Utopian aspirations in a dystopian world: “Health for all” and the Universal Health Coverage agenda - an Introduction

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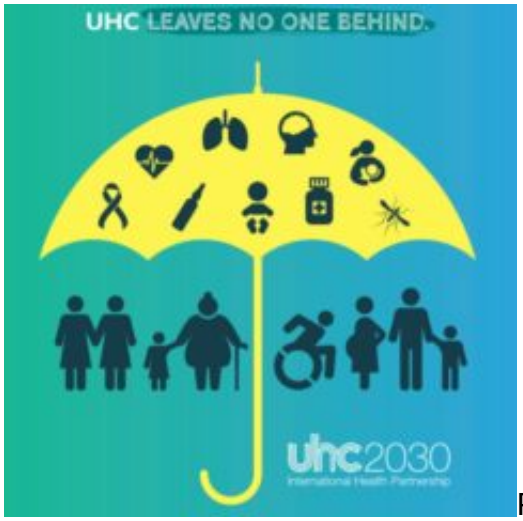

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“Health for All?” critically explores global moves towards Universal Health Coverage and its language of rights to health, equity, social justice and the public good. Highlighting emerging ethnographic and historical research by both young and established scholars, the series explores the translations and frictions surrounding aspirations for “health for all” as they move across the globe. The series is edited by Ruth Prince.

As the COVID-19 pandemic spreads across the world, drawing everyone into its orbit, whether through lock-downs, quarantines, curfews, fear of sickness, the experience of sickness itself or the death of loved ones, the argument for strengthening national health systems and creating truly universal, publicly-funded health services that reach and include national populations, has never been stronger (Yates 2020, Whittal 2020). In much the same way that the 2014 Ebola epidemic exposed the fragility of West African health systems, undermined by decades of structural adjustment and fragmented health funding, the COVID-19 pandemic is exposing the

ravages of austerity for health systems in countries like the UK, Spain and Italy, and the black hole that stands for public healthcare in the United States (Horton 2020, Holmes & Buchbinder 2020). The pandemic is also painfully exposing the human cost of inequality, as millions living in cramped accommodation, without access to water or sanitation, have little opportunity to follow social distancing rules, and as livelihoods dependent on daily income are threatened by emergency public health measures (Shoki 2020, Schmidt 2020). And it is not sparing the middle and upper classes: in many countries private health insurers are refusing to cover COVID-19 cases, throwing into relief the dependence of all but the wealthiest on (often fragile and under-funded) public healthcare systems; while, unlike in the Ebola epidemic, society's most privileged individuals no longer have the option of flying overseas for optimal medical care (Maja-Pearce 2020).

As COVID-19 creates medical and economic havoc the world over, it is highlighting the vital role of the state not only in public health and national healthcare systems but also in welfare and social protection. This is what the World Health Organization's pursuit of Universal Health Coverage (UHC), in its most ambitious iteration, calls for: the creation of strong, resilient public health systems ensuring access to healthcare for all, through publicly financed health services and systems of financial protection, where the state takes responsibility for ensuring access to healthcare for all those living within its jurisdiction, and where emergency preparedness and response functions are integrated with service delivery (Ngozi et al. 2018).

This series was conceived before COVID-19 appeared in the Chinese city of Wuhan. At the time of writing, governments in the global South that had been slowly making moves towards universal health coverage and experimenting with various models of financing health systems and strengthening primary health care (whether these materialised as a serious commitment or a performative spectacle) have suddenly, within the space of weeks, been forced to turn all their attention to containing the virus. Governments have introduced dramatic and wide-reaching measures, which now affect the lives of many millions of people the world over. They do this because they know that if the virus spreads too rapidly, few health systems will cope. This series on UHC turns our attention to these health systems – to the financing mechanisms and experiments, organizations and infrastructures that sustain or undermine them, to the health workers and the materials they work with, and the visions and aspirations for the future that they hold.

As a global policy that aspires to universal values of equity and social justice, which advocates state responsibility for healthcare and urges governments towards ambitious goals, which dares to speak about

'health for all' and introduces serious proposals for how to achieve it, UHC appears to many of its proponents as a practical utopia (Sen 2015). Yet this vision glosses over heated disagreements about the goals of UHC and diverse approaches for achieving it. The rest of this introduction discusses these contradictions – which have divided the global health community before COVID-19 and will probably continue to do so after it. As the study of UHC encompasses social and political, economic and financial, as well as health and medical practices, systems, structures and values, it offers fertile ground for critical engagements with the aspirations and contradictions of global health – even as the terrains on which it has been located and grounded are, as I write, massively shifting (Dalglish 2020).

Definitions and contradictions

Defined as ensuring that everyone can access affordable, essential, and quality health care without financial hardship (WHO 2010), UHC was described in 2012 by the former WHO Director-General Margaret Chan as "the single most powerful concept public health has to offer" (Chan 2012). Embraced by a multitude of actors beyond the WHO itself, in 2015, UHC became part of the Sustainable Development Framework. At the United Nations General Assembly in September 2019, member states issued a Political Declaration on UHC for the first time, committing their countries to the aim of realizing UHC by 2030 through the promotion of "nationally determined sets" of health services and medicines.

