

B1 | THE CURRENT DISCOURSE ON UNIVERSAL HEALTH COVERAGE (UHC)¹

The current discourse on Universal Health Coverage (UHC) dominates most international discussions on healthcare. UHC is presented as *the* solution to pressing healthcare needs in low- and middle-income countries (LMICs) and enthusiastic proponents have termed it the ‘third great transition’ in health, changing how services are financed and how systems are organized (Rodin and De Ferranti 2012).

On the international stage, one of the earliest mentions of UHC was at the 58th World Health Assembly in 2005, in a resolution calling on member states to: ‘ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care’ (WHA 2005). Thus, from its early days, the emphasis was on ‘sustainable health financing’. The use of the term ‘coverage’ rather than ‘care’ symbolizes the move away from concerns of health-systems design towards financing.

International agencies quickly rallied behind UHC as a response to the precipitous rise in catastrophic out-of-pocket expenditure on healthcare. As a consequence of a prolonged period of neglect of public healthcare and privatization of health systems, by the turn of the millennium healthcare in most LMICs was characterized by:

- 1 A crumbling public health system, with poor infrastructure, falling morale among health workers and diminishing resources.
- 2 Increased penetration of the private sector, especially for secondary and tertiary care.
- 3 A consequent rise in catastrophic health expenditures by households, a large proportion of which was ‘out-of-pocket’.

To remedy the situation, there could have been efforts to prioritize the rebuilding and strengthening of public systems. Instead, the emphasis shifted from how services should be provided to how services should be financed, under the rubric of UHC. The underlying belief appeared to be that if the finances were secured, provisioning of health services could be taken care of by a variety of mixes that involved both the private and the public sector. Such an assumption completely missed the point that a health *system* is not a mere aggregate of dispersed facilities and service providers, but is an integrated



Image B1.1 A woman from Malawi with her health card: reforms in the 1980s led to crumbling health systems (David Sanders)

network of facilities and services that are appropriately situated at primary, secondary and tertiary levels.

The contours of UHC that began to take shape were based on some early initiatives in the late 1990s and early 2000s – especially in parts of Latin America, where reforms were based on universal insurance schemes (see Chapter A3). These reforms led to increases in national healthcare expenditures, both public and private; and promoted a market logic centred on ‘individual care’ conceived as a ‘private’ good. There was no clear evidence that the reforms improved public health outcomes. In fact, evidence from Colombia and Chile suggested that quality of care did not improve, equity and efficiency were negatively influenced, and transnational corporations and consultancy firms accrued significant benefits (Homedes and Ugalde 2005). Worse, the market logic destroyed the institutional scaffolding of public and collective health. The result was the re-emergence of previously controlled diseases and the reduction of preventive interventions (Laurell 2010). However, these reforms were given a positive spin to justify the push for a certain model of UHC.² The World Bank played a key role in consensus-building around reforms that were to become precursors to UHC, before the World Health Organization (WHO) formally adopted it as part of its policy.³

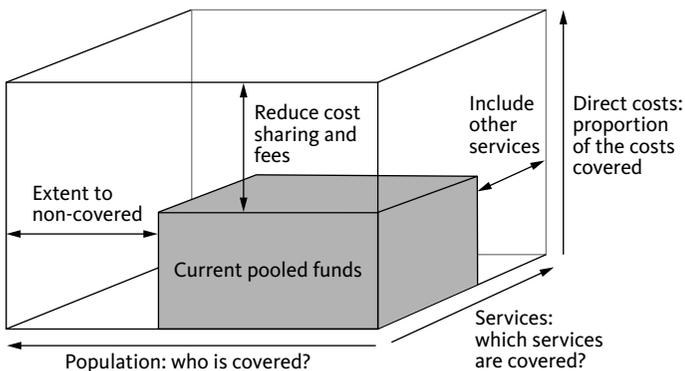


Image B1.2 Massive demonstrations against health-system reforms in Bogotá, Colombia (Mauricio Torres)

The ideological foundations of UHC

The 2010 *World Health Report* illustrated the concept as a diagram, reproduced in Figure B1.1.

In the cube UHC is conceived as a system that would progressively move towards: i) the coverage of the entire population by a package of services, ii) inclusion of an increasing range of services, and iii) a rising share of pooled funds as the main source of funding for healthcare, and thereby a decrease in co-payments. Julio Frenk, the architect of the Mexican health insurance system,



B1.1 The UHC cube (source: World Health Organization, World Health Report, WHO, Geneva, 2010)

suggests that stewardship (including deployment of equitable policies) and fair financing are essential public responsibilities, whereas delivery of services is best served through a pluralistic mix that includes the private sector and civil society (Frenk and De Ferranti 2012). Such a model of UHC requires a clear ‘provider–purchaser’ split, the issues of financing and management being entirely divorced from provisioning. The importance of public healthcare services is not a part of this narrative and the state is confined to the role of manager of this system. The split between the state as a provider and as purchaser of services means that health services can be entirely provided by private enterprises while the state mediates to secure the funding for such services and regulates their quality and range. A provider–purchaser split puts a price on services; that is, it commodifies them, which is the precondition for their transaction in the marketplace (Laurell 2007).

