Universal Health Coverage
a background note

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Introduction

'Universal Health Coverage' (UHC) has dominated global health dialogue over the last decade. It was strongly promoted by Margaret Chan, the previous DG of WHO and by Jim Kim, the immediate past president of the World Bank.

It has also been promoted through a multi-stakeholder global public private partnership – UHC2030 – which includes countries, development banks, global public private partnerships, philanthropies, civil society organisations and private sector entities. UHC2030 originated as the International Health Partnership (IHP+) in 2007.

UHC has been included in the Sustainable Development Goals (SDGs) (UN, nd):

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.

WHO and the World Bank (2015) have defined UHC in the following terms:

Universal health coverage means that all people receive the health services they need, including public health services designed to promote better health (such as anti-tobacco information campaigns and taxes), prevent illness (such as vaccinations), and to provide treatment, rehabilitation and palliative care (such as end-of-life care) of sufficient quality to be effective, while at the same time ensuring that the use of these services does not expose the user to financial hardship.

Two broad sets of indicators have been developed to follow the achievement of this goal, one based on a composite indicator of essential health care services coverage and the other based on financial protection, including the incidence of catastrophic health expenditure and of health care impoverishment (World Health Organisation and World Bank, 2017).

UHC is scheduled to be discussed at a special high level meeting of the UN General Assembly in September 2019 (WHO, 2018).

While UHC is widely lauded, and Goal 3.8 is the only broad health system goal in the SDGs, there is no unanimity, including between WHO and the World Bank, about what is required to achieve UHC. Two key issues concern, first, the national financing model and second, the role of the public and private sectors in health care delivery.

While a range of technical papers produced through WHO have emphasized the importance of single payer health care financing, the World Bank has continued to promote competitive health insurance markets as the principal financing platform for UHC. There is a similar debate regarding health care delivery: public sector provision versus marketised health care with a dominant role for private providers. While WHO endorses the logic of single payer systems (in relation to health care

financing) it remains agnostic regarding service delivery. The World Bank unequivocally supports mixed public private delivery.

Notwithstanding the importance of these issues, in much of the promotional material produced around UHC, these differences are generally downplayed or obscured. The various intergovernmental and partnership organisations have judged that the legitimation benefits of a 'united front' around the slogan of 'universal health cover' might be vitiated by a more robust public discussion of technical considerations such as efficiency, equity and quality.

The emergence of UHC as a leading health policy slogan and the obfuscation around disagreements about how it might be implemented reflect the configuration of forces within which global health policy is shaped, including the politics of WHO decision making, and the rise of the market paradigm in health policy discourse over several decades.

The achievement of UHC is closely linked to a further set of policy questions around:

- the challenges of domestic resource mobilisation and fiscal capacity;
- the critical shortages with respect to human resources for health, including continuing brain drain; and
- the prices of medicines and vaccines.

As countries review their own health policies in the light of the SDGs and prepare to participate in the UN General Assembly debate on UHC, it is timely to lay bare the policy tensions obscured by the term 'UHC'; to review the technical evidence regarding the different policy models; to explore the interplay of fiscal capacity, human resources and the affordability of medicines in the challenge of UHC; and to delineate the political forces at play in contemporary debates over health system strengthening.

This paper:

- provides an overview of the technical evidence regarding health care financing and models of service delivery;
- reviews the policy issues associated with fiscal capacity, human resources and the affordability of medicines;
- provides some historical background to the debates around health financing, nationally and globally;
- reflects on the dynamics of health system development and the kinds of policy strategies which may yield progress towards meaningful universal health coverage including equitable and affordable access to safe, effective and efficient health care.

Efficiency, equity, quality: core considerations in health system policy

As the magnitude of public expenditure on health care (including through private sector channels) has increased, so has the concern of national finance officials regarding the efficiency with which it is spent; the concern of national health officials regarding effectiveness and safety; and public concerns about equity.

Health care financing

The main policy choice in health care financing is between single payer systems, which generally means government in one form or another, versus competitive health insurance markets.

Single payer systems provide policy makers with powerful levers to promote efficiency, equity, and quality. Paradoxically, the main weakness of single payer systems lies in their effectiveness at cost control and the risks to equity and quality from under-funding.

In contrast, the allocation of resources and cost pressures in competitive health insurance markets are much harder to control. The incentives in such markets are to maintain market share, push up premiums, select for healthy low risk customers, and contain expenditures. The supposed benefits of price competition in the marketplace can be largely avoided by competing through advertising, market segmentation, and brand promotion while obscuring price through complex plan variations.

In many countries health insurance has started with relatively generous plans for government officials, followed in due course by (less generous) plans for employees in formal employment. This leaves farmers and workers in the informal sector without insurance; they are generally less attractive to commercial insurers. Three broad strategies to respond to this are common: (i) so-called 'community health insurance'[1] (which is inefficient and largely ineffective); (ii) government subsidy (direct funding or tax benefits) to encourage commercial insurance; and (iii) public financing with a commitment to working progressively towards integration of the different schemes (Thailand, China, Brazil).

The policy levers available to governments to promote technical efficiency in competitive health insurance markets are weak or non-existent; weak control over efficiency generally leads to increasing pressure for government funding although still unaccountable for efficiency. However, the starkest and most recalcitrant weakness of health insurance markets concerns equity: equity regarding health care costs, access to care (including access to medicines) and quality of care.

