Universal health coverage: a case study of the political economy of global health

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2021-09-25

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1. Introduction

This chapter is prepared as a contribution to the struggle for 'Health for All', including for equitable and efficient health care financing and for health systems which are accessible, efficient, and deliver high quality care and prevention.

The chapter focuses on one of the most prominent slogans in recent global health policy debates, Universal Health Coverage or UHC. But it is more than a slogan. It is also a policy narrative, a global conversation, and a social movement (albeit largely populated by health economists, global health academics and think tanks, global philanthropies, and transnational corporations).

The outcomes promised by the slogan - access to essential health care and protection from catastrophic health care costs – are reasonably well defined and widely endorsed (UN General Assembly 2019).

However, consideration of the implementation pathways and policy models which figure in the policy narrative reveals unacknowledged contradictions and silences which cast doubt on the promises of access and financial protection. They point instead to the irreversible installation of privatised, multi-tiered health care. A policy conversation which started out addressing whole-of-health-system financing has been deformed into a policy model for a safety net while making space for marketisation and privatisation of health care generally.

1. The advice, support and encouragement of Tuba Agartan in the development of this paper is greatly appreciated.

The UHC conversation takes place at the intersection of technical health policy development and the wider forces of political economy. Participating in the policy conversation and engaging in the politics around UHC involve evaluating the evidence and arguments regarding implementation pathways as well as mapping the political forces and interests shaping the policy narrative. Technical policy analysis must be complemented with a political economy analysis.

Overview

The chapter commences with a brief review of the outcomes and metrics which define UHC, followed by a history of the UHC conversation including some of the main players participating in this conversation.

I then trace implementation scenarios and highlight some critical contradictions and silences in the prevailing policy narrative. These suggest that UHC provides for no more than a safety net while making space for marketisation of health care generally. These conclusions point towards the need to explore the political economy of UHC as well as the more restricted technical policy analysis.

The framework I deploy to examine the political economy of UHC centres on the *points of articulation* between global health and the political economy of global capitalism. My purpose is to identify the *dynamics of stability and change* at these points of articulation. These dynamics involve the entanglement of interests, the discourses of evidence and ideology; and the deployment of power.

This political economy analysis makes sense of the contradictions and silences revealed in the policy analysis of implementation scenarios. Low and middle income countries are a significant market for transnational health care supply industries, in particular, pharma and electronics. In the context of a global crisis of overproduction, the health care markets of L&MICs offer much needed virgin territory for expansion.

Finally, I reflect upon the strategic implications of this analysis for Health for All activism and draw out broad directions for activist engagement around UHC and the pursuit of 'Health for All' more generally.

2. UHC: definitions and metrics

Definition

UHC is included in the UN's Sustainable Development Goals (SDGs) as Goal 3.8, "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (UN DESA Statistical Division 2017). (In 2015 WHO and the World Bank (2015) defined UHC in similar terms except that affordable access to medicines was not included. Since then both appear to have accepted the UN definition.)

Indicators and trends

Two broad indicators have been developed to follow the achievement of this goal. These indicators are used by the UN's Sustainable Development Agenda for monitoring Target 8 (UHC) of SDG Goal 3 (Good health and wellbeing). The indicators are also used by WHO for its UHC monitoring framework. The first indicator (3.8.1, 'Service coverage') is a measure of 'essential health services' coverage; the second indicator (3.8.2, 'Financial protection') measures the incidence of catastrophic health expenditure and health care impoverishment (WHO and World Bank 2017b).

SDG indicator 3.8.1, 'Coverage of essential health services', is a composite indicator based on tracer interventions including reproductive, maternal, newborn and child health; infectious diseases;

noncommunicable diseases; and service capacity and access (the 'UHC Service Coverage Index (SCI)', see Fig 1.1 from WHO (2019a)). It is designed to enable disaggregation by income decile. The SCI is a very basic indicator. A community could score well on this index and still have a level of service coverage well below public expectations in high and middle income countries. The SCI indicator is heavily biased towards interventions which are supported by large vertical disease focused 'development assistance' programs (in part because these have established indicators). The index does not measure 'of sufficient quality to be effective' for most of the elements of the index (see Table 1.1 of WHO & WB 2017, page 6). Astonishingly, service coverage for non-communicable disease is (for the time being) 'measured' by the prevalence of normal blood pressure and fasting blood sugar (based on household survey).

The UHC service coverage index (SCI) improved from 2000 to 2017 (from 45 to 66), but the pace of progress has slowed since 2010. The number of people with low SCI ratings is projected to increase between now and 2030. The improvements in service coverage for infectious disease were the main contributors to increases in the UHC SCI from 2000 to 2017.

There are wide differences in service coverage by household income for many of the separate indicators included in the SCI, differences which are obscured by the integration into a single index. 'Improved sanitation' varies from 20% to 90% by wealth deciles. Antenatal care coverage ranges from 40% to 80% from the poorest to the wealthiest deciles. (See WHO (2019a) for more detail.)

SDG indicator 3.8.2, 'Financial protection', is an estimate of the proportion of the population experiencing catastrophic household expenditures on health (expressed as a share of total household expenditure or income) in each year. This is commonly based on surveys seeking householder recall over the last month but then expressed as an annual incidence measure and expressed in terms of the proportion of the population whose household expenditure on health exceeds total household expenditure or income by either 10% or 25%. 'Health care impoverishment' refers to the number of people being pushed into poverty through health care expenditure. The criterion for *poverty* in measuring health care impoverishment can be against absolute poverty lines ($1.90 or $3.20 per day as) or a relative poverty line (based on 60% median per capita consumption for that country).

Most measures of financial protection (3.8.2) show a deterioration between 2000 and 2015 (WHO 2019a). A growing number of people and a growing share of the population incurred catastrophic health spending across this period. The incidence of health care impoverishment fell when measured against the absolute poverty lines of $1.90 or $3.20 per person per day but increased when measured against the relative poverty line. The higher the level of per capita health spending the higher the incidence of catastrophic health expenditure. (See Fig 2.6 in WHO (2019a) for more detail.) Catastrophic health spending and health care impoverishment are both higher in countries where out of pocket payment comprises a higher proportion of total health expenditures.

In six of eight countries in WHO's South-East Asia Region (WHO 2019a, p43) spending on medicines accounts for more than 75% of total out of pocket spending in households incurring any out of pocket spending. Poorer households spend disproportionately more on medicines as a share of their out-of-pocket spending. Data from WHO's European Region (WHO 2019a, p45) indicate that unmet need correlates with catastrophic health spending, particularly in countries where out of pocket payment constitutes a high proportion of total health expenditure.

3. History of UHC

In this section I trace the emergence of the term 'universal health coverage' in the context of international policy discussions regarding health care financing and service delivery. I sketch the evolution of the prevailing policy narrative regarding UHC and describe the phalanx of agencies and individuals who have come together to promote this narrative and who constitute the (self-described, top down) 'UHC movement'.

Health systems policy 1948-2005

Basic health services

WHO's commitment to UHC from 2005 needs to be seen in the context of WHO's work on health systems dating back to the 1950s. In the early years such work was packaged under the term 'basic health services'.

In 1953 the basic health services model included "maternal and child health, communicable disease control, environmental sanitation, maintenance of records for statistical purposes, health education of the public, public health nursing and medical care, the extent varying with the needs of the area and access to large hospitals". By 1965 it was defined as "a network of coordinated peripheral and intermediate health units with a central administration capable of performing effectively a selected group of functions essential to the health of an area, and assuring the availability of competent professional and auxiliary personnel to perform these functions" (WHO 2008b, p117).

The kinds of activities through which WHO promoted 'basic health services' during this period included expert committee reports, training fellowships and expert secondments. There was a strong focus on administration, public health protection and organisational relationships. (WHO is constitutionally required to wait until it is asked by member states for technical support regarding health system strengthening (International Health Conference 1946, Article 2(c)) and in the early years it needed to market itself as a source of such advice.) Meanwhile a range of vertical disease prevention programs such as malaria (and later smallpox) eradication were being given top billing.

WHO's tentative and conservative construction of 'basic health services' stands in contrast to the forward-looking ideas that had been advanced at the 1937 Bandung rural hygiene conference. This conference was organized by the League of Nations Health Organisation with the support of the Rockefeller Foundation and the participation of a number of colonised states (represented by colonial officials) from the South East Asia region. Participants in this conference highlighted the importance of intersectoral collaboration in a way that connects health to other key sectors such as agriculture, nutrition and education. They looked towards 'horizontal' health system strengthening highlighting the importance of community involvement in health development and the importance of non-medical health personnel (League of Nations Health Organisation 1937).

A report on the DingXian project in China (1932-37) was circulated for conference participants. This project, which had been supported by Rockefeller's John B Grant, pioneered community based health care with a strong multisectoral approach to population health (Chen and Bunge 1989).

The Cold War played a key role in circumscribing WHO's position on health systems in the 1950s; partly through the enthusiastic funding support given to malaria eradication and other vertical disease control programs; but also explicitly limiting the scope of WHO's involvement in health systems policy. In 1952 WHO and ILO collaborated on a report on the 'medical aspects of social security'. The report emphasized the need for many policies that would be anathema for rich country medical associations

but was enthusiastically endorsed by the Director-General, Dr Chisholm. These policies included: universal access; priority for the poor; integration of safety net provisions into general health services; opposition to means testing, user fees and fee for service medicine; and the use of 'lesser-trained "indigenous practitioners" in poorer countries. Conceding to strong opposition from the US delegate the Executive Board refused to endorse the report as WHO policy and both the ILO and the WHO were forcefully attacked by the American Medical Association, after which the "WHO's interest in such matters more or less collapsed" (Farley 2008, pp116-8)

With an influx of newly decolonized states into the Assembly in the 1960s WHO started, tentatively, to address the tensions between vertical disease control programs and more comprehensive health system strengthening. The UNICEF/WHO Joint Committee on Health Policy in 1965 urged UNICEF to give assistance to smallpox vaccination 'within the framework of basic health services' (Executive Board 1965).

By the mid 1970s the new director general (Dr Mahler, 1973-1978) was clearly aware that training for bureaucrats and technical policy advice was not achieving the health system reforms that were needed. He was also aware that there was readiness among the low and middle income countries to support more far-reaching reforms and that community mobilization around 'primary health care' might the key (Mahler 1978). Newell (1988) argues explicitly that the rise of PHC as a key WHO policy was a necessary response to the failure of malaria eradication.

Alma-Ata

In September 1978 UNICEF and WHO jointly convened the International Conference on Primary Health Care, hosted by the USSR in Alma-Ata, the capital of Kazakhstan. The back story to the conference has been well told by Litsios (2002, 2004). A complex range of factors contributed to producing the Declaration:

- The rolling progress of decolonization (Sá e Silva 2009);
- The establishment of the Groups of 77 (G77) in the UN General Assembly (1964);
- The election of Halfdan Mahler as Director General in 1973; impatient with WHO's caution in relation to health services development and its failure to progress the intersectoral approach to health development;
- The widening appreciation of the failure of the malaria eradication campaign and the limits to vertical disease control more generally;
- The "Declaration on the Establishment of a New International Economic Order", in the UN General Assembly's Sixth Special Session in May 1974 (Murphy 1984).
- Lobbying by the Christian Medical Commission, based on a number of inspiring case studies of primary health care in action (Newell 1975);
- The close relationship between Halfdan Mahler and Henry Labouisse (then head of UNICEF but shortly to be replaced by James P Grant, see below); and
- The lobbying of the USSR for a conference on primary health care (hoping to showcase the Soviet medical care system).

In WHA32.30 the Assembly endorsed the Declaration and in WHA34.36 WHO adopted the Global Strategy for Health for All by the Year 2000 (WHA 1981). The Global Strategy indicates the broad lines of action to be taken in the health sector to implement comprehensive PHC and specifies intersectoral activities that contribute to human and health development. With respect to user charges, financial barriers to access and medical impoverishment the strategy is silent. The Secretariat emphasised country leadership (WHO 1987) and in particular the role of ministries of health (WHO Expert Committee 1988).

Selective PHC

In April 1979, seven months after the Alma-Ata conference, a workshop on health and population in developing countries was held in Rockefeller's Bellagio conference centre, co-sponsored by the Ford and Rockefeller Foundations. In attendance were representatives of the World Bank, the US Agency for International Development, and the Canadian International Development and Research Center. The WHO DG attended albeit reluctantly. The keynote paper, authored by Julia Walsh and Kenneth Warren of the Rockefeller Foundation (1979), declared that the objective of health for all by the year 2000 was unattainable because of the unattainable because of the cost and numbers of trained personnel required. The selective primary health care agenda focused on a small number of specific low-cost technical interventions for addressing the needs of developing countries.

Under the leadership of James P Grant UNICEF picked up the selective approach, replacing its earlier commitment to comprehensive PHC with the "child survival revolution", centred on 'GOBI': growth monitoring, oral rehydration, breast feeding and immunisation (Werner and Sanders 1997). The previous Executive Director of UNICEF, Henry Labouisse, had worked closely with Mahler. His successor, James P Grant (from January 1980) was the son of the legendary John B Grant and also closely affiliated with the Rockefeller Foundation.

Kenneth Newell, whose 'Health by the people' had informed Alma-Ata described selective PHC initiative (1988) as a "counter-revolution":

> *The advocates of highly selected and specific health interventions plus the managerial processes to implement them have ignored, or put on one side, the ideas which are at the core of what could be described as the primary health care revolution. They are in this sense counter revolutionaries.*

Selective PHC was well suited to the new regime of 'structural adjustment'. This was the policy package required of highly indebted countries seeking IMF support in managing their debts. It included a range of economic and policy measures required to generate cash to service their debts. These measures included cuts in government spending (including on health care, food subsidies), user charges for health care, currency devaluation to make exports more competitive (but increasing the cost of imported goods), and the removal of import tariffs (and the protection of local enterprise).

The structural adjustment package was not solely applied to highly indebted countries seeking IMF bailouts. Rather it became the foundation of neoliberal 'development policy advice' proffered by the World Bank under the rubric of the 'Washington consensus' (Williamson 1990, 2000). Key elements of this program included fiscal conservatism, liberalization of capital, services and commodity flows, privatization and New Public Management (NPM) practices in the public sector.

The impact of structural adjustment on health and health care was (predictably) devastating and in 1987 a powerful denunciation was published with the support of UNICEF (still under James P Grant) under the title "Adjustment with a human face" (Cornia, Jolly, and Stewart 1987). *Adjustment with a human face* came out just as the Jubilee movement was gaining ground and contributed to a global discomfort / revulsion at the human damage being done by the IMF's structural adjustment policies.

The burden of odious debt and the brutality of structural adjustment triggered to the first legitimation crisis of neoliberalism in global health. Responding to this crisis, the World Bank mounted a glossy defence of structural adjustment in its World Development Report 1993 "Investing in health", arguing essentially that well designed structural adjustment was compatible with health improvement. The report broke new ground in two respects, first the introduction of the disability adjusted life year (DALY) to measure disease burden and second its cost-effectiveness calculations (the DALY per dollar).

On the basis of its estimates of disease burden and cost-effectiveness of a range of interventions the report constructs a package of public health interventions and a minimal package of clinical interventions appropriate for government subsidy, preferably targeted to the poor. Implementing this package would contribute to improved population health and would still be compatible with the structural adjustment disciplines of the IMF.

In an interview conducted in 2008 (a decade after he had retired), Mahler criticized the neoliberal agenda and structural adjustment programs advocated by the International Monetary Fund and the World Bank and described their involvement in the primary health care debate as a major blow to the vision of Alma Ata that "weakened commitment to the primary health care strategy" (WHO 2008: 748).

However, WHO under Nakajima (1988-97) was unable to counter the neoliberal project in the face of increasing dependence on donor funding and charges of corruption and incompetency that initiated its own legitimacy crisis (Chorev 2013; Walt 1993; Godlee 1994b, 1994a).

Access to medicines

AIDS first appeared in the early 1980s and the official response initially was permeated with a kind of passive fatalism (exemplified by the lack of urgency shown by Dr Nakajima). Partly in response to this passivity there was a global mobilization of people living with AIDS and with a strong human rights orientation.

Two key developments in the mid-1990s were first, the TRIPS agreement (which came into force in 1995) and second, the introduction of antiretroviral (ARV) medications which brought a dramatic change in mortality and morbidity prospects.

In 1997, three years after the democratic transition, the South African Government, still under Nelson Mandela, was facing a huge AIDS burden and an insistence by pharma that South Africa should pay rich world prices for access to ARVs (around $US10,000 per treatment year). The government elected to use one of the core flexibilities available under TRIPS, namely, procuring from suppliers in other countries where prices were more reasonable (eg as low as $500 per treatment year).

Global pharma took the government to court in South Africa claiming that their use of parallel importation was not consistent with their TRIPS commitments. Over the next four years there was a massive mobilization of people living with AIDS both in South Africa and around the world. By 2001 Clinton and Gore had been shamed for their backing of US pharma and withdrew their support leaving pharma no option but to withdraw (after paying for the costs of the South African Government).