The retreat of the state as a provider of public services has been accompanied by a clear reform push in public services, often referred to as ‘new public management’ (Vabø 2009). The UHC proposal is no stranger to this trend. The strategy has been to introduce private sector management, organization and labour market ethos and practices into the public sector, with a push to introduce ‘internal markets’ within the domain of public provision. While public funding is retained (and in some cases expanded), mechanisms are introduced to isolate the purchasers from the providers. The intention is that individual ‘units’ should compete for consumers and patients should be able to move between providers with relative ease. This reorganization along the lines of new public management is crucial to subsequent privatization of public services, as erstwhile public services in their classical form were not marketable commodities (Pierson 2001: 157). The current discourse on UHC accomplishes the almost seamless transition in the role of the government from provider of services to purchaser of services. For example, an issue of the WHO *Bulletin* argues: ‘To sustain progress, efficiency and accountability must be ensured. The main health financing instrument for promoting efficiency in the use of funds is purchasing, and more specifically, strategic purchasing’ (Kutzin 2012).

This reconceptualized role of governments is defined in the 2010 *World Health Report*: ‘Governments have a responsibility to ensure that all providers, public and private, operate appropriately and attend to patients’ needs cost effectively and efficiently.’ This ‘impartial’ role of governments can be interpreted in many ways. With most public health systems in a state of disarray, it is an appealing option for governments to choose not to rebuild public systems but to rely increasingly on private providers. The logic is that the catastrophic impact of out-of-pocket expenditures needs an immediate remedy, and as the public system is too weak to respond, it is more strategic to turn to the private sector. The UHC model, thus, provides the opportunity to make the choice to open up a country’s health system to private providers rather than consider public provision of services as the mainstay of its healthcare system.



Image B1.3 A health worker in the Philippines: basic and not comprehensive public services was the message from the World Bank (Third World Health Aid)

Further, under the UHC model, governments can choose more progressive options for financing – such as tax-based funding in a progressive regime of taxation. However, in situations where the state itself is committed to pursuing neoliberal policies, such progressive options may not be adopted.

This current discourse on UHC is in sharp contrast with the vision of Primary Health Care envisaged in the Alma Ata declaration of 1978, which called for the building of health systems that would provide comprehensive care, would be integrated, organized to promote equity, and driven by community needs (GHW I 2005: 56). Instead, UHC envisages healthcare as bits and pieces of a jigsaw puzzle, connected only by a common financing pool and by regulation of an array of private and public providers. What is also glossed over is that universal health ‘coverage’ is only one aspect of universal health ‘care’. Coverage as a strategy focuses primarily on the achievement of a wide network of health providers and health institutions extending access to health services to the population. The components that are ‘sufficient’ to be considered for adequate coverage remain highly contested, however (Stuckler et al. 2010).

Nonetheless, UHC is a step forward to the extent that it represents an explicit recognition of two important aspects of public health. First, by prescribing a central role to the state in securing funding for healthcare and in regulating the quality and range of services, UHC recognizes that ‘market failures’ are a feature of private healthcare. Secondly, UHC also recognizes that health is a ‘public good’ with externalities, and that the state has a responsibility to ensure access to health services. Thus, UHC provides the possibility of exercising a choice, and progressive governments can try to privilege public systems and examine funding mechanisms that promote equity. Financial pooling through

UHC (a ‘single payer’ system) makes it easier to develop comprehensive public systems, but whether that will happen is a political choice.

The ambiguities of UHC

The dominant concept of UHC proposes that funding for health should be pooled; it does not propose the same for the provision of services – that is, it does not propose a unified system of public provision. Neither does it define the ‘depth’ of coverage and hence allows an interpretation that coverage can mean a very basic package, akin to the World Bank’s prescriptions of the previous decades. This latter point is captured by the UHC proposition that the exact mechanisms for pooling will depend on social processes and political action that establish the parameters for an acceptable public role in healthcare. In some cases, the result will be a government that primarily regulates the healthcare sector, while in other cases a government that finances and directly provides care (Savedoff et al. 2012). These obscurities were clearly captured by a recent literature survey of peer-reviewed publications on UHC. Of 100 papers analysed only twenty-one provided an explicit definition of UHC. Among these twenty-one, there was little consensus on the concept, and its meanings were often unclear. The majority referred to UHC as universal coverage, but differed in regard to whether they meant a comprehensive set of healthcare services or a limited initiative (Stuckler et al. 2010).

The UHC model provides choices in a particular political and economic environment that is not neutral. The dominant neoliberal environment can exploit the ambiguities inherent in the UHC model and promote a model that is market-driven. Such a model, through a combination of pooling of funds and private provision, becomes an efficient way for private capital to extract profits. With the state intervening to pool healthcare funds in one basket (the locus of collection may range from primarily tax-based to a combination of employee, employer and government contributions), new avenues for profit-making are opened up through the medium of insurance companies and health management organizations.

