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Universal Health Coverage:

Beyond rhetoric

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ABOUT THE PROJECT

The Municipal Services Project (MSP) is a research project that explores alternatives to the privatization and commercialization of service provision in electricity, health, water and sanitation in Africa, Asia and Latin America. It is composed of academics, labour unions, non-governmental organizations, social movements and activists from around the globe who are committed to analyzing successful alternative service delivery models to understand the conditions required for their sustainability and reproducibility.

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EXECUTIVE SUMMARY

“There is a rich man’s tuberculosis and a poor man’s tuberculosis. The rich man recovers and the poor man dies. This succinctly expresses the close embrace between economics and pathology.”

Norman Bethune, *circa* 1930

This paper raises critical questions around the wide and growing enthusiasm for Universal Health Coverage (UHC), which is increasingly seen as a silver-bullet solution to healthcare needs in low- and middle-income countries. Although confusion still exists as to what UHC actually means, international development agencies typically define it as a health financing system based on pooling of funds to provide health coverage for a country’s entire population, often in the form of a ‘basic package’ of services made available through health insurance and provided by a growing private sector.

Global health agencies such as the World Health Organization, and international financial institutions such as the World Bank, are promoting this approach in response to the rise in catastrophic out-of-pocket expenditure¹ for health services, and in the face of crumbling public health systems in the global South (both of which were precipitated by the fiscal austerity imposed by these same international financial institutions in the 1980s and early 1990s). In this new model, UHC prescribes a clear split between health financing and health provision, allowing for the entry of private insurance companies, private health providers and private health management organizations. The logic is that healthcare challenges require an immediate remedy, and since the public system is too weak to respond, it is strategic to turn to the private sector.

In short, the UHC model is built on, and lends itself to, standard neoliberal policies, steering policy-makers away from universal health options based on public systems. Building and improving the public healthcare system is not part of this mainstream narrative, with the state generally confined to the role of system manager.

Although these programs are now zealously promoted by global health agencies, the evidence to support their implementation remains extremely thin. Reliable data upon which to evaluate their performance are hard to come by (Giedion et al 2013) and methodologies designed to collect good evidence are singularly lacking, illustrated in this paper by the highly contested data of some early health reforms based on universal insurance in the South (e.g. Chile, Colombia and Mexico), which have nonetheless been used to legitimize the current UHC agenda.

The paper argues that secure finances for health care are a necessary but insufficient condition for systems that are equitable and provide good quality care. We analyze the reasons why finances need to be channeled through well-designed public systems if they are to be spent efficiently. We further argue that, in glossing over the importance of public provisioning of services, many proponents of UHC are actually interested in the creation of health markets that can be exploited by capital.

To contextualize the UHC debate, we look at Europe's experiences in constructing similar models, whereby health becomes a marketable commodity. We also present the cases of Brazil, India and Thailand to illustrate how this trend has become global, reinforced by the implementation of new UHC initiatives. Our analysis shows that despite policies in favour of universal public health care, the neoliberal ethos has become dominant in these countries' health systems. Thus, even in the case of widely acclaimed reforms, equity and efficiency tend to be compromised because ideological pressures prevent the adoption of an entirely *public* system of care provision.

The challenges of high quality and equitable health care are most acute in low and middle-income countries because of faster growing populations, higher prevalence of infectious diseases, and growing burdens of non-communicable illnesses. Re-imagining public health care – rather than the private sellout of health systems via UHC – is argued to be the only way forward in building truly *universal* health outcomes.

UHC to the rescue?

In less than a decade the discourse on Universal Health Coverage (UHC) has come to dominate most international discussions on healthcare access. Some analysts have termed it the ‘third great transition’ in health, changing how services are financed and how systems are organized (Rodin and de Ferranti 2012). UHC is now broadly seen as *the* solution to pressing healthcare needs in low and middle income countries (LMICs), making it all the more important to understand what it actually promises.

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, the conceptual underpinning of UHC lay in ‘sustainable health financing’ and not in the mechanisms of healthcare delivery or nature of health systems. Soon, universal health coverage as a vehicle for securing sustainable *financing* for health systems began to conflate with health systems design, promoting the systematic participation of the private sector in *provision* of health services.² The use of the term ‘coverage’ rather than ‘care’ symbolizes the move away from concerns of health systems design toward financing.