Interestingly Dr Brundtland (Director General from 1998) was still encouraging the much more conservative option of tiered pricing even when pharma was just about to concede defeat.

Later that year, at the Doha meeting of the TRIPS Ministerial Council (Dec 2001) the Doha Declaration on Trade and Health affirmed that the "TRIPS Agreement does not and should not prevent Members from taking measures to protect public health" (WTO Ministerial Council 2001).

The access to medicines campaign triggered the second major legitimation crisis for neoliberal globalization. Responses to this crisis took two paths; one of which was the appointment of the Commission on Intellectual Property, Innovation and Public Health in 2004 (Commission on Intellectual Property Rights Innovation and Public Health 2006), and the second was framed around the MDGs which would demonstrate that the rich world did care, after all.

Macroeconomics and health

Gro Harlem Brundtland took over as DG in 1998, in the midst of the access to ARVs crisis. She was keen to give increased attention to health systems strengthening and in particular health care financing (Brundtland 1999). She was also keen to work more closely with the World Bank and other potential funding partners.

The 2000 World Health Report was focused on 'Health systems: improving performance' (WHO 2000). The writing groups and steering committee included a number of experts with long associations with the World Bank, including Dean Jamison, the lead author of the 1993 report on *Investing in Health*.

WHR2000 was widely criticized for the methodologically bankrupt attempt to rank national health systems, its reductionist 'building blocks' approach to conceptualizing health systems, and its ideologically informed defence of health insurance over tax-funded health care ("Evidence from many health systems shows that prepayment through insurance schemes leads to greater financing fairness.").

The development of WHR2000 was undertaken in parallel with the deliberations of WHO's Commission on Macroeconomics and Health (Commission on Macroeconomics and Health 2001), appointed by Brundtland in January 2000. This was a large-scale effort with six working groups who produced a total of 85 discussion papers. Many of the leading authors had also worked on Investing in Health in 1993 (Waitzkin 2003).

The Commission on Macroeconomics and Health (CMH) recognized the importance of a multisectoral approach to health but opted to support a small number of specific interventions which would yield the maximum health gain. The Commission identified a minimum per capita health expenditure target of $US34 per year for low-income countries; the bulk of this would need to come from a scaling up of donor funding. Under the CMH plan developing countries were to develop health investment plans which would be funded by donors in accordance with poverty reduction strategy papers (PRSPs). (The PRSP model was developed by the World Bank in response to criticisms of IMF's structural adjustment policies. However, the conditionalities remained.) The commission endorsed the newly established Global Fund for AIDS, TB and Malaria (GFATM) as a conduit for donor funding. The commission saw its recommendations as critical for achieving the health related Millennium Development Goals (MDGs).

This Commission was in many ways a reprisal of the 1993 World Bank report, with the focus on the economic benefits of better health and a limited number of identified interventions. However, there were two striking differences. First, the chairman of the Commission, Jeffrey Sachs was quite explicit about the legitimation crisis facing the globalization project:

> *The benefits of globalization are potentially enormous, as a result of the increased sharing of ideas, cultures, life-saving technologies, and efficient production processes.* **Yet globalization is under trial**, *partly because these benefits are not yet reaching hundreds of millions of the world's poor, and partly because globalization introduces new kinds of international challenges as turmoil in one part of the world can spread rapidly to others, through terrorism, armed conflict, environmental degradation, or disease, as demonstrated by the dramatic spread of AIDS around the globe in a single generation.*

The second departure from *Investing in Health* was the increased focus of the Commission on international funding for a new suite of vertical disease focused programs.

> *The epidemiological evidence conveys a crucial message: the vast majority of the excess disease burden is the result of a relatively small number of identifiable conditions, each with a set of*

> *existing health interventions that can dramatically improve health and reduce the deaths associated with these conditions. The problem is that these interventions don't reach the world's poor. Some of the reasons for this are corruption, mismanagement, and a weak public sector, but in the vast majority of countries, there is a more basic and remediable problem. The poor lack the financial resources to obtain coverage of these essential interventions, as do their governments.*

Sachs was a leading advocate for the Millennium Development Goals which emerged out of the UN Millennium Summit in 2000. Over the succeeding decade which there was a dramatic expansion of 'international development assistance' for health, with funding from bilateral donors, private philanthropy (in particular the Gates Foundation) and the WB and disbursed through narrowly focused global health initiatives (GHIs) including GAVI (from 2000), the Global Fund for AIDS, TB and Malaria (from 2002), the US's PEPFAR (from 2003) and the World Bank's Multi-Country AIDS Program (MAP) from 2000. The MDGs were largely focused on L&MICs; there were no goals for the rich countries to commit to.

In the several years following publication of the CMH report, WHO, with funding from the Gates Foundation, the Government of Italy, the Government of Norway and the Government of Sweden, worked closely with a number of least developed and lower middle-income countries to promote the development of health investment plans and PRSPs as recommended by CMH 2001 (WHO 2004a, 2006).

However, by the middle of the decade fundamental flaws in the CMH model were becoming increasingly apparent. First, it was becoming clear that the increasing flow of DAH was not impacting on the burden of out-of-pocket payment (causing barriers to access and medical impoverishment), in particular in relation to conditions which were not subsidized through the GHIs (World Bank 2006).

Second, it was becoming clear that the increasing flow of disease specific funding was having a fragmenting impact on health systems, carried heavy transaction costs for governments (associated with application, reporting and acquittal procedures for the different donors and GHIs) and encouraged internal brain drain (with government officials leaving for better paid jobs with the local administration of the GHIs and health practitioners moving from state funded comprehensive health care delivery to externally funded vertical programs). It was also clear that despite repeated global declarations regarding 'aid effectiveness' (OECD 2016) the donors and GHIs were either unwilling or unable to untie their funding streams.

The CMH had proposed that using PRSPs as a planning tool would encourage donors and GHIs to sign up to 'country-owned' health investment plans leading to closer alignment and greater efficiency. Not only was this hope not realized but funding flows through PRSPs were sometimes held up by concerns from the IMF economists regarding 'fiscal space', 'absorptive capacity' and 'fiscal sustainability' (Heller 2005).

In retrospect the Brundtland's attempt through WHR 2000 to focus on health systems development was undermined by CMH negativity regarding comprehensive health system development and its preference for a small number of disease prevention interventions.

Health system policies in the MDGs era

UHC, as WHO's leading policy slogan for health system development, emerged out of a complex policy conversation in which different policy directions writhed and entwined. These included primary health

care, social determinants of health, affordability of medicines, and the incoherence of the vertical programs addressing the MDGs.

One of those streams of work was centred on primary health care, kept alive largely by recurring anniversaries of 1978 and continuing advocacy from civil society and from some L&MIC governments. The World Health Report in 2008 (the thirtieth anniversary) was entitled 'Primary health care: now more than ever' and promised action on health equity, social justice and inclusion "primarily by moving towards universal access and social health protection – universal coverage reforms". The report was prepared under the direction of physician economist Tim Evans who, joined WHO (from the Rockefeller Foundation) as assistant director general in 2003 and in that role guided WHO's early thinking on UHC, and subsequently joined the World Bank (2013-2019) from whence he continued to shape the UHC narrative.

Attention to PHC returned in 2018 with the 40th anniversary of Alma-Ata which was celebrated in Astana in Kazakhstan and marked by the Astana Declaration (Global Conference on Primary Health Care 2018). This declaration again sought to link UHC with PHC, "PHC is a cornerstone of a sustainable health system for universal health coverage". Astana was reported to the WHA in April 2019 under the title, "Universal health coverage: Primary health care towards universal health coverage". Albeit incoherent, these references appear to locate PHC as somehow subordinate to but associated with UHC. Astana also projected a vision of "Partners and stakeholders [including the private sector] aligned in providing effective support to national health policies, strategies and plans".

Astana repeated the commitments from Alma-Ata for community involvement, local clinical care, supportive links with secondary and tertiary sectors, public health and prevention, and intersectoral advocacy for health. Missing from Astana were community action for social justice and an ecologically sustainable environment and support for a new international economic order. The Astana Declaration makes no reference to action on the social determinants of health. While the importance of a multisectoral approach to public health has been long recognized by public health leaders (Virchow 2006[1848]), building it into the norms and practices of on-the-ground health care delivery has been much more challenging. The Alma Ata Declaration highlighted the importance of intersectoral advocacy based on primary health care. However, as we have seen, the neoliberal ascendancy from the 1980s restored the vertical interventionist approach, first through selective PHC and later through the MDGs. Vertical disease-centred programs limit the capacity for intersectoral advocacy as well as for comprehensive, community-oriented, person-centred health care.

The 2006-8 Commission on the Social Determinants of Health gave prominence to the need for a multisectoral approach but the ghettoization of SDH in the WHO Secretariat and the refusal of donors to support action on SDH has ensured that the Commission's legacy has been largely rhetorical. The significance of the social determinants approach, in terms of UHC, lies in its absence from the UHC narrative.

The affordability of medicines had been a major issue for developing countries since the adoption of the first essential medicines list in 1977 (Laing et al. 2003). The role of intellectual property in maintaining high prices came to prominence with the South African case (1997-2001). Debate in the World Health Assembly since then has variously focused on WHO's role in providing advice to countries regarding the TRIPS agreement (Williams 2006; Cawthorne et al. 2007); the failure of IPRs to incentivise the development of medicines for the specific needs of developing countries (Commission on Intellectual Property Rights Innovation and Public Health 2006); and calls for transparency in relation to medicines trial data, cost of production and prices (Fletcher 2019). In the context of the COVID-19 pandemic the conflict was fierce, focused on vaccines and the proposed 'TRIPS Waiver'.

The significance of the access to medicines movement in relation to the UHC story is two-fold. First, the conflicts over access and affordability have contributed to the continuing crisis of legitimation facing the neoliberal project and big pharma. The second linkage arises from the significance for L&MICs of the price of medicines in delivering health care to their people. In the rich world, workforce costs dominate total health expenditure. However, in L&MIC while salaries are generally not high, medicines have to be purchased in the global marketplace and at global prices. L&MICs generally do not have the pricing power that developed countries, with national procurement programs, have. The cost of medicines for L&MICs generally comprises around two to four times the proportion of total health expenditure of the HICs. The inclusion of medicines affordability in the SDG definition of UHC reflects its particular importance for L&MICs.

A further strand in WHO's thinking about health systems under the MDGs was focused on addressing the adverse consequences of development assistance programs including health system fragmentation, transaction cost burden, internal brain drain and lack of long term planning (because of unpredictability).

The principal solution to such adverse consequences centred around the 'harmonisation' of development assistance for health, including bilateral and multilateral donors and the different global health initiatives addressing the MDGs. This harmonisation approach was consistent with a wide range of declarations, initiatives and processes promulgated to promote 'aid effectiveness' including the World Bank's sector wide approaches and poverty reduction strategy papers and the OECD high level fora on aid effectiveness (OECD 2016). The proposals from the CMH for development assistance for health to be mediated through PRSPs in order to encourage harmonisation have been noted above.

In 2007 the International Health Partnership + was established, focusing specifically on 'harmonisation' and 'ownership' of development assistance for health (GHW 2011). In this case 'country compacts' were supposed to provide the platform for harmonisation and ownership. Assessment of the success of the IHP+ was handicapped by the complexity of the undertaking and lack of data from the donors but if it had a positive impact it was marginal (Shorten et al. 2012).

In 2009 WHO assembled the 'Maximising Positive Synergies Collaborative Group' (Samb et al. 2009) which was directed to encouraging vertical program donors to contribute more to broader health systems strengthening. This initiative does not appear to have borne fruit, but its failure may have contributed to the transformation of IPH+ into UHC2030 in 2015; from asking for harmonisation across separate silos to a singular campaign for access and financial protection (see below).

Keijzer and Black (2020) comment that despite repeated commitments to cultivating 'ownership' in aid giving it has been implemented in a predominantly piecemeal fashion and marginalised by the rise of 'mutual benefit' co-operation which means donors being more honest about their purposes. They cite Brown (2020) who documents the role of Canadian aid to Peru in creating a favourable investment climate for Canadian mining corporations.

The £32m investment by the UK's Department for International Development's investment arm, CDC Group, Narayana Health, an Indian corporate hospital chain (Hunter and Murray 2015) will clearly benefit Narayana; how it benefits either India or the UK is unclear. McCoy and colleagues (McCoy, Chand, and Sridhar 2009) have urged closer monitoring of global health finance to critically examine who benefits from the rise in global health spending under the MDGs.

GHW (2018) notes that the two largest PPPs in the health sector, the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) were both deliberately positioned outside the UN system in order to provide a space for private entities in their

governance structures and comment on the distortions in global governance that arise as a result of such partnerships.

In 1971 Teresa Hayter wrote Aid as Imperialism which she introduced thus: “There is a dying belief that aid is a form of disinterested international munificence. Those who cling to this view fly in the face of clear evidence of its role as a weapon of the foreign policy of the 'donor' countries” (Hayter 1971). Hayter constructed her critique around the purposes of nation states using aid to advance national foreign policy. However, in the present period it could be argued that ‘development assistance’ plays a major role in legitimising the global neoliberal regime which reproduces growing inequality and deepening poverty. Perhaps we might speak of an ‘aid neoliberalism dipole’ where neoliberalism deepens the need for aid while aid contributes to legitimising neoliberalism.

In 2015, with the launch of the SDGs the IHP+ reinvented itself as UHC2030 as an international cheer leader for UHC. The project of harmonising separate vertical silos was replaced by the promise of international funding support for health system strengthening through UHC. However, it remains to be seen how willing the bilateral and multilateral donors, the global health partnerships, and philanthropies will be to untie their intervention focused funding in favour of budget support for UHC.

Universal health coverage

One of the first explicit uses of the term can be found in Joe Kutzin’s 2000 World Bank discussion paper (Kutzin 2000), which refers to “universal health care coverage”. This remains one of the better discussions of the key elements of health care financing. It appears that Kutzin was thinking about national health care financing as a single (albeit complex) system. However, he makes it clear that the purchase of services beyond the ‘benefit package’ will be paid for out-of-pocket. He does not address the possibility of supplementary health insurance for such services.

WHO

By 2004 WHO was under increasing pressure from the L&MICs to return to health system development including health care financing. In May 2004 a new item entitled ‘Social Health Insurance’ appeared on the EB agenda (at the request of Kenya), supported by a brief report by the Secretariat (WHO 2004b). (A later technical brief, by Carrin and colleagues (2005) elaborated). The debate at EB114 was fierce, including an apoplectic outburst (Executive Board 2005, p73) from the US delegate, Dr Steiger, who “was disappointed with the deep-seated bias shown in WHO, including the Executive Board, against private enterprise.” The EB adopted a fairly bland draft resolution (‘Sustainable health financing, universal coverage and social health insurance’) which was considered by the Assembly in May 2005. The Assembly considered a range of conflicting amendments but was not able to find consensus and ended up accepting the EB’s draft, endorsed as WHA58.33 (WHA 2005). The resolution was reviewed at WHA59 in May 2006 but in contrast to the conflict the previous year, only three countries spoke. The Kenyan delegate said that:

> *health systems in Africa were seriously affected by the heavy disease burden, inadequate funding, a shortage of health-care workers, weak infrastructure, and high poverty levels. Generally speaking, African countries were introducing a mixture of health-financing strategies, and the sharing of their experiences would be coordinated by the Regional Office for Africa. Despite major obstacles to the introduction of social health insurance in Africa, such as a small formal sector, many governments had decided to introduce social health insurance as an additional strategy in order to fund health services, improve health care and ensure equity. WHO, in collaboration with ILO and other agencies, was urged to provide technical support for*

> *the development of social health insurance in Africa, particularly as the customary out-of-pocket financing promoted poverty and inequity in health care. (*WHA 2006*)*

The World Health Report 2010 was a turning point in terms of crystallizing the UHC concept. The report introduces the UHC cube (the three dimensions being the proportion of the population covered, services covered and costs covered) and explores how resources might be mobilised to ensure everybody can access essential services without incurring excessive out of pocket costs. The political momentum for UHC continued with the World Health Assembly's Resolution 64.9 of May 2011 (WHA 2011b); and then the 2012 UN General Assembly Resolution on 'Global health and foreign policy' (UN General Assembly 2012) which called on all countries to move their health systems towards universal health coverage (UHC). This resolution was co-sponsored by the US and passed unanimously.

Finally, in UN General Assembly Resolution 70/1 ('Transforming our world: the 2030 Agenda for Sustainable Development'), UHC was included in the SDGs as Target 3.8 "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (UN General Assembly 2015). (The inclusion of medicines in this definition may be significant as it was not included in the definition provided in the WHO/World Bank first UHC global monitoring report (WHO and World Bank 2015)). The adoption of Target 3.8 was followed up with the 2019 High Level Political Declaration on UHC, endorsed in UN General Assembly Resolution 74/2 (UN General Assembly 2019).

