

B1 | UNIVERSAL HEALTH COVERAGE: ONLY ABOUT FINANCIAL PROTECTION?

The struggle for health is partly about the struggle for decent healthcare and for functioning health systems that care for sick people and contribute to improving population health. There is much at stake in health system reform, and not just the provision of decent healthcare. The field is intensely contested among various parties (providers, suppliers, insurers and so on) who have a powerful economic interest in the outcomes of the debate. Such interest groups project a policy narrative that proposes ‘public interest’ logic to their preferred pathways while obscuring their vested interests. Getting a clear picture of the substantive policy issues and choices requires penetrating the fog and reinterpreting the rhetoric.

The pressures for health system reform arise in the systemic problems perceived by different players: community concerns about quality and access,



Image B1.1 Community mobilisation can shape health systems: Women in India demonstrate against privatisation of health services (Sulakshana Nandi)

the grievances of providers regarding conditions and remuneration, and corporate concerns about barriers to profitable engagement. These pressures are variously expressed through community mobilization, professional advocacy, research findings, corporate lobbying and bureaucratic task groups. Whether or not change takes place depends on the stability of existing structures and the feasibility of and support for available policy options.

Civil society sentiment and various forms of community mobilization are always part of the dynamic. Effective engagement by community activists involves clear-sighted analysis, a long-range vision for healthcare that can inform policy advocacy around specific opportunities for change, and movement-building in support of both the vision and the specific policy options.

‘Universal health coverage’ – *slogan de jour*

Universal health coverage (UHC) is the *slogan de jour* in global health systems policy but its meaning is highly contested. At one pole are those, including many World Bank economists, who use the term simply to refer to financial protection: out-of-pocket payment should not be a barrier to accessing services and families should not be impoverished by healthcare costs. According to this view UHC, understood as universal financial protection, can be achieved through different approaches to collecting and pooling funds and paying providers, including through competitive voluntary health insurance and private-sector healthcare delivery. Others, including many WHO officials, accept that financial protection is central to UHC but recognize that having regard to other policy objectives, including quality, equity, efficiency and prevention, adds to the case for tax-based funding, single payer systems, capped programme funding and effective clinical governance. The debate is clouded by politicians such as Margaret Chan, the (former) director-general of the WHO, who has been at pains to present a united front with the World Bank regarding UHC and to paper over the different assumptions about implementation.

Appreciating the different meanings and purposes of the slogan is critical to understanding the politics of the debate, promoting a vision of ‘health for all’ and mobilizing around specific policy initiatives.

Our purpose in this chapter is to explore the emergence of UHC. The chapter traces some of the political influences and pressures that are at play, defines key policy objectives that are at stake, reviews the evidence regarding how these objectives might be achieved in different settings and formulates political strategies for civil society engagement in the ongoing debates about UHC and health systems development more generally.

We start with an overview of the historical context in which ‘universal health coverage’ has emerged as the leading slogan in global health system policy debate. We then review the implications of a wider raft of policy objectives, beyond financial protection, for different healthcare financing models. We then

explore some perplexing features of the economic discourse of healthcare financing, focusing particularly on market framing, the commodification of the healthcare relationship, the metaphor of ‘purchasing’ and the ubiquitous ‘benefit package’. We then step back in terms of scale and locate the debates around healthcare financing within the context of economic globalization and the neoliberal project. Finally we review what is known about the dynamics of health systems development and how policy generalizations find their way into institutional structures on the ground. Our purpose in this final section is to contribute to discussion within civil society about how popular movements can drive healthcare reform.

The emergence of UHC

The history of global health system policy debates can be traced in terms of the salient themes and slogans that have characterized each period.

There is no clear slogan that can be associated with the early years of the WHO. Rather, there was a continuing tension between the advocates of ‘social medicine’ and those of ‘disease-specific programmes’, notably malaria, smallpox and polio. This was the period of the Cold War and the WHO Secretariat was closely scrutinized by the USA, the largest donor. The replacement of Brock Chisholm as director-general by Marcelino Gomes Candau in 1953 symbolizes the marginalization of the health system policy by specific disease-control programmes.

The WHO was pushed into paying closer attention to health systems during the 1970s, in part by the then Soviet Union wanting to demonstrate the benefits of its Semashko model (Litsios, 2002, pp. 709–32) and in part by the Christian Medical Commission advocating what was to become, through the 1978 Alma-Ata Conference, ‘primary healthcare’ (Litsios, 2004, pp. 1884–93). However, the global economy at the end of the 1970s was confronted by global stagflation, leading in the early 1980s to the debt crisis, with the emergence of ‘structural adjustment’ as a driver of health system policymaking (largely public-sector disinvestment). With the support of the Rockefeller Foundation, primary healthcare (PHC) morphed into ‘selective primary healthcare’ and under the newly appointed James Grant the United Nations International Children’s Emergency Fund (UNICEF) retreated to GOBI (growth monitoring, oral rehydration, breast feeding and immunization) (Cueto, 2004, pp. 1864–74). However, the 1980s are remembered more as ‘the lost decade’ rather than for selective primary healthcare.

In an attempt to re-legitimize structural adjustment, the World Bank produced the ‘Investing in Health’ report in 1993, which argued for stratified health insurance and private/voluntary healthcare delivery (The World Bank, 1993). The report pressed for a safety net for the poor, based on a minimal, tax-funded ‘benefits package’. This minimalist model included provisions for selected ‘cost effective’ ‘interventions’, including vaccination, insecticide-treated

bed nets and nutritional supplementation, but did not provide for the diagnosis and treatment of the millions suffering from AIDS/HIV. However, by the mid-1990s the benefits of anti-retroviral treatment for AIDS/HIV had been demonstrated and stoked the rights-based demand for access to treatment (Fee & Parry 2008, pp. 54–71) and the minimalist model of investing in health receded into history.

Gro Harlem Brundtland (director-general of the WHO, 1998–2003) sought to return the focus of global health policy to health systems with the ‘World Health Report 2000’. This report was strongly influenced by World Bank thinking and sought to establish a framework that naturalized the role of private providers and private health insurance in healthcare delivery. The report was accompanied by a league table of national health systems based on questionable concepts, methods and data. The report did not reflect well on either the WHO or its director-general.