International agencies rallied behind UHC as a response to the precipitous rise in catastrophic out-of-pocket expenditure on healthcare, in the backdrop of crumbling public health systems. The latter was a consequence of a prolonged period of neglect of public health care and privatization of health systems, as prescribed by global financial institutions’ infamous Structural Adjustment Programs in the 1980s (McPake and Mills 2000). The neglect of public services was not peculiar to the health sector, of course, but a function of the broad ideological position of global financial institutions against public services in general.³ By the 1980s arguments for privatizing health systems were frequently reflected in publications of the World Bank that echoed the position, first developed in the 1960s, that health care had no characteristics to differentiate it sharply from other market goods (McPake and Mills 2000, 812).

In its 1993 World Development Report, the World Bank had published a ranking of common health-care interventions according to their cost-effectiveness and used it to propose a minimum package of public healthcare services for low and middle income countries. At best, the minimum package would avert one third of the estimated burden of disease in low-income countries and a fifth in middle-income countries. According to this approach, examples of common ailments that were excluded from public funding in poorer countries included: emergency treatment of moderately severe injuries and treatment of chronic conditions including diabetes, cataract, hypertension, mental illness and cervical cancer (Segall 2003). This package came to be widely accepted and incorporated in policies adopted by most LMICs thanks to international financial agencies’ continued influence throughout the 1990s.

Reforms during that period led to massive cuts on public healthcare expenditure. Already, in the poorest 37 countries, public per capita spending on health had shrunk by half in the 1980s (Sanders 2000). In Mexico, for example, per capita expenditure on health care had dropped by 50 to 60% between 1982 and 1987. Subsequent restoration was slow, and in 2000, public health expenditure was still lower than pre-1982 levels in real terms (Laurell 2007). In 1991, Peru was spending US\$12 per capita on health and education, one-fourth of what it had spent a decade before – and half the amount it was spending on debt payments to Western banks (Sanders 2000). In India, the already grossly under-funded public health system faced a further squeeze with the neoliberal economic reforms of 1991 (Berman and Ahuja 2008). There was a significant decline in public health expenditure in most African countries as well, even though they were starting from an extremely low base. Between 1980-1985 (average for this period) and 1986 there was a real decline of 9.3% and 9.1% respectively for what the World Bank classified as medium and low expenditure countries (World Bank 1994, 145). Such a reduction in health finances in LMICs was felt directly by publicly run services, as in most LMICs a bulk of public finances was utilized to directly run public health facilities (unlike in many high income countries, where public funding was in many cases utilized for private sector provision of services).

By the turn of the millennium the overall situation as regards health care 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, which expanded to fill the vacuum created by the retreat of public services. This was especially true in the case of secondary and tertiary care services, where the profit opportunities for the commercial sector were greater.
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 network of facilities and services that are appropriately situated at primary, secondary and tertiary levels.

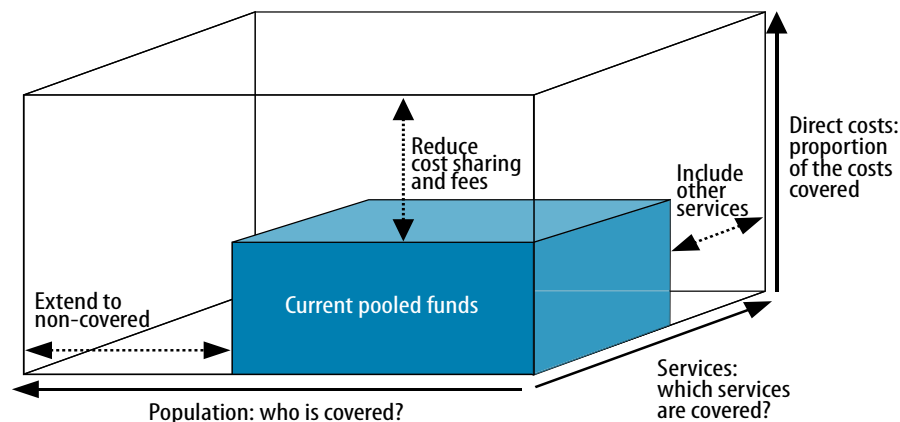
The contours of UHC that began to take shape were based on some early initiatives in the late 1990s and early 2000s – especially in Latin America where reforms were based on universal insurance schemes. Mechanisms adopted in Chile, Colombia and Mexico, for example, shared certain