During this period WHO also published a number of documents on more technical aspects of UHC including fiscal space (WHO 2014; Cashin et al. 2017); strategic purchasing (WHO-SEARO 2017); and health benefit packages (WHO 2021a).

Following the Astana meeting in 2018 WHO continued to promote primary health care as the 'cornerstone of', or the 'pathway to', UHC. In addition to the 'vision' document prepared by WHO and UNICEF for the Astana meeting (WHO and UNICEF 2018), in 2019 the WHO Secretariat produced a 'draft operational framework' for the implementation of the Astana commitments (WHO 2019b) and the WHA adopted WHA72.3 on the role of community health workers in delivering primary health care (WHA 2019).

World Bank

Notwithstanding its long record of promoting user fees, restricting public expenditure on health, supporting commercial health insurance markets (Lindner, Preker, and Chernichovsky 2013) and promoting the private sector in health care (Nuruzzaman 2007), the World Bank has taken a prominent role in the UHC conversation, particularly since a World Bank, Gavi, Global Fund workshop in June 2009 which was directed to exploring the scope of vertical global health initiatives in health system strengthening (World Bank 2009); the workshop appears to have concluded that its scope was limited. In 2013 the Bank published a review of UHC schemes in developing countries (Giedion, Alfonso, and Díaz 2013) and from 2015 the Bank has worked with WHO on the periodic UHC global monitoring reports (WHO and World Bank 2015, 2017b). In 2017 WHO and the World Bank, as part of UHC2030 (see below), co-authored a UHC 'vision document' (WHO and World Bank 2017a).

The UHC 'movement'

In addition to WHO and the World Bank there is a mesh of networks and partnerships, many supported by the Rockefeller Foundation (less prominently Gates), promoting UHC.

This US dominated network of UHC champions describe themselves as being part of the UHC 'movement'. The principal objective of the movement appears to be the promotion of UHC as a

slogan, emphasising access to services and financial protection, while obscuring a range of more problematic objectives (discussed further below). Much of the activities and materials produced through the 'movement' are directed at the governments of low and middle income countries, including both health and finance ministries. The network entrepreneurs have reached out to officials and academics in L&MICs, funding conferences and workshops, and a range of learning opportunities.

The network entrepreneurs have also invested heavily in recruiting corporate 'sign-ons', in particular from pharma and medical electronics. The arguments being advanced to these corporate strategists are not clearly articulated in the publicly available materials. Presumably the corporate strategists foresee the possibility of UHC benefiting their bottom line (perhaps in terms of market access) and that partnering in UHC will help to shore up their intellectual property privileges (notwithstanding the references to affordable medicines in Target 3.8).

The third constituency being targeted by the movement entrepreneurs are the putative funders: the bilateral, multilateral, partnerships and philanthropies who are being asked to contribute directly to the costs of UHC in the low income countries. They are being asked to pool their funds, loosen their conditions, collaborate in the formal terms and procedures, and offer medium to long term predictability. In other words they are being asked to realise the aid effectiveness principles of Busan and Addis Ababa (which they have been hitherto loath to do).

At the core of the UHC 'movement' are: UHC2030, reinvented as from 2015 from its earlier incarnation as the IHP+; the Joint Learning Network (JLN) for UHC; US think tank Results for Development (R4D); and the Rockefeller Foundation.

UHC2030 (2021) brings together a wide range of 'partners': governments, international organisations, civil society organisations, the private sector, academia, and media. Its private sector members include many global pharmaceutical (eg Pfizer) and medical equipment companies (eg GE and Philips) as well as their industry organisations (IFPMA). The mission of UHC2030 is "to create a movement for accelerating equitable and sustainable progress towards universal health coverage (UHC)" or "to provide a platform where the private sector, civil society, international organizations, academia and governmental organizations can collaborate together to create a movement for accelerating equitable and sustainable progress towards universal health coverage (UHC) and health systems strengthening at global and country levels". Its strategic focus is "to mobilise political commitment and collective action for UHC". UHC2030 collaborates with the JLN for UHC, the UHC Partnership and the P4H.

The **Joint Learning Network for Universal Health Coverage** (JLN4UHC 2021). "is an innovative, country-driven network of practitioners and policymakers from around the globe who co-develop global knowledge products that help bridge the gap between theory and practice to extend health coverage to more than 3 billion people." It has members – largely L&MICs – whose officials participate in learning activities which are resourced by 'facilitator' who are experts, largely drawn from the World Bank and from JLN 'partners' a category which includes private sector consultancies (eg R4D, Abt, etc), technical agencies (eg IHI, NICE, etc) and bilateral donors (eg USAID, JICA). The JLN is funded by the Gates Foundation, the World Bank, and GIZ (German Cooperation); partners also contribute to the cost of learning activities.

"All of our activities are prioritized, shaped, led, and co-facilitated by JLN member countries. Using a unique joint learning approach – that includes a combination of multilateral workshops, country learning exchanges, and virtual dialogue – JLN members build on real experience to produce and experiment with new ideas and tools to implement universal health coverage."

A key program offered through the JLN is the **Private Sector Engagement Collaborative** which works "to advance international guidance on engaging the private sector to achieve PHC-oriented UHC". This work is largely directed to health officials from L&MICs, providing "practitioners, development agencies, and research institutes with practical guidance for public-private engagement to deliver primary health services for UHC". The Private Sector Engagement Collaborative is led by Abt Associates who are contracted to USAID under the SHOPS Plus project (Sustaining Health Outcomes through the Private Sector) (SHOPS Plus 2021). "The project supports financing and delivery of essential health services, including family planning (FP) that underpin UHC through private sector engagement. It supports peer learning and became the technical facilitator for the JLN's PSEC in 2019. SHOPS Plus is leveraging existing relationships to convene and amplify the voice of private sector stakeholders with our members. In the past, participants in the PSEC represented exclusively the public sector. As part of this transition, SHOPS Plus began to include private sector counterparts in these important discussions to learn how better conduct public-private engagement for UHC."

Results for Development (R4D) (R4D 2021)is a not for profit consultancy based in Washington DC which provides much of the technical materials supporting the JLN and UHC2030. R4D was started in 2008 by former World Bank Vice President David de Ferranti. Its staff include a number of economists and policy analysts, several with close links with the World Bank. Much of R4D's work on UHC is supported by the Rockefeller Foundation.

One of R4D's first projects was the *Role of the Private Sector in Health Systems* supported by the Rockefeller Foundation. One of the key outputs of this project was a paper on *Provider Purchasing and Contracting Mechanisms* (England 2008) which sets forth the Rockefeller agenda in relation to UHC more openly than most of the later material. Its starting position is the need for reform: "An entrenched public service that absorbs almost all of the money governments make available, mostly in the salaries and wages of public service workers, and that is largely inefficient, unresponsive, and unaccountable to consumers." The program of reform envisages several possible configurations, not necessarily a sequence: first, government becomes the payer/purchaser and reduces its role in direct service provision; second, government transfers its purchaser function to an autonomous national funding body but remains provider and third, government ceases both provider and purchaser functions. The paper explores the perceived benefits and drawbacks of these different configurations and explores the technical requirements for effective purchasing. It provides a useful overview of the purchasing experience of eight L&MICs.

A 2009 report from the Rockefeller project, focused on the role of government in regulating private providers in mixed health systems (Lagomarsino, Nachuk, and Kundra 2009). This report summarized the findings of the research commissioned in 2008 by the Rockefeller Foundation examining the role of the private sector in health systems in developing countries. The R4D research underlines the importance of public stewardship of the private sector but concludes that many governments are not performing that stewardship role particularly well at present. A more comprehensive report on the findings of the projects was published in Lancet in 2012 (Lagomarsino et al. 2012): *Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia*. As an outcome of this research the Foundation launched its Transforming Health Systems initiative in late 2008 (see also Horton (2013)).

A later resource produced by R4D for the JLN provides "practical guide for countries working towards universal health coverage" (Cashin 2015) addressed policy issues relating to coverage, benefit packages, contracting (from whom to buy which health care goods, services, and interventions, and at what prices), provider payment, and quality.

The **UHC Partnership** (2019) is a somewhat different creature; oriented around WHO's technical assistance to countries in advancing universal health coverage through a primary health care approach (working with 115 countries, representing a population of at least 3 billion people in 2019). The UHC Partnership is supported by the European Union, the Grand Duchy of Luxembourg, Irish Aid, the French Ministry for Europe and Foreign Affairs, the Government of Japan, the United Kingdom, Belgium, Canada and Germany. It appears to be largely directed to supporting WHO's technical assistance work.

People

The organisations mobilised around the UHC project are part of the picture but they need to be seen in relation to the (relatively small number of) individuals whose drive and expertise gives life and meaning to the network of organisations. More than this, by their movement between organisations and their relationships to Rockefeller, Gates and other funders, they are the glue which holds the network ('movement') together.

A full description of the history and direction of the UHC movement would need to encompass people such as Dean T Jamison, Richard G A Feacham, Tim Evans, Chris L Murray, Joseph Kutzin, Jeffrey Sachs, Judith Rodin, David de Ferranti, Gina Lagomarsino, Cheryl Cashin, Anne Mills and Viroj Tangcharoensathien (apologies for exclusions from this list).

4. Contradictions and silences in the UHC policy narrative

In this section I interrogate the UHC policy narrative within a generic health systems framework. I explore possible scenarios arising from the standard narrative which I evaluate against generally accepted principles of health system design: quality, efficiency and equity.

My analysis is based on the international debate, even while recognising that the implementation of UHC is shaped by national contingencies. However, the global debate powerfully affect what happens in countries, including through 'development assistance' funding, the advice of experts, and the prevailing international consensus.

Reducing user charges

WHO has campaigned around reducing user charges, particularly since WHR 2010, on the grounds that they create barriers to accessing care and carry a significant risk of medical impoverishment. The need to reduce (or eliminate) user charges has been the principal argument for UHC. However, all versions of UHC currently under discussion emphasise that coverage includes only 'essential services' (commonly referred to as the 'defined benefit package'). Accordingly, there will also be a sector of service delivery of 'non-essential services' (or non UHC services) the cost of which will be met through user charges, in some cases supported by complementary private insurance. People without complementary private health insurance who need services beyond the package will face user charges which will precipitate some into medical impoverishment.

Under certain scenarios, discussed below, the UHC safety net languishes while voluntary insurance for beyond-the-package services flourishes. Under such circumstances, the promises of access and financial protection appear unlikely to be realised.

Complementary private health insurance

With a limited benefit package under UHC there will be pressures to allow complementary private insurance, with a strong political demand from the wealthy for beyond-the-package coverage and commercial demand from the financial sector to access this opportunity. Where there are pre-existing

health insurance plans, the more basic plans will be absorbed into the UHC arrangements but there will be strong pressures from the more generous plans for them to continue and to offer beyond-the-package services.

The availability of private insurance will jeopardise the political solidarity needed to sustain UHC and to progressively expand it. Where private complementary health insurance operates beside UHC provision the incentive on governments will be to encourage the private sector to expand its offerings and coverage rather than expanding the UHC benefits package.

Under such circumstances the UHC program will languish as a residual safety net, the lowest stratum in a multi-tiered health care funding regime.

Purchasing and purchaser provider separation

The term 'purchasing' is frequently repeated in descriptions of UHC; reference to purchaser provider separation is less frequent but this is generally implied. For this to work, publicly administered health service agencies, where the government owns the assets and staff are directly employed, will need to be somehow set adrift (autonomised, corporatized and privatised in the language of the World Bank (Preker and Harding 2003)). Insofar as they are providing services within the UHC benefit package they will now be funded through the UHC scheme, so if they are to manage their own revenues and pay their staff they will need to be corporatized. In such circumstances a single government owned program of services will be transformed into a decentralised fleet of corporatized service agencies.

Once publicly administered agencies have been corporatized as separated providers for the basic benefit package their role in delivering beyond-the-package services will need to be addressed. Given the need for funds for the UHC scheme, governments will be reluctant to provide beyond-the-package services free; particularly if there are private insurance schemes operating. However, once corporatized the agencies themselves will insist on being allowed to provide beyond-the-package services (on a user pays basis). Once these agencies are established as independent service providers, billing both the UHC payer and the private health insurers, there will be increasing pressure to privatise them. Once privatised their focus will turn to the more profitable districts and more profitable items of service.

While 'purchasing' could be interpreted as including government budget transfers to publicly owned service agencies, the term is generally used to refer purchasing from a range of arm's length providers. In view of the frequent affirmation that UHC providers may be public, voluntary or private the clear implication is that publicly owned providers will be 'separated' or corporatized so that they are in the UHC market selling services to the funder.

[Insert boxes here about Egypt and Philippines]

The UHC single payer

While the World Bank has long supported competitive private health insurance markets (Brunner et al. 2012) it appears to have accepted the logic of single payer financing in relation to UHC (WHO and World Bank 2017a). The single payer function will require dedicated systems for managing and disbursing funds and for monitoring service delivery and in the first instance the single payer is likely to be a government instrumentality. Kutzin (2014) argues that this will require a dedicated agency with specialist data systems and significant autonomy, freed of many of the routine disciplines of the public service, including both financial and personnel management. In the first instance this suggests corporatisation but once the corporatized agency has achieved stability and its systems are working smoothly there will be pressure from the financial markets for further privatisation.

The path to single payer health care financing is dependent on what has come before and, in many settings, it would involve the progressive amalgamation of different funding schemes, often with very different resourcing and benefit packages. This is always highly political and very difficult (consider Brazil, China and South Africa). Such challenges can be avoided by treating UHC as a residual safety net (providing the minimum benefit package) while accommodating the more generous funds in a more pluralist market for beyond-the-package services.

Capitation

Most of the expert documents regarding UHC tread cautiously around the mode of payment, the unit which is to be purchased. However, budget funding has been precluded by the insistence on bringing the private sector into the UHC market and the challenges of regulating fee-for-service payment are generally acknowledged. Output funding may be considered for inpatient care (although it involves complex and information rich systems) but there are no such systems for ambulatory care. In this context there will be strong arguments for capitation payment, particularly for primary care.

Capitation payment raises questions about the size and competence of the provider agency, whether it is derived from agencies previously in government service, or from voluntary or private agencies. How solo practitioners and street vendors would fit in such a scheme has not been explained. Promoting quality and efficiency under capitation is a regulatory challenge, even in well-funded settings. Predictably, there will be experts from managed care systems who will be pleased to provide advice. Poorly regulated privately operated managed care carries significant risks of underservicing.

Regulation

The UHC marketplace evoked by this analysis would comprise a corporatized single payer disbursing funds to hospitals and to geographically based managed care organisations (MCOs). Both hospitals and MCOs will also provide beyond-the-package services for which users will be charged, in some cases covered by complementary private health insurance. Regulating for quality, efficiency, and equity in such markets would be particularly challenging.

The following comparisons of the management of quality, efficiency and equity in publicly administered systems and in regulated markets assume accountability and probity in both public management and market regulation.

Quality

WHR 2010 estimated that up to 40% of health care is ineffective or worse. Managing quality of care requires attention to *structure* (buildings, equipment, systems, staff, etc), *process* (eg the development, promulgation and compliance with clinical practice guidelines), and *outcomes* (evaluation and improvement) (Donabedian 1980). Putting in place the systems and culture needed for effective clinical governance are critical for quality and safety at the agency and program level while functions such as monitoring, planning, procurement and training are critical at the system level (Halligan and Donaldson 2001; Scally and Donaldson 1998).

These systems are difficult to establish and manage in publicly administered health systems in wealthy countries and more so in mixed health care delivery systems but the challenges in the kind of health care markets being proposed for low income countries under the rubric of UHC are at another level.

Efficiency

The meaning of technical efficiency in relation to health care is contested. Many health economists prefer to deal with the cost of interventions than the cost of outcomes – hoping that someone else is

managing the relations between interventions and outcomes. However, while the measurement of outcomes is fraught, technical efficiency is fundamentally about outcomes and demands some kind of assessment of the cost of outcomes. In publicly administered systems, the assessment of technical efficiency lies with agency and system managers who can deploy experience and judgement in integrating information about the cost *and* efficacy of interventions, even if they do not have a simple metric for outcomes. However, the assessment of efficiency in the public private marketplace rests with regulators who generally have more limited data and no personal exposure to the clinical world.

Allocative efficiency, understood as referring to investment choices between different programs, levels of care, or options for improvement, calls for a capacity to estimate the marginal benefits associated with different allocation choices and to direct resources accordingly. In publicly administered agencies and systems these choices involve managerial judgement exercised in the context of budgeting. However, in the UHC model on offer, the scope for such decisions is limited to adjusting the benefit package, but with only crude indicators to estimate need, waste and equity.

Equity

The concept of equity overlaps somewhat with that of allocative efficiency. In this discussion the focus is on distributional equity (including geographic, gender-, and ethnic-based distribution).

In publicly administered systems distributional equity depends on budget decisions and political accountability. In market-based systems health care providers are drawn to servicing the wealthy because that's where the money is.