Models of service delivery

The main policy choices with regard to service delivery turn on varying degrees of reliance on public versus private sector providers.

Public sector provision gives policy makers significant power over efficiency, effectiveness, quality and equity. Importantly this applies at the provider level and at the wider network and program level. The main risks associated with public sector provision arise from under-funding.

Private sector service delivery insulates providers from policy control over efficiency and quality. In a fee-for-service environment the incentive is to maximize volumes and minimize inputs. In a capitation environment the incentive is to avoid delivering services. Under per bed day reimbursement hospitals are under an incentive to keep patients in hospital for longer. Under episode payment the incentives are for skimping on inputs and skimming for high margin cases. The degree to which efficiency is sacrificed for profit depends on the effectiveness of regulation and effective regulation of private sector providers is difficult and expensive.

A major cost of provider autonomy concerns quality of care, including effectiveness and safety. The determinants of quality of care are complex and certainly there can be serious shortfalls in quality in public sector service delivery (particularly in low resource settings) as well as in the private sector. It is also true that some private sector providers deliver high quality, effective and safe care. However, as a general rule, the institutional provisions needed to measure and maintain quality, safe

1. Community health insurance refers to a community managed voluntary scheme for collecting premiums and disbursing benefits. It generally has high administrative overheads and faces challenges in encouraging the young and healthy to join and thereby support the older and higher risk members.

and effective care ('clinical governance'[2]) are more difficult to put in place in relation to the private sector (Rust, 2017).

The implementation of effective clinical governance in private hospitals with visiting (private) medical staff is made difficult if not impossible by the mix of contracts and incentives. The private medical specialist is in effect the customer of the private hospital; in return for admitting privileges the specialist brings patients for admission. The dependence of the hospital on the custom of the specialist imposes limits on the degree to which the hospital can require appropriate measurement of quality and safety and impose clinical governance arrangements to guarantee quality and safety.

Likewise there are significant limits on the willingness and capacity of private health insurers to use their financial leverage to promote efficiency, quality and safety in a competitive health insurance market. By contrast, in a single payer system, with either public or mixed service delivery, the funder has significant leverage over efficiency, quality and safety and has an incentive to use such leverage.

UHC as a slogan which obscures important policy differences

We have focused attention in this section on the policy debates over health care financing and models of service delivery because these debates have been obscured by an apparent consensus among intergovernmental organisations, global health partnerships and bilateral donors around UHC as a unifying slogan, while avoiding policy debates over what it means. We will return to this consensus around obscurity below.

Fiscal capacity, human resources and the affordability of medicines

In this section we review three key policy areas which are critical for the achievement of UHC:

- domestic resource mobilisation and fiscal capacity;
- critical shortages with respect to human resources for health, including continuing brain drain; and
- medicines affordability.

Fiscal capacity and domestic resource mobilisation

Fiscal capacity is a critical limit on how fast low and middle income countries (L&MICs) can move towards UHC based on single payer funding and public sector provision. This points to the need for close attention to the limits on tax capacity including illicit financial flows, tax evasion, tax competition and administrative challenges of income tax collection in the informal sector.

The energy which the rich countries have put into the liberalization of trade and investment and various 'behind the border' barriers to 'free trade' contrasts sharply with the lack of action on international tax reform.

Tax competition is another major limit on domestic resource mobilization which points to the need for L&MICs to stand together against foreign investors' auction for tax concessions. This may be a talking point at the UNGA HLM on UHC in September.

Inequality is a further limit on domestic resource mobilization. The more unequal the population the more resistance can be expected from the middle class to contributing through progressive

2. Clinical governance refers to the structural arrangements, information flows and cultural norms required in health care agencies and systems in order to guarantee quality and safety.

taxation to universal health cover. A stratified health insurance market enables the wealthier to buy more generous plans without contributing to the health care costs of the poor.

Action on these fronts, domestic and international, is urgent. The longer it is delayed the more entrenched is the health insurance market and private sector provision.

Human resources for health and continuing brain drain

The health care workforce is the core resource for health systems development. There are gross differences in health workforce density between low income developing countries and high income countries; a problem exacerbated by density differentials between urban and rural.

The causes are complex and include limited training capacity and fragile and under-resourced health systems; however migration patterns are a major problem. Migration is more complex than simply South to North brain drain; some people come home and there are domino sequences of migration within the Global South. Migration includes: public to private; public to partner-funded vertical programs; domestic to foreign; and out of the health system entirely.

However, net outward migration from South to North impacts significantly on workforce density in many countries and sharply constrains the scope for health systems strengthening in those countries. These net outflows constitute a transfer of value from the South to the North (corresponding to local investment in education and training).

Significant improvements have been achieved through the WHO Code of Practice on Ethical Recruitment, particularly in terms of data collection. However, the Code does not address the need for compensation to be paid for the transfer of value associated with migration. It is disingenuous for the rich countries to urge L&MICs to increase domestic resource mobilization whilst refusing to pay for the net transfer of value, in human resources, from South to North.

