Health is based on interdisciplinary approaches which assume, as a premise, the articulation of the political, economic and social dimensions in a dynamic process which has contradictions and historicity.

In spite of this, many of the descriptions and explanations available as from the end of the 1990s assume a reductionist bias that interrogates the scheme of intermediation of healthcare constituted by the companies as something strictly related to market phenomena without any direct relationship with the public sphere, with the externalities in health shared by the population or with conceptions of health and illness that are structural for the system[24].

Dichotomic analyses that divide the health system into two separated compartments, one *public,* and the other *private,* in which there would be included an effective *market* in the allocation of the best healthcare resources, do not help in understanding the collection of phenomena located at the extensive interface between public and private that is part of the day-to-day reality of healthcare.

Hence the importance of evoking the process of construction of concepts on public/private articulation in healthcare[25], and highlighting the subsistence of critical formulations in the interior of this group of themes, represented, to a great extent, by the field of Collective Health itself, as a space of practice and theoretical elaboration that has the potential to circumnavigate the totalizing dichotomy of 'public versus private'.

There are many dichotomies that simplify and homogenize the description of the reality which results, in general, in unidirectional causal models that are divided between separate compartments which have no articulation between them. *Public or private, financial capital or productive capital, SUS or health plans, government actions or private initiatives, entrepreneurs or doctors, finances or health* – these are connected examples that tend to gain space in a scenario that is instructed by a climate of applying a simplified reading.

Paradoxically, it is the premise that each one of the elements that are components of the great public/private dichotomy is qualitatively different, and thus cannot be homogenized, that makes it possible to establish a gradient of interface and to identify the hues that exist in the empirical reality. Put another way: In the analyses of health policies the categories *social, private and public* are indissociable[26], and apply to an extensive interface of phenomena of *articulation* where the institutional actions of governments determine and are determined by private agents in a two-way line of causality that needs to be considered in spite of the difficulties inherent in construction of data on sectorialized private companies.

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