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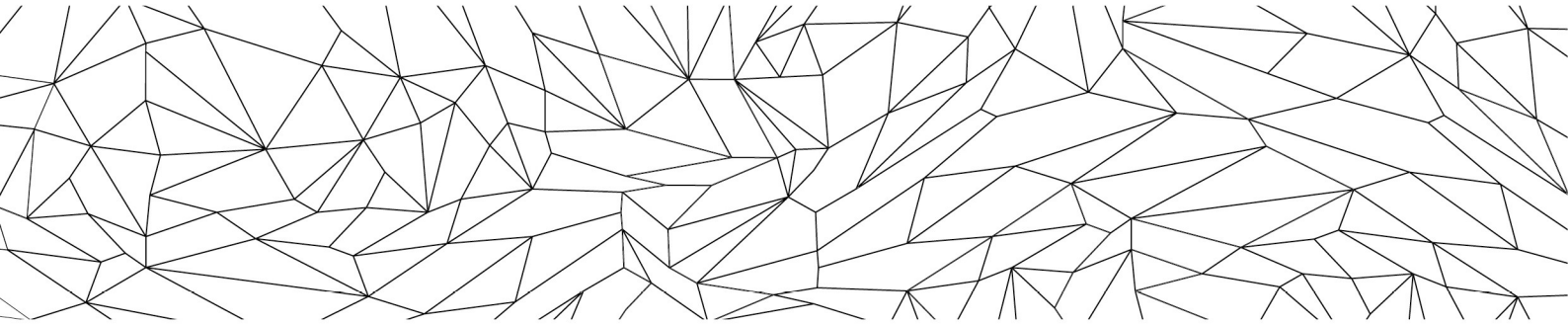

Health policy and changing perceptions of Universal Health Coverage

Julia Ngozi Chukwuma

Working paper

No. 251

September 2022

SOAS University of London

The SOAS Department of Economics Working Paper Series is published electronically by SOAS University of London.

ISSN 1753 – 5816

Suggested citation
Chukwuma, Julia (2022), "Health policy and changing perceptions of Universal Health Coverage", SOAS Department of Economics Working Paper No. 251, London: SOAS University of London.

Department of Economics
SOAS University of London
Thornhaugh Street, Russell Square, London WC1H 0XG, UK
Phone: + 44 (0)20 7898 4730
Fax: 020 7898 4759
E-mail: economics@soas.ac.uk
http://www.soas.ac.uk/economics/

Health policy and changing perceptions of Universal Health Coverage

Julia Chukwuma[1]

Abstract

This paper focuses on health policy, with healthcare as a fitting example of the broader trend of the narrowing scope of social policy and the associated marketisation and commodification of social services. Through a historical account, today's calls for Universal Health Coverage (UHC) and practices of implementing a basic minimum package are contrasted with previous conceptions of health as a human right. I present some of the political and economic factors that may help explain the degree of universalism of different health systems as well as policy makers' willingness and ability to assure access to healthcare for all.

Keywords: Universal Health Care, health inequalities, social policy, privatisation

JEL classification: I14, I38, P16

Acknowledgements: This paper is based on a chapter of my PhD thesis. I would like to sincerely thank my PhD supervisor Elisa Van Waeyenberge for all her guidance and feedback on my PhD.

[1] School of Social Sciences & Global Studies, Faculty of Arts and Social Sciences, The Open University, Milton Keynes, UK; Email: julia.chukwuma@open.ac.uk

1. Introduction

Most social security and human rights declarations since the 1950s have made reference to the right to health, maintaining that physical and mental well-being are essential for human progress. Prominently, the 1978 Alma-Ata Declaration put emphasis on the universal human right to a comprehensive set of primary healthcare services, going beyond the right to receive medical treatment only in the case of sickness (Yi, Koechlein and de Negri Filho, 2017, p. 5).[0] Moreover, it was maintained that achieving *health for all* (by the year 2000) is only possible, if, simultaneously, global efforts are aimed at fighting imperialism and neo-colonialism and correcting international inequities and injustice (UNGA, 1974).

According to Koivusalo and Mackintosh (2005, p. 5), "health policies define the direction towards which health systems are geared, how health systems are resourced and on what basis these operate". Health policy, as an aspect of social policy, has been particularly exemplary of the impact that different interpretations of universalism have on the realities and practices of healthcare delivery. Moreover, the provision of healthcare, alongside educational services, are central to social policy, occupying, in most places, a large share of public budgets (Fischer, 2018). Furthermore, the intersections between health and social inequalities and other forms of discrimination (i.e. on basis of race/ethnicity, indigenous status, immigrant status, gender, sexuality, disability, age, etc.) are critical (Navarro and Shi, 2001; Navarro, 2007; Krieger, 2014). For instance, O'Laughlin (2016, p. 687) emphasises that "what was once the rather marginal specialized field of international health development has been transformed into a new field – global health – in which inequality is a central issue".

This paper documents how health policy and healthcare delivery systems have been impacted by shifts in views, priorities and practices of social policy. Specifically, I explore the effect of the diversity of interpretations of what social policy is in the context of health and healthcare provisioning systems. I highlight that the narrowing scope of social policy is particularly visible in the area of health. The rise of neo-liberalism, accompanied by the intensification of the commercialisation and commodification of social services, has had significant implications for the distribution of roles between private and public sectors in health and has impacted the practices of universal provision of healthcare. Like the variety of positions and views on what social policy is and what functions it needs to fulfil, there are a multitude of perceptions of what universal health **care** (nowadays, universal health **coverage** [UHC]) is and entails – and how it can and should be attained. Different actors understand and conceptualise universalism differently, and while the goal of UHC "has risen to the top of the global health agenda, even becoming one of the key

[0] Commonly, three different levels of care are distinguished: (i) primary level (the first contact level with patients, including health posts, smaller healthcare facilities, dispensaries); (ii) secondary level (a more sophisticated hospital, e.g. at provincial level); and (iii) tertiary level (the most sophisticated hospital, such as teaching hospitals located in provinces' capitals); see here: https://2018.iupesm.org/wp-content/uploads/2014/06/WHO-LevelsofHealthServices.pdf (last accessed 15/07/2020).

pillars of the UN's SDGs …, [the] UHC cooptation story is illustrative of the fate of many progressive international and global health policy efforts in the context of neoliberal globalization over the past three decades" (Birn et al., 2016, p. 735). Ultimately, the way UHC is understood and the shape different countries' healthcare systems take depend on localised political struggles and processes (McKee *et al.*, 2013; Fox and Reich, 2015; Greer and Méndez, 2015). Against this backdrop, I argue that the notion of comprehensive primary healthcare, previously considered a universal human right, has been replaced by a concept of universal health coverage, which pays less attention to integrated provisioning modalities or quality of services.

This paper proceeds as follows. Section 2 presents how global health policies and perceptions of what universal healthcare service provision should entail have shifted over time and continue to differ across countries and regions. I emphasise that the vision of universal and comprehensive healthcare, that prevailed until the 1980s, was weakened with the emergence of neo-liberalism. Since then, cost-efficiency considerations were brought to the forefront and the door was opened to the commercialisation and privatisation of health sectors.

In section 3, I focus on how UHC is understood today and the political and economic factors that impact the varying degrees of universalism in different healthcare systems. I outline how more recent calls for UHC are not necessarily echoing the spirit of the Alma-Ata declaration – in spite of a (nominal) return to universalism and a (nominal) renunciation of selectivity. While existing characterisations of UHC are discussed and set out, it is also maintained that the definition of UHC remains "nebulous" (Stuckler et al., 2010, p. 8) and that, overall, the meaning of universalism has been diluted. Today, the focus seems to be on increasing the proportion of people "covered" with services, but discussions on who is responsible for guaranteeing and financing access to which health service as well as whether healthcare services are being provided in an integrated and equalising manner have been marginalised (Fischer, 2018, p. 241).

Section 4, then, turns to the different manifestations of healthcare delivery systems in practice more specifically. I provide an overview of (the lack of) progress made towards UHC on the African continent and appraise different health financing systems. I review the consequences of the commercialisation of health sectors and the increased role of the private sector in healthcare systems in further detail, challenging the assumption that health services provided by the private sector are of superior quality.

Section 5 summarises the contributions of this paper, including a review of shifts in global health policy, a discussion of concepts and theories of UHC and universalism, and an overview of practices of UHC.

2. Shifts in global health policy

This section emphasises that already in the 19th century, activists highlighted the important link between social conditions and health. Later on, the 1978 Alma-Ata Declaration, in particular, took aboard these reflections and promoted the reduction of societal inequities to be accompanied by efforts targeted at attaining health for all as a human right. I emphasise that in the aftermath of the Alma-Ata conference, the vision of universal and comprehensive primary healthcare was challenged and weakened. User fees were introduced as part of neo-liberal reforms and more responsibility was placed on the individual and the household to provide for their health. In particular, the World Bank and the Bill and Melinda Gates Foundation have (strongly) promoted this shift towards private responsibility and provisioning.

2.1. *Social conditions, a fair international economic order and health*

In 1845, Friedrich Engels published his famous essay on *The Conditions of the Working Class in England*, which described the disastrous link of a hazardous working environment and poor housing conditions with the state of health of members of the working class (Engels, 1845). Prominently, Engels highlighted the adverse effect that the industrialised, capitalist mode of production had on workers, considering illness, disease, work-related accidents as well as high levels of poverty to be "deliberate by-products of capitalism" (Sell and Williams, 2019, p. 3). Engels' observations were similar to the ones made by Edwin Chadwick at the time, who authored the UK's 1842 Sanitary Report (which is, every so often, considered as the beginning of modern public health), namely that "poverty was a conscious and deliberate part of a structure of accumulation associated with industrial capitalism, creating … a new system of wage slavery and inequality that had devastating impacts on health" (Sell and Williams, 2019, p. 3).

Engels' assessment of the relation between the exploitative nature of capitalism and ill-health is also well-reflected in the body of work of the Prussian 19th century physician Rudolf Virchow. Virchow has become known to have popularised the concept of "social medicine", as he, too, considered societal problems to be the root cause of disease and illness (Waitzkin, 1978; Waitzkin *et al.*, 2001). Virchow's view of how to counteract the spreading of epidemics was to avoid concentrating on medical solutions only – contrary to what the most prominent proponents of germ theory of the time were advocating[0] – but to intervene in the political arena in order to compel economic and social change in favour of the working class (Waitzkin, 1978). Especially after the revolutions of 1848 against European monarchs, Virchow became an outspoken political advocate, pleading for improved working conditions, better remuneration and a more progressive tax system (Waitzkin, 1978). Krieger (2016) documents how Virchow was convinced that more focus needed to be put on actions addressing social conditions fostering illness and that doctors and medical facilities needed to be put under state control.

The perspectives of Engels and Virchow, however, did, at the time, not receive much traction within Europe, where responsibility for health or sickness was seen to rest

[0] I.e., Louis Pasteur and Robert Koch.

with the individual and considered to be unrelated to the environment the individual lived and worked in (Navarro, 1976). Nonetheless, in the late 19th and early 20th centuries, public health initiatives (e.g. sanitation programmes) as well as forms of health insurance schemes were introduced, e.g. in Germany under Otto von Bismarck and in the UK under David Lloyd George. Also, during this period, in 1913, the US business magnate John Rockefeller founded a private charity, the Rockefeller Foundation, kickstarting the new American movement of scientific philanthropy, which, at the time, looked into applying technical solutions to specific health problems and disregarded underlying causes of sickness, such as poor housing conditions (Birn and Richter, 2018, p. 157).

In 1937, however, the Bandung conference under the leadership of the League of Nations Health Organisation (LNHO) took place, advocating for better rural hygiene as an important component of public health (Medcalf et al., 2015, p.4; Brown and Fee, 2008, p. 42).[0] Then, after the end of the two major European wars, welfare states, including platforms supporting health sectors, emerged across most European countries with the aim to ease the worst impact of industrial capitalism on the working class. Furthermore, the World Health Organisation (WHO) was established in 1948, but initially had its primary focus on vertical health programmes (notably, malaria eradication) (see Litsios 2020).

Concerns related to mounting a health infrastructure in countries of the Global South, which was capable of providing basic healthcare services, only emerged from the 1960s onwards (Litsios, 2004, p. 1885; Cueto, 2004, p. 1864). Especially, African and Asian nations, newly decolonised and part of the non-alignment movement, criticised the WHO's narrow vertical approach, advocating for a broader social and political response to health crises (Birn and Richter, 2018, p. 161). Moreover, outside of the European continent, Virchow's ideas had already been influential earlier.[0] Notably, Vladimir Lenin in the Soviet Union (which had a public health system since 1922), Salvador Allende in Chile (where social medicine was promoted since the 1920s), Mao Zedong in China (where a rural health system was introduced after the revolution in 1949), or Che Guevara in Cuba (where universal healthcare was adopted in the 1960s) were adamant to build strong public health systems, recognising the important relationship between politics, economics and health (Waitzkin, 1978). Especially, China's "barefoot doctors" (or, since the 1980s, "village doctors") are considered a "major inspiration to the primary health care movement leading up to the conference in Alma-Ata, in in the former Soviet Republic of Kazakhstan in 1978" (Weiyuan, 2008, p. 914). China's rural health system, put into

[0] However, as Medcalf et al. (2015, p. 4) highlight: "as important as this conference was, there is little direct evidence that it had an impact on global health thinking following World War II".

[0] Even prior to Virchow, in the early 1880, a form of state-sponsored public health programme, comprising vaccination campaigns in order to reduce infant mortality and fight epidemics, had been introduced to Egypt under its ruler Muhammad Ali. However, as Esposito (2004, p.191) highlights: "The British occupation of Egypt in 1882 thwarted Ali's efforts, however. Colonial authorities introduced a Western form of medicine to the country. Furthermore, they privatized medical education and established English as the language of instruction".

place in the mid-19th century, prioritised primary health care (PHC) and played a vital role in facilitating access to preventive and basic healthcare services for people living in the rural areas of China (Hu *et al.*, 2017).