The rise and rise of the treatment access movement (Robins, 2010, pp. 651–72) represented a setback for the neoliberal project. It was forced to address the demand to find the resources to ensure treatment access, and also to respond to the widespread delegitimation of the Trade-Related Aspects of Intellectual Property Rights (TRIPS) agreement (‘T Hoen, 2009) and the associated drive for trade liberalization (Smith, 2002, pp. 207–28). A striking reflection of this popular delegitimation was the adoption in December 2001 by the Ministerial Council of the World Trade Organization (WTO) of the Doha Declaration on the TRIPS Agreement and Public Health, which affirmed that ‘the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health’ and reaffirmed ‘the right of WTO Members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose’ (WTO Ministerial Council, 2001).

The need to shore up the legitimacy of the neoliberal regime was addressed with the Millennium Development Goals (MDGs), the greatly increased flow of resources and the flourish of new ‘global health initiatives’ (GHIs), led by the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM), Unites States President’s Emergency Plan for AIDS Relief (PEPFAR), GAVI, the Vaccine Alliance and Bill & Melinda Gates Foundation (BMGF) (Sanders, n.d.). (See Chapters D2 and D4.)

Within a few years into the new millennium the flaws of this regime were becoming evident: multiple top-down vertical initiatives increased the administrative burden on ministries of health, fragmented health systems in vertical silos and a brain drain from national health systems into those vertical silos. In response to these adverse consequences, a new slogan, ‘health systems strengthening’ (HSS), emerged. This was in part a recognition that weak health systems were a major barrier to the effective application of the increased flow of resources, but it also reflected a recognition of the fragmenting effect of vertical global programmes and the cost of coordination locally (High-Level

Taskforce on Innovative International Financing for Health Systems 2008; WHO, 2007).

When Margaret Chan took over the leadership of the WHO after the death of Lee Jong-Wook in May 2006, she announced a return to comprehensive primary healthcare (WHO, 2006), but over the next few years it became evident that her passion was not going to inspire a large-scale diversion of resources from the vertical programmes into PHC-inspired health systems strengthening and certainly not a return to Alma-Ata.

Meanwhile, a parallel movement for universal coverage was developing within the WHO. The WHO's Executive Board in April 2004 considered the report on 'Social Health Insurance' (WHO 2004a), which introduced the elements of healthcare financing (revenue collection, funds pooling, resource allocation/purchasing), noted the broad choice of tax-based versus social insurance-based revenue collection and then proceeded to explore the conditions for a social insurance approach to healthcare financing. The report was returned to the Executive Board in December 2004 with the same title 'Social Health Insurance' but substantially redrafted (WHO, 2004b). The focus was now on healthcare financing more generally and with the policy goal of universal health coverage much more prominent. Social health insurance was no longer presented as the preferred option.

The USA's response in the Executive Board was explosive.

"Dr Steiger (United States of America) said that he was disappointed with the deep-seated bias shown in WHO, including the Executive Board, against private enterprise. All proposals embodied a statist approach and reflected a presumption that the private sector's motives were questionable, on subjects such as infant formulas, pharmaceuticals and food. In the '3 by 5' initiative, for instance, there was little mention of the private sector or of the advantage that could be taken of the many non-state providers. The report regrettably reflected that bias. There was no comprehensive description of the full range of public and private options for comprehensive health insurance for all. The Secretariat, and the relevant documentation, ought to make clear the advantages of private providers, such as responsiveness to patients, flexibility, innovation and efficiency. Subsidies to purchase private insurance could achieve equity in a mixed system, and every government needed a reasonable overall regulatory regime. WHO should continue its work on the subject but propose a broader range of schemes and mixes that would expand coverage and minimize problems such as those mentioned by the previous speaker. The range should include the private and public systems, and blends of the two, depending on a country's political and economic realities, while striving for efficiency and sustainability". (WHO, 2005a)

The draft resolution prepared by the WHO Secretariat was substantially modified in response to the US tirade (and adopted as EB115.R13). When

the revised paper A58/20¹ and resolution were considered again at the World Health Assembly (WHO, 2005b) the US delegate was again insistent about competitive health financing and mixed service delivery.

“Mr Abdo (United States of America) endorsed the goal of comprehensive health insurance. All Member States would benefit from a robust discussion of how to strengthen health-care coverage. It would be useful for the Secretariat to provide a report on the various possibilities for achieving universal coverage, including market-based approaches. Member States and the Secretariat should give due consideration to the benefits of a private system that could focus direct government resources where they were most needed. Those benefits included individual choice, reduction in tax burdens, flexibility, innovation and efficiency. Subsidies to purchase private insurance could achieve equity in a private system. Further, government systems had several disadvantages: greater bureaucracy, higher taxation, long waiting times, rationing of care and less efficiency, thereby decreasing access to and quality of health care; they were also difficult to sustain in the face of growing demand, ageing populations and increasing costs. Countries required competitive financing and delivery systems that were responsive to health-care needs and made the most of advances in medical science and technology. Member States would therefore be best served by the provision of data on the broadest possible range of options, private and public systems and mixes of the two, that would expand coverage and minimize out-of-pocket payments while achieving efficiency, transparency and sustainability and be adaptable to meet their specific political, socioeconomic and health situation. The public and private sectors both had critical roles to play”. (Ibid.)

During the debate, Thailand, Kenya and the UK proposed significant changes to the draft resolution forwarded from the 115th Session of WHO Executive Board while the USA sought to change all references to universal health coverage to universal insurance coverage. In the end it was decided to adopt the resolution forwarded from the Executive Board with the addition of a paragraph about reviewing progress on implementation and all of the other issues raised at the 58th Session of World Health Assembly. The issue was scheduled for discussion the following year but when it was reviewed at the 59th Session of the WHA in May 2006 there was no discussion of any of the amendments! As a major donor to the WHO, the strength of the US position must have been somewhat intimidating for the WHO Secretariat.

It is not likely that the health financing experts at the WHO would have received any support from the World Bank, at this time, led as it was by Paul Wolfowitz (previously undersecretary for defence under George W. Bush). The prevailing attitude within the World Bank is reflected in two reports on private health insurance, both co-authored by Alexander Preker (Preker, Sheffler & Bassett, 2007; Preker, Zweifel & Schellekens, 2010). The 2010 report argues

for a strong emphasis on private voluntary health insurance so that “private means can make a significant contribution to public ends”.