Access to medicines

Medicines are a critical resource for health care and constitute a large component of total health expenditure. Price barriers to procuring necessary medicines prevent many families from accessing treatment and prevent many governments from providing decent health care to their people. UHC means nothing if people cannot afford medicines. WHO (2015) reports that,

> *[m]edicines account for 20–60% of health spending in low- and middle-income countries, compared with 18% in countries of the Organisation for Economic Co-operation and Development. Up to 90% of the population in developing countries purchase medicines through out-of-pocket payments, making medicines the largest family expenditure item after food. As a result, medicines, particularly those with higher costs, may be unaffordable for large sections of the global population and are a major burden on government budgets.*

Cameron and colleagues (2008) report on a secondary analysis of 45 drug price surveys in 36 low and middle income countries. They express their findings in relation to international reference prices from open international procurements for generic products for 15 medicines included in at least 80% of the surveys.

> *Median government procurement prices for 15 generic medicines were 1·11 times corresponding international reference prices, although purchasing efficiency ranged from 0·09 to 5·37 times international reference prices. Low procurement prices did not always translate into low patient prices.*

Private sector patients paid 9–25 times international reference prices for lowest-priced generic products and over 20 times international reference prices for originator products across WHO regions.

In the private sector, wholesale mark-ups ranged from 2% to 380%, whereas retail mark-ups ranged from 10% to 552%.

A 2004 study by Wagner and McCarthy put it succinctly: "In low-income countries the vast majority are unwilling to pay for effective drugs simply because they are unable to pay. Low-income nations need more price discrimination—and vastly lower prices—if they are ever to afford the world's most effective medicines."

In the context of UHC and financial protection, the high prices of medicines are a barrier for national policy makers as well as for families.

The causes of unaffordability (and unavailability) are complex and highly contested but rules around intellectual property protection play a key role.

The international pharmaceutical industry played a prominent role in the negotiation of the TRIPS Agreement which required WTO members (other than 'least developed countries', LDCs) to legislate for 20 year patents. This provision ensured the new drugs would be secure from generic competition for the duration of their patent and hence they would be able to set prices to maximize revenue.

Fig 1, from MSF (2012) shows how the price, per treatment year, of the first-line AIDS combination of stavudine, lamivudine, and nevirapine, fell consistently from 2000 until 2006 once challenged by generic competition. The price per treatment year of USD10,439 in 2000 was knowingly priced completely out of reach for most people with AIDS.

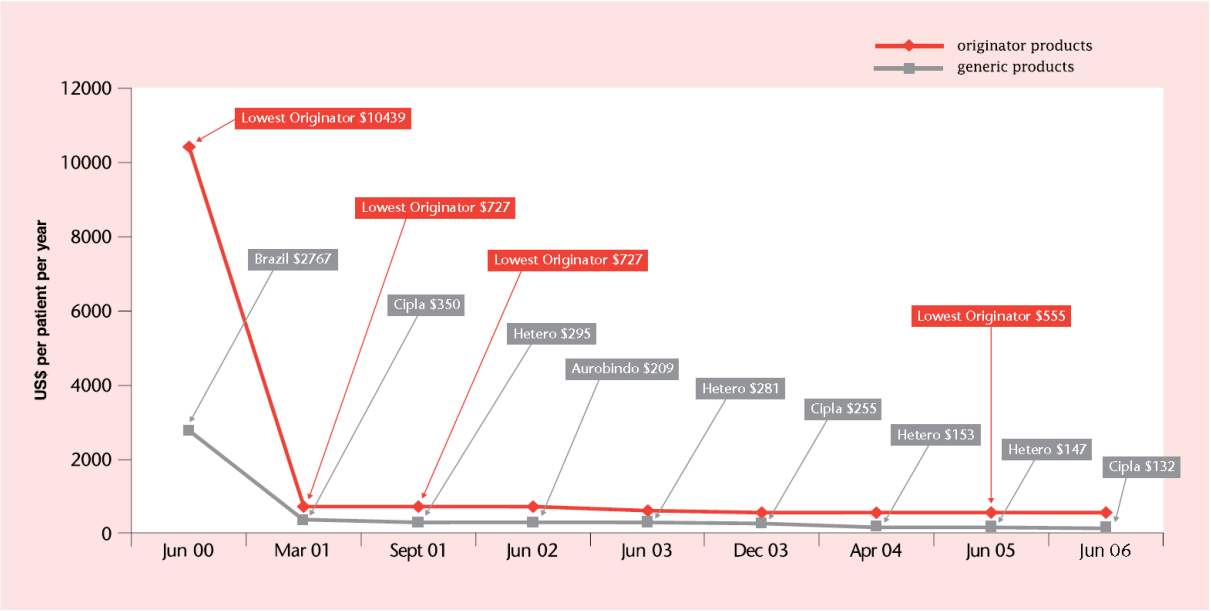

Figure 1. Generic competition a catalyst for price reductions, Graph 4, page 10, MSF (2012)

However, the TRIPS Agreement also allowed countries to issue compulsory licenses[3] or to arrange for purchasing on the international market (parallel importation), which are commonly referred to as TRIPS flexibilities.