By the 1960s, the importance of developing integrated health systems had moved to the forefront at the WHO (at the time, under the leadership of Marcolino Candau).[0] This culminated in the adoption of a resolution on basic health services in May 1973, which emphasised the importance of extending preventive and curative basic services to all people. A few months later, Halfdan Mahler, who had been instrumental in driving basic health services within the WHO in his role as one of five assistant directors-generals, became the director-general of the world's leading intergovernmental health agency. He collaborated notably with UNICEF as well as with the Christian Medical Commission (CMC) to reinforce health systems across the world (Litsios, 2004). At the same time, the WHO started engaging with the social determinants of health (although the formal Commission on the Social Determinants of Health (CSDH) was only founded many years later in 2005).[0] Notably, WHO senior staff member, Kenneth Newell, who spearheaded the formal creation of the organisation's PHC programme in 1975, highlighted that there are "studies demonstrating that many of the 'causes' of common health problems derive from part of society itself and that a strict health sectoral approach is ineffective, other actions outside the field of health perhaps having greater health effects than strictly health interventions" (Newell, 1975, p. xi).[0] Moreover, the role of the CMC, in particular, was influential and decisive in promoting comprehensive primary healthcare as an entitlement and universal human right and in reinforcing the fight against health inequities – ideas, which were taken fully aboard by the WHO by the mid-1970s:

To do so, the CMC from its inception gave priority to what it termed comprehensive health care – "a planned effort for delivering health and medical care attempting to meet as many of the defined needs as possible with available resources and according to carefully established priorities." Such a program "should not be developed in isolation but as the health dimension of general development of the whole society" (CMC's letter of application for NGO relationship with the WHO from 3 February 1969, cited in Litsios (2004, p. 1888).

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[0] Health systems are understood as "activities whose primary purpose is to promote, restore or maintain health" (WHO, 2000, p. 5).

[0] As stated on the WHO website, the social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries; see: https://www.who.int/social_determinants/sdh_definition/en/ (last accessed 09/07/2020).

[0] In parallel, Marc Lalonde, Minister of National Health and Welfare in Canada, had published a report in 1974, making the similar argument that healthcare services themselves are not the most important determinants of health, but also lifestyle, environment and human biology (alongside healthcare organisation) are determinants of health (Hancock, 1986; Glouberman and Millar, 2003). Other influential works of the time, promoting similar perspectives, were Carl Taylor's work on rural medicine in India (Taylor, 1976) as well as the work by the British historian Thomas Mckeown (McKeown, 1976).

Thus, the combination of these experiences, influences and efforts aimed at promoting PHC service delivery, embedded in broader ambitions of addressing international inequities, resulted in the organisation of the land-mark international conference on PHC in Alma-Ata in the former Union of Soviet Socialists Republics (today, Almaty in Kazakhstan) in September 1978.[0] The enthusiasm for PHC as a corner stone of a fairer world order echoed the political climate of the time. Many African countries had newly gained their independence from colonial powers and were engaged with nation-building and actively advocating for anti-imperialism. A few years before the Alma-Ata conference, in May 1974, the United Nations General Assembly adopted its *Declaration on the Establishment of a New International Economic Order* (NIEO). The declaration, initiated by a group of developing countries that had formed part of the Non-Aligned-Movement during the Cold War, was meant to support the struggle against neo-colonialism and imperialism and to "correct inequalities and redress existing injustices [and to] make it possible to eliminate the widening gap between the developed and the developing countries" (UNGA, 1974)[0]. As Cueto (2004, p. 1865) contends: "[m]odernization was no longer seen as the replication of the model of development followed by the United States or Western Europe. For example, Prime Minister Lester B. Pearson of Canada and Chancellor Willy Brandt of West Germany chaired major commissions on international development emphasizing long-term socioeconomic changes instead of specific technical interventions".

Against this backdrop, the Declaration of Alma-Ata emphasised the need for social and economic development on basis of the principles established in the declaration on the NIEO in order to attain "health for all".[0] At first, the commitments made in Alma-Ata (and endorsed at the 32nd World Health Assembly in Geneva in 1979), grounded in an understanding that health problems need to be addressed by correcting social and economic inequalities and by adopting an intersectoral and community-based PHC approach rather than focusing on "top-down, techno-biological campaigns", seemed to have been well-received by most governments (Birn et al., 2016, pp. 738–739). Nonetheless, the consensus achieved at the conference did not stand strong for long and critical voices emerged soon, worrying that the ideal of universal care for all by 2000 was not affordable (Stuckler *et al.*, 2010).

2.2. *From comprehensive to selective primary healthcare*

In 1979, the Rockefeller Foundation,[0] with the assistance of the World Bank (Brown et al., 2007, p. 67), organised a meeting in Bellagio (Italy) to discuss more cost-

[0] 134 countries were represented at the conference; yet, the Chinese delegation, which had initiated the discussions around organising such a conference and whose rural health systems had inspired the notion of PHC, was absent because of worsening relations with the Soviet Union (Cueto, 2004).

[0] Declaration on the Establishment of a New International Economic Order; online available: https://digitallibrary.un.org/record/218450?ln=en#record-files-collapse-header (last accessed 03/07/2020).

[0] Declaration of Alma-Ata; online available: https://www.who.int/publications/almaata_declaration_en.pdf (last accessed 03/07/2020).

effective disease control programmes, building on an idea brought forward by Julia Walsh and Kenneth Warren, who suggested the pursuit of an (interim) strategy of offering "selective" primary health care (SPHC):

> The goal set at Alma Ata is above reproach, yet its large and laudable scope makes it unattainable in terms of its prohibitive cost and the numbers of trained personnel required. … How then, in an age of diminishing resources, can we best attempt to secure the health and well-being of those trapped at the bottom of the scale long before the year 2000 arrives? We believe that a *selective* attack on the most severe public health problems facing a locality should be considered in order for us to have the greatest chance to improve health and medical care in less developed countries (Walsh and Warren, 1980, p. 145).

The concept of SPHC was promoted by a multitude of actors, notably the World Bank. Also, UNICEF, which had co-sponsored the Alma-Ata conference only a short time earlier, started promoting and implementing its "GOBI-FFF" programme from 1982 onwards. The organisation deemed a focus on "**G**rowth; **O**ral rehydration therapy; **B**reast feeding; **I**mmunisation; **F**amily spacing; **F**ood supplements; **F**emale education" to be more cost-effective (Stuckler et al., 2010, p. 14). Thus, under the auspices of UNICEF's new executive director, James Grant, the son of a Rockefeller Foundation medical doctor, UNICEF made a U-turn, replacing PHC with SPHC, which it believed created the right balance between political opportunity, scare resources and outcomes (Cueto, 2004). Besides UNICEF, also other aid organisations favoured the SPHC approach, which was perceived to be "more measurable, rapid, and less risky than PHC" (Medcalf et al., 2015, p. x). Yet, the proponents of PHC were clear on the limits and shortfalls of turning away from PHC towards the SPHC approach. Notably, Newell (1988, p. 904) clearly articulated that "[t]o the convinced PHC advocate such SPHC proposals are not PHC at all but are the antithesis of it. They are disease control programmes which are ideologically similar to the malaria eradication disaster and are a regression to the very qualities of imposed systems which were described in the Organisational Study".

Subsequently, many governments turned away from the Alma-Ata principles with the rise to prominence of neo-liberal ideology and the ensuing push for budget discipline throughout the 1980s. For instance, as Birn et al., 2016 (p. 739) highlight, "most Latin American governments rejected, or in some cases coopted, the Alma-Ata approach, instead favouring SPHC, which fitted the ascendant strategies of targeted short-term programmes in the absence of rights, fragmentation of social policy, and increased community responsibility for health services delivery". In the African

[0] As Martens and Seitz (2015, pp. 23-24) highlight, in the first half of the 20th century, the Rockefeller Foundation was one of the most influential actors shaping the discourse on global health governance, focusing on innovations on biomedical solutions to health problems. Yet, as Levich (2015, p. 709) emphasises, the Rockefeller Foundation's motive was not only altruistic and "as Rockefeller expanded its international health programs in concert with U.S. agencies and other organizations, additional advantages to the imperial core were realized. Modern medicine advertised the benefits of capitalism to "backward" people, undermining their resistance to domination by imperialist powers while creating a native professional class increasingly receptive to neocolonialism and dependent on foreign largesse".

context, however, where a majority of countries had by now attained their independence and were hoping for favourable economic and political conditions to provide impetus to their development, PHC was seen as a way of improving the mainly curative and urban-centred health systems inherited from the colonial period. And, in spite of economic difficulty and high public debt levels throughout the 1980s and 1990s, there were "clear attempts to abide by the orientations of the PHC strategy" (Chatora and Tumusime, 2004, p. 297).[0]

Nonetheless, in 1987, on the initiative of UNICEF (and backed by the WHO), African ministers of health adopted the Bamako Initiative (to be implemented alongside UNICEF's GOBI-FFF programme). The Bamako Initiative sought to ensure drug availability and community participation but was rooted in individualistic presuppositions as it introduced "co-financing" responsibilities for health service users. Thus, the poorest members of communities were now asked to pay for services, which previously had been accessible for free, often leading to their exclusion from service delivery (Yi et al., 2017, p. 5). Already at that point in time, there were concerns that "[q]uite apart from the debatable long-term impact of the health strategy being advocated, the Bamako Initiative poses serious questions related to equity and the implementation of fee systems which must be answered" (Kanji, 1989, p. 110).

2.3. *The rise of the World Bank and the Gates Foundation in global health policy*

In 1988, Mahler handed over leadership at the WHO to the Japanese researcher Hiroshi Nakajima.[0] Nakajima "rapidly became the most controversial director general in WHO's history" being criticised for "his autocratic style and poor management, his inability to communicate effectively, and, worst of all, cronyism and corruption" (Brown et al., 2007, p. 68). Moreover, the WHO was confronted with a shortfall in funding, as the organisation's dependence on extrabudgetary resources from donors and multilateral agencies increased, replacing income generated from states' membership fees (Walt, 1993; Godlee, 1994). Especially, the reduction of US financial support – which is the WHO's largest donor, but against several of the WHO's positions (its stance on PHC; its support for generic essential medicines; its reluctance to promote breast-milk substitutes) – considerably weakened the organisation's position (Birn et al., 2016, pp. 738–739). Thus, while the WHO was still an important cradle of technical expertise, its leadership role in the global health policy area was contested, with the World Bank in particular taking advantage of the WHO's crisis, assuming the role of the lead agency in the global health space (Abbasi, 1999, p. 868). Brown et al. (2007, p. 68) highlight that "in the late 1980s and early 1990s, the World Bank moved confidently into the vacuum created by an

[0] The authors mention Botswana, Burkina Faso, DR Congo, Malawi, Guinea, Namibia and Tanzania (Chatora and Tumusime, 2004, pp. 297–298). Also, Nigeria launched its first comprehensive health policy based on the principles of PHC and Alma-Ata in 1988 and instituted the NPHCDA in the 1992 (Aregbeshola, 2017, p. 48).

[0] Interestingly, Nigeria's former Minister of Health, Dr. Olikoye Ransome-Kuti was amongst those contesting for the top position.

increasingly ineffective WHO … The Bank maintained that existing health systems were often wasteful, inefficient, and ineffective, and it argued in favo[u]r of greater reliance on private-sector health care provision and the reduction of public involvement in health services delivery".

With the World Bank in the driving seat, the commercialisation and privatisation of health sectors, which had started in the 1970 as part of neo-liberal reforms, intensified (Yi et al., 2017, p. 4). As Adejumobi (1999, p. 88) highlights, "what is new in the present conjuncture is that the privatisation project hitherto confined to the areas of industry, manufacturing and agriculture, which the state participated in, is now being extended to the area of social welfare services and the state infrastructure sector".[0] And, with the new predominance of the World Bank on matters of global health, and the publication of the World Bank's 1993 report, *Investing in Health*, the shift away from provision of health as a public duty towards private responsibility, in favour of healthcare being seen as private good, was solidified (Laurell and Arellano, 1996). Since then, a pro-market stance has been the outspoken position of the World Bank, with the 1993 report promoting cost-effectiveness and policies for privatisation and commercialisation (Hunter and Murray, 2019, p. 4; Pfeiffer, 2019, p. 52). In essence, the role of the government is confined to offering basic services to the poorest members of society as provider of last resort and, if necessary, to performing a regulatory function (World Bank, 1993, pp. 5; 164). The Bank's main reasoning for their proposition was grounded in the view that government subsidies support richer rather than poorer segments of society, as articulated in the same report (World Bank, 1993, p. 11).

While a strong case can be made for integrated and well-funded public systems and, according to Ruckert and Labonté (2014, p. 1600), "full-scale privatisation of health was abandoned" by the mid-1990s, in reality, the emphasis on private sector engagement in the area of health continues – in particular as promoted by the World Bank, but also private foundations, such as the Bill and Melinda Gates Foundation (BMGF). Bill and Melinda Gates entered the global health arena, first with the establishment of the William H. Gates foundation and the Bill and Melinda Gates Children's Vaccine Programme and then with the launch of the BMGF in 2000, replacing the Rockefeller Foundation as the most powerful private foundation in global health governance[0] (Birn, 2014). The same year, the Global Alliance for

[0] Commercialisation is defined to include "the provision of health care services through market relationships to those able to pay; investment in, and production of, those services, and of inputs to them for cash income or profit, including private contracting and supply to publicly financed health care; and health care finance derived from individual payment and private insurance" (Mackintosh and Koivusalo (2005, p. 3) cited in Yi et al. (2017, p. 4)). As Koivusalo and Mackintosh (2005, p. 18) argue, this makes commercialisation a broader category than privatisation (transfer of ownership of an asset from the public to the private) or marketisation (change from a government-led provisioning system to a market-led system of provision) and distinguishes it from commodification (creation of a sellable product). In the context of the latter, Fischer (2018) and Mackintosh (2006) make reference to Karl Polanyi, who speaks of fictitious commodification as healthcare or education are not like "normal" commodities, which are produced for market exchange.

[0] Levich (2015) makes an important point when stating the following: "**Global health governance,** the phrase typically used to describe health management in the era of Bill Gates, is perhaps too narrow to

Vaccines and Immunisation (GAVI) was founded by the Gates, operating as a private-public partnership.[0] Two years later, the Global Alliance for Improved Nutrition (GAIN) was launched (and co-founded by the Gates) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (commonly known as the Global Fund) was initiated, also with the financial support of the Gates. Buse and Walt (2000) point at the emergence of a multitude of such global public-private partnerships – or global health initiatives (Storeng, 2014; Languille, 2017) – since the late 1990s, defining them as "a collaborative relationship which transcends national boundaries and brings together at least three parties, among them a corporation (and/or industry association) and an intergovernmental organization, so as to achieve a shared health-creating goal on the basis of a mutually agreed division of labour" (Buse and Walt, 2000, p. 550).

