



**CENTER FOR GLOBAL
HEALTH DELIVERY**
HARVARD MEDICAL SCHOOL

PROCEEDINGS

Re-conceptualizing Health for All: The Alma-Ata Declaration and the Future of Global Health



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PROCEEDINGS

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Harvard Medical School Center for Global Health Delivery

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1 Introduction	11
1.1 Conference organization	12
1.2 Organization of the proceedings	12
1.3 Tribute to David Sanders	12
1.3.1 Sanders' work and legacy in the fight for health	12
1.3.2 Nutrition, health, neoliberalism, and transnational corporations	13
2 The roots of Alma-Ata and selective primary care	15
2.1 A double-truth doctrine? Primary health care between empire and emancipation	15
2.1.1 The paradox of Alma-Ata: NHS through a glass darkly	15
2.1.2 Alma-Ata's incoherence	16
2.1.3 Origins of the term "primary health care"	17
2.1.4 Alma-Ata's incoherence, revisited	18
2.1.5 A double-truth doctrine	20
2.2 Alma-Ata, an unfinished revolution in the history of global health?	21
2.2.1 Understanding Alma-Ata: health inequality and the agenda of health for all	21
2.2.2 An unfinished revolution?	22
2.2.3 Primary Health Care 4.0	24
2.3 Selective primary health care and equity: current relevance for global health	24
2.3.1 Selective primary health care: an interim strategy for disease control in developing countries	25
2.3.2 From the World Development Report on Health (1993) to the Millennium Development Goals	26
2.3.3 Global health improvements and remaining inequities	27
2.3.4 Achieving the Sustainable Development Goals and UHC 2030	28
2.3.5 Improving equity in health coverage	29
2.3.6 Relevance of Selective Primary Health Care to Universal Health Coverage	30
2.3.7 Making short shrift of primary health care: Tanzania, TB, and global health (1977-1995)	30
2.3.8 WHO, tuberculosis, and primary health care	31
2.3.9 WHO, the Union, and Tanzania	32
2.3.10 From Tanzania to global health science	33
2.3.11 Discussant remarks	33
2.3.12 Discussant: Suman Seth	33
2.3.13 Discussant: Anne-Emanuelle Birn	35

2.4 General discussion.....	36
2.4.1 Selective PHC, a stop-gap solution or a derailment of progress?	36
2.4.2 Importance of context in considering Alma-Ata and its legacy.....	37
2.4.3 Affordability of UHC and need for political commitment	37
2.4.4 On the need to bring the advancements of the human rights discourse to the forefront of global health action.....	38
2.5 The UN political declaration on UHC undermines health as a human right	38
2.5.1 The unfulfilled promise of Alma-Ata and the 2019 UNGA declaration on UHC.....	38
3 Politics of rights expansion	41
3.1 Milestones in the history of rights expansion	41
3.1.1 American Declaration of Independence	41
3.1.2 French Declaration of the Rights of Man and of the Citizen.....	41
3.1.3 Purna Swaraj.....	42
3.1.4 UN Universal Declaration of Human Rights	42
3.2 Three debates of rights expansion	43
3.2.1 Prioritization of rights	43
3.2.2 Positive versus negative liberties	43
3.2.3 Access versus outcomes	44
3.2.4 Impact of the debates on modern discourse about rights expansion and primary health care.....	44
3.3 Two alternative approaches for using a rights framework.....	45
3.3.1 Limitations of the equity approach	45
3.4 Pursuing global health through equity and empowerment models	46
3.5 General discussion.....	48
3.5.1 Driving the supports of transformation versus driving political outcomes.....	48
3.5.2 Transformation, evaluation, and prioritization	49
3.5.3 Equity, empowerment, and transformation.....	49
3.5.4 Global economic development, incentives, and rights protection	49
3.5.5 Multiplicity of conceptual models	49
3.5.6 The American Declaration of Independence, Alma-Ata, and ownership.	50
4 Health as a human right	51
4.1 Does the right to health make sense?	51
4.1.1 Successes and failures of Alma-Ata.....	51
4.1.2 Is a rights-based approach to health care sensible?.....	52

4.1.3 Is the “the highest attainable” standard of health helpful?	53
4.1.4 Should primary health care be the focus of health investment moving forward?.....	53
4.1.5 Moving forward with UHC	54
4.1.6 General discussion	54
4.2 Progressive realization of UHC and the right to health for all	56
4.2.1 The right to health for all.....	56
4.2.2 Progressive realization of UHC.....	57
4.2.3 Overall strategy and pathways to achieve universal health coverage.....	58
4.2.4 Unacceptable trade offs	59
4.2.5 Progress toward universal health coverage.....	60
4.3 The contributions of a human rights approach to achieving UHC.....	60
4.3.1 Contribution of the human rights model to UHC	61
4.4 Sexual and reproductive health rights: questions of justice and human rights.....	62
4.4.1 Quality in healthcare.....	62
4.4.2 Rights to sexual and reproductive health	63
4.4.3 Maternal deaths as an indicator of health services quality	64
4.4.4 Impact of respectful maternity care: results of a pilot project.....	65
4.5 Coverage, care, and changing perceptions of health in East Asia.....	66
4.5.1 The state of health coverage in East Asia.....	66
4.5.2 Dementia prevalence and care in China, Japan, South Korea, and Taiwan	67
4.5.3 Global narratives and literature on dementia.....	68
4.6 Friable concepts or imaginative failures? Ethnographic reflections on rights, equity, and solidarity in the contemporary US.....	69
4.6.1 Idioms of social justice mobilization for health	69
4.7 Discussant remarks.....	73
4.7.1 Discussant: Sarah Zaidi	73
4.7.2 Discussant: Eric Sawyer	74
4.8 General discussion	76
4.8.1 Prioritization, funding, and activism	76
4.8.2 UHC and the exclusion of non-citizens	79
5 UHC as universal health coverage versus universal health care	80
5.1 The value of caregiving	80
5.2 Universal health coverage versus universal health care: rethinking UHC	80

5.2.1 Widening inequalities in access and unmet need	81
5.2.2 Inefficiencies and the innovation paradox	81
5.2.3 Transforming health systems to achieve universal health care.....	82
5.2.4 Discussion	83
5.3 Interpretation and UHC	84
5.3.1 Human impact of UHC policies	84
5.3.2 Need for comprehensive health services at all levels	85
5.3.3 Government accompaniment instead of vertical funding	86
5.3.4 Model of national health reform	87
5.3.5 Liberation movements and global health	88
5.3.6 Discussion	89
5.4 Commercialization of health systems and the subversion of universal health care	90
5.4.1 Historical and ideological roots of universal health care and universal health coverage	90
5.4.2 From Alma-Ata to the commercialization: universal coverage or care? ..	92
5.4.3 Discussion	93
5.5 How PHC got lost in translation	94
5.5.1 Establishing the principles of PHC	94
5.5.2 From selective care to coverage in the modern era	96
5.5.3 Discussion	99
5.6 Discussant remarks	99
5.6.1 Discussant: Rob Yates	100
5.7 General discussion	101
5.7.1 Moral considerations and strategic approaches to advocating for global health	101
5.7.2 The shortcomings of political arguments for UHC	101
5.7.3 Activism, ideology, and the role of academia in bringing about change	102
5.7.4 Global challenges of aging populations.....	104
5.7.5 Foreign aid, privatization, and the technology-driven global health agenda	104
6 Reflections on health for all and paths moving forward	106
6.1 Closing remarks: Vikram Patel	106
6.2 Collaborative discussion regarding options moving forward	108
6.2.1 Colonial and neocolonial history in health	108
6.2.2 Framework to achieve justice.....	108

6.2.3 Creative strategies that challenge, transgress, and invert power	109
6.2.4 General discussion.....	109
7 References	113
8 Appendices	118
Appendix 1. Conference agenda.....	118
Appendix 2. Participant List.....	121
Appendix 3. Lifesaving and low-cost technical interventions used in USAID’s Child Survival & Health Grants Program.....	123

Abbreviations

AIDS	acquired immune deficiency syndrome
BCG	Bacillus Calmette–Guérin
BMRC	British Medical Research Council
CDC	Centers for Disease Control and Prevention
DOTS	directly observed treatment, short-course
EPI	WHO's Expanded Programme on Immunization (EPI)
GDP	gross domestic product
HIV	human immunodeficiency virus
HPV	human papillomavirus
LIC	low-income country
LMIC	low- and middle-income country
MDG	Millennium Development Goal
NCD	noncommunicable disease
NGO	nongovernmental organization
NIEO	new international economic order
PEPFAR	US President's Emergency Plan for AIDS Relief
PHC	primary health care
SDG	Sustainable Development Goal
SRH	sexual and reproductive health
TB	tuberculosis
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

1 Introduction

On October 25 and 26, 2019, the Harvard Medical School Center for Global Health Delivery–Dubai hosted a conference on “**Re-Conceptualizing Health for All: the Alma-Ata Declaration and the Future of Global Health**” in Cambridge, Massachusetts, US. The conference convened experts from diverse fields, including the social sciences and medical history, in order to elucidate the contexts and motivations surrounding the events of Alma-Ata. Co-sponsors included the Harvard University Asia Center, the Center for the History of Medicine at Countway Medical Library, the Harvard University Center for Middle Eastern Studies, the Davis Center for Russian and Eurasian Studies at Harvard University, the Harvard Global Health Institute, and the Middle East Initiative at the Harvard Kennedy School. More information about the Center for Global Health Delivery-Dubai is provided in Box 1-1.

The objective of the conference, explained Center director Salmaan Keshavjee, of Harvard Medical School, the Brigham and Women’s Hospital, Partners In Health, and Advance Access & Delivery, was to explore how primary health care (PHC) and universal health coverage (UHC) can be reimagined through the lessons of history—not to litigate the past, but to understand and learn from it. Forty years after the “Health For All” Declaration of Alma-Ata, the solutions and ideas that arose from the post-colonial context of the 1970s remain topics of intense debate. Concepts such as human rights, cost-effectiveness, and neoliberalism all continue to impact global campaigns for primary health care (PHC) and universal health coverage (UHC), including. The conference, said Keshavjee, was intended to inform a discussion of the modern era of global health care delivery and the path forward.

Box 1-1. Harvard Medical School Center for Global Health Delivery-Dubai

Harvard Medical School’s mission is to nurture a diverse, inclusive community dedicated to alleviating suffering and improving health and wellbeing for all through excellence in teaching and learning, discovery and scholarship, and service and leadership. The Center contributes to this mission through its focus on the last mile of health care delivery. Research, medical, education, and training activities at the Center are aimed at addressing some of the most pressing health challenges in the region and at improving health care delivery systems and patient outcomes for diseases prevalent in the United Arab Emirates, Middle East, North Africa, and neighboring regions in Africa, Asia, and Europe. The Center’s areas of focus are diabetes and obesity, surgical care, infectious disease, and mental illness, with special consideration granted to projects that focus on the health of women and children. Cooperative and faculty research awards offered at the Center link Harvard researchers with local practitioners and scientists working to ask important questions and generate new knowledge around the myriad delivery gaps being faced. The Center has hosted workshops, symposia, and major courses for more than 2,500 attendees from more than 100 countries, with accompanying proceedings and policy briefs. The goal of the Center’s work is to affect meaningful changes through two-pronged approach of accompaniment and praxis—that is, the process by which a theory, lesson, or skill is enacted, embodied, or realized.

1.1 CONFERENCE ORGANIZATION

The conference took place over two days, comprising four sessions and one keynote address:

- Session 1: The Roots of Alma-Ata and Selective Primary Care
- Keynote address: Politics of Rights Expansion
- Session 2: Health as a Human Right
- Session 3: UHC as Universal Health Coverage versus Universal Health Care
- Closing session: Reflections on Health for All and Paths Moving Forward

Sessions 1 and 2 each comprised several presentations, followed by remarks from discussants and group discussions. The keynote address and Session 3 were followed by group discussions with the audience. The closing session comprised concluding remarks followed by a collaborative discussion with the audience and participants. Additional short discussion and question-and-answer sessions were held throughout the conference. The conference agenda and list of participants are provided in Appendix 1 and Appendix 2.

1.2 ORGANIZATION OF THE PROCEEDINGS

These proceedings are organized into six chapters:

- Chapter 1: Introduction
- Chapter 2: The roots of Alma-Ata and selective primary care
- Chapter 3: Politics of rights expansion
- Chapter 4: Health as a human right
- Chapter 5: UHC as universal health coverage versus universal health care
- Chapter 6: Reflections on health for all and paths moving forward

1.3 TRIBUTE TO DAVID SANDERS

David Sanders, a clinician, professor, and health activist, passed away shortly before the conference, at which he had been scheduled to speak. His life's work was deeply connected to the issues at hand (see Box 1-2). In tribute to his life and in his memory, his colleague and friend, Sunanda Ray, professor of public health medicine in the department of community medicine at University of Zimbabwe College of Health Sciences, spoke about his life, the impact of his efforts in the fight for health, and other topics about which Sanders was passionately concerned.

1.3.1 Sanders' work and legacy in the fight for health

Sanders published numerous books and over 200 scientific articles throughout his career, said Ray, and was a leader in the People's Health Movement. In a paper published shortly before his untimely death, he criticized the Declaration of Astana by the Global Conference on Primary Health Care in October 2018, pointing out that it paid little attention to the drivers of ill health and inequity, giving no hint of the need for a new global economic order despite the stark social inequalities and concentration of wealth.¹ Sanders was insistent that PHC requires an equitable global economic system and that even well-designed health systems have little influence on the economic forces that shape their operation and their ability to improve health.² A proponent of the social movement for health, he wrote that "the revitalization of primary health care and progress toward health equity are unlikely without strong regulation of the market. The further development and strengthening of social movements for health will be key to successful advocacy action."

Ray discussed her work with Sanders during a 2018 cholera outbreak in Zimbabwe. Zimbabwe's government had expressed pride that this outbreak did not result in many deaths, as had a previous outbreak of the disease in 2008. This "success" was attributed to the functionality of

1 Sanders et al 2019

2 Sanders et al 2011

Zimbabwe's public health services. Still, Ray and Sanders argued that the epidemic was avoidable altogether. It was caused by neglect of Zimbabwe's water supply, and highlighted the need for macroeconomic reform. The spread of infectious disease was just one episode in the cycle of disease and neglect commonly encountered in many places around the world, including Africa. Many countries still rely on colonial-era water infrastructure, and little consideration is given to protecting the water supply. In such settings, a wealthy urban-dweller may live next door to a person who uses an outhouse. For instance, in Botswana, an upper-middle-income country, many people in urban areas still use toilets that are not connected to sanitation systems. Sanders was passionate about these issues, said Ray. He spoke out about the need for macroeconomic reform during the era of the millennium development goals, pointing to considerable evidence demonstrating the contribution of improved income, environmental factors, and social factors to health improvement.³ Sanders argued that while there has been short-term improvements in health, without macroeconomic reforms, this progress will not be sustained.

1.3.2 Nutrition, health, neoliberalism, and transnational corporations

Sanders, said Ray, was greatly concerned about the relationship between neoliberal economic policies and nutrition. The global diabetes epidemic is being driven by type 2 diabetes, which is deeply rooted in poor nutrition. Since the 1980s, the globalization of food and agriculture has accelerated with many countries lowering barriers to trade and investment, reducing subsidies on inputs to agricultural production, and dismantling state food marketing monopolies, including the public holding of food stocks. Rising food prices have led to growing food insecurity and malnutrition, evidenced by high rates of stunting and micronutrient malnutrition. The combination of intensified global trade, trade liberalization, and strengthened

property rights has given increasing power to the corporate food industry and undermined food security in many countries. Food-related transnational corporations (TNCs) account for a substantial share of the world's largest 100 TNCs— between 1990 and 2001, their foreign sales rose from US\$88.8 billion to US\$234.1 billion, with total foreign assets rising from US\$34.0 billion to US\$ 257.7 billion. These TNCs dominate the whole food supply chain, including seeds, fertilizers and pesticides, production, processing, and manufacturing of foods, and marketing and sales of these products to consumers. TNCs are now leading traders of food, said Ray. Forty percent of food imports and exports are between and within TNCs.

These trends, together with the recent sharp increase in the proportion of US maize being used for biofuels and the increasing impact of climate change, are primarily responsible for recent critical food shortages in many poor countries. Furthermore, foods sold by TNCs contain ingredients which are drivers of diabetes and obesity, such as palm oil, soy oil, and high-fructose corn syrup. Dominance over food markets by TNCs is especially apparent in Africa, Ray explained. Fried chicken, soft drinks, and other non-traditional foods have become the meals of choice for special occasions and treats. As people gain access to foods sold by TNCs, they are increasingly exposed to the health risks associated with these consumption items. Overweight and chronic disease in rural South Africa has increased in recent years; one study of the rural black population from Limpopo Province found that 51% of female participants were overweight or obese, over 8% of participants had been diagnosed with diabetes, and over 20% of participants were found to have hypertension.⁴

Sanders, Ray explained, was a strong advocate of one solution to these challenges: increasing the capacity and responsibilities of community health workers. Standard models of health care assume that it will be dominated by physicians, and reliance on community health workers can

³ Sanders 2004

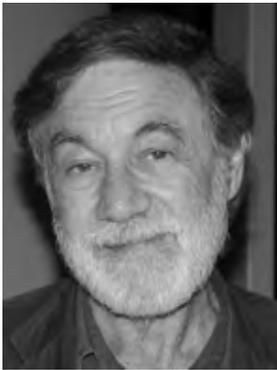
⁴ Alberts et al 2005

be a source of concern. Ray suggested that these concerns may be attributed either to questions of the competence of community health workers or to the desire by physicians to protect their professional interests and territories. A trial in Tigray, Ethiopia, trained local coordinators to teach mothers how to administer antimalarials in home settings.⁵ The intervention showed a 40% reduction in under-5 mortality. Furthermore, a meta-analysis of community-based trials of pneumonia case management suggests an overall reduction of mortality by 24% in neonates, infants, and preschool children.⁶ Currently, 29

countries in Africa allow community health workers to administer antibiotics for pneumonia. Ray said that the spread of antibiotic resistance in these settings is being driven by inappropriate prescribing on the part of physicians, not inadequate care by community health workers.

Sanders helped found the People's Health Movement, said Ray, because he believed that these kinds of health issues must be addressed by civil society. Civil society organizations must address health problems and challenge the market systems that promote ill health.

Box 1-2. David Sanders (1945-2019): An inspiration in the struggle for health for all



David Sanders trained in medicine in Zimbabwe and in pediatrics and public health in the UK in the 1960s and 1970s. In 1993, he established the master's in public health program at the University of the Western Cape School of Public Health and served as the program's founding director; he held this position until 2009. Since its founding, the University of the Western Cape School of Public Health has become the leading institution in public health education research in South Africa and Africa, taking in students from almost 20 African countries and India. Sanders' 35-year career in Zimbabwe and South Africa spanned multiple disciplines, including public health, health and development, child health, nutrition, primary health, and human resource development. From 1980-1989, he was responsible for designing and coordinating a large rural health program in Zimbabwe, which influenced and modeled the implementation of post-independence policies based on PHC. During this time, he initiated and chaired an internationally recognized multisectoral national program addressing child malnutrition. He received numerous designations and served many positions throughout his career. In 2005, he was the Heath Clark Visiting Lecturer at the London School of Hygiene and Tropical Medicine, and he was an Honorary Professor at that institution from 2005 to 2007. He served as a Visiting Professor at Charité–Universitätsmedizin, Berlin as well as at the Centre for International Health, University of Bergen, Norway. In 2013, he was appointed an Honorary Professor in the department of paediatrics and child health, faculty of health sciences, UCT and as Professor in the School of Medicine, faculty of health sciences, Flinders University of South Australia.

⁵ Kidane and Morrow 2000

⁶ Sazawal and Black 1992

2 The roots of Alma-Ata and selective primary care

This chapter summarizes the conference session on the roots of Alma-Ata and selective primary health care. It featured presentations that examined the incoherence and historical contexts of Alma-Ata that shaped PHC, the revolutionary aims of Alma-Ata, the emergence of selective PHC as an approach to fulfilling those aims, and the politics and conflicts around global TB care that eventually led to the transformation of the model for global health policy. The session's discussants considered the complex historical and contextual presuppositions of these presentations, highlighting both the presenters' focus on policy over the knowledge that informed those policies and the contextual deficits in the presenters' perspectives on Alma-Ata and WHO. During the discussion, participants explored whether selective PHC was a stop-gap solution or a diversion that represented the undermining of progress, the significance of the context of Alma-Ata and its legacy, the question of affording UHC and the need for political commitment, and the value of conceptual advancements in the human rights discourse since Alma-Ata for taking action on global health.

The first session of the conference was moderated by Allan Brandt, professor of the history of science and Amalie Moses Kass Professor of the History of Medicine at Harvard University and Harvard Medical School. He opened the session by underscoring the importance of reflecting on the history of Alma-Ata in a way that is accompanied by consideration of the progress that has been made since that historic declaration in terms of health status, health disparities, health systems, and human rights. He noted that without a commitment to studying the past, it is impossible to develop a path forward. The session gathered diverse speakers to offer their reflections on this history with the intent of informing action in the present to promote the ideal of health for all.

2.1 A DOUBLE-TRUTH DOCTRINE? PRIMARY HEALTH CARE BETWEEN EMPIRE AND EMANCIPATION

Aaron Shakow, director of the Initiative on Healing and Humanity at the Center for Global Health Delivery, Harvard Medical School, explored the incoherence of the Declaration of Alma-Ata and described the motivating ideas and historical contexts that contributed to this incoherence. He discussed the origins of the concept of "primary health care" and described how Alma-Ata's incoherence parallels the historical trajectories of colonialism. Finally, he considered how the use of a "double-truth" doctrine in global public health has been used to maintain a double standard in the quality of health care services delivered.

2.1.1 The paradox of Alma-Ata: NHS through a glass darkly

Shakow opened by connecting the circumstances of "Brexit"—the UK's withdrawal from the European Union in 2020—to the Alma-Ata Declaration and the future of global health. He pointed out that the era of decolonialization did not actually end in the 1960s and 1970s. In fact, the colonial era may only now be coming to an end after 500 years, as England may soon set Ireland free—at least in terms of tariff regimes. This transition is being led not by the political left, who have consistently ratified colonial and neoliberal policies in order to level labor and living standards around the world. Rather, this radical devolution seems to have been a special project of billionaires in England, America, and elsewhere who are seeking to evade the application of labor and public welfare standards. The Brexit that was supposed to save the UK's National Health Service (NHS) by excluding migrants from former territories now threatens to cut off the NHS's supply chain.

These developments, Shakow observed, reflect a devolution that first visible in post-colonial states. The agenda of primary healthcare

at Alma-Ata, Shakow observed, highlighted a paradox that he characterized as “NHS through a glass darkly.” States like India, Malaysia, and Sierra Leone construe health care as a basic right of citizenship; Sierra Leone even went so far as to name its government biomedical institutions “national health services.” This parallel was encouraged by American politicians such as US presidents Roosevelt, Truman, and Kennedy. However, once Sierra Leone gained independence in 1961, the UK labor government of Harold Wilson refused to forgive millions of pounds in debt taken out decades before by the British colonial office, because the government needed every farthing to keep NHS solvent. Thus, Sierra Leone’s NHS was a stillborn mandate, even in a decade when its economic and political growth were steady. The public health implications of these events were reported with frustration and alarm each year by the Sierra Leone’s representatives to the World Health Assembly (WHA). No analysis has been conducted for Sierra Leone or other African nations that is comparable to Utsa Patnaik’s published estimate that British colonialism siphoned \$45 trillion from India between 1765 and 1979; nonetheless, it is clear that the geographical imbalance of the welfare state owed much to the political economic relationship that preceded decolonization.⁷ PHC was supposed to be part of the new international economic order (NIEO), which was described by the World Health Organization (WHO) in 1979 as “a state of internationally just redress of the present imbalances between the developing and the affluent countries [that was] to be achieved by means of a series of reforms aimed at improving the lot of developing countries.”⁸ But a meaningful implementation of NIEO would have required something akin to reparations. Instead, the reality of NIEO was quite different, between the burdens of the domestic welfare states in former colonial powers and the disinterest of Western bankers in wiping anything off their ledgers. These circumstances were exacerbated by the impacts on the developing world of two oil shocks and the servicing of commercial debt that had, in some

cases, been assumed at the explicit recommendation of the World Bank and WHO to fund health services expansion after Alma-Ata. In light of these factors, Shakow argued that in retrospect, the vision of PHC expressed at Alma-Ata was counter-revolutionary, rather than revolutionary.

2.1.2 Alma-Ata’s incoherence

Alma-Ata held off demands for real international social change—or at least it accommodated a patronage system that was not prepared to address those demands—and the failure of “health for all” as the spirit of social change owed substantially to the incoherence of the Declaration’s framing concept, Shakow contended. Alma-Ata’s references to PHC invoked fashionable language of space-age welfarism, but they were actually a particularly unwieldy portmanteau, fusing a concept of “primary care” that had been elaborated in the 1960s by health economists in affluent countries who were attempting to limit the use of expensive hospital services with the model of dispensary-based “basic health care” that was common in many colonial settings. The adoption of jargon from developed economies was not benign. On one hand, it helped to formalize a global “separate-but-equal” doctrine according to which primary health care meant different things in different places. On the other hand, it exported to impoverished communities a host of neoliberal ideals that had become prominent in wealthier countries during the 1960s as counterweights to health sector expansion: human capital, consumer choice, and cost-effectiveness. These strategic missteps of the global PHC campaign serve as a cautionary tale for advocates of UHC.

Stripped of superficial and often contradictory rhetoric, PHC, as described at Alma-Ata, was little advanced from the basic health services agenda mandated by the WHO executive board in 1971, said Shakow. That agenda was, in turn, a restatement of principles that had been pursued by WHO since the early 1950s and by the League of Nations health organization, which ultimately derived from colonial insti-

⁷ Cooper 1996; Nielsen 2019

⁸ Pan American Health Organization and World Health Organization 1979

tutions.⁹ In its tolerance for a sharply limited menu of health interventions, justified on the promise of comprehensive services later, the WHO agenda of PHC was explicitly calling upon the colonial discourse of progressive realization, which was later embedded in international treaty law. These essential continuities are why attempts to realize Alma-Ata's Declaration quickly fell back on three familiar health system elements: 1) institutional (the village health center), 2) occupational (the community health worker), and 3) subjective (human capital).

2.1.3 Origins of the term “primary health care”

Shakow traced the origins of the term “primary health care,” which was described by Paul Starr as, “the protagonist in a pitch battle against health sector inflation.”¹⁰ By Starr's account, the health system's focus on medical research and hospital construction after the World War II was unbalanced and became increasingly costly and irrational. He wrote that what made the system unbalanced was its failure to provide for primary care. The main problem with this story is that the concept of PHC did not exist for more than a decade after 1945. In 1920, Bertrand Dawson called for the construction of primary health centers in the UK, but this concept failed for largely sociological reasons. Primary health centers did, however, appear during this period in Latin America and colonial Asia and Africa. It must be noted that in these particular institutions the use of the word “primary” was in reference to the institution itself, not a reference to a kind of service, practice, or care. The services on offer at primary health centers in Hungary, India, and Chile were referred to as “basic” health services. The context in which “primary health care” arose in wealthy countries was, paradoxically, the sudden disappearance of the jack-of-all-trades approach to medicine after World War II.