key features: increases in national healthcare expenditures, both public and private; and a market logic centred on 'individual care' conceived as a 'private' good. At the end of the day, there was no regional consensus on the success of those reforms, and some reviews of the Chile and Colombia experiences suggest that they did not improve quality of care, equity and efficiency; yet 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, the powerful global institutions that were behind these reforms were able to give a positive spin to their impact.⁴ Notably, the World Bank played a key role in consensus-building around reforms that were to become precursors to UHC, much before the World Health Organization (WHO) formally adopted it as part of its policy plank (e.g. see Kutzin 2000).

The ideological foundations of UHC

It is important to understand the theory behind UHC. The 2010 World Health Report illustrated the concept as a diagram, reproduced in Figure 1.

FIGURE 1: The UHC Cube



Source: WHO 2010, p. 12, Fig. 1

In the cube, UHC is conceived as a system that would progressively move toward: i) the coverage of the entire population by a package of services; ii) an increasing range of services; and iii) a rising share of pooled funds as the main source of funding for health care, and thereby a decrease in co-payments by those accessing healthcare services. Such a system 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 part of this narrative and the state is confined to the role of manager of this system.

This conception of UHC has been defended forcefully by its main proponents. Among them, Julio Frenk, the architect of the Mexican health insurance system, 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).

It is useful to note here that the split between the state as health provider and as purchaser of services has been the hallmark of reforms in other public services as well.⁵ In the health sector, theoretically, it 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 in the expectation that public services can be made to deliver with the efficiency that the private sector (and its competitive environment) has supposedly realized. More specifically, there has been an aspiration to introduce 'internal markets' within the domain of public provision. As part of these reforms, public funding has been retained but steps have been taken to isolate the purchasers from the providers. The intention is that individual 'units' should compete for consumers. The purchaser of these services (patients or their surrogates) should be able to move between providers with relative ease. This reorganization along the lines of new public management appears crucial for subsequent privatization of public services, as erstwhile public services in their classical form are not marketable commodities (Pierson 2001, 157).

The role of the state is defined in the 2010 World Health Report in the following manner: "Governments have a responsibility to ensure that all providers, public and private, operate appropriately and attend to patients' needs cost effectively and efficiently" (WHO 2010, p. xviii). In other words, UHC does not discriminate between public and private services, its only concerns are 'cost-effectiveness' and 'efficiency'. In practice, this impartial role of the state can be interpreted in many ways and largely depends on the functioning of public health services in any given country. With most public health systems in a state of disarray, it is an appealing option for states 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 seems 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 considering public provision of services as the mainstay of this system. 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.

In fact, influential supporters of UHC are happy to emphasize the key role played by governments in strategically 'purchasing' care to improve 'efficiency', rather than advocating for them to get involved in providing services. For example, an issue of the *WHO Bulletin* argues: "Countries cannot simply spend their way to universal health coverage. 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 discourse 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 (PHM et al 2005, 56). Instead UHC envisages health care 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.

In fact, 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 vast majority of the population. The components that are 'sufficient' to be considered adequate coverage remain highly contested, however (Stuckler et al 2010). UHC is essentially designed to universalize 'coverage' rather than 'care'.

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 health care and in regulating the quality and range of services, UHC recognizes that 'market failures' are a feature of private health care that is detrimental to the interests of patients. Second, UHC also recognizes that health is a 'public good' with externalities, and that the state has responsibility to ensure access to health services. Thus, UHC provides the possibility to exercise a choice, and progressive governments can try to privilege public systems and examine funding mechanisms that promote equity. Financial pooling through UHC makes it easier to develop comprehensive public systems, but whether that will happen is a political choice.

The ambiguities of UHC

There are two levels of ambiguities embedded in the present concept of UHC. First, while it 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. Second, it does not define the 'depth' of coverage and hence allows an interpretation that coverage can mean a very basic package, akin to the World Bank's health 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 health care.