3. Government authorized licenses to manufacture, notwithstanding the patented status of the medicine.

The TRIPS Agreement did not include all of the benefits that the pharmaceutical industry had been seeking and from the mid 1990s the USA embarked on a program of bilateral and plurilateral trade agreements directed variously to negating access to TRIPS flexibilities and imposing further conditions on patenting and marketing approval, directed to strengthening the market position of the big originator manufacturers. These further conditions are referred to as TRIPS Plus provisions.

Following the 1997-2001 South African access to medicines case (Heywood, 2009) WHO commissioned an inquiry into Intellectual property rights, innovation and public health which reported in 2006 (Commission on Intellectual Property Rights Innovation and Public Health, 2006). Following receipt of this report WHO adopted Resolution WHA59.26 on Trade and Health which authorized WHO to provide advice to countries negotiating 'free trade' deals on how to preserve access to TRIPS flexibilities and how to avoid the most restrictive of the TRIPS Plus provisions. However, by this time WHO's operations were completely dependent on donor funding and this resolution was never implemented, partly because of lack of funds but also because of strong opposition from the USA.

The pharmaceutical industry defended its high prices on the grounds that profits on successful drugs were needed to fund research and development. WHO's Commission on IPRIPH was critical of this argument, partly because the companies were not willing to open their books regarding the cost of R&D, but partly because the corollary of this logic was that diseases which did not promise blockbuster status (rare disease or diseases largely restricted to L&MICs) did not attract such investments. Their investment in R&D for antibiotics which are only used for a few days was likewise relatively low. The Commission raised for consideration the possibility of public funding of pharmaceutical R&D and delinking R&D from monopoly pricing.

Public funding of pharmaceutical R&D would enable investment to be aligned more closely with public health needs. Delinking R&D expenditure from monopoly pricing would enable medicines to be marketed at around the cost of production and hence more affordable.

In fact the pharmaceutical industry spends more on marketing than it does on R&D and this has implications for quality and efficiency as well as access. Despite repeated WHA resolutions on the rational use of medicines and on ethical promotion of pharmaceuticals, the industry spends billions on marketing events and personal benefits for clinicians and through its support for journals and conferences exercises powerful influence over prescribing practices. Accordingly the logic of delinking also raises the possibility of turning off this flow of resources into marketing and perhaps directing some of it to independent and evidence-based sources of prescribing advice.

Following consideration of the Commission's report the WHA adopted the General Strategy and Plan of Action on Public Health Innovation and Intellectual Property in 2008 (GSPOA, WHA61.21) and initiated a further program of activities regarding alternative approaches to the financing and coordination of pharmaceutical research and development (CEWG R&D F&C).

These issues bounced around within WHO for the next decade but were making little progress. The debate was re-ignited with the publication in September 2016 of the report of the UN Secretary General's High Level Panel on Access to Medicines. The HLP called for:

- WTO member states to make full use of TRIPS flexibilities to ensure affordable access and urges countries negotiating trade and investment agreements outside the WTO to avoid TRIPS plus restrictions;
- new and additional models for financing and rewarding public health R&D, including developing a binding R&D convention that 'delinks the costs of research from end prices to promote access to good health for all';
- governments to require manufacturers and distributors to disclose to regulatory and procurement authorities the costs of R&D, production, marketing and distribution and public funding received in the development of such technologies;

- mandatory publication of all clinical trials, and
- an international, easily searchable database of patent information regarding medicines and vaccines.

The USA, supported by Europe, Switzerland and Japan, was strongly opposed to WHO considering the HLP's report but eventually it made its way onto the agenda and in May 2017 the WHA decided to "to elaborate a road map report, in consultation with Member States, outlining the programming of WHO's work on access to medicines and vaccines". The roadmap was adopted by the WHA in May 2019.

In May 2019 the consideration of the roadmap was complicated by a draft resolution on medicines transparency promoted by Italy but with a large number of supporting countries. The resolution was eventually adopted (WHA72.8) albeit in a somewhat watered down form.

High prices of medicines remain a huge barrier to the achievement of UHC whether it is funded through health insurance or tax based single payer financing. Action to achieve more affordable prices will continue on several different but interlinked fronts:

- national laws which ensure governments' capacities to fully deploy as needed the flexibilities built into TRIPS;
- resistance to the inclusion of TRIPS Plus provisions in 'free trade' agreements outside the WTO and strategic law making to reduce their impact where they have been agreed to;
- continued prosecution of the proposed R&D Treaty to mobilise funding for pharmaceutical R&D which is needs driven rather than profit driven; and
- continued strengthening of pharmaceutical regulation, clinical governance and independent prescribing advice with a view to promoting the rational use of medicines.

The domestic politics of health care financing

The collective funding of health care (through taxes or insurance) has historically been a popular demand but opposed by doctors in private practice, because of a perceived impact on their commercial autonomy. It was also opposed by governments, because of the need to raise taxes in order to be able to pay. Public or collective funding has commonly been introduced in response to working class demands (the NHS in 1948), to contain working class unrest (Bismarck 1883) or as a tool of macroeconomic policy (as in China from 2009). The introduction by Bismarck in 1883 of employer supported mandatory health insurance for low income workers was explicitly designed to quell the threat of revolution. The decision to make health insurance premiums tax deductible in the USA in 1944 was designed to appease union pressure for wage increases during the War.