In the current UHC model services will be provided by private or voluntary providers and by erstwhile public sector agencies. Under the scenarios discussed above, where public sector agencies are progressively corporatized and privatised, they too will be drawn to servicing the urban areas and the more wealthy districts in the cities. There are few levers in this model which might encourage / require providers to locate in under-served districts.

Intersectoral collaboration for action on the social and political determinants of health

WHO repeatedly asserts that primary health care provides the 'pathway' to UHC. However, there is virtually nothing in the various technical papers about UHC which recognises the challenge of intersectoral collaboration for better health highlighted in the Alma-Ata Declaration (and repeated in Astana). Alma-Ata projects a model of comprehensive primary health care with local practitioners and agencies accountable to their communities for service delivery and working with their communities to discern and act upon the social and political determinants of health. This is hard to achieve in publicly administered programs. It has been virtually removed from the agenda under UHC.

Affordable medicines

The cost of medicines is a major determinant of the reach of UHC, the scope of the benefit package. While low and middle income countries are required to pay global originator prices (or more) for medicines and vaccines the scope of UHC benefit packages will seriously restricted. The answers are obvious: pooled procurement; full deployment of TRIPS flexibilities; support for local production. These policies are surprisingly absent from most of the technical commentary and advice on how to implement UHC.

Workforce

The availability of enough appropriately trained staff is an absolute limit on the scope of any UHC program.

Addressing brain drain would be a critical first step including a commitment from the middle income and high income countries to train enough of their own staff and the payment of compensation for the embodied loss of investment in training. Neither appear likely.

A further scenario, in view because of the stratified health care system envisaged under UHC, would be internal migration from agencies mainly providing UHC services to those providing more beyond-the-package services. Such agencies are likely to be able to offer higher remuneration and better conditions.

Clearly effective coverage of 'essential services' would require a steep increase in health worker training in many countries. However, while leakages from both external and internal migration continue the benefits of such increased investment would be vitiated.

Fiscal space

There is general agreement in the technical literature that government revenues in low income countries are not sufficient to support the most basic package. Accordingly, there is an assumption floating in the literature that donor funding will be available to support UHC. In fact, it is not clear that the big global health funders will be willing to untie and redirect their funds into funding UHC in a predictable and sustainable way.

The support of the World Bank for 'domestic resource mobilisation' for UHC is paradoxical in view of the massive defunding of health care instituted by the WB and the IMF under structural adjustment. The prospect of an expanded private sector supported by complementary private health insurance to serve the wealthy while the donors support UHC suggests a breach of the principle of pooling which is so central to the UHC narrative.

The public sector alternative

Stratified competitive health insurance markets provide for weak or no control of distributional equity, efficient use of resources or quality of care. FFS reimbursement schemes encourage premium inflation and low risk selection. Managed care schemes based on capitation carry substantial risks of under provision. Mixed public private health care delivery incorporates weak system-wide linkages and powerful disincentives with respect to efficiency, equity and quality.

Publicly administered health systems provide policy makers with potent levers to promote efficiency, equity and quality, and to realise primary health care principles. However, the public sector alternative has been effectively removed from the UHC agenda.

Questions arising

The analysis presented in this section, structured within the boundaries of a generic health systems framework, highlights a number of contradictions and silences in the prevailing UHC policy narrative.

These contradictions and silences are not explicable within this health systems framework and suggest the need for a wider frame of analysis - a political and economic analysis - within which we may discern more clearly the political and ideological influences shaping the UHC narrative.

With a view to undertaking such an analysis it is necessary to first delineate the political economy framework which will structure the analysis.

5. The political economy of global health and UHC

In this section I explore the political economy of UHC. In embarking on this exploration I have benefited from the sweeping analysis of Hernández-Álvarez et al (2020) and the narrative review of Rizvi et al (2020).

The framework for the analysis outlined in this section centres on critical points of articulation between global health and political economy and explores the dynamics of stability and change at each point. The framework has been developed iteratively; iterating between theoretical insights arising in political economy generally (including, for example: Stillwell 2012; Smith 2016; Patnaik and Patnaik 2021; Robinson 2004) and reflection on the trajectories and transitions of global health over the last 200 years (including, for example: Howard-Jones 1981; Stefanini 2008; Rosen 1993 (1958); Birn, Pillay, and Holtz 2009). The points of articulation of relevance here are:

- Vertical silos versus integrated health system development,
- Multisectoral action for health,
- The health workforce,
- Imported health products and affordability,
- Domestic resource mobilisation and fiscal space,
- Health services as markets for transnational suppliers,
- Regulatory capture,
- Labour productivity, access to commodities and healthy markets,
- Securitisation of contagion,
- The systemic crises of global capitalism,
- Financial regulation, trade and investment agreements,
- Global health governance,
- The power and purpose of philanthrocapital, and
- The dance of legitimation.

These points of articulation are ranked in relation to scale, proceeding from issues located primarily within the health sector to larger scale issues of global economics and governance.

Donor preference for vertical silos

A long-standing debate in global health has been around the role of 'development assistance for health' (DAH) donors and advisors in promoting vertical, disease-oriented, intervention-focused health programs rather than supporting the development of comprehensive integrated health care and/or addressing the social, economic and political determinants of health (Loevinsohn et al. 2015; Warren et al. 2013; Ooms et al. 2008; Magnussen, Ehiri, and Jolly 2004; Newell 1988; Regan et al. 2021).

Specialist programs play an essential role when they are integrated with comprehensive health care delivery and prevention but in many instances donor supported programs have been associated with the neglect of more comprehensive services or were explicitly implemented instead of developing such services. The programs against hookworm, malaria, smallpox, polio, AIDS were all characterized by vertically organized, staffed and funded programs with only loose links to more comprehensive service development.

The case for selective primary health care, elaborated by Walsh and Warren in 1979 (1979) was a response to the much more ambitious Alma-Ata Declaration and was implemented from the 1980s through UNICEF's 'child survival revolution' with its focus on GOBI (growth monitoring, oral

rehydration, breast feeding and immunisation). Walsh and Warren argued that implementing Alma-Ata would be too expensive and UNICEF (under James Grant) took its cue, arguing that these more targeted interventions could be delivered with donor support and would yield measurable improvements in child health.

Similar logic underpinned the World Bank's (1993) use of disability-adjusted life years (DALYs) to identify cost effective interventions for inclusion in a core 'benefits package'. The Bank's use of age-weighting in its cost-effectiveness calculations (prioritising the health of young adults) was also directed to ensuring that donor assistance for health should contribute to improved labour productivity as part of reducing the burden of disease.

The criticisms of vertical disease-focused interventions in the context of the MDGs included internal brain drain, health system fragmentation and high transaction costs. The continuing burden of user charges for services *not covered* by vertical programs (outside the 'essential benefits package') created barriers to access and/or led to medical impoverishment. The more basic critique of the vertical programs has been that they aim to improve health outcomes without addressing the human rights breaches and poor living conditions which contribute to specific disease ecologies.

The promise of UHC for the LICs depends on donors being willing to provide broad budget support, tied only to the funding of UHC. In the context of the MDGs the donors were reluctant to adopt common application and reporting procedures and common program delivery structures (notwithstanding repeated promises in Rome, Paris, Accra and Busan (OECD 2016)), much less provide untied budget support (Swedlund and Lierl 2020).

It appears that the policy entrepreneurs driving the UHC project believe that the donors will be persuaded by the benefits to domestic capital of the market-forming potential of UHC (see below) or perhaps they will see that the relegitimation objective (see below) can be achieved through the promise of UHC without that promise necessarily being redeemed.

Models of health care *least* able to promote intersectoral collaboration

Health is created before and beyond health care. Much can be done to improve population health through organised public health programs and decent health care. However, interventions from within the health system need to be complemented by multisectoral action to address the determinants of population health that lie beyond the reach of the health system. These range from undernutrition, to sanitary infrastructure, to occupational hazards, to alienation and powerlessness.

Multisectoral action which contributes to population health is often progressed for reasons unrelated to health outcomes. The concept of intersectoral collaboration as a public health principle speaks to practice within the health system directed to policy advocacy and alliance building towards action in other sectors.

Intersectoral collaboration is a core principle of primary health care, as elaborated at Alma-Ata and reinforced at Astana. The articulation of this principle at Alma-Ata was inspired by the case studies of primary health care in action collected by Newell and published in 1975. Other paradigm instances include Pholela in South Africa, Ding Xiang in China, and contemporary indigenous community-controlled health services.

These instances all show how primary health care practitioners might work with their communities to address social determinants of health; for example, issues of nutrition addressed through agricultural reform. Underpinning the Alma-Ata Declaration is the importance of ensuring that the delivery of

primary health care should be designed so as to facilitate this kind of intersectoral collaboration, including community engagement and an appropriate workforce mix.

Intervention focused donor funded public health programs leave no space for such intersectoral collaboration even when the disease in focus (eg malaria or hookworm) is deeply imbricated in living (and working) environments and practices.

Likewise, the concept of minimal benefit packages, which list the services for which practitioners will be reimbursed, do nothing to support primary health care practitioners working flexibly with their communities to address the leading social determinants of health for their community.

The UHC narrative does not offer more than token support for multisectoral action on health; certainly there is no suggestion of a role for PHC providers to support intersectoral advocacy. The UHC narrative assumes that the private sector will play a central role in health care delivery but the evidence for private sector efficacy in intersectoral advocacy is slim. The UHC model proposes to purchase a defined benefit package from providers. Intersectoral advocacy does not appear to be contemplated as an element in the benefits package, nor are there any indicators proposed that would follow such advocacy.

Both Chan and Tedros have identified PHC as key to implementing UHC (Ghebreyesus 2019; Chan 2009). PHC clearly promises action on the social determination of health (although the reference to the NIEO has disappeared from Astana) but private practice with health insurance is not well suited to realising this promise.

The lack of donor enthusiasm for models of service delivery and financing which facilitate intersectoral collaboration may also reflect the ambivalence of the political elites regarding social change from below; for example, addressing income inequality or the need for land reform.

In many countries organized medicine is also upfront in defending private sector sickness care without any acknowledgement of the arguments for health care providers to contribute to multisectoral action for health. This is particularly so in countries where medical practitioners stand out as beneficiaries of the prevailing socio-economic status quo (Waitzkin and Working Group on Health Beyond Capitalism 2018).

The health workforce: brain drain, medical dominance and the role of community health workers

The health system is constituted in large part by its people and the dynamics which shape availability, training, relationships and morale of the health workforce are critical in shaping health care delivery and public health.

Training health care practitioners is not cheap. Many countries, rich and poor, do not train enough practitioners to meet their domestic needs. Lack of personnel is an absolute limit on capacity to deliver effective health care.

For many low-income countries investment in workforce development is hamstrung by the legacies of colonisation, the harms done under structural adjustment, the policy demands for austerity and the continuing extractions of neoliberal globalisation.

The situation for low-income countries is further exacerbated by health worker migration, particularly between anglophone countries. For rich countries to fail to train enough practitioners and then make up the shortfall by relying on foreign trained practitioners amounts to theft (notwithstanding the right

to migrate, the push factors which encourage people to leave and the fact that some will return). The theft lies in the investment in training in the lower income country for which there is no return.

Some lower income countries encourage health worker migration because of the impact of remittances on the exchange rate; this is encouraged by the IFIs. In countries where private training colleges are authorized to operate, the debt burden at the end of training drives migration (from lower to higher income country; from publicly administered service delivery on lower salaries to private practice; from low income and rural communities to richer districts).

The 'appropriateness' of workforce structures and relationships is contingent and controversial. Ongoing debates concern medical dominance, the lack of nurses and the role of community health workers (CHWs), however labelled.

Debates about medical dominance tend to focus on hierarchical relationships within the health care team and associated rigidities and inefficiencies. But another dimension is accountability, including accountability at the institutional and national levels for quality, efficiency and equity. In countries where the medical profession is closely aligned with the ruling class, professional accountability is often weak.

The nursing and midwifery workforce in many L&MICs is inadequate, inequitably distributed, and inefficiently deployed. These may reflect a legacy of medical dominance as well as long standing lack of investment in training and leadership.

Issues of medical dominance also play a part in the debates and struggles regarding the role of community health workers. David Werner has commented on the different roles played by CHWs in different contexts. He described CHWs as either 'lackeys' (embedded in professional hierarchies with limited autonomy, 'extending' the reach of tertiary trained practitioners), or 'liberators' (working with both colleagues and community in clinical roles, in planning, priority-setting and accountability and in intersectoral collaboration for action on the social and political determinants of health).

A key phrase in this space is 'task shifting' which superficially implies that as technologies advance many tasks previously seen as highly technical can be routinised and shifted to lesser trained staff. Realizing this potential may involve empowering less highly trained members of the team with capacity building and professional responsibility. However, it can also involve emplacing less highly trained staff in rigid hierarchies of control, where tight management is necessary to coordinate the contributions of different staff members.

Workforce issues at the country level are influenced by global power and policy in several ways, including brain drain and the theft of training investment and the privatisation of training and the consequences of graduation debt. Policy regarding workforce structures in developing countries is commonly influenced by rich world practice through personal experience, journal articles and conferences.

Issues of workforce production, structure and culture have been largely ignored in much of the UHC conversation, perhaps because the donors are sensitive about workforce theft and compensation and the policy entrepreneurs are reluctant to spell out the scale of investment in training that is needed.

Health care affordability and the price of medicines

Input prices clearly influence health care affordability both for the family and for institutional payers.

Input prices are particularly significant for L&MICs who face lower labour costs than the HICs but must procure electronics, pharmaceuticals, and many consumables at global market prices. As a

consequence, the cost of imported supplies, pharmaceuticals in particular, constitutes a disproportionate financial burden. Pharmaceuticals as a proportion of total health expenditure (THE) is around 18% in the global North and between 20-60% in global South.

Cameron (2008) reviewed 45 drug price surveys in 36 L&MICs and reported that governments generally paid around 11% above international reference prices while private patients paid 9-25 times international reference prices and over 20 times international reference prices for originator products. They found very high mark-ups in the private sector: from 2 to 380% in the wholesale market and from 10 to 552% in retail.

Global dynamics which affect input prices include: monopoly pricing, massive marketing expenditures (including corrupt practices), barriers to local production, and barriers to large scale joint procurement.

Monopoly pricing is protected by the extreme intellectual property provisions of the TRIPS Agreement and comparable provisions in other bilateral and plurilateral agreements. These provisions are policed aggressively by the US. Even after patents have expired corporate pricing is insulated from price competition by marketing investments including brand promotion.

Transnational pharmaceutical companies have repeatedly demonstrated a disregard for poor people's access to medicines in setting prices to maximise profits rather than access. The claim that high returns are needed to fund further research and development is weak; much of the R&D on which new drugs are based is publicly funded but the IP is gifted by governments to pharma. Profit directed investment in pharmaceutical R&D aligns poorly with public health needs. Much of the IP protected monopoly profit of pharma goes to marketing as well as obscene executive salaries, generous dividends and share buybacks. Pharma generally spends more on marketing than on R&D. High spending on marketing is directed to increasing sales volumes (including overuse) and to embedding brand consciousness in consumers and prescribers.

Generic pharmaceutical manufacturers should be able to enter the market once patents (and data exclusivity periods) have expired. However, it is common for generic manufacturers to be taken over by the large originator corporations, in order to stifle price competition. Industry consolidation (and increased monopoly) through mergers and acquisitions is a reflection of the financialisation of the modern capitalist economy.

Public sector manufacturers are in theory protected from such take-overs but under the neoliberal regime many countries have privatized their publicly owned manufacturers. A range of provisions in WTO and other agreements (ISDS, in particular) further limit the scope of public production. Further barriers to price competition have emerged with the advent of biological therapeutics and regulatory barriers to the approval of biosimilars (Sengupta 2018).

There are provisions in the TRIPS Agreement which, if deployed through national legislation, can enable countries to issue compulsory licenses or to procure in foreign markets where prices are lower. However, many countries have been placed under heavy pressure (from the drug industry and from powerful countries) to adopt legislation which precludes the use of TRIPS flexibilities.

The monopoly pricing capacity of big equipment manufacturers is less due to patents but more due to scale of manufacturing, reach of marketing and control of distribution. As with pharma, emerging competitors can be taken over.

The prices of imported health care supplies are also affected by barriers to local production, including the combination of trade liberalization and the emergence of huge transnational corporations sitting astride tightly controlled and far-reaching supply chains. The consequence is that the transnational

corporations can often market better quality products more reliably than small local producers and have deep enough pockets to under-price local manufacturers if need be.

One of the strategies of the big equipment makers is to build into their design an exclusive requirement for patented consumables and to adopt pricing structures with disproportionate margins for those consumables.

Arrangements for large scale joint procurement have the potential to negotiate lower prices through monopsonic purchasing power tied to scale. Examples of successful joint procurement include national purchasing (as in national health schemes), pooled procurement by pharmacy chains, health maintenance organisations and global health initiatives (Gavi and the Global Fund), and multi-country schemes such as the EU Joint Procurement Agreement and the PAHO Revolving Fund. However, such schemes can be complex to negotiate, particularly joint country schemes. Joint procurement assumes a common framework for regulatory approval which is complex to put in place.