Pooling of funds provides an effective demand (i.e. purchasing power) for the healthcare industry in settings where most people live in extreme poverty. It also opens up a new and lucrative private market: the administration of health insurance funds. In an insurance-based model, although more public funds are earmarked for health, this is done through demand subsidization (putting money in the hands of the users) rather than subsidizing supply by increasing the budget of public institutions. As a result, a new layer of competition is added to the system. Not only do public and private service providers compete, we also see competition between public and private insurance plans. Furthermore, private companies are offered a series of advantages in order to break the ‘monopoly’ of public institutions (Laurell 2010).

Where is the evidence?

The unquestioning faith in the ‘efficiency’ of private healthcare services in the mainstream UHC model is related to the complexity in measuring the quality and efficacy of integrated public health services (see Box B1.1). Usual measures of health outcomes – e.g. child mortality, life expectancy, etc. – cannot be linked directly to healthcare services, as they often depend more fundamentally on other determinants of health (poverty, housing, nutrition, employment, environment, gender roles, etc.). In fact, only 10–15 per cent of gains in life expectancy are estimated to be attributable to healthcare (Leys 2009: 6). Yet existing measures of health coverage tend to focus on quantitative assessments of access to particularly high healthcare expenses (Moreno-Serra and Smith 2011). Another common method of measuring ‘efficiency’ in healthcare services is by looking at subjective perceptions such as ‘patient satisfaction’, ‘behaviour of health workers’ and crude criteria such as waiting times at clinics and hospitals. The use of such metrics often places public health services at a disadvantage as private care providers are likely to be more adept at addressing these concerns, although they may not be relevant as regards the actual quality of care. Patients are rarely in a position to correctly judge the quality of services, given the huge information asymmetry that exists in the case of medical care.

Finding evidence to assess the impact of newly implemented UHC schemes

Box B1.1 The World Bank’s attempt at generating ‘evidence’

A recent World Bank Publication, *The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence* (Giedion et al. 2013), examines all the possible meanings of and approaches to UHC and then details its final conclusions.

The review analyses 309 papers identified by searching known web-based databases of biomedical and social science publications using a few chosen keywords. Of these, 204 are excluded for not being relevant to LMICs or because they are not based on primary data – leaving 105 in the final review. The review then scores the papers for quality of the work and finds that only 41 make it to a minimum necessary score. Of these 41 papers, 29 papers are able to correlate UHC with outcomes of access and utilization, 21 with financial protection and 13 with health status. Only three studies are able to comment on all three outcomes.

The introductory section on conceptual framework does not adequately clarify what can be considered a ‘UHC effort’. It implies that virtually every health system, programme or intervention could potentially be classified as a UHC scheme as long as it claims to pursue the goals of

UHC. It explicitly states that the report goes beyond the consideration of insurance schemes, but of the final 41 papers, all except 3 papers discuss insurance-based systems. Even in the first shortlist of 105 papers, there are almost no examples of budget-based resource allocation to public provisioning of services. Clearly, a filter has been applied to privilege insurance-based approaches to UHC.

Much of the public support for UHC is mobilized on the expectation that it would contribute to a significant increase in access to a wide range of services – going beyond the narrow package of Reproductive and Child Health (RCH) services that many public health systems in LMICs restrict themselves to. It therefore comes as a surprise that most of the schemes studied are insurance schemes, and that the packages covered by insurance are very limited. The entire methodology, thus, virtually accepts that UHC can often (or usually) mean coverage by an extremely narrow package of services. Thus, of the 17 studies in the evidence base that assessed impact of UHC on access, 6 studies only discuss care during pregnancy and one of these only measures the number of visits for prenatal care! The remaining 11 studies in the review that examine impact of UHC on access simply enumerate number of visits or admissions, without any reference to the type of care sought and what proportion of health needs was met.

The conclusions of the review border on the bizarre. The evidence base for ‘impact of UHC on health status’ is provided by 19 papers and the authors conclude from the evidence that: ‘... it is hard to achieve and show such impacts’. The authors also conclude that: ‘... while an earlier section provided convincing evidence on the positive impact of UHC schemes on access and utilization, this is much less so with regard to financial protection’. In other words: i) no convincing evidence of any impact of UHC on financial protection; and ii) claimed impact of UHC on access based on evidence generated regarding provision of a very narrow and selective set of packages, and by the use of indicators that provide no real analysis of the quality of services. The review finds reason to further hedge its bets by saying: ‘... the lack of impact on out of pocket expenditures does not necessarily imply a failure of the programme given that this result might be explained – at least partly – by a desirable effect (increased utilization)’. This is indeed circular logic at its best (or worst!) – first provide no real evidence regarding ‘better utilization’ and then assert that lack of evidence for financial protection is explained by ‘increased utilization’! It is worth noting that only 15 of the 41 papers that qualified for the evidence base had even measured for impact on financial protection.

is particularly challenging (ibid.) and methodologies designed to collect good evidence are singularly lacking. Many evaluations of UHC schemes end up measuring the impact on ‘out-of-pocket’ expenses incurred (ibid.: 101) but do not measure the quality and depth of services offered. As a consequence, the ‘proof’ of positive impact on health outcomes remains extremely thin, with huge methodological challenges. For example, some evaluations of the much-acclaimed ‘*Seguro Popular*’ scheme in Mexico reported no effect on self-reported health indicators and did not report change in general patterns of service use (Moreno-Serra and Smith 2012).