Shakow explained that as this shift became more pronounced, Kerr White, a health economist at the University of North Carolina, was

awarded a grant to study hospitals and medical facilities. He analyzed patient referrals from the shrinking contingent of general practitioners to specialists at medical centers and concluded that patients may be a more relevant primary unit of observation than diseases, visits to health centers, or admissions.¹¹ Surprisingly, he discovered that patients were often referring themselves—rather than being referred—to specialists, for what he called “primary continuing medical care.” This was the genesis of term “primary health care” White complained that academic medicine and public health were having no impact on arrangements for health care delivery to consumers. Rather than being concerned with the substantive problems of medical care, these sectors were concerned with the distribution of health care and the norms and ethics of the health care professions. White was explicitly focused on patients as consumers; thus, patients were his central unit of observation because they define the primary unit of illness by arriving at the tertiary care hospitals to consume its services. White was dismissive of the social responsibilities with which academic medicine was concerned and instead proposed a cybernetic, demand-driven health care system model. The functional aspects of this model were remarkably similar to the neoclassical model of the market that was being conceptualized at the time by Theodore Schultz, Gary Becker, Kenneth Arrow, and Selma Mushkin.

White was focused on establishing a new economic discipline: primary care, using consumers as the primary unit of observation, was the epistemic field in which consumption by these units took place. But despite his subsequent claims, the immediate impact of this abstract concept was somewhat secondary on the practice of caregiving. Only after Medicare began to unify the fragmented American health system, and discipline the forces that were profiting from it, did primary medical care emerge in a manner that was only tangentially related to White's analysis and was clearly the outcome of parochial interests. In 1966, for instance,

⁹ Packard 2016

¹⁰ Starr 1982

¹¹ White et al 1996

the American Medical Association reported on supply functions rather than demand functions. It held that “a primary physician, rather than a patient, was the basic unit of observation and this individual or unit was defined as the provider of comprehensive and continuing health care.” That was what was provided by the primary physician—comprehensive and continuing healthcare. In the early 1970s, state health officials reported both a consensus regarding serious deficiencies in the delivery of primary care and a lack of consensus on the meaning of PHC. The lack of consensus regarding the meaning of PHC emerged as a struggle over the

good, said Shakow. In competition for health care dollars, every stakeholder wanted to be “primary.” Around 1973, the health system in the US finally reached equilibrium, which was symbolized by the passing of the Health Maintenance Organization Act. At this time, the concept of primary care coalesced in the US. It described institutions where patients could access treatment for a comprehensive list of health issues within a comfortable travel time and with minimal inconvenience. As the first link in the referral chain, PHC was also designated, not coincidentally, as the pinch point for the rationing of care.

Box 2-1. Primary Health Care as Defined at Alma-Ata

“Primary health care is *essential health care* based on practical, scientifically sound and socially acceptable methods and technology *made universally accessible* to individuals and families in the community through their full participation and *at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination*. It forms an integral part both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. *It is the first level of contact* of individuals, the family and community with the national health system *bringing health care as close as possible to where people live and work* and constitutes the first element of a continuing health care process.”

2.1.4 Alma-Ata’s incoherence, revisited

Shakow returned to Alma-Ata’s conception of PHC. As shown in Box 2-1 above, the Alma-Ata Declaration defined PHC in a familiar way: “the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work.”¹² However, the Declaration of Alma-Ata added that PHC is “essential care,” indicating that there was a certain set of services that were being pitted against other services that were not essential. In this sense, Alma-Ata’s definition of PHC was antithetical to the concept of primary care as comprehensive that had evolved in the US and the UK in the 1960s. Alma-Ata called

for these essential services to be made universally *accessible*, rather than to be universally *provided*, leaving a gaping hole in the Declaration’s promise of universality. The Declaration also maintained that the costs of these essential services must be affordable for communities and countries to maintain at every stage of development. This clause not only embedded the inevitable double standards associated with progressive realization into the definition of PHC itself, but it also implied an allergy to recurring costs that ruled out all but the simplest medical procedures. This implied that the source of revenue for PHC should be found within the boundaries of the villages, neighborhoods, and nation—not outside of them. This implicit financial restriction became overt nine

¹² World Health Organization 1978a

years after the Declaration of Alma-Ata, when a policy of community financing was announced at the annual meeting of WHO's African Regional Committee in Bamako, Mali. This policy seemed to openly contradict the official Alma-Ata meeting report, which said that individual payment on a fee-for-service basis is not a solution that could be widely applied. Nonetheless, the Declaration's references to the community as a key source of financing were couched as part of then WHO Director-General Halfdan Mahler's fashionable commitment to decentralization and left the possibility wide open: "members of the community can contribute financial and other resources to primary health care." In a passage in the report on local participation, community members were asked to contribute their own resources in cash and kind in order to develop PHC in accordance with the program they had worked out.¹³ Community members were asked to contribute. A WHO/UNICEF report on alternative approaches to basic health needs included a case study from Nigeria that described a revolving drug fund just like the ones that were mandated at Bamako, Mali.¹⁴ Moreover, in WHO's elaboration of the financing issues associated with PHC published shortly before the Alma-Ata conference, clinics at the village level were encouraged to charge small fees for drugs and governments were told to find new types of official institutions through which health care could be cooperatively developed with partial financing coming from the local people. They cautioned against government and international donor exploitation of this local participation, or "self-reliance." However, it was clear that if the Declaration of Alma-Ata's invitation to channel increased technical and financial support into primary care did not materialize, then these small fees would become increasingly central to the success of the larger enterprise.

A close reading of WHO literature from around the time of Alma-Ata reveals two distinct forms of incoherence, said Shakow. On one hand, PHC was a hodgepodge of concepts related to health at the community level, several of which were

incompatible. He pointed out that the vagueness and variability of WHO and UNICEF definitions of PHC were criticized sharply by a Tanzanian representative at WHO executive board meetings in 1977. The representative expressed hope that the Alma-Ata conference would clarify the definition of PHC, but the incoherence persisted. On the other hand, the aspects of Alma-Ata that were clear, which all related to the basic health care agenda, placed far too much of the burden of national health sector development on village communities, leading to a deep strategic incoherence. This feature became increasingly pronounced after the Joint Report on Alternative Approaches To Basic Health care, which resulted in villages frequently bearing the costs of care.¹⁵ Shakow argued that both of these missteps resulted in significant measure from the haphazard attempt to rebrand the basic health care agenda, as it evolved between the 1952 WHA discussions on health protection in a local area and the 1975 report on basic health care in which WHO's definition of PHC was first laid out. The Alma-Ata conference report stated defensively that PHC means much more than the mere extension of basic health care services, yet its attempt to marry a model of comprehensive care to a limited health systems model was bound to collapse into the simpler version. It was fundamentally incompatible with the brief list of basic procedures which could be undertaken by minimally trained and often underpaid community health workers under the WHO and UNICEF "health for all" banner. The collapse, however, was frequently chaotic. Because WHO and the World Bank had encouraged countries to take out commercial debt as a financing strategy for PHC, these deficiencies exacted a profound social cost. Here, the paradox lies in the fact that WHO had segregated the concept of PHC, but the dissemination of the terminology nonetheless traced the globalization of health policy networks. These networks have been explored by Kelly Lee, Marcos Cueto, Vincanne Adams, and others. To illustrate these paradoxes, Shakow presented a photograph of Ted Kennedy seated next to Half-

13 World Health Organization 1978b

14 Djukanovic et al 1975

15 Djukanovic et al 1975

dan Mahler. Kennedy was the architect of several unsuccessful attempts to realize what was already by then a 50-year-long campaign for national health insurance in the US. Within a few years of its founding, WHO was filled with health economists who had cut their teeth on attempts to scale back universal access to health care in Britain and the US. For instance, Brian Abel-Smith, who published one of the first cost studies of NHS in 1956, played a key role in developing the austerity plank of WHO's PHC system platform, which emphasized community financing and promoted cost-benefit studies and other systems analysis approaches.¹⁶ This was the subject of a special study group that published its report well in advance of the Alma-Ata Declaration. Shakow noted that in the US government's Africa strategy document of 1979, WHO's PHC approach was endorsed specifically because it "appear[ed] to be the most cost-effective means of applying US resources." Mahler had become a proponent of systems analysis as the head of the organization's tuberculosis (TB) program in the 1960s. In 1967, he invited Martin Feldstein, a prominent American backer of rational choice theory and systems analysis in health care, to visit India and make a prescription for its TB programs.¹⁷ Feldstein's analysis, which was published by WHO shortly after Mahler's appointment as director-general in 1973, contributed to a notably austerity-minded revision of the organization's subsequent TB policy a year later.

The significance of these professional and intellectual associations is clear when considered alongside an examination of the proceedings and membership of the WHO's executive board, which included high-ranking health officials from developed countries, if not health ministers themselves. WHO dues and extraordinary contributions were commonly a line item in national health budgets, creating the perception—if not the reality—of a zero sum. For instance, as Canada and Australia embarked on a dramatic expansion of their health systems in the 1950s, their board members intervened repeatedly to limit WHO spending on its TB program. Shakow reiterated the less direct but still

suggestive coincidence of NHS's expansion in the 1960s and the offloading of colonial-era debt obligations by the Wilson government. This was the moment at which the NHS had developed a mania for cost-benefit analysis due, in part, to the fact that the system's annual costs had proved to be more than three times larger than the £95 million that had originally been estimated for England and Wales in 1946. "The real danger to the social services comes from the risk of bankruptcy," stated the chancellor of the Exchequer in 1952. Shakow returned to his observation that the fundamental financial injustices of the colonial era were never addressed, the deeply intertwined nature of global health policy and financing meant that poor countries had a line item in a budget battle that they could never win. Without a secure internal tax base and their debt obligations swollen by late colonial expenditures, the national health services of poor nations would always be "basic" and never "primary." This reality quickly became clear in the aftermath of the WHO/UNICEF PHC campaign.

2.1.5 A double-truth doctrine

The title of Shakow's presentation, "a double-truth doctrine," makes reference to a medieval philosophical tradition that used esoteric language in a way that the masses were intended to read one way and the initiates were to read in another. This practice was dramatically rejected in the 18th century by egalitarians like Condorcet, who rightly deemed it anti-democratic and unacceptable in democratic discourse. The question of why Mahler and colleagues adopted such a disparate definition of PHC at Alma-Ata is worth further archival research. On first glance, it seems plausible that the jargon was originally borrowed, because it allowed advocates of health care expansion in the developing world to leverage existing budget allocations for PHC in donor countries. A darker reading suggests that this ambiguity allowed officials to promote half measures in austerity budgets as instruments of liberation. This calls into question whether Mahler was a neoliberal agent or

¹⁶ Abel-Smith and Titmuss 1956

¹⁷ Feldstein went on to become the chairman of Ronald Reagan's council of economic advisors and George W. Bush's point person on social security privatization.

well-meaning. In other words, was Mahler trying to upend the state-based system of health care in favor of an unregulated world market, or was he trying to preserve the state system in very inimical circumstances? To answer this question, Shakow offered his own definition of a neoliberal as someone who tolerates a double-truth doctrine and lays claim to egalitarian principles, but is tolerant of those principles being applied differently in different places—that is, a double standard. The neoliberal double-truth doctrine is in many ways an explicit continuation of colonial policy. He foreshadowed Norheim’s presentation on progressive realization by pointing out that one of the most prominent early uses of the term “progressive realization” before the post-WWII period—when it became a liberal byword—was in the Montague Declaration of 1917, which stated that British policy in India was one of “progressive realization of a limited national autonomy.” Shakow reframed this as “basic sovereignty, not comprehensive primary sovereignty” to highlight the ideological parallel between colonial-era diplomacy and global health policy after World War II.

Because of UNICEF and WHO’s double-truth doctrine, PHC was selective from its inception, but Shakow was hopeful that the concept might perhaps be recovered. Many dedicated practitioners courageously attempt to do so every day, but PHC is now freighted with decades of disparate treatment. He suggested that advocates of global health equity may be better served by abandoning the concept entirely in favor of focusing instead on the specifics of universal and comprehensive health care, coupled with a clear-eyed political strategy for overturning the structures of power that prevent its realization. Whether the same calculation also applies to the current campaign for UHC remains to be seen, he concluded.

2.2 ALMA-ATA, AN UNFINISHED REVOLUTION IN THE HISTORY OF GLOBAL HEALTH?

Michael Knipper, associate professor of history, anthropology and ethics in medicine, and

global health at University Justus Liebig, Gießen, explored the question of whether Alma-Ata represents an unfinished revolution in global health. He considered the events and motivations that shaped the Declaration of Alma-Ata and reflected on whether certain key aspects of the Declaration were, in fact, revolutionary. He concluded by introducing the concept of Primary Health Care 4.0—the next conceptualization of PHC—and described the global social movement that will be needed to bring about this next iteration of primary health care.

2.2.1 Understanding Alma-Ata: health inequality and the agenda of health for all

Knipper opened by reflecting on the meaning of “health for all” and “primary care,” explaining that he first encountered person-centered care while working in Ecuador in the early 1990s. In Ecuador, he saw physicians living and working in rural areas, collaborating in communities, and giving ownership of the health care program to the community members. For instance, this health care project had invited a geographer to conduct a cartographic survey that was intended to serve as a basis for the indigenous people’s claim to ownership of their land, upon which they relied to maintain their livelihoods. The project of guaranteeing land rights to these communities through such actions was inspired and funded by health activists working in the region. The rights secured by these activities have been protected ever since. After witnessing this work, he realized that his own experience in medical school had been technical, clinical, and hospital-based; the model of health care being utilized in Ecuador was aimed at addressing the social determinants of health. The health workers in Ecuador had a different understanding of health and the actions that should be taken to promote health. These experiences prompted Knipper to investigate PHC, social medicine, and activities related to PHC.

Knipper explained that the task of defining PHC is challenging. While the Declaration of Alma-Ata purports to define “primary health care,”

the Declaration is contradictory in its descriptions of PHC.¹⁸ In section VI of the Declaration, PHC is described as “essential health care,” whereas in section VII, the Declaration lists principles that should be reflected in the implementation of PHC, which are related to intersectional concerns and the social determinants of health. As it was written, the Declaration is open to various interpretations that have been carried forth by various members of global health community with diverse and disparate backgrounds and experiences.

It is not surprising, therefore, that there is still a range of interpretations of the implications of the Declaration of Alma-Ata and the meaning of PHC today, 40 years later. Knipper suggested that rather than seeking a single unified and “correct” understanding, Alma-Ata and how it has shaped PHC are best understood as reflecting of the actions of multiple stakeholders in the historical context of the events leading up to and following Alma-Ata. These actors and events converged as a result of WHO’s interest in developing an agenda to achieve health for all in the 1970s and 1980s. The Declaration of Alma-Ata was only one intermediate result of this agenda, which did not start or end with that historic conference. The agenda of health for all is still being pursued, as evidenced by the focus of the conference. Every 10 years since Alma-Ata, events have been held to commemorate the event and evaluate the progress toward health for all, most recently in Astana in 2018. These meetings have yielded new interpretations of and reflections on the Declaration of Alma-Ata, as well as new initiatives to promote the agenda of health for all.¹⁹ Thus, he concluded that the most productive way to conceive of Alma-Ata is within this framework of ongoing reflection and evaluation of the health-for-all agenda.

Many modern reflections on Alma-Ata are focused on certain principles about health, medicine, and the conditions that are necessary in order to achieve health for all, said Knipper. Foremost among these principles is the recognition—

made in the Declaration of Alma-Ata itself—of “the gross inequality of health status of people particularly between developed and developing countries as well as within countries,” along with the moral assertion that these inequalities are “politically, socially, and economically unacceptable, and [are], therefore, of common concern to all countries.” Invoking Shakow’s question of whether Halfdan Mahler (then Director-General of WHO) and his colleagues were well-intentioned or agents of neoliberalism, Knipper suggested that they seemed to be well-meaning. In his opening address at the Alma-Ata conference, Mahler called for the gap between the “health haves” and the “health have-nots” to be closed. Furthermore, the core principle of health equity is the apparent motivation behind the events leading to Alma-Ata. Technical, vertical, and disease-specific approaches to malaria, TB, and other diseases had been shown to leave many people behind. Concurrent with the failure of these vertical approaches and the agenda of health for all, there had been an ongoing discussion of an alternative approach: the provision of “basic health services,” as opposed to “primary health care.” Knipper suggested that the momentum leading up to Alma-Ata was fueled by a reflection on the failures and shortcomings of these previous and alternative approaches. This is evidenced by the 1966 report from a conference held in Makerere, Uganda, that focused on rural health and health care for the developing world.²⁰ Similarly, a study published in 1975, *Health by The People*, investigated alternative approaches to health care; it considered to the roles of community collaboration and traditional medicine.²¹ These works and reflections, taken as the precursors to the Declaration of Alma-Ata, suggest that the Declaration was, in fact, intended to be revolutionary for global health.

2.2.2 An unfinished revolution?

Knipper explored the question of whether Alma-Ata represents an unfinished revolution in global health by considering three issues: 1) the value

18 World Health Organization 1978a

19 World Health Organization 2018; World Health Organization 1988b

20 King 1966

21 Newell and World Health Organization 1975

and prioritization of health as a human right, 2) consideration of the terminology “primary health care,” and 3) whether the vagueness of “primary health care” is a flaw or a feature.

Regarding the first issue, Knipper noted the conceptualization of health as a human right and the commitment to overcoming inequalities in health status feature prominently in the Declaration of Alma-Ata and in the subsequent meetings and declarations, including those held at Riga and Astana.²² The Sustainable Development Goals promote the principle of equity through the aim to leave no one behind and to prioritize those who are furthest behind and most difficult to reach. Related to the principle of equity are the aims of inverting the priorities of health systems and organizing them around the goal of supporting primary care and the populations most in need. This aim calls for a model of PHC in which university professors, clinicians, and health managers are primarily committed to supporting health workers in villages and underserved communities, addressing not only the signs and symptoms of disease but also the determinants of health. In this conception, the promotion of PHC rests on the foundational principle of health equity and is a revolutionary notion.

With respect to the second issue, Knipper asserted that the adoption of the terminology “primary health care” was an error. This terminology implies the need for a focus on health care access and elicits a comparison of “care” versus “coverage”; however, this terminology omits the crucial dimensions of values, social determinants of health, and intersectionality. The notion of PHC was inserted into an ongoing dialogue related to basic health services and other such models, but ultimately, this terminology distorted that dialogue. For instance, in addition to omitting the dimensions of values, the terminology of PHC fails to highlight the role of prevention in health. Knipper suggested that it would be beneficial to develop a new terminology that better reflects the holistic aims of the agenda of “health for all.”

Regarding the third issue, Knipper pointed to documents and legal definitions regarding health as a human right that Alma-Ata might have referenced, such as the 1966 International Covenant on Economic, Social, and Cultural Rights.²³ Instead of drawing upon these references, the Declaration leaves much open to interpretation. One of the authors of the Declaration reported to Knipper that the conceptualization of health as a human right was adopted at the Alma-Ata conference for convenience, rather than clarity. Noting that the vagueness of the Declaration of Alma-Ata is commonly critiqued, Knipper proposed that this vagueness may have not only been intentional, but that its vagueness may be one of the strengths of the Declaration. In Mahler’s opening address at the Alma-Ata conference, he explained that the guiding principle for PHC should be “don’t adopt, adapt.” This suggests an intention to offer guidance, goals, and principles that could be adapted in various contexts, rather than making highly specific recommendations for implementers.²⁴ Knipper surmised that the authors of the Declaration of Alma-Ata deliberately left their recommendations vague, as demonstrated by the focus on values and goals to be considered and the lack of technical guidelines for implementation. He proposed that this values-focused approach implored health professionals to take time to engage with communities and focus on the social and structural dimensions of health to identify local, feasible solutions. This process requires commitments of time, humility, and structural and cultural competencies—i.e., an ethnographic perspective. Such a perspective calls on stakeholders to engage and locally and contextualize health knowledge. This stands in contrast to most health education, health research, and medical systems, which are primarily organized around decontextualizing health knowledge. He suggested that if this was in fact the intent of the authors, then this was another revolutionary aspect of the Declaration of Alma-Ata.

²² World Health Organization 1988a; World Health Organization 2018

²³ UNICEF 1966

²⁴ World Health Organization 1988b

2.2.3 Primary Health Care 4.0

Knipper closed with a consideration of a concept he described as “Primary Health Care 4.0,” given that 2018 marked the 40th anniversary of Alma-Ata and was commemorated with the recommitment to PHC at Asana. The modern discussion of UHC may be well suited to carry forth the mantle of the health-for-all agenda, he said. Terminology notwithstanding, the questions raised by Alma-Ata’s unfinished revolution must still be addressed; the values and priorities of health equity must still be brought to bear on the forthcoming conceptions of PHC. The international legal and conceptual framework of rights-based approaches to health and health equity have advanced substantially from those of the 1960s and 1970s, allowing for a stronger case to be made for a commitment to the right to health. He argued that global health issues and local health realities should be considered within a framework of health care as a social movement with a clear, consistent commitment to health and health equity as a human right. It is critical that so-called “universal” approaches, in fact, deliver health to all, with no one left behind. For instance, in the past 50 years no attempt to deliver universal health care has adequately addressed the health of migrants. Knipper reported his difficulties in advocating to national delegations at WHO meetings for the inclusion of migrants in their universal coverage programs. He asserted that approaches to health care that do not consider the health of migrant populations do not meet the standard of universality and, in that sense, migrant health can serve as a litmus test for universal health care programs. Furthermore, the rights-based approach to health must not be narrowly constrained to the realm of health care and medical services; the rights-based approach must also address the determinants of health through a local, or ethnographic, perspective. The strength of cities, local networks, and local partnerships can be powerfully harnessed to address diseases. For instance, the WHO European Healthy Cities

Network was developed as a global movement that is working to put health high on the social, economic, and political agendas of city governments.²⁵ Additionally, the ZeroTB initiative, developed by the Harvard Medical School Center for Global Health Delivery – Dubai in collaboration with other organizations, brings the principles of TB eradication into local collaborations with cities to create islands of TB elimination.²⁶ This model is focused on local communities as units of elimination, because national-level focus is too broad to ensure success in elimination. The local ethnographic approach to global health is a key component of PHC that also has great value as a research tool, allowing the implementation of global health concepts to be evaluated within local contexts. Finally, Knipper reiterated that global health is a social movement. Even in toxic political environments, academia and civil society must take up the task of engaging policy makers in the consideration of the conditions of health, the determinants of health, and access to health care. He concluded by emphasizing that these demands must be a part of the discussion in the formulation of Primary Health Care 4.0 and that it is through the global health social movement that this can be ensured.

2.3 SELECTIVE PRIMARY HEALTH CARE AND EQUITY: CURRENT RELEVANCE FOR GLOBAL HEALTH

Julia Walsh, retired professor of maternal and child health and international health in the School of Public Health at the University of California, Berkeley, discussed the relevance of “selective primary health care” to global health. She traced the history of the selective primary care movement, which forged a path to the modern era of SDGs and UHC. She suggested that until high-quality UHC is available to all, countries should provide smaller packages of cost-effective community-based services with a focus on delivering services to the poorest and most marginalized groups. In that sense, selective primary care could serve as an interim approach while services are expanded.

²⁵ For more information, see <http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/who-european-healthy-cities-network> (accessed Feb 15, 2020)

²⁶ For more information, see <https://www.zerotbinitiative.org/> (accessed February 15, 2020)

Walsh opened by outlining her core argument that health investment should target the most cost-effective community interventions for those who are most in need. While health services and health service coverage have dramatically improved globally, sharp inequities still exist. She asserted that the implementation of truly universal health coverage would resolve those remaining health inequities. She noted that Sustainable Development Goals were intended to resolve these inequities, but resource limitations have stifled progress. As large investments begin to flow toward addressing these resource limitations, it heightens the

risk that those resources will flow disproportionately to the elite—who are least in need of them—rather than to the most disadvantaged. Thus, Walsh proposed prioritizing the most cost-effective community interventions for the poor, with strong, continuous, and innovative monitoring and management systems to make inequities more transparent and to facilitate increasing resource utilization. These kinds of monitoring and management systems will allow for a rapid assessment and response to ensure that, at minimum, the designated package of services is reaching those who are most in need.

Box 2-2. Interpretation of the Definition of Primary Health Care in the Alma-Ata Declaration

Primary Health Care includes at least:

- Education concerning prevailing health problems and the methods of preventing and controlling them
- Promotion of food supply and proper nutrition and adequate supply of safe water and basic sanitation
- Maternal and child health, including family planning
- Immunization against the major infectious diseases
- Prevention and control of locally endemic diseases
- Appropriate treatment of common diseases and injuries
- Provision of essential drugs

2.3.1 Selective primary health care: an interim strategy for disease control in developing countries

Walsh presented the definition of PHC that she published in 1979, which was based on her own interpretation of the Alma-Ata Declaration²⁷ (see Box 2-2 above). She recalled that when she and her colleague, Kenneth Warren, considered these requirements for PHC, they lauded the aims of Alma-Ata but recognized that these provisions were far too costly for most coun-

tries to provide for all people. Thus, they enumerated the most common causes of death globally, particularly in poor countries, and conducted an analysis to determine how these causes of deaths could be prevented and treated. In addition to an approach for prevention and treatment, they identified the need for a method of evaluation in order to determine what interventions were successful in preventing and treating these causes of death. Finally, they evaluated the costs and cost-effectiveness of those interventions to set priorities for disease control based

²⁷ Walsh and Warren 1979

on mortality, feasibility, and cost-effectiveness. Their approach, called “selective primary health care,” called for the implementation of a small number of high-priority interventions that should be delivered to all people who would benefit from them. These interventions include vaccines, oral rehydration therapy for diarrhea, malaria control, breast feeding, and immunization with the addition of regional priorities. This approach was adopted by UNICEF in its implementation of the 1981 program that targeted growth monitoring, oral rehydration therapy, breast feeding promotion, and immunization (GOBI); in 1990, UNICEF added family planning, food, and female education to the programs (GOBI FFF). Since then, maternal and child health programs have also been incorporated. By 1982, USAID declared that it would offer an additional \$100 million in funding through its Child Survival Initiative; this funding has since expanded to over \$500 million.²⁸ The goal of this funding was to ensure access to a small set of lifesaving behavioral and health interventions including vaccines, oral rehydration, and malaria control. This initiative was designed, in part, to convince the US Congress of the value of investing in child health.

Walsh remarked that her 1979 publication on selective PHC inflamed the controversies that had arisen around vertical versus horizontal health programs, technocratic versus community-based programs, and the role of health donors and governments in setting global health priorities. These controversies notwithstanding, she noted that there is now a sound body of evidence demonstrating that the resources invested into child survival efforts by USAID, UNICEF, and WHO’s Expanded Programme on Immunization (EPI) have 1) funded community health worker outreach, 2) increased coverage of health services, and 3) strengthened PHC systems with respect to management, logistics, cold chain, surveillance, information systems, and supervision. Additionally, these programs have built public-private relation-

ships for advancing health, influenced global and national practice and policy, and quantified the number of lives saved each year. See Appendix 3 for more information on the lifesaving and low-cost technical interventions used in USAID’s Child Survival & Health Grants Program.

Walsh noted that a countermovement arose—primarily in Latin America—around an alternative approach to PHC in the 1980s and 1990s: the expansion of social health insurance. In countries such as Columbia, Peru, Uruguay, and Mexico, these social health insurance programs complemented and expanded employer-based health insurance through the expansion of public health facilities for the poor supported by community health worker outreach.