The issues of price transparency, pooled procurement, full deployment of TRIPS flexibilities, and local public sector production have been largely avoided by the policy entrepreneurs driving the UHC conversation. Presumably this reflects the political and financial support provided to the UHC 'movement' by big pharma (see above).

The structural constraints on domestic resource mobilisation

Domestic resources for health care are sharply limited in L&MICs for many reasons, starting with the legacies of colonisation, structural adjustment and structured exploitation (unequal exchange) arising from their location in the global flows of commodities, manufactured goods, and finance.

Unequal exchange is managed by the transnational corporations which control global supply chains and policed by transnational finance which can discipline all but the most powerful states. It is further locked in by trade 'agreements' which drive liberalisation of the movement of goods, services and finance; drive privatisation with respect to knowledge and technology; and ensure irreversibility through various ratchets built into trade and investment agreements.

Constraints on domestic resources are in many countries complicated by widening inequality and insecurity which weaken community solidarity and contributes to increased resistance from the wealthier strata to progressive taxation.

Further constraints on fiscal capacity include:

- The neoliberal doctrines of austerity and small government;
- Illicit financial flows and tax evasion;
- Tax competition and corporate extortion;
- National debt and debt servicing burden; and
- Challenges of tax collection in the informal sector.

Constraints on donor funding to support UHC also arise from limited *absorptive capacity* (and the risk of foreign funding increasing competition for scarce resources and driving inflation) and uncertainties regarding *fiscal sustainability* (the prospect of increasing domestic capacity over time). The IMF polices these contingencies closely (Ruckert and Labonté 2013).

Against these limits on domestic resource mobilisation, there can be macroeconomic arguments for increasing health sector spending.

China, from 2009, massively increased health expenditure through government run reimbursement schemes, explicitly with a view to unlocking household spending by reducing the need to save. By

providing assurances of financial protection in health care, households would increase consumption expenditure and stimulate the domestic economy (Du et al. 2010). In contrast, the US accepts very high per capita health expenditure, as a form of industry policy, encouraging the development of US health care supply industries including new products for global markets.

Along these lines WHO has sought to challenge doctrines of austerity in health care funding by pointing to the benefits to other sectors of the economy from local expenditure and employment in health care (health care Keynesianism) (WHO 2021b).

However, in the absence of meaningful reform of neoliberal globalisation the scope for significant increases in domestic resources for health care in LICs appears limited and the promise of donor assistance uncertain.

Health services as markets for transnational suppliers

It may be that the increasing support for UHC among the G7 confederacy reflects the pressures of the global supply industries (and their think tanks and lobbyists) for expansion of the health care market globally.

The health sector globally, including the middle classes of L&MICs, is a rich market for transnational suppliers, including pharmaceuticals, electronics, hospital chains, and health insurance. Not surprisingly these industries are powerful drivers of trade liberalization (including trade in services and e-commerce) as well as various forms of investor protection and 'non-discrimination' rules.

The neoliberal program looks towards the expansion of the high technology hospital sector, catering to middle class consumers and offering new profit opportunities for corporate hospital chains and their suppliers, including through medical tourism and cross border servicing.

The World Bank actively provides funding support for companies investing in private hospitals in developing countries including exploiting market opportunities in the trade in health services. In addition to the long-standing international brain drain there is a growing domestic brain drain as new graduates are soaked up in the private high technology sector and donor funded projects and the staffing of primary health care services continues neglected.

In the context of a global crisis of overproduction and underconsumption, health care (and in particular, high tech health care) is a market of great promise. From a corporate perspective it makes little difference if it is funded by LMIC governments or middle class insurance premiums or philanthrocapital and the tax payers of the rich world.

The UHC narrative explicitly envisages private providers in the UHC sector and in the market for 'beyond-the-package' services, supported by complementary private health insurance.

UHC2030 (a global public private partnership advocating around UHC) has recruited a large private sector constituency as part of the UHC 'movement', including big corporate names from pharmaceuticals, electronics and finance. It is beyond credible that their support is based purely on altruism.

Regulatory capture and affordable access to medicines

An important set of articulations between global health and global political economy are the various international agreements and regulatory bodies whose regulations impact on population health and health care, including environmental, food, and pharmaceutical regulation.

The principal dynamic at these points of articulation (health-related regulation) involves the harnessing imperial diplomacy to advance the interests of transnational corporations which might be subject to such regulation. Two cases which are directly relevant to the affordability of pharmaceuticals in L&MICs and the realisation of the UHC promise are the guidelines for marketing approval for biosimilars and the 'counterfeit scare'.

In the biosimilar case, pharma and its national supporters have sought to require biosimilar marketing applications to be assessed as completely new drugs; involving further cost and delay, not to speak of the ethical breach of requiring repeat efficacy trials (Sengupta 2018).

The counterfeit case has involved a long-standing campaign by pharma and its national supporters to exaggerate the risks of 'counterfeit' drugs in attempting for encourage L&MICs to legislate to preclude the use of TRIPS flexibilities (which might provide for swifter access to safe and effective generics) and to require national medicines regulators to police intellectual property rights (hitherto belonging to the civil rather than criminal code (Son et al. 2018).

Policy attention to ensuring rapid affordable access to biosimilars and generic small molecules has been strangely absent from the UHC conversation.

Labour productivity and healthy markets

Improvements in labour productivity through donor supported disease programs has been a significant dynamic in the political economy of global health. Rockefeller's support for hookworm eradication in the early decades of the last century is the paradigm case historically (Brown 1979).

The argument about labour productivity surfaced again in the World Bank's Investing in Health in 1993 in which the bank argued that economic growth benefits health and health improvement benefits economic growth. In advancing this argument the bank was able to refer to the AIDS crisis and the economic disability arising from the illness and deaths of young adults.

The Bank proposed an approach to health care funding based on the 'defined benefit package' and developed a sophisticated metric for assessing the benefit cost ratio (disability adjusted life years (DALYs) gained per dollar spent) for a range of interventions. While the report did not explicitly recommend priority be given to diseases which impacted on labour productivity, it did include an age weighting in its calculation of the DALY which assigned premium value to young adulthood.

The Commission on Macroeconomics and Health argued that the scaling up of essential health interventions in L&MICs would cost around $66 billion per year but would yield between $186 and $500 billion in 'direct benefits'. The Commission argued that increased household income would translate into faster economic growth and projected annual gains in GDP in the low income countries of $180 billion per year.

This argument was directed to the donor countries seeking to persuade them to increase their aid commitments. The Commission's argument for such a scaling up of donor funding was couched in terms of global solidarity, forging 'a true global community'. However, economic policy makers in the donor countries would be very alive to the implications for their own economies of increased consumer demand in the LICs as well as increased security for investors in extractive industries or assembly platforms.

The labour productivity / consumer markets argument has not figured prominently in the UHC narrative but the wide range of corporations who have joined the UHC2030 'private sector constituency' suggests that it is widely appreciated. However, much of the corporate interest in

consumer markets in developing countries has been focused on the wealthy rather than the masses; a market which deepens with widening inequality. In this light, the encouragement of two-tiered healthcare through UHC (as discussed above) might help to adapt to income inequality while securing consumer markets based on the wealthy as well as securing access to resources and (more productive) labour.

Securitization of contagious risk

Health policies and practices which highlight the threat to 'us' of disease prevalence amongst 'other there' can veer towards treating 'the other' as the existential threat.

The first International Sanitary Conference (in 1851) was convened in the shadow of recurring epidemics of cholera. There were 11 such conferences over the succeeding decades. The conferences were dominated by the colonial powers of Europe and were largely directed to protecting trade and commerce from epidemic disruption, in particular 'Asiatic cholera'. Much of the focus was on the various arrangements adopted by different countries to control the spread of disease through shipping (Howard-Jones 1975).

The economic benefits of disease control extend beyond shipping. In his analysis of WHO's malaria eradication program Packard (1997) quotes Professor Missiroli of Italy as saying in 1948 that, "Africa cannot be fully exploited, because of the danger of flies and mosquitoes; if we can control them the prosperity of Europe will be enhanced."

In 2005, following the SARS crisis, the International Health Regulations were revised with a range of new provisions to broaden their reach. While couched in the language of public health they continued to emphasise restraint in any interruptions of trade and there remained a subtext which speaks of protecting the rich world against the pestilence of the poor.

The IHRs set forth the obligations of national authorities in the event of infectious disease epidemics with international implications. The revised IHRs imposed new obligations on states parties including to put in place a set of 'core capacities' seen as needed for full global security. The IHRs provide for the appointment by the DG of review committees to make recommendations regarding the functioning of the IHRs and review committees in 2011 and 2015 were sharply critical of countries which had not put in place the core capacities required by the regulations (Review Committee 2011, 2015).

Many L&MICs see the high standards required by the IHRs with respect to 'core capacity' as serving a 'global health security' agenda which may be a higher priority for the rich countries than for the poorer ones. The opportunity costs of investing in core capacities are very different for poor countries, compared with rich countries, particularly for those with fragile health systems. In many countries the marginal dollar would go much further if, for instance, it was directed to reducing maternal mortality rather than strengthening port of entry monitoring. IHR capacities are global public goods; there is no guarantee that the benefits of such investments will flow to the people of the country making such investments.

The benefits to global health security are clearly part of the case for progressing UHC (see for example, Jain and Alam 2017). The public health capacities called for by the IHRs need to be developed as integral parts of a fully functioning health system; not as a stand-alone add on demanded by other countries.

Undoubtedly the potential benefits in terms of global health security have figured prominently in advocacy to potential international donors. However, the arm twisting is likely to continue, including making donor support for UHC conditional upon giving priority to achieving the core capacities.

The systemic crises of global capitalism

Global capitalism faces three systemic crises: geopolitical, macroeconomic and ecological. Crises and transitions in all three domains have powerfully shaped the context in which the UHC narrative has emerged.

Geopolitical transitions

Geopolitical transitions have impacted upon global health in many ways. Two historical instances which have shaped contemporary global health governance are:

- The high level of decentralisation built into the organisation of WHO as the legacy of the integration of the PASB into WHO (and the refusal of the US to contemplate full incorporation into an organisation over which it might have less control) (Howard-Jones 1980); and
- The impact of decolonisation on the membership of the World Health Assembly and the need of the rich world to hobble WHO financially (to prevent it implementing programs which reflect consensus in the Assembly) and to develop new models for global health implementation (in particular the multi-stakeholder global public private partnership, as in the ACT Accelerator for COVID-19).

The central tension in contemporary geopolitics is between the USA and China. China's Belt and Road Initiative has offered infrastructure spending for scores of L&MICs which has boosted China's standing in many countries. More recently, the brutal vaccine nationalism of the rich countries, and their support for pharma's refusal to support a rapid scale up of global vaccine production, have greatly damaged the standing of the rich countries in the eyes of the global South; in particular, in comparison to China's vaccine diplomacy.

The need to restore the political standing of the old imperialism (vis a vis a rising China) in the eyes of the L&MICs has not figured explicitly in the UHC discourse but undoubtedly it is being considered in decisions about mobilising the donor funding needed to implement UHC in LICs.

Macroeconomic crisis

The instabilities of globalized transnational capitalism and the neoliberal policies being deployed to manage those instabilities are critical articulations between macroeconomics and global health and powerfully affect the UHC conversation.

The wave of decolonization in the 1950s and 1960s corresponded to a long period of relatively high growth rates globally – the 'long boom'. High rates of economic growth after the second world war were associated with new technologies (including steep increases in the use of fossil fuels), the conversion of war industries, urgent demand for consumer (and producer goods) and the liberalization of trade in goods (Amin 2003).

Decolonisation in the context of the long boom was associated with a certain optimism which was expressed in the emergence of the non-aligned movement and the call for a new international economic order (NIEO) in 1974 (Sneyd 2005).

However, by the early 1970s economic growth was slowing and inflation was growing, so called 'stagflation'. (The Alma-Ata Declaration on PHC in 1978 (and its reference to the need for a NIEO) was one of the last expressions of the Third World optimism which flourished during the 'long boom'.) It is now evident that the economic slowdown of the 1970s reflected an emerging mismatch between the expansion of global productive capacity and slower growth in consumer demand, increasingly limited by the displacement of labour by technology and fossil fuels, and the growing dominance and efficiency of global supply chains. Associated with this 'crisis of overproduction' (and

underconsumption) was a spiral of price and wage increases as capital and labour both sought to preserve income flows.

In the end, capital, led by Thatcher, elected to 'fight inflation first', setting out to destroy the trade union movement with a view to combatting wage increases. In 1980 the US Treasury joined the attack with a sharp escalation of interest rates, close to 20% in 1981. The consequence was a prolonged recession but union power was weakened (and corporate pricing moderated) and inflation was brought under control.

While the unions of the developed countries may have been the principal targets of the increased interest rates, they had a devastating impact on the countries in the Global South. Many developing countries had borrowed from the international banks when interest rates were low or even negative in the early 1970s but when interest rates increased the debt trap was sprung and the regime of IMF determined structural adjustment was launched.

While inflation was brought under control, the problem of anaemic economic growth has continued. During this time 'financialisation' has emerged as a dominant feature of contemporary capitalism. This refers to the increasing proportion of economic activity which is taking place in the financial sector, only indirectly related to the production and consumption of real goods and services.

As market demand has remained sluggish the proportion of profit going to productive investment in people, buildings, and machines has fallen, with an increasing flow into the purchase of existing assets (including companies, shares, derivatives as well as housing) for either speculation on asset price inflation or for concentrating control of particular supply chains.

The macroeconomic crisis impacts on global health in a myriad of ways, both directly and as a consequence of the package of neoliberal policies put in place since the 1980s to manage the economic crisis (in the interests of the transnational capitalist class). These impacts include:

- Widening inequality (poverty and hunger coexisting with obscene wealth) as a consequence of the shrinking productive base and domination of global supply chains and the wealth being conjured out of the stock market;
- War, migration, displacement, and asylum seeking as a consequence of economic stagnation and drought;
- Unhealthy products and processes, ranging from tobacco, chemicals, air pollution, occupational hazards;
- The hobbling of economic development in L&MICs as a consequence of the monopoly power of transnational corporations and their control of global supply chains and the drive for trade liberalisation and monopoly protection through trade and investment agreements; and
- Small government, austerity, and privatization.

Direct impacts on the UHC project include:

- The extent and depth of poverty in L&MICs and its manifestation in avoidable ill-health, barriers to care and medical impoverishment;
- Widening inequality globally with the emergence of elite consumer demand in many poor countries and the fraying of social solidarity as the lived experience of elites moves away from that of the masses;
- Tax competition, tax avoidance, and illicit financial flows all contribute to weakening L&MIC financing capacity;
- Institutional disabilities which are the legacies of colonisation, structural adjustment and the continuing doctrines of small government;

- Barriers to accessing affordable health care products and to the local production of such commodities; and
- The need of capital to find new markets for health care products, consumer goods generally, and finance capital.

The neoliberal policy package is directed to stabilising globalised capitalism in the face of this crisis of over-production and financialisation. It is directed to stabilising it in the interests of transnational capital. However, the impact of the crisis on ordinary lives continues, exacerbated by the impact of neoliberal polices.

In this context the conversion of the World Bank and corporate elites to the cause of UHC seems counter-intuitive. However, the need to shore up the legitimacy of the neoliberal regime is self-evident; the development of two tiered health care promises a tight limit on public expenditure; and there are material benefits for the corporates arising from the way in which UHC is being implemented (discussed elsewhere in this section).

Ecological crisis

Global warming, loss of biodiversity, and pollution constitute the third crisis of global capitalism with horrific implications for global health, including:

- Zoonotic illnesses and pandemics;
- Hunger from drought; deaths from heat stress;
- Climate induced disasters; storms, floods, and fires; and
- Climate refugees facing displacement, migration, asylum seeking and war.

One of the most horrific aspects of this crisis has been the refusal of the transnational class, including business and political leaders, to acknowledge or take action to mitigate global warming until it is (apparently) too late.

A key argument for UHC arises from the recognition of the role of functioning health services in responding to humanitarian emergencies. Whether UHC, as currently promoted, will meet this need is moot.

Financial regulation, trade and investment agreements

A complex body of international law sets out the rules for global order, including rules governing banking, taxation, trade and investment. In large part these rules are directed to stabilising globalised capitalism and to progressing the neoliberal project although some are directed to issues such as human rights and biodiversity.

Many of the rules which comprise international law do not have effective enforcement mechanisms. Trade and investment agreements are different in that they are equipped with enforcement powers through the authorisation of bilateral retaliation. This is highly asymmetrical in that the sanctions available to the economic hegemon are much more powerful than those available to small and middling states.

The consequences for global health of international economic law are profound. They play a key role in regulating economic globalisation; in emplacing and protecting the neoliberal regime; and protecting the transnational capitalist class from the consequences of the rolling crisis of overproduction and financialization, even while exacerbating the crisis. In this respect they contribute to the global health consequences of macroeconomic crisis reviewed in the preceding section.