The popular demand for collectivising the cost burden of illness and injury remains a powerful driver of policy in many countries. Another driver, historically, has been the need to improve the health and fitness of young men being drafted into the army (eg after the Boer War in England and after WW1 in Germany). Similarly, the World Bank's 1993 World Development Report argued that extending health care to people with treatable illnesses (such as AIDS) would have productivity benefits at family and national levels.

Despite their initial opposition, there comes a time in all health care systems when the health care industry (initially the providers and later the insurers and suppliers) turns to support an increasing role for taxation and/or insurance premiums in health financing because it increases the size of the market as a whole. A classic example is the reversal of medical opposition to health insurance during the Depression in the US to avoid the threat of hospitals closing for lack of customers.

However, the issue of provider autonomy, especially with respect to billing practices, remains important to private sector players. The defence of such autonomy rested on arguing for insurance rather than publicly funded service delivery. Where public funding was established the private sector demand was for it to be channeled through market mechanisms; in particular through tax expenditures which provide the weakest of policy levers.

During the 1980s debt crisis, the World Bank and the IMF pushed strongly for both health insurance markets and private sector-dominated health care delivery. Their principal argument was about protecting fiscal capacity to pay down foreign debt but there was clearly also an agenda about opening developing country health systems to foreign commercial insurers and hospital corporations.

The private sector demand on government goes beyond tax subsidies to also include regulatory provisions which assure provider autonomy while supporting revenues and profits. Examples include the long standing demand of the pharmaceutical industry to advertise directly to consumers and the determination of private medicine to avoid fee control.

However, in circumstances where rising health care costs contribute to rising insurance premiums, thus threatening the viability of the insurance model, the private sector has been happy to transfer the function of revenue raising to government. This has occurred particularly in aged care and disability provision. The advent of Medicare in the US in 1967 removed the high cost aged care sector from private health insurance, thereby ensuring that commercial premiums would remain (relatively) affordable. The private health insurers still manage although they do not underwrite the payment of Medicare benefits.

Another twist has been the emergence of low cost managed care where maintaining market share is judged to be a priority over maximizing revenue. Managed care can be very effective in controlling expenditure and therefore premiums. This makes it well suited to low cost insurance plans for the low income strata of the health insurance market. In this situation the insurers are looking to government to create a supportive regulatory framework rather than simply looking for subsidies.

Global health systems policy

From PHC to UHC (and back)

The role of the WHO in health systems policy changed dramatically from the 1950s to the 1970s as a consequence of newly decolonised countries joining the Organisation. In the 1950s WHO made tentative gestures in relation to health insurance but were chastised by the USA for over-stepping their mandate (Farley, 2008)[4]. By the early 1970s, however, the developing countries were starting to assert their needs, notably through the G77 and the Non-Aligned Movement.

In 1975 WHO published a collection of case studies of health care innovation in developing countries (Newell, 1975) which highlighted the concept of primary health care. In 1978, at the Alma-Ata Conference on Primary Health Care, the WHO and UNICEF adopted the Alma-Ata Declaration on

4. Farley describes a 1951 WHO project based in Sri Lanka (led by Milton Roemer) which was directed to creating a model comprehensive health service to meet the needs of the 66,000 residents of Devamedi Hathpattu north of Colombo. Roemer was subsequently forced to resign from WHO owing to US pressure and this approach to health system development withered. In 1952 WHO was asked by ILO to advise on medical aspects of social security. An advisory committee was formed (chaired by Sigerist and including Roemer and Sand) and produced a remarkably prescient report. However, the US delegate insisted that the report not be adopted by the Executive Board and both the ILO and WHO were lashed by the American Medical Association.

Primary Health Care which argued for a focus on delivering primary care and basic public health in the community with a strong emphasis on community involvement, appropriate technologies and intersectoral collaboration to create the conditions needed for good health. While the Declaration was not explicit about single payer public funding or public sector service delivery it would be very difficult to deliver PHC in other circumstances. Importantly the Alma-Ata Declaration highlighted the call for a New International Economic Order (NIEO)[5] as a necessary precondition for the economic development needed to implement PHC and to create the social and economic conditions needed for 'Health for All'[6].

However, just as the Alma-Ata Declaration was being adopted the global economy was sliding into recession, a recession accompanied by rampant inflation, so called ‘stagflation’. After failed attempts to deploy Keynesian remedies, the Reagan and Thatcher administrations adopted the ‘fight inflation first’ strategy from 1980. Fighting inflation first involved dramatic increases in official interest rates, with a view to deepening the recession, breaking the labour unions and thereby reducing wage pressures.

Unfortunately the rising interest rates also precipitated the Third World debt crisis as countries which had borrowed when money was cheap (owing to the early 70s flush of petrodollars) found it impossible to roll over their debts. As unpayable debt accumulated, countries were forced to approach the IMF as lender of last resort and to implement ‘structural adjustment’ policies as a condition for debt relief. Structural adjustment had devastating impact on health systems as health care budgets were slashed and families’ capacity to pay out of pocket was greatly reduced through unemployment. Structural adjustment policies also impacted on the conditions for health development including reduced wages, increased prices, and the abolition of food subsidies.