In some cases, the result will be a government that primarily regulates the healthcare sector, while in other cases it will be a government that finances and directly provides care (Savodoff et al 2012).

These obscurities were clearly captured by a recent literature survey of peer reviewed publications on UHC. Of 100 papers analyzed only 21 provided an explicit definition of UHC. Among these, 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 it 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. Further, in a UHC 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).

Whither integrated public health systems?

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. 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 (e.g. poverty, housing, nutrition, employment, environment, gender roles, etc). In fact, only 10-15% of gains in life expectancy are thought to be attributable to health care (Leys 2009, 6). Yet existing measures of health coverage tend to focus on quantitative assessments of access to particularly high healthcare services (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, on the other hand, 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.

Where is the evidence?

Finding evidence to assess the impact of newly implemented UHC schemes is particularly challenging (Giedion et al 2013, 101) 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 (Giedion et al 2013, 101) but do not measure the quality and depth of services offered. As a consequence, the proof of UHC's 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 2011).

The most 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 because 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).

Given this thin evidence, it is impossible to claim that UHC strategies – as a whole – work. There is even less evidence available about what strategies within the UHC approach are more promising. And there is virtually no data that compares 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 system efficiencies

There are, however, clear structural reasons why market-driven health care and competition do not in fact promote efficiency⁶ or quality (Rice 1997). Market competition does not make for better care as most patients do not have enough knowledge to make informed choices – a situation called information asymmetry in the healthcare 'market'.

Commercialized healthcare systems often have very high transaction costs, which are necessary to manage or regulate the market. A study of long-term care facilities in the US estimated that in 1999, as much as \$294.3 billion was used for administrative costs, representing 31% 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 System in the mid-1970s, before it began to convert into a market, were estimated at between 5 and 6% of total expenditure (Leys 2009, 18).

Public systems are more efficient because they ensure economies of scale in the purchasing, supply and distribution of drugs and equipment (Robinson and White 2001). In the Indian state of Tamilnadu, for example, pooled purchasing of medicines through a public sector entity has driven down medicine costs significantly and other states are engaged in duplicating the model (Singh et al 2013). Public systems are best placed to avoid wasteful capital investment, duplication of equipment and services, and the emphasis on frills that are endemic to hospitals in a competitive market environment (Ramesh et al 2013, 13-14).

Public systems also perform tasks that are not directly linked to providing care. These include maintaining disease surveillance systems, providing immunization to the entire population, vector control measures, health promotion activities such as ante natal and school health checkups, and so on. It can be argued that an array of private providers could offer these services if robust regulatory mechanisms impose conditions that mandate them 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 programs rather than the sum of regulated private programs (Sachs 2012, 945).

If health systems are to provide universal care, there are significant marginal costs involved in delivery to the most inaccessible or the most disadvantaged sections of the population. Health services to those with pre-existing chronic conditions are often relatively more expensive as is the treatment of rare diseases (Allotey et al 2012). In rapidly aging 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 find such costs to be unacceptable and would attempt to avoid care provision to people who live in underserved areas, who are disadvantaged, or those who suffer from conditions that require expensive care or long-term care. Public systems, thus, promote equity while even the best-designed private systems risk undermining it. 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 for wider and better care is clearly misplaced. The large out-of-pocket expenditures and the

importance of private provision in low-income countries is mainly a reflection of inadequate public services, forcing the middle and upper classes to go directly to private providers while the poor are left without reliable basic services. This reality is unfortunate, but it is not a convincing case for private provision; rather it should serve as a call to action to bolster the deeply under-financed 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 19th century. Such models inform the design of health systems in most developed countries to this day (with the notable exception of the US).

While trying to project the future trajectory of UHC in LMICs it is important to learn from these historical experiences for two reasons. First, because models of UHC being promoted in LMICs today are justified on the basis of evidence from models in developed countries, yet they are blind to the fact that these are imperfect ones born out of a long history of social struggle and compromise in capitalist states. Second, many of these systems are now under strain and face the prospect of reforms, which are largely designed to open up opportunities for the private sector as is happening in the global South.