2.3.2 From the World Development Report on Health (1993) to the Millennium Development Goals

Walsh described the history of global health investment after the Alma-Ata era, which paved the way for the Millennium Development Goals (MDG). The landmark World Development Report in 1993 provided a detailed quantification of the causes of death globally and in high-, middle-, and low-income countries and ranked the cost-effectiveness of interventions.²⁹ The report also set forth priorities in clinical care and community care and made a strong case for the role of health investment in economic development. Since this report’s publication, the World Bank’s health investment has risen to over \$200 million per year. The same report was also the basis for the establishment of the Institute of Health Metrics and Evaluation.³⁰ Public health packages for low- and middle- income countries (LMICs) were expanded to include broader sets of services, including school health, family planning, nutrition and health information, public health education, tobacco and alcohol control, mass treatment for worms, AIDS prevention,³¹ and EPI with the addition of 95% vaccine cover-

28 Kureshy et al 2018

29 Lea 1993

30 For more information, see <http://www.healthdata.org> (accessed February 15, 2020)

31 Walsh noted that treatments for AIDS were limited and very expensive in 1993.

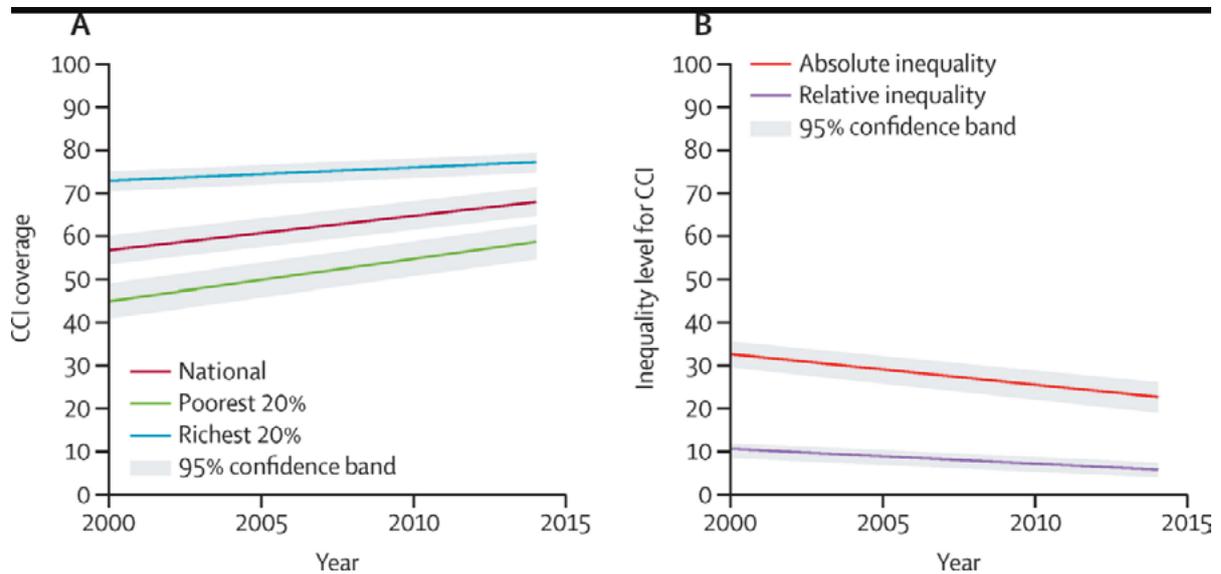
age, and mass vitamin A treatment (EPI Plus). This public health package was estimated to avert 8% of the burden of disease on low-income countries and 4% of the burden of disease in middle-income countries. In addition to the public health package, a clinical services package was developed for health centers and first-level hospitals. This package included directly observed treatment, short-course (DOTS) for tuberculosis, management of sick children, prenatal and delivery care, family planning, treatment of sexually transmitted disease, and limited care for the treatment of infections and minor trauma. These two packages combined were estimated to avert 32% of the disease burden in low-income countries at a cost of approximately \$12 per capita and to avert 15% of the disease burden in middle-income countries at \$21.5 per capita. In 2000, the Millennium Development Goals established eight key goals for development to be achieved by 2015, noted Walsh. Four of these goals were health-related: eradicating poverty and hunger, reducing child mortality, improving maternal health, and combating HIV/AIDs, malaria, and other diseases. In line with previous global health efforts, the MDGs identified a small number of interventions that should be delivered to all who would benefit from them.

2.3.3 Global health improvements and remaining inequities

Walsh credited the implementation of these selective PHC approaches and economic devel-

opment for much of the extraordinary global reduction in deaths of children under 5 between 1993 and 2017, particularly in the Americas, Europe, Asia, the Middle East, North Africa, Latin America, the Caribbean, and East Asia, and the Pacific region. In that time, the number of births has increased, but the total number of under-five deaths per year has reduced by nearly half. Similarly, global life expectancy has increased from approximately 52 years in 1960 to over 70 years in 2015. While these improvements represent a remarkable achievement in global health, Walsh pointed out that they hide extraordinary inequalities. Within countries, the gaps between the wealthiest and poorest quintiles have narrowed on average, but in some countries, they have widened or stayed the same.³² Additionally, the interventions delivered at health institutions—such as safe delivery—were among the least equitable, while those delivered by community health workers were more equitable. Walsh said that this is due to the difficulties facing marginalized populations who wish to go to facilities to receive care and the difficulties encountered by facilities in maintaining the quality of care. Figure 2-1 shows that although indicators of coverage for reproductive, maternal, newborn, and child health care serves have improved since 2000, with the greatest rate of increase among the poorest quintile, the absolute and relative measures of inequality have decreased only slightly.

³² Li et al 2017

Figure 2-1. Equity among the 75 countries monitored for the Millennium Development Goals

Sources: Walsh presentation based on Victora et al. 2016

2.3.4 Achieving the Sustainable Development Goals and UHC 2030

Walsh explained that in 2008, WHO refined and improved their definition of PHC, identifying the roles of basic inpatient care, skilled child-birth, community health care, and family care at home. In 2015, the Sustainable Development Goals (SDGs) were established with a range of goals and targets to be achieved by 2030.³³ SDG 3 focuses on health and wellbeing and calls for:

- reducing maternal mortality to < 70 per 100,000 live birth
- reducing neonatal mortality to <12 per 1000
- reducing under-5 mortality to <25 per 1000
- ending epidemics of AIDS, TB, malaria, and neglected tropical diseases
- combating hepatitis, water-borne diseases, and other communicable diseases
- reducing premature mortality from noncommunicable disease by 1/3

- promoting mental health and wellbeing
- strengthening prevention and treatment of substance abuse
- improving tobacco control
- reducing traffic accidents by 50%
- supporting the research and development of new vaccines and medicines
- substantially increasing health worker financing in poor countries
- strengthening capacity in poor countries for early warning and risk reduction for global health risks
- providing universal access to reproductive health services including family planning
- reducing deaths from air, water, and soil pollution, as well as hazardous chemicals
- establishing UHC by 2030

Walsh questioned whether the many goals of SDG 3, including the global establishment of

³³ For more information, see <https://www.undp.org/content/undp/en/home/sustainable-development-goals.html> (accessed February 15, 2020)

UHC, would be achieved by 2030. The establishment of UHC is defined as meeting the goals of 1) providing access to high-quality essential health services (over 90 specific interventions); 2) offering financial risk protection; 3) providing essential medicines and vaccines; 4) offering public health services to promote health and prevent illness; and 5) providing treatment, rehabilitation, and palliative care of sufficient quality to be effective. WHO estimated that an additional \$371 billion in annual funding would be needed by 2026-2030 for the 67 low- and middle- income countries to achieve the goals of SDG 3.³⁴ Whether this increase in funding has begun to materialize is not yet known, however. In low-income countries (LICs) the requisite investment of approximately \$76 per person would require an average increase in health spending as a share of GDP from 5.6% to 7.5%. It is expected that economic growth will result from these improvements in health, but in order to provide these services for free, tax-based funding will be necessary. This places a great burden on governments to increase their funding and budgeting for these services.

An assessment of health service user fees in public clinics and hospitals in 46 countries in Africa found high proportions of user fees in LMICs; only in higher-middle-income countries was the proportion of user fees low.³⁵ Significant changes will be needed to reduce the proportions of user fees in these countries and provide financial risk protection, noted Walsh. The assessment also looked at which services comprised the basic package in these countries. Over 90% of these countries provided free immunization, TB, and AIDS services. Additionally, more than half of these countries provided bed nets, malaria treatment, antenatal care, treatment for acute respiratory infection in children, C-section, and normal deliveries. According to the assessment, outpatient primary care, specialized outpatient care, other inpatient services, and X-rays were offered without user fees only in a limited number of African countries. While the

services that are provided for free in most African undoubtedly save lives, Walsh pointed out that development assistance cannot be relied upon to fund the less-covered services; rather, countries will be reliant on their tax bases and internal budgets to develop their UHC benefits packages. Furthermore, it is important to ensure that these countries do not expand these health care packages such that only the elites and middle class have access to free health care. She cautioned that countries often develop health benefit packages that promise more than they can deliver, leading to rationing and limited access to care across settings. This can prevent the most cost-effective interventions from reaching all of those who would benefit.

2.3.5 Improving equity in health coverage

Walsh proposed an interim solution to the challenges she described, suggesting that countries should develop smaller packages of high-priority services with a focus on outreach to all. These packages should be designed with strong information and monitoring systems. It is well established that the provision of basic, high-priority health services coupled with outreach by community health workers are among the most important interventions for improving health equity and ensuring financial protection, particularly in settings with limited resources and weak health systems. These packages should include family planning, vaccines, vitamin A, breast feeding and nutrition, oral rehydration therapy, hygiene, malaria treatment and control including bed nets, sick child management, safe delivery, TB treatment, and limited chronic disease interventions.

Walsh also proposed that conditional cash transfer programs could be used to cover a small package of basic services. For instance, Mexico's *Oportunidades* and Brazil's *Bolsa Familia* services provide conditional cash transfers for basic maternal and child health service utilization, nutrition supplements, and child

³⁴ Stenberg et al 2017

³⁵ Cotlear and Rosemberg 2018

participation in school. These programs have been replicated in Nicaragua, Peru, Honduras, Jamaica, Chile, Malawi, and Zambia and have been shown to be successful. However, systems of evaluation and monitoring are critical for ensuring transparency and accountability. Monitoring for UHC basic packages typically relies on household surveys, but those methods tend to exclude indicators of service capacity and access, such as the number of hospital beds, health workers per person, access to essential medicines, equity, or financial risk protection.³⁶ Measures of equity are available in very few countries and measures of financial risk protection are generally not available. She emphasized the importance of developing innovative methods and measures of monitoring, such as

- Vital registration of births and deaths with cluster and/or capture-recapture surveys in disadvantaged areas

- Biomarker tracking with basic health services tracking
- Mobile phone tracking for monitoring vaccination, TB treatment, HIV/AIDS treatment and prevention, and antenatal care

2.3.6 Relevance of Selective Primary Health Care to Universal Health Coverage

Walsh closed by highlighting the relevance of selective PHC to UHC. Until high-quality UHC is available to all, countries should provide smaller packages of cost-effective community-based services that reach all, focusing the poorest and most marginalized groups. While doing so, countries should establish robust, innovate information systems for monitoring to ensure coverage, strengthen management to respond to gaps in coverage, and gradually expand interventions. Key points from Walsh's presentation are summarized in Box 2-3.

Box 2-3. Key Points (Walsh)

- Health service coverage and health has substantially improved.
- Sharp health inequities within countries and between countries remain.
- The Sustainable Development Goals and universal health coverage, if achieved, will resolve those inequities, but resources required are substantial.
- There is a high risk that the benefits of health reforms will be captured by the elites, with those who are most disadvantaged benefiting less.
- The most cost-effective community interventions for the poor should be prioritized.
- Strong continuous, innovative information, monitoring, and management systems are required to make inequities transparent and facilitate increasing utilization.

2.3.7 Making short shrift of primary health care: Tanzania, TB, and global health (1977-1995)

Christoph Gradmann, professor in the department of community medicine and global health at the University of Oslo Institute of Health and Society, detailed the transformation of WHO's role in primary health and global health policy.

Using three narratives, he explained how this transformation was the result of the conflict that emerged between WHO and the International Union Against Tuberculosis and Lung Disease (the Union) over the Union's TB trials in Tanzania. He described how this conflict eventually led to a new model of global health focused on cost-effectiveness and how WHO transitioned from a policy owner to a facili-

³⁶ Hogan et al 2018

tator of this new model. He opened with an excerpt from a letter written in 1983 from Halfdan Mahler, then Director-General of WHO, to Annik Rouillon, then executive director of the Union. In the letter, Mahler reminds Rouillon:

We know...that when health care delivery is excellent the actual treatment regimen is of little importance...National TB programs have not failed because of faulty technology, but because of a lack of productive interaction between the health system and the people. The question is not whether PHC can improve the delivery of TB programs, but how the TB program should contribute to primary health care.³⁷

Gradmann explained that the excerpt reflects Mahler's discontent with the Union's involvement in building up a national TB control program in Tanzania—the Union's activities were seen as a challenge to WHO's policy. To consider the question of how one national TB program could pose a threat WHO's global health policies, Gradmann shared three stories: 1) the importance of TB control to PHC, 2) how the Union challenged WHO policy by building a national TB program in Tanzania, and 3) how these events led to the emergence of a core component of what is now called "global health."

2.3.8 WHO, tuberculosis, and primary health care

WHO became involved with TB shortly after World War II, said Gradmann. The late 1940s were a unique period in the history of TB. In the first half of the 20th century, TB had greatly reduced in so-called industrialized countries. This reduction of TB can be seen as a triumph of social medicine and public health rather than the clinicians' therapeutic repertoire, as vaccines and chemotherapies were only developed after those reductions in TB. These new therapeutics came into widespread use from 1945 onward in industrialized nations. In developing countries where TB had not yet declined, the perceived character of TB itself shifted. What had been framed as a social disease in industrialized nations was now being framed as a techno-

logical challenge that could be addressed independently of addressing social conditions. Over time, WHO became dominant in developing and implementing technology-oriented TB control programs as organizations such as the British Medical Research Council (BMRC) reduced the number of trials they conducted on TB. By the 1970s, in the wake of decolonization of the British Empire, WHO attempted to develop national TB control programs in newly independent countries that were designed to amend some of the weaknesses of the drug trials conducted by the BMRC in the preceding decades. The trials produced a host of combination treatments for tuberculosis that were designed to reduce costs by shortening treatment time, controlling drug resistance, or facilitating outpatient treatment. Unfortunately, this remained trial science and was never effectively translated into any national TB control programs. And as BMRC bureaucrat Brendan Lush commented in 1962, "...we must not delude ourselves into thinking that the trials by themselves will solve the numerous problems of TB in East Africa. The trials are essentially confined to treating advanced cases..."³⁸ Gradmann noted that these trials were confined to treating advanced cases because no systems were being developed to detect new cases of TB.

This was the context in which WHO developed a policy that focused on integrating TB control into primary health services and prioritized prevention with BCG vaccination over treatment, said Gradmann. He pointed out that BCG vaccines had been evaluated favorably at the time; it seemed sensible that a control strategy could rest on vaccination with the expectation of declining rates of clinical cases over time due to effective vaccination policies. The policies developed by WHO were inspired by TB control programs being utilized in developing nations, particularly that of India; Mahler had been responsible for WHO's TB operation in India before his appointment as Director-General. The strategy used in India—and later promoted by WHO—relied on affordable technology, prioritization of prevention, and delivery of treat-

³⁷ H. Mahler to A. Rouillon, 4/1983, WHO archives

³⁸ Lush 1962

ment through general outpatient treatment facilities. At the time, it was difficult to determine whether WHO's approach to TB control was effective, but there was some indication of a modest, slow decline in TB incidence during the 1970s in some LICs.³⁹ There were two lines of arguments used by critics of this approach: 1) challenging the efficacy of the BCG vaccine and 2) demonstrating that more specialized, high-tech treatments deliver better outcomes than treatment with the cheapest regimens recommended for use in BCG-based control strategies.

2.3.9 WHO, the Union, and Tanzania

Gradmann explained that by the late 1970s, confidence in the presumed efficacy of BCG had wavered and the Union had begun a series of trials in East Africa to show that the more expensive, short-course regimens developed by the BMRC delivered better outcomes than WHO-recommended treatments. The Union conducted these trials in three African countries, including Tanzania. The national TB control programs in these countries were engaged by the Union's mutual assistance program, which had been expanded as part of an effort to preserve the Union from bankruptcy. WHO refused to participate in these trials, but the BMRC as well as Dutch and Swiss sponsors contributed to the project.

The project in Tanzania began in 1977 with an evaluation of the WHO-recommended treatment, said Gradmann. This was done in part to appease WHO, but it also served as a smoke screen that allowed the Union to create a specialized vertical TB program. This approach facilitated the building of a robust epidemiological reporting system and allowed the Union to build a case against the use of the WHO-recommended treatment. Evidence gathered in Tanzania quickly pointed to the low efficacy of WHO-recommended treatment regimens. After two years, only about 31% had been cured by the treatment (i.e., they were smear-negative) and about 13% had completed treatment, but did not have a smear examination; about 23% of patients had defaulted. In a 1981 report, the Union's research director said,

"If treatment of newly discovered smear-positive cases remains unsatisfactory, this will result in a high number of chronic tuberculous excretors with all the consequences. It was, therefore, proposed to explore the yield of short-course chemotherapy under routine conditions." Thus, the Union had created a scenario that allowed for a direct comparison of WHO-recommended TB treatment regimens with short-course chemotherapy treatment. Starting in 1982, the Union began implementing a new 8-month regimen in Tanzania that included an initial 2-month period of hospitalization. This regimen was very similar to the regimen now associated with the DOTS program, he noted. This implementation was the motivation for Mahler's letter and his discontent with the Union's activities. According to Mahler, the implementation of short-course regimens was an apparent violation of PHC principles; thus, the Union's program in Tanzania led to the eruption of an open conflict between the Union and WHO. WHO attempted to stop the program by petitioning its Swiss and Dutch funders to cut its funding, but the program ultimately went on to be successful in demonstrating the effectiveness of short-course chemotherapy. In 1988, Tanzania had one of the only effective long-term TB programs among poor developing countries. Under Tanzania's new program, 80% of patients were smear-negative after 8 months of treatment and the treatment success rate was estimated to be nearly 90%.

Despite strong evidence for its success, there were criticisms of program in Tanzania, said Gradmann. For example, critics maintained that the program skated over the complications raised by the HIV and TB co-epidemics, because HIV co-infection was not even mentioned in the Union's report on the program in Tanzania. The Union was also criticized for downplaying the issues of drug resistance and for failing report or address the fact that the Tanzanian program had become unsustainable. Still, the program was lauded as a successful implementation of selective PHC through a specialized technology-driven vertical program that was both effective and efficient.

³⁹ British Medical Research Council and East Africa 1978

2.3.10 From Tanzania to global health science

Next, Gradmann explained how Tanzania's TB control program became the inspiration for global health science. In 1980, the World Bank was searching for cost-effective specialized treatment programs that addressed major health challenges; the Union's trials in Tanzania were identified as a blueprint for such programs. The rich epidemiological data created by the program provided a basis for analysis by the World Bank. The Union had evaluated the annual costs of delivering the program in Tanzania, which became a metric for economic analysis and future projection. This analysis showed that upon implementing a new program, there will be an initial increase in cost per patient, but both the long-term cost per patient and overall costs are reduced by reversing the epidemic's trend and saving money due to declining incidence. Investment and real costs in the present were calculated against future profits; this conceptualization would later lead to the terminology of "deaths averted" and "disability-adjusted life years." The Tanzanian program was certainly treating patients effectively, he said, but the challenge would be to interrupt transmission and realize the reduction in cost that had been projected. A joint analysis conducted by the World Bank and the Union found that the model used in Tanzania was more cost-effective than many other popular cost-effective interventions, such as rehydration therapy and screening for HIV. Later, in the World Development Report (1993), the model used in Tanzania was again praised for its cost-effectiveness. The report pointed out that the cost-effectiveness of WHO's vaccination strategy could not be calculated with any certainty.⁴⁰ Around 1990, many PHC policies were abandoned due to changes in the field of TB control. Short-course chemotherapy increased the efficacy of treatment while also serving as a tool for making short shrift of WHO's PHC policies.

Beginning in 1994, a new WHO policy was developed based on the model used in Tanzania: the DOTS program.⁴¹ National TB programs were now obliged to comply with this new program in order to benefit from sponsor funding. WHO, having given up their original strategy, now took on the role of facilitator and brought the Tanzanian model to China for large-scale implementation. In the intervening years, DOTS was adapted to better account for the neglected issues of HIV co-infection and drug resistance; this model is now better known as StopTB. Gradmann argued that the role of WHO and its conception of PHC had now become marginalized, with WHO's role shifting fundamentally from the creator and "owner" of policies to serving as a "door-opener" for initiatives it had long opposed.

2.3.11 Discussant remarks

Suman Seth, professor in the department of science and technology studies at Cornell University, and Anne-Emanuelle Birn, professor of critical development studies (UTSC) and of social and behavioural health sciences (Dalla Lana School of Public Health) at the University of Toronto, each presented remarks on the presentations of Shakow, Walsh, Knipper, and Gradmann. Seth considered each presentation's key points and made efforts to put the ideas of the panelists into dialogue with one another. He highlighted the common theme among the panelists, that each of the panelists focused their analysis on the policies at hand over the knowledge and information used to shape those policies. Birn highlighted the symbolic importance of Alma-Ata and considered three areas of consideration that were absent in the panelists analysis. These remarks were followed by open discussion and questions and answers with the audience and participants.

2.3.12 Discussant: Suman Seth

Seth remarked that the subject matter of the panel intersected with topics discussed in his recent book *Difference and Disease*, which looks at medicine and race in the 18th century British

⁴⁰ Murray et al 1991

⁴¹ World Health Organization 1994

empire.⁴² While the dates of the events of his studies and Alma-Ata range from the 1770s to the 1970s and beyond, Seth observed a familiarity with the moral valences involved with supplying medical care to underserved populations and the economic, political, and moral arguments that accompany claims to that care. In his case, Seth has studied the role of medical care in abolitionist debates in the British empire in the late 18th century. Those critical of the slave trade were able to point to many examples of appalling treatment and negligence. In the 1780s, a new set of critiques was made popular by Reverend Ramsey, who began his career as a surgeon working in a maternity hospital; these critiques revolved around the inadequate medical care available to those who were enslaved. He noted that these critiques were effective in that many legislatures in the West Indies passed laws mandating the provision of medical care for the enslaved, but those laws, assuming they were meant to be efficacious, quickly butted against moral, political, and economic roadblocks. Questions arose regarding the definition of “adequate care,” which led to one solution: slaveholders paid medical practitioner per head. As a result, some practitioners had 4,000-5,000 people under their care. One critic of this practice wrote:

...once, twice, or thrice in a week, to gallop to a plantation to take a peep into the hospital or hothouse, writing in a book “bleed this,” “purge that,” “blister another,” “here give an opiate,” “there the bark,” is not in my opinion “taking care of”; although, it may be called “taking charge of” the health of 4,000 or 5,000 negros.

Leaving aside the arguments of innate physiological differences between races, economics could be invoked as a simple answer for why the enslaved would receive substantially worse treatment, said Seth. For example, one physician at the time wrote that “...the very small annual sum allowed to surgeons for the care of negros in the country parts will not admit of the exhibition of very expensive medicines...” In 1784, another physician discussing small pox inoculation wrote, “...white children generally use the [foot bath] for some nights before the period of

eruption, but the number of negro patients was so great as to render it impracticable or, at least, very inconvenient.” Seth suggested that minor alterations to the language used to discuss these issues in the 1780s would make it recognizable those studying the topics of this conference.

Seth sought to evaluate the presentations of the panel to foster a dialogue and stimulate closing questions for further consideration. He began with Walsh’s paper, which filled him with a sense of the optimism of the 1970s. Given his familiarity with the issues of race, he was relieved to see no arguments as to whether “people are, in fact, people.” In her paper, Walsh painted Alma-Ata as utopian in its dream of delivering basic levels of health for all people. In addition to her narrative of utopian promise, Walsh describes what happened when those dreams butted against harsh economic and political realities, as “health for all” quickly became “health for some at reduced costs.” While Walsh’s presentation was, at its core, about a history of compromises, it did well to highlight the successes of these compromises: from UHC to selective PHC to a focus on, at least, child mortality and illness. Walsh discussed the key shift in global health strategy in the 1990s in a way that is emblematic of neoliberal logic, as the World Bank stressed importance of health for economic development. Alongside this shift and, in striking tension with it, was a growing, yet still inadequate, emphasis on community health. Health inequality remains and its most striking instantiations involve hospital visits and other formal and institution medicine, with the best improvements showcased by those diseases and illnesses that are well suited to the treatments that can be delivered by community health workers.

Forgoing an analysis of SDGs and the modern era, Seth juxtaposed Walsh’s narrative of Alma-Ata and its aftermath to that of Shakow’s presentation. Where Walsh portrayed the optimism of the 1970s, foiled by harsh economic realities, Shakow described these cynical realities built into the logic and language of the Declaration of Alma-Ata itself. From this juxtaposition rises a poignant question: is the defining down of which

⁴² Seth 2018

services the third-world poor received a failure of liberal optimism or a logical outcome of neoliberal suppositions? In regard to the contemporary concerns of Walsh's presentation, the further question arises as to whether those logics are still built into the SDGs. Seth questioned whether it is possible to conceive of the project of UHC outside of neoliberal regimes and logic.

Seth next considered Knipper's presentation which presented the vision of Alma-Ata as incoherent and incoherent. Unlike Shakow, Knipper saw both positive and negative implications of this complexity and suggested that this incoherence could, in fact, be seen as a feature of the Declaration. If this is true, it is possible that the authors of the Declaration overestimated the capacities and willingness of those who were to carry out the vision of Alma-Ata. Finally, Gradmann's presentation revealed that even if many outcomes may have been foreseen from the outset of the Alma-Ata Declaration, there were a number of remarkable counter developments. In the case of Tanzania, the story begins with a classic low-cost, high-population strategy that has become the marker of UHC efforts. This approach relied on affordable technology, prioritized prevention, and the delivery of treatment through the general health service. In spite of this classic approach, by the 1990s WHO had come to recommend TB programs that were neither inexpensive nor delivered by the general health service. Gradmann's presentation raised the question of how the high costs of more effective treatments came to be accepted for TB treatment. Apparently, this cost came to be accepted through the development of a new metric whereby costs were calculated not in terms of dollars per patient in the present, but in terms of costs saved in the future. By this metric, the new method of TB treatment is indeed cheaper. Seth remarked that this is rare case where the epitome of neoliberal logic, put forward by the World Bank, created a situation that would have been embraced by a utopian liberal society—that is, a scenario where higher-quality, higher-cost-per-patient treatments becomes the standard of treatment. Seth highlighted the impact of this changing metric and pointed out a common theme among all four presentations: they

focused on policy changes over the knowledge on which these policy changes were based. Seth expressed curiosity about the forms of knowledge that were associated with Alma-Ata and its successes. Statistics come with many built-in conscious and unconscious presumptions. Ian Hacking, philosopher of science, has written about the subversive outcomes of enumeration. Seth called into question what contestations and assumptions might be revealed by an investigation into the data presented by the presenters.