However, they also have very direct impacts on global health, including through intellectual property laws, 'trade in services' provisions, investment treaties, competition policy, and government procurement restrictions (Gleeson and Labonté 2020). These include:

- intellectual property provisions (in TRIPS and various plurilateral agreements) which keep the prices of medicines high, impacting affordability, access and impoverishment in L&MICs;
- trade in services provisions (in the General Agreement on Trade in Services (GATS), various plurilateral agreements and being pushed through a range of parallel pathways) which serve a ratchet-like function in preventing the winding back of any privatisation or marketisation of national health services;
- investor state dispute settlement provisions (in many investment agreements) which can prevent action on health hazards arising from foreign investment (for example, in extractive industries); and
- competition policy (in particular, most favoured nation and national treatment provisions), with the potential to prevent national procurement programs.

In terms of the direct implications for the UHC project I highlight: first, the failure in the UHC narrative to address the role of IP in preventing affordable access to quality medicines; and second, the role of UHC (as currently promoted) in driving marketisation and privatisation of health services, and thus exposing countries to barriers in trade rules to any return to publicly administered health services.

Global health governance

Global health governance encompasses a complex interplay of multilateralism, imperialism, rich country confederacy, philanthrocapitalism and multistakeholderism. It includes the sponsorship and operations of GHIs and the projection of corporate power, including through multistakeholderism.

The changing organisational forms of global health coordination provide a useful window through which to review the articulations between global governance and global health over the last 70 years.

The design of WHO was largely determined in negotiations between Europe and the US. However, postwar decolonisation brought more L&MIC voices to the Assembly and over the years there were increasing number of issues where the Assembly supported policy positions which challenged capitalist hegemony. These included: support for the NIEO in the Alma-Ata Declaration, the essential medicines list (Laing et al. 2003) and the marketing of breast milk substitutes in 1980s (Richter 2002), the proposed R&D treaty (Velásquez 2012) and the rebuff to pharma over the counterfeit scare in the 2000s (Shashikant 2010).

While the rich countries are now in a numerical minority in the Assembly, they are still able to deploy the power of the purse. Right from the start the member states were quite parsimonious over the level of assessed contributions (ACs, the mandatory annual contribution) and from the start extra-budgetary funding (now referred to as voluntary contributions or VCs) played an important role in funding WHO's operations. In the early years much of this came from other UN organisations but the high income countries were also funding specific projects which they supported (for example, the US support for the malaria eradication (Litsios 1997); US, Soviet and Swedish support for smallpox eradication) (Henderson 1998).

Over the succeeding decades WHO (and the UN more broadly) became increasingly dependent on tied donor funding. In 1971 voluntary contributions amounted to 25% of WHO's total revenues (most of which came from UNDP and UNFPA). By 1986/7 voluntary contributions amounted to 45% of total (Walt 1993). By 2020-21 it was 84%. The combination of the freeze on ACs and tight earmarking of voluntary contributions has meant that virtually all operational expenditure (other than basic

administrative costs) is dependent on donor funding. From 2000 the Bill and Melinda Gates Foundation was providing an increasing proportion of donor funding, tightly ear-marked and focusing largely on vertical disease focused interventions.

WHO adopts a budget every two years reflecting the priorities of the member states. However, the donors (including in particular the World Bank, the Gates Foundation, the US and the EU) only fund projects of which they approve. Thus the de facto budget is based on what the donors will fund rather than the priorities of the World Health Assembly.

In this situation WHO's leadership has to be very careful not to disregard donor preferences lest the donors place further restrictions on their funding or even cut it back (as the US did in 1986 and periodically threatens to do again).

The other major change, dating back to the turn of the millennium, was the emergence of multiple global health initiatives where donor funding went straight to specialist organisation (Gavi, Global Fund for AIDS, TB and Malaria, Global Polio Eradication Initiative, etc). The President's Emergency Fund for AIDS Relief (PEPFAR) operates in a similar mode although it is an initiative of the US Government.

Reframing global health in terms of multi-stakeholder partnerships rather than multilateralism and member state sovereignty has ensured that the World Bank, the rich countries, the philanthropic foundations and increasingly the corporates all have a seat at the table. The creation of the Access to Covid Tools Accelerator (ACT Accelerator) in the context of the Covid pandemic illustrates this multistakeholder model, including in this case, the involvement of the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) in the design of the Accelerator.

WHO's confused and incoherent approach to UHC reflects the power of the donor chokehold. WHO has entered a Faustian pack with neoliberalism: WHO gets the credit for addressing health care access and financial protection in return for endorsing the neoliberal project in health (under the cover of UHC).

The power and purpose of philanthrocapital

The creation of the Rockefeller Foundation (RF) in 2013 was a significant moment in global health history (Palmer 2010). The Foundation has donated to a very wide range of issues, institutions and countries since its creation (Birn and Fee 2013). The Bill and Melinda Gates Foundation, from 2000, reprised the Rockefeller history. It has contributed to global health (both research and disease focused interventions), to agricultural 'development' in Africa, and to education (Youde 2013; People's Health Movement, Medact, and Global Equity Guage Alliance 2008).

Clearly philanthrocapitalism is an important point of articulation between global health and global political economy (Birn 2014).

John D Rockefeller Sr operated a vertically integrated oil monopoly which he built through managerial efficiency, predatory pricing, corruption, and anti-union thuggery. Bill Gates benefited from being a pioneer in software development and charging very high prices under the intellectual property protection including, from 1995, the protection put in place through the TRIPS Agreement. He also sought to use his operating system monopoly to force users to use his browsing application and similarly to increase his pricing power through bundling Microsoft's Office apps. Warren Buffet who is part of the BMGF made his wealth through asset price speculation in the era of financialisation. All three have benefited from tax deductibility of charitable donations; in effect a huge tax payer subsidy to their foundations.

Both Rockefeller and Gates turned to philanthropy at a time when their corporations were under public opprobrium and legal threat. Their turn to philanthropy may have contributed to rehabilitating their public image.

The giving strategies of these two philanthropies have been quite different. The RF has placed a strong emphasis on institution building (including the institutions of public health research, education and practice, and the institutions of global health coordination from the LNHO to WHO). Rockefeller's support for UHC could be seen as continuing this institution building theme.

Gates practises measurable impact philanthropy with a focus on finding, researching and deploying technical fixes including through Gavi, the Global Fund, GAIN, CEPI and FIND. Gates explorations of agricultural development in Africa (AGRA) are focused largely on technology and scale without regard to the way cheap processed foods from the global North are undercutting market prices for locally produced foods.

The effects of RF's investment in public health capacity in the US has been to strengthen capitalism by improving it and their investments in disease prevention in low income countries may have provided some gloss to the workings of US imperialism, at least as seen from the US. Gates's funding of medicines and vaccines has served to ameliorate one of the consequences of the intellectual property regime installed through TRIPS namely the high cost of medicines and vaccines. It is this regime on which Microsoft's profits were based.

The philanthropy of both foundations has had specific effects on global health. The RF has contributed to global health coordination, and to the development of institutions of public health research, education and practice. It is useful to ask, what the institutions of global health would look like today if not for the RF investments. It is possible that public health might have developed with a stronger sociological and political economy perspective which might have nicely complemented the metrics of epidemiology and biostatistics.

In sharp contrast to the RF's contribution to the coordination of global health (including its support for the LNHO and contribution to the launching of WHO) the Gates Foundation is contributing to the destruction of WHO through the subordination of WHO to global capital in the shape of philanthrocapitalism, the IFIs and the G7 confederacy.

In relation to UHC:

- RF has taken the lead in promoting the UHC narrative (and insisting on ensuring a healthy role for the private sector); and
- Gates has supported several of the platforms promoting UHC including UHC2030 and its private sector constituency and the think tank R4D which has spearheaded the promotion of UHC in L&MICs.

The dance of legitimation

The legitimation cycle starts with policies which kill (structural adjustment, high prices for AIDS drugs, medical impoverishment), leading to calls for reform, leading to programmatic initiatives designed to palliate the harmful policies while avoiding fundamental reform. Perceived legitimacy plays a major role in maintaining political stability; the contestation of legitimacy is a key strategy in political engagement (Bexell 2014).

In the 1980s the legitimacy of neoliberal globalisation and the role of the IFIs came into question globally as a consequence of the brutality of the IMF's SAPs including their impact on health (Breman and Shelton 2007). The World Bank's 1993 report, Investing in Health (World Bank 1993), was a major

investment in seeking to relegitimise structural adjustment by claiming that it was compatible with health improvement.

The launch of the WTO in 1995 was associated with a further liberalisation of trade in goods which created new barriers to domestic manufacture in L&MICs while doing nothing about agricultural protection in Europe and North America (and the barriers to agricultural exports from L&MICs). Meanwhile there was continuing pressure around investor protection and further liberalisation of trade in services. However, it was the TRIPS Agreement, which highlighted most clearly the structural barriers to social and economic development in L&MICs which were embedded in the new global trade regime. This was expressed most sharply in the pharmaceutical industry's attack on South African access to medicines initiatives (1997-2001).

In this context the huge increased in development assistance for health associated with the launch of the MDGs in 2000, can be seen as a massive investment in the relegitimation of the neoliberal regime.

However, by the middle of the first decade the legitimacy of the MDGs and GHIs was being questioned as the drawbacks of narrow vertical programs were increasingly clear: internal brain drain, health system fragmentation, transaction cost burden, barriers to access and medical impoverishment (because vertical disease focused programs left access to too many services totally dependent on user fees) (WHO 2011).

The delegitimation of the MDGs and vertical disease prevention were followed by UHC and the SDGs. WHO had been arguing for UHC from 2005 and it was prioritised from 2011 and included in the SDGs from 2015. UHC promised relegitimation for the WB and the G7, and for the neoliberal project more generally. Corporate friendly UHC also promised new markets for global supply chains and new opportunities for finance capital. The concessions that WHO made in the representation of UHC was the price paid for a new respectability in the eyes of its donors.

The Covid pandemic of 2020-21 led to a new round in the dance of legitimation with the lack of solidarity shown in the vaccine nationalism of the rich world and the insistence of the G7 on protecting pharma from any accountability for the limits imposed on production volumes. At a time when vaccine coverage in Africa was less than 4%, Europe and North America had achieved vaccination rates of around 80% and were planning to introduce booster doses. The loss of legitimacy of the G7 and its corporate elites in the eyes of the global South has been profound. How this will play out is unclear.

Notwithstanding its money, institutional power and military force the transnational capitalist class is vulnerable to delegitimation in the eyes of the global South (and progressive domestic forces). This points to the strategic significance, for Health for All activists, of strong dialogical critique, well communicated and widely distributed.

6. The agency of 'community' in global health

The political economy of global health is not just about the public health experts, the politicians and government officials, the bureaucrats of the international organisations, the corporate strategists, the transnational elites, and the philanthrocapitalists. At each point of articulation described in the preceding section the dynamics of stability or change are contested, including by political forces which reflect in various ways the communities whose health and whose health care is at stake.

The political dynamics of stability and change

The dialectical method is useful in analysing the political dynamics of stability and change. This involves identifying contradictions between opposing forces which are shaping the outcomes which we are trying to understand and to intervene in. In terms of analysing the global dynamics of stability and change, I focus on class, gender, ethnicity, and nationalism.

Class analysis has a long history in political economy. Traditionally it posits a struggle between capital and labour over surplus value and this framing remains useful. However, the emergence of transnational capitalism and the transnational capitalist class calls for some further development of the model. In contemporary capitalism the transnational capitalist class confronts, not just one national proletariat but an aggregate of dispersed middle classes, working classes, and displaced and impoverished populations. The security of capitalism depends on maintaining the dispersed and fragmented character of this opposition.

Analysis of contradictions around gender adds to the usefulness of class analysis. Patriarchy (comprising the structures, practices and ideologies of gender oppression) plays a key role in maintaining the dispersal and fragmentation of the global subordinate masses. If the energy which goes into oppressing women, and in fighting that oppression, was to come together to confront the transnational capitalist class the prospects for progressive social change would greatly improve. However, patriarchy is not just a force for weakening a 'class' response. Patriarchy is intrinsic to capital accumulation; the surplus value extracted from 'women's work' reflects a continuing process of primitive accumulation.

Ethnicity and nationalism also add usefully to class and gender analysis. As with gender, hostilities across national borders or ethnic identities serve to weaken the potential opposition to the depredations of capital. However, racism has been and remains intrinsic to capital accumulation; historically in the form of colonialism, and contemporaneously through the continuing dynamics of internal colonialism. The economic challenges facing many countries in the global South can be traced directly to the experience of colonisation and to the continuing dynamic of imperialism.

The forces working towards 'Health for all' in different settings around the world can have little hope if they cannot build stronger alliances across the various class, gender, ethnic and national divisions. Fascism exemplifies the role of division in maintaining capitalist hegemony. Roberto (2018) identifies three conditions for the emergence of fascism: an aggrieved constituency, demagogic leadership, and the support of (at least) a fraction of capital. These conditions were evident under Trump: a white working class aggrieved by the structured exclusions of neoliberal globalisation and resentful at the failures of the Enlightenment Promise; the demagogue (personified by Trump); and the mobilisation of national capital against the dominance of transnational capital.

In contrast to the dispersed plebians, the forces of transnational capital are coherent, self-conscious, well resourced and well informed. The Private Sector Constituency of UHC2030, working to secure a dominant role for the private sector in the roll out of UHC, illustrates the coherence of transnational capital in relation to global health.

Social and political movements

The second theoretical resource I draw on is the concept of social and political movements which provides a useful framework for describing, analysing and strategizing the agency of communities; including those who carry unfair and avoidable health burdens through the dynamics discussed above.

The social movement is a collectivity who shares (in some degree) a concern, a set of experiences, an analysis and a sense of direction. It includes a range of organisations (including political parties) encompassing different segments of this collectivity, but the movement itself is not organised in the sense of having an explicit set of policies and a disciplined coherence of action. Paradigm cases of the social movement are the environment, the women's, the labour, and the Islamist movements.

The focus of social and political movements may correspond to a dialectical analysis but not necessarily. One of the main political movements engaging in global health policy in recent years has been that built around the experience of people living with AIDS/HIV. The power of the movement depends in part on how strongly people *identify* with the experiences and aspirations underpinning the claims of the movement. However, movements are not exclusive; there are no barriers to people identifying with several such movements.

The advocates of UHC often refer to themselves as a movement; the 'movement for UHC'. However, it is a movement largely based in US think tanks, neoliberal economists, international bureaucrats, and philanthrocapitalists.

Connecting the dots: the importance of political economy

Some of the dynamics discussed in this chapter only come into focus when approached through a political economy lens. These include:

- the significance of health services as markets for transnational suppliers (and the role of UHC in ensuring access to such markets);
- the significance of population health as a factor in labour productivity, in ensuring secure access (for the transnationals) to primary commodities and in guaranteeing healthy consumer markets;
- the significance of the global crisis of overproduction in necessitating (from the point of view of transnational capital) the neoliberal program and the significance of trade agreements in locking in the neoliberal regime; and
- the dance of legitimation.

If these dynamics are to be fully recognised in the struggle for health the various civil society movements in health need to build their political economic literacy.

A strong political economy narrative also provides common ground for collaboration between many different social movements, including and beyond health. Without such an analysis they may view their struggles in isolation; through the political economy lens they can see why they need to collaborate.

The role of the State

The confrontations between the governments of the global South and the governments of the G7 play a critical role in shaping our shared future.

However, the State and its officials are torn in the struggle for health; torn between joining the imperialist project (or at least succumbing to its pressures) versus resisting such pressures and charting an independent path towards a more equitable, sustainable, convivial, and peaceful future.

The State is therefore a key focus of activist advocacy, including around issues such as the transaction costs and health system fragmentation associated with vertical silos; trade agreements which lock in neoliberal policies, the loss of national investment in training through the brain drain; and the unaffordability of medicines. More generally the struggles over democratic practice, human rights,

official accountability, and community participation contribute to empowering the state to resist the empire in concert with other governments of the global South.

However, Health for All activists are also confronting the imperialist project directly as nodes in global networks of civil society activism. Struggles around the neoliberal trade agenda bring together labour activists and various civil society networks concerned with quite specific issues at risk through those trade agreements, including health. Civil society networks also play a major role in challenging transnational pharma on a range of fronts (including the abuse of intellectual property protection).

Strategies

The forms of struggle and strategic principles evident in the articulations and dynamics discussed earlier are, in general terms, familiar. They include advocacy, refusal, electoral engagement, movement building, capacity building, etc. Other dynamics which can also have far reaching impacts include research and development and institutional innovation.

One aspect of strategy which has emerged from the preceding account is the significance of delegitimation; the vulnerability of the corporates and elite political structures to perceptions of illegitimacy and the power of civil society campaigning to gain leverage from this. The avoidable deaths consequent upon the deliberate supply limitations imposed by pharma (and supported by the G7) in the Covid context provide some leverage around corporate impunity and against extreme intellectual property protection. Wider appreciation of the use of 'UHC' to provide cover for the implementation of health care privatisation may provide some leverage to resist the imposition of two tiered health care.