By 1987 the impact of structural adjustment policies on developing countries was leading to widespread criticism on the IMF and the World Bank and to a fraying of the perceived legitimacy of the global regime of which they were part. This ‘legitimation crisis’ was articulated most clearly in the UNICEF sponsored report *Adjustment with a human face* (Cornia, Jolly, & Stewart, 1987).

This legitimation crisis was the principal driver behind the World Bank’s 1993 World Development Report *Investing in Health*. This report sought to reconcile health policy with structural adjustment arguing that with a focus on cost effectiveness, mixed service delivery, pluralistic health insurance and a minimal safety net, acceptable health care could be achieved. The role of the public sector was to be reduced to providing a safety net through which an 'essential benefit package' would be provided to the poor. Public support for the safety net was to be provided through direct public sector provision or subsidies to private and voluntary service providers and to basic health insurance provision. *Investing in Health* was the beginning of a major investment by the World Bank in the provision of advice and loans to developing countries to support the implementation of this model.

"Investing in health" was the dominant policy reference for several years, and remains influential, but it was overtaken in the mid to late 1990s by the Access to Treatment movement. The AIDS crisis was devastating many developing countries, particularly in Sub-Saharan Africa, overwhelming health systems and arresting economic development. In the early 1990s anti-retroviral medications became available – for those who were able to afford the exorbitant prices that the pharmaceutical companies were demanding.

5. A package of global economic policy settings that would discriminate positively in favour of L&MICs to facilitate their economic development. See Sneyd (2005) for more detail.

6. See Litsios (2002) for an account of the events leading up to the Alma-Ata Declaration on Primary Health Care.

During this period four important transformations coincided: the AIDS epidemic, the growth of the AIDS/HIV movement, qua social movement; the availability of anti-retroviral medications, and the TRIPS Agreement. A global campaign erupted around the right of South Africa to take advantage of parallel importing, in accordance with TRIPS, to procure drugs to treat AIDS. The campaign was successful when the drug companies withdrew their suit against the South African government in May 2001 and this success was underlined with the WTO Declaration on Trade and Health in December of that same year which affirmed that trade policy should not take precedence over public health needs.

The project of economic globalisation, driven in part by multilateral trade liberalisation, suffered a serious setback in the leadup to the millennium, including over trade in services, investor protection and agriculture as well over the TRIPS Agreement and access to medicines. The 2001 WHO Commission on Macroeconomics and Health issued an explicit warning, "Globalisation is on trial". Responding to this negative sentiment the rich world (countries and philanthropies) mobilised a dramatic increase in development assistance for health under the banner of the Millennium Development Goals. Most of this new money was to be disbursed through narrow function vertical global health partnerships such as the Global Fund against AIDS, TB and Malaria, GAVI the Vaccine Initiative, Stop TB, Roll Back Malaria, Global Polio Eradication Initiative, etc.

Thus was born the fourth generation health services delivery model (for L&MICs) dominated by vertical programs focusing on disease-focused technical interventions. The increased flow of resources made a significant impact, particularly in relation to AIDS/HIV but within the first decade of the new millennium it became apparent that this model was fragmenting health systems. Different programs were competing for external funds and for staff. There was an internal brain drain (from general health services to better paid jobs in vertical programs). The system also carried high transaction costs in terms of procuring and acquitting grants. The challenges of public health were reduced to specific technical interventions, discounting the broader issues of social and economic development (including housing, transport, food, water and sanitation).

WHO went through some policy turmoil around this time experimenting variously with 'health system strengthening', 'the revitalisation of primary health care', 'integrated people centred health care', and 'universal health cover'. The latter slogan, UHC, won out largely because the World Bank was willing to sign on.

WHO has joined the World Bank and various global health partnerships and bilateral donors in a broadly based united front around UHC. However, the cost of this grand alliance has meant restricting its meaning to 'financial protection' and 'access to essential services' leaving the policy model completely silent on health care financing and models of service delivery. This is not surprising given that the World Bank, the large philanthropies and many of the bilateral donors endorse competitive health insurance markets as a preferred framework for achieving UHC. On the other hand, WHO's technical experts have repeatedly emphasised the need for single payer financing if any policy weight is to be given to efficiency, equity and quality.

The contradiction between supporting UHC, notwithstanding its ambiguities, versus recommending single payer financing, reflects the schizophrenic character of WHO: accountable to the Assembly (dominated by developing countries) for policy making but accountable to its donors (dominated by rich countries, development banks and private philanthropies) for its budget. Over several decades WHO has been increasingly disabled by the freeze on assessed (mandatory) contributions (now funding less than 20% of expenditure) and its dependence on tightly targeted donations. While the World Health Assembly can adopt resolutions and budgets, the donors will only fund those programs which they support.

WHO's policy advice has changed erratically over the last three decades, in large part reflecting the funding pressures the Organisation is under. In 1978 WHO adopted primary health care (PHC) as its preferred model for health system development. The PHC model formed the basis of WHO's promise of 'Health for All by the Year 2000' in 1981. It was strongly promoted by Dr Halfdan Mahler, the DG from 1974-1988; ignored by Dr Nakajima (1986-1998) and Dr Brundtland (1998-2003); but restored to prominence under Dr Lee (2003-2006). PHC was initially supported by Dr Chan (2006-2018) but in the latter years of her tenure the comprehensive PHC approach was very much subordinated to the slogan of UHC.