2.3.13 Discussant: Anne-Emanuelle Birn

Birn explained that she is an insider to the history and activism around Alma-Ata; she dedicated her discussion to the memory of the late David Sanders and his commitment to health justice and social equity. She acknowledged that the presenters invoked various interpretations of Alma-Ata, but Birn aimed to elucidate why there has been a need for the perennial rallying cry for health equity and the symbolic importance of Alma-Ata. In spite of the numerous critiques put forward against Alma-Ata, she pointed out Alma-Ata's distinction as an international conference that has been continuously referred to and has been the subject of decennial meetings. She asserted that three pieces were absent from the presenters' analyses: 1) there is much missing context in the depictions of Alma-Ata set forth by the presenters; 2) struggles over power have not been adequately understood in the events around Alma-Ata; and 3) the voices of those in the global South were not represented in the presenters' depictions of events.

Birn characterized the perspectives presented by Walsh and Shakow as distinctly American, suggesting this perspective is not entirely appropriate when considering the legacy of Alma-Ata. While Mahler was very concerned with the US's reaction to Alma-Ata, the US was a minor player in the crafting of the Declaration of Alma-Ata. Furthermore, the economic thinking presented by Walsh derives from US traditions that were not in the hearts of Alma-Ata's authors. This points to the disjuncture of perspectives that, in contrast to Shakow's description of Alma-Ata as NHS "through a glass darkly," could

be more aptly characterized as “through American glasses” and indicative of enormous power struggles. None of the presenters brought to light the significance of the Soviet Union and the Cold War in Alma-Ata’s creation. Birn has argued in past work that Alma-Ata has been misremembered in a way that omits the role of the Soviet Union⁴³ and that accounting for the role of the Soviet Union in Alma-Ata is illuminating in several ways. The Soviet Union hosted the Alma-Ata conference by default; the only agenda of the Soviet Union was to reorient against the reductionist vertical technocratic approach to international health. When the Soviet Union re-entered WHO, they did so with the thought that some of the Soviet approaches to health should be part of the discussion at WHO, such as the roles of housing, employment, and nutrition in health. The irony of the situation was that the Soviets missed the opportunity at Alma-Ata to showcase their investments and resolve to address the societal determination of health. Birn also remarked on the pattern of cooperation and intended emulation between the Soviet Bloc and recipient countries, such as Vietnam, North Korea, Cuba, and other nations. Even the most progressive high-income countries never purported to export their own standard of care to recipient countries, whereas the Soviet Bloc countries strived to bring their standard of care to the countries where they were working to improve health.

Regarding Gradmann’s presentation, Birn was puzzled by the omission of Julius Nyerere in his depiction of the Tanzanian context. She suggested that the role of villagization—i.e., the Ujamaa approach—must be recognized as the context in which TB control efforts were undertaken in Tanzania.

Birn also considered the question of whether Mahler was a neoliberal agent or was simply working within the constraints of his situation. Based on his work to sideline the celebration of smallpox eradication and WHO’s disappointment that investment in smallpox did not result in returns of cost-savings, Mahler did not see himself as a capitulator, but as a maneuverer. This is evidenced in the way he articulated his speeches

to WHO internal staff versus those working in the field. When speaking with those in the field he might have denied the requests of regional offices by invoking restrictions placed on him by the executive board. Alternatively, when speaking to the executive board and at WHO headquarters, he might have invoked the demands of regional offices as the basis for proposals. Birn proposed that this duplicitousness may reveal more about Mahler’s motives or intentions than the proposal that he was a closeted neoliberal.

In closing, Birn highlighted the need to understand the context which precluded WHO from being prescriptive. Unlike UNICEF, WHO was not an implementing agency; rather, they were engaged in policy and knowledge gathering. Furthermore, at the time of Alma-Ata, much of the world was under the rule of authoritarian regimes. Therefore, one might reinterpret the notions of village-level intervention or community participation as a means of bypassing repressive regimes. This is evidenced by the collective health movement in Brazil and rejection of the notion of public health, which represented the Brazilian dictatorship. Thus, she suggested that the conception of PHC and Alma-Ata’s (perhaps intentional) vagueness could be considered as a form of resistance.

2.4 GENERAL DISCUSSION

2.4.1 Selective PHC, a stop-gap solution or a derailment of progress?

Randall Packard, William Henry Welch Professor of the History of Medicine at the Institute of the History of Medicine at Johns Hopkins University, praised Walsh’s work and her prescience in arguing for selective PHC as a stop-gap effort. While there have been improvements in global health in recent decades, the World Bank reported in 2017 that 70% of the world’s population lacks access to basic health care. He asked whether selective PHC still has value as a stop-gap approach or whether it has derailed the progress toward UHC. Walsh acknowledged that this is the persistent question and controversy around selective PHC. Comprehensive PHC as recom-

⁴³ Birn and Kremmentsov 2018

mended by the Declaration of Alma-Ata and UHC includes a wide range of health services and is enormously expensive to implement. Throughout her career, she added, she had visited many healthcare centers in developing countries and very few facilities offered comprehensive PHC to their populations. The limited political will for investment in these settings limits the potential for providing comprehensive care. Given the reality that health funds and services were being rationed after Alma-Ata, Walsh argued that the rationing of funds and services should be done in a logical and knowledgeable manner in order to save lives. Otherwise, the rationing of funds and services disproportionately benefit those who were already well off. She said that when selective PHC was developed she had wished that comprehensive PHC was a viable alternative; at the time, comprehensive PHC for all did not seem like a realistic aim.

2.4.2 Importance of context in considering Alma-Ata and its legacy

Sunanda Ray, professor of public health medicine in the department of community medicine at University of Zimbabwe College of Health Sciences, noted the importance of context, as highlighted by Birn. She pointed out that Britain is radically different in the present era than it was when NHS was established in 1948. The model of PHC practiced by general practitioners with specialists providing certain services was subsequently exported to British colonies. In many countries, the power struggle between general practitioners, specialists, and mid-level health workers created by this model is being replicated today. She rejected the argument that mid-level health workers are a stop-gap and that there should be general practitioners at every level of the health system. This argument is based on the model used in Europe, but physicians are not the most competent people to serve at the primary level. She noted that the struggle for independence in Zimbabwe in 1980 spurred a public sentiment that people should have access to a basic level of health care. In the past, the entire health budget had been spent on two or three hospitals in the main cities, while services in the predominantly Black areas

were provided primarily by missionaries. For 10 years, the government supported PHC and consequently reduced infant mortality, maternal mortality, and TB incidence and prevalence. However, this progress was stymied by the emergence of the HIV epidemic. She remarked that the outbreak of HIV was not incidental; it was the result of economic forces of capitalism, migrant labor systems, and the displacement of people from their homes. The aim of UHC should be to create locally owned and locally determined health systems. However, whenever progress is made toward that end, donors assert their own priorities. While it is true that people want health care, it is also true that becoming healthy does not revert the economic forces that undermine peoples' capacity for self-determination.

Shakow expressed broad agreement with these comments. He pointed out that he, Yates, and Keshavjee have written about Alma-Ata from the perspective of Sierra Leone. He acknowledged that the story of Alma-Ata can be seen from numerous perspectives and can look very different in the contexts of Sierra Leone, Costa Rica, or Chile, which was one of the sites of the first primary health centers in Latin America. From the perspective of certain countries in the global South, the intervention of PHC was immediately catastrophic. A user fee program was specifically mandated as part of the initial PHC programs established after 1979. This was partly organized by one of the representatives of Sierra Leone to the WHO panel on health financing, and the model, regardless of the overarching macroeconomic context, was not constructive for the evolution of the health sector in that country. The implications and the aftermath of these and other policies are debatable; however, these complex geopolitical situations highlight the significance of context.

2.4.3 Affordability of UHC and need for political commitment

Robert Yates, director of the global health programme and the executive director of the Centre for Universal Health at Chatham House, challenged the notion that countries are unable to afford a decent package of health services, such as a UHC package, beyond conventional

PHC services. Ample evidence demonstrates that publicly financed free health care systems can be established, as illustrated by examples from the health systems of Cuba, Bhutan, Sri Lanka, and the barefoot doctors of China. He pointed out that both Britain's and Japan's health systems were destroyed during World War II, yet both nations have since built up successful publicly financed universal health systems. He said cautioned against the notion that countries be discouraged from introducing full benefits packages on the basis of costs. Yates pointed out that when Thailand launched its successful UHC program, its GDP per capita was \$1,900. Nigeria now has a GDP per capita of nearly \$2,000, suggesting that it could easily afford truly universal package of services. However, because health spending is primarily a political decision, political commitment and buy in from policy makers is critical. Walsh agreed, citing her own analysis of four countries with remarkably high life expectancy despite low GDP per capita. The notable commonality between Sri Lanka, Kerala, China, and Costa Rica was the great political will to improve wellbeing and health. The leaders in these nations had invested in health and education, nutrition, and health services, demonstrating the value of political will and investment.

2.4.4 On the need to bring the advancements of the human rights discourse to the forefront of global health action

Knipper commented on the focus on access to health services and the technical aspects of health over the determinants of health. A key lesson from Alma-Ata is that power relations and determinants of health need to be addressed. In contrast to the 1970s, there are now advanced legal instruments for human rights concepts and institutions, but these advancements do not automatically translate into action. Advocacy by civil society and academia is needed to bring these rights to the forefront of the discussion around health care. Health must be understood in terms of its social value, not only in terms of

the technical aspects of health that are easily measured, financed, and profited from. He noted that the human rights perspective and the role of power relations are related to other civic rights and considerations; the right to health does not stand alone, distinct from other rights and considerations. It has been shown throughout history that governments will not tackle inequities unless prompted to do so—particularly the inequities among migrants, indigenous peoples, and other marginalized populations. Although much has changed in the 40 years since Alma-Ata, much of the problematic thinking that undermined the Declaration of Alma-Ata still poses a threat to the success of modern efforts for UHC: namely, the reduction of UHC to technocratic approaches and the failure to address social and cultural issues. Brandt remarked that strong social and public policy is dependent on a strong knowledge base, political will, and social strategy. These key factors are interrelated and without one, the others will be ineffective. It seems that there is an adequate knowledge base in the case of UHC and the agenda of health for all. However, there is a significant deficit of and failure to rally adequate political will. The panel has highlighted opportunities for social strategy that can bring the knowledge base to bear on political will and subsequent action, he remarked.

2.5 THE UN POLITICAL DECLARATION ON UHC UNDERMINES HEALTH AS A HUMAN RIGHT

Jean Claude Mugunga, Partners In Health, reflected on the 2019 United Nations General Assembly (UNGA) meeting on UHC and shared his perspective on the need for comprehensive UHC.⁴⁴

2.5.1 The unfulfilled promise of Alma-Ata and the 2019 UNGA declaration on UHC

Mugunga opened by sharing the title of his opinion piece in Devex, *The UN Political Declaration on UHC Undermines Health as a Human Right*.⁴⁵

⁴⁴ United Nations General Assembly 2019

⁴⁵ For more information, see <https://www.devex.com/news/opinion-the-un-political-declaration-on-uhc-undermines-health-as-a-human-right-95675> (accessed February 15, 2020)

He was born in Rwanda in 1983 and was among the beneficiaries of the health interventions that took place subsequent to the Declaration of Alma-Ata. He remarked on his great fortune to have found professional success in spite of the poverty he and his family faced during his childhood. During his childhood, Mugunga witnessed the implementation of health programs such as vaccination and nutrition efforts; however, Alma-Ata had promised far more than what was actually delivered in terms of real improvements to people's health statuses. For instance, in spite of the inclusion of growth monitoring and nutrition interventions in health improvement plans, one in four children in Rwanda is stunted. He felt a great sense of unease attending the 2019 UNGA meeting on UHC, given that 40 years after the Declaration of Alma-Ata, children with easily curable cancerous tumors are still dying simply because they were born in villages in poor countries. He pointed out the "them/us" mentality that pervades conversations about global health and is used implicitly or explicitly to justify global health inequity. He also pointed out the role of immigration in global health. For example, his sister cannot afford health insurance for her family and she does not qualify for free care because her brother (Mugunga) lives in the US and is expected to cover the cost of insurance for her family. These kinds of policies affect the delivery of health interventions regardless of the intentions of global health policymakers, he noted.

Mugunga recounted his disappointment when he first saw the draft of the UNGA declaration on UHC, pointing out that the declaration did not include any specific action that should be taken to reach the goal of UHC by the year 2030. The declaration neither specifies what should be provided under UHC nor how those provisions will be funded. The declaration says that countries should choose sets of services that they can afford, seek out funding for health services, and aim to utilize their resources efficiently. He described this as lack of foresight and even insouciance on the part of the policymakers who made such vague recommendations. It is apparent, he said, that countries like Rwanda face a health funding gap of many

millions of dollars. The UNGA recommendation to address this funding gap through internal fundraising is unworkable. Furthermore, the failure to address these funding gaps ensures that this new declaration will amount to little more than another empty promise of health for all. He acknowledged the value of prioritizing among health services, but he decried the implication that countries should be expected to prioritize the cheapest, most cost-effective, most convenient-to-provide health services. This practice has been employed to forestall the truly equitable delivery of health care and to give policymakers the satisfaction of taking action without truly advancing the agenda of health equity.

Mugunga invoked a metaphor of three children under a tree to convey his view of health equity, as represented in Figure 2-2. The tree's fruit represents modern medicine, and when a child is brought high enough to reach the tree's fruit, they receive the benefits of modern medicine. Each child, for various reasons, requires a different degree of assistance in order to reach the tree's fruit. In this metaphor, each child is given the appropriate accommodation so that they can reach the tree's fruit: one child stands on a stool to reach the fruit; one child is standing on low ground, so they get a very tall stool to reach the fruit; another child is in a wheelchair, so they have been given a ramp and platform that brings them high enough to reach the fruit. Within this metaphor, the three children have achieved health equity. Mugunga likened policies that fail to deliver equitable health care to bringing a child closer to the tree, but not close enough to reach the fruit. Such approaches rely on the cynical perspective that those who are accustomed to poverty will be happy to receive marginal improvements and benefits, he said.

The argument that UHC is prohibitively expensive fails to acknowledge that many poor countries are currently burdened by excessive global taxes and colonial-era debts, said Mugunga, and the dollar value of these unjust financial burdens could easily offset the funding gap to achieve UHC. Comprehensive care must be provided and managed by public systems. He denounced the use of private hospitals for the rich to subsidize services for the poor, because these kinds of

approaches will lead to the destruction of health systems. In closing, he invoked the adage “nothing about us, without us”: it is critical to hear the voices of those impacted by health policies. The global community can achieve the right to health for all only through a transformative approach

to UHC that comprises vision, commitment, solidarity, and the rejection of the status quo.

Figure 2-2: Health equity



Source: Mugunga presentation

3 Politics of rights expansion

Danielle Allen, Director of the Edmond J. Safra Center for Ethics and James Bryant Conant University Professor at Harvard University, discussed the history of human rights discourse and its implications for the agenda of “health for all.” She described the emergence of the modern rights framework through a discussion of the milestones in the history of rights expansion and presented three debates of rights expansion, considering how these debates and the history of rights expansion relate to the challenges of PHC. She closed by evaluating two alternative approaches for using a rights framework and reflecting on how global health could be pursued through these models. During the discussion, participants explored the distinction between fostering the supports of political transformation and fostering explicit political outcomes, the connections between health system transformation, health service prioritization, and health system evaluation, the use of language regarding equity versus empowerment and the transformative implications of these uses. They also considered the appropriate role of global economic incentives, the split aims within global health of developing conceptual models and pursuing global health action, and the conceptual significance of community ownership in the American Declaration of Independence and in the Declaration of Alma-Ata.

3.1 MILESTONES IN THE HISTORY OF RIGHTS EXPANSION

Allen opened by highlighting several milestones in the history of rights expansion: the American Declaration of Independence (1776); the French Declaration of the Rights of Man and of the Citizen (1789); the Purna Swaraj (1929); and the UN Universal Declaration of Human Rights (1948).

3.1.1 American Declaration of Independence

The American Declaration of Independence (1776) was seminal in its core focus on political rights.⁴⁶ It includes language that guarantees “life, liberty, and the pursuit of happiness” and sets forth a broad yet non-exhaustive conception of human rights: “We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.” As such, the document is an open-ended conversation about the rights of humans based on the tenet that humans build governments in order to secure their own rights. Thus, the right of political participation is fundamental in allowing the people to steer structures in their interests, particularly in terms of securing other rights. She described this as formal institutionalization of a conversation about human rights, with a strong focus on political rights.

3.1.2 French Declaration of the Rights of Man and of the Citizen

The French Declaration of the Rights of Man and of the Citizen, ratified in 1789, reprises the US’s focus on political rights while also beginning to introduce elements of social and economic rights that were novel in comparison to the American Declaration⁴⁷:

Law is the expression of the general will. Every citizen has a right to participate personally, or through his representative, in its foundation. It must be the same for all, whether it protects or punishes. All citizens, being equal in the eyes of the law, are equally eligible to all dignities and to all public positions and occupations, according to their abilities, and without distinction except that of their virtues and talents. [Article 6]

⁴⁶ For more information, see http://avalon.law.yale.edu/18th_century/declare.asp (accessed February 15, 2020)

⁴⁷ For more information, see http://avalon.law.yale.edu/18th_century/rightsof.asp (accessed February 15, 2020)

A common contribution is essential for the maintenance of the public forces and for the cost of administration. This should be equitably distributed among all the citizens in proportion to their means. [Article 13]

Allen pointed out that Article 6 is one of the first efforts to express aspirations toward social equality and the provision of social rights, although the rights granted by the French Declaration do not meet the modern standards of social rights. Article 13 is noteworthy in that it acknowledges the need for a common contribution to maintain public services, while also recognizing that the need for economic rights with respect to proportional taxation—e.g., that citizens with more means should contribute more than those with fewer means.

3.1.3 Purna Swaraj

The discourse around rights changed dramatically over the ensuing century, Allen explained. These changes were driven by the industrial revolution, the transformation of the global economy, the immiseration of working-class populations in urban areas, and the unfolding of colonialism in the 19th century. In 1929, as the independence movement was coalescing in India, a key rights document called the Purna Swaraj drew upon the language of the Declaration of Independence to claim a significantly expanded set of rights⁴⁸:

The British Government in India has not only deprived the Indian people of their freedom but has based itself on the exploitation of the masses, and has ruined India economically, politically, culturally, and spiritually. We believe, therefore, that India must sever the British connection and attain Purna Swaraj, or complete independence.

The Purna Swaraj laid claim to a set of economic, political, cultural, and spiritual rights that

has become the basis for the modern rights discourse. Allen pointed out that in this new modern discourse, the prioritization among economic, political, cultural, and spiritual rights has varied; this variance has had a significant impact on the perception of human rights and the unfolding of action around human rights. The Purna Swaraj places of economic rights ahead of political rights, which would go on to have an impact throughout 20th century politics.

3.1.4 UN Universal Declaration of Human Rights

The Universal Declaration of Human Rights, ratified in 1948, is a crystalized articulation of this new discourse on human rights, said Allen.⁴⁹ It includes all the sets of rights—political, economic, and social—that had been developed over the course of several centuries. For instance, Article 25 of the Declaration ensures social rights:

Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection. [Article 25]

Article 21 makes further rights guarantees, including 1) right to government participation through freely chosen representatives, 2) right to equal access to public services, and 3) the will of the people to be the basis of the authority of government.⁵⁰ Allen noted the import of the right to equal access to public services to modern discussions of UHC and the right to health. However, these social and political

48 For more information, see <http://www.indiaofthepast.org/contribute-memories/read-contributions/major-events-pre-1950/283-purna-swaraj-the-demand-for-full-independence-26-january-1930-> (accessed February 15, 2020)

49 For more information, see <http://www.un.org/en/universal-declaration-human-rights/index.html> (accessed February 15, 2020)

50 (1) Everyone has the right to take part in the government of his country, directly or through freely chosen representatives. (2) Everyone has the right of equal access to public service in his country. (3) The will of the people shall be the basis of the authority of government; this will shall be expressed in periodic and genuine elections which shall be by universal and equal suffrage and shall be held by secret vote or by equivalent free voting procedures. Universal Declaration of Human Rights (1948); Article 21.

rights had been deprioritized in the suite of rights granted by the Universal Declaration of Human Rights: they do not appear until Articles 21 and 25, preceded by articles on the rights of expression, religion, mobility, and migration.

Allen traced this de-prioritization and downgrading of the significance of political rights in the global rights discourse—as evidenced in the Universal Declaration of Human Rights—back to Franklin Delano Roosevelt’s Four Freedoms speech, delivered in 1941.⁵¹ In this speech, Roosevelt argued for the universal protection of rights; like the Purna Swaraj, this speech was influential in the rights discourse leading up to the Universal Declaration of Human Rights in 1948. Speaking about the prioritization of rights, Roosevelt remarked:

The first is freedom of speech and expression – everywhere in the world. The second is freedoms of every person to worship god in his own way – everywhere in the world. The third is freedom from want...everywhere in the world. The fourth is freedom from fear...anywhere in the world. That is no vision of a distant millennium. It is a definite basis for a kind of world attainable in our own time and generation.

The fact that Roosevelt did not mention political freedom speaks to the politics of the age and reflects the circumstances that contributed to the de-prioritization of political rights in the 1948 Universal Declaration of Human Rights, said Allen. At the time, people were seeking to conceive of a rights framework that could be applied globally in a world full of non-democratic states that would clearly be unwilling to commit to the inclusion of political freedom as a prominently featured universal human right. She noted that these debates and philosophical tensions that drove these decisions in the past continue to echo in today’s rights discourse, with particular salience in the discourse around the right to health.

3.2 THREE DEBATES OF RIGHTS EXPANSION

Allen identified three debates that underline changes in the rights discourse over time: 1) the justice debate about the prioritization of political, economic, and social rights, 2) the liberties of the ancients versus the liberties of the moderns, and 2) conceptual distinctions between access and outcomes in the discourse on political, economic, and social rights.

3.2.1 Prioritization of rights

The first debate centers on which types of rights should be most highly prioritized—political, economic, or social. She noted that rights are not prioritized to the exclusion of other rights; rather, the lesser prioritized rights will be conceived of in terms of their support for the prioritized right(s). For instance, if political rights are prioritized, it is still necessary to advocate for economic and social rights to provide the supports that enable egalitarian empowerment within the context of a political regime. In the history of rights expansion, this debate has largely been shaped by the unfolding of global political, social, and economic forces.

3.2.2 Positive versus negative liberties

Allen explained that the second debate was launched in the early 19th century by the French Swiss philosopher Benjamin Constant in his speech *De la Liberté des Anciens comparée à celle des Modernes* [The Liberty of Ancients Compared with that of Moderns].⁵² He argued that ancient societies such as Greece and Rome had prioritized liberty, which they understood as participation in government. Their notion of human flourishing included the ability to shape one’s world, both in terms of personal choices and in terms of contributing to communal choices. These concepts were described as “positive liberties” by later philosophers. Constant argued that the modern industrialized

⁵¹ For more information, see <https://www.fdrlibrary.org/four-freedoms> (accessed February 15, 2020)

⁵² Constant 1819

society of his day conceived of liberty as the freedom from government interference to enable people to pursue commercial transactions and maximize their material wellbeing. Later philosophers designated this “liberty of the moderns” as “negative liberties.” Allen framed the distinction between these two notions of liberty as “freedom of” versus “freedom from.” Positive liberties include the freedoms to participate in government, serve in political offices, and play a leadership role in the community; negative liberties include freedom from government interference and the rights of free expression and association. She emphasized that advocates of positive liberties generally incorporate negative liberties into their frameworks to some extent, as political empowerment requires a certain degree of free expression, self-determination, and free association. In contrast, advocates of negative liberties tend to be far less concerned with positive liberties. In fact, advocates of negative liberties are often concerned primarily with their ability to control their personal property, their contracts, and their associations; they are generally less concerned about government activity as long as it does not infringe on those negative liberties. In other words, the positive liberties always bring with them the negative liberties, while the negative liberties do not necessarily bring with them the positive liberties.

3.2.3 Access versus outcomes

As the rights discourse expanded from an exclusive focus on political rights to include consideration of economic and social rights, another conceptual distinction came to the fore: access versus outcomes. Allen explained that political rights are focused primarily on access to certain rights and processes, such as the right to vote, to run for office, to have legal representation, and to have a trial by jury. Outcomes become important when economic and social rights are introduced into the discourse, because some evaluation of outcomes is necessary in order to evaluate the provision or protection of such rights. A funda-

mental conceptual challenge emerges when frameworks built for thinking about access are used to think about outcomes—this can lead to instability and uncertainty in the rights discourse.

3.2.4 Impact of the debates on modern discourse about rights expansion and primary health care

These three debates are reflected in modern political realities and current discourse about rights expansion, said Allen. For instance, there is scholarly debate regarding whether the shift from the 18th century to the 20th century is more aptly understood as a story of continuity or a story of change, with the latter characterized by an abrupt break in mid-20th century politics.⁵³ Without delving into the details of that debate, she noted that this shift during the 20th century involved the effort to apply a rights paradigm that had previously operated only at the national level to paradigm of universal rights operating at the global level. This effectively pushed political rights out of the conversation in a way that has subsequently been very consequential in the de-prioritization and abatement of political rights.

Allen remarked that the phrase “primary health care” is beset with difficulties, because it is unclear whether PHC is intended to ensure access versus outcomes, or health services versus social determinants of health. This difficulty owes to the conceptual instabilities of the underlying rights framework. Comparing the language of the Declaration of Alma-Ata (1978) with the Declaration of Astana (2018) underlines how political rights have been “squeezed out” of the picture over time and how the place for the role of the people has shifted. The Alma-Ata Declaration requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources. The ability of communities to participate is developed through appropri-

⁵³ Allen referred to scholarly works of Lynn Hunt, who has argued for continuity, and Sam Moyn, who has argued for discontinuity.

ate education. These concepts of participation, self-reliance, and community engagement—which pertain to political rights—are absent from the Declaration of Astana, which reflects the de-prioritization of political rights in the modern era. She suggested that some of the conceptual difficulties that underlie PHC could be resolved by recognizing and addressing the instabilities in its underlying rights frameworks.

3.3 TWO ALTERNATIVE APPROACHES FOR USING A RIGHTS FRAMEWORK

Allen considered two alternative approaches for using a rights framework: the empowerment approach and the equity approach—and considered the limitations of the latter (dominant) approach. Under the empowerment approach, rights are for the sake of securing human empowerment, which is often interpreted as political equality; thus, justice is best defined as dignity on the basis of effective material supports for full participation. This approach prioritizes political rights and sets economic and social rights as supports for achieving empowerment. She pointed out that this approach is intuitive when considered in the context of democracy, but rather unintuitive in non-democratic settings. Although the empowerment framework is currently precluded by global politics, vestiges of this approach can be observed in the language of international organizations when they call for engagement with all stakeholders.

3.3.1 Limitations of the equity approach

Within the equity approach, rights are for the sake of securing material wellbeing; thus, justice is best defined as effective material supports for flourishing private lives. In this approach, private life can be broadly understood either as individual or community lives. But under either interpretation, the equity approach omits the rights of political participation and full societal empowerment. The equity

approach is currently dominant and is the driving framework behind selective PHC. However, it is unclear whether this approach would be able to achieve the goal of health for all or UHC.