“It is the poor and most vulnerable that are at greatest risk due to lack of protection against the impoverishing effects of illness. The research for this volume shows that, when properly designed and coupled with public subsidies, health insurance can contribute to the well-being of poor and middle-class households, not just the rich. And it can contribute to development goals such as improved access to health care, better financial protection against the cost of illness, and reduced social exclusion. Opponents vilify health insurance as an evil to be avoided at all cost. To them, health insurance leads to overconsumption of care, escalating costs—especially administrative costs—fraud and abuse, shunting of scarce resources away from the poor, cream skimming, adverse selection, moral hazard, and an inequitable health care system. Today many low- and middle-income countries are no longer listening to this dichotomized debate between vertical and horizontal approaches to health care. Instead, they are experimenting with new and innovative approaches to health care financing.

Health insurance is becoming a new paradigm for reaching the Millennium Development Goals (MDGs). They emphasize the need to combine several instruments to achieve three major development objectives in health care financing: 1) sustainable access to needed health care; 2) greater financial protection against the impoverishing cost of illness; and 3) reduction in social exclusion from organized health financing instruments. The use of insurance was recommended to pay for less frequent, higher-cost risks and subsidies to cover affordability for poorer patients to higher-frequency, lower-cost health problems”.

The World Bank and the major GHIs were subjected to a certain amount of prodding at this time through the High-Level Taskforce on Innovative International Financing for Health Systems² (September 2008 to May 2009), which was set up in response to concerns about the fragmenting impact of the vertical GHIs and their impact on the balance of healthcare spending.

“Development assistance for health (DAH) has more than doubled since 2000 and has played a major role in making these gains. However, without more effort to build stronger national health systems in the 49 poorest countries, each year half a million women will continue to die from preventable complications in pregnancy, a quarter of a million adults will die from HIV and up to 11 million unplanned pregnancies will occur. And if the current financial crisis persists, these numbers will be even worse. The World Bank estimates between 200,000 and 400,000 additional children may die every year—between 1.4 and 2.8 million before 2015. Progress is impeded by insufficient funding, poor use of resources, and fragmented and largely

unpredictable financing flows. Low-income countries currently spend only USD 25 per capita on health; of this USD 10 comes from out-of-pocket payments and only USD 6 from DAH. More than 50 per cent of DAH provided directly to countries is allocated to infectious diseases, while less than 20 per cent is invested in basic health-care services, nutrition and infrastructure". (High-Level Taskforce on Innovative International Financing for Health Systems, 2008)

The World Bank was further challenged in July 2012 with the appointment of Jim Yong Kim as its president, on the nomination of President Barack Obama. Kim's background in Partners in Health, a US non-governmental organization, was well known, as was his support for primary healthcare and a social-justice approach to health policy. In his speech to the World Health Assembly in May 2013 (WHO 2013), Jim Kim said:

"Thirty-five years ago, the Alma Ata Conference on Primary Health Care set powerful moral and philosophical foundations for our work. The Declaration of Alma Ata confirmed the inseparable connection between health and the effort to build prosperity with equity, what the Declaration's authors called 'development in the spirit of social justice.

The fragmentation of global health action has led to inefficiencies that many ministers here know all too well: parallel delivery structures; multiplication of monitoring systems and reporting demands; ministry officials who spend a quarter of their time managing requests from a parade of well-meaning international partners. This fragmentation is literally killing people. Together we must take action to fix it, now".

Notwithstanding his recognition of Alma-Ata, the main focus of Jim Kim's speech was on universal health coverage, which he clearly identified as including both financial protection and health systems strengthening. However, he made no reference to the challenges of integrating private finance and private providers in his vision of ensuring "that everyone in the world has access to affordable, quality health services in a generation".

Meanwhile Margaret Chan was also moving her rhetoric from her earlier celebration of primary healthcare to an increasing focus on universal health coverage. In her acceptance speech in November 2006 (WHO 2006) there were five mentions of PHC and one of universal access. In the following year, in the director-general's report to the World Health Assembly (WHO, 2007) there were six mentions of PHC and one each of universal coverage and universal access. Fast-forwarding to the director-general's report of May 2012 (WHO, 2012), there were three mentions of PHC, five mentions of universal coverage, two of universal health coverage and one of universal access.

PHC versus UHC While there is some overlap in terms of the policy specifics, the differences in emphasis between the PHC and UHC approaches are

significant. The Alma-Ata discourse involves a focus on building and supporting the primary healthcare sector and envisages a prominent role for community health workers and community involvement in planning, accountability and prevention. The PHC approach envisages primary healthcare practitioners working closely with their communities on the social and environmental determinants of health as well as in healthcare development. This implies a dominant role for public-sector providers because private-sector providers are demonstrably unable to realize the broader principles of PHC in their practice. By contrast, the UHC discourse (the WHO version) starts with a focus on financial protection and argues explicitly for public, single payer *financing* (not care). It includes a commitment to health systems strengthening and the importance of primary care but treads lightly around community involvement and the role of private providers.

Jeffrey Sachs (2012, pp 944–47) presented a cogent set of arguments for public-sector provision of primary healthcare in low-income countries. He cited, first, the incentives for private providers to inflate costs, second, the strong tendencies of private providers to congregate in wealthier communities and, third, the reasons of efficiency and governance. Sachs's position is complicated because he is a strong advocate for the 'minimum benefit package' model, based on specified cost-effective interventions. However, it is unrealistic to expect publicly owned and delivered primary healthcare to restrict its service delivery to such highly specified programmes. By contrast, the advocates of



Image B1.2 Health worker at a public facility in Namibia (Eric Miller)

health insurance claim that the ‘purchase’ of specified health services through a restricted publicly subsidized benefit package can focus public (and foreign) funding on the priority ‘interventions’ and poor communities. The corollary of this is that payment for all other services is entirely out of pocket, which fails the financial protection objective unless it is linked to voluntary health insurance that is quite inequitable.

In 2010 the WHO’s World Health Report focused on healthcare financing and universal health coverage, including a return to Resolution A58.33 from 2005. While the report is understandably cautious, it affirms some important principles: abolish user charges at the point of service; a small number of big pools, preferably a single national pool, is more equitable and sustainable than many different pools; equity, efficiency, quality and prevention in service delivery matter and are affected by resource allocation/purchasing mechanisms (in particular fee for service); effective governance is the key to improving efficiency and quality.