The basic argument for pooled financing and insurance (the hallmark of UHC) is that it reduces financial risk. However, insurance also opens up new opportunities for consuming expensive high-technology care that permits health improvements that are valued by the patient – especially since the private provider is able to exploit its informational advantage; it is an open question, however, whether insurance (of any form) will in practice reduce financial risk. A large 2005 study of China’s health insurance schemes indicates that it may, to the contrary, be associated with increased risk of large out-of-pocket payments (Wagstaff and Lindelow 2005).

There is even less evidence available about what strategies within the UHC approach are more promising. And there are virtually no data that compare the relative merits of approaches that are premised on predominant public delivery of services versus those that follow a private–public mix with predominant private sector delivery of services.

Public systems efficiencies

There are, however, clear structural reasons why market-driven healthcare and competition do not in fact promote efficiency⁴ or quality (Rice 1997). Commercialized healthcare systems have higher transaction costs, required to manage or regulate the market. A study of long-term care facilities in the USA estimated that in 1999 as much as \$294.3 billion was used for administrative costs, representing 31.0 per cent of healthcare expenditures in the country. Transaction costs tend to be much lower in more public systems; for example, the transaction costs in the National Health Service in the UK in the mid-1970s, before it began to be converted into a market, were estimated at between 5 and 6 per cent of total expenditure (Leys 2009: 18).

Public systems are more efficient also because they ensure economies of scale in the purchasing, supply and distribution of drugs and equipment (Robinson and White 2001). They are also best placed to avoid wasteful capital investment, duplication of equipment and services, and an emphasis on frills that are endemic to hospitals in a competitive market environment (Ramesh et al. 2013). Public systems perform a broad range of public health tasks that are not directly linked to providing care. It can be argued that an array of private providers could offer these services if robust regulatory mechanisms

imposed conditions that mandated private providers to do so. In practice, however, public goods such as mass coverage, public awareness, community outreach and emergency services are more effectively provided through public programmes rather than the sum of regulated private programmes (Sachs 2012).

Further, there are significant marginal costs involved in delivery of care to the most inaccessible or the most disadvantaged sections of the population. Health services for those with pre-existing chronic conditions are often relatively more expensive, as is the treatment of rare diseases (Allotey et al. 2012). In rapidly ageing societies a very high proportion of healthcare needs are concentrated in the last few months or years of life. Public systems can absorb these marginal costs and spread them across an entire population. Private systems, on the other hand, would typically attempt to exclude those who have special needs or are otherwise disadvantaged. Finally, competition harms collaboration between different providers, often an important ingredient of good-quality care, especially in relation to referrals between different kinds of specialists or between different levels of the healthcare system.

The argument that health systems in LMICs should leverage the already dominant private sector is clearly misplaced. The large out-of-pocket expenditures and private provision in low-income countries are mainly a reflection of the paucity of public services, especially for the poor, forcing the middle and upper classes to go directly to private providers, while the poor are left without reliable services. This reality is unfortunate, and not a convincing case for private provision, but rather should serve as a call to action to bolster the deeply underfinanced public sector (Sachs 2012: 945).

UHC in advanced capitalist countries

Variants of the UHC model that is being proposed today have existed in parts of the globe for over 130 years, starting with Germany under Bismarck in the second half of the nineteenth century. Such models inform the design of health systems in most developed countries to this day (with the notable exception of the USA).

Health and the negotiating power of labour The introduction of universal health coverage schemes in Europe and elsewhere has its roots in attempts to quell rising discontent among the working class. Initially, they were designed as welfare payments during sickness and later integrated into entitlements to healthcare. The primary reason for the emergence of these programmes in Europe was income stabilization and protection against the wage loss of sickness, rather than payment for medical expenses, which came later. Programmes were originally conceived as a means to maintain incomes and buy the political allegiance of workers (Palmer 1999). The impetus came from a need to offer concessions to the working poor, and not from a coherent view of how health services were to be organized. As we discuss later, all developed capitalist countries shied

away from adopting an entirely public system, though there was enormous variation in the public–private mix that was implemented. The fact that social health insurance systems in western Europe are still largely functioning is not a commentary on their viability and efficiency. Rather, it reflects the ability of the ruling classes, when forced to respond to popular mobilization against poor healthcare access, to offer ideological resistance to the introduction of entirely public-funded care provided through a single, publicly run system.

Internal contradictions The current strains facing universal health systems in the North – in the form of rising costs and the inability of the systems to keep pace with the health needs of the population – are a function of the reluctance to build truly comprehensive public systems for the delivery of healthcare. Such challenges have led to health-system reforms in many of these countries. Paradoxically, almost without fail, the prescription offered is to introduce more pronounced market mechanisms.