This apparent consensus obscures strong disagreements about UHC, captured in the use of the term "coverage" rather than "care." Since its launch in 2010, the WHO and the World Bank have focused largely on "coverage" in terms of financial protection and sustainable financing for healthcare, with debates about tax-based financing versus health insurance schemes, and experiments with different forms of the latter (Saksena et al. 2014). Quality of care has received much less attention, despite criticism from within the WHO and from organizations like Global Health Watch. It was only in October 2018, forty years after the Alma Ata Declaration, that the WHO reaffirmed its commitment to primary healthcare, arguing that UHC should be based on "strong, people-centered, primary health care" (Abadía-Barrero & Bugbee 2019). And despite the WHO's focus on "strengthening health systems", emergency response, surveillance and preparedness has not been well integrated into moves towards UHC (Ngozi et al. 2018).

Entitlements and obligations

The turn towards UHC revives a rights-based language of health, solidarity, inclusion and social justice. In doing so, UHC appears to

rebalance relations between the state, its citizens and other populations living within its jurisdiction, with their health as a matter of entitlement and obligation. Consciously echoing the language of Alma Ata ("health for all"), it marks a decisive move away from the cost-sharing policies advocated by the World Bank and IMF from the 1980s, which, as the Bank now recognizes, (continue to) push people further into poverty. Indeed, UHC appears to signal a new, more utopian, era of global health (Sen 2015), with a recognition that vertical disease programmes do not create more equitable health systems and that the state should take a leading role in ensuring equitable access to quality healthcare (Lancet 2012). But how radical is this move? Does advocacy for UHC represent new ways of thinking about health and development, poverty and redistribution, the state and citizenship (see also Ferguson 2015)?

As UHC has gained traction during the past decade, it has taken shape in a very different world from the 1970s (Prince 2017). In pre-COVID-19 Europe (who knows what will happen next?), welfare was being cut back and state services retrenched under austerity policies. Worldwide, resources are increasingly concentrated in the hands of the wealthy while public resources are dwindling (Wilkensen & Pickett 2009). Social inequality and exclusion have been rapidly growing, reaching levels not experienced since the 1930s. In this context, UHC, like the 'new welfare' of humanitarian and social assistance programmes in the Global South, has hardly posed a radical challenge to the status quo. There is a strong argument that these innovations are a cheap way of managing poverty, offering a biopolitics not of care but of 'bare life'. The fact that the World Bank has become an avid proponent of both UHC and Cash Transfer Schemes suggests that these are not incompatible with neoliberal policy goals (see Collier 2011). It is clear that UHC can serve competing social and political agendas (Funahashi 2016; Seo 2016; Kittelsen, Fukuda-Parr, & Storeng 2019) and it might not serve social justice ends after all.

The financialisation of health

UHC has also been taking shape in a world where market values dominate discussions about the financing of healthcare. While it is now recognized that poor people should not be financially burdened by health-care costs, other aspects of the Washington Consensus have remained intact. Governments have been encouraged to find ways of raising domestic revenue (by introducing new taxes, for example), but markets remain at the heart of attempts to "extend coverage." As political will for investing in public goods is dwindling and amidst the drying up of bilateral and multilateral development aid, global health is increasingly reliant on financial markets (Stein and Sridhar 2018).[1] Major global players such as the World Bank and the Gates foundation are turning their attention to new terrains of capital and to the potential of investor capital and "catalytic

capital" to finance public goods (Hunter and Murray 2019, Erikson 2015, Lachenal 2018).

The financialisation of global health refers to the "increasing role of financial motives, financial markets, financial actors, and financial institutions in the operation of domestic and international economies" (Epstein 2005, quoted in Stein and Sridhar 2018). Morality is not divorced from this market; financial markets are deemed to be "good for health, as they channel money into healthcare at unforeseen speed and scale, and because they discipline governments and companies around the globe into taking healthcare seriously" (Stein and Sridhar 2018). Left out of these ambitious claims are questions about what is funded, which populations, groups and individuals benefit, about "boom and bust cycles" inherent to financial markets, and about the unaccountable power of financial investors over the health of poor people (Eriksen 2015).

Digital technologies and data

A third game-changing arena is the role of digital technologies and of big data in healthcare, an arena populated by investor capital, global health funds, Silicon Valley tech companies, as well as experimental start-ups run by concerned data scientists amidst the global expansion of internet coverage and mobile phone use.[2] The oft-repeated mantra is that digital technology unlocks or unleashes potential, where private sector innovation (as opposed to state ineptitude) can be "harnessed" to transform access to health care and public health goods. To offer an example of how this plays out on the ground, in East Africa, NGOs partner up as "entrepreneurial organizations" with governments, global health funders, investors and digital technology companies to develop digital apps that aim to reach vulnerable populations. Here, digital technology offers to leap-frog developments, plugging gaps to offer or promise increased access to healthcare.