Allen explored the limitations of the equity model. By virtue of focusing on the distribution of material goods, the equity model runs head on into the question of access versus outcomes. An outcomes-based answer is required in this case, given that the goal of the equity approach is material wellbeing, which is inherently defined in relation to outcomes. The next task is to define the outcome standard. A purely egalitarian outcome standard is off the table for a number of reasons, including its infeasibility. The most common outcome standard in this context draws upon the approach to distribution based on the theory of justice arguments by philosopher John Rawls.⁵⁴ He argued (roughly) that inequalities are acceptable as long as they are working to the advantage of the least well off. This underpins the notion that structural wealth inequalities in global wealth are acceptable when coupled with redistributive practices directed at the least well off.⁵⁵ Another limitation of the equity model is that this redistribution necessarily involves a technocratic process of managing those wealth transfers. Consequently, the extent to which the equity model can effectively redistribute depends upon how well that technocracy functions.

Allen argued that the technocratic view is inherently constricting due to technocracy's incentive structures and because technocrats tend to represent the interests of developed economies. She suggested that a developed economy can reasonably hold the positions that 1) material transfers should not exploit less developed economies and 2) developed economies should invest in ways that make the globe more stable for everyone. This technocratic formulation of the argument for investing in global health is rational if rationality is defined as pure alignment of the interests of the underlying sovereign state for whom the technocrat works. In other words,

⁵⁴ Rawls 1971

⁵⁵ Allen noted that this position seems evident in some of the arguments for selective PHC programs.

even technocrats working in international organizations such as the UN or WHO are ultimately constrained by their own national interests. This is distinct from the more equity-driven aim of investing in ways that make each place the best it can be for the people who live there. The technocratic view is more limited, given its focus on attaining global stability rather realizing a world in which every society has a maximum opportunity for flourishing—the former vision can be achieved before the latter, she noted. Donor dollars are justified based on the technocratic argument. Therefore, the equity model—due to its dependence on technocrats who are nationally affiliated—is given to developing in the direction of the operations of “rational technocracy,” with “rational” defined in the economic sense of rational self-interest. The equity model is also limited by its lack of a built-in mechanism for protecting the people. This is precisely because the equity model was developed in a global context that was not amenable to the inclusion of empowerment mechanisms within a rights framework. While it is possible to add such mechanisms to the equity model to protect its beneficiaries, it is not one of the model’s core concepts.

Allen noted that this is reflected in concerns that elites will capture material transfers made in the effort to bring about UHC, which were discussed by Julia Walsh. Allen said that there are two options for protecting the people within the equity framework: democracy or benevolent (as opposed to rational) technocracy. Both options can protect people when governments are operated in the interests of the people. Allen highlighted the contrast between benevolent technocracy and rational technocracy. Rational technocracies operate in the interest of donor states, while benevolent technocracies operate in the interest of recipient states. The current incentive structures ensure that only rational technocracies will emerge, she suggested. This give rise to the substantial challenge of converting rational technocracies into benevolent technocracies.

3.4 PURSUING GLOBAL HEALTH THROUGH EQUITY AND EMPOWERMENT MODELS

Allen reflected on whether the empowerment model or equity model should be used for pursuing global public health. First, she considered what it would take to “save” the equity model by shifting from rational technocracy to benevolent technocracy, which would require increasing material transfers. She noted that the reparations discourse is a tool that is implicitly being used to spur the transition toward what might be called a “restorative justice” technocracy. This seems like a plausible strategy, but it faces substantial barriers because domestic politics does not motivate technocrats to be benevolent. For instance, survey data have revealed that Americans’ tend to be categorically against increases in foreign aid, even when they are informed that they have vastly overestimated the actual amount of money that the US spends on foreign aid as a proportion of the overall budget. This indicates that the underlying issue is not how much money is spent on foreign aid, but rather the lack of alignment between national interests and the provision of foreign aid. Making the transition to a benevolent technocracy will require fostering national interest in investing in other countries, she said. This would require a specific political effort that might even bring public health advocates together with unexpected bedfellows, such as anti-immigration advocates who support such investment inasmuch as it might reduce immigration.

Next, Allen discussed how to build an empowerment model for global health (see Box 3-1). She considered whether a restorative justice technocrat who focuses on reparations might help to build an empowerment model. Although this might be part of a solution, reparations fail to address the underlying problem, which is the absence of a rights concept that focuses on protecting the people. Such a concept could either allow people to protect themselves or could involve some alternative to democracy with built-in protections for people. Material transfers are insufficient to bring about such a change and, although restorative justice may support an

empowerment model, the empowerment model would need to bring novel solutions to the problem of protecting the people. Until there is a structure in place that allows for decision-making and protects the people most in need, merely increasing material transfers is akin to throwing good money after bad. Material transfers should not be increased until the underlying structures are transformed. That is, rather than just sending more money, investment should be channeled into fundamentally transforming the system to protect the people and ensure that recipient countries can make their own functional decisions about resource allocation, for example.

Allen also highlighted the importance of identifying and engaging in appropriate partnership structures. She suggested that the global health conversation could link in and engage with broader global economic, migration, and foreign policy conversations. For instance, a network of political economists is working to develop a new paradigm for political economics that is aimed at pushing aside the neoliberal paradigm. Global health advocates could join forces with such groups to develop shared policy frameworks. Similarly, the concerns of global health are deeply connected with global migration and foreign policies. An empowerment model for global health could emerge by marshaling the resources of these other forms of expertise. She described the paradox of “cosmopolitan insularity”—the tendency for insular groups to communicate in a manner that is shared internally, but is incomprehensible to the broader community. All global policy

domains, including global health, are at risk of exhibiting this phenomenon, so efforts should be made to allow “outsiders” to more easily join the discourse. She herself has found it challenging dial in to the vocabulary of the global health conversation. Cosmopolitanism has great value for global communities, but insularity is a threat to the success of those communities.

Allen proposed that the global health community use different models for pursuing a rights framework in democratic states than in non-democratic states—and within the latter category, different models for what Rawls calls “decent” and “non-decent” non-democratic states. Some non-democratic states are amenable to working in the interest of the people, while others are not. Thus, three approaches to promoting a rights framework for health should be developed to address each of these types of states.

She also suggested broadening the language used within an empowerment model to focus, for example, on the provision of “primary health supports,”⁵⁶ which is a term that can encompass both primary health care and the social determinants of health. This language has the advantage of being conducive to the use of metrics to measure the extent to which efforts to improve health actually facilitate the empowerment of individuals and communities. She suggested that “supports” may also a more intuitive and accessible term for the general population. Finally, she argued that in addition to the lives saved, it is necessary to quantify results in terms of increased local capacity to save lives.

⁵⁶ Allen specified that her use of the word “supports” is roughly aligned with Amartya Sen’s notion of “capabilities.”

Box 3-1. Building an empowerment model for global health

- Link global health conversation in practical terms to international economic policy, global migration policy, and global foreign policy conversations.
- Surmount the challenge of cosmopolitan insularity.
- Use different model for states proactively pursuing democracy versus for states not doing so.
- Use different models for “decent” versus “non-decent” non-democratic states.
- Focus on the provision of primary health supports to include both social determinants and care.
- Quantify results in terms of increase in local capacity to save lives, in addition to lives saved.

3.5 GENERAL DISCUSSION

Robert Yates, director of the global health programme and the executive director of the Centre for Universal Health at Chatham House, asked which economists or groups the global health community should engage with for support in rethinking the health paradigm. Allen replied that numerous groups around the world would likely be amenable to such efforts, including Oxford Business School and the Institute for New Economic Thinking.

3.5.1 Driving the supports of transformation versus driving political outcomes

Randall Packard, William Henry Welch Professor of the History of Medicine at the Institute of the History of Medicine at Johns Hopkins University, compared Allen’s description of the empowerment model to the US rationale for democratization in the 1990s (e.g., the invasion of Iraq and the overthrow of governments in Latin America). Allen conceded that the empowerment model can move in better or worse directions. In contrast to Packard’s examples, she cited former US Secretary of State and Secretary of Defense George Marshall’s perspective on the empowerment agenda after World War II. In the 1990s, the driving logic was that democratization could serve as the sole solution.

George Marshall’s perspective was that it was necessary to understand all the supports that would be necessary to allow empowerment to emerge, including the rule of law, the functionality of economies, the distribution of resources, and societal health. A parallel argument is that global wellbeing, peace, and stability emerge from the same conditions that allow free governance to emerge. This perspective can be useful in the modern era, but it must be distinguished from the approach of simply inserting democratic systems into societies without considering the other factors that make societies healthy. A modern empowerment model should foster the emergence of the supports that will bring rise to democracy with all relevant stakeholders being engaged; this approach can promote the development of democratic structures, even in non-democratic institutions. Packard argued that the distinction between democratizing and fostering the emergence of supports that will bring rise to democracy is fairly weak, pointing to Cold War era efforts to remove the perceived barriers to the emergence of democracy. Allen suggested that the focus on empowerment, capabilities, or supports that are necessary to allow the people to undertake self-determination is, in fact, distinct from the notion that nations should be acting to drive a certain political result such as democratization in other nations.

3.5.2 Transformation, evaluation, and prioritization

Sunanda Ray, professor of public health medicine in the department of community medicine at University of Zimbabwe College of Health Sciences, considered the practice of impact assessments used to evaluate climate and environmental interventions. She asked how institutions might use impact assessments to ensure that their activities abroad are having the desired impacts and to identify opportunities to improve the impacts of their activities. She added that such activities could help institutions and actors find new approaches to form impactful partnerships. Allen replied that achieving structural transformation will require assessments of impacts including empowerment and capacity. She suggested that her proposed empowerment model could be thought of as a mechanism for prioritization, although the prioritization of services or interventions is an ongoing debate that will continue even after an increase in material transfers.

3.5.3 Equity, empowerment, and transformation

Natalia Linos, executive director of the FXB Center for Health and Human Rights at Harvard University, remarked on Allen's distinction that equity approaches focus on individuals, while empowerment approaches focus on structures. She noted that this distinction is the inverse of the way those terms are used by international agencies—that is, equity is associated with structural transformation and empowerment is associated with empowerment of individuals. Allen replied that the concept of empowerment as currently used is rather narrow; linking of these issues to the global political, economic, climate, and migration conversations could bring about a better understanding of the structural transformation needed to support the empowerment of all people and the rebalancing of global power dynamics. Regarding the language of equity, Allen disputed the common belief that the equity approach is transformational. Through a focus on redistribution, the equity model primarily works to manage a problematic global structure

rather than to transform it. Material transfers are necessary to bring about transformation, but other economic considerations are relevant prior to considering the redistribution question. In economics for instance, the distribution of gains throughout societies are often discussed in terms of redistribution. For example, an economy that delivers good jobs will support health, because good jobs are defined in ways that relate to the determinants of health; global foreign policy norms can be developed that promote the prioritization of good jobs globally. Such considerations can be applied to determine which type of infrastructure organization that redistribution should be used to invest in and develop.

3.5.4 Global economic development, incentives, and rights protection

Julia Walsh, retired professor of maternal and child health and international health at University of California, Berkeley, compared examples of countries with benevolent technocratic leaderships to countries with less-benevolent technocratic leadership. For example, in the 1980s Bangladesh was much poorer than Pakistan, yet it has realized advances in health beyond those of Pakistan, including comparatively lower total fertility rates and better health among its children. She suggested that an incentive system may be effective in driving technocracies toward benevolence, particularly considering that the worst-off countries in the world are those with the weakest governance. Like the issues of global health, Allen remarked that the issues of development economics are challenging, but evidence suggests that well-intentioned Western policy paradigms have been disabling in many recipient countries. She highlighted the primacy of building capacity of civil society as a strategy for rights protection in settings with ill-functioning governments.

3.5.5 Multiplicity of conceptual models

Ezekiel Emanuel, vice provost for global initiatives, Diane v.S. Levy and Robert M. Levy University Professor, and Chair of the Department of Medical Ethics and Health Policy at University of Pennsylvania, remarked that although there

is much work to be done, tremendous progress has been made in global health since 2000. As momentum gathers toward a single, overarching conceptual view to supplant neoliberalism, he cautioned that attempting to articulate and implement that new ideology—particularly in donor countries—may distract from the mechanisms already in place that have and can continue to improve global health. He asked how to disentangle China’s remarkable economic progress from the ways in which global health policy has moved forward. Allen suggested that the pursuits of conceptual models and continuing the current work of global health are not mutually exclusive; a division of labor could enable them to be pursued in tandem. She added that it would be a mistake to curtail exploration of the post-neoliberalism paradigm. Meanwhile, immediate work needs to be done to improve the equity framework; for instance, the benevolent technocracy concept is vulnerable to the destabilizing critique that it reiterates the colonial paradigm. Maximizing the benefits of the benevolent technocratic model is a worthy aim, she said, but the scope of global health work should not be limited by that model.

3.5.6 The American Declaration of Independence, Alma-Ata, and ownership

Aaron Shakow, director of the Initiative on Healing and Humanity at the Center for Global Health

Delivery, Harvard Medical School, remarked on Allen’s depiction of the American Declaration of Independence as an embryonic document that may have been deliberately incomplete because it was intended to be rooted in and cultivated by social life. He drew a parallel to the Declaration of Alma-Ata. If the aim of the health-for-all-agenda is rooted in a commitment to comprehensive health care, it may have been strategic for the authors to begin this transformation with a deliberate incompleteness and require that people fight for it. Allen replied that part of the conversation about global health is to fight for the concept of health as a right; she suggested that a rights-based framework can be valuable in that respect. She remarked that the American Declaration of Independence primarily represents its authors’ efforts to determine what should be fought for; it is not a document that they intended the people to fight for themselves. She suggested that community ownership of a document is more important than “completing the incompleteness” of a document like Alma-Ata. For example, that communities could assume ownership by engaging in deliberative processes whereby they re-articulate their own vision for the community based on the document and decide how to advocate to achieve that vision.

4 Health as a human right

This chapter summarizes the conference session on health as a human right. It featured presentations on whether the rights-based approach to health is sensible or useful for achieving global health goals, the progressive realization of UHC and the rights-based rationale for this approach, and the conceptual contributions of the human rights model to UHC. Additional presentations addressed health-care quality and the right to sexual and reproductive health, the quality, status, and perceptions of health care in East Asia, and idioms of social justice mobilization. The session's discussants explored key issues related to the right to health, including the value of a rights-based perspective for protecting vulnerable populations and setting health systems priorities and a recounting of the rights-based activism that transformed HIV/AIDS care. During the discussion, participants deeply explored the connections between the prioritization of health services, health funding, and health activism, along with the concern that UHC programs have systematically excluded non-citizens.

4.1 DOES THE RIGHT TO HEALTH MAKE SENSE?

Ezekiel Emanuel, vice provost for global initiatives, Diane v.S. Levy and Robert M. Levy University Professor, and chair of the department of medical ethics and health policy at University of Pennsylvania explored the question of whether a rights-based approach to health is useful or sensible along with related questions within the context of Alma-Ata and the agenda of health for all. He considered whether health care should aim to meet a standard of maximal attainable health or a standard of some minimal threshold of health, and he discussed the role of PHC as the core component of UHC. His presentation was followed by a brief discussion.

4.1.1 Successes and failures of Alma-Ata

Emanuel opened by reflecting on the successes and failures of the Declaration of Alma-Ata. The

Declaration famously defined the attainment of the highest possible level of complete physical, mental, and social wellbeing as a most important worldwide social goal, which Emanuel considers somewhat grandiose. The Declaration defined health as a human right and condemned inequalities between and within developed and developing countries as unacceptable. It also set forth the commendable target of achieving health for all by 2000 and recognized that health requires both social and economic development, thus improving health requires addressing the social determinants of health (e.g., food supply, housing, transportation). Finally, the Declaration identified primary care as the foundation of health.

Emanuel highlighted three successes of the Declaration of Alma-Ata. Firstly, it had an important effect in encouraging global investment in health and in attempting to expand health coverage. Secondly, it promoted a more comprehensive notion that linked health to social and economic development, recognizing that healthcare is not an island but is influenced and part of other social sectors. "If you want to improve health, healthcare may not be the most important element at all," he said, "... and this is something every generation keeps learning over and over again, but it is fundamentally important because we waste so much money on healthcare." Thirdly, the Declaration promoted global health as a human right.

Turning to the Declaration's key failures, Emanuel maintained that the Declaration's definition of health was widely viewed as unrealistic, because the "the highest possible level" is not a feasible goal, for a host of reasons. Furthermore, the Declaration of Alma-Ata was not successful in establishing PHC as the focus in health care. Instead, the intervening decades saw the focus become increasingly disease-specific, with interventions devoted to malaria, HIV/AIDS, and maternal and child health. He emphasized that significant progress has been made in those domains: HIV/AIDS related deaths have fallen by 56% since 2004, malaria-related deaths have

declined by 28% since 2010; and global infant mortality has decreased by 28% since 1990. He argued that these huge achievements were realized over a short period of time and should not be overlooked. Furthermore, this progress was primarily achieved through disease-focused interventions—which is neither his preferred approach nor the approach prescribed by Alma-Ata—but it was effective nonetheless. While the Declaration of Alma-Ata helped bring determinants of health to the table for discussion, interventions addressing the social determinants of health were not actually prioritized or integrated into health care budgets and policies in the last four decades. These efforts are “...more taken up in the rhetoric than in the actuality,” he noted.

Emanuel focused on three fundamental questions that came out of Alma-Ata and contextualized them within the challenges facing global health and universal health coverage today. One of the overarching questions to address is which services health care systems should provide at each stage of the system’s development. With the proclamation that everyone should get health care and have the opportunity for well-being, the key issue is which services to prioritize. A related question concerns the appropriate degree of financial risk protection. This protection is necessary because health care can be expensive and thrust people into poverty, thus health coverage is necessary, in part, to avert poverty. A third question is how to balance various principles that are broadly affirmed—e.g., efficiency, priority to the worst off, and participation—but will inevitably conflict. In light of these pressing health system concerns, Emanuel raised three questions about the legacy of Alma-Ata: 1) whether the concept of health as a human right helps to focus attention and resources on improving global health; 2) whether it is helpful to define health using the a standard of “the highest possible”; and 3) whether or not primary care should be the focus.

4.1.2 Is a rights-based approach to health care sensible?

Emanuel argued that construing health as a human right makes no sense and may also undercut the importance of using a rights-

based framework. A human right is a right that imposes duties and responsibilities on others, he explained. Human rights are plural—in that health is not the only human right—and most importantly, human rights are universal, applying equally to all people. A human right is a highest priority of utmost importance; it garners attention and demands action by other people because they have a responsibility to uphold and protect that right. He outlined several problems with calling health a human right. Because there is no global consensus on what human rights actually are, the definition is subject to ongoing dispute that have to resolved by “looking under” human rights to examine the justification for those rights, how they are understood, and which rights make the most sense. From his perspective, this wastes valuable time. He suggested that in her keynote, Allen focused not on the rights themselves, but on their underlying conceptions, such as empowerment and equity, which inform how we understand human rights and the notion of right to health care.

We must ask ourselves why health is important and why we think people ought to have health and—in some ways—to be guaranteed health, said Emanuel. Unpacking the notion of health as a human right gives rise to different conceptions. Health is important in enabling human agency and autonomy; it is difficult to live a flourishing life without prolonged health. Thus, good health empowers people in a personal (rather than political) sense by enabling them to live a full life and, as such, it is a fundamental interest of all people. These types of relatively uncontroversial claims are often used to justify the prioritization of health funding. In Emanuel’s view, the notion that health is important to autonomy and individuals’ ability to live a flourishing life are able to do the intellectual and moral work of asking people to put resources into guaranteeing adequate healthcare and health for people around the world, because it is such a fundamental interest of everyone who wants to live a full life. “I don’t think we advance the argument by then in casting it in terms of rights,” he argued, “...I think we have to focus in on the underlying rationale.” Framing health as a human right does not benefit deliberations about which services should be

guaranteed, because it suggests that there is no limit to the services that should be provided to ensure that human right. On the other hand, the aim of guaranteeing people autonomy and a way to live a full and flourishing life does offer a perch from which to address questions about which services to guarantee, the degree of financial protection, and how to balance competing values. People are inevitably drawn to the underlying justifications of human rights. However, adding the gloss of a human right does not actually help and, in some ways, it hurts by distracting from the fundamental question, he said. He conceded that human rights language can be helpful in getting people to intuitively accept the universality element, but suggested that the underlying notion of life, liberty and pursuit of happiness may do that work more effectively.

4.1.3 Is the “the highest attainable” standard of health helpful?

Next, Emanuel considered whether the standard of health should be set at the maximum attainable wellbeing or construed in terms of a minimal threshold. “Maximal attainable” is an exceedingly high threshold, he noted, and human rights writ broadly are typically framed as minimal thresholds. Defenders of the human rights view often think of human rights as thresholds above which individuals are left to themselves; this is evident in Alma-Ata and other declarations which reference an “adequate standard” of living. Thus, the fundamental question is whether to adopt adequate health as a minimal threshold or set the maximally attainable level of health as the more important social goal, he said.

Emanuel suggested that an intuitive notion of “a fulfilling human life” likely resembles the former more so than the latter. Typically, adequate standards rather than maximum ones are used to define what it takes for a person to live an autonomous, flourishing life, he suggested. Additionally, setting the highest attainable health as a standard is problematic for resource allocation. Maximum standards can create a “resource black hole,” because there will always be some additional health service that could bring some people ever closer to the maximal attainable level of health. In this regard, the maxi-

imum standard creates never-ending demand. Resource misallocation in the US can serve as a cautionary tale of using a maximum standard that no amount of resources can fulfil, he said. Furthermore, the maximum standard is counterproductive for determining which health care services should be guaranteed in countries at different levels of development. In LMICs and LICs in particular, the pursuit of a maximum standard would be impractical and unrealistic, whereas an adequate threshold provides a better way to make those determinations.

An adequate standard also offers a better way to evaluate the success or failure of global health activities, he added. For example, the measure of years of life lost (YLL) indicates the total number of years of life that individuals did not live relative to some threshold age; this provides a good measure of the inadequacy of a health system. If all individuals lived to the age of 75 years in a health system that measured YLL with 75 as the threshold age, there would be little societal concern that everyone was not living to the maximal age threshold. In his opinion, individuals can live a rich, flourishing life if they have health until the age of 75 years. Society does not have obligations to ensure that people have maximal wellbeing until the age of 90 or 100 years, as the language of human rights and the Declaration of Alma-Ata suggest. “Thinking of health as a threshold to get people to 75 is a much better way of thinking than maximal wellbeing,” he argued.

4.1.4 Should primary health care be the focus of health investment moving forward?

Finally, Emanuel considered the question of whether primary care should be the focus on health investment going forward. He reiterated that huge strides have been made in global health in the last several decades in specific diseases such as malaria and HIV, but those vertical interventions have not made real progress toward the goal of getting everyone to the age of 75 years. The Ebola virus disease crisis in West Africa as well as current ongoing crises highlight the deficiencies of the disease-specific approach and the need to strengthen health systems. He agreed that a core focus on strengthening health

systems requires primary care, thus investing in and focusing on primary care will strengthen health systems overall. This will become increasingly important as NCDs continue to escalate across the world, because unlike communicable diseases, NCDs cannot be adequately addressed through disease-focused interventions. Rather, they must be addressed through functional health systems centered upon primary care. In that sense, Alma-Ata was prescient in anticipating the importance of primary care as the foundation for providing health to all people during the impending transition of the global burden from communicable disease to NCDs.

4.1.5 Moving forward with UHC

Emanuel closed by arguing that the fundamental questions moving forward concern which services that UHC should guarantee to people at specific stages of a country's and health system's development. The focus should shift to answering those questions—and on finding the resources to implement those guaranteed services—rather than debating whether or not health care is a human right or whether maximum attainable wellbeing should be the goal, he said. However, putting primary care “front and center” will be fundamental to ensuring that people have access to whatever package of health care services is guaranteed as part of UHC.

4.1.6 General discussion

Robert Yates, director of the global health programme and the executive director of the Centre for Universal Health at Chatham House, challenged the idea that the notion of a right to health is not useful. In the UK, for example, the right to health has been called the closest thing the British people have to religion. In the UK and elsewhere, the right to health has been instrumental in obliging politicians to ensure that health systems are properly financed to provide universal access to health services. In the US, there is no such explicit right to health, yet the national health expenditure is double that of the UK; this undercuts the contention that creating the expectation of the right to health results in higher costs. Emanuel replied that he is not arguing that the right to health care itself

leads to higher costs. Rather, the problem is the lack of budget to provide an upper limit and constrain costs, as seen in the US and Switzerland, which have the highest health care expenditures in the world. The UK has a budget that controls costs but also famously underspends given its GDP per person, rendering the right to health somewhat peculiar. People can demand a right to health, but the NHS has been substantially underfunded for decades. The intellectual work to be done centers on what, exactly, populations are universally entitled to in terms of specific services within UHC. In low-resource countries, the claim to a right to health does not answer that fundamental question. Instead, defining the purpose of health care and what it is supposed to achieve—e.g., allowing people to live a good life with moderately good health for a certain number of years—provides much more coherent insight into what services are needed to achieve those aims, said Emanuel.

Eric Sawyer, founding member of ACT UP, challenged Emanuel's assertion that the rights-based approach to health has not contributed to the advances in global health that have been achieved. Emanuel clarified his position, stating that the substantial global improvement of health statuses owes not to the expansion of PHC, as prescribed at Alma-Ata, but to the success of disease-targeted interventions around the world. Sawyer pointed out that the HIV/AIDS activist movement was primarily driven by human rights to health, life, and the right to access to services to address the social determinants of health. Before this transformative movement, people with HIV/AIDS were being denied access to this public safety net of services because they often did not live long enough to receive the disability designation that would qualify them for those services. It was the rallying cry for the right to basic necessities that resonated culturally and eventually politically to bring greater public concern and policies to protect those living with HIV/AIDS. Emanuel replied that it is up for debate whether it was the human rights language or the development of effective interventions that could prolong life that made it untenable to deny people those services.

Ray pointed out that in many settings, including rural African countries, primary care is the entry point, with HIV, TB, maternal, and antenatal care being primarily provided in primary care through task shifting. Thus, strengthening health systems should be the focus, rather than arguing about primary care. She reiterated the crucial role of the human rights agenda in transforming HIV/AIDS care in the 1990s, pointing out that in South Africa, it was the activism of the gay community that led to reduced prices for antiretrovirals. Emanuel agreed that health system strengthening is necessary, but he questioned the role of the human rights agenda in the transformation of HIV/AIDS care. He said it is unclear whether PEPFAR, for instance, was justified as a human rights issue.

Mary Jo Delvecchio Good, professor of good health and social medicine emerita, Harvard Medical School, invoked the adage “nothing about us without us.” She pointed out that much of the discourse in bioethics excludes the voices of its subjects and asked how Emanuel would conceptualize the model he formulated with respect to this type of us/them dichotomy. In response, Emanuel highlighted two key processes involved in determining which services should be provided by different health systems. First, a core set of services must be defined that every country should cover; then, a set of discretionary services can be defined based on priority or context. Beyond the highest-priority services, discretion will drive the decision-making process; thus, some political process must be used to engage people to make choices about the health services they wish to receive. Choosing between health services to prioritize is a necessary but difficult task, because some people will inevitably die as a consequence of the choices that are made. This an unpleasant reality of the current situation, but neither the claim to the right to health nor the standard of the maximal attainable level of health will necessarily make those difficult decisions any easier, he suggested.