The October 2018 Conference on Primary Health Care in Astana celebrated 40 years since the 1978 Declaration. Some confusion within WHO was evident in the papers prepared for this Conference as to whether implementing PHC was a step towards UHC or whether it was a precondition for achieving UHC. The PHC model, as reinvented for Astana, highlights local service delivery with primary care and basic public health services. It returns to community involvement, strong referral relationships, system-wide logistic infrastructure and intersectoral collaboration for better health. However, it forgets the reference in the Alma-Ata Declaration to the role of macroeconomics in framing people's health chances (and the need for a new international economic order).

The status of PHC in WHO policy advice reflects the tension between responding to the policy preferences of member states (as expressed in Assembly resolutions) versus bowing to the requirements of donors. The continued endorsement of single payer health care funding is a credit to WHO although it is not prominent in the policy headlines. The principle of intersectoral collaboration has been repeatedly endorsed by the Assembly and is paid lip service by WHO's donors, but is largely starved of budget funding. The call for a NIEO is as relevant today as it was in 1974 but runs directly counter to the prevailing neoliberal policy package.

Privatisation, marketization and the liberalisation of trade and investment

The support of the World Bank and the major donors for health insurance markets and mixed service delivery is not based on evidence regarding efficiency, equity and quality. Rather it reflects a wider policy framework associated with the liberalization of trade and investment, including the opening up of health care financing and health care delivery to foreign investment.

With the rise of globalisation the private health care corporations and health insurers have looked to their governments to support their expansion into overseas markets, either through trade in goods (medicines) or trade in services (cross-border diagnostics, medical tourism, etc) or through foreign direct investment in private hospitals, clinics, diagnostic facilities and insurance (often with World Bank support). The WTO from 1994 broke new ground with provisions for irreversible services liberalisation as well as extreme patent protection.

While the developing countries resisted the push for investor protection in the Uruguay Round (that led to the WTO) investor state dispute settlement provisions were included in the suite of bilateral investment agreements and trade agreements negotiated outside the WTO framework.

Investor state dispute settlement (ISDS) is designed to protect foreign transnational corporations from national regulation and to guarantee corporate impunity. ISDS has huge implications for health, particularly in relation to tobacco control, junk food and alcohol but in many other sectors as well. The risks of services liberalization plus ISDS, in relation to health insurance, is exemplified by the 2008 Austria Slovakia case[7].

7. The Slovakian government in 2008 decided to require health insurers to be not for profit. An Austrian bank that owned shares in one of the for-profit companies claimed compensation for loss of the money that it might

From a corporate perspective, a further objective has been to maintain control over pricing and protect assets and profit expectations from government policy changes. For these reasons, extreme IP, investor protection and regulatory harmonization have also been key items on the trade agreement agenda.

The Doha Round of WTO negotiations finally ground to a halt in 2003-5, in part through the refusal of developing countries to agree to further liberalization of trade in services while the developed countries made no concessions on agriculture. The large international financial corporates have been major players in pushing for the liberalization of trade in services, in particular, financial services, which includes health insurance.

Even before the failure of the Doha Round, the US and later Europe were already pursuing bilateral and plurilateral trade agreements as vehicles for locking in extreme patent protection (TRIPS Plus provisions), preventing the use of TRIPS flexibilities, and opening up health care to foreign investment.

Closely associated with the opening up objective has been a policy discourse about privatization, marketization and public-private partnerships. These policies have failed to deliver efficiency, equity and quality, but the spin has clearly helped to open new markets for the international insurance companies, hospital corporations and supply industries. The World Bank and USAID have been active in supporting and encouraging foreign investment in the health sector including through public private partnerships.

An additional consideration driving the privatization agenda is the pressure on fiscal capacity and hence tax policies. In this context the financial press, the ratings agencies and 'investor sentiment' play a powerful role in discouraging governments from mobilizing the resources needed to invest in single payer health care financing and health care provision. Maintaining a low tax environment is a prominent demand of foreign investors generally and the pressures of 'tax competition' can weigh heavily on finance ministries.

The drive towards the privatisation and marketization of health care has been a major feature of health system policy since the 1980s. In that early period it was identified with structural adjustment (including ‘health care reform’) in developing countries. More recently similar policies have been advanced also in high income countries under the slogan of austerity.

The liberalization agenda reflects much deeper imperatives than simply advancing the interests of national corporations. Rather it puts into effect strategies which are directed to managing the looming threats of macroeconomic instability globally.

Capitalism always faces a recurring threat of crisis, variously imminent and sometimes less so. The underlying dynamic is generally a rising crisis of overproduction whereby increasing productive capacity outstrips demand, particularly, as high wage employment shrinks and is replaced by precarious casual low wage service workers and manufacturing is transferred to low wage platforms. As the excess productive capacity becomes increasingly evident, capital shifts from investing in productive capacity to speculating in shares, housing, currency and financial derivatives. With the increasing flow of capital to the banks, rather than real investment, the urgency (for the banks) of increasing bank lending rises. This is effected through a myriad of pathways, including credit cards, mortgages, government bonds, corporate consolidation and lending for speculation. For a while debt

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have made if profit making from national health insurance had continued. It invoked an Austria-Slovakia investment agreement negotiated in 1990 by the Czechoslovak government and inherited by Slovakia. This treaty allows commercial entities to claim compensation from public funds through ISDS style “investor protection” rules against “expropriation” (Reynolds and McKee, 2015).

funded consumption supports demand until confidence lapses and the edifice collapses, variously through a financial crisis or the collapse of a housing or stock market or tulip bubble[8]. The arrest of production and destruction of value clears the deck for the next cycle. While this pattern has historically unfolded in the context of national economies, with globalization it is increasingly synchronized and affects everyone.