The European experience is important to our discussion because health systems on the continent tended to be built around the notion of social solidarity. Irrespective of the forces that led to their inception, this principle of social solidarity is inherent to the two principal models present in Europe: the so-called Bismarck model that exists in large parts of continental Europe (a similar model was also extended to other countries such as Australia, Canada, Japan and, more recently, Singapore and South Korea) and the Beveridge model in the UK, which emerged post-Second World War. A third model that was prevalent in the erstwhile socialist states in the Soviet Union and eastern Europe (the Semashko model)⁵ has virtually disappeared.

The Bismarck model, nowadays typically known as social health insurance, pooled health funds contributed by the state, employers and employees in a common fund, while healthcare was provided by a mix of public and private facilities. The organization of care delivery differed by country, but in situations where private facilities were involved, they were tightly controlled. Across the English Channel, the Beveridge model's financing was tax-based and primary care was provided by a network of general practitioners, and secondary and tertiary services by public institutions. The general practitioners, while not technically government employees, were tightly bound to the system through contracts with the National Health Service. The Semashko system, which existed in the Soviet Union and eastern Europe, was state-funded and care provision was the sole prerogative of state-run facilities.

Both the Bismarck and the Beveridge models explicitly recognized the role of social solidarity, while devising ways to fund healthcare. They were, however, built around fundamental contradictions. The first was the contradiction (especially in the Bismarck model) between the solidarity character of the financing and the private appropriation of the collectively financed funds by care providers, including industries such as pharmaceutical enterprises and

producers of medical equipment. The second was the contradiction between the interests of individuals and the society as a whole in safe, efficient and cheap healthcare on one hand, and the interests of private providers and producers in selling more products, performing more operations, etc., on the other (Pato 2011). Thus, for example, European patients contribute to the super-profits of pharmaceutical manufacturers through solidarity funding (either through tax contributions or contributions to health funds).

The demise of solidarity-based systems The private sector never ceased to exist in western Europe, in spite of solidarity-based health systems being introduced, and it re-emerged in eastern Europe after the 1980s. This private healthcare sector has made new inroads into the public sector (ibid.: 20), especially in the last two decades. While there are several factors at play in the transformation of solidarity-based health systems into market-based ones, a major enabling factor has been the weakened bargaining power of labour post-1970s.

A combination of tax cuts and budget austerity (well before the 2008 financial crisis broke) heralded the European health system reforms in the 1980s (see Chapter A2). This not only affected the tax-based systems but also countries with social health insurance. In the latter case, hospital infrastructure was typically funded by local government funds, which came under strain. Social insurance was also affected because of the difficulty in raising premiums paid by workers already suffering from stagnation in wages (Hermann 2009: 127). Reforms of a particularly brutal egregious nature are ripping apart the National Health Service (NHS) in the UK (see Chapter B2). The NHS represented what was anathema to capital – a well-functioning tax-funded and predominantly public health system in a developed capitalist economy. The ideological underpinnings of health reforms in Europe lie at the very foundation of the UHC model that is being promoted in LMICs today.

UHC in low- and middle-income countries

Low- and middle-income countries face a series of challenges that high-income countries did not confront when they began to develop universal health coverage systems. The demands on healthcare systems were fewer in the early twentieth century because the available medical technologies were less developed. Epidemiological challenges facing LMICs today are more serious because they have faster-growing populations, a higher prevalence of infectious diseases, and a growing burden of non-communicable illnesses compared with countries that attained universal health coverage in the past century (Savedoff et al. 2012).

We turn to three countries – Brazil, Thailand and India – to highlight current challenges faced by LMICs while trying to secure universal healthcare. The examples are illustrative and should not be seen as entirely representative of UHC models being implemented elsewhere in the world. Brazil and Thailand

are interesting cases given that they are cited (often correctly) as successful models of universal care. As for India, global attention has been devoted to its health-system reforms and the rapid rollout of social health insurance programmes, and these are useful to scrutinize because they typify some of the negative aspects of a health financing and insurance-based approach to healthcare.

Before we proceed, however, it is important to mention that beyond the confines of ‘coverage’, there are several alternative examples of how quality care has been, or is being, provided by public systems in the global South, such as in China, Costa Rica, Cuba, Malaysia, Sri Lanka, and in Rwanda and Venezuela much more recently. That there may have been a complete or partial reversal of the role of public systems in many of these countries is reflective of how neoliberal economics prevailed over evidence. We can nevertheless summarize the stories of Brazil, Thailand and India to understand how UHC is being interpreted in LMICs today, in contrast with such models of comprehensive, integrated healthcare systems, and how the approach is imbued with a neoliberal ethos.

Thailand: high coverage, low public expenditure In 2002 Thailand’s National Health Insurance Bill was enacted, creating the Universal Health Care Coverage scheme, primarily funded by the government based on a per capita calculation, and administered by the National Health Security Office. The focus has been on providing primary healthcare services to Thais who were left out of the healthcare system prior to 2002. Within just over a decade, coverage has increased dramatically and now reaches almost the entire population (Sengupta 2012: 200). However, there is another part of the story that is generally not discussed. The Thai reform of 2002 was preceded by the ‘Decade of Health Centre Development Policy (1986–1996)’ which worked to establish primary health centres in rural areas. Public investment in health also increased quite dramatically towards the end of this period, and the government’s share of total health expenditure increased from 47 per cent in 1995 to 55 per cent in 1998 (Ramesh et al. 2013: 8). Consequently, before the turn of the millennium there were few geographical barriers to healthcare access in the country. Thanks to massive infrastructure creation, 78 per cent of hospital beds were in the public sector by 1999 – a trend that has remained fairly constant, with 77 per cent of hospital beds continuing to be in the public sector in 2012.