This techno-optimism may be well-placed – the field is rapidly developing—yet the essays in this series call for caution. Often, populations are approached as an emerging market, with digital technologies companies moving into what is seen as a lucrative field of healthcare (and welfare), further blurring boundaries between philanthropy, development, and capitalism (McGoey 2015; Webb 2016) with negligible improvements in public health (Al Dahdah 2019a). All too often, the hopes invested in technological fixes and "magic bullets", whether vaccinations, pharmaceuticals or oral-rehydration therapy, have proven fallible, as technology proves unable, by itself, to address the challenge of building up national healthcare systems. In the focus on increasing access and gathering data, "care" may be removed from sight (Adams 2016).

The future of public healthcare: COVID-19 and "health for all"

Taken together, these developments have huge implications for the future of (public) healthcare and raise important questions about new permutations between the state, financial capital, global health, data, and digital technology in the name of increasing access to services (see Breckenridge 2016; Al Dahdah 2019b). What this means for health equity in terms of access to healthcare, quality of healthcare, and the establishment of robust primary healthcare systems – the stated goals of UHC programme – remains an open question. The implications of UHC for citizenship – or more radically, for claims based on "presence" (Ferguson 2019) – and indeed, the form of the state, likewise need scrutiny. The COVID-19 pandemic is already radically shifting the grounds of these debates.

Is this new landscape extractive? Clearly, investors are motivated by profit motives and only secondarily by the "social good". And even if philanthropic motivations fuel such projects, such impulses should not be made the basis for the provision of public health goods (Quadeer and Baru 2016). Indeed, UHC appears not only easily coopted by neoliberal agendas (Birn 2016, Quadeer 2013) but deeply implicated in novel ways of performing power and exercising domination. Still, we should not lose sight of the fact that UHC does put a more progressive language into circulation, a language that is being used by citizen and pressure groups the world over to advocate for better health. The language of UHC underscores a move towards large-scale ambitions, an aspiration to the universal and a recognition of state responsibility for citizens' (and residents'?) health. Despite the seeming return to mid-20th century agendas, this is new territory, underlined by the language of innovation and experimentation.

Threaded through with paradoxes and contradictions, Universal Health Coverage offers anthropologists and historians fertile ground for research. Moves towards UHC offer important sites for examining issues of redistribution, inequality, and solidarity, ideals of the commons and the public good, how these are being debated, and how these debates might be inflected by past aspirations and experiences. Global discussions about UHC offer social scientists an opportunity to explore the social and political collectives forming around struggles for public health. Following UHC brings into focus digital technology, data, and financial capitalism and how these implicate the state, citizenship, inequality and political strategies for addressing poverty and exclusion. Finally, UHC allows us to pursue traditional themes in medical anthropology concerning access to health care, distributions of responsibility, and the experience of patients, while also pushing us toward new fields of inquiry, such as the emerging anthropology of mHealth (mobile health) and health insurance.

In this series, we invite potential authors to approach UHC ethnographically and historically, as a policy and as a set of aspirations; to explore how it has travelled and is translated, and the frictions, tractions and tensions that ensue. We seek essays that explore its imbrications with markets and states, technologies and data, with bodies and medicines, with politics and power, with health workers, civil servants, tech entrepreneurs and human rights activists, as well as with past aspirations and policies. We ask what a closer look at UHC – as both global and local, universal and experimental – might tell us about the world we live in, may be leaving behind, or are moving toward. As the world's attention is turned on the COVID-19 pandemic, it is important to ask what has become of these aspirations for universal health coverage. What will remain of government moves towards strengthening primary health care systems and increasing access to affordable services? Will these efforts gain renewed urgency, as they did in West Africa after the Ebola epidemic, or will they fade into the background, as financial crisis deepens and we head into a global economic recession? Whether the COVID-19 pandemic will lead to sustained state intervention into welfare and healthcare or further consolidation of financial capital, whether it will lead to serious redistribution or to business-as-usual, to resurgent forms of solidarity or to further nationalism and isolation, remains to be seen.

Amidst the waning of historicity, as our present is telescoped to the next day's infection numbers (or indeed the hourly figures flitting across our smartphone screens) and the future beyond COVID-19 appears alarmingly obscure, we need the sanity of a longer-term perspective, of a return to a forward momentum, of planning for a better future, one that we can build and act upon. Against the dystopian present and the "slow cancellation of the future" (Fisher 2014) as a horizon of possibility that the present pandemic appears to curtail, aspirations for universal healthcare and Universal Health Coverage are a necessary utopia, practical and within reach if we can recover a prospective time and muster a collective political will. While strikingly dissimilar in their outlook and their temporalities, the dystopian COVID-19 present and the utopian horizons of UHC do converge on one point: both draw our attention to fundamental questions about social justice and to the challenge that inequality poses to humanity and the social collective.

Notes

[1]See, for example, "Financing UHC in Kenya", a report by the SDG Partnership Platform, https://www.sdgphilanthropy.org/Financing-Universal-Health-Coverage-in-Kenya (accessed November 28th, 2019)

[2] Forthcoming pieces by Thomas Neumark, Marine Al Dahdah, and Ruth

Prince explore the role of digital technology in access to health care, Tanzania, Kenya, Ghana and India.

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