In July 2012 Jim Kim inherited a project at the World Bank, the Universal Health Coverage Series, which distinguishes very clearly the Bank’s approach to UHC from that of the WHO’s. The concluding report from the series was published in 2013. The astonishing thing about this report (Giedion, Alfonso & Díaz, 2013), indeed the whole project, was that it explicitly refrained from considering quality, equity or efficiency. In methodological terms the project sought to correlate funding arrangements in 22 countries (and one US state) with their ‘outcomes’, conceptualized as access, financial protection and health status. The authors acknowledged that “other relevant outcomes might also be analyzed, such as quality, equity, and efficiency. However, to keep the study manageable, we selected just three—access, financial protection, and health status—given their immediate relation to UHC and their importance.”

The assumption that health status is an appropriate indicator of universal health coverage is most unusual. While effective healthcare with universal access will contribute to population health gain, it is small compared with effective action on the wider social determinants of health. A focus on access and financial protection, without regard to quality, efficiency or equity, has the effect of discounting the importance of health system capacity and side-stepping the WHO’s arguments about single payer financing and strong health system governance.

Notwithstanding the flying rhetoric of Jim Kim at the WHA in 2013, it appears that the warm collaboration between the World Bank and WHO obscures some very significant differences in approach, exemplified by Preker’s enthusiastic defence of competitive voluntary health insurance and the decision of Giedion, Alfonso and Díaz to exclude quality, equity and efficiency from the scope of their study of ‘the impact of universal coverage’. Understanding the pragmatism behind this unholy alliance is absolutely necessary to participating strategically in healthcare financing debates and the politics of implementation.

From a financial protection perspective (preventing cost barriers to access and healthcare impoverishment) both tax-based financing and various insurance arrangements (including a subsidy for the poor) may be viewed as comparable strategies. However, in terms of equity they are not comparable: competitive health insurance markets provide different products for different income strata and offer different benefit packages according to ability to pay. Certainly they do not provide for equitable redistribution of resources through pooling across income levels.

The competitive health insurance market in the USA illustrates this particularly well. Insurance plans for low-income workers are more likely to have tight utilization control, high deductibles, primary care fund-holding, and restricted benefit packages, including restrictions on choice of providers. Plans for high-income earners are likely to have looser utilization controls, fee for service reimbursement and more generous benefit packages (Gabel, 1999, pp. 62–74; Hellander and Bhargava, 2012, pp. 161–75). WHO technical papers have repeatedly emphasized the need for a compulsory rather than voluntary approach to revenue generation and for a few large pools rather than many smaller pools (Kutzin, 2014).

Why and emphasis on public provision of care is important From a purely financial protection perspective, service delivery through public or private or mixed providers may be comparable. However, they have very different implications for quality, equity, efficiency (technical and allocative) and prevention (which makes the exclusion by Giedion Alfonso and Díazof quality, equity and efficiency from the World Bank's UHC Series all the more regrettable)³.

In the World Health Report of 2010, the WHO cites estimates of healthcare efficiency to the effect that up to 40 per cent of healthcare expenditure globally may be wasted. In a very useful background paper Chisholm and Evans (2010) summarize the sources of inefficiency (Table 1) and assemble the evidence for this estimate.

TABLE B1.1: Sources of inefficiency in healthcare provision

Healthcare workers	Inappropriate or costly staff mix
Medicines	Underuse and overpricing of generic drugs
Medicines	Irrational use of drugs
Medicines	Substandard or counterfeit drugs
Healthcare products	Overuse of procedures, investigations and equipment
Healthcare services	Suboptimal quality of care and medical error
Healthcare services	Inappropriate hospital size
Healthcare services	Inappropriate hospital admissions or length of stay
Health system leakages	Corruption and fraud

Source: Chisholm and Evans (2010)

Clearly, promoting efficiency in the management of funds and in service delivery is of critical importance to universal health coverage. In an open-ended competitive voluntary health insurance scheme there is a constant tension between premium levels and payments to providers and this can be extremely expensive to manage. In single pool, single payer systems (as in, among others, the UK, France, Italy, Canada and Australia) the cost of collection and disbursement is much less. Different modes of provider payment also have implications for efficiency. Although there are no specific modes of payment that create a perfect incentive environment for all types of service providers, efficiency can be promoted by adapting particular modes of payment for particular types of service and avoiding open-ended financing commitments. What are critical are: first, the information systems which monitor service delivery (Chaudhry et al., 2006, pp. 742–52); second, the management systems which constrain or redirect resource flows; and third, the capacity to innovate as needed (Sparkes Durán & Kutzin, 2017). An organized and accountable approach to all three requirements is more practicable with public-sector providers supported by single payer financing, in comparison with a much more arm's-length relationship between the financial stewards and private health insurance funds and private providers.

Allocative efficiency is also an important policy goal, incorporating the distribution of resources across geography, workforce, institutions, services and programmes. Resource flows should be directed to those regions, workforce categories, institutions and programmes where more outcomes can be achieved for the same investment. There is a range of tools for redistributing resource flows in a purchasing environment, including technology assessment, varying prices, capping programme expenditures, regulation and subsidy, but they require excellent information systems and can be difficult to manage. The hovering of private practitioners around wealthier communities is one of the most reliable (and understandable) findings in health systems research and represents an almost insurmountable problem for regulators. Government funders/regulators working with public sector providers also face challenges in promoting allocative efficiency but have significant advantages in terms of the capacity to effect such adjustments (Gao et al., 2011, pp. 655–63).

The same is true of quality and safety. Clearly, perverse incentives impacting on quality and safety can be identified in both public and private healthcare delivery. Arguments for the inherent advantages of different modes of provision tend to get bogged down in competing examples or high-level theorization of different incentive environments. A more useful approach may be to focus on the challenge of regulating for quality and safety. A useful paradigm for thinking through such regulatory challenges is the idea of 'clinical governance' (Hammond, 2010, pp. 1–12). Clinical governance is a complex multi-component endeavour that calls for good information systems, competent governance and management, and the deliberate cultivation of patient centredness and



Image B1.3 Health workers in Manila agitate against privatisation of a public hospital (M3M)

continuous improvement. The evidence relating different modes of provider payment to the effectiveness of clinical governance is scanty (Brand et al., 2012, pp. 483–94). However, the autonomy and privacy of private ambulatory practice (as compared with community health centre practice) certainly limits the scope for measurement, peer review, regulatory initiatives and appropriate professional development. Likewise, the commercial relationship between private hospitals and their visiting private practitioners militates against the kind of monitoring and stewardship that can be achieved in more hierarchically organized healthcare institutions.