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 for health care. European countries introduced compulsory sickness insurance for workers beginning in Germany in 1883; other countries, including Austria, Britain, Hungary, the Netherlands, Norway and Russia all followed by 1912. Other European countries, including Sweden in 1891, Denmark in 1892, France in 1910, and Switzerland in 1912, opted to subsidize the mutual benefit societies formed by workers. The primary reason for the emergence of these programs in Europe was income stabilization and protection against the wage loss of sickness, rather than payment for medical expenses, which came later. Programs were originally conceived as a means to maintaining incomes and buying political allegiance of workers (Palmer 1999).

The impetus for UHC 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 universal 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 health needs of the population – are a function of the reluctance to build truly comprehensive public systems for the delivery of health care. 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 were generally 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 after World War II. A third model that was prevalent in the erstwhile Socialist states in the Soviet Union and Eastern Europe, the Semashko model,⁷ 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 health care 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, financing of the Beveridge model was tax-based. 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 System. 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 different ways to fund health care. They were, however, built around fundamental contradictions. First was the contradiction 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. Second was the contradiction between the interest of individuals and the society as a whole in safe, efficient and cheap health care on the one hand, and on the other the interest of private providers and producers in selling

ever more products, performing ever more operations, etc (Pato 2011). This resulted, for example, in European patients contributing 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

Cost containment and efficiency are driving a re-commodification of health care in Europe even if no convincing evidence has been offered to support the idea that private markets accomplish these goals. To the contrary there is evidence globally that systems that are non-profit score better on both counts. Across the Atlantic, a review of 132 studies comparing for-profit and not-for-profit hospitals and other healthcare institutions in the US, between 1980 and 2000, showed that non-profits were often superior in terms of cost-efficiency and quality (Leys 2009, 17).

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 (Leys 2009, 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 after the 1970s. This weakness of labour has become an opportunity for capital to strike back and reclaim health services for profit-making.

A combination of tax cuts and budget austerity heralded the European health system reforms of the 1980s. This not only concerned 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).

The story of health system reforms in Europe would not be complete without mention of the National Health System (NHS) in the UK, which has been progressively dismantled and privatized by successive governments over the past quarter-century. This process and its consequences have been profoundly anti-democratic and opaque. Catchphrases such as 'public-private partnerships', 'modernization', 'value for money', and 'local ownership' conceal the extent and real nature of what has happened, and the complexity of health care allows the reality of its transformation to be buried under a thousand half-truths (Pollock 2009). But the NHS represented what was anathema to capital, a well-functioning tax-funded and predominantly public health system in a developed capitalist economy.⁸

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 health-care systems were fewer in the early 20th century because the available medical technologies were also less developed. Epidemiological challenges facing LMICs today might also be 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 have, in earlier sections, briefly discussed the trajectory of UHC reforms in some Latin American countries such as Mexico and Colombia in the 1980s and '90s. We will now turn to three countries – Brazil, Thailand and India – to highlight current challenges faced by LMICs while trying to secure universal health care. The examples are illustrative but 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 programs, and these are useful to scrutinize because they typify some of the negative aspects of a health financing and insurance-based approach to health care.

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 another story. It is a story of how neoliberal economics prevailed over evidence. The history of these public systems, the extent of their success and the reasons thereof, and importantly, the reasons for their partial or complete demise (in countries such as Malaysia, Sri Lanka and China) and the attendant consequences require another much larger discussion.⁹ 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

Health reforms in Thailand have drawn global attention for their rapid gains in achieving universal coverage. These reforms were an indigenous process not overtly linked to pressures from global institutions (unlike in the Latin American case).

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 scheme was a shift away from the earlier means-tested insurance program for low-income patients. Originally, participants in the scheme were charged a co-payment of THB 30 (approximately US\$1), but this payment was later abolished. 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 covers 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)" that worked to establish primary health centres in rural areas. Public investment in health also increased quite dramatically toward the end of this period and the government's share of total health expenditure increased from 47% in 1995 to 55% 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% of hospital beds were in the public sector by 1999 – a trend that has remained fairly constant with 77% 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. Further, while formally allowing private sector participation, the reforms delayed private sector entry pending the implementation of regulatory mechanisms. Finally when private providers were allowed to join the scheme their participation was limited by the prohibition on new private providers established after April 1, 2001 – as a way to avoid new opportunistic investors. Further, private practice by public sector doctors, though allowed, was minimized by providing hefty incentives to those who worked solely in the public sector (THB 10,000 in 2002) (Pitayarangsarit 2004).