The Thai reforms, thus, leveraged upon a newly built *public* health infrastructure. Under the UHC reforms, both public and private facilities can be providers of health services. However, in practice, private participation is low because it was made mandatory for private providers offering tertiary care to also provide primary-level care.

However, these genuine attempts to provide access to healthcare services are taking shape in an overall neoliberal climate in Thailand. This places strains

on the health system and may well undermine its viability in the long term. Public financing (most of which is consumed by public services) remains fairly low: health expenditure increased from 1.7 per cent of GDP in 2001 to 2.7 per cent in 2008, but this remains lower than the global average for LMICs. The percentage of funds earmarked for the public system has increased from 50 to 67 per cent (Limwattananon et al. 2012), yet in terms of human resource development low expenditures have meant that there are just three physicians for every 10,000 patients, compared to 9.4 in Malaysia, 11.5 in the Philippines, 12.2 in Vietnam and 18.3 in Singapore, and barely 1.5 nurses for every 1,000 people, compared to 2.3 in Malaysia and 5.9 in Singapore. The shortage of health workers, especially nurses, is serious in many public facilities. Some are hired on temporary contracts, which must be renewed every year. Better wages in private hospitals (the private sector is still strong and draws further strength from a burgeoning medical tourism market) draws nurses away from the public sector, as does the lucrative market for nurses in nearby Singapore (Saengpassa and Sarnsamak 2012).

Brazil: comprehensive primary care, private hospital care Brazil is a different kind of enigma. It went against the neoliberal trend in vogue in the rest of Latin America by creating the tax-funded *Sistema Único de Saúde* (SUS, the Unified Health System) in 1986 and by proclaiming in its 1988 constitution the government's duty to provide free healthcare for all (see Chapter B4).

The creation of the SUS has resulted in the rollout of an impressive primary-care scheme, which covers almost the entire country (Paim et al. 2011). However, while most primary healthcare is provided by a vast network of public providers and facilities, hospital care is largely provided by private facilities. Based on an arrangement typical of the UHC approach,⁶ the state purchases a bulk of secondary and tertiary care from the private sector and only a small percentage of such care is provided by public facilities.

This places several kinds of strain on the system. The private sector continues to ratchet up the cost of care it provides, and with health expenditure standing at 9 per cent of GDP, Brazil now has one of the most expensive health systems in the world. Such dominance of the private sector (in tertiary-care provision) introduces inequity in access and is further reinforced by the fact that most Brazilians who can afford it (including an influential and growing middle class) purchase private insurance to 'top up' services that they are able to access through the public system (ibid.).

India: poor public care, ineffective health insurance UHC as implemented in India exemplifies an entirely different set of issues and challenges, which have accompanied the introduction of social health insurance programmes elsewhere. The public sector in India is in a state of neglect and has traditionally been poorly funded. Public expenditure on health stood at around 1.04 per cent of



Image B1.4 Delegates at the People's Health Assembly in 2012 (Louis Reynolds)

GDP in 2012, one of the lowest rates in the world (Planning Commission of India 2013: 3). With private healthcare accounting for 80 per cent of outpatient and 60 per cent of inpatient care, India is one of the most privatized systems in the world (NSSO 2006).

Out-of-pocket expenditure on healthcare (approximately 70 per cent of households' healthcare expenses) contributes to widespread poverty in India (HLEG 2011: 43). In an attempt to protect patients from 'catastrophic' health expenses, publicly funded social health insurance schemes have been rolled out in recent years. The Rashtriya Swasthya Bima Yojana (RSBY), a national, entirely public-funded scheme, was launched in 2009 and has been hailed as a major achievement by the government, and in the current 12th Five-Year Plan similar insurance schemes have received even greater attention and support. The RSBY is supplemented by several state-level health insurance schemes that have been launched or are in the pipeline. Scaling up of the social health insurance schemes has been impressive: by the end of 2010 an estimated 247 million people – a quarter of the population – were covered by one or more of these schemes, and coverage has since expanded (GHW 3 2011: 108).

The social health insurance schemes provide coverage only for hospital-based care for a specified list of procedures. Patients are provided with a choice of accredited institutions where they can receive treatment and be reimbursed for costs not surpassing a set ceiling. A large majority of accredited institutions are in the private sector (Yellaiah 2013: 14). The net impact of the publicly funded and largely private-provisioned social health insurance schemes has been to further distort the entire structure of the country's health system.

Public money is now being employed to strengthen an already dominant private sector. The schemes are also distorting the flow of resources to the hospital-based tertiary-care sector (largely private) and away from primary care services. In 2009/10, direct government expenditure on tertiary care was slightly over 20 per cent of total health expenditure, but if one adds spending on the insurance schemes that focus entirely on hospital-based care, total public expenditure on tertiary care would be closer to 37 per cent (Reddy et al. 2011: 13).