Finally, consider prevention (encompassing individual services such as screening and vaccination, and community programmes such as young mothers' groups), action on environmental hazards and action on the wider social determinants of health (employment, education and infrastructure). The minimal benefit package does not include advocacy alongside communities and in the absence of a benefit most private practitioners regard such engagement as way beyond their remit. However, there are many contemporary examples (TWH and PHM, 2017) as well as iconic projects guided by the Alma-Ata Declaration (Newell, 1975), which have enabled clinicians to feed their experience and expertise into community action.

At this point in our discussion we can identify three questions that may guide the rest of our analysis. These are:

- What lies behind the World Bank's wilful exclusion of quality, efficiency, equity and prevention, from their analyses of healthcare financing?
- What sense can be made of the unholy alliance of the World Bank and WHO to proselytize their ideas about UHC?

How might community activists, including progressive practitioners and academics, engage in this snakepit?

The economistic mindset

We start with some reflections on the disabilities associated with the conventional economics paradigm in which every social problem, it would seem, must be framed in terms of market relations so that the tools of economics can be brought to bear on the discussion. In prevailing policy discussions of UHC, this framing is reflected in the commodification of 'service', the tortured metaphor of 'purchasing', and the construction of priority-setting purely in terms of technology assessment (and benefit packages).

The problems with the commodification of healthcare services are partly about the specification and standardization of the 'commodity', but more profoundly about the extraction of the act of service provision from the human relationships within which it takes place. Every service takes place between one or more clinicians and the patient and their family. The service that is to be included in the benefit package only makes sense in terms of the wants and needs of the patient (and family and community): diagnostic, prognostic, therapeutic, emotional and social. The first principle in redesigning healthcare for quality (Institute of Medicine, 2001) is that 'Care is based on continuing healing relationships'. To specify and price this service without regard to the clinical relationship discounts the values that make healthcare important. To contract with providers for the delivery of services that are divorced from the clinical relationship renders meaningless any provisions regarding accountability for outcomes. A marketplace in which providers compete to deliver specified services for specified prices in completely unspecified contexts is a weak mechanism for promoting efficient, quality healthcare.

The metaphor of purchasing (See also Box B1.1) invites further reflection on the economistic mindset. Neoliberal economists rail against 'big government' and the perversions of the 'principal-agent relationship'. In this context the principal is the citizen and the agent is the parliament/bureaucracy. The argument is that government is not sufficiently accountable to the citizen and pursues its own interests but that transforming government services into markets where services are commodified, priced and bought and sold (for example, vouchers for education) returns sovereignty to the principal (citizen). However, the purchasing metaphor, as applied to health insurance or the 'purchaser-provider split', involves a surrogate purchaser, be it the health insurance plan or the purchasing agency. In this case the accountability of the

agent (health insurer) to the principal (the patient) is weak. The neoliberal solution lies in a competitive market for health insurance so that consumer sovereignty can be restored through ‘choice’. The purchasing paradigm and the market template have no solutions to the continuing challenge of information asymmetry (regardless of who the purchaser is).

What is ignored by the purchasing metaphor (and practice) is the relationship (between patient and family with clinicians) and the context (including the judgement about the need for a particular programme of interventions and the care with which those interventions are carried out). Healthcare is co-produced, not just by patient/family and clinicians but also by the myriad of support functions and personnel. In accordance with the principle of ‘total quality management’, the outcomes of the clinical programme (efficiency as well as quality) depend on the whole system. The purchasing metaphor renders the periphery of this complex system invisible.

The economic mindset is nowhere more evident than in policy discussions of priority-setting, which is commonly constructed purely in terms of technology assessment: evaluating the cost-effectiveness of a diagnostic test or a drug or surgical procedure. The application of such findings will inform a decision about entitlement (including the ‘intervention’ in the benefit package) and about price setting (in terms of reimbursement). Priority-setting, structured around the benefit package, assumes health insurance-based financing. Technology assessment has an important role to play in shaping clinical practice, but not all resource allocation choices can be reduced to a ‘benefit package’ design. In the context of administered systems of healthcare, such as public-sector hospitals, resource allocation choices are made in the context of budgeting, and promoting allocative efficiency involves evaluating the prospective outcomes of different choices with respect to programme funding. This approach enables a much broader range of considerations in determining priorities.

The macroeconomic imperative

Debates over healthcare financing are embedded in wider tensions about the management of the global economy. The 1980s debt crisis (and the retreat from primary healthcare to GOBI) reflected a major change in the trajectory of the global economy, from the ‘long boom’, following the Second World War, to an era of slower growth but accelerated globalization and financialization. The assumptions underlying ‘investing in health’ were not about healthcare at all. They were about managing the instabilities and vulnerabilities of global capitalism in the 1990s and ensuring that the poor countries knew their place in that system. The MDGs and the associated flush of resources through the GHIs were as much about re-legitimizing economic globalization following Jubilee 2000, the Treatment Action Campaign and the Battle of Seattle, as they were about ‘development’.

Box B1.1 The drive for ‘Strategic Purchasing’

Strategic Purchasing’ (‘SP’) has been advocated as a healthcare financing measure which is central to improving health system performance and making progress towards universal health coverage (UHC). The World Health Report 2000 unveiled a full-section on ‘Strategic Purchasing’ used interchangeably with ‘active purchasing’. It argued for the move from ‘Passive Purchasing’ to ‘Active or Strategic Purchasing’. ‘Passive purchasing’ implies following a predetermined budget or simply paying bills when presented. ‘Strategic purchasing’ involves a continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom’ (WHO, 2000). The World Bank’s advocacy has been explicitly focused on contracting private sector for healthcare provisioning (World Bank, 2004).

It has been argued that just having more money for health will not ensure universal coverage, unless it is spent more efficiently – therefore, the call for health systems to seek greater ‘value for money’. ‘Selective Contracting’ is a central feature of ‘SP’ as a mean to improve efficiency. Providers – ‘public’ or ‘private’ are to be contracted based on who offer the best ‘value for money’ in terms of prices and quality. ‘SP’ is essentially seen as means to harnessing energies of the private sector for public health goals (Palmer, 2000).

The theoretical assumptions behind the concept of ‘SP’ are based on the logic of the market and assumes that ‘SP’ will lead to greater competition and greater choice for users by making the money follow the patient. It seeks to incentivise performance through ‘contracts’ and assumes that information systems can be created to allow the ‘Purchaser’ as well as the patients to pick the best amongst the ‘providers’ and to measure their results and quality. It argues for autonomy for ‘purchaser’ and ‘provider’ and thereby separation of these two roles (Mathauer, 2015). This is influenced by the ‘New Public Management’ discourse of the 1980s that asked governments to enter into contracts with their own hospitals, so as to use ‘contract’ as a mode of governance and fund allocation and to bring in efficiency by creating ‘internal markets’ (Lewis, 1996).