The articulations described in this chapter are manifest in many different forms and are being contested in different settings, with different forces and dynamics. The forces working towards Health for All in these different settings need to address the specificities of those struggles but to do so in ways which also challenge the structural forces which reproduce those needs; to do so in ways which also help to build solidarity across difference within the wider plebian collectivity.

Primary health care has a special place in relation to civil society activism for health because of the proposition that it is part of the job of primary health care practitioners and agencies to work with their communities to build an understanding of the social determinants of health and participate in addressing them. Models of health care delivery which seek to reduce health care to sickness care and disease prevention (and to commodify these) would have the effect of removing intersectoral advocacy from the primary care sector.

Engaging with health systems development

The struggle around the conceptualization and implementation of UHC is a priority for the Health for All movement at the present time.

In framing a Health for All strategy in this struggle, it is necessary to consider how health systems develop and to articulate principles and strategies for engaging in these processes.

Health systems mainly develop through small dispersed incremental changes but change sometimes emerges as part of large scale structural change. Health activists must prepare for and contribute to both pathways.

The incremental model of health systems development envisages windows of opportunity opening at different times, in different sectors of health care, at different levels and in different circumstances. Progressing the struggle for Health for All in these times and places depends on having practical policy solutions ready in each setting and an informed, organized political constituency ready to drive them.

Windows of opportunity arise when established institutions 'unfreeze' (often because of increasingly evident dysfunction or wider institutional turmoil). Change can be achieved at such moments and places if there are clever policies on hand, and public interest constituencies driving towards a coherent vision for change (Kingdon 1984).

The timing and location (level, sector, place) of the institutional unfreezing and consequent opportunities for change are unpredictable. Activists must cultivate reform readiness (across levels, sectors and places). This involves building consensus around preferred directions and building policy capacity and policy dialogue among stakeholders, including various affected communities, to ensure that there will be constituencies ready to drive clever policies to address the various contingencies that will emerge; strengthening the political leadership needed to drive change (WHA 2011a).

While health systems develop incrementally, there is also a need for a broader coherence of the reform trajectory so that the sum of specific reforms across time and place is coherent; progressing the development of a decent health system. This points to the importance of building a widely shared vision of what a decent health system looks like.

Policy debate around the promises of UHC has an important place in such policy conversations. However, it is also essential to articulate clearly how the neoliberal health project is embedded in the discourse of UHC.

Health reform can also take place as part of whole of society disruptions (China, Thailand, Brazil, South Africa). Opportunities to achieve health reform in such circumstances depend on being part of the broader constituency for change and committing to health reform as part of the broader social change project. This will involve health activists working across difference in building a common program (for decent health care *and* for a better world).

Not just about health

The struggle for an equitable, sustainable but 'reasonably prosperous' civilisation cannot be just about health. Beyond health care the neoliberal project promises deepening inequality, accelerating global warming, an increasing flow of refugees and the risk of devastating conflict arising from the combination of these.

While the ecological crisis presents significant global health issues there is in place a global movement to contain global warming, preserve biodiversity and stop pollution and for a wide range of reasons. The health activists working on zoonotic pandemics, antibiotic resistance or deaths from heat stress need to see themselves as part of this movement.

The associated challenges include building solidarity across difference, in particular, across gender and ethnicity, and rolling back the hegemony of the transnational capitalist class while also reaching out to various aggrieved and resentful constituencies.

7. Conclusions: The promises of UHC

For the strategists of transnational capitalism UHC promises opening of new markets for health commodities and market opportunities for consumer goods more generally. UHC will contribute to the relegitimation of the global neoliberal regime, demonstrating that it is not so heartless after all.

For national politicians, officials and civil society activists concerned about health development UHC promises a pathway to health system strengthening but there are grounds for caution. UHC as currently promoted will lock in two tiered health funding and two tiered service delivery. Under the

model on offer the controls over quality, efficiency and equity are weak, particularly in the private sector. Weak cost control in the private sector is likely to lead to premium inflation and political pressure to subsidise private insurance and widen access to insurance rather than expanding the basic package. There appears to be no capacity in the model on offer for intersectoral collaboration and action on the social determinants of health, particularly at the primary care level.

For poor people facing financial barriers to care and the risk of medical impoverishment UHC promises financial protection but there are grounds for caution here also. Widening inequality and two tiered health funding compromise solidarity and revenue mobilisation and the prospect of widening the benefits package. Barriers to access and medical impoverishment are a reflection of widening economic inequality associated with the global crisis of overproduction. The UHC narrative offers no suggestions for reform here, indeed it is part of the neoliberal program which is perpetuating that crisis.

The challenges for the Health for All movement include: integrating a technical policy analysis with a political economy analysis; working in community on the specific and immediate health issues but in ways which also address the larger structural issues which reproduce those needs; promoting a vision of what a decent health system would look like; working in ways which deepen solidarity across difference in building a better world.

8. References

Amin, S 2003, 'The political economy of the twentieth century', *Obsolescent capitalism*, Zed Books, London & New York, pp. 7-21.

Bexell, M 2014, 'Global Governance, Legitimacy and (De)Legitimation', *Globalizations*, vol. 11, no. 3, pp. 289-99, <http://dx.doi.org/10.1080/14747731.2014.919744>, viewed 2015/07/15.

Birn, A-E 2014, 'Philanthrocapitalism, past and present:

The Rockefeller Foundation, the Gates Foundation, and

the setting(s) of the international/global health agenda ', *Hypothesis*, vol. 12, no. 1, p. e8.

Birn, A-E & Fee, E 2013, 'The Rockefeller Foundation and the international health agenda', *The Lancet*, vol. 381, no. 9878, pp. 1618-9, <http://dx.doi.org/10.1016/S0140-6736(13)61013-2>, viewed 2017/12/02.

Birn, A-E, Pillay, Y & Holtz, TH 2009, 'The historical origins of modern international health', in Anne-Emanuelle Birn, Yogan Pillay and Timothy H. Holtz (eds), *Textbook of International Health: Global Health in a Dynamic World*, Oxford Universithy Press, New York & Oxford, pp. 17-60.

Breman, A & Shelton, C 2007, 'Structural adjustment programs and health', in Ichiro Kawachi and Sarah Wamala (eds), *Globalization and health*, Oxford University Press, New York, pp. 219-33.

Brown, ER 1979, *Rockefeller medicine men: medicine and capitalism in America*, University of California Press, Berkeley, Los Angeles, London.

Brown, S 2020, 'Foreign aid, the mining sector and democratic ownership: The case of Canadian assistance to Peru', *Development policy review*, vol. 38, no. S1, pp. O13-O31, <https://doi.org/10.1111/dpr.12454>, viewed 2021/09/10.

Brundtland, GH 1999, *Looking ahead for WHO after a year of change*, WHO, Geneva, <http://apps.who.int/iris/bitstream/handle/10665/79260/ew4.pdf>.

Brunner, G, Gottret, P, Hansl, B, et al. 2012, *Private Voluntary Health Insurance : Consumer Protection and Prudential Regulation*, World Bank, Washington, DC, <http://hdl.handle.net/10986/13093>.

Carrin, G, James, C & Evans, DB 2005, *Achieving universal health coverage: developing the health financing system, Technical brief for policy-makers,*

<http://www.who.int/health_financing/documents/cov-pb_e_05_1-universal_cov/en/>.

Cashin, C 2015, *Assessing health provider payment systems: a practical guide for countries working towards universal health coverage*, Joint Learning Network for Universal Health Coverage & Results for Development, <https://www.jointlearningnetwork.org/resources/assessing-health-provider-payment-systems-a-practical-guide-for-countries-w/>.

Cashin, C, Bloom, D, Sparkes, S, et al. 2017, *Aligning public financial management and health financing: sustaining progress toward universal health coverage.*, World Health Organisation & Results for Development, Geneva, <https://apps.who.int/iris/handle/10665/254680>.

Cawthorne, P, Ford, N, Limpananont, J, et al. 2007, 'WHO must defend patients' interests, not industry', *Lancet*, vol. 369, no. 9566, pp. 974-5.

Chan, M 2009, *Address by Dr Margaret Chan, Director-General to the Sixty-second World Health Assembly*, WHO, Geneva, <https://apps.who.int/gb/ebwha/pdf_files/A62/A62_3-en.pdf>.

Chen, CC & Bunge, FM 1989, *Medicine in rural China : a personal account*, University of California Press, Berkeley, pp. xix, 218 , [8] of plates.

Chorev, N 2013, 'Restructuring neoliberalism at the World Health Organization', *Review of International Political Economy*, vol. 20, no. 4, pp. 627-66, <http://dx.doi.org/10.1080/09692290.2012.690774>, viewed 2015/07/30.

Commission on Intellectual Property Rights Innovation and Public Health 2006, *Public health, innovation and intellectual property rights*, WHO, Geneva, <http://www.who.int/intellectualproperty/en/>.

Commission on Macroeconomics and Health 2001, *Macroeconomics and Health: Investing in Health for Economic Development*, WHO, Geneva, <http://whqlibdoc.who.int/publications/2001/924154550x.pdf>, viewed 26 Feb, 2013.

Cornia, G, Jolly, R & Stewart, F 1987, *Adjustment with a human face : protecting the vulnerable and promoting growth*, Clarendon Press, Oxford.

Donabedian, A 1980, *The definition of quality and approaches to its assessment*, Explorations in quality assessment and monitoring, Vol. 1, Health Administration Press, Ann Arbor, Michigan.

Du, L, Killingsworth, J, Liu, G, et al. 2010, 'Macroeconomics and health', in Vivian Lin, Yan Guo, David Legge and Qunhong Wu (eds), *Health policy in transition: the challenges for China*, Peking University Medical Press, Beijing, pp. 350-67 (English), 34-46 (Chinese).

England, R 2008, *Provider Purchasing and Contracting Mechanisms, Technical partner papers: The Rockefeller Foundation–Sponsored Initiative on the Role of the Private Sector in Health Systems in Developing Countries*, R4D, <https://r4d.org/wp-content/uploads/Provider-Purchasing-and-Contracting-Mechanisms.pdf>.

Executive Board 1965, *Report of the UNICEF/WHO Joint Committee on Health Policy: fourteenth session*, Geneva.

——— 2005, *Executive Board, January 2005, Summary records* WHO, Geneva, <https://apps.who.int/gb/ebwha/pdf_files/EB115/B115_REC2-en.pdf#page=91>.

Farley, J 2008, *Brock Chisholm, the World Health Organisation and the Cold War*, UBC Press, Vancouver, Toronto.

Fletcher, ER 2019, 'Italy Floats Proposal For New Deal On Drug Pricing At World Health Assembly', <https://www.healthpolicy-watch.org/italy-floats-proposal-for-new-deal-on-drug-pricing-at-world-health-assembly/>.

Ghebreyesus, TA 2019, *Address by Dr Tedros Adhanom Ghebreyesus, Director-General*, WHO, Geneva, <https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_3-en.pdf>.

GHW 2011, 'D6 | the international health partnership+: glass half full or half empty?', in Medact People's Health Movement, Health Action International, Medico International, Third World Network, Zed Books (ed), *Global Health Watch 3: an Alternative World Health Report*, Zed Books, London, pp. 298-303, <https://www.ghwatch.org/sites/www.ghwatch.org/files/D6.pdf>.

—— 2018, 'D4 | GAVI and Global Fund: Private governance structures trump public oversight in public private partnerships', in Medact People's Health Movement, Third World Network, Health Povery Action, Medico International, ALAMES, Zed Books (ed), *Global Health Watch 5: an Alternative World Health Report*, Zed Books, London, pp. 298-315, <https://phmovement.org/wp-content/uploads/2018/07/D4.pdf>.

Giedion, U, Alfonso, EA & Díaz, Y 2013, *The impact of universal coverage schemes in the developing world: A review of the existing evidence*, World Bank, Washington DC, <http://hdl.handle.net/10986/13302>.

Gleeson, D & Labonté, R 2020, *Trade Agreements and Public Health: A Primer for Health Policy Makers, Researchers and Advocates*, Springer, Singapore.

Global Conference on Primary Health Care 2018, *Declaration of Astana*, WHO, Geneva, <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>.

Godlee, F 1994a, 'WHO in crisis', *BMJ*, vol. 309, no. 6966, pp. 1424-8, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2541365/pdf/bmj00467-0046.pdf>.

—— 1994b, 'WHO in retreat: is it losing its influence?', *British Medical Journal*, vol. 309, pp. 1491-5, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2541606/pdf/bmj00468-0043.pdf>.

Halligan, A & Donaldson, L 2001, 'Implementing clinical governance: turning vision into reality', *BMJ*, vol. 322, no. 7299, pp. 1413-7, <http://bmj.com>.

Hayter, T 1971, *Aid as imperialism*, Pelican, Harmondsworth.

Heller, PS 2005, *Understanding fiscal space*, IMF Policy Discussion Paper, IMF, Washington DC.

Henderson, D 1998, 'Smallpox eradication - a cold war victory', *World Health Forum*, vol. 19 pp. 113-9, <https://apps.who.int/iris/bitstream/handle/10665/55594/WHF_1998_19(2)_p113-119.pdf>.

Hernández-Álvarez, M, Eslava-Castañeda, JC, Henao-Kaffure, L, et al. 2020, 'Universal health coverage and capital accumulation: a relationship unveiled by the critical political economy approach', *Int J Public Health*, vol. 65, no. 7, pp. 995-1001.

Horton, R 2013, 'Offline: The Rockefeller Foundation is back', *The Lancet (British edition)*, vol. 381, no. 9865, p. 438.

Howard-Jones, N 1975, *The scientific background of the International Sanitary Conferences 1851-1938*, WHO, Geneva, <http://whqlibdoc.who.int/publications/1975/14549_eng.pdf>, viewed 1 Aug 2014.

—— 1980, 'The Pan American Health Organization: origins and evolution', *WHO Chronicle*, vol. 34, pp. 367-75, 419-26, <http://www.jstor.org.ez.library.latrobe.edu.au/stable/24625782>.

—— 1981, 'The World Health Organization in Historical Perspective', *Perspect Biol Med*, vol. 24, no. 3, pp. 467-82, <https://muse-jhu-edu.ez.library.latrobe.edu.au/article/403593/pdf>.

Hunter, BM & Murray, SF 2015, '"Beyond aid" investments in private healthcare in developing countries', *BMJ*, vol. 351, p. h3012, <http://www.bmj.com/bmj/351/bmj.h3012.full.pdf>.

International Health Conference 1946, *The constitution of the World Health Organisation*, <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>, viewed 28 August 2012.

Jain, V & Alam, A 2017, 'Redefining universal health coverage in the age of global health security', *BMJ Glob Health*, vol. 2, no. 2, pp. e000255-e.

JLN4UHC 2021, *Joint Learning Network for Universal Health Coverage*, <https://www.jointlearningnetwork.org/>, viewed 12 September 2021.

Keijzer, N & Black, D 2020, 'Special issue introduction Ownership in a post-aid effectiveness era: Comparative perspectives', *Development policy review*, vol. 38, no. 1, pp. O1-O12, <https://onlinelibrary.wiley.com/doi/10.1111/dpr.12490>.

Kingdon, JW 1984, *Agendas, alternatives, and public policies*, University of Michigan, Boston.

Kutzin, J 2000, *Towards Universal Health Care Coverage : Goal-oriented Framework for Policy Analysis, HNP discussion paper series*, World Bank, Washington, DC, <http://hdl.handle.net/10986/13772>.

—— 2014, 'Health financing for UHC: why the path runs through the Finance Ministry and PFM rules', Fiscal space, public finance and health financing, Montreux, Switzerland.

Lagomarsino, G, Garabrant, A, Adyas, A, et al. 2012, 'Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia', *The Lancet*, vol. 380, no. 9845, pp. 933-43, <http://www.sciencedirect.com/science/article/pii/S0140673612611477>, viewed 2012/9/14/.

Lagomarsino, G, Nachuk, S & Kundra, SS 2009, *Public stewardship of private providers in mixed health systems*, Results for Development Institute, Washington, DC, <http://bit.ly/1gpmsq>.

Laing, R, Waning, B, Gray, A, et al. 2003, '25 years of the WHO essential medicines lists: progress and challenges', *Lancet*, vol. 361, no. 9370, pp. 1723-29.

League of Nations Health Organisation 1937, *Report of the Intergovernmental conference of Far-Eastern countries on rural hygiene, held at Bandoeng (Java), August 3rd to 13th, 1937*, [Geneva, p. 119 p., <https://hdl.handle.net/2027/mdp.39015014706116>.

Lindner, ME, Preker, AS & Chernichovsky, D 2013, *Scaling Up Affordable Health Insurance*, World Bank, Washington DC.