A common trend The three countries, taken together, represent some interesting similarities about UHC. While the settings are diverse, there is a similar persistence with private sector participation in provision of care. In all the cases, public funding does not match needs, and this opens space for the progressive creep of the private sector into the larger health system. Consequently all three countries have a powerful private sector that influences the functioning of the system as a whole, jeopardizing the integrity of the public sector and drawing away resources, both financial and human, from resource-starved public facilities. Several detailed country studies in the subsequent chapters of this section further highlight these issues.

Conclusions

If health outcomes are to be improved the central question that needs to be asked is not how public systems are to be privatized but how existing public systems could be made truly universal. Public systems need to be reclaimed by citizens, reformed in the interests of the people and made accountable. People's movements and organizations have much to lose from the present drift, legitimized by a particular discourse in the name of UHC. Historically, healthcare systems worldwide have been shaped by labour's fight for better living conditions – either through transformation of the capitalist system itself or through the extraction of better terms from the ruling classes. The fight for a just and equitable health system has to be part of the broader struggle for comprehensive rights and entitlements. To take this struggle forward, the dominant interpretation of UHC today – weakening public systems and the pursuit of private profit – needs to be understood and questioned.

Notes

1 A previous, longer version of the major contents of this chapter is available at: www.municipalservicesproject.org/publication/universal-health-coverage-beyond-rhetoric.

2 For example, an article in *The Lancet* in 2009 argues: 'The entire Latin American continent is on track to achieve universal health coverage within the next decade. The achievement of Latin America offers hope to

Africa, the Middle East, and Asia – but success looms only because of years of hard work and innovation across the continent' (Garrett et al. 2009: 1297).

3 See, for example, Kutzin (2000).

4 Here we use the term 'efficiency' not in the way it would be used in a market environment, but in terms of the returns achieved through investment in a public good.

5 The 'Bismarck' model is so termed as it was introduced in Germany during the reign of Chancellor Otto von Bismarck, beginning with the introduction of a health insurance bill to mandatorily cover all workers, in 1883. The Semashko system was named after the first minister of health of the USSR. The Beveridge system was introduced (in the form of the National Health Service) by the government in the post-Second World War UK, based on the report of the Inter-Departmental Committee on Social Insurance and Allied Services, known commonly as the Beveridge Report (it was chaired by the British economist William Beveridge).

6 It should be noted that the Brazilian reforms started before UHC was developed as a model, and the Brazilian system has not been designated as being modelled on the concept of UHC. However, nomenclature notwithstanding, Brazil's problems are very similar to those being faced by UHC models elsewhere.

References

- Allotey, P., S. Yasin, S. Tang et al. (2012) 'Universal coverage in an era of privatisation: can we guarantee health for all?', *BMC Public Health*, 12(suppl. 1): S1.
- Frenk, J. and D. de Ferranti (2012) 'Universal health coverage: good health, good economics', *The Lancet*, 380(9845): 862–4.
- Garrett, L., A. M. R. Chowdhury and A. Pablos-Méndez (2009) 'All for universal health coverage', *The Lancet*, 374(9697): 1294–9.
- GHW 1 (Global Health Watch 1) (2005) *Health Care Systems and Approaches to Health*, London: Zed Books.
- GHW 3 (Global Health Watch 3) (2011) *Dysfunctional Health Systems: Case studies from China, India and the US*, London: Zed Books.
- Giedion, U., E. A. Alfonso and Y. Díaz (2013) *The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence*, UNICO Study Series 25, Washington, DC: World Bank, January.
- Hermann, C. (2009) 'The marketisation of healthcare in Europe', in L. Panitch and C. Leys (eds), *Morbid Symptoms: Health under Capitalism*, Pontypool: Merlin Press.
- HLEG (High Level Expert Group on Universal Health Coverage for India) (2011) *High Level Expert Group Report on Universal Health Coverage for India*, Planning Commission of India, New Delhi, planningcommission.nic.in/reports/genrep/rep_uhco812.pdf, accessed 7 May 2014.
- Homedes, N. and A. Ugalde (2005) 'Why neo-liberal health reforms have failed in Latin America', *Health Policy*, 71(1): 83–96.
- Kutzin, J. (2000) 'Towards universal health care coverage', Health, Nutrition and Population (HNP) Discussion Paper, Washington, DC: World Bank, July.
- (2012) 'Anything goes on the path to universal health coverage? No', *Bulletin of the World Health Organization*, 10 October.
- Laurell, A. C. (2007) 'Health system reform in Mexico: a critical review', *International Journal of Health Services*, 37(3): 515–35.
- (2010) 'Can insurance guarantee universal access to health services?', *Social Medicine*, 137(3): 137–8.
- Leys, C. (2009) 'Health, health care and capitalism', in L. Panitch and C. Leys (eds), *Morbid Symptoms: Health under Capitalism*, Pontypool: Merlin Press.
- Limwattananon, S., V. Tangcharoensathien, K. Tisayaticomet et al. (2012) 'Why has the universal coverage scheme in Thailand achieved a pro-poor public subsidy for health care?', *BMC Public Health*, 12(suppl. 1): S6, www.biomedcentral.com/1471-2458/12/S1/S6, accessed 7 May 2014.
- Moreno-Serra, R. and P. C. Smith (2011) 'Towards an index of health coverage', Discussion paper 2012/11, Imperial College Business School and Centre for Health Policy, December.
- (2012) 'Does progress towards universal health coverage improve population health?', *The Lancet*, 380(9845): 917–23.
- NSSO (National Sample Survey Organisation) (2006) 'Morbidity, health care and the condition of the aged', Report no. 507, NSS 60th round (January–June 2004), New Delhi: Ministry of Statistics and Programme Implementation, Government of India, mospi.nic.in/rept%20_%20pubn/507_final.pdf, access 7 May 2014.
- Paim, J., C. Travassos, C. Almeida et al. (2011) 'The Brazilian health system: history, advances, and challenges', *The Lancet*, 377: 1778–97.
- Palmer, K. S. (1999) 'A brief history: universal health care efforts in the US', Transcribed from a talk given at a Physicians for a