Much of the discourse on ‘SP’ shows public systems of provisioning in poor light and government directly providing services by allocating budgets is seen by the proponents of ‘SP’ as the central problem in efficient delivery of healthcare. Direct provision is judged to be inefficient and branded as ‘passive purchasing’, and it is proposed that it be replaced with ‘active or strategic purchasing’ through ‘selective contracting’ (Mathauer, 2015).

The transformation of NHS in England is an early example of ‘purchaser-provider split’, which followed the path of ‘marketisation’ which

in turn opened the gates of ‘privatisation’ of a large chunk of its health-care provisioning (Fillippon, 2016). Many countries with well-functioning health systems based on public provisioning, including the Scandinavian countries, introduced ‘internal markets’ by separating the purchaser and provider roles. Literature on their experience suggests that the promised gains in efficiency rarely happened and any gains were not attributable to marketization or contracting (Robinson, 2003). New Zealand introduced the ‘purchaser-provider split’ and after experience of a decade, decided to revert back (Cumming, 2016). The evidence from LMICs is limited and does not really show any significant successes of ‘SP’ in improving equity or quality.

References:

- Cumming J 2016, ‘Commissioning in New Zealand: learning from the past and present’. *Aust J Prim Health*. 2016;22(1):34-9. doi: 10.1071/PY15164.
- Filippon J et al. 2016, ‘Liberalizing” the English National Health Service: background and risks to healthcare entitlement’. *Cad Saude Publica*. 2016 Aug 29;32(8):e00034716. doi: 10.1590/0102-311X00034716.
- Lewis J 1996, ‘The Purchaser/Provider Split in Social Care: Is It Working?’ *Social Policy Administration*. Volume 30, Issue 1 March 1996 Pages 1–19 <http://onlinelibrary.wiley.com/doi/10.1111/j.1467-9515.1996.tb00478.x/full>
- Mathauer I 2015, ‘Setting the scene: Moving towards UHC through strategic purchasing of quality health care’, 29 June 2015, Department of Health Systems Governance and Financing, World Health Organization
- Palmer N 2000, ‘The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries’. *Bulletin of the World Health Organization*, 2000, 78 (6) 829
- Robinson M 2003, ‘The Australian Budgeting System: On the Cusp of Change’. Discussion Paper No. 165 December 2003. Queensland University of Technology, Australia. http://eprints.qut.edu.au/314/1/WP_Robinson_Cooperation.pdf
- WHO 2000, ‘World Health Report 2000’, WHO
- WHO n.d., ‘passive to active purchasing’ http://www.who.int/health_financing/topics/purchasing/passive-to-strategic-purchasing/en/
- World Bank 2004, ‘Health Financing for Poor People, Resource Mobilisation and Risk Sharing’ World Bank, 2004

The ascendancy of UHC was partly a response to the failures of narrow vertical disease-focused GHIs and the need for a more comprehensive approach to healthcare financing. However, UHC really took off following the global financial crisis in 2008 when continued liberalization of trade, increasing economic integration and the runaway financialization of the global economy were being widely questioned. Again the dance of legitimation is a useful trope: the legitimacy of the global regime came into question and hence the need to address the more egregious criticisms of that regime.

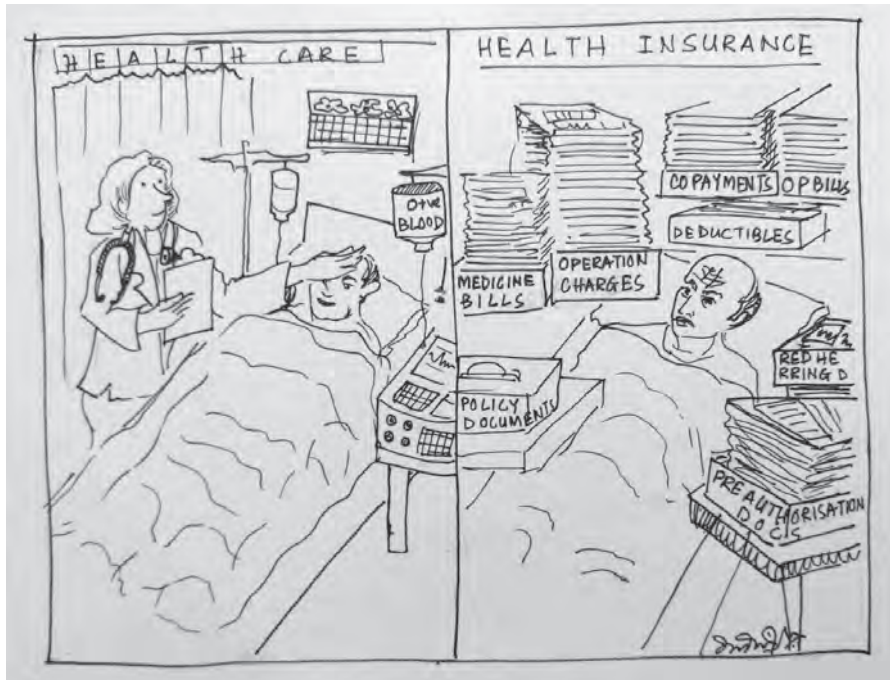


Image B1.4 An economic mind-set promotes health insurance (IndranilMukhopadhyay)

This background is crucial to understanding the gulf between the recommendations of the WHO's healthcare financing experts and the economists of the World Bank, and the struggle of Margaret Chan and Jim Kim to establish the (apparent) unity of the WHO and the World Bank around the slogan of UHC and the focus on financial protection.

The global financial crisis reflected the looming overhang of global productive capacity over aggregate demand. For a decade global consumption had been supported by debt, and by China and Germany buying US bonds to prevent their own currencies from appreciating while keeping the US dollar strong and the US consumer buying. The economic policy priorities in the wake of the global financial crisis were to:

- refinance the banks through imposing austerity
- open new markets for private investment (including healthcare and health insurance markets)
- contain taxation so as to reduce the corporate tax burden (and release resources for shareholder dividends) and force governments to create space for the privatization
- render inequality acceptable by providing safety nets for the poor (rather than adopting policies that would reverse widening inequality)

- encourage continuing expansion of trade in services (including trade in healthcare and health insurance).