Litsios, S 1997, 'Malaria control, the cold war, and the postwar reorganization of international assistance', *Medical Anthropology*, vol. 17, no. 3, pp. 255-78, <http://dx.doi.org/10.1080/01459740.1997.9966140>, viewed 2015/07/05.

—— 2002, 'The long and difficult road to Alma-Ata: a personal reflection', *International Journal of Health Services*, vol. 32, no. 4, pp. 709-32, <http://baywood.metapress.com/media/p621a3kj7p6vpp483t6y/contributions/r/p/8/c/rp8cl5ub4rafnrh2.pdf>.

—— 2004, 'The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach', *American Journal of Public Health*, vol. 94, no. 11, pp. 1884-93, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448555/>.

Loevinsohn, M, Mehta, L, Cuming, K, et al. 2015, 'The cost of a knowledge silo: a systematic re-review of water, sanitation and hygiene interventions', *Health Policy and Planning*, vol. 30, no. 5, pp. 660-74, <http://heapol.oxfordjournals.org/content/30/5/660.abstract>.

Magnussen, L, Ehiri, J & Jolly, P 2004, 'Comprehensive versus Selective Primary Health Care: Lessons For Global Health Policy', *Health Aff*, vol. 23, <http://dx.doi.org/10.1377/hlthaff.23.3.167>.

Mahler, H 1978, 'Promotion of Primary Health Care in Member countries of WHO', *Public Health Reports*, vol. 93, no. 2, p. 107.

McCoy, D, Chand, S & Sridhar, D 2009, 'Global health funding: how much, where it comes from and where it goes', *Health Policy and Planning*, vol. 24, no. 6, pp. 407-17, <http://heapol.oxfordjournals.org/content/24/6/407.abstract>.

Murphy, CN 1984, *The Emergence of the NIEO Ideology*, Westview Press, Boulder, Colorado.

Newell, KW 1988, 'Selective primary health care: the counter revolution', *Social Science & Medicine*, vol. 26, no. 9, pp. 903-6, <https://www.sciencedirect.com/science/article/pii/0277953688904091>.

Newell, KW 1975, 'Health by the people', WHO, Geneva.

Nuruzzaman, M 2007, 'The world bank, health policy reforms and the poor', *Journal of Contemporary Asia*, vol. 37, no. 1, pp. 59-72, <https://doi.org/10.1080/00472330601104599>.

OECD 2016, *The high level fora on aid effectiveness: a history*, OECD, Paris, <http://www.oecd.org/dac/effectiveness/thehighlevelforaonaideffectivenessahistory.htm>, viewed 10 Oct 2016.

Ooms, G, Van Damme, W, Baker, B, et al. 2008, 'The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems?', *Globalization and health*, vol. 4, no. 1, p. 6, <http://www.globalizationandhealth.com/content/4/1/6>.

Palmer, S 2010, *Launching Global Health: The Caribbean Odyssey of the Rockefeller Foundation*, University of Michigan Press, Ann Arbor.

Patnaik, U & Patnaik, P 2021, *Capitalism and imperialism: theory, history and the present*, Monthly Review Press, New York.

People's Health Movement, Medact & Global Equity Guage Alliance 2008, 'The Gates Foundation', in People's Health Movement, Medact and Global Equity Guage Alliance (eds), *Global Health Watch 2*, Zed Books, London, pp. 240-59, <http://www.ghwatch.org/>.

Preker, AS & Harding, A 2003, 'Innovations in health service delivery: the corporatisation of public hospitals', The World Bank, Washington, pp. 23-78.

R4D 2021, *Results for development: Universal health coverage*, R4D, <https://r4d.org/health/universal-health-coverage/>, viewed 12 September 2021.

Regan, L, Wilson, D, Chalkidou, K, et al. 2021, 'The journey to UHC: how well are vertical programmes integrated in the health benefits package? A scoping review', *BMJ Global Health*, vol. 6.

Review Committee 2011, *Implementation of the IHRs (2005): report of the Review Committee on the Functioning of the IHRs (2005) in relation to Pandemic (H1N1) 2009*, WHO, <http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf>.

—— 2015, *Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation*, WHO, <https://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22Add1-en.pdf>.

Richter, J 2002, *Codes in context: TNC regulation in an era of dialogues and partnerships*, The Corner House, Newton, Dorset, UK, <http://www.thecornerhouse.org.uk/sites/thecornerhouse.org.uk/files/26codes.pdf>, viewed 7 Jan, 2014.

Rizvi, SS, Douglas, R, Williams, OD, et al. 2020, 'The political economy of universal health coverage: a systematic narrative review', *Health Policy Plan*, vol. 35, no. 3, pp. 364-72.

Roberto, MJ 2018, *The coming of the American Behemoth: the origins of fascism in the United States, 1920-1940*, Monthly Review Press, New York.

Robinson, WI 2004, *A Theory of Global Capitalism: Production, Class, and State in a Transnational World*, Themes in global social change, ed. Christopher Chase-Dunn, Johns Hopkins University Press, Baltimore, MD.

Rosen, G 1993 (1958), *A history of public health (expanded edition)*, Johns Hopkins University Press, Baltimore.

Ruckert, A & Labonté, R 2013, 'The financial crisis and global health: the International Monetary Fund's (IMF) policy response', *Health Promotion International*, vol. 28, no. 3, pp. 357-66, <http://heapro.oxfordjournals.org/content/28/3/357.abstract>.

Sá e Silva, MM 2009, 'South–South cooperation: past and present: Conceptualization and practice', in L. Chisholm and G. Steiner-Khamsi (eds), *South-South cooperation in education and development*, HSRC Press, Cape Town.

Samb, B, Dybul, M, Atun, R, et al. 2009, 'An assessment of interactions between global health initiatives and country health systems', *Lancet*, vol. 373, no. 9681, pp. 2137-69.

Scally, G & Donaldson, LJ 1998, 'Clinical governance and the drive for quality improvement in the new NHS in England', *BMJ*, vol. 317, pp. 61-5, <http://www.bmj.com/cgi/content/full/317/7150/61?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=scally&author2=donaldson&searchid=QID_NOT_SET&stored_search=&FIRSTINDEX=0&volume=317&firstpage=61&fdate=7/1/1998&tdate=7/31/1998>.

Sengupta, A 2018, *Biological Drugs – Challenges to Access*, Third World Network, <http://www.twn.my/announcement/biologicaldrugs/Biologics%20English.pdf>.

Shashikant, S 2010, *The IMPACT counterfeit taskforce, intellectual property rights enforcement and seizure of medicines*, Third World Network, Geneva, <http://www.twn.my/title2/IPR/pdf/ipr13.pdf>, viewed 13.

SHOPS Plus 2021, *SHOPS Plus*, <https://www.shopsplusproject.org/>, viewed 12 September 2021.

Shorten, T, Taylor, M, Spicer, N, et al. 2012, 'The International Health Partnership Plus: rhetoric or real change? Results of a self-reported survey in the context of the 4th high level forum on aid effectiveness in Busan', *Globalization and health*, vol. 8, no. 1, p. 13, <http://www.globalizationandhealth.com/content/8/1/13>.

Smith, J 2016, *Imperialism in the twenty-first century: globalization, super-exploitation, and capitalism's final crisis*, Monthly Review Press, New York, p. 384.

Sneyd, A 2005, 'New International Economic Order', in William D. Coleman and Nancy Johnson (eds), *Globalization and Autonomy Online Compendium*.

Son, K-B, Lopert, R, Gleeson, D, et al. 2018, 'Moderating the impact of patent linkage on access to medicines: lessons from variations in South Korea, Australia, Canada, and the United States', *Globalization and health*, vol. 14, no. 1, p. 101, <https://doi.org/10.1186/s12992-018-0423-0>.

Stefanini, A 2008, 'From Alma-Ata to the Global Fund: the history of international health policy', *Social Medicine*, vol. 3, no. 1, pp. 36-48.

Stillwell, F 2012, *Political economy: the contest of economic ideas*, 3rd edn., Oxford University Press, Melbourne.

Swedlund, HJ & Lierl, M 2020, 'The rise and fall of budget support: Ownership, bargaining and donor commitment problems in foreign aid', *Development policy review*, vol. 38, no. S1, pp. O50-O69, <https://doi.org/10.1111/dpr.12463>, viewed 2021/09/10.

UHC2030 2021, *Taking action for universal health coverage*, <https://www.uhc2030.org/>, viewed 13 September 2021.

UN DESA Statistical Division 2017, *SDG indicators: revised list of global sustainable development goal indicators*, UN, New York, <https://unstats.un.org/sdgs/indicators/indicators-list/>.

UN General Assembly 2012, *Global health and foreign policy* UN, New York, <https://undocs.org/A/RES/67/81>.

——— 2015, 'Transforming our world: the 2030 Agenda for Sustainable Development ', in UN (ed), *70/1*, United Nations, New York, <https://undocs.org/en/A/RES/70/1>.

——— 2019, 'Political declaration of the high-level meeting on universal health coverage', in UN (ed), *Resolution 74/2*, United Nations, New York, <https://undocs.org/en/A/RES/74/2>.

Velásquez, G 2012, *Rethinking The R&D Model for Pharmaceutical Products: A Binding Global Convention, Policy Briefs*, South Centre, Geneva, <http://www.southcentre.int/policy-brief-8-april-2012/#more-1995>.

Virchow, R 2006[1848], 'Report on the typhus epidemic in Upper Silesia', *Social Medicine*, vol. 1, no. 1, pp. 11-99, <http://www.socialmedicine.info/index.php/socialmedicine/issue/view/5/showToc>.

Waitzkin, H 2003, 'Report of the WHO Commission on Macroeconomics and Health: a summary and critique', *The Lancet*, vol. 361, no. 9356, pp. 523-6, <http://www.sciencedirect.com/science/article/pii/S0140673603124919>.

Waitzkin, H & Working Group on Health Beyond Capitalism 2018, 'Health care under the knife: moving beyond capitalism for our health', Monthly Review Press, New York.

Walsh, JA & Warren, KS 1979, 'Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries', *N Engl J Med*, vol. 301, no. 18, pp. 967-74.

Walt, G 1993, 'WHO under stress: implications for health policy', *Health Policy*, vol. 24, pp. 125-44.

Warren, A, Wyss, K, Shakarishvili, G, et al. 2013, 'Global health initiative investments and health systems strengthening: a content analysis of global

fund investments', *Globalization and health*, vol. 9, no. 1, p. 30, <http://www.globalizationandhealth.com/content/9/1/30>.
Werner, D & Sanders, D 1997, *Questioning the solution: the politics of primary health care and child survival*, Healthwrights, Palo Alto.
WHA 1981, *Global strategy for health for all by the year 2000*, Geneva.
—— 2005, *Sustainable health financing, universal coverage and social health insurance* WHO, Geneva, <https://apps.who.int/gb/ebwha/pdf_files/WHA58-REC1/english/A58_2005_REC1-en.pdf#page=141>.
—— 2006, *WHO, 59th WHA, May 2006, Summary records of committees* WHO, Geneva, <https://apps.who.int/gb/ebwha/pdf_files/WHA59-REC3/A59_REC3-en.pdf#page=194>.
—— 2011a, *Strengthening national policy dialogue to build more robust health policies, strategies and plans (WHA64.8)*, WHO, Geneva, <http://apps.who.int/gb/ebwha/pdf_files/WHA64-REC1/A64_REC1-en.pdf#page=36>.
—— 2011b, *Sustainable health financing structures and universal coverage*, WHO, Geneva, <https://apps.who.int/gb/ebwha/pdf_files/WHA64-REC1/A64_REC1-en.pdf#page=38>.
—— 2019, *Community health workers delivering primary health care: opportunities and challenges*, WHO, Geneva, <https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_R3-en.pdf>.
WHO-SEARO 2017, *Provider payment methods and strategic purchasing for UHC*, World Health Organization. Regional Office for South-East Asia, New Delhi, <https://apps.who.int/iris/handle/10665/258894>.
WHO 1987, *Health for All leadership information material*, World Health Organization, Geneva, <https://apps.who.int/iris/handle/10665/61623>.
—— 2000, *The World Health Report; Health Systems: Improving Performance*, WHO, Geneva, <http://www.who.int/whr/2000/en/>.
—— 2004a, *Macroeconomics and health : an update : April 2004*, World Health Organization, Geneva, <https://apps.who.int/iris/handle/10665/69514>.
—— 2004b, *Social health insurance* WHO, Geneva, <https://apps.who.int/gb/ebwha/pdf_files/EB114/B114_16-en.pdf>.
—— 2006, *Tough choices : investing in health for development : experiences from national follow-up to the Commission on Macroeconomics and Health*, (Sergio Spinaci, Valerie Crowell, Louis Currat, Jenni Kehler and Padma Shetty, chairman), World Health Organization, Geneva, <https://apps.who.int/iris/handle/10665/43422>.
—— 2008a, *Primary health care: now more than ever*, WHO, Geneva, <https://www.who.int/whr/2008/whr08_en.pdf>.
—— 2008b, *The third ten years of the World Health Organization: 1968-1977*, WHO, Geneva, <http://apps.who.int/iris/bitstream/10665/43924/1/9789241563666_eng.pdf>, viewed 1 July 2012.
—— 2010, *The World Health Report; Health Systems Financing: the Path to Universal Coverage*, WHO, Geneva, <https://apps.who.int/iris/handle/10665/44371>.
—— 2011, *Health system strengthening: Current trends and challenges* WHO, Geneva, <https://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_13-en.pdf>.
—— 2014, 'Fiscal space, public finance and health financing', Fiscal space, public finance and health financing, Montreux, Switzerland, WHO, <http://www.who.int/entity/health_financing/events/Montreux/en/index.html>.
—— 2019a, *Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report*, WHO, Geneva, <https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf>.
—— 2019b, *Primary health care: Draft operational framework: Primary health care: transforming vision into action*, WHO, Geneva, <https://apps.who.int/gb/ebwha/pdf_files/EB146/B146_5-en.pdf>.
—— 2021a, *Principles of health benefit packages*, World Health Organization, Geneva, <https://apps.who.int/iris/handle/10665/340723>.

—— 2021b, *Working for health: five-year action plan for health employment and inclusive economic growth (2017–2021)*, WHO, Geneva, <https://apps.who.int/gb/ebwha/pdf_files/WHA74/A74_12-en.pdf>.

WHO & UHC Partnership 2019, *Universal Health Coverage Partnership Annual Report 2019*, UHC Partnership, <https://www.uhcpartnership.net/wp-content/uploads/2021/05/UHC-Annual-Report-2019-updated.pdf>.

WHO & UNICEF 2018, *A vision for primary health care in the 21st century: towards universal health coverage and the Sustainable Development Goals*, World Health Organization, Geneva, <https://apps.who.int/iris/handle/10665/328065>.

WHO & World Bank 2015, *Tracking universal health coverage: first global monitoring report*, WHO, Geneva, <http://www.who.int/healthinfo/universal_health_coverage/report/2015/en/>, viewed 17 Feb 2019.

—— 2017a, *Healthy systems for universal health coverage - a joint vision for healthy lives, UHC2030 International Health Partnership*, WHO & World Bank, <https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/mgt_arrangemts__docs/UHC2030_Official_documents/UHC2030_vision_paper_WEB2.pdf>.

—— 2017b, *Tracking Universal Health Coverage: 2017 Global Monitoring Report*, WHO and WB, Geneva, <https://apps.who.int/iris/bitstream/handle/10665/259817/9789241513555-eng.pdf?sequence=1>, viewed 17 Feb 2019.

WHO Expert Committee 1988, *Strengthening ministries of health for primary health care : report of a WHO Expert Committee [meeting held in Geneva from 10 to 16 November 1987]*, World Health Organization, Geneva, <https://apps.who.int/iris/handle/10665/37204>.

Williams, DC 2006, *World health: A lethal dose of US politics*, Asia Times On Line, <https://www.bilaterals.org/?world-health-a-lethal-dose-of-us>, viewed 25 October 2013.

Williamson, J 1990, 'What Washington Means by Policy Reform', in John Williamson (ed), *Latin American Adjustment: How Much Has Happened?*, Institute for International Economics, Washington, D.C.

—— 2000, 'What Should the World Bank Think About the Washington Consensus?', *World Bank Research Observer*, vol. 15, no. 2, pp. 251-64.

World Bank 1993, *World Development Report 1993: Investing in Health*, World Bank, Washington DC, <https://openknowledge.worldbank.org/handle/10986/5976>.

—— 2006, *Health Financing Revisited: A Practitioner's Guide*, World Bank, Washington, <http://tinyurl.com/rcnqu>.

—— 2009, 'Health systems strengthening workshop', Technical workshop on health systems strengthening, Washington DC, World Bank.

WTO Ministerial Council 2001, *Doha declaration on the TRIPS Agreement and Public Health*, WTO, <https://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.htm>.

Youde, J 2013, 'The Rockefeller and Gates Foundations in Global Health Governance', *Global Society*, vol. 27, no. 2, pp. 139-58, <http://dx.doi.org/10.1080/13600826.2012.762341>, viewed 2015/08/01.