Jean Claude Mugunga, Partners In Health, asked whether Ethiopia, for example, should be expected to shoulder the entire cost of health care without assistance (given that it can only

spend \$32 per person on health) or whether global solidarity should coalesce to help countries bridge the gap. Emanuel decried the plateau in global health funding over the past decade, asserting that the lack of funding for global health is a tragedy because it is one of the best buys available to provide assistance. He explained that his argument is based on the realities of current trends in funding. Even if global health assistance were doubled, Ethiopia would still be faced with the difficult task of selecting which services it can provide. He compared Ethiopia’s health spending to that of Turkey, which spends \$1,000 per person on health care. Global funding will not close that gap between Ethiopia and Turkey. Mugunga pointed out that high-income countries could, in fact, close this gap by providing a tiny percentage of their GDP in global health funding. Emanuel agreed with Mugunga’s sentiment but asserted that there are political barriers that make that impossible.

Byron Good pointed out that many developed nations spend 10%-12% of their GDP on health care, with the US as a notable exception that spends approximately 20% of its GDP on health care. Given that the UK spends 9.8% of its GDP on medical care, it is hard to argue that the NHS has been starved by those standards, because their health spending is within one or two standard deviations of comparable nations. Emanuel acknowledged that the US overspends and agreed that an efficiently run health system in developed nations can provide all desired services by spending 10%-12% of GDP on health services. He suggested that the UK should increase its health spending by 1% to resolve problems such as overcrowding and shortages. Yates disputed Emanuel’s depiction of the NHS’s challenges but agreed that more funding would be beneficial in the UK.

Natalia Linos, executive director of the FXB Center for Health and Human Rights at Harvard University, pointed to an apparent tension in Emanuel’s implication that 75 healthy years of life can might be considered the minimal threshold for health. She pointed out that in much of the world life expectancy is far below 75; in much of Africa, life expectancy is closer to 60 than 75. Thus, it appears that Emanuel’s proposed

threshold of 75 years of life is, in fact, greater than the highest attainable level of health in much of the world. Emanuel clarified that he not satisfied with the current global health system. He said that his proposals for global health do not carry an endorsement of the current global health system; rather, much of his work has highlighted the need to “pop-up” the global delivery of services as a best buy for global health. Citing the declining trends in global health spending, he asserted that the realities of limited funding demand the wise allocation of funds. Resources are often misallocated in the poorest countries. Given the limited resources available, choices must be made about services that will have real health consequences, but the human rights frame does not help with those difficult decisions. The human rights framework does not help determine which services will provide the best bang for the buck, which is a fundamental criterion. For instance, many countries waste money on new cancer drugs rather than focus on a limited set of easily cured cancers that can be treated with generic drugs. These new drugs are not a “good buy” for these countries, yet drug companies make millions of dollars selling these new and expensive drugs to developing nations each year. The claim that a person has a human right to those new and expensive drugs is counterproductive to what needs to be achieved, he said. He agreed that 60 years is not an acceptable life expectancy, but he countered that 84 years, the life expectancy in Japan, would not be a realistic target for global life expectancy.

4.2 PROGRESSIVE REALIZATION OF UHC AND THE RIGHT TO HEALTH FOR ALL

Ole Norheim, professor of medical ethics in the department of global public health and primary care at University of Bergen, discussed the progressive realization of UHC as a right to health. He opened with a quote from Amartya Sen⁵⁷:

The invoking of human rights tends to come mostly from those who are concerned with changing the world rather than interpreting it...it is not hard to understand their unwillingness to spend time trying to provide conceptual justification, given the great urgency to respond to terrible deprivations around the world.

4.2.1 The right to health for all

To explore the concept to the right to health, Norheim explained that the notion of health as a human right is built into the International Covenant on Economic, Social, and Cultural Rights (1966), which holds that health facilities, goods, and services must be affordable for all.⁵⁸ It also holds that payment for health care services, as well as services related to the underlying determinants of health, must be based on the principle of equity, thus ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Further, equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households. He pointed out that the Covenant emphasizes fair financing practices for the provision of health services. In 2000, the UN office of the High Commissioner for Human Rights specified several obligations at the core of the right to health⁵⁹:

- To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups
- To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone
- To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water

57 Sen 2004

58 UNICEF 1966

59 General Comment 14, The Right to the Highest Attainable Standard of Health, para. 12. U.N. Doc. E/C.12/2000/4 (2000)

- To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs
- To ensure **equitable distribution** of all health facilities, goods and services, and
- To adopt and implement a **national public health strategy** and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population.

Although these notions of the right to health are somewhat vague, Norheim conceded, they introduced key elements of the rights-based claim for the provision of health and these documents fail to address the quality of health services. Ensuring equitable distribution of health facilities does little if there is no assurance of the quality of services being delivered. He noted that rights-based framework for health care had recently been developed, which focuses strongly on equitable financing, equitable access to services, non-discrimination, marginalized groups, power structures and structural violence, determinants of health, and transparent processes.⁶⁰ He emphasized that the right to health is related not only to receiving services, but also to the power over the delivery of services and a transparent process of health care delivery. He acknowledged the criticism that has been raised by Emmanuel and others that the right to health framework is not always attentive to resource constraints and alternative costs.⁶¹

4.2.2 Progressive realization of UHC

To discuss the progressive realization of UHC, Norheim drew upon his work as chair of a WHO committee that developed the report *Making Fair Choices on the Path to Universal Health Coverage*.⁶² The report, which was intended to provide

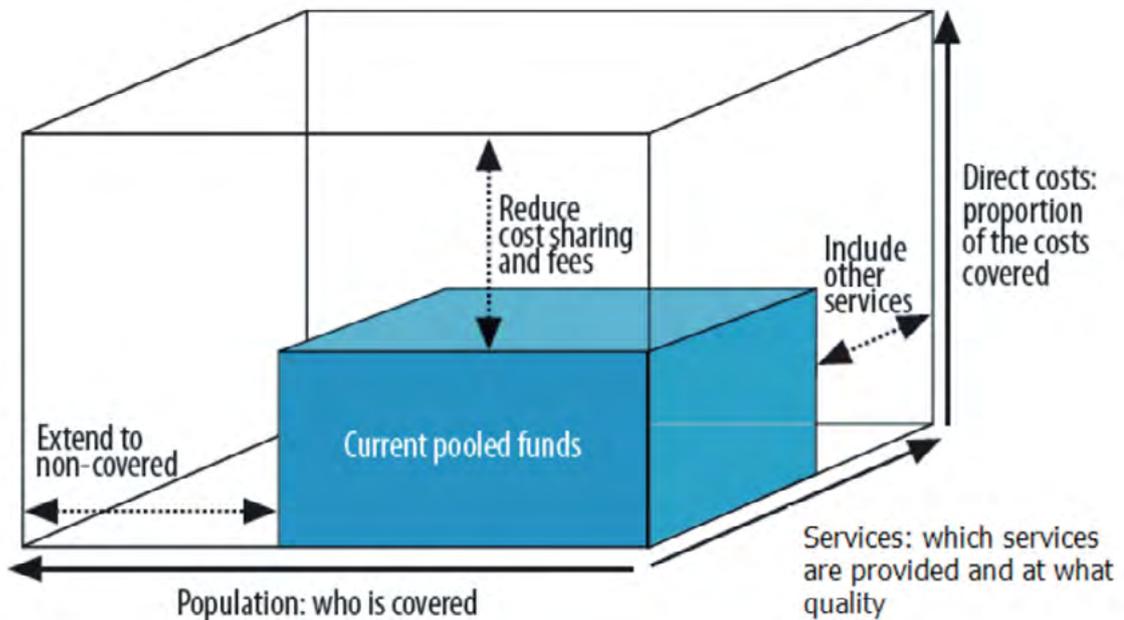
guidance and inform incremental steps in countries working toward UHC, is largely informed by notions of equity and fairness as framed within theories of distributive justice. Fairness and equity are crucial values for public policy; they are powerful ideas in public, political, and legal debates; and they are fundamentally related to the distribution of benefits and burdens in society. The report begins with a critique of WHO's contention that UHC would be achieved by "all people receiving quality health services that meet their needs without being exposed to financial hardship in paying for the services."⁶³ In their report, Norheim and colleagues countered that "given resources constraints, this does not entail all possibly effective services, but a comprehensive range of key services that is well aligned with other social goals." For instance, Ethiopia has only \$32 per capita available—which includes aid, government expenditures, and out-of-pocket expenditures—making it impossible to provide all needed services. Furthermore, Ethiopia has goals beyond offering a full suite of health services to its population, such as education and infrastructure development. For reference, Norway is able to spend \$8,000 per capita. This type of disparity needs to be accounted for when guiding countries toward the development of UHC programs, he maintained. Figure 2-1 illustrates the three dimensions of UHC described in the report, which can be useful in considering how a country like Ethiopia (represented by the blue inner cube) could expand to its targeted coverage, services, and costs. The report also offers recommendations about how countries should navigate tradeoffs along these dimensions, he added.

⁶⁰ Yamin 2016

⁶¹ Rumbold et al 2017, Chapter 4.1

⁶² Voorhoeve et al 2017; Voorhoeve et al 2016a; Voorhoeve et al 2016b; Voorhoeve et al 2016c; World Health Organization 2014

⁶³ Norheim et al 2014

Figure 4-1: The three dimensions of UHC

Sources: Norheim presentation, World Health Organization 2013
 UHC = universal health coverage

4.2.3 Overall strategy and pathways to achieve universal health coverage

The committee identified a broad strategy and three pathways to enable countries to move toward UHC, Norheim explained. First, countries must categorize health services into priority classes. Second, coverage for high-priority services should be expanded for all; this step includes the elimination of out-of-pocket payments while increasing mandatory, progressive prepayment with the pooling of funds. In the first stages of development, these pooled funds will not cover all services, but they can be used to reduce copays for high-priority services. The third is to ensure that disadvantaged groups (e.g., low-income groups, rural populations) are not left behind throughout this process.

4.2.3.1 Prioritizing services

The committee recommended the prioritization of both treatment and preventive services.⁶⁴ The

Disease Control Priorities project has demonstrated that it is possible to evaluate community health services and define the most essential services, most of which can be delivered at the primary care level rather than the secondary and tertiary care levels.⁶⁵ Although this strategy is intended to develop a comprehensive health care system, all services cannot be delivered at once in many settings. Therefore, each country must develop a process to prioritize and progressively develop services based on the local values and context. The committee identified three criteria for priority setting: cost-effectiveness, priority to the worse off, and financial risk protection. Norheim defended the committee's choice to use cost-effectiveness as a primary criterion for prioritization, asserting that it is unethical to ignore cost-effectiveness. Cost-effectiveness analysis takes alternative costs into consideration—for example, that it is better to spend \$1 million on vaccination or childhood health services than to spend

⁶⁴ Norheim et al 2019

⁶⁵ Jamison et al 2018

that same \$1 million on renal dialysis services. However, cost-effectiveness should not be the only consideration and it will often be in conflict with the other criteria. The equity criterion prioritizes those who are worse off. People who are worse off in terms of health might include people who die prematurely or people whose mental health issues limit their opportunities for wellbeing. If a conflict emerges between maximizing health and distributing health equally, a tradeoff may be required, because both criteria are so important. Financial risk protection is the third criterion, which may require a tradeoff between providing financial risk protection and adverse health impacts. For example, some countries have set up catastrophic health funds for expensive services. Thailand, for instance, has argued that renal dialysis should be part of UHC because it can push people into poverty. Although that is a legitimate reason for inclusion in the essential package, it involves a tradeoff between providing a high degree of financial risk protection at the expense of other adverse health impacts. Norheim emphasized that above all, ...“there needs to be an open, transparent process in applying these criteria and going through relevant interventions to be prioritized at each level of the healthcare system.”

4.2.3.2 Reducing out-of-pocket payment

As UHC programs are developed, they must move away from out-of-pocket payment and toward mandatory prepayment with the pooling of funds, Norheim said. This is aligned with the current focus in global health on fair financing practices and advising countries on the mobilization of resources. The right to health notwithstanding, if countries cannot harness their tax base, mobilize resources, and redistribute resources, then it will be very difficult to achieve UHC. As countries shift toward the reduction in out-of-pocket payments, the committee recommended that they first eliminate out-of-pocket payments for high-priority services for all. As more progress is made, countries should

then prioritize the elimination of out-of-pocket payments for low-income groups and other disadvantaged groups. The committee recommended ensuring that those most in need are among the recipients as coverage is expanded, said Norheim. Those in need typically include the worse-off quintiles, women, and other groups that are systematically disadvantaged. However, tradeoffs may need to be made. For example, it may be more efficient to increase vaccine coverage in the larger cities, while expanding coverage to hard-to-reach groups would be more costly. The tradeoff between prioritization to the worse off and the maximization of health benefits must be navigated with careful consideration about how the expansion of services will impact those who are among the most in need. The path toward UHC and reducing inequality should be guided by the ethos of *equitable coverage at the highest possible level*, he said.

4.2.4 Unacceptable trade offs

“Priority setting is all about tradeoffs,” said Norheim.⁶⁶ In their report, the committee identified certain unacceptable tradeoffs that were inspired by rights language. For instance, countries should not expand coverage for low- or medium-priority services before there is near-universal coverage for high-priority services, nor should they reduce or out-of-pocket payments for low-priority or medium-priority services before they have eliminated out-of-pocket payments for high-priority services. The right to core services should be considered an absolute priority. For instance, if a country is considering the introduction of heart transplant surgery before there is nearly universal coverage for vaccines, treatment of pneumonia, and other high-priority services, then that country is engaged in an unacceptable tradeoff, because it is unfair and inefficient. Similarly, the common practice of introducing health insurance by providing insurance first to civil servants is an unacceptable tradeoff in the progression toward UHC. Expanding UHC preferentially to civil servants or the formal employment sector

66 For more information, see Norheim 2015; Norheim 2016

excludes the informal employment sector, the poor, and others. As an example of the pitfalls of preferential expansion of services, Norhiem pointed to Latin American countries that have struggled to harmonize multiple fragmented programs into a unified UHC program. Like the right to core services, the right to universal inclusion should be considered an absolute priority.

4.2.5 Progress toward universal health coverage

The aim of the progressive realization of UHC is to help countries make progress toward UHC in a fair and equitable manner and to ultimately realize the right to health for all, said Norheim (see Box 4-1). With the 2030 deadline for UHC

fast approaching, it may be challenging to bring about this progressive realization in such a short time. Still, the committee designed their report to guide countries toward the best practices. He concluded with the caveat that UHC does not address the determinants of health, which warrant consideration. By virtue of SDG 3.8, UHC is a global target and the progressive realization of UHC should be seen as a key tool in answering that mandate. To do so, countries must focus on fair financing and in-country resource mobilization, although some countries may also need overseas development aid. Critical functions of UHC are to redistribute resources “from the rich and the young to the sick and the old,” he added, as well as to ensure fair inclusion of everyone, including illegal migrants.

Box 4-1. Progressive realization of the right to health through UHC

- **Fair financing** through resource mobilization, taxation, mandatory insurance, aid, redistribution, and financial risk protection
- **Fair inclusion** through universal, equal access to core services and non-discrimination
- **Fair priority** setting through cost-effectiveness, priority to the worse off, and financial risk protection
- **Fair process** through openness, inclusivity, and accountability

4.3 THE CONTRIBUTIONS OF A HUMAN RIGHTS APPROACH TO ACHIEVING UHC

Audrey Chapman, professor of community medicine and health care and Joseph M. Healey Memorial Chair in medical ethics and humanities at University of Connecticut School of Medicine, evaluated the benefits of a rights-based approach to UHC. She opened by acknowledging that numerous documents have been ratified that affirm international consensus about the prioritization of UHC. This consensus has limitations in that the signing of documents does not necessarily indicate that countries will take action or have a serious commitment to achieving UHC. If each country that has signed on to the goal of UHC were fully committed to that goal, then most countries would already

have achieved it. The lack of agreement on how countries should attempt to progress toward UHC further confounds global progress toward UHC. She explained that there is much progress to be made in order to reach the target of UHC by 2030, reporting that only 30%-50% of the world’s population were covered by essential health services in 2017. If current trends continue, only 40%-63% of the world’s population will be covered by 2030. In many countries, the pace of progress toward UHC has slowed since 2010. Poor people have low rates of coverage even for the most basic services, such as immunization, sanitation, and antenatal care. For these basic services, rural areas generally have scientifically lower rates of coverage. Poverty related to health care expenditure is increasing, and incidents of catastrophic health expen-

ditures increased between 2000 and 2015; in 2015, nearly one billion people spent more than 10% of household income on basic health care and 210 million people spent over 25%.⁶⁷

4.3.1 Contribution of the human rights model to UHC

Chapman explained that UHC is recognized as a political choice that requires ongoing commitment from political leaders and a paradigm shift in the health system. This suggests that the human rights model helps to strengthen political commitment and encourage the realization of paradigm shifts. A majority of countries have constitutional provisions with language that recognizes the right to health care or the obligation of the government to provide basic health care services; thus, framing UHC as a way to fulfill the right to health may provide additional incentives to political leaders to prioritize its achievement. Furthermore, the rights model can empower populations to demand the expansion of coverage so that every person will be able to benefit from the human right to health. Chapman further emphasized the importance of a pro-poor approach to UHC. If coverage cannot be extended quickly to all people, then choices must be made about how to expand services. Historically, countries have expanded coverage first to those who are easiest to reach, rather than to those who are most difficult to reach. Most often, coverage has been expanded to the formal labor sector and those living in urban areas. This approach often ends with the expansion of coverage to easiest to reach and never delivers coverage to hard-to-reach populations. This is why an intentionally pro-poor approach is needed; such an approach aims to ensure that vulnerable groups are not left behind as they were by the implementation of the MDGs. The UN's 2015 MDG report indicated that the poorest and most disadvantaged people must be specifically targeted by health care expansion efforts.⁶⁸ Nonetheless, UHC progress analysis indicates that many countries are inclined to

begin with the easier to reach populations rather than those in less accessible areas. Because many countries' health systems have been weakened, some countries are relying on the private sector to extend coverage; this is problematic because the private sector is unlikely to focus on the poor and establish facilities in rural and hard-to-reach areas. Furthermore, the private sector is more likely to invest in tertiary care than primary care. Only by framing UHC in the model of human rights will governments be moved to expand coverage to the hardest to reach.

General Comment 14: The Right to the Highest Attainable Standard of Health, is considered a primary document for interpreting the right to health care, said Chapman. It calls for the prioritization of coverage for disadvantaged, poor, and vulnerable populations.⁶⁹ It identifies as a core obligation the need to "ensure the right of access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable and marginalized groups." The rights approach to health care embraces the provision of health services and the addressing of the underlying social determinants of health. Furthermore, this approach evaluates the realization of rights in terms of the enjoyment and status of targeted groups, not by country averages; this requires disaggregation of poor, wealthy, urban, and rural populations in monitoring and reporting. The human rights model also requires attention to equity considerations in the design of health systems and the process of health coverage expansion. General Comment 14 calls for countries to "ensure equitable distribution of all health facilities, goods, and services"; thus, a human rights approach emphasizes the importance of measures to remove or reduce financial barriers and respond to unmet needs for health and related social services for disadvantaged groups throughout the process of expansion. The WHO committee on equity and UHC used a human rights approach to develop a three-part strategy for countries to seek the progressive realization of UHC: 1) categorize

⁶⁷ World Health Organization 2019

⁶⁸ The United Nations 2015

⁶⁹ Office of the High Commissioner for Human Rights 2000

services into priority classes on the basis of cost-effectiveness, priority to the worse off, and financial risk protection; 2) expand coverage for high-priority services to everyone; and 3) as coverage is expanded, take measures to ensure that the disadvantaged are not left behind.⁷⁰

The human rights approach emphasizes participation, said Chapman. UHC policies have typically been formulated by bureaucrats and implemented in a top-down manner with little consultation with representatives of population groups. However, citizens' preferences and priorities may differ from those of the members of the ministry of health, especially when difficult decisions must be made regarding prioritization and funding. Not only is a participatory approach required by the human rights model, the participatory approach can boost public confidence in UHC program prioritization and help to foster accountability, which is another human rights norm.

Finally, the rights-based model includes the provision of services that address the social determinants of health, said Chapman. The social determinants of health have a significant impact on health outcomes; the WHO commission on the social determinants of health has stressed that achieving health equity within and between countries is dependent on improvements in the social determinants of health.⁷¹ Additionally, General Comment 14 interprets the right to health to extend to the determinants of health, including access to safe and potable water, sanitation, food, nutrition, and housing.⁷² Thus, the right to health framework embraces both the provision of health services and the addressing of underlying determinants of health. As countries begin to grapple with the problems raised by climate change, addressing the determinants of health will become more important.

4.4 SEXUAL AND REPRODUCTIVE HEALTH RIGHTS: QUESTIONS OF JUSTICE AND HUMAN RIGHTS

Sunanda Ray, professor of public health medicine in the department of community medicine at University of Zimbabwe College of Health Sciences, discussed the role of workplace environment on health outcomes as well as the quality of care and the role of human rights in the delivery of reproductive health services. She discussed the need for system-wide solutions that address the links between health workers, physicians, and patients. She also described her work conducting respectful maternity care training interventions, which demonstrate how simple action effects positive changes in health systems. Ray opened by reflecting on the differences in opinion about whether health care is a matter of institutions or ideology. She explained that her experiences brought her to PHC as a means of supporting and empowering the liberation struggle in Zimbabwe, and she characterized the battle for health care funding as a power struggle to persuade policymakers to invest in health systems.

4.4.1 Quality in healthcare

To illustrate the importance of focusing on the quality in healthcare, Ray shared the testimonies of a district medical officer at a rural hospital and a midwife at a teaching hospital:

...we have stopped reporting maternal deaths where we think we will be blamed. This may mean being shouted at or worse being sent for re-training which is very humiliating especially when the problem is not that we are not skilled enough... [District medical officer at a rural hospital]

...we shout at women in labor because we are afraid that if she does not progress, she will have a stillbirth. Every time there is a stillbirth, we are sent to the clinical director and have to wait outside his office, knowing we are going to be shouted at... [midwife at a teaching hospital]

⁷⁰ World Health Organization 2014, Chapter 4.2

⁷¹ World Health Organization 2008

⁷² Office of the High Commissioner for Human Rights 2000

Regarding the first quote, Ray pointed out the irony that retraining is conducted at the tertiary hospital, a very different setting than the rural hospital where these health care workers actually deliver care. Regarding the second quote, she noted that this cycle of shouting is driven by the need to meet targets. These testimonies are corroborated by scholarly works investigating the quality of health care, which have revealed that “the safety, quality and efficiency of most healthcare delivery system are far from the best they could be...”⁷³ and that “...without quality assurance, access may be an irrelevant...large gaps exist between what doctors know and what they actually do.”⁷⁴

Ray further explored the issues facing non-physician health care workers, pointing out the focus that has been put on the role of non-physician clinicians; there has been some indication that such health care workers may deliver better outcomes than fully trained doctors. She shared that her experience with the clinicians has revealed that they are very competent in managing the majority of cases. In some small percentage of cases, however, these workers will encounter complications that have not been addressed in their training. These are the cases for that are most likely to be recorded as failures and to negatively impact the measured performance of those clinicians and health systems. She argued that non-physician clinicians are well suited to handle routine cases, but they should not be expected to manage more difficult cases. Furthermore, junior doctors who have recently completed their training in a tertiary hospital are unlikely to be better prepared than non-physician clinicians to manage difficult cases. This raises the question of what is actually being compared in analyses of this type of performance data used to evaluate health care providers and, importantly, it underscores the need to find better methods of evaluation.

4.4.2 Rights to sexual and reproductive health

Turning to the primary focus of her presentation—sexual and reproductive health (SRH) rights—Ray noted that the concepts of justice and rights apply to health professionals as well as to service users, communities, and families. In fact, the attitudes and behaviour of service providers can even be a barrier to high-quality SRH services, so the health workforce must be considered in the approach to ensuring SRH rights. Health systems should utilize existing resources as efficiently as possible in order to provide a basis for advocating for specific resources. Further, it is important to identify weaknesses in the system in order to resolve them, rather than using those weaknesses to propagate a culture of “blaming and shaming” that creates poor work environments.

4.4.2.1 Quality of the health care work environment

Health workers in a poor work environment often report that they are overworked, understaffed, and lack supplies and resources, said Ray. However, those perceptions are often more indicative of the poor quality of the working environment itself—e.g., inadequate management support and feeling undervalued by management—rather than the fact that they are objectively overworked, overstaffed, or under-resourced. For example, seeing just five patients a day in a poor work environment can feel like a heavy workload. Adequate management, health worker support, and a clear sense of being valued are key factors that influence the perceived quality of a work environment. Many mid-level health workers feel demotivated and un-incentivized because of the perception that management would prefer a “real doctor,” and that they are being utilized only as a stop-gap measure. This response is warranted, says Ray, because health systems openly deal with non-physicians in a way that indicates a preference for physicians. For instance, health

73 Jha et al 2016

74 Das et al 2018

systems justify their investment in non-physician clinicians by pointing out that non-physician clinicians cannot go abroad to work, as physicians often do. If health workers feel devalued, they cannot be expected to do their best work.

4.4.3 Maternal deaths as an indicator of health services quality

Ray explained that maternal deaths, although rare, are often used as an indicator for quality. However, no amount of educational programs, poverty reduction, and other social services will reduce maternal mortality if there is no access to quality health services.⁷⁵ For instance, women can be properly educated, sheltered, and provided care during pregnancy, but if they enter the hospital for delivery and experience a complication that that hospital is not equipped to manage, they are unlikely to survive their pregnancy. Studies of maternal mortality internationally (including Europe, North America, and South Africa) have shown that “substandard care” is a major contributing factor to maternal mortality. Additionally, for every case of maternal mortality, there are 30 or more cases of morbidity, ie “near-misses.”

Ray described the underlying factors that contribute to maternal deaths. Often health care workers do not recognize when a serious condition is presented, nor do they always call in a senior clinician to advise in complicated cases. Health care workers often do not know how to intervene in serious cases and they often fail to follow up on outcomes to learn from their clinical choices. Poor teamwork, poor communication, poor adherence to guidelines and protocols, and poor education on current evidence also contribute to maternal deaths. Ray said that a junior doctor reported that when he requested help from a senior doctor, they told him that if he asked for help again, he would have to redo his rotation. This kind of disincentive to ask for help encourages clinicians to muddle through their work and does not ensure the best outcomes.

Ray pointed out that addressing these factors that underlie maternal deaths does not necessarily require more money; rather, they can be addressed through a culture of patient safety.

Ray participated in a root cause analysis of maternal deaths in Botswana; the researchers were interested in finding ways to reduce maternal mortality in Botswana in order to achieve the Millennium Development Goals.⁷⁶ Their analysis drew on research insights related to airplane crashes, which suggested that each crash is attributable to a series of 4-7 mistakes, rather than a single one. This was found to be the case in maternal mortality as well; rather than singular mistakes causing maternal mortality, it was observed that maternal mortality was caused by systemic gaps. If there are large enough gaps, or enough gaps, in the system, then cases will slip through and there will be maternal deaths. This highlights the importance of a team approach to quality improvement and the need to develop a culture of patient safety. The African surgical outcome study found that the most common surgery performed in Africa and Southern Africa is C-section.⁷⁷ There is a great unmet surgical need in the region, particularly for obstetric services. These services are not typically a part of PHC—they are most often included in secondary health care or provided at district level hospitals. For instance, when women suffer disability from vaginal fistula, they often receive care at hospitals or in camps; these approaches do not provide continuity of care for these women. Women who have cervical cancer that is identified through visual inspection often have no access to surgical treatment and are sent away with this diagnosis to die from cancer. The study found that most of the patients who died were young patients, with a mortality rate that was twice the global average, largely attributable to poor post-operative care in recovery wards and complications that were not managed aggressively. Ray explained that in some cases, women were dispatched from their C-section procedures immediately to a post-natal ward,

⁷⁵ Maine 1997

⁷⁶ Madzimbamuto et al 2014

⁷⁷ For more information, see <https://clinicaltrials.gov/ct2/show/NCT03044899> (accessed February 15, 2020)

where they received little attention compared to the care that would be provided in a post-operation ward. These issues cannot be addressed through PHC expansion alone, she emphasized.