The WHO's healthcare financing experts work within a culture that is preoccupied with improving population health and healthcare. They are not responsible for managing the world economy. The World Bank's experts on the other hand work within a culture that has to be seen to have answers in relation to healthcare (and other sectors) while playing its role in managing the global economy for the transnational capitalist class.

The differing mandates of the two bodies align perfectly with their respective approaches to UHC. The imperatives of institutional politics and leadership legacy underlie the logic of an apparent united front.

The pragmatics of global health governance

The saga of UHC provides a window on the dynamics of global governance in the present period. This is not merely of academic interest; it is of immediate and practical importance for activists who are struggling to achieve UHC within a 'right to health' framework.

The dynamics of global health governance can be described at different levels, from individuals, to institutions, to systemic forces.

The role of individuals and political parties is real but limited. The outstanding examples in this story were the election of Obama, the appointment of Jim Kim as president of the World Bank and subsequent appointments at the World Bank. It may be also that Margaret Chan's adoption of the UHC motif in part reflected an aspiration to leave behind her a recognizable legacy like Halfdan Mahler did with primary healthcare and Gro Harlem Brundtland with the Framework Convention on Tobacco Control.

The institutional level of analysis highlights further influences such as:

- the differing mandates and cultures of the two organizations, as discussed
- the dependence of the WHO on the large donors, including in particular the World Bank, BMGF and Rockefeller Foundation, the USA and Europe;
- the overt bullying by the USA directed towards containing the technical advice of WHO's healthcare financing experts
- the institutions and culture of conventional economics and their role in framing the health policy discourse
- political institutions at the national level, including ministries of finance and various elite formations.
- Beyond specific institutions are the large-scale political or systemic forces that are clearly at play in the saga of UHC. These include:
- the subprime mortgage collapse, including the bloated financial sector (which was its genesis), the cost of bailing out the banks and the resistance of the banks to effective regulation

- the demands of the transnational corporations (TNCs) for lower taxes and their power to extort tax concessions through the promise of investment, jobs and foreign currency
- the pressures for liberalizing trade in services: for example, from the financial sector for trade in financial services (including health insurance) and various middle-income countries who see increasing economic returns from trade in health services, including both medical tourism and remittances
- the dance of legitimation; the social movements and ideological industries that contend over the prevailing sentiment regarding the legitimacy of the global regime and the pressure for policy concessions as needed to assuage sagging perceptions
- the rise in xenophobia (and demagoguery) associated with economic stagnation and insecurity, a significant dampener on expressions of wider solidarity.

Activist strategies for healthcare reform need to drive change at all three levels.

How health systems develop

The final feature of the UHC discourse that needs to be highlighted is the mechanistic and top-down understanding of policy implementation that permeates the technical literature. This was particularly well reflected in the World Health Report in 2010, which frames the ‘agenda for action’ in terms of a crude version of the ‘policy cycle’ (assessment, strategy development, implementation, evaluation and so on).

Whether they are based in Washington or Geneva, policy experts providing technical advice to governments see themselves as dissociated from the ebbs and flows of institutional stability within their client countries. Indeed, if you are providing advice to whole categories of countries it seems to make sense to subsume the barriers of the real world into the processes of ‘assess’,



Image B1.5 Different interpretations of UHC (IndranilMukhopadhyay)

‘strategize’ and ‘implement’, rather than acknowledge the different political realities with which advocates for reform must deal.

An alternative narrative of health systems development might focus more on the incremental nature of the development and the ways in which episodes of incremental reform are dispersed across time and across different parts of the system. As particular institutional domains unfreeze, often quite unpredictably, and new ‘windows of opportunity’ open, localized reforms can be effected if the perceived problems, the circulating policy options and the political winds are aligned (Kingdon, 1984).

The concept of incremental health systems development, with dispersed reform initiatives determined by opportunity, practicable policies and sufficient consensus, raises questions about coherence across this sequence of dispersed policy reforms. Certainly, examples are common of incoherent health systems development where particular reform initiatives are determined only by localized political pragmatism. What can give coherence to a sequence of reforms is a common vision of ‘the health system we want’. In this case policy formation and political consensus are shaped by a shared vision that across space and time gives a degree of coherence to the accumulation of more specific initiatives.

Constructing the processes of health system reform as a sequence of dispersed opportunities for incremental reform has important implications for activists. It can be difficult to predict when or where windows of opportunity for health system reform will open. For this reason there is a strong case for working on a whole-of-system basis to project a whole-of-system vision and create a policy environment that is conducive to strategic health system reform. This strategy assumes that no matter where or when the opportunities arise, appropriate policy ideas for this sector will be circulating; the various constituencies will be ready to support change; and there will be a broadly shared vision in place that will help to align the various dispersed reform initiatives.

Notes

1 See http://apps.who.int/gb/archive/pdf_files/WHA58/A58_20-en.pdf

2 See <https://www.internationalhealthpartnership.net/en/about-ihp/past-ihp-meetings/high-level-taskforce-for-innovative-international-financing-of-health-systems/>

3 By way of contrast see Morgan, Ensor & Waters (2016, pp. 606–12).

J U & Cameron, PA2012, ‘A review of hospital characteristics associated with improved performance’, *International Journal for Quality in Health Care*, vol. 24, no. 5, pp. 483–94, DOI10.1093/intqhc/mzso44.

Chaudhry, B, Wang, J, Wu, S, Maglione, M, Mojica, W, Roth, E, Morton, S C & Shekelle, PG2006, ‘Systematic review: impact of health information technology on quality, efficiency, and costs of medical care’, *Annals of Internal Medicine*, vol. 144, no. 10, pp. 742–52, DOI10.7326/0003-4819-144-10-200605160-00125.