- National Health Program (PNHP) meeting, San Francisco, www.pnhp.org/facts/a-brief-history-universal-health-care-efforts-in-the-us, accessed 7 May 2014.
- Pato, T. (2011) 'Health systems in Europe: changes and resistance', Opening report to health workers' conference, 4 July, internationalviewpoint.org/spip.php?article2180, accessed 7 May 2014.
- Pierson, P. (2001) *The New Politics of the Welfare State*, Oxford: Oxford University Press, rszarf.ips.uw.edu.pl/welfare-state/pierson.pdf, accessed 7 May 2014.
- Planning Commission of India (2013) *Twelfth Five Year Plan (2012–2017): Social Sectors*, vol. 3, New Delhi: Government of India, planningcommission.gov.in/plans/planrel/12thplan/pdf/vol_3.pdf, accessed 7 May 2014.
- Ramesh, M., W. Xun and M. Howlett (2013) 'Second best governance? Governments and governance in the imperfect world of health care delivery in China, India and Thailand', Paper presented at the International Conference on Public Policy, Grenoble, 26–28 June, www.icpublicpolicy.org/IMG/pdf/panel_11_s3_ramesh.pdf, accessed 7 May 2014.
- Reddy, K. S., S. Selvaraj, K. D. Rao et al. (2011) 'A critical assessment of the existing health insurance models in India', New Delhi: Public Health Foundation of India, planningcommission.nic.in/reports/serereport/ser/ser_heal1305.pdf, accessed 7 May 2014.
- Rice, T. (1997) 'Can markets give us the health system we want?', *Journal of Health Politics, Policy and Law*, 22: 383–426.
- Robinson, M. and G. White (2001) 'The role of civic organizations in the provision of social services: towards synergy', in G. Mwabu, C. Ugaz and G. White (eds), *Social Provision in Low-Income Countries – New Patterns and Emerging Trends*, Oxford: Oxford University Press.
- Rodin, J. and D. de Ferranti (2012) 'Universal health coverage: the third global health transition?', Rockefeller Foundation, *The Lancet*, 380(9845): 861–2.
- Sachs, J. D. (2012) 'Achieving universal health coverage in low-income settings', *The Lancet*, 380(9845): 944–7.
- Saengpassa, C. and P. Sarnsamak (2012) 'Thailand public health service in critical condition', *The Nation*, 15 October.
- Savedoff, W. D., D. de Ferranti, A. L. Smith et al. (2012) 'Political and economic aspects of the transition to universal health coverage', *The Lancet*, 380(9845): 924–32.
- Sengupta, A. (2012) 'Creating, reclaiming, defending: non-commercialised alternatives in the health sector in Asia', in D. A. MacDonald and G. Ruiters (eds), *Alternatives to Privatisation*, New York: Routledge.
- Stuckler, D., A. B. Feigl, S. Basu et al. (2010) 'The political economy of universal health coverage', Background paper for the global symposium on Health Systems Research, 16–19 November, Montreux, Switzerland.
- Vabø, M. (2009) 'New public management the neoliberal way of governance', Working papers no. 4, thjodmalastofnun.hi.is/sites/thjodmalastofnun.hi.is/files/skrar/working_paper_4-2009.pdf, accessed 7 May 2014.
- Wagstaff, A. and M. Lindelow (2005) 'Can insurance increase financial risk?: the curious case of health insurance in China', *Journal of Health Economics*, 27(4): 990–1005, repository.upenn.edu/gansu_papers/20/, accessed 7 May 2014.
- WHA (World Health Assembly) (2005) 'Sustainable health financing, universal coverage and social health insurance', Resolution WHA58.33, Geneva.
- Yellaiah, J. (2013) 'Health insurance in India: Rajiv Aarogyasri health insurance scheme in Andhra Pradesh', *IOSR Journal of Humanities and Social Science*, 8(1): 7–14.