4.4.3.1 Solutions to reduce maternal mortality

To prevent maternal deaths and improve quality of care, health systems must be strengthened at the community, primary, secondary, and referral levels. However, progress will not be achieved without strong leadership to improve staff morale and consequent quality of the services they deliver. Ray reiterated that the factors that underlie maternal mortality can be addressed with solutions that do not necessarily require large increases in funding. Many improvements can be made through culture shifts and minimal training efforts. For instance, practices of blaming and shaming can be replaced with a constructive approach that focuses on inclusion and morale-building. Supportive and integrated management and the promotion of teamwork can help create a positive working environment. Post-natal monitoring, formalized handovers and multidisciplinary ward rounds can help improve patient safety and reinforce staff responsibilities. In many hospital wards, handovers are not routinely conducted. Ray shared an example from Cuba, where clinicians working in an English-speaking facility were writing their notes in Spanish; this was a barrier for clinicians who did not understand Spanish. The doctors did not feel the need to write their notes in English, because it had not occurred to them that their notes should be able to be read by other clinicians. An attitude of teamwork and shared responsibility can have an impact on these kinds of workplace environments and situations. From training to practice, clinicians should share the responsibility for problem solving. Additionally, critical incidents should be analyzed through continuous audits using root cause analysis.

Ray further discussed the link between staff morale and quality improvement. Patient satisfaction has been linked to both the service received and the attitudes of health staff. Thus, it is critical to invest in health staff and ensure that they feel valued. Good teamwork, commu-

nication, and working environment are essential factors for both the quality of service and morale. Staff that do not receive recognition, or who are burned out due to heavy workload, are less likely to be concerned with patients' experience or the opinions of their peers. These links further highlight the importance of workplace environment and culture for the delivery of high-quality care.

4.4.4 Impact of respectful maternity care: results of a pilot project

Ray described her work on a small pilot with 30 midwives; she conducted a 12 week training where she taught these midwives about respectful maternity care practices and the human rights of women in labor: 1) the right to confidentiality, 2) the right to privacy, 3) the right to have a birthing companion, and 4) the right to be treated with dignity. The project was funded through small-scale personal fundraising by Ray and her colleagues. She remarked that the rights-based model of training had a powerful impact on the perspectives of these midwives. The midwives reported that they had never considered the rights of their patients; once they were aware of this perspective, their approach to providing care was changed. Ray shared a testimonial from one midwife, which demonstrates the social distance that can arise between patients and clinicians.

I requested the obstetrician to come to see a woman post-delivery who was showing signs of shock. She was not bleeding externally but her blood pressure was dropping, and she was agitated. The doctor said to continue, that the woman was probably attention-seeking. I had to ask the matron to call the doctor who finally came. In theatre it was confirmed that the woman was bleeding internally from a ruptured uterus. I was proud that I had identified this woman as being at risk, and that I was able to assert myself to insist that the doctor came.

Ray explained that the training consisted of simple activities, including personal reflections and journaling about the midwives' experiences, but these exercises showed these midwives that they had resources available to them that they had not been utilizing. This training has apparently improved the quality of

service delivered by these midwives. She shared two more testimonies from a midwife reporting on her experience with a patient who was very happy with the care that they had received and a midwife who changed their perspective after her respectful maternity care training:

She thanked me wholeheartedly, and I was so touched. She said I explained well and I was patient with her. I was happy to know that I had made a change to a woman who was said to be uncooperative.

It was good to fully explain the condition, doing individualized care no matter the condition. I felt proud of myself, it's good to give life and to be a better midwife.

Before the respectful maternity care training, I would have shouted and scolded the girl, why she didn't book ... why she had kept the pregnancy a secret to the family...I would have blamed her ... why she slept with an unknown person without protection and got pregnant... (following respectful maternity training) I treated her with love and caring, explaining everything that was happening, the reason for the transfer...

Ray closed by reiterating that while resources for large new wards may not be available, there are existing human resources that are being underutilized and mistreated. By treating all clinicians with respect, making them feel valued even in difficult situations, the quality of health care can be improved. She reported that a grant has been received to develop a toolkit and curriculum for respectful maternity care training; additionally, each midwife who has received the training is sharing insights with people in their workplaces as champions of respectful maternity care. This project has created a positive culture that gives people hope and can be replicated on a large scale, yet ownership of the project has remained entirely among its participants.

4.5 COVERAGE, CARE, AND CHANGING PERCEPTIONS OF HEALTH IN EAST ASIA

Karen Thornber, professor of comparative literature and of East Asian languages and civilizations at Harvard University, discussed the

current states of health coverage and health care in East Asia, focusing on the state of dementia care and the impact of dementia on families, patients, and communities. She described the approaches to dementia care in the four largest countries in the region—China, Japan, South Korea, and Taiwan—and assessed whether these efforts adequately address the challenges associated with dementia among aging populations. She also explored depictions of dementia in literature and discussed examples of literature from the perspective of caregivers of persons with dementia.

4.5.1 The state of health coverage in East Asia

Thornber explained that the East Asian region comprises China, Hong Kong, Macau, Japan, North Korea, South Korea, Mongolia, and Taiwan. In total, the region's population exceeds 1.6 billion, with a population of 1.4 billion in China alone. Vietnam has historically been considered to be a part of the East Asian cultural sphere, but it is now studied as part of the Southeast Asia region. She explained that her focus would be on the three largest populations in East Asia: China (population 1.4 billion), Japan (population 128 million), and South Korea (population 51 million). East Asian nations have among the best health care coverage in the world; however, their health care systems are facing new challenges to address. Noncommunicable diseases of all types are on the rise, as are mental health concerns. Rates of dementia have been steadily increasing across East Asia as the region's societies transition from aged to super-aged. This transition raises issues across a broad range of sectors as well as giving rise to challenges in financing and staffing. Friends, family, and professional caregivers are needed to meet the needs of East Asia's aging population.

National health insurance programs cover the majority of the populations of China, Japan, Korea, and Taiwan, including most foreigners. One group not covered by these programs is undocumented workers, who are often neglected by national health programs in many societies. Thornber said that the quality of care provided by these national programs is generally good, but it

varies widely across the region. In China, approximately 95% of the population has basic health insurance coverage; however, this coverage is expensive and not comprehensive. The Chinese government is actively working to reduce costs and make basic care affordable to all residents within the next 10 years. The Chinese government has been working on major health care reform since 2000, and there have been improvements, but disparities remain between public and private hospitals and between the care available in urban and rural areas. High-quality care is available at most urban, international hospitals, but limited services are available in rural areas, even for those willing to pay for good care. In Japan, universal coverage is provided to everyone but undocumented workers. Japan has both an employment-based insurance system and a national health insurance system. Access is free, and people are able to choose the doctors and hospitals from whom they receive care. This free choice sometimes causes delays in care, but Japanese patients can generally access even the most sought-after specialists with minimal delays. Fees for health care in Japan are set by the government based on income. Thornber asserted that the Japanese health care system works fairly well except for its exclusion of undocumented workers. Taiwan also offers a national health insurance system (established in 1995) that also functions well: services are generally accessible, specialist services are available, wait times are generally low, and cost is low. Notably, Taiwan's health insurance system covers a broad range of services, including Western medicine, Chinese medicine, preventive services, and elderly home care.

4.5.2 Dementia prevalence and care in China, Japan, South Korea, and Taiwan

Thornber discussed how these health coverage policies relate the quality of care delivered to the populations of East Asia and considered whether good coverage translates to care beyond acute and communicable disease. In her opinion, the excellent coverage in East Asia does not necessarily translate into excellent care, particularly for individuals with diseases that are highly stig-

matized, including the aged with dementia and their families. Given the rising rates of dementia in the region, this is a concerning issue. It is estimated that by 2030, more than 16% of China's population will be aged ≥ 65 years, making it an aged society by WHO standards. It has been reported that Japan has the highest percentage of population aged ≥ 65 years of any country in the world. Currently, over 28% of Japan's population is aged ≥ 65 ; this proportion is expected to rise to 30% by 2025 and to exceed 35% by 2040. By 2030, over 23% of South Korea's population is estimated to be aged ≥ 65 years and similar trends have been observed in Taiwan's population. Among the greatest challenges of providing health care for these aging populations is the provision of dementia care, she noted.

Thornber explained that although China has a relatively young society compared to those other countries in the region, it has the world's largest population of people with dementia because its overall population is so large. The number of people with dementia in China has grown rapidly—from 3.5 million in 1995 to 5.1 million in 2000 to 14 million in 2019—and it has been estimated that more than 23 million people in China will have dementia by 2030. This growing population has drawn global concern in recent years; this public health challenge has been characterized as a “tidal wave” of dementia that is likely to become one of the world's largest and costliest public health crises. In China, the very wealthy generally have access to high-quality dementia care that meets the highest global standard. However, the majority of people receive a lower standard of care. Widespread stigmatization of dementia and the perception that dementia is a natural part of the aging process have posed barriers to the improvement of dementia care. Dementia is not seen as a disease, or even something that demands special attention, and great stigma is attached to words for dementia. Thus, dementia is rarely diagnosed and when it is, it rarely talked about. Even though it is well known that China faces a great burden of dementia, families go to great lengths to hide the diagnosis of dementia in the family. This stigmatization leads to lower quality of care for those with dementia and forces families to bear much of

the burden of care. Furthermore, the Chinese government has actively blocked NGO efforts to address dementia in China. She noted that this kind of denial has been seen before in China with respect to diseases such as HIV/AIDS and SARS.

In Japan, there are currently 4.6 million people with dementia and by 2025, this population is expected to grow rapidly to 7.3 million (i.e., one-fifth of the projected population aged ≥ 65 years). Similar trends have been observed and projected for South Korea and Taiwan. Some initiatives have been developed to improve the quality of life of those with dementia and their families. It has been recognized throughout various communities in the East Asian region that supporting caregiver populations is a critical factor in addressing the challenges of dementia care. For instance, the health system in Japan is transitioning away from the medicine-based institutional approach to dementia care toward community-based care. In 2012, the Japanese Ministry of Health introduced the “Orange Plan,” which aimed to tackle dementia not through patient- or physician-centered approaches, but through community-centered approaches. The plan enabled neighborhood volunteers to conduct home visits, supported family caregivers, educated schoolchildren, and created drop-in centers where families could bring their loved ones with dementia. Thornber remarked on the great challenge of managing adults with dementia who get lost or wander off. Many aging adults live alone, which can make it especially difficult to keep track of and ensure the safety of individuals with dementia. Each year in Japan, around 15,000 elderly adults go missing. To address this issue, QR codes have been utilized help identify lost individuals. The Japanese government subsequently adopted a new Orange Plan which aimed to prioritize the perspectives of people with dementia and their families. Instead of focusing on top-down approaches, the new plan was more focused on integrating care and meeting the individual needs of patients, families, and communities. It included the development of dementia villages and Alzheimer’s cafes, where people with dementia and their families can meet. These projects are primary organized by community care centers.

The Taiwanese Alzheimer’s Association has worked for many years to create a dementia-friendly society, Thornber said. This effort involves educating schoolchildren, setting up dementia-friendly shopping hours so that people with dementia and their loved ones can do their shopping in a low-stress environment, and establishing the Dementia Guardian Angel project to pair members of the public with individuals who have dementia. While these community-based dementia programs are well-meaning, they are merely a stop-gap solution. They do not address the core challenge of managing the growing population of individuals with dementia and addressing the desperation among those impacted by dementia. For instance, a 2017 court case in Osaka, Japan, involved an 82-year-old woman who had strangled her 85-year-old husband who suffered from dementia. The woman attempted suicide afterward, but her son intervened, leading to her arrest. She was given a suspended sentence, with the judge remarking, “...it cannot be said that the burden of nursing care was not heavy. The fact that she committed the crimes after being cornered psychologically deserves our sympathy.” There are other examples of such desperation, she noted. Community-based programs only address the needs of a small portion of the population and are only effective in highly engaged communities. Due in part to the strong stigma attached to dementia, the number of individuals committed to engaging in these programs is small. Men who take on caregiving roles are particularly stigmatized, she added. For example, the mayor of one Japanese city took time off from his duties to care for his mother who suffered from dementia and was harshly criticized for his decision due to the perception that caregiving should be done by women.

4.5.3 Global narratives and literature on dementia

The large body of literature on dementia—which includes poetry, prose fiction, and patient and family memoirs—is not often brought into discussions of how to improve dementia care, said Thornber. In her work, she has explored global literature that grapples with the chal-

lenges of improving care and strengthening advocacy.⁷⁸ She suggested that in conversations about how to improve health and healing, literature is a valuable resource that can offer unique and distinctive perspectives of individual and family experiences that are generally absent from conversations about healing and health. Most literature on dementia is written by patients, physicians, and caregivers. Thornber introduced the novels *Inheritance from Mother*, published in 2012, and *The Twilight Years*, published in 1972.⁷⁹ These Japanese novels offer remarkably similar depictions of the experiences of dementia caregivers. In her work, Thornber brings light to how apparently little has changed since 1972 in terms of the reported lived experience of those caring for people with dementia. *Inheritance from Mother* tells the story of two sisters from a wealthy family who must care for their aging mother as she begins to develop symptoms of dementia. The novel highlights the vulnerability of families, even those with privilege and access to health services. The novel is based on Mizumura's own experience caring for her mother with dementia. In 2014, after the publication of *Inheritance from Mother*, Mizumura published an article in *The New York Times* describing her experience caring for her mother with dementia and grappling with her sense of anticipation of her mother's death. In the article, Mizumura described the outpouring of reader support and gratitude for her 2012 novel. Many readers reported that they resonated with Mizumura's depictions of the struggles and difficulties of caring for a loved one with dementia. A great sense of desperation can be observed across East Asia among those whose loved ones suffer from dementia. In closing, Thornber remarked that UHC is taken for granted in that region, but that the coverage provided does not necessarily guarantee health or care for all

4.6 FRIABLE CONCEPTS OR IMAGINATIVE FAILURES? ETHNOGRAPHIC REFLECTIONS ON RIGHTS, EQUITY, AND SOLIDARITY IN THE CONTEMPORARY US.

Sarah Willen, associate professor of anthropology at University of Connecticut, discussed three idioms of social justice mobilization for health. She explored these idioms through cultural and research examples and considered how the idiom of UHC may clarify, confront, or resolve barriers to its success.

4.6.1 Idioms of social justice mobilization for health

Willen began by invoking one of the aims of the conference: to reflect on efforts to guarantee access to health care as a universal right of citizenship and common humanity. Many health researchers, public health professionals, activists, and health philanthropists identify with those efforts. However, the claim to this right and its anchoring premises are not universally supported among the general public or by those who shape health policy. In the modern polarized environment, support for policies that move toward UHC has considerably eroded or, at least, the landscape of support for such policies has become difficult to utilize as a basis for political strategizing. Drawing on insights from medical anthropology, Willen's presentation focused on the ways that health and justice are framed in the US. Her interests lie in the travel and transit of parallel yet occasionally competing idioms of social justice mobilization for health.

Willen presented three idioms of social justice mobilization for health for consideration: 1) health and human rights, 2) health equity, and 3) solidarity. These idioms serve as "... a framework for thinking about the relationship between health and (in)justice. The term 'idiom' evokes a language – a mutually accessible way of organizing thought and consolidating interest and commitment."⁸⁰ In her work published

⁷⁸ Thornber 2020

⁷⁹ Mizumura and Winters Carpenter 2012; Sawako Ariyoshi 1972

⁸⁰ Willen 2019

in the Lancet, Willen and colleagues argued that these idioms can also be thought of as “a concrete strategy for melding scholarly insight and ethical values with the goal of promoting social justice in the health domain.”⁸¹ They asserted that different idioms are grounded

in different traditions of scholarship and practice; thus, they reflect the principles, priorities, and goals of those fields. They proposed that idioms of social justice mobilization for health share five common principles (see Box 4-2):

Box 4-2. Idioms of social justice mobilization for health: common principles

- Upstream factors can cause grave harm to the health of individuals and populations.
- Since the effect of these factors is uneven, some populations are more vulnerable to health risks than others.
- Vulnerable individuals and populations must not be overlooked; they too deserve health-related attention, investment and care.
- Health inequities can best, and perhaps only, be remediated through upstream intervention.
- Sustainable reduction in health inequities will require collaboration between clinicians, public health officials, policy makers, civil society actors, and other key stakeholders both within and beyond the health domain.

Source: Willen et al 2017

Social justice mobilization idioms fall into three broad categories, said Willen. Descriptive idioms highlight health disparities, inequalities, and inequities. Action-oriented idioms drawn on human right models, humanitarianism, liberation theology, global health, and health equity; the category also includes certain branded idioms, such as *Primary Health Care*, *Health in All Policies*, *Healthy People 2020*, and *Culture of Health*. Scholarly idioms include social medicine, social epidemiology, medical humanitarianism, human rights, critical medical anthropology, syndemics, global health, and health equity. These idioms are more than just buzzwords: each takes a different tack and aims to debunk claims that health disparities are somehow natural or beyond the scope of human intervention. They strive to catalyze different forms of action, but they all stand in variable relation to each other. They are often invoked together, sometimes even with competing idioms. Willen and colleagues analyzed many of these idioms and identified their core discipline, core principles, and core aims.⁸² For instance, health

equity comes from the bioethics and public health ethics disciplines. Its core principle is that unnecessary and avoidable health differentials are unfair and unjust, and it aims to develop tools to assess which health inequalities constitute health inequities (i.e., are avoidable and unjust) and determine which actions ought to be taken in response.

Willen pointed out that this conference was designed to evaluate the strengths and limitations of UHC as an idiom of social justice mobilization for health. Drawing on her insights from two ethnographic studies, she considered the strength and limitations of the three aforementioned idioms of social justice mobilization for health in the US.

4.6.1.1 Health and human rights

In 2014, the David J. Sencer CDC Museum hosted an exhibition titled *Health is a Human Right*⁸³ in recognition of the 25th anniversary of the Office of Minority Health and Health Equity. The exhibition chronicled the enduring impact of over a century of discriminatory laws, policies, and practices in the US. Remarking on the exhibition’s title, Willen

⁸¹ Willen et al 2017

⁸² Willen et al 2017

⁸³ For more information, see <https://www.cdc.gov/museum/exhibits/health.htm> (accessed February 15, 2020)

noted that the US is not among the 170 countries that have ratified the International Covenant on Economic, Social, and Cultural Rights and that the right to health has not been granted in the US.⁸⁴ She spent much time studying this exhibition and its source materials and discussing it with people who created it, conceived of it, and used it as a part of their curriculums in universities. She reported that there was internal dispute about whether the CDC should host an exhibition with the title “Health is a Human Right” at all, given the country’s lack of commitment to health as a human right. Willen suggested that this apparent inconsistency cannot be reconciled; rather, it seems that the David J. Sencer CDC Museum’s exhibition was something of a fluke. The exhibition itself underwent extensive review and the exhibition’s title was the sole innovation of the curators responsible for the exhibition’s contents. Further, the exhibition was not universally well received by CDC staff. Still, Willen suggested that despite the lack of legal grounding for the exhibition’s title, the exhibition reflects a strong sense of congruence between the title and the aims of CDC staff to educate and inspire. These factors and the insistence in the exhibition title that health is a human right serve to confirm that human rights can function as an idiom of social justice mobilization for health.

4.6.1.2 Health equity

Willen presented three images that present the idiom of health equity, shown in Figure 4-2. The Americans’ Conceptions of Health Equity Study (ARCHES) has been investigating why the idiom of equity has had more traction in the US than the idioms of human rights.⁸⁵ This idiom has also become a powerful frame for public health research, policymaking, and practice in the US; it is embedded in the work of the American Public Health Association and other civil society, academic research, and philanthropic organizations. However, despite its traction, there is still no consensus on the meaning or significance of this idiom. Phase I of ARCHES involved qualitative research in the Greater Cleveland area

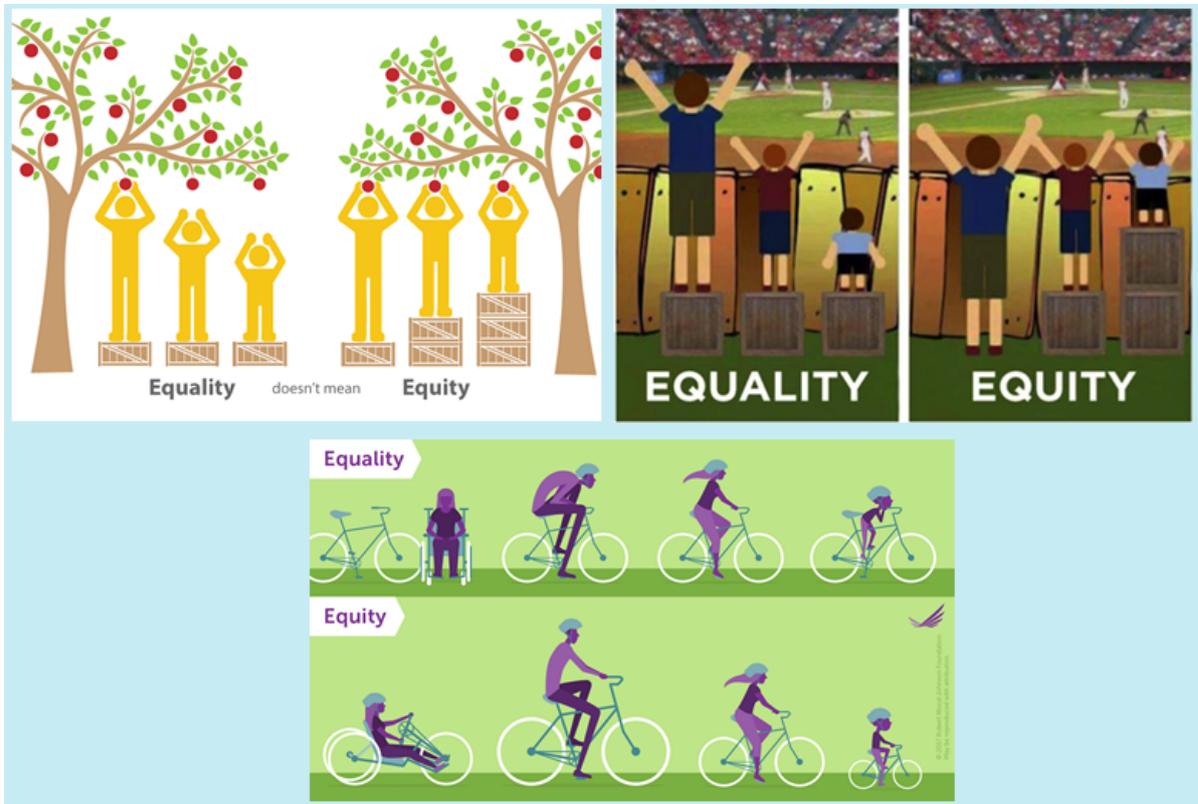
in Ohio, US. The study conducted participant observation in a county-wide health and equity initiative and semi-structured interviews and surveys with a wide range of 170 stakeholders. The study observed participants in the Northeast Ohio health and equity initiative called Health Improvement Partnership - Cuyahoga. The partnership was created to frame a conversation around health disparities and health inequities in the region; it involved county and city health departments, hospitals, medical schools, and community-based organizations. The observation, interviews and surveys used in Phase I were used to develop a national survey that will be used for Phase II of the study. The study interviews cover topics such as personal background, key relationships, self-descriptions of flourishing, self-descriptions of healthiness, self-assessment of feeling valued, sense of societal fairness, opinions regarding health disparities, understanding of health equity, and changes in views and values regarding fairness, health, and race.

Willen summarized some of the findings of the ARCHES project. Researchers showed participants the image depicting the idiom of health equity shown in the top left of Figure 4-2 and asked them about 1) their familiarity with the image, 2) their explanation of the image, and 3) whether they think the image clarifies the distinction between equity and equality. They found that the distinction between health equity and health equality is not particularly well understood, even among health professionals. Furthermore, it seems that this idiom may not travel well outside of the domains of health research and public policy practice. Many members of the public were unsure of what the image was trying to convey or what it means. She suggested that this commonly used image does little translational work. Most problematically, the notion of health equity seems to operate as a euphemism to signal conversations about injustice without catalyzing substantive reflection on the forms of redistribution that would actually be needed to move toward a more equitable distribution of resources.

⁸⁴ UNICEF 1966

⁸⁵ For more information, see <https://arches.chip.uconn.edu/> (accessed February 15, 2020)

Figure 4-2: Visual representations of the health equity idiom



Source: Willen presentation

4.6.1.3 Solidarity

Willen explained that the funder of ARCHES, The Robert Wood Johnson Foundation, is a proponent of the culture of health model that has driven the funding of much health philanthropy in the US. The culture of health action framework consists of four action areas that are intended to lead to improved population health, wellbeing, and equity: 1) making health a shared value, 2) fostering cross-sector collaboration to improve wellbeing, 3) creating healthier, more equitable communities, and 4) strengthening integration of health services and systems. At its core, the culture of health model holds that advancing a culture of health in the US will depend on catalyzing a social movement rooted in the recognition that the health of everyone is interdependent—i.e., the recognition of solidarity, which

is necessary to achieve meaningful change in terms of health and the determinants of health.⁸⁶ She connected this model to the framework of solidarity because solidarity is an area of engagement among bioethicists. One leading definition of solidarity in that field points toward shared practice reflecting a collective commitment to carry financial, social, emotional, and other costs. One aim of the ARCHES study is to determine the extent to which people see their health as interdependent with the health of others. They are particularly interested in whether people feel a sense of solidarity with those who are members of social groups that are perceived to be substantively different from their own social groups, such as members of other races or ethnic groups, people of different socioeconomic status, and people who make different health-related lifestyle choices. Early analysis has already

⁸⁶ Lamont and Berezin 2016; Trujillo and Plough 2016

given rise to interesting questions for further consideration, she said. What brings Americans to feel a sense of solidarity with others in terms of health? How might solidarity be conceptualized, promoted, or deepened? What would it take to capitalize such a movement, and who would lead it? How might ethnographic insight sharpen and advance investigation into these themes?

In closing, Willen considered the questions raised by the title of her talk: *friable concepts or imaginative failures*? She noted that the idioms of social justice mobilization for health have similarities, differences, and inter-relations. Rather than standing alone, these idioms tend to be used together and serve to complement, clarify, or contradict each other. She questioned whether there were inherent problems with these concepts, ideas, and terms or whether these idioms were robust but have failed to land on hospitable ideological terrain. Perhaps they are robust idioms, but are inaccessible, illegible, or unpalatable and require better retranslation. If so, qualitative research, including ethnography, could help to translate these idioms. She invoked Allen's reflection on the insularity of certain discourses of global health and justice that can render them inaccessible to the uninitiated public. Finally, she posed the question of whether the idiom of UHC will help to clarify, confront, or resolve obstacles to its success and whether this conceptual frame might set the stage for the discussion of universal health coverage versus universal health care, which was the topic of Session 3 of the conference.