There have been other important policy instruments designed to promote equitable service delivery, which accompanied the reforms. These include regulations that mandate three years of rural service for doctors and nurses, and a radical shift in funding away from urban hospitals to primary care across the country. The latter is credited with significantly controlling overall healthcare costs (Towse et al 2004).

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 has increased from 1.7% of GDP in 2001 to 2.7% 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% (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. This is a consequence of tough work conditions, poor job security and low pay. 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) draw 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 Salud* (SUS, the Unified Health System) in 1986 and by proclaiming in its 1988 constitution the government's duty to provide free health care for all, despite strong opposition from a powerful and mobilized private health sector. This progressive stance was the culmination of decades of mobilization in favour of better health care that was part of the struggle to restore democracy in Brazil.

The creation of the SUS resulted in the rollout of an impressive primary care scheme, which now covers almost the entire country (Paim et al 2011). Paradoxically, when in June 2013 millions came out to demonstrate on the streets of several Brazilian towns, one of the key concerns expressed was the lack of access to health care (Gupta and Crellin 2013). The problem is that while most primary health care 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,¹⁰ 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. An important part of healthcare services is contracted out to the private sector by the SUS, especially in the case of high-cost, tertiary care procedures. Primary care clinics and emergency units remain largely public, whereas hospitals, outpatient clinics as well as diagnostic and therapeutic services are in private hands (Paim et al 2011). A renewed public-private segmentation of health services has been created since the launch of the 1988 reforms whereby the public sector is responsible for high-volume basic health services as well as some high-cost services while the private sector covers the more profitable services (Elias and Cohn 2003).

This places several kinds of strains on the system. The private sector continues to ratchet up the cost of care it provides, and with health expenditure standing at 9% of GDP, Brazil now has one of the most expensive health systems in the world. No less than 57% of public funding goes to private care

(one of the highest in the Latin American region in terms of percentage of total health expenditure, even higher than in the United States). Such dominance of the private sector 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 can access through the public system (Paim et al 2011).

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 programs elsewhere. Historically the government's intervention in health care has largely been through direct provision of services, through a network of public hospitals, primary healthcare centres and dispensaries. This was supplemented by relatively small social health insurance schemes – the Central Government Health Scheme (CGHS) and the Employees State Insurance Scheme (ESIS) for workers in larger industrial units.

However, the public sector is in a state of neglect and has traditionally been poorly funded. Public expenditure on health stood at around 1.04% of GDP in 2012, one of the lowest in the world (Planning Commission 2013, 3). Consequently, large sections of the population depend on a poorly regulated private sector, increasingly dominated by networked corporate hospital chains, which have an infamous track record of unethical practices. With private health care accounting for 80% of outpatient and 60% of in-patient care, India is also one of the most privatized systems in the world (NSSO 2006). The program initiated in 2005 to strengthen the public health system, the National Rural Health Mission, has made some inroads but positive changes are still uneven and inadequate.¹¹

Out-of-pocket expenditure on health care (approximately 70% of households' health care expenses) contributes to widespread poverty in India (HLEG on UHC 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 (starting with the *Rajiv Arogyasri* scheme in the state of Andhra Pradesh in 2007). The *Rashtriya Swasthya Bima Yojana* (RSBY), a national, entirely public-funded scheme was launched in 2009, modelled on the *Arogyasri* scheme. The RSBY has been held out 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 (PHM et al 2011, 108).

The social health insurance schemes only cover for hospital-based care for a specific list of procedures. Patients are provided 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. For example, in the case of the *Arogyasri* scheme in Andhra Pradesh, the total payments to facilities accredited under the scheme from 2007 to 2013 amounted to INR 47.23 billion, of which INR 10.71 billion was paid to public facilities and Rs 36.52 billion went to private facilities (Yellaiah 2013, 14).

Beneficiaries are insured against a set of ailments that require hospitalization, but almost all infectious diseases that are treated in out-patient settings, such as tuberculosis which requires prolonged treatment, most chronic diseases (diabetes, hypertension and heart diseases) or cancer treatments that do not call for hospitalization, are excluded from coverage. In the case of *Arogyasri*, for example, the scheme draws 25% of the state's health budget while covering only 2% of the burden of disease (Purendra Prasad and Raghavendra 2012, 125).