References

Brand, C A, Barker, A L, Morello, RT, Vitale, MR, Evans, S M, Scott, I A, Stoelwinder,

- Chisholm, D & Evans, DB 2010, *Improving health system efficiency as a means of moving towards universal coverage*, World health report background paper 28, World Health Organization.
- Cueto, M 2004, 'The origins of primary health care and selective primary health care', *American Journal of Public Health*, vol. 94, no. 11, pp. 1864–74.
- Fee, E & Parry, M 2008, 'Jonathan Mann, HIV/AIDS, and human rights', *Journal of Public Health Policy*, vol. 29, pp. 54–71, DOI10.1057/palgrave.jphp.3200160.
- Gabel, JR 1999, 'Job-based health insurance, 1977–1998: the accidental system under scrutiny', *Health Affairs*, vol. 18, no. 6, pp. 62–74, DOI10.1377/hlthaff.18.6.62.
- Gao, J, Moran, E Almenoff, P L, Render, M L, Campbell, J & Jha, AK 2011, 'Variations in efficiency and the relationship to quality of care in the veterans health system', *Health Affairs*, vol. 30, no. 4, pp. 655–63, DOI10.1377/hlthaff.2010.0435.
- Giedion, U, Alfonso, E A, & Díaz, Y 2013, *The impact of universal coverage schemes in the developing world: a review of the existing evidence*, Washington, DC.
- Hammond, S 2010, 'Clinical governance and patient safety: an overview', in Haxby, E, Hunter, D & Jaggar, S (eds), *An Introduction to clinical governance and patient safety*, Oxford University Press, pp. 1–12.
- Hellander, I & Bhargava, R 2012, 'Report from the United States: the US health crisis deepens amid rising inequality – a review of data, fall 2011', *International Journal of Health Services*, vol. 42, no. 2, pp. 161–75, DOI10.2190/HS.42.2.a.
- High-Level Taskforce on Innovative International Financing for Health Systems 2008, *More money for health, and more health for the money*, https://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Results__Evidence/HAE_results__lessons/Taskforce_report_EN.2009.pdf
- Institute of Medicine (US) Committee on Quality of Health Care in America 2001, *Crossing the quality chasm: a new health system for the 21st century*, National Academies Press, Washington, DC.
- Kingdon, JW 1984, *Agendas, alternatives, and public policies*, University of Michigan, Boston.
- Kutzin, J 2014, *Health financing for UHC: why the path runs through the finance ministry and PFM rules*, paper presented at the Fiscal Space, Public Finance And Health Financing, Montreux, http://www.who.int/health_financing/events/1_kutzin_dis1_hf_for_uhc_fiscal_pfm.pdf?ua=1
- Litsios, S 2002, 'The long and difficult road to Alma-Ata: a personal reflection', *International Journal of Health Services*, vol. 32, no. 4, pp. 709–32, <https://doi.org/10.2190/RP8C-L5UB-4RAF-NRH2>
- Litsios, S 2004, 'The Christian Medical Commission and the development of the World Health Organization's primary health care approach', *American Journal of Public Health*, vol. 11, pp. 1884–93, <http://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.94.11.1884>
- Morgan, R, Ensor, T & Waters, H 2016, 'Performance of private sector health care: implications for universal health coverage', *The Lancet*, vol. 388, no. 10044, pp. 606–12, [http://dx.doi.org/10.1016/S0140-6736\(16\)00343-3](http://dx.doi.org/10.1016/S0140-6736(16)00343-3)
- Newell, K W (ed.) 1975, *Health by the people*, WHO, Geneva.
- Preker, A S, Sheffler, R M, & Bassett, MC 2007, *Private voluntary health insurance in development: friend or foe?* <http://hdl.handle.net/10986/6641>
- Preker, A S, Zweifel, P & Schellekens, OP 2010, *Global marketplace for private health insurance: strength in numbers*, The World Bank, Washington, DC.
- Robins, S 2010, "'Long live Zackie, long live": AIDS activism, science and citizenship after apartheid', *Journal of Southern African Studies*, vol. 3, pp. 651–72, DOI10.1080/0305707042000254146.
- Sachs, JD 2012, 'Achieving universal health coverage in low-income settings', *The Lancet*, vol. 380, no. 9845, pp 944–47.
- Sanders, Dn.d., *Global health initiatives: context, challenges and opportunities, with particular reference to Africa*, WHO Collaborating Centre for Research and Training in Human Resources for Health http://www.who.int/healthsystems/reference_Africa.pdf
- Smith, J 2002, 'Globalizing resistance: the Battle of Seattle and the future of social movements', in Smith, J & Johnston, H (eds.), *Globalization and resistance: transnational*

- dimensions of social movements*, Rowman & Littlefield, Lanham and Oxford, pp. 207–28.
- Sparkes, S, Durán, A, & Kutzin, J 2017, *A system-wide approach to analysing efficiency across health programmes*, http://www.who.int/health_financing/documents/system-wide-approach/en/
- *T Hoen, E F M 2009, *The global politics of pharmaceutical monopoly power, drug patents, access, innovation and the application of the WTO Doha Declaration on TRIPS and Public Health*, AMB Publishers, Diemen.
- The World Bank 1993, *World development report: investing in health*, The World Bank, Washington, DC.
- TWHA & PHM 2017, *Manual 'building a movement' – case studies*, <https://twha.be/manual-building-movement-case-studies>
- WHO 2004a, *Social health insurance, report by the secretariat*, 29 April, http://apps.who.int/gb/archive/pdf_files/EB114/B114_16-en.pdf
- WHO 2004b, *Social health insurance, report by the secretariat*, 2 December, http://apps.who.int/gb/ebwha/pdf_files/EB115/B115_8-en.pdf
- WHO 2005a, *Executive Board 115th session, summary records*, 17–24 January, http://apps.who.int/gb/ebwha/pdf_files/EB115/B115_REC2-en.pdf#page=91.
- WHO 2005b, Fifty-eighth World Health Assembly, summary records of committees, reports of committees, 16–25 May, Geneva, http://apps.who.int/gb/ebwha/pdf_files/WHA58-REC3/A58_REC3-en.pdf#page=193
- WHO 2006, *Dr Margaret Chan director-general elect speech to the first special session of the World Health Assembly*, 9 November, http://apps.who.int/gb/archive/pdf_files/WHASSA1/ssa1_div6-en.pdf.
- WHO 2007, *Address by Dr Margaret Chan, director-general to the sixtieth World Health Assembly*, 15 May, http://apps.who.int/gb/archive/pdf_files/WHA60/A60_3-en.pdf
- WHO 2012, *Address by Dr Margaret Chan, director-general, to the sixty-fifth World Health Assembly*, 21 May, http://apps.who.int/gb/ebwha/pdf_files/WHA65/A65_3-en.pdf
- WHO 2013, *Sixty-sixth World Health Assembly*, 19 July, http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_DIV4-en.pdf
- WTO Ministerial Council 2001, *Doha declaration on the TRIPS Agreement and Public Health*, https://www.wto.org/english/thewto_e/minist_e/mino1_e/mindecl_trips_e.htm