4.7 DISCUSSANT REMARKS

In response to the session's presentations, discussants Sarah Zaidi, Co-director, Q Continuum Consulting, and Eric Sawyer, founding member of ACT UP, shared their insights on the right to health. Zaidi was unable to attend the conference, but her written remarks were summarized and reported by panel moderator, Mary Jo Delvecchio Good. Zaidi's remarks highlighted the value of the rights-based approach to health care. She raised a series of questions aimed at challenging the claim that a rights-based approach is unhelpful, and she discussed the impact of rights-based

approaches on activism and language in health systems. Sawyer shared his personal experience as a health activist and the history of the HIV response. He discussed how successful health advocacy approaches utilized in the US have inspired global action on HIV/AIDS treatment. He closed with call to action for UHC, asserting that the same activism that was required to bring about change for HIV/AIDS care is needed to bring about change toward UHC. These remarks were followed by open discussion among presenters, audience, and participants.

4.7.1 Discussant: Sarah Zaidi

Zaidi asked whether a human rights framework, or an idiom of human rights, can achieve social justice and what the role of human agency should be in the delivery of health care, given the medicalization of the health sector. She disputed Emanuel's suggestion that investment in health increased because of the spread of HIV/AIDS, specifically criticizing the implication that investment in HIV/AIDS was unrelated to the promotion of the rights-based claim to health care. From the beginning of the HIV/AIDS epidemic, activists have demanded that human rights are a central aspect of HIV/AIDS programs. Activists have successfully demanded that HIV/AIDS patients be well-informed to make health care decisions; they have also successfully demanded to have greater participation in the design and implementation of HIV/AIDS interventions. The success of HIV/AIDS programming is the direct result of ground-up empowerment and mobilization, motivated by a rights-based framework and enforcement of this framework at the national level.

In regard to the human rights approach endorsed by Norheim and Chapman, Zaidi agreed that this model is the best way to ensure a pro-poor orientation and to carve out a pathway to universal coverage. Furthermore, making choices along the axes of out-of-pocket expenditures and health services may require a rights-based perspective that includes people as partners in decision-making. Zaidi raised a host of poignant questions that point to the value of a rights-based framework in health care:

- Who should set priorities for health?
- Who should make determinations about the provision of health services for populations?
- Who will ensure that health policy decisions protect vulnerable populations?
- Who will set prices in order to reduce out-of-pocket expenditures?
- How will hidden epidemics, such as that of mental health, be put on health agendas and prioritized, especially in settings that are lacking qualified medical professionals?
- How will broad policies regarding coverage for non-nationals and migrants be determined?
- Who will ensure access to services for criminalized populations, such as sex workers, homosexuals, and drug-users?

Zaidi pointed out that even when adequately funded services for HIV/AIDS are available, fear of stigma and discrimination are major barriers to access, along with violations of privacy and confidentiality. While Global Fund grants emphasize health system strengthening, limited funds are allocated for retraining staff on attitudes and behaviors relating to stigma. Those accessing health care face other barriers relating to cost, such as the need to hire caregivers, transportation, loss of income. It must be considered how UHC will address these barriers.

Regarding the role of human agency in medical care, Zaidi compared the culture of HIV/AIDS care with that of TB. The community advocating on behalf of those affected by HIV/AIDS has been successful in confronting programmatic norms and has used rights-based approaches to organize and demand policy changes. Even marginal and socially excluded communities, such as sex workers, have been empowered by subsequent changes to health care systems. In contrast, the biomedical public health approach, utilized widely in policies around TB, has taken to labeling people with TB as “suspects,” “defaulters,” and “index cases.” In response to this culture of care, there is now a community organizing around the promotion of rights-based language and a patient-centered approach to TB care.

Zaidi remarked on the competing idioms of health justice, as laid out by Willen. The health and human rights idiom is the only of the three idioms that puts the agency of individuals as a priority in terms of self-determination. The human rights language, she said, is a language of empowerment; it gives individuals a sense of competence and self-esteem through sharing knowledge, experience, and solidarity. Her remarks concluded with the assertion that for UHC to succeed, it should include bottom-up approaches to educating and empowering community stakeholders.

4.7.2 Discussant: Eric Sawyer

Sawyer underlined several false dichotomies implicit in the conference’s presentations and discussions: “universal health care” versus “universal health coverage”; the standard of health as “the highest attainable” versus some minimal threshold; and health as a human right or not a human right. Sawyer chose not to delve into those dichotomies more deeply or wade into academic discourse festooned with “ivory tower” terms like social medicine, social epidemiology, health equity, medical humanitarianism, social justice, equitable resource allocation, and cost-effectiveness. Instead, he shared valuable insights from his own personal experience as a patient, a person living with HIV, an activist, and a first-hand participant in the development of the HIV response.

In the 1980s, HIV was a new, fatal, horrible disease that killed primarily healthy young people within a few short years. No one knew the cause of the epidemic, the method of transmission, the means of prevention, or how it could be treated. Because HIV most commonly affected groups characterized as “junkies, queers, and whores,” the disease drew little attention from the government or pharmaceutical industry. In the face of this neglect, effective community response was crucial. HIV activists fought for the funding and prioritization of research and development to address HIV. At the time, it took 10-15 years to approve new treatments, but HIV patients were dying within 2 years of diagnosis. HIV activists determined that the US’s drug approval process needed to be changed in order

to address the epidemic. Once HIV drugs were developed, HIV activists fought for the creation of mechanisms that enabled poor people to access these drugs. This led to the establishment of the AIDS Drug Assistance Program, a federally mandated and funded program that pays for HIV medications for poor people.

The HIV epidemic created a large social stigma against those with HIV, said Sawyer. Homelessness became common among those affected by HIV, because they were often fired due to stigma or were unable to work because they became too sick. Many of the social safety nets in the US did not apply to HIV patients during those years. HIV patients were not “disabled,” so they did not qualify for housing vouchers. Often, they were not poor enough for a long enough time to reach the threshold to qualify for housing assistance and obtain subsidized housing. To address this challenge, HIV activists fought for expedited housing qualification and placement for HIV patients. One of HIV activists’ victories included the Housing Opportunities for People with AIDS Act, which provided funding to build medically appropriate housing. Similarly, people with HIV/AIDS often faced food security challenges; HIV activists fought for HIV patients to get expedited access to food stamps. HIV activists fought for expedited access to other supportive services, such as substance abuse services and mental health services. The Ryan White CARE Act granted funding to improve the availability of care for low-income, uninsured, and under-insured victims of AIDS and their families. These funds and services aimed at addressing the social determinants of health for those with HIV/AIDS were obtained solely through the activism of the HIV/AIDS community.

Sawyer explained that these resources were secured by “mounting a war” for the lives of those living with HIV/AIDS. The process began by building an army of supporters and stakeholders. Nurses, doctors, lawyers, researchers, clergy members, writers, celebrities, and social justice activists were enlisted to play various roles in the fight for the health of those with HIV/AIDS. Their activism leveraged the power of disruption: they disrupted government meetings; took over drug company offices; and interrupted presi-

dential speeches in order to demand attention and action. Once the disruptors were placated, the doctors, lawyers, and health policy experts would be sent in with detailed accounts of the challenges facing the HIV/AIDS community and plans to address those challenges through immediate solutions and systemic changes. ACT UP is well known for its work in shortening the US drug approval process; the time to develop a new drug reduced from 10-15 years to 3-5 years. Additionally, HIV/AIDS activists filed lawsuits to bring about changes for those with HIV/AIDS. For instance, a lawsuit was brought against New York state to fight for medically appropriate housing. The state government had decided to develop co-located medical housing for HIV/AIDS patients and TB patients, a decision that would have guaranteed the spread TB among HIV/AIDS patients. Through legal action, they were able to ensure medically appropriate housing for HIV/AIDS patients. Under the new state policy in New York, any person with HIV/AIDS who was homeless was entitled to medically appropriate housing within 48 of appearing for housing placement.

Public relations strategies and stunts were also utilized to bring attention to the health concerns of the HIV/AIDS community. For instance, old furniture was collected and brought to the doorstep of a housing authority office and protestors chained themselves to this symbolic “HIV housing” to bring attention to the housing needs of those with HIV/AIDS. This stunt required police intervention and tow trucks and it garnered extended media coverage, all of which brought needed attention to the concerns of the HIV/AIDS community. This action was successful and led to the provision of \$25 million in funding for HIV/AIDS housing in New York.

Once a diverse and committed army had been developed and found success in the US, the attention of HIV/AIDS activists turned overseas and to the global South. People in the developing world still faced many of the challenges that had been addressed in the US, including lack of access or funding for drugs and lack of medically appropriate housing. Health policy experts, health economists, humanitarian health care providers, and social justice activists were enlisted to create a coalition to bring HIV treatment to

the developing world. Activists found opportunities to disrupt existing systems; humanitarian health care providers found ways to prove that HIV/AIDS care can be delivered in resource-poor settings. Health economists and intellectual property experts worked to develop and promote multi-stakeholder agreements, trigger the production and importation of generic drugs, and develop educational programs. Other stakeholders worked directly with drug manufacturers to reduce the costs of HIV/AIDS treatments to \$1 per day. At this lowered price, it was no longer possible for governments to claim that it was not cost-effective to save lives for \$1 per day.

Sawyer concluded by arguing that health is a human right and that everyone should have access to clean air and water, sanitation, and housing. It will be necessary to fight to give everyone access to every service that money can be raised to provide. New international agreements are needed to set specific targets and funding amounts in order to address the weakness of the UN political declaration on UHC. An army of stakeholders should be assembled to unify supporters from academia, governments, and the public to develop a war plan and fight for UHC.

4.8 GENERAL DISCUSSION

4.8.1 Prioritization, funding, and activism

Keshavjee opened the discussion by reflecting on Sawyer's description of how he and fellow activists were able to surmount multiple barriers to HIV treatment: the lack of desire to treat HIV/AIDS, the lack of available drugs, and the unaffordability of drugs. He described this as a successful example of the human rights frame and civil society working together to push down the price of drugs and drive the development of a delivery mechanism for treatment.

Keshavjee was concerned by Norheim's call for prioritizing high-priority issues over medium- and low-priority issues. He pointed out that in Boston, open-heart surgery is available on short notice to patients who need it, yet there are still high rates of maternal mortality and TB. He asked whether Norheim's model would

argue for the discontinuation or de-prioritization of high-tech care in Boston, for example, until all high-priority health issues have been addressed. Similar questions can be raised for Canada and Denmark, who also offer high-tech care but struggle with certain high-priority health conditions. Keshavjee maintained that efforts to improve various levels of the system—from specialized hospital care to primary care—should be carried out in parallel. He highlighted the tension between ostensibly supporting human rights while also advocating for setting-specific standards for prioritization of services and accepting progressive realization for certain populations based on the post-colonial construct of national borders. In effect, these people are being told that after centuries of oppression, the most we can do is to help them prioritize rather than to help them comprehensively improve their entire health systems.

Norheim replied that decision makers are faced with ethical considerations about how to balance the burdens and benefits among everyone who has a legitimate claim on scarce resources. Resource constraints are ubiquitous, he noted. For instance, in Norway they do not provide certain expensive cancer drugs because they have chosen to prioritize the provision of mental health services and other services. The principles for priority setting to which Keshavjee referred were designed for low-resource countries. In a resource-scarce setting such as Ethiopia, the first unfairness is their significant lack of resources; this unfairness could be addressed through global solidarity and increased funding from donor countries, such as the US, which would enable Ethiopia to expand the provision of effective services. However, the reality is that resources are not distributed fairly, thus Ethiopia must make a different set of choices than wealthier nations. Given these circumstances, Norheim asserted that Ethiopia's priorities should be set to ensure a fair distribution of available funds and services. This is the basis for his argument for the prioritization of services for those most in need, such as treating simple infections, providing vaccines, and other services with large population impact. In Ethiopia, it is not currently possible to provide

these services simultaneously with high-tech services such as open-heart surgery. He argued that the diversion of resources to open-heart surgery in Ethiopia would siphon resources away from delivering services that could help more people who are in greater need. He acknowledged that this is a contentious ethical dilemma.

Sawyer remarked that the issue of drug pricing has been one of the more difficult issues in health care. For instance, Gilead developed the first cure for hepatitis C and priced it exorbitantly—a 3-month treatment cost about \$1000 per day). Subsequently, the generic version of the drug was made available for \$1 per day, making it affordable to cure hepatitis C and thus making eradication of the disease a feasible goal. He pointed out that if the high cost of Gilead's treatment caused the de-prioritization of hepatitis C, then the generic drug may not have been developed. A balance should be struck between improving health and access to care and rewarding companies for research, development, and innovation, he said.

Byron Good, professor of medical anthropology at the department of global health and social medicine at Harvard Medical School, remarked that the cost-benefit analyses are often flawed because they assume that the drug cost is fixed. However, treatments for TB and HIV/AIDS have clearly illustrated that costs may be fixed in the moment, but they can subsequently change dramatically. Another common problem in public health is the assumption of a set budget; Sawyer's story demonstrated that it is possible to start with no budget at all and end up with hundreds of millions of dollars. A participant agreed that public health professionals often take budget constraints for granted, whereas Sawyer's story demonstrated that effective activism can drastically expand health budgets.

Sunanda Ray, professor of public health medicine in the department of community medicine at University of Zimbabwe College of Health Sciences, highlighted a unique challenge that can emerge in the context of prior-

itizing services based on cost-effectiveness. She described how a pharmaceutical company began a human-rights-based campaign to advocate for the provision of its own breast cancer drug. Directors of public health programs had determined that that drug had limited effectiveness and that its provision would disproportionately drain the health budget and divert funding from mental health, neonatal care, and other services. The public demand for this particular breast cancer drug prevailed, but no additional funding was provided to offset this cost, so other services had to be sacrificed. Ray said that it is the people with the least power, such as adolescents with mental health issues, who are most at risk in such situations. However, she suggested that a system that attempts to serve everyone is better than a system that primarily serves those with money or better insurance. Keshavjee suggested that the directors of those public health programs could have confronted the drug company and demanded a lower price for the breast cancer drug. Ray cited the lengths to which the HIV/AIDS activists had to go to get the attention of drug companies—which, to some extent, made HIV exceptional. "Nobody is demonstrating to make sure that girls have HPV vaccination; nobody is demonstrating to make sure that elderly people have access to dementia care," she said. This underscores the importance of supporting civil society organizations to bring about change through advocacy and activism, particularly because many drug companies are subsidized by governments

Aaron Shakow, director of the Initiative on Healing and Humanity at the Center for Global Health Delivery, Harvard Medical School, invoked an argument made at a World Bank board meeting in 1993 by Bimal Jalan, who pointed out that millions of people around the world are at high risk of heart disease make around \$1 per day. According to the cost-benefit analysis that was cornerstone of the 1993 World Development Report, those people would have to die.⁸⁷ Jalan asked, "...can it be the principle of state policy that the poor should die of heart disease?" He

87 Lea 1993

maintained that when putting forth a report on health that deals with life and death, compassion is warranted rather asserting that the poorest people should not have access to services based on cost-effectiveness arguments. To this, the authors of the report conceded that the word “compassion” should be added to the report. Shakow asked about the role of compassion and how it fits into the broader discussion of human rights. Willen remarked that some of the idioms of social justice mobilization for UHC are effective because they speak beyond the technocratic and professional domains directly to personal experience. However, other idioms are meant to travel in different circles where they are intended to sanitize suffering, or at least to bureaucratize human hardship. Norheim said that the role of compassion in health care is crucial, pointing out that health care systems should be thought of as social institutions with an obligation to respond to suffering. Communities themselves should discuss and determine the key principles that should drive these responses. In Ethiopia, for example, they deliberated and decided to start by prioritizing based on the burden of disease, followed by cost-effectiveness, equity, budget impacts, social acceptability, and political acceptability. These principles can be disputed, but the key is that communities can take ownership over how their resources are shared. Although compassion is crucial, social institutions cannot be built on compassion alone if there are not sufficient resources available. Thornber added that compassion has been a significant factor in global discussions about patient-centered care. Compassion is also prominent in the narrative literature and memoirs, as there is great frustration on the part of caregivers, patients, and other concerned individuals about the lack of compassion in health care systems. She acknowledged that compassion without resources will not save lives, but she argued that the lack of compassion leads to greater loss of life and suffering.

Ray highlighted the importance of using activism to address the social determinants of health challenges. For instance, the biggest threats to health in terms of NCDs are salt and sugar, but doctors are not in the position to address this

threat. It is food manufacturers who should be held accountable for these health threats. Another example is inadequate housing in most urban areas in African countries, which reflects complicated issues of social justice that are at the core of many global health concerns. She argued that because the US is responsible for much of the inequalities around the world, Americans must campaign for the protection of the climate to prevent further harm to global South.

Anne-Emanuelle Birn, professor of critical development studies (UTSC) and of social and behavioural health sciences (Dalla Lana School of Public Health) at the University of Toronto, questioned the conference’s narrow focus on language, priority setting, and resource allocation in global health, suggesting that military spending and other considerations should be brought into the discussion. She cited the Costa Rica’s use of political and social struggles to improve wellbeing beyond just health—for example, they eliminated their military after the Costa Rican civil war in the 1940s. Despite being a low-income country, Costa Rica marshaled power in a democratizing—or socializing—sense to make drive improvements. She called for the global health discourse to “transcend its technocratic bubble.” She also disagreed with the discourse around resource scarcity, because the approach is inadequate to address modern social challenges. The needed changes will only be brought about by a reorientation and redistribution of power and resources. Those in academic and technical fields ought to see themselves as working in solidarity with and in the interest of social movements; otherwise, these circular conversations of language, prioritization, and resource allocation will continue indefinitely.

Julia Walsh, retired professor of maternal and child health and international health in the school of public health at University of California, Berkeley, commented that all health systems have implicit rationing. If these rationing systems are not made more explicit, more accountable, and more open to community participation, then it is unlikely that countries will be able to develop affordable health packages. The development of unaffordable health packages leads to further implicit rationing, which disproportion-

ately benefits those who are most able to utilize health systems, such as people in urban areas. She commended the work of activists and NGOs to expand the pool of resources, but she noted that health systems must be developed such that they can operate within existing resource constraints. This can be assured through more accountable and transparent rationing systems, such as those described by Norheim.

Robert Yates, director of the global health programme and the executive director of the Centre for Universal Health at Chatham House, cited an example of the challenges of prioritization and drug prices from the UK. The NHS chooses which drugs and services are provided in the country, and only selects those that can be made available to everyone who needs them. In a recent case, a pharmaceutical company wanted to sell the NHS a cystic fibrosis drug for an exorbitant price. The NHS determined that purchasing the drug at this price would not be an appropriate use of funds and refused to pay; however, a public campaign was launched to demand that NHS provide the drug. NHS then moved to strike a deal with the pharmaceutical company for the drug, the terms of which were confidential. This is an example of how a balance can be struck in health systems between the many competing aims and interests. However, it also raises a more poignant question about pharmaceutical pricing and the appropriate role of pharmaceutical research and development. Based on mounting evidence, he proposed that pharmaceutical research and development should become more nationalized. Sawyer remarked that in the US, a bill has been proposed but not passed, called “the R&D treaty,” which calls for governments to create research and development reserves that are proportional to GDP to fund future pharmaceutical research. Under this legislation, new drugs would not be eligible for patent; rather, the creators of drugs would be directly compensated with awards or prizes with the understanding that their newly

discovered drug would be immediately available in the public market and produced generically. Such a paradigm shift would eliminate the profit motive from the pharmaceutical industry, especially for the most essential drugs.

Willen noted that the activist struggles described by Sawyer have become an inspiring part of cultural history—in fact, the work of Sawyer and the HIV/AIDS community was showcased at the “Health is a Human Right” exhibit at the David J. Sencer CDC Museum, which she described in her presentation. Their inclusion in the exhibit is tantamount to an acknowledgement that the human rights framework is related to the mechanisms of activism. She noted an “us/them” divide had recurred throughout the present conference and suggested that the greatest promise and excitement in the discourse had emerged when participants found ways to introduce “we/us” language, to recognize human interconnectedness, and to acknowledge what the idioms of human rights can offer to people who are suffering and in desperation.

4.8.2 UHC and the exclusion of non-citizens

Byron Good, professor of medical anthropology at the department of global health and social medicine at Harvard Medical School, remarked on the consistent and inherent exclusion of non-citizens in UHC programs. For instance, Thailand only began excluding non-citizens when they developed their UHC program; the same effect can be seen in many American cities and elsewhere. The systematic exclusion of non-citizens from new and existing UHC programs must be addressed, he said. Thornber noted that this trait of UHC programs is even present in Japan, which has a quite small undocumented population and ample resources to provide coverage to that small population. This suggests that the exclusion of non-citizens is linked to a sense of principle rather than cost.

5 UHC as universal health coverage versus universal health care

This chapter summarizes the conference session on UHC as universal health coverage versus universal health care. The session was opened with a consideration of the value of caregiving; it featured presentations on transforming health systems to achieve UHC and the impact of UHC policies, the need for comprehensive health services, and the connection between global health and liberation movements. Additional presentations described how the commercialization of health systems has subverted UHC and how the chipping away of the principles PHC began with Alma-Ata itself. The session's discussant highlighted the need for strategic action and political commitment to address global health issues, the need to publicly finance health systems, and the need to expand the funding for health services globally. During the discussion, participants considered the moral concerns related to allocating health resources, the value of strategic approaches to taking action on global health issues, the inadequacy of political will alone to correct for inequities and deficiencies in health and health systems, the role of academics as activists, and the health resource challenges associated with aging populations.

5.1 THE VALUE OF CAREGIVING

Arthur Kleinman, Esther and Sidney Rabb Professor of Anthropology at Harvard University and professor of medical anthropology in global health and social medicine and professor of psychiatry at Harvard Medical School, moderated the session. He opened the session with brief remarks on the value of caregiving and insights from his personal experiences and published works.⁸⁸ He remarked that links between social factors and health are often discussed by public health advocates, but honest evaluation of the quality of care and caregiving is less common. He summarized the current global state of primary care as “lousy...

and getting worse”; this can be said both of care provided by health and of care provided by families, the latter being the majority of care worldwide. Caregiving is disappearing for many of the same reasons that health status is being impacted around the world. The consequence is that with the progressive loss of caregiving comes the progressive loss of humanity. While there has been tremendous concern for mortality and the conditions of human health, public health advocates have failed to give adequate consideration to the human itself, the quality of human relationships, and the impacts of the absence of human dignity, respect, and affirmation in caregiving. These deficiencies result in a quality of care that would not be accepted by those in power, but it is accepted routinely when provided to those without the ability to control the quality of care they receive. For instance, the quality of care provided in China is unacceptable, despite China's remarkable success in terms of economic development. The reason for China's poor care is related to the legacy of China's barefoot doctors, who were good at public health tasks, but incompetent at caregiving. Therefore, the sentiment lingers among Chinese citizens that quality care cannot be delivered at the PHC level and Chinese hospitals are flooded with patients who actually need primary care services. These considerations should be introduced into the public health discourse along with the acknowledgement that all people are entitled not only to health services, but to care.

5.2 UNIVERSAL HEALTH COVERAGE VERSUS UNIVERSAL HEALTH CARE: RETHINKING UHC

Rifat Atun, professor of Global Health Systems at Harvard University and director of global health systems cluster at Harvard T.H. Chan School of Public Health, submitted a video presentation to the conference in which he discussed

⁸⁸ Kleinman 2019

the rethinking of UHC. He described the challenges of UHC, the innovation paradox that is a barrier to achieving universal health care, and the transformation that must occur in order to achieve universal health care. His presentation was followed by a brief discussion.

5.2.1 Widening inequalities in access and unmet need

The greatest challenge faced globally in health systems—and more broadly—are widening inequalities in income and wealth that are impacting health, said Atun. Numerous publications have clearly demonstrated the breach of the social contract worldwide that has led to these inequalities.⁸⁹ A comparison of Gini coefficients of disposable income inequality in 1980 versus those of 2014 reveals that most countries have seen an increase in inequality, including many European countries.⁹⁰ Inequalities are widening even in countries with explicit commitments to reducing inequalities in income and wealth, which have been compounded by significant increases in national debt in each global region since 2007. These increases have greatly constrained countries' investments in health, as debt service expenditures compete with health programs in national budgets. The impact of these constraints is evidenced by access-to-care data in countries with UHC.⁹¹ For instance, self-reported unmet needs for medical care due to costs, distance to travel, and waiting times vary substantially among European countries. Unmet need is high in LICs, with lower rates of unmet need in higher-income countries. Thus, issues of distribution must be appropriately addressed if access to effective health care is to be truly universal. Furthermore, an analysis of the trends in all-cause mortality, stratified by individual education, has revealed that the relative index of inequality among both men and women increased significantly between 1980 and 2014.⁹² This demonstrates the consequences of widen-

ing inequalities in access and unmet medical needs. Much of the discourse around UHC has focused on coverage, which is not sufficient in and of itself. Atun explained that health care must be both universal and equitably targeted to those in greatest need to reduce inequalities.

5.2.2 Inefficiencies and the innovation paradox

Health systems will need to change if they are to provide effective universal health care, but this will require addressing a challenge related to innovation, said Atun. Even countries that have achieved UHC face a sustainability challenge, because the health systems themselves have become highly ineffective, inefficient, and inequitable. In an editorial piece in the *Financial Times*, Atun argued that although scientific developments have spurred unprecedented delivery of innovations such as new medicines, medical devices, and health technologies, innovation in the delivery of care has faltered. This has created a paradoxical misalignment in that many innovative new technologies are available, but they cannot be delivered to the people who need them. This misalignment has many consequences. For instance, many countries fall short in terms of efficiency of health expenditures. WHO has estimated that ineffectiveness in intervention mix accounts for a loss equal to 10%-15% of health expenditures; inefficiency accounts for similar, but smaller, losses in human resources, medicine procurement, and supply chain management spending.⁹³ Due to these existing inefficiencies in health systems, there are potential gains equal to 20%-40% of current expenditures.

Achieving universal health care will require fixing the efficiency problem and resolving the innovation paradox, said Atun. However, health systems are also ineffective as well as being highly inequitable. A recent study evaluating the diabetes care cascade in 29 LMICs found significant drop-

89 Milanovic 2016; Piketty 2013; Stiglitz and Pike 2004; Stiglitz 2012

90 For more information, see oe.cd/idd (accessed February 15, 2020)

91 For more information, see <https://ec.europa.eu/eurostat/web/main/home> (accessed February 15, 2020)

92 Mackenbach et al 2018

93 For more information, see https://www.who.int/healthsystems/topics/financing/healthreport/whr_background/en/ (accessed February 15, 2020)

offs at each stage of the cascade.⁹⁴ In the countries studied, only 64% of people with diabetes were detected; among those detected, only 48% were diagnosed; among those diagnosed, only 45% initiated treatment; and among those who initiated treatment, only 30% of cases were controlled. Many of the countries in the study had UHC programs, particularly those middle- and upper-middle-income countries. However, universal health care is clearly not being achieved in the case of diabetes, which one of the most common NCDs worldwide. Diabetes is estimated to have a global cost of about \$1.3 trillion (around 1.8% of the global GDP) that is projected to increase to almost \