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 2009-2010, direct government expenditure on tertiary care was slightly over 20% 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% (Reddy et al 2011, 13).

A common trend

The three countries, taken together, present some interesting commonalities when it comes to their UHC approach. While the settings are diverse, there is a similar persistence with private sector participation in provision of care, despite the fact that all are tax-funded health systems. In all 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. In spite of strong policies in favour of universal public health care (in the case of Brazil and Thailand at least), the neoliberal ethos appears too strong to shake off. In other words the three countries typify the kind of challenges that LMICs face while attempting to construct universal systems that borrow from the internal logic of UHC.

Conclusions

In this paper, we have discussed the genesis of UHC and how it builds on the notion of health systems as promoted by the World Bank and other global institutions: segmented parallel private and public systems, in which the poor are provided only 'basic services' by under-funded public facilities while the rich migrate to a burgeoning private system. The logic for UHC is driven by the need to secure pooled funds for health systems that are organized on market principles. The role of the state is increasingly that of a 'steward' and not of a provider of healthcare services. New management techniques are being introduced in order to accomplish this, based on the notion of a 'purchaser-provider' split. The state, in such a system, harnesses public funds and then as a purchaser of services makes these funds available for private capital to extract profits. At a global level, we are now seeing a convergence of health systems in the developed and the developing countries whereby health becomes a marketable commodity. North and South, countries are reforming existing systems and are moving away from solidarity-based health care to market-based provision of health services.

We have briefly looked at early (Chile, Colombia, Mexico) and more recent evidence (Brazil, India, Thailand) that shows how systems that are being built in the name of UHC, usually as an insurance-based model of fund pooling and increasing private provision, end up decreasing equity and efficiency in health systems. Our discussions lead us to conclude that the dominant UHC approach that is being promoted worldwide – based on 'universal' insurance – offers no proven advantage and indeed presents many disadvantages over a single public health system, funded by tax revenue, and offering universal and free access to health care. The latter continues to promise more equitable health outcomes, and it is more affordable for LMICs as it keeps investments and social control in public hands and limits administrative expenses (Laurell 2010).

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 interest of the people and made accountable. Peoples' movements and organizations have much to lose from the present drift legitimized by the UHC discourse. Historically, healthcare systems worldwide have been shaped by labour's fight for better conditions of living – 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.

Endnotes

- 1 Catastrophic expenditure on health care is defined as expenditure of a household on health care that exceeds 10% of its total expenditure. Out-of-pocket expenses mean expenditure on health care borne by households at the point of care delivery, and generally is an indicator that care delivery is not free or the costs are not covered by a reimbursement scheme – such as insurance of some kind, which may be publicly funded, co-funded by individual and social contributions, or entirely privately funded.
- 2 While most LMICs already had a significant presence of the private sector in health care delivery, the UHC model provided a framework for the incorporation of private providers in a planned manner.
- 3 By public services we mean services both publicly financed and provisioned.
- 4 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).
- 5 Privatization of public services in sectors as varied as electricity, water, telecom services, railways have all followed a pattern. The first step has been to disaggregate various roles that the state traditionally played. In the electricity sector, for example, it involved the ‘unbundling’ of different functions (generation, transmission and distribution).
- 6 Here we use the term ‘efficiency’ not in the way it would be used in a market environment, but as regards the returns achieved through investment in a public good.
- 7 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, for its part, was introduced (in the form of the National Health System) by the government in post-World War II 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).
- 8 The story of the privatization of NHS has been described in detail by Leys and Player (2011). The book details how global (mainly US-based) health management organizations, managed care providers, insurance companies and consultancy firms plotted in tandem with the British political class to bring down the edifice that was the NHS.
- 9 For a brief discussion on trends in Malaysia and Sri Lanka see, for example, Sengupta (2012).
- 10 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 modelled on the concept UHC. However, nomenclature notwithstanding, Brazil’s problems are very similar to those being faced by UHC models elsewhere.
- 11 For a detailed discussion on the Indian situation, see Sengupta (2013).

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