Since its inception, the BMGF has played a decisive and priority-setting role in the field of global health. It has become the second-largest donor to the WHO after the US (Martens and Seitz, 2015, p. 31). As of 31 December 2018, the BMGF had asset endowments of US$ 46.8 billion and provided direct grantee support of US$ 5 billion in 2018 only.[0] This compares to the WHO's 2018-2019 budget of US$ 4.4 billion.[0] Yet, little of their funding is consigned to entities located in the Global South as research conducted by McCoy et al. (2009) highlighted: between 1998 and 2007, 40 percent of the BMGF's resources were channelled via supranational organisations (global health initiatives and intergovernmental organisations), while, of the remaining share, 95 percent of grants went to organisations located in the US, Europe or other high-income countries. Moreover, most of the BMGF's grants directly channelled to the WHO are earmarked funds, leaving the WHO with limited scope to push forward its own priorities. Former director-general Margaret Chan observed: "[m]y budget [is] highly earmarked, so it is driven by what I call donor interests." (Martens and Seitz, 2015, p. 31 citing an interview Chan gave to the New York Times in 2014).[0] Therefore, like the Rockefeller Foundation in the first half of the 20th century, the BMGF has become "the most influential agenda-setter in the global health and nutrition arena (and in agriculture, development, and education)" (Birn and Richter, 2018, p. 155). Birn and Richter (2018) further contend that while both of these private foundations were created by the richest men of their times and on basis of a view that public health is a necessity for capitalism to thrive, the

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comprehend the character and ambitions of the project I have attempted to outline. It may be more useful to employ the term **global health imperialism**" (p.732; emphasis added).

[0] See, e.g. the description of their operation model on their website: https://www.gavi.org/our-alliance/operating-model (last accessed 06/07/2020).

[0] See the foundation's fact sheet at: https://www.gatesfoundation.org/Who-We-Are/General-Information/Foundation-Factsheet (last accessed 06/07/2020).

[0] See annex of adopted resolution of the WHO 2018-19 programme budget: https://www.who.int/about/finances-accountability/budget/PB2018-2019_en_web.pdf?ua=1 (last accessed 06/07/2020).

[0] See: https://www.nytimes.com/2014/09/04/world/africa/who-leader-describes-the-agencys-ebola-operations.html?_r=0 (last accessed 06/07/2020).

Rockefeller Foundation, still, emphasised the State's duty to provide healthcare, whereas the BMGF seems to prefer collaboration with corporate (and) non-governmental partners, having a less favourable view of and interest in the public sector.

Therefore, in line with the World Bank's promotion of the private sector, the BMGF favours a business-oriented and technology-driven approach to tackling a specific health problem instead of a broader health systems strengthening approach (Birn, 2005; Storeng, 2014; Martens and Seitz, 2015). Levich (2015, p. 706), for instance, insists that the Gates are only providing "brief lip service to the idea of strengthening public health services in poor countries". Along similar lines, an interview with a GAVI employee conducted by Storeng (2014, p. 868) uncovered the following:

The Gates Foundation was 'a very loud, vocal voice, saying that we do not believe in the strengthening of health systems', said one of GAVI's strongest health systems proponents, recalling that Bill Gates often told him in private conversations 'that he is vehemently against health systems ... he basically said it is a complete waste of money, that there is no evidence that it works, so I will not see a dollar or cent of my money go to the strengthening of health systems'.

While more resources for health appear good and necessary, the caution that e.g. Birn and Richter (2018) maintain with regard to the scale and nature (and ensuing influence) of "selfless philanthropic generosity" seems justified (see also McCoy and McGoey, 2011; O'Laughlin, 2016, p. 20; Storeng, 2014). Firstly, so-called philanthro-capitalists'[0] often are motivated by their own concerns around their reputation and their corporate interests; secondly, there are issues of democratic accountability and transparency;[0] and thirdly, much of their profits made over the past decades were to the detriment of the working class, were the result of the exploitation of elaborate tax avoidance schemes and contributed to increasing inequality (Curtis, 2016; Birn and Richter, 2018, p. 171). As Curtis (2016, p. 8) expresses: "there is something wrong when any individual is allowed to accrue such a vast fortune while billions languish in poverty".

3. Universalism and Universal Health Coverage: how is it understood today?

In October 2019, following a high-level meeting on UHC, which had taken place the preceding month, the UN General Assembly adopted a political declaration, repeating the pledge of the world's national leaders to achieve UHC[0] – praised as

[0] Birn and Richter (2018, p. 156) refer to the US business editor of the Economist, who first coined the term philanthrocapitalism, which refers to "both to infusing philanthropy with the principles and practices of for-profit enterprise and as a way of demonstrating capitalism's benevolent potential through innovations that allegedly 'benefit everyone, sooner or later, through new products, higher quality and lower prices'".

[0] See e.g. Erikson (2015) on clandestine financial dealings in global health.

[0] Interestingly, these efforts were led by the Nigerian Tijjani Muhammad-Bande, who acted as President of the 74th session of the UNGA. It is also to note that the declaration was adopted without a

"the single most powerful concept that public health has to offer" by the former head of the WHO, Margaret Chan.[0] Accordingly, a 2019 UNGA resolution puts emphasis on health being a human right with the government being the primary duty bearer, contends that health is both a condition as well as an outcome of social and economic circumstances, and further highlights that attaining UHC, as part of efforts to attain the SDGs by the year 2030, is conditional upon improving PHC service delivery. This is stated in paragraphs 1, 5 and 13 of the declaration (UNGA, 2019).[0]

Thus, for proponents of a rights- and solidarity-based understanding of universal health care, embedded in broader economic and social policies promoting international equity and justice, the mention of the Alma-Ata conference in this new resolution is particularly encouraging. Seven years earlier, in December 2012, the UNGA had adopted a similar resolution, urging national decision-makers to accelerate efforts towards the attainment of UHC.[0] Yet, while the 2012 declaration makes mention of "comprehensive PHC" (once) and refers to the social determinants of health, there is no reference to the Alma-Ata Declaration nor global justice. It does, however, mention the Report of the 1994 International Conference on International Population and Development, which, in turn, refers to Alma-Ata. Other important resolutions at the UN since then, which make reference to UHC, include, most prominently, the 2030 Agenda for Sustainable Development (targets 3.8),[0] but also the 2015 Addis Ababa Action Agenda on development finance[0] and the 2016 resolution on global health and foreign policy, health, employment and economic growth.[0] Additionally, the International Health Partnership for UHC 2030 (known as UHC 2030) was established in 2016, and over the course of the last few years, many other development agencies, partners, regional bodies and national governments, including in Africa, have adopted several declarations and agendas, committing themselves to support efforts targeting the improvement of PHC service delivery and/or the attainment of UHC by the year 2030.[0] Furthermore, in April 2020 – in the

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vote.

[0] See: https://www.who.int/life-course/news/events/uhc-day/en/#:~:text=Dr%20Margaret%20Chan%2C%20WHO%20Director,based%20on%20primary%20health%20care.%E2%80%9D (last accessed 08/07/2020).

[0] The resolution adopting the political declaration of the high-level meeting on universal health coverage; online available: https://undocs.org/en/A/RES/74/2 (last accessed 08/07/2020).

[0] The 12 December, the day the resolution was adopted in 2012, was made the "UHC Day": https://undocs.org/a/res/72/138 (last accessed 08/07/2020).

[0] Target 3.8 of Sustainable Development Goal 3 "Good health and well-being" reads as follows: "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".

[0] Online available: https://undocs.org/en/A/RES/69/313 (last accessed 08/07/2020).

[0] Online available: https://undocs.org/A/RES/71/159 (last accessed on 08/07/2020).

[0] These include the 2005 World Health Assembly resolution on universal coverage and social insurance, the 2006 Addis Ababa Declaration on Community Health in Africa, the 2008 Ouagadougou Declaration on PHC and health systems in Africa, the 2010 World Health Report on health systems financing and the path to UHC, the 2014 Luanda commitment to UHC, the 2016 World Bank-WHO

midst of the COVID-19 crisis – the heads of several West African states (of the Economic Community of West African States [ECOWAS]) reiterated their commitment to the 2001 Abuja Declaration of spending at least 15 percent of their annual budgets on their health systems.[0]

Hence, a plethora of declarations on and commitments to UHC exists and assuring universal access to healthcare has been adopted as a global goal.[0] In reality, however, national health systems and reform proposals differ greatly, and countries are progressing at different pace towards assuring that people have access to the health services they require. Thus, while the formal commitment to UHC has been vast, it remains "primarily a normative concept" and views on how UHC should be achieved and can be operationalized are manifold (MacGregor, 2017, p. 61). Health policy trajectories and reforms across countries heavily depend on political processes as well as the balance of power between supporters of private service delivery and supporters of solidarity-based universalism (Yi, Koechlein and de Negri Filho, 2017). National debates on health system reforms aimed at paving the way to UHC have proven to be "intrinsically political" (Greer and Méndez, 2015, p. 637) and "highly politicised" (Koon and Mayhew, 2013, p. 1). While some view health care as a fundamental human right and rely on the core principle that "people should contribute according to their ability to pay and receive health care in response to their need" (MacGregor, 2017, p. 64), others view it "as a tradable commodity" (McKee et al., 2013, p. 39). Hence, as Lagomarsino et al. (2012, p. 933) put it, "there is little consensus about how low-income and lower, middle income countries should structure reforms aimed at moving towards universal coverage". Yet, for Greer and Méndez (2015, p. 637), "it is a political victory that UHC is discussed at all".

3.1. *Conceptualising Universal Health Coverage*

The WHO definition of UHC is 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 (WHO and World Bank, 2019, p. 7).

Framework for Action for UHC in Africa, the 2017 G20 Berlin Declaration, 2017 Tokyo Declaration on UHC, the 2018 WHO-UNICEF sponsored Declaration of Astana, the 2019 Africa Health Agenda International Conference Declaration, etc. – alongside many national declarations on UHC.

[0] See: https://www.theafricareport.com/26912/coronavirus-ecowas-appoints-buhari-as-pandemic-response-champion/amp/?utm_source=twitter.com&utm_campaign=post_articles_twitter_27_04_2020&utm_medium=social&__twitter_impression=true (last accessed 09/07/2020).

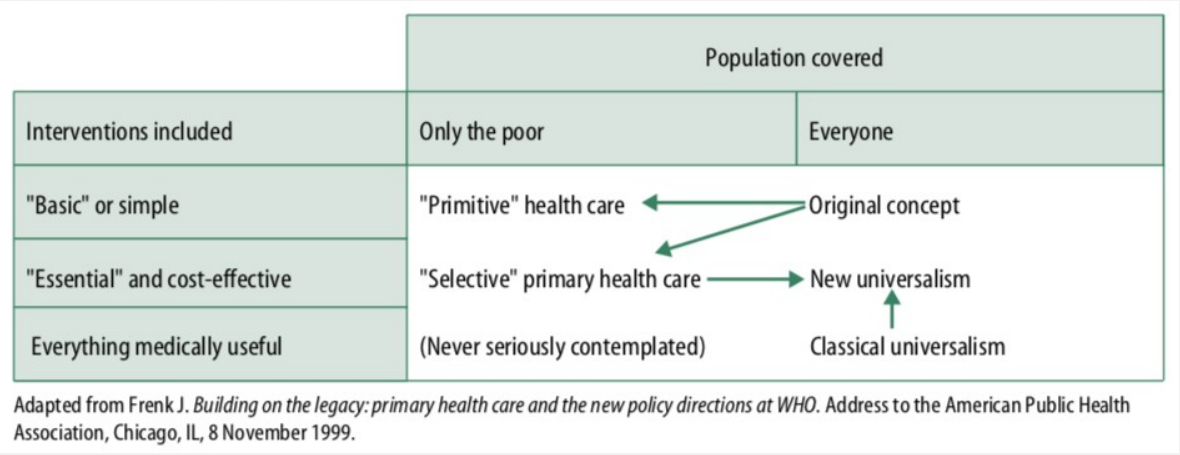
[0] This includes the US: https://usun.usmission.gov/explanation-of-position-on-the-high-level-political-declaration-on-universal-health-coverage/ (last access 08/07/2020).

Nonetheless, the concept of universalism itself is vague. This may be a reason for the considerable range of different modes of operationalising some form of UHC in reality and the broad adoption of UHC in the first place (Stuckler et al., 2010, p. 8; Fischer, 2018, p. 225; MacGregor, 2017, p. 65). Overall, however, the tendency since the 1980s has been to mainstream a narrower understanding of universalism. While universalism may have once meant creating healthcare provisioning systems that are public, integrated, free/subsidized, equitably-accessible and socially-equalizing, today's focus seems to be on assuring universal coverage and guaranteeing access with less focus on who provides the services and at what price (Fischer, 2018). Fischer (2018, p. 222) further contends that "the strongest influence on this shift of meaning probably comes from the World Bank, which explicitly takes the position that universalism is achieved as long as everyone has access to something, regardless of how this is provided". In addition, the influence of the BMGF, who seem to have a similar understanding to World Bank-like "universalism", in promoting this view cannot be underestimated. Hence, while some organisations and actors, such as the UN and notably the WHO, may advocate for the institution of healthcare systems based on notions of inclusion, social cohesion and equity, the World Bank, the BMGF and others continue to argue in favour of more neo-liberal forms of health services delivery systems, with an enhanced role for the private sector. Furthermore, while at the time of Alma-Ata, a more just distribution of power and resources across the globe was seen as an integral part of efforts targeted at improving people's health status, more recent calls for UHC "are silent on social determinants of health and community participation" (Sanders et al., 2019, p. 619).

Scholars as well as international organisations like the WHO have proposed to evaluate national healthcare delivery systems based on their degree and/or depth of universalism as well as extent of elements of selectivity. Richard Titmuss (in Abel-Smith and Titmuss, 1987) and Skocpol (1991) have highlighted that some level of selectivity and targeting within universalism (e.g. on basis of age, dis/ability or sex) may be important and justifiable. Thus, in order to appraise a national health system's degree of universalism, there is need to address questions such as: who should access which service? For free or at a subsidised price? Which interventions should be included? Who should be providing these services? Who is ultimately responsible for the quality of care and its accessibility?

These question around what universal, comprehensive primary health care entails featured prominently in a 2000 WHO report (see Figure 1). The WHO conceptualises UHC on the basis of three key dimensions: (i) population: who is covered; (ii) services: which services are covered; and (iii) direct costs: proportion of the costs covered (see Figure 2). True universalism would imply that the entire population is covered, has access to all medically relevant services and all direct cost are covered and paid for from a pooled fund (older versions of the same graph of the WHO explicitly state "public health expenditure" in the place of "current pooled funds").