From the perspective of transnational corporations and their nation state sponsors this scenario can be deferred through a range of policies commonly described as 'neoliberal'. These include the drive towards privatising and marketising health systems, including through diverse 'public private partnerships'. Such policies help to defer the crisis by providing new markets and investment opportunities. However, they also risk the loss of legitimacy through the impacts of austerity, precarity and barriers to accessing health care.

In this context the celebration of ‘sustainable development goals’ including ‘universal health cover’ helps to shore up the legitimacy of the current regime. However, if UHC is to be consistent with the neoliberal program it must be realised through privatised and marketised health care funding and service delivery.

How health systems develop

Health systems develop through incremental change. Such change takes place when established institutions ‘unfreeze’ (often because of increasingly evident dysfunction or wider institutional turmoil), *and* there are clever policies on hand, *and* public interest constituencies are driving towards a coherent vision for change (Kingdon, 1984).

Opportunities for change arise unpredictably; both in terms of timing and location of the institutional unfreezing. Accordingly the system as a whole, and all of the various loci of possible reform, need to be prepared so that opportunities can be converted into the implementation of progressive change when they emerge. Creating such ‘reform readiness’, locally and generally, involves:

- building consensus around preferred directions and why change is necessary;
- 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.

Building a shared vision of how the system as a whole should be developing is a critical part of this approach to ensure that incremental changes taking place at different times and places are coherent and synergistic. The Alma-Ata Declaration and WHO’s framework on integrated and people-centred health services provide a vision of the kind of health system we are striving towards.

Promoting this vision, engaging stakeholders in policy dialogue and supporting the emergence of community constituencies whose interests will be served by policy reform are critical tasks for policy leaders. Public interest civil society organisations can play a significant role in this process.

Many perhaps most L&MICs have inherited mixed public private delivery systems and stratified financing with the political constituencies which are associated with these institutions. Progressively remodeling such systems towards single payer financing and public sector dominance is a complex

8. From Graeber (2011), p 341: "The Dutch Republic, which pioneered the development of stock markets, had already experienced this in the tulip mania of 1637-the first of a series of speculative "bubbles," as they came to be known, in which future prices would first be bid through the ceiling by investors and then collapse."

and long term project. Projecting a vision which explicitly prioritises access, affordability, equity, quality and efficiency is a critical part of this project.

Working towards this vision requires effective regulation of private sector insurers, providers and suppliers in the short to medium term as well as the progressive development of single payer financing and integrated people-centred health system development.

Conclusions

UHC is the leading slogan in health systems policy globally, despite the obfuscations and ambiguities regarding its implementation. As the leading health systems policy slogan, UHC features in a number of high level instruments such as the SDGs, and fora such as the scheduled UN General Assembly discussion.

UHC (like global health policy more generally) is powerfully influenced by wider political forces, within and beyond the health sector, which in turn are influenced by the imbalances and vulnerabilities of the global economy. The neoliberal policy paradigm (and its promotion of low tax, corporate friendly, private sector health care delivery and marketised health care funding) is a program of action directed to protecting the global capitalist system from the risks associated with the recurring crises of global over-production. Running in parallel with neoliberal policies are the various program and funding initiatives directed to shoring up the perceived legitimacy of the prevailing regime, in health and elsewhere. UHC is an outstanding example.

WHO (like other UN bodies) is subject to brutal donor pressure regarding the political and economic implications of its policies, pressure which is also rooted in global politics and the macro-economy.

These various pressures help to explain the positions that different organisations have taken on UHC and the important differences between WHO and various multilateral, bilateral, philanthropic and partnership organisations contributing to discussions around UHC. Health officials from developing countries who engage in discussions regarding the SDGs or participate in the High Level Meeting on UHC at the UN General Assembly in September should have a clear perspective on these dynamics and influences.

UHC (as a policy goal which prioritises social protection and access to essential services and products) is important. However there is much more to health systems policy than this over-arching goal, including how it is to be operationalized. In this context system-wide policy models (in particular comprehensive primary health care and integrated people centred health services) are particularly useful. The challenges of fiscal capacity, human resources for health and affordable medicines must also be addressed, at national and global levels.

Of comparable importance are the policy strategies that are required to actually implement incremental change. The term 'health system strengthening' (HSS) was for a while the *slogan de jour* but has been superseded by UHC in recent years. Nevertheless, health system strengthening remains of paramount importance for achieving Health for All because it deals with both the policy models and the implementation strategies.

There is an urgent need for new conversations at the global level in which developing country voices are heard more clearly; addressing health policy issues with an understanding of the wider force fields of which they are part; sharing experiences regarding policy models and implementation strategies; building consensus around the kind of health system needed to achieve Health for All; building the constituencies for change at the global and national levels.

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