Figure 1: Coverage of population and of interventions under different notions of primary health care



Adapted from Frenk J. *Building on the legacy: primary health care and the new policy directions at WHO.* Address to the American Public Health Association, Chicago, IL, 8 November 1999.

Source: WHO (2000)

Figure 2: The three dimensions of universal health coverage

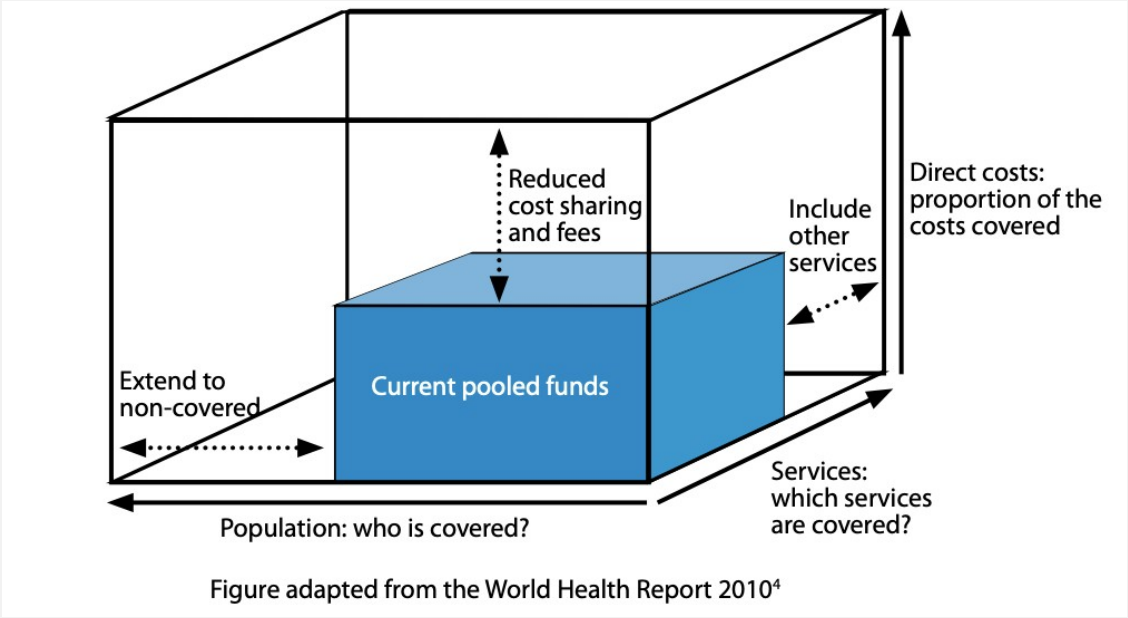


Figure adapted from the World Health Report 2010[4]

Source: WHO (2014)

Fischer (2018) suggests measuring the degree of universality on a spectrum and breaks down universalism into three components. These include: (i) provisioning modalities, concerned with expanding coverage and assuring equitable access to services, delivered in an integrated manner (no matter the ownership status of the service provider); (ii) costing and pricing, which in a strong universalistic system would be decommodified and independent of market behaviour; and (iii) the modality of financing, relating to the question of how services are being paid for (directly, e.g. via user fees, or indirectly, e.g. via progressive taxation). Inspired by Fischer (2012), Martinez-Franzoni and Sánchez-Ancochea (2014; 2016) propose the three dimensions of coverage, generosity (in level and quality) and equity, to measure the extent of universality of a country's social service delivery system. In line with

Fischer (2012, 2018), they stress that universalism is a continuous variable, but put particular emphasis on the importance not to confuse policy instruments (e.g. how to meet UHC) with policy principles (i.e. what form of UHC do governments want to achieve) (Martinez Franzoni and Sanchez-Ancochea, 2016, p. 31).

Averill and Mariott (2013) have identified four “key ingredients” for UHC. They argue it is necessary to: (i) promote equitable access by removing financial barriers, especially direct payments; (ii) make prepayment compulsory; (iii) ensure that there is a large risk pool; and (iv) ensure that the Government covers the health costs of people who cannot afford to contribute. Also, MacGregor (2017) identifies three aspects which are important when discussing UHC: first, access to quality health services for all; second, interventions to promote a healthy society and individual well-being; and, third, sickness benefits to cover absence from the labour force due to acute or chronic conditions. Her principles seem to reflect the importance to promote UHC in accordance with addressing the social determinants of health. Similarly, Stuckler et al. (2010), aware of multiple definitions of UHC, have identified five themes that are commonly associated with UHC. These include: (i) access to care or insurance; (ii) coverage; (ii) package of services; (iv) rights-based approach of UHC; and (v) social and economic risk protection.

Lastly, Yi et al. (2017) have proposed a model to assess the degree of universality of a healthcare provisioning system. This is based on the following six dimensions:

(i) Entitlement, which refers to the importance of a legal basis as well as political and institutional mechanisms in place for citizens to claim their right to health

(ii) Eligibility, which, in universalism, means that every person regardless of gender, age, class, health status, etc. is allowed treatment

(iii) Access, which depends on enabling factors (i.e. availability, location, cost, etc.) and is the extent to which beneficiaries can actually consume and use services

(iv) Appropriateness, which relates to the extent of (quality) services and benefits being provided

(v) Distributive rules of benefits, impacting poverty and inequality

(vi) Organising principles, which addresses the question the extent to which the public should assume responsibility for welfare and social services

Therefore, while, perhaps pragmatically, universalism may be “best considered as an ideal, a vision and a goal, serving as a rallying call and aid to mobilization” (MacGregor (2017, p. 65), national policy-makers need to address these six dimensions when designing and operationalising health systems. The outcome will depend on processes of domestic negotiation, contestation and priority-setting,

themselves influenced by the power of different actors (including “outside” actors), their views and ideological stance, existing norms and contextual factors, such as historical/colonial legacy, degree of social cohesion, organisation of the state including degree of decentralisation, economic standing, etc.

However, from a pro-universalism, rights-based perspective, policy makers, committed to attain UHC, should **strive** towards ensuring that healthcare services are provided in a comprehensive and integrated as opposed to a fragmented manner, with the responsibility lying with a unified institutional structure (the state), which guarantees that every person has access to quality services, regardless of their sex, age, dis/ability, ethnicity/race, etc. and financial situation, by assuring that healthcare is decommodified and mainly tax-funded. Thus, as Andersen (2012, p. 164) has summarised, a country’s healthcare system would be only truly universal, if health is a human right, enforceable due to compulsory legislation, tax-financed, uniform throughout the country, designed for the entire population, which has equal access and most of them make use of these services. Nonetheless, the ultimate decision on the degree of universalism, which can be achieved within a specific country, depends on global political processes and interplays as well as distinctively context-specific factors.

3.2. *Determinants of the degree of universalism in healthcare*

Several scholars have put forward theories that help explain the practice of universalism and have further explored factors and determinants of universalization. Navarro groups these theories that aim to explain variation in healthcare systems reforms into four groups: first, pluralist theories (popular choice theories), which highlight the interplay and preference of multiple different actors and citizens and their impact on policy making (e.g. via voting systems or behaviour as a market participant); second, institutional theories (power groups theories), which focus on institutions and interest groups such as medical professionals, representatives of pharmaceutical enterprises, insurance providers, etc. and how they impact and are impacted by policy dynamics; third, development theories, which suggest that when countries get richer, they will also increase their public social spending; and finally, class theories, which see healthcare systems of provision as an outcome of struggles between the capitalist and the working class (Navarro, 1989; Stuckler *et al.*, 2010; McKee *et al.*, 2013).

Inspired by such theories explaining health policy development, scholars have identified possible factors that determine the degree of universalism in a country’s health system. For instance, according to Greer and Méndez (2015), democratization, partisanship and strong left-wing parties are enabling factors for successful UHC reform at country-level, although they highlight that political support at international level is equally important to avoid competing advocacy for e.g. single-disease focused programmes (Greer and Méndez, 2015). A comparative analysis of health insurance reforms in several African and Asian countries, conducted by Lagomarsino et al. (2012), draws a similar conclusion, namely that UHC reforms are

political and country-context dependent, often correlated with the degree of domestic support, the power of donors as well as fiscal constraints and operational capacity.

Along similar lines, Stuckler et al. (2010) as well as (McKee *et al.*, 2013) have conducted an extensive literature review and have identified five main determinants, apt to explain cross-national variations in UHC. These include: (i) the existence of powerful left-labour coalitions, which prioritise redistribution and state intervention; (ii) the wealth of a nation, as richer nations seem more likely to have higher levels of universal coverage; (iii) political regimes, institutions and degree of social cohesion, as societies which are more divided and more unequal are less prone to put into place redistribute policies; (iv) initial social welfare conditions, assuming that existing health systems configurations influence future reform paths; and (v) the existence of a "political window of opportunity", e.g. in response to a natural disaster, social turmoil, or financial crisis. In similar fashion, Fox and Reich (2015) as well as Rizvi et al. (2020) refer to four explanatory factors (known as the "four I's"), which explain health outcomes and have been identified in classical political science frameworks, namely interests (all actors and interest groups that will benefit or lose out as a consequence of a certain policy change), institutions (both formal and information political institutions and norms influence policy change), ideas (i.e. specific policy solutions, concepts, information, etc.) and ideology (i.e. a particular world view used to justify policy change).

Researchers at the United Nations Research Institute for Social Development (UNRISD) have specified six enabling factors, which have shown to facilitate progress towards universalism in healthcare delivery (UNRISD, 2017). First, they argue, an empowered civil society, which closely collaborates with the government, has played a major role in driving efforts towards UHC, notably in Thailand and Brazil. Secondly, they highlight the importance of political will and support as well as institutional capacity to make available the necessary financial resources for UHC reforms. Third, they contend that approaches to and concepts of universalism are often contested (as e.g. in the case of South Africa) and highlight the significance of finding ways to build consensus (through democratic mechanisms) across a multitude of stakeholders and policy sectors in order to accomplish successful reforms. Fourth, the need to find ways to mitigate and reduce resistance in and from the private sector is highlighted, as in many emerging economies pro-market views are deep-rooted and may pose a hinderance to UHC reforms (e.g. Russia, China or South Africa). Fifth, their research has shown that efforts to decentralise service provision played an important role in expanding access to health services (e.g. in Brazil) but need to be part of a comprehensive and coherent national framework. And, sixth, they highlight the benefits of tax-financed healthcare systems, for instance, to people of the informal sector over e.g. employment-based contributory insurance systems. These enabling factors identified by UNRISD as well as by other scholars are helpful in theorising and explaining a country's progress towards creating a policy environment conducive to attaining UHC.

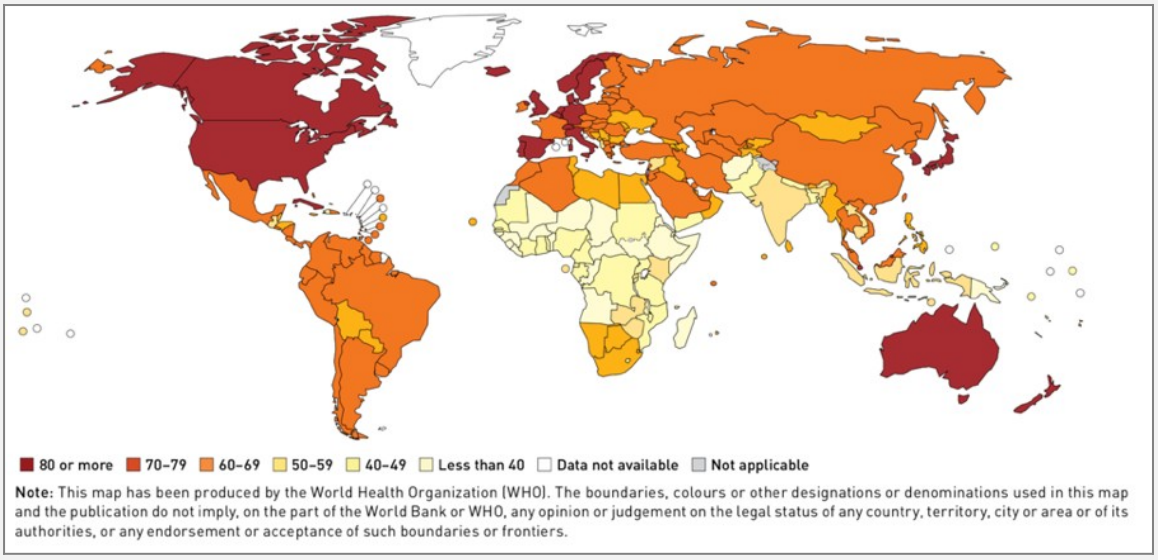
4. Practices of Universal Health Coverage

A number of developing/emerging countries in Latin America and Asia have made considerable advancements in putting into place health systems that are progressing towards increasing their degree of universalism. A 2013 Oxfam report mentions the success stories of Thailand, Malaysia, Sri Lanka and Brazil – which all "share a common understanding that entitlement to health care should be based on citizenship and/or residency and not on employment status or financial contributions" (Averill and Mariott, 2013, p. 8). Other nations and regions, too, have been lauded for their public-sector driven UHC reforms, including Cuba, Costa Rica or the Indian State of Kerala (Sen, 2015). On the African continent, the Seychelles provide free primary healthcare services to all its citizens (Workie *et al.*, 2018, p. 364). Other countries, such as Burundi, Zambia or Niger provide some free health services to selected groups such as children under age five and/or pregnant women (Nimpagaritse and Bertone, 2011; Lagarde, Barroy and Palmer, 2012). Many other countries (or regions within countries) on the continent have adopted UHC or PHC strategies and policies, created budget lines and introduced or reinforced community-based and/or national health insurance schemes.[0] The WHO, with the support of the World Bank and others, monitors countries' progress towards the attainment of the UHC targets 3.8.1 and 3.8.2.[0] Yet, as can be seen in Figure 3 and Figure 4, in many African countries, coverage needs to be expanded further and the pressure on households relating to health expenditure needs to be relieved.

[0] A 2018 report prepared by the WHO Africa programme features some of these programmes and strategies; online available: https://www.who.int/docs/default-source/primary-health-care-conference/phc-regional-report-africa.pdf?sfvrsn=73f1301f_2 (last accessed 13/07/2020).

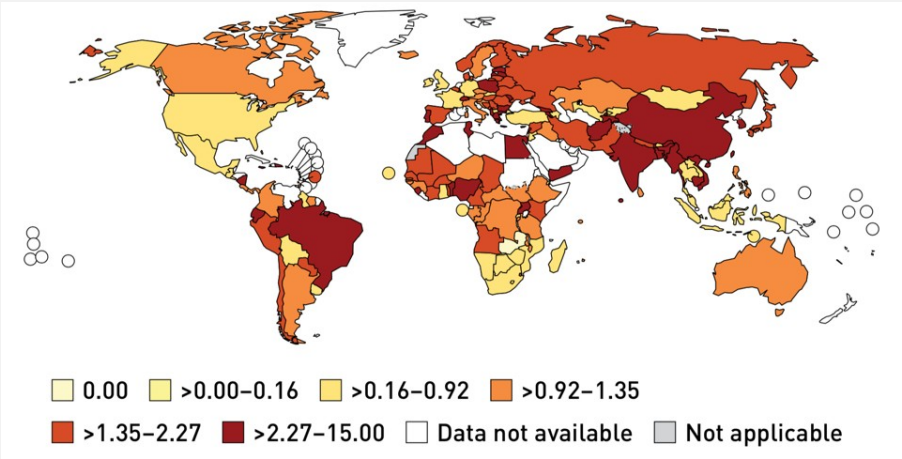
[0] The targets are formulated as follows: (i) SDG indicator 3.8.1: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; and service capacity and access; among the general and the most disadvantaged population); (ii) SDG indicator 3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income.

Figure 3: UHC service coverage index, 2017



Source: WHO and World Bank (2019)[0]

Figure 4: Percentage of population with impoverishing health spending
(at the relative poverty line of 60 percent of median per capita consumption)



Source: WHO and World Bank (2019)

4.1. Health system financing modes

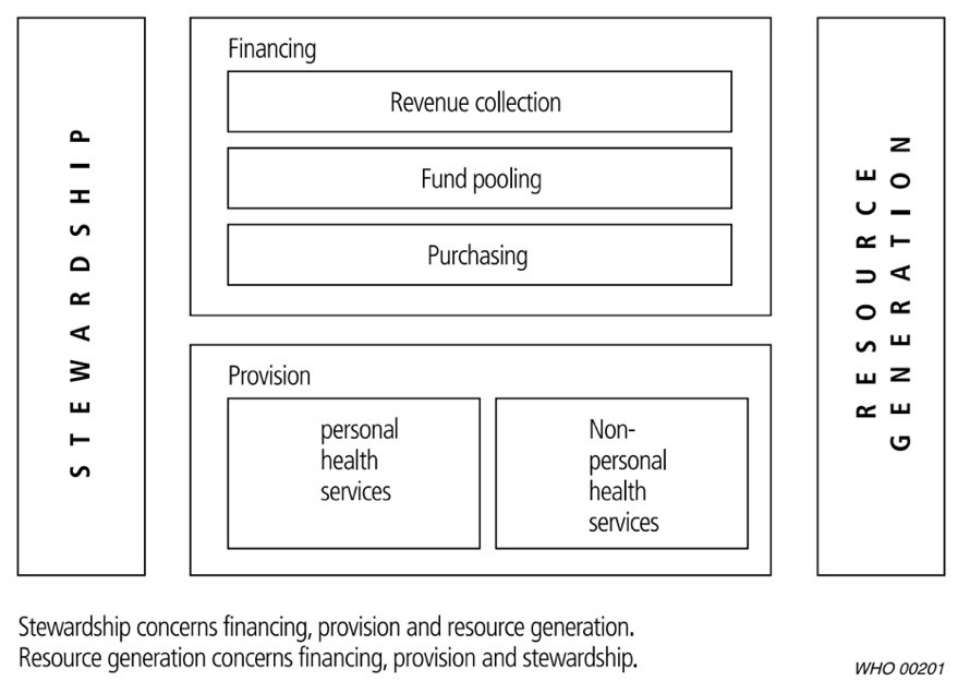
The approaches at country-level to achieve UHC are diverse and, as argued earlier, depend on political processes and a multitude of context-specific factors. In particular, health system financing or how to mobilise resources for service delivery is often subject to domestic contestation.[0] Murray and Frenk (2000, p. 724) define

[0] The UHC service coverage index (SCI) is composed of 14 tracer indicators, covering four essential health services areas (reproductive, maternal, newborn, and child health, infectious diseases, non-communicable diseases, and service capacity and access).

[0] According to the WHO, the six building blocks of a health system include service delivery, health workforce, health information systems, access to essential medicines, financing and leadership/governance.

health system financing as “the process by which revenues are collected from primary and secondary sources, accumulated in fund pools and allocated to provider activities”.[0] As they suggest, commonly three sub-functions are distinguished, namely revenue collection, fund pooling and purchasing (see Figure 5).

Figure 5: Functions of a health system with financing at its core



Source: Murray and Frenk (2000)

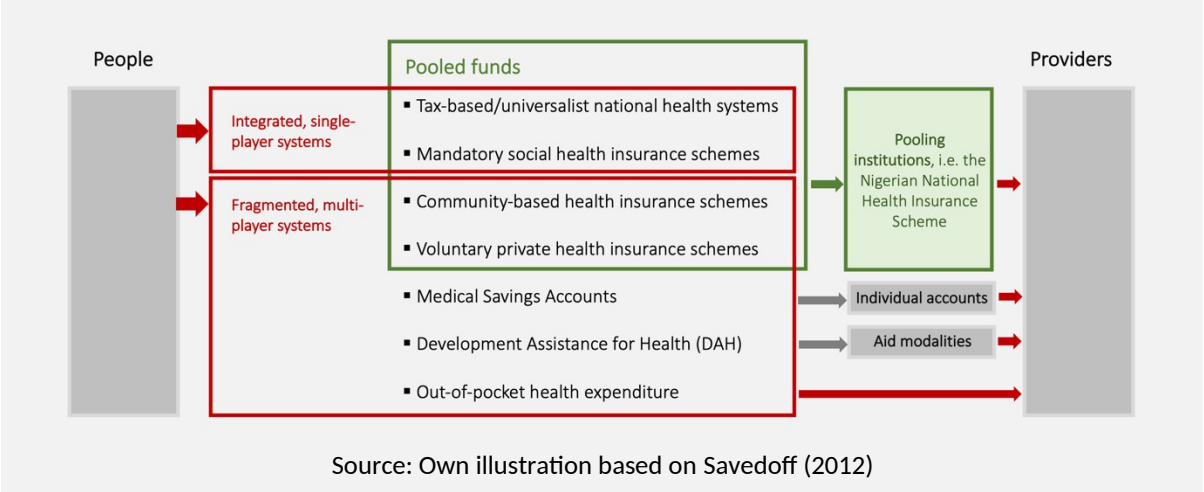
Revenue collection relates to the mobilisation of resources for healthcare e.g. from individuals, households, employers, governments or bi- and multilateral donors. Averill and Mariott (2013, p. 8), for example, stress that expanding mandatory national social insurance schemes has been identified as a crucial strategy to contribute to the attainment of UHC, while voluntary, private or community-based insurance schemes still need to be proven to be effective. Nonetheless, African countries have opted for a broad range of health financing policies and strategies; i.e. Ghana has been analysed for having expanded health coverage with the help of a national insurance scheme (Agyepong *et al.*, 2016), whereas Rwanda has been promoting community-based health insurance (Chemouni, 2018). Notably, Gautier and Ridde (2017) have reviewed African country studies, which have addressed health financing options and policies as well as their enabling variables and varying degrees of success.

[0] As Kutzin (2013) highlights, health financing arrangements are not the only component that influence the objectives of a health system, such as improving health outcomes and boosting social equity. Therefore, health policies and strategies need to be in concord with policies and aims of other economic and social sectors, as such other societal goals are interconnected with the health systems (Murray and Frenk, 2000, p. 719; Kutzin, 2013, p. 603).

These different financing models can be differentiated on basis of several criteria, i.e. the nature of the scheme (public versus private), its compulsoriness (voluntary versus mandatory), its competitiveness (single- versus multiple player), its contribution method (tax-financed, social security contributions or insurance premiums) and its basis of eligibility (i.e. residency status, citizenship, only contributors eligible, etc.) as summarised by Toth (2016). In this context, there have been important scholarly contributions reviewing and categorising the different types of financing schemes, while acknowledging that in many countries a mix of financing schemes may co-exist (see for instance, Field, 1973; Frenk and Donabedian, 1987; Navarro, 1989; OECD, 1994; Lee et al., 2008; Savedoff, 2012; Averill and Mariott, 2013; Toth, 2016; Onwujekwe et al., 2019). Based on a review of the existing literature as well as on an assessment of what is deemed relevant and applicable to the African context, Figure 6 schematises seven different types of financing modes, which are the following:

1. **Tax-based/universalist national health systems**, where healthcare is paid for through the Government's budget
2. **Mandatory social health insurance schemes**, which is an employment-based, contributory system, allowing for cross-subsidisation between the healthy and wealthy and the sick and the poor (Fenny, Yates and Thompson, 2018), i.e. the Formal Sector Social Health Insurance programme in Nigeria, which is one of the country's programmes under the National Health Insurance Scheme
3. **Community-based health insurance schemes**, also known as *mutuelles de santé*, which are solidarity-based, not-for-profit, voluntary schemes, covering a small group of, most commonly, low-income people living in rural areas and working in the informal sector
4. **Voluntary private health insurance schemes**, which are for-profit arrangement, where individuals can opt to choose an insurance provider (i.e. managed care systems using Health Maintenance Organisations in the US as well as Nigeria)
5. **Medical Savings Accounts**, where individuals decide to put aside part of their own resources to be used to pay for healthcare services when they become necessary at a later time, but without the benefit of pooling resources and risks with other contributors (see e.g. Savedoff, 2012)
6. **Out-of-pocket health expenditure**, where individuals use their own financial means to pay for healthcare directly at point of service
7. **Development assistance for health (DAH)**, notably in form of grants of loans, disbursed on basis of the agreed-upon aid modality, i.e. project financing, technical assistance, budget support, etc.

Figure 6: Types of health financing schemes



Source: Own illustration based on Savedoff (2012)

Nevertheless, while there are several ways of mobilising resources to pay for health services, MacGregor (2017) highlights that the wider the pooling of resources and risks into one unified fund, with contributions no longer being tied to the particular contributor, the more universal the scheme. According to Savedoff (2012, p. 4), tax revenues (levied on income, consumption/value-addition, imports, etc.) as well as mandatory insurance contributions most commonly present the largest source of pooled funding for health. Voluntary private and/or community-based health insurance schemes also function as pooled funding; yet, countries, which largely rely on private health insurance schemes are often faced with considerable equity concerns and make it harder (and, even, hardly possible) to attain UHC (Averill and Mariott, 2013). Additionally, as e.g. Wagstaff (2007) has highlighted, so-called "purchaser-provider models", where the purchaser is a third party (such as an insurance scheme/company) kept separate from the health care provider, introduced to create competition and commonly promoted, have not been proven to be more effective than tax-financed purchasers.

With regard to purchasing, which is "a generic term that refers to the transfer of pooled funds to providers on behalf of a population" (Kutzin, Cashin and Jakab, 2017), different countries have also employed different purchasing mechanisms. Passive purchasing means that a government allocates funds to a health facility or service provider on basis of its last year's budget (and, in the better cases, its actual disbursement of it). In contrast, active or strategic purchasing – acclaimed to be the best way forward to achieve UHC (Mathauer, Dale and Meessen, 2017; Etiaba *et al.*, 2018; Hanson *et al.*, 2019) – intends to improve quality and efficiency by basing purchasing decisions on thorough needs assessments and ample information relating to prices, quality and quantity of services, treatment choices and health staff performance (WHO, 2010, p. xviii). The purchasing of healthcare services from service providers, hence, is a crucial component of health financing systems, involving three sets of decisions as e.g. Figueras et al. (2005) point out: namely, the identification of the right benefits entitlements (what to buy?), the selection of service providers, e.g. public, private for-profit, private not-for-profit or a combination of

providers (from whom to buy?) and the choice of a mechanism/arrangement to purchase these services, so-called provider payment mechanisms (how to buy?). The purposefulness of adopting strategic purchasing strategies is to ensure that available resources are used in the most "cost-effective" manner while health gains are maximised, thus requiring continuous negotiation and interaction of governments, providers, patients and purchasers (Busse *et al.*, 2007; Hanson *et al.*, 2019; Sanderson, Lonsdale and Mannion, 2019).[0]

Yet, while it seems intuitive that governments should use their resources wisely and should pay for the health services that the population needs, the focus on allocative efficiency means that "medical needs" and "health gains" need to be quantified and made measurable. Today, often, the utility and cost-effectiveness of a health intervention is evaluated with the help of metrics such as the "disability-adjusted life year" (DALY) or the "quality-adjusted life year" (QALY). There are, however, considerable limitations in employing such measures (see e.g. Pettitt et al. (2016) for a literature review), most striking relating to concerns of valuing once individual's life over another's and incentive to neglect diseases of the few. In any case, today, many countries, including in Africa, are committed to make their purchasing of healthcare services more strategic in order to make their health systems more efficient, yet again employing a variety of different approaches, as Hanson et al. (2019) highlight.

While agreeing on the right benefits package is important, especially payment-provider mechanisms (PPM) – how to best pay the providers of services – are another significant point of contestation in many countries. Common ways to purchase healthcare services from providers include monthly salary payments to staff, capitation systems, fee-for-service (FFS) arrangements, diagnosis related groupings (DRG) or case-based payments, per-diem payments and advance payments to health facility to cover specific costs (line-item budgets) or aggregate costs (global budget). Appendix A provides an overview of these PPMs, including information on their strengths and shortcomings as identified in the literature. Countries like Thailand, considered a UHC success story, have pursued a capitation payment system for their social insurance scheme (Tangcharoensathien *et al.*, 2019) and other African countries have seen animated debates on whether (and on ways of making) capitation systems work (see e.g. Atuoye et al. (2016) and Obadha et al. (2020) for Ghana and Kenya, respectively).

Yet, the World Bank seems to have positioned itself in favour of a fee-for-service system, which they more frequently refer to as performance-based financing (PBF).

[0] It has been pointed out that mainstream neo-classical theories (focusing on market competition) were particularly influential in shaping healthcare purchasing reforms for decades; today, the most common theories include principal-agent theory, transaction cost economics, and more recently, theories of inter-organisational relationships (Hanson *et al.*, 2019, p. 501; Sanderson, Lonsdale and Mannion, 2019, p. 5). Notably, Hanson and colleagues have applied principal-agent theory to low-/middle-income countries (including in Nigeria) in view of analysing how the relationships between governments, providers, patients and purchasers are altered through incentives, available information, power and accountability (Hanson *et al.*, 2019).

Research conducted by Gautier and Ridde (2017), analysing government ownership and donor influence on different health financing policies in Africa, have found that "there is limited evidence that PBF policymaking processes were government-owned". Similarly, Barnes et al. (2015) have documented unbalanced power relations in negations on PBF scheme designs.

4.2. Private sector involvement in healthcare

In April 2019, the African Union member states came together in Egypt for the occasion of the 64th Ordinary Session of the African Commission on Human and Peoples' Rights.[0] Amongst the resolutions adopted during the session was a resolution voicing concern regarding the reality that "the growth of private actors' involvement in health and education services delivery often happens without the consideration of human rights resulting in growing discrimination in access to these services, a decrease in transparency and accountability, which negatively impact the enjoyment of the rights to health and education".[0] While the resolution calls upon national governments to assure appropriate regulation of private sector actors involved in the provision of social services, the resolution also highlights discontent about mounting pressure of "bilateral donors and international institutions […] to privatize or facilitate access to private actors in […] health and education sectors".

The privatisation of service delivery has been pushed forward by proponents, who are of the opinion that market mechanisms can more economically and efficiently provide public goods and services (Rondinelli et al., 1989, p. 59). And, today, many African Governments rely on private entities to support the provision of healthcare services (Mills et al., 1990, p. 23). A report by a consortium of progressive NGOs picked up on this reality, highlighting that discussions around strengthening public-private-partnerships are being held in 50 developing countries and in spite of absent proof of their advantageousness, "there has been a large push by the multilateral banks and the IMF […] to leverage private sector investments for development purposes" (Ortiz and Cummins, 2019, p. 43). Birn et al. (2016, p. 741) refer to several different channels through which private sector involvement materialises. These include:

- the promotion of a private health insurance marketplace;
- support to private pharmaceutical companies instead of public drug manufacturers;
- encouragement of the provision of healthcare services in private hospitals and healthcare centres;
- and the outsourcing and subcontracting aspects of public health care systems (information management, human resource recruitment, support services

[0] Nigeria is signatory of African Charter on Human and Peoples' Rights, known as the African Charter, and ratified the document in 1983.

[0] See: https://www.achpr.org/sessions/resolutions?id=444 (accessed 08/10/2019).

such as patient transportation) as well as of service delivery (laboratories and pharmacies).

While it depends on the specific country-context whether some sort of private sector involvement in healthcare delivery may have benefit, it has been highlighted that, generally, the private sector's ambition to maximise profit has proven problematic for healthcare provision (Mills *et al.*, 2002; Hanson *et al.*, 2008; Oxfam, 2009).[0] Nonetheless, in spite of widespread concern, compelling evidence of the excluding effect of privatised health, the World Bank, in particular, continues its push for an increased participation of the private sector in healthcare systems (see e.g. World Bank, 2003, 2007, 2008, 2011, 2016). More recently, the World Bank as well as other pro-private sector proponents (such as the BMGF) actively endorse PPPs as a new way forward to collaboratively attain UHC (Lethbridge, 2017), in spite of contradictory evidence of their benefits (see e.g. Marriott, 2014).[0] For instance, Languille (2017), reviewing PPPs in health and education, Bayliss and Van Waeyenberge (2018), reviewing PPPs for infrastructure, and Romero (2015) and Eurodad (2018), reviewing PPPs in developing countries more broadly, have engaged thoroughly with the risks and problems associated with PPPs. These include high risks and costs for national Governments, a diversion of development aid towards the private sector, adverse effects on public sector administrative capacity, negative impact on equity, and limited transparency and, as a consequence, and a weakening of democratic accountability.

Generally, scholars have cautioned against a dominant private sector in healthcare delivery systems on the one hand. Reasons include that strong private sector involvement may result in overpriced and distorted provision and over-medication/diagnosis, marginalises high-risk groups (MacGregor, 2017, p.67), commonly excludes poorer people from accessing healthcare of a certain quality standard (Mackintosh *et al.*, 2016) and replicates social inequities (Oxfam, 2009; Wilkinson and Pickett, 2011). Furthermore, it has been contended that market-based healthcare provision is "imperfect", as this may cause localised monopolies (only one hospital serving a specific geographic area) and unethical rent-seeking, as for-profit private firms operate in their own interest and demand for healthcare is inelastic (health is a necessary pre-condition for human well-being) (Mooney, 2012; Fischer, 2018; Clarke *et al.*, 2019). Also, research findings of a comparative study of private and public healthcare systems in low- and middle income countries conducted by Basu et al. (2012, p. 10) have shown that the private sector, contrary to claims by private sector advocates, appeared to be less efficient compared to the public sector, for reasons such as higher drug costs, the prescription of unneeded treatment and testing, higher risk of complications and weak regulation. And, McPake and Hanson (2016, p. 626) alert that investing in corporate, commercial providers may reduce the

[0] This has also become once more apparent in the context of the COVID-19 pandemic, which produced "mass market failures in private health services globally" (Williams, 2020, p. 1).

[0] Languille (2017, p.156) as well as Romero (2015, p.4) accentuate the heterogenous nature of PPPs and explain that there is no commonly agreed upon definition of what a PPP is.

effective coverage of public primary care services – "whether because services become unavailable altogether or because fewer facilities can provide services of a basically adequate quality standard".

On the other hand, the reasoning and existing evidence in favour of strong public systems are compelling. For example, Martinez Franzoni and Sanchez-Ancochea (2016) provide a solid case for universalism on basis of their research findings in Latin America, demonstrating that countries' governments that have pursued (seemingly, more expensive) universal policies, overall, made a net profit, as these social policies had a positive effect on economic growth and competitiveness (Martinez Franzoni and Sanchez-Ancochea, 2016, p. 42). Another argument in favour of strong government-led systems is that a public healthcare provision system may (re-)build trust in governments and enhance social cohesion and a sense of solidarity (MacGregor, 2017, p. 67). There is evidence from Latin America, Asia and Southern Africa that a drop in public health investment negatively impacts the state of public health infrastructure and further magnifies inequities in accessing healthcare services (Qadeer and Baru, 2016, p. 776; Oxfam, 2009, p. 36). Also, Jasso-Aguilar and Waitzkin (2015, p. NA) conclude that "between 1980 and 2010, the policies of privatization, deregulation, and liberalization led to a massive transfer of resources from the public to the private sector, the systematic elimination of the safety net, and the worsening of existing social and economic inequalities". Also, the perspective of a restricted role for the state in healthcare delivery raises concerns about the danger of providing a too basic package of selected services via fragmented service delivery systems and of excluding the rest of the population (Laurell and Arellano, 1996; Koivusalo and Mackintosh, 2005).

In light of the continued promotion of the private sector, however, it is important to note that the private sector itself – defined by Mills et al. (2002) as "all providers who exist outside the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease" – is diverse and heterogeneous. The WHO, for instance, makes the distinction between the for-profit (corporate) and non-for-profit private sector, the informal and formal private sector and the domestic and international private sector.[0] Mackintosh et al. (2016) have identified characteristics and patterns that help to understand the extent, importance and dominance of the private sector in public healthcare systems in developing countries.[0] Their classification is compelling and is based on three metrics. These allow to identify five distinct types of public-private "mixed" health systems. The metrics include: (i) the size and pattern of the private share in overall health spending; (ii) the share of visits to privately-owned primary and secondary health facilities; and (iii) the extent to which the public sector relies on household's out-of-pocket health expenditure. The five types of health systems, as outlined by Mackintosh et al. (2016), are:

[0] See: https://www.who.int/publications/i/item/the-private-health-sector-an-operational-definition (last accessed 06/07/ 2020).

[0] E.g. Wendt (2009) has conducted a similar exercise for European countries.

(i) a **dominant private sector** marked by high OOP and widespread private service delivery (like in Nigeria and India)
(ii) a **non-commercialised public sector** and complementary private sector, with rather low shares of private expenditure and widespread public service provision which is largely user fee-free (like in Sri Lanka and Thailand)
(iii) a **private sector at the top of a stratified system**, with relatively high shares of private and social insurance, widespread private service provision and low public sector reliance on user fees (e.g., South Africa and Argentina)
(iv) a **highly commercialised public sector**, with a small private sector but a commercialised public sector, which relies on user fees (e.g., China before its most recent healthcare reform)
(v) a **stratified private sector**, shaped by low incomes and little public sector intervention, with the wealthier segments of the population visiting private hospitals and the poorer segments private medicine vendors (e.g., Tanzania, Ghana, Malawi and Nepal)

Many African countries operate mixed healthcare systems and, taking into account specific countries' realities, some form of engagement with the private sector, if well regulated, may be beneficial (Clarke *et al.*, 2019). For instance, MacGregor (2017, p. 68) summarises that, at times, public sectors may be confronted with rising public expenditure and inflationary pressures, may have less opportunity to offer specialised service delivery, may be subject of vested interests and courruption within their civil service and their public good may be less-well appreciated. In this regard, McPake and Hanson (2016) signal that an extreme stance against any role for the private sector in a pluralistic healthcare system may neglect already very strong interlinkages between the public and the private sector in countries' health systems. While they state clearly that UHC does require the centralised pooling of funds and adequate levels of Government resources as well as "effective public stewardship", this may be compatible with granting certain roles to the private sector (McPake and Hanson, 2016, p. 628).

Nonetheless, as Mackintosh et al. (2016) argue, the behaviour and size of the public sector influence the behaviour and the role the private sector comes to play. They highlight that "[a] reinvigorated and accessible public sector, sometimes alongside major expansion of social insurance, can **reshape private sector roles and behaviour** within mixed health-care systems in low-income and middle-income countries to support moves towards universal health coverage" (Mackintosh et al., 2016, p. 603). In short, the privatisation of healthcare system has led to a reality in many countries, where (underfunded) public sectors (try to) cater for the poorest and the (highly variegated) private sector addresses the needs of the members of society with some financial means (Mackintosh, 2001).

5. Conclusion

The purpose of this paper was three-fold. First, I illustrated that the tendency of a narrowing scope of social policy is particularly well-reflected in the area of health. My review of global health history has demonstrated that while in the 1970s,

comprehensive primary health **care** was meant to be a public good and a human right, more recent calls for universal health **coverage** pay less attention to the way health services are being provided and the inter-connectedness of social inequities. Second, I argued that universalism and UHC themselves have been subject to their own contestations. Interpretations of what universalism entails are manifold, and context-specific factors determine how UHC is conceptualised and understood. Third, as a result of the fuzziness of the concept of UHC, healthcare systems across the world take distinctive shapes and forms. Healthcare systems differ, notably, with regard to who bears responsibility for financing and providing healthcare, to what segment of the population and under what conditions.

References

Abbasi, K. (1999) ‘The World Bank and world health: changing sides’, *BMJ (Clinical research ed.)*, 318(7187), pp. 865–869. Available at: https://doi.org/10.1136/bmj.318.7187.865.

Abel-Smith, B. and Titmuss, K. (1987) *The Philosophy of Welfare*. London: Routledge.

Adejumobi, S. (1999) ‘Privatisation Policy and the Delivery of Social Welfare Services in Africa: A Nigerian Example’, *Journal of Social Development in Africa*, 14(2), pp. 87–108.

Agyepong, I.A. *et al.* (2016) ‘The “Universal” in UHC and Ghana’s National Health Insurance Scheme: policy and implementation challenges and dilemmas of a lower middle income country’, *BMC Health Services Research*, 16(1), p. 504. Available at: https://doi.org/10.1186/s12913-016-1758-y.

Andersen, J.G. (2012) ‘Universalization and de-universalization of unemployment protection in Denmark and Sweden’, in A. Anttonen (ed.) *Welfare State, Universalism and Diversity*. Edward Elgar Publishing, pp. 162–186. Available at: https://vbn.aau.dk/en/publications/universalization-and-de-universalization-of-unemployment-protecti (Accessed: 9 July 2020).

Aregbeshola, B.S. (2017) ‘Enhancing Political Will for Universal Health Coverage in Nigeria’, *MEDICC review*, 19(1), pp. 42–46.

Atuoye, K.N. *et al.* (2016) ‘Financial sustainability versus access and quality in a challenged health system: an examination of the capitation policy debate in Ghana’, *Health Policy and Planning*, 31(9), pp. 1240–1249. Available at: https://doi.org/10.1093/heapol/czw058.

Averill, C. and Mariott, A. (2013) *Universal Health Coverage: Why health insurance schemes are leaving the poor behind*. Oxfam, p. 36.

Barnes, A., Brown, G.W. and Harman, S. (2015) ‘Locating Health Diplomacy through African Negotiations on Performance-based Funding in Global Health’, p. 19.

Basu, S. *et al.* (2012) ‘Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review’, *PLOS Medicine*, 9(6), p. e1001244. Available at: https://doi.org/10.1371/journal.pmed.1001244.

Bayliss, K. and Van Waeyenberge, E. (2018) ‘Unpacking the Public Private Partnership Revival’, *The Journal of Development Studies*, 54(4), pp. 577–593. Available at: https://doi.org/10.1080/00220388.2017.1303671.

Birn, A.-E. (2005) ‘Gates’s grandest challenge: transcending technology as public health ideology’, *The Lancet*, 366(9484), pp. 514–519. Available at: https://doi.org/10.1016/S0140-6736(05)66479-3.

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*, 12(1). Available at: https://doi.org/10.5779/hypothesis.v12i1.229.

Birn, A.-E., Nervi, L. and Siqueira, E. (2016) ‘Neoliberalism Redux: The Global Health Policy Agenda and the Politics of Cooptation in Latin America and Beyond’, *Development and Change*, 47(4), pp. 734–759. Available at: https://doi.org/10.1111/dech.12247.

Birn, A.-E. and Richter, J. (2018) ‘U.S. Philanthrocapitalism and the Global Health Agenda:: The Rockefeller and Gates Foundations, Past and Present’, in H. Waitzkin (ed.) *Health Care Under the Knife*. NYU Press (Moving Beyond Capitalism for Our Health), pp. 155–174. Available at: https://doi.org/10.2307/j.ctt1pwt8bd.13.

Brown, T.M., Cueto, M. and Fee, E. (2007) ‘The World Health Organization and the Transition from “International” to “Global” Health’, in A. Bashford (ed.) *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present*. London: Palgrave Macmillan UK, pp. 76–94. Available at: https://doi.org/10.1057/9780230288904_5.

Brown, T.M. and Fee, E. (2008) ‘The Bandoeng Conference of 1937: A Milestone in Health and Development’, *American Journal of Public Health*, 98(1), pp. 42–43. Available at: https://doi.org/10.2105/AJPH.2007.119222.

Buse, K. and Walt, G. (2000) ‘Global public-private partnerships: Part I--A new development in health?’, *Bulletin of the World Health Organization*, 78(4), pp. 549–561.

Busse, R. *et al.* (2007) ‘Strategic Purchasing to Improve Health System Performance: Key Issues and International Trends’, *HealthcarePapers*, 8(sp), pp. 62–76. Available at: https://doi.org/10.12927/hcpap.2007.19221.

Chatora, R.R. and Tumusime, P. (2004) ‘Primary health care: a review of its implementation in sub-Saharan Africa’, *Primary Health Care Research and Development*, 5(4), pp. 296–306. Available at: https://doi.org/10.1191/1463423604pc220oa.

Chemouni, B. (2018) ‘The political path to universal health coverage: Power, ideas and community-based health insurance in Rwanda’, *World Development*, 106, pp. 87–98. Available at: https://doi.org/10.1016/j.worlddev.2018.01.023.

Clarke, D. *et al.* (2019) ‘The private sector and universal health coverage’, *Bulletin of the World Health Organization*, 97(6), pp. 434–435. Available at: https://doi.org/10.2471/BLT.18.225540.

Cueto, M. (2004) ‘The ORIGINS of Primary Health Care and SELECTIVE Primary Health Care’, *American Journal of Public Health*, 94(11), pp. 1864–1874. Available at: https://doi.org/10.2105/AJPH.94.11.1864.

Curtis, M. (2016) *Gated Development*. Global Justice Now. Available at: https://curtisresearch.org/wp-content/uploads/Gated-Development.-final.pdf (Accessed: 7 July 2020).

Engels, F. (1845) *The Condition of the Working Class in England*. 2009 UK edition. Edited by V. Kiernan. London: Penguin Classics.

Erikson, S.L. (2015) 'Secrets from Whom?: Following the Money in Global Health Finance', *Current Anthropology*, 56(S12), pp. S306–S316. Available at: https://doi.org/10.1086/683271.

Esposito, J.L. (2004) *The Islamic World: Past and Present*. Oxford University Press.

Etiaba, E. *et al.* (2018) 'Strategic purchasing for universal health coverage: examining the purchaser–provider relationship within a social health insurance scheme in Nigeria', *BMJ Global Health*, 3(5). Available at: https://doi.org/10.1136/bmjgh-2018-000917.

Eurodad (2018) *History rePPPeated: How public private partnerships are failing*. Eurodad. Available at: http://d3n8a8pro7vhmx.cloudfront.net/eurodad/legacy_url/396/1546956-history-repppeated-how-public-private-partnerships-are-failing-.pdf?1594238168 (Accessed: 9 July 2020).

Fenny, A.P., Yates, R. and Thompson, R. (2018) 'Social health insurance schemes in Africa leave out the poor', *International Health*, 10(1), pp. 1–3. Available at: https://doi.org/10.1093/inthealth/ihx046.

Field, M.G. (1973) 'The concept of the "health system" at the macrosociological level', *Social Science & Medicine (1967)*, 7(10), pp. 763–785. Available at: https://doi.org/10.1016/0037-7856(73)90118-2.

Figueras, J., Robinson, R. and Jakubowski, E. (eds) (2005) *Purchasing to improve health systems performance*. Maidenhead: Open Univ. Press (European observatory on health systems and policies series).

Fischer, A. (2018) *Poverty as Ideology: Rescuing Social Justice from Global Development Agendas*. London: Zed Books.

Fischer, A.M. (2012) *Inequality and the uiversalistic principle in the post-2015 development agenda*. The Hague, Netherlands: Institute of Social Studies, Erasmus University Rotterdam, p. 29.

Fox, A.M. and Reich, M.R. (2015) 'The Politics of Universal Health Coverage in Low and Middle-Income Countries: A Framework for Evaluation and Action', *Journal of Health Politics, Policy and Law*, 40(5), pp. 1023–1060. Available at: https://doi.org/10.1215/03616878-3161198.

Frenk, J. and Donabedian, A. (1987) 'State intervention in medical care: types, trends and variables', *Health Policy and Planning*, 2(1), pp. 17–31. Available at: https://doi.org/10.1093/heapol/2.1.17.

Gautier, L. and Ridde, V. (2017) ‘Health financing policies in Sub-Saharan Africa: government ownership or donors’ influence? A scoping review of policymaking processes’, *Global Health Research and Policy*, 2(1), p. 23. Available at: https://doi.org/10.1186/s41256-017-0043-x.

Glouberman, S. and Millar, J. (2003) ‘Evolution of the Determinants of Health, Health Policy, and Health Information Systems in Canada’, *American Journal of Public Health*, 93(3), pp. 388–392.

Godlee, F. (1994) ‘WHO In Crisis’, *BMJ: British Medical Journal*, 309(6966), pp. 1424–1428.

Greer, S.L. and Méndez, C.A. (2015) ‘Universal Health Coverage: A Political Struggle and Governance Challenge’, *American Journal of Public Health*, 105 Suppl 5, pp. S637-639. Available at: https://doi.org/10.2105/AJPH.2015.302733.

Hancock, T. (1986) ‘Lalonde and beyond: Looking back at “A New Perspective on the Health of Canadians”’, *Health Promotion International*, 1(1), pp. 93–100. Available at: https://doi.org/10.1093/heapro/1.1.93.

Hanson, K. *et al.* (2008) ‘Is Private Health Care the Answer to the Health Problems of the World’s Poor?’, *PLOS Medicine*, 5(11), p. e233. Available at: https://doi.org/10.1371/journal.pmed.0050233.

Hanson, K. *et al.* (2019) ‘Strategic Purchasing: The Neglected Health Financing Function for Pursuing Universal Health Coverage in Low- and Middle-Income Countries’, *International Journal of Health Policy and Management*, 8(8), pp. 501–504. Available at: https://doi.org/10.15171/ijhpm.2019.34.

Hu, D. *et al.* (2017) ‘Development of village doctors in China: financial compensation and health system support’, *International Journal for Equity in Health*, 16(1), p. 9. Available at: https://doi.org/10.1186/s12939-016-0505-7.

Hunter, B.M. and Murray, S.F. (2019) ‘Deconstructing the Financialization of Healthcare’, *Development and Change*, 50(5), pp. 1263–1287. Available at: https://doi.org/10.1111/dech.12517.

Jasso-Aguilar, R. and Waitzkin, H. (2015) ‘Resisting the Imperial Order…in Medicine and Public Health’, *Monthly Review* [Preprint]. Available at: https://monthlyreview.org/2015/07/01/resisting-the-imperial-order-and-building-an-alternative-future-in-medicine-and-public-health/ (Accessed: 5 July 2018).

Kanji, N. (1989) ‘Charging for drugs in Africa: UNICEF’S “Bamako Initiative”’, *Health Policy and Planning*, 4(2), pp. 110–120. Available at: https://doi.org/10.1093/heapol/4.2.110.

Koivusalo, M. and Mackintosh, M. (2005) ‘Commercialization of health care: global and local dynamics and policy responses’, in. Geneva: UNRISD.

Koon, A.D. and Mayhew, S.H. (2013) ‘Strengthening the health workforce and rolling out universal health coverage: the need for policy analysis’, *Global Health Action*, 4. Available at: https://doi.org/10.3402/gha.v6i0.21852.

Krieger, N. (2014) ‘Discrimination and health inequities’, *International Journal of Health Services: Planning, Administration, Evaluation*, 44(4), pp. 643–710. Available at: https://doi.org/10.2190/HS.44.4.b.

Krieger, N. (2016) *Embodying Inequality: Epidemiologic Perspectives*. Routledge.

Kutzin, J. (2013) ‘Health financing for universal coverage and health system performance: concepts and implications for policy’, *Bulletin of the World Health Organization*, 91(8), pp. 602–611. Available at: https://doi.org/10.2471/BLT.12.113985.

Kutzin, J., Cashin, C. and Jakab, M. (2017) *Implementing Health Financing Reform: Lessons from countries in transition*. WHO. Available at: https://www.who.int/publications-detail-redirect/implementing-health-financing-reform-lessons-from-countries-in-transition (Accessed: 15 July 2020).

Lagarde, M., Barroy, H. and Palmer, N. (2012) ‘Assessing the Effects of Removing User Fees in Zambia and Niger’, *Journal of Health Services Research & Policy*, 17(1), pp. 30–36. Available at: https://doi.org/10.1258/jhsrp.2011.010166.

Lagomarsino, G. *et al.* (2012) ‘Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia’, *Lancet (London, England)*, 380(9845), pp. 933–943. Available at: https://doi.org/10.1016/S0140-6736(12)61147-7.

Languille, S. (2017) ‘Public Private partnerships in education and health in the global South: a literature review’, *Journal of International and Comparative Social Policy*, 33(2), pp. 142–165. Available at: https://doi.org/10.1080/21699763.2017.1307779.

Laurell, A.C. and Arellano, O.L. (1996) ‘Market Commodities and Poor Relief: The World Bank Proposal for Health’, *International Journal of Health Services*, 26(1), pp. 1–18. Available at: https://doi.org/10.2190/PBX9-N89E-4QFE-046V.

Lee, S.-Y. *et al.* (2008) ‘The National Health Insurance system as one type of new typology: the case of South Korea and Taiwan’, *Health Policy (Amsterdam, Netherlands)*, 85(1), pp. 105–113. Available at: https://doi.org/10.1016/j.healthpol.2007.07.006.

Lethbridge, J. (2017) ‘World Bank undermines right to universal healthcare’, *Critical Voices on the World Bank and IMF*. Available at: http://www.brettonwoodsproject.org/wp-content/uploads/2017/04/At-Issue-health-PDF.pdf (Accessed: 7 August 2018).

Levich, J. (2015) ‘The Gates Foundation, Ebola, and Global Health Imperialism’, *American Journal of Economics and Sociology*, 74(4), pp. 704–742. Available at: https://doi.org/10.1111/ajes.12110.

Litsios, S. (2004) ‘The Christian Medical Commission and the Development of the World Health Organization’s Primary Health Care Approach’, *American Journal of Public Health*, 94(11), pp. 1884–1893.

Litsios, S. (2020) ‘The World Health Organization’s changing goals and expectations concerning malaria, 1948-2019’, *História, Ciências, Saúde-Manguinhos*, 27, pp. 145–164. Available at: https://doi.org/10.1590/s0104-59702020000300008.

MacGregor, S. (2017) ‘Universalism and Health: The Battle of Ideas’, in *Towards Universal Health Care in Emerging Economies - Opportunities and Challenges*. Palgrave Macmillan. Available at: //www.palgrave.com/gb/book/9781137533760 (Accessed: 29 June 2018).

Mackintosh, M. (2001) ‘Do health care systems contribute to inequality?’, in D. Leon and G. Walt (eds) *Poverty, Inequality and Health: An International Perspective*. Oxford: Oxford University Press, pp. 175–193. Available at: http://www.oup.com/uk/catalogue/?ci=9780192631961#contents (Accessed: 1 July 2020).

Mackintosh, M. (2006) ‘Commercialisation, inequality and the limits to transition in health care: a Polanyian framework for policy analysis’, *Journal of International Development*, 18(3), pp. 393–406. Available at: https://doi.org/10.1002/jid.1290.

Mackintosh, M. *et al.* (2016) ‘What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries’, *Lancet (London, England)*, 388(10044), pp. 596–605. Available at: https://doi.org/10.1016/S0140-6736(16)00342-1.

Mackintosh, M. and Koivusalo, M. (2005) ‘Health Systems and Commercialization: In Search of Good Sense’, in *Commercialization of Health Care - Global and Local Dynamics and Policy Responses*. Palgrave Macmillan. Available at: //www.palgrave.com/gb/book/9781403943491 (Accessed: 29 October 2018).

Marriott, A. (2014) *A Dangerous Diversion: Will the IFC’s flagship health PPP bankrupt Lesotho’s Ministry of Health?* Oxfam, p. 28.

Martens, J. and Seitz, K. (2015) *Philanthropic power and development: who shapes the agenda?* Aachen: Bischöfliches Hilfswerk MISEREOR.

Martinez Franzoni, J. and Sanchez-Ancochea, D. (2016) *The Quest for Universal Social Policy in the South: Actors, Ideas, and Architectures*. Cambridge: Cambridge University Press. Available at: https://doi.org/10.1017/CBO9781316410547.

Martinez Franzoni, J.M. and Sánchez-Ancochea, D. (2014) ‘Putting universalism to the service of social justice: Can two-tiered systems be avoided?’, *Global Social Policy*, 14(3), pp. 417–421. Available at: https://doi.org/10.1177/1468018114544414a.

Mathauer, I., Dale, E. and Meessen, B. (2017) *Strategic purchasing for UHC: Key policy issues and questions*. WHO, p. 23.

McCoy, D. *et al.* (2009) ‘The Bill & Melinda Gates Foundation’s grant-making programme for global health’, *The Lancet*, 373(9675), pp. 1645–1653. Available at: https://doi.org/10.1016/S0140-6736(09)60571-7.

McCoy, D. and McGoey, L. (2011) ‘Global Health and the Gates Foundation — In Perspective’, in S. Rushton and O.D. Williams (eds) *Partnerships and Foundations in Global Health Governance*. London: Palgrave Macmillan UK (International Political Economy Series), pp. 143–163. Available at: https://doi.org/10.1057/9780230299474_7.

McKee, M. *et al.* (2013) ‘Universal health coverage: a quest for all countries but under threat in some’, *Value in Health: The Journal of the International Society for Pharmacoeconomics and Outcomes Research*, 16(1 Suppl), pp. S39-45. Available at: https://doi.org/10.1016/j.jval.2012.10.001.

McKeown, T. (1976) *The Modern Rise of Population*. New York: Arnold.

McPake, B. and Hanson, K. (2016) ‘Managing the public-private mix to achieve universal health coverage’, *Lancet (London, England)*, 388(10044), pp. 622–630. Available at: https://doi.org/10.1016/S0140-6736(16)00344-5.

Medcalf, A. *et al.* (eds) (2015) *Health For All: The Journey of Universal Health Coverage*. Hyderabad (IN): Orient Blackswan (Wellcome Trust–Funded Monographs and Book Chapters). Available at: http://www.ncbi.nlm.nih.gov/books/NBK316270/ (Accessed: 3 July 2020).

Mills, A. *et al.* (1990) *Health system decentralization : concepts, issues and country experience*. World Health Organization. Available at: https://apps.who.int/iris/handle/10665/39053 (Accessed: 28 August 2020).

Mills, A. *et al.* (2002) ‘What can be done about the private health sector in low-income countries?’, *Bulletin of the World Health Organization*, 80(4), pp. 325–330.

Mooney, G. (2012) *The Health of Nations: Towards a New Political Economy*. London, UNITED KINGDOM: Zed Books. Available at: http://ebookcentral.proquest.com/lib/gmul-ebooks/detail.action?docID=896260 (Accessed: 21 May 2020).

Murray, C.J.L. and Frenk, J. (2000) ‘A framework for assessing the performance of health systems’, *Bulletin of the World Health Organization*, p. 15.

Navarro, V. (1976) ‘Social class, political power and the state and their implications in medicine’, *Social Science & Medicine (1967)*, 10(9), pp. 437–457. Available at: https://doi.org/10.1016/0037-7856(76)90112-8.

Navarro, V. (1989) ‘Why some countries have national health insurance, others have national health services, and the U.S. has neither’, *Social Science & Medicine (1982)*, 28(9), pp. 887–898. Available at: https://doi.org/10.1016/0277-9536(89)90313-4.

Navarro, V. (2007) *Neoliberalism, Globalization, and Inequalities: Consequences for Health and Quality of Life*. 1 edition. Amityville, N.Y: Baywood Publishing.

Navarro, V. and Shi, L. (2001) ‘The political context of social inequalities and health’, *International Journal of Health Services: Planning, Administration, Evaluation*, 31(1), pp. 1–21. Available at: https://doi.org/10.2190/1GY8-V5QN-A1TA-A9KJ.

Newell K.W. (1975) *Health by the people*. World Health Organization. Available at: https://apps.who.int/iris/handle/10665/40514 (Accessed: 3 July 2020).

Newell, K.W. (1988) 'Selective primary health care: the counter revolution', *Social Science & Medicine*, 26(9), pp. 903–906. Available at: https://doi.org/10.1016/0277-9536(88)90409-1.

Nimpagaritse, M. and Bertone, M.P. (2011) 'The sudden removal of user fees: the perspective of a frontline manager in Burundi', *Health Policy and Planning*, 26(suppl_2), pp. ii63–ii71. Available at: https://doi.org/10.1093/heapol/czr061.

Obadha, M. *et al.* (2019) 'Health care purchasing in Kenya: Experiences of health care providers with capitation and fee-for-service provider payment mechanisms', *The International Journal of Health Planning and Management*, 34(1), pp. e917–e933. Available at: https://doi.org/10.1002/hpm.2707.

Obadha, M. *et al.* (2020) 'Preferences of healthcare providers for capitation payment in Kenya: a discrete choice experiment', *Health policy and planning* [Preprint]. Available at: https://doi.org/10.1093/heapol/czaa016.

OECD (1994) *The Reform of Health Care Systems: A Review of Seventeen OECD Countries*. Organisation for Economic Co-operation and Development.

O'Laughlin, B. (2016) 'Pragmatism, Structural Reform and the Politics of Inequality in Global Public Health', *Development and Change*, 47(4), pp. 686–711. Available at: https://doi.org/10.1111/dech.12251.

Onwujekwe, O. *et al.* (2019) 'Exploring effectiveness of different health financing mechanisms in Nigeria; what needs to change and how can it happen?', *BMC Health Services Research*, 19(1), p. 661. Available at: https://doi.org/10.1186/s12913-019-4512-4.

Ortiz, I. and Cummins, M. (2019) *Austerity the New Normal: A Renewed Washington Consensus 2010-24*, p. 78. Available at: http://policydialogue.org/files/publications/papers/Austerity-the-New-Normal-Ortiz-Cummins-6-Oct-2019.pdf.

Oxfam (2009) 'Blind Optimism', p. 55.

Pettitt, D.A. *et al.* (2016) 'The limitations of QALY: a literature review', *Journal of Stem Cell Research and Therapy*, 6(4). Available at: https://ora.ox.ac.uk/objects/uuid:d22a9b1b-c2f0-4f6c-83ee-fdc320e4af61 (Accessed: 16 July 2020).

Pfeiffer, J. (2019) 'Austerity in Africa: Audit cultures and the weakening of public sector health systems', *Focaal*, 2019(83), pp. 51–61. Available at: https://doi.org/10.3167/fcl.2019.830105.

Qadeer, I. and Baru, R. (2016) 'Shrinking Spaces for the "Public" in Contemporary Public Health', *Development and Change*, 47(4), pp. 760–781. Available at: https://doi.org/10.1111/dech.12246.

Rizvi, S.S. *et al.* (2020) 'The political economy of universal health coverage: a systematic narrative review', *Health Policy and Planning*, 35(3), pp. 364–372. Available at: https://doi.org/10.1093/heapol/czz171.

Romero, M.J. (2015) *What lies beneath: a critical assessment of PPPs and their impact on sustainable development*. Eurodad. Available at: http://d3n8a8pro7vhmx.cloudfront.net/eurodad/legacy_url/648/1546450-what-lies-beneath-a-critical-assessment-of-ppps-and-their-impact-on-sustainable-development-1450105297.pdf?1594238244 (Accessed: 9 July 2020).

Rondinelli, D.A. *et al.* (1989) 'Analysing Decentralization Policies in Developing Countries: A Political Economy Framework.' Development and', *Change*, pp. 57–87.

Ruckert, A. and Labonté, R. (2014) 'Public–private partnerships (ppps) in global health: the good, the bad and the ugly', *Third World Quarterly*, 35(9), pp. 1598–1614. Available at: https://doi.org/10.1080/01436597.2014.970870.

Sanders, D. *et al.* (2019) 'From primary health care to universal health coverage—one step forward and two steps back', *The Lancet*, 394(10199), pp. 619–621. Available at: https://doi.org/10.1016/S0140-6736(19)31831-8.

Sanderson, J., Lonsdale, C. and Mannion, R. (2019) 'What's Needed to Develop Strategic Purchasing in Healthcare? Policy Lessons from a Realist Review', *International Journal of Health Policy and Management*, 8(1), pp. 4–17. Available at: https://doi.org/10.15171/ijhpm.2018.93.

Savedoff, W.D. (2012) *Transitions in Health Financing and Policies for Universal Health Coverage:* Final Report of the Transition in Health Financing Project. Results for Development Institute, p. 36.

Sell, S.K. and Williams, O.D. (2019) '21st-century capitalism: structural challenges for universal health care', *Globalization and Health*, 15(1), p. 76. Available at: https://doi.org/10.1186/s12992-019-0517-3.

Sen, A. (2015) 'Universal Health Care: The Affordable Dream', *GLOBAL HEALTH*, 4, p. 8.

Skocpol, T. (1991) 'Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States', in C. Jencks and P. Peterson (eds) *The Urban Underclass*. Washington D.C.: The Brookings Institution.

Storeng, K.T. (2014) 'The GAVI Alliance and the "Gates approach" to health system strengthening', *Global Public Health*, 9(8), pp. 865–879. Available at: https://doi.org/10.1080/17441692.2014.940362.

Stuckler, D. *et al.* (2010) 'The political economy of universal health coverage', in. Montreux. Available at: http://pacifichealthsummit.org/downloads/UHC/the%20political%20economy%20of%20uhc.PDF (Accessed: 29 June 2018).

Tangcharoensathien, V. *et al.* (2019) 'The Political Economy of UHC Reform in Thailand: Lessons for Low- and Middle-Income Countries', *Health Systems &*

Reform, 5(3), pp. 195–208. Available at: https://doi.org/10.1080/23288604.2019.1630595.

Taylor, C.E. (1976) *Doctors for the Villages: Study of Rural Internships in Seven Indian Medical Colleges*. Asia Publishing House.

Toth, F. (2016) 'Classification of healthcare systems: Can we go further?', *Health Policy (Amsterdam, Netherlands)*, 120(5), pp. 535–543. Available at: https://doi.org/10.1016/j.healthpol.2016.03.011.

UNGA (1974) *Declaration on the Establishment of a New International Economic Order*. Available at: http://digitallibrary.un.org/record/218450 (Accessed: 13 January 2021).

UNGA (2019) *Resolution adopted by the General Assembly on 10 October 2019: Political declaration of the high-level meeting on universal health coverage*. Available at: https://undocs.org/pdf?symbol=en/A/RES/74/2 (Accessed: 8 July 2020).

UNRISD (2017) *Health for All, All for Health: Lessons from the universalization of health care in emerging economics*. Research and Policy Brief 22. UNRISD. Available at: http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/D118466FA82BAF00C1258168004B689F/$file/RPB22-Universal%20health%20care.pdf (Accessed: 13 July 2020).

Wagstaff, A. (2007) *Social Health Insurance Reexamined*. 4111. World Bank. Available at: http://documents1.worldbank.org/curated/en/914391468178446567/pdf/wps4111.pdf (Accessed: 16 July 2020).

Waitzkin, H. (1978) 'A Marxist view of medical care', *Annals of Internal Medicine*, 89(2), pp. 264–278. Available at: https://doi.org/10.7326/0003-4819-89-2-264.

Waitzkin, H. *et al.* (2001) 'Social Medicine Then and Now: Lessons From Latin America', *American Journal of Public Health*, 91(10), pp. 1592–1601.

Walsh, J.A. and Warren, K.S. (1980) 'Selective primary health care: An interim strategy for disease control in developing countries', *Social Science & Medicine. Part C: Medical Economics*, 14(2), pp. 145–163. Available at: https://doi.org/10.1016/0160-7995(80)90034-9.

Walt, G. (1993) 'WHO under stress: Implications for health policy', *Health Policy*, 24(2), pp. 125–144. Available at: https://doi.org/10.1016/0168-8510(93)90030-S.

Weiyuan, C. (2008) 'China's village doctors take great strides', *Bulletin of the World Health Organization*, 86(12), pp. 914–915. Available at: https://doi.org/10.2471/blt.08.021208.

Wendt, C. (2009) 'Mapping European healthcare systems: a comparative analysis of financing, service provision and access to healthcare', *Journal of European Social Policy*, 19(5), pp. 432–445. Available at: https://doi.org/10.1177/0958928709344247.

WHO (2000) *The world health report 2000 - Health systems: improving performance*. Available at: https://www.who.int/whr/2000/en/ (Accessed: 25 September 2019).

WHO (2010) *Health systems financing: the path to universal coverage*. Available at: http://www.who.int/whr/2010/en/ (Accessed: 28 September 2018).

WHO (2014) *Making fair choices on the path to universal health coverage*. Available at: https://apps.who.int/iris/bitstream/handle/10665/112671/9789241507158_eng.pdf?sequence=1 (Accessed: 9 July 2020).

WHO and World Bank (2019) *Primary Health Care on the Road to Universal Health Coverage: 2019 Global Monitoring Report*. Available at: https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf.

Wilkinson, R. and Pickett, K. (2011) 'Greater Equality: The Hidden Key to Better Health and Higher Scores', *American Educator*, 35(1), pp. 5–9.

Williams, O.D. (2020) 'COVID-19 and Private Health: Market and Governance Failure', *Development (Society for International Development)*, pp. 1–10. Available at: https://doi.org/10.1057/s41301-020-00273-x.

Workie, N.W. *et al.* (2018) 'Who Needs Big Health Sector Reforms Anyway? Seychelles' Road to UHC Provides Lessons for Sub-Saharan Africa and Island Nations', *Health Systems & Reform*, 4(4), pp. 362–371. Available at: https://doi.org/10.1080/23288604.2018.1513265.

World Bank (1993) *Investing in health*. World Development Report. Oxford: Oxford Univ. Press, p. 329.

World Bank (2003) *Private Participtionin Health Services*. World Bank. Available at: https://openknowledge.worldbank.org/handle/10986/15147.

World Bank (2007) *Establishing Private Health Care Facilities in Developing Countries: A Guide for Medical Entrepreneurs*. The World Bank. Available at: https://doi.org/10.1596/978-0-8213-6947-0.

World Bank (2008) *The business of health in Africa: partnering with the private sector to improve people's lives*. 44143. The World Bank, pp. 1–154. Available at: http://documents.worldbank.org/curated/en/878891468002994639/The-business-of-health-in-Africa-partnering-with-the-private-sector-to-improve-peoples-lives (Accessed: 1 October 2018).

World Bank (2011) *Healthy Partnerships: How Governments Can Engage the Private Sector to Improve Health in Africa*. Available at: https://openknowledge.worldbank.org/handle/10986/2304.

World Bank (2016) *Public-Private Partnerships in Health: World Bank Group Engagement in Health PPPs*. World Bank. Available at: https://openknowledge.worldbank.org/handle/10986/25383.

Yi, I., Koechlein, E. and de Negri Filho, A. (2017) ‘Introduction: The Universalization of Health Care in Emerging Economies’, in *Towards Universal Health Care in Emerging Economies - Opportunities and Challenges*. Palgrave Macmillan. Available at: //www.palgrave.com/gb/book/9781137533760 (Accessed: 29 June 2018).

Appendix

Appendix A: Definitions of common provider payment mechanism

Provider-payment mechanism	Definition	Incentives for healthcare providers
Salaries	Regular payment to staff	No (monetary) incentive for health staff to improve performance, potentially reducing quality or resulting in underprovision of services
Capitation	Advanced, fixed payment to service provider on behalf of an enrolee	Incentive to improve efficiency, to attract more enrolees, but to select the healthier ones and to underprovide services or refer them to onwards to control costs
Fee-for service (FFS)	Payment for each individual service provided	Overprovide services above necessary and increase costs
Global budget	Advanced payment to a facility to cover aggregate expenditures for service delivery	Incentive to refer patients to other providers and to underprovide services, but to improve efficiency
Line-item budget	Advanced payment to a facility to cover specific line item such as expenditure related to staff, supplies, drugs, etc.	Incentive to spend all the money before the end of the financial year, to refer patients to other facilities and underprovide services and no incentive to improve efficiency
Per diem payments	Daily fixed payment for service delivery	Incentive to increase the number of days that a patient is admitted, to improve efficiency but no incentive to improve quality
Case-based payments / diagnosis related group (DRG)	A specific amount paid to provide all services per episode of illness	Incentive to increase the admissions more than necessary and to then discharge the patients early

Source: Obadha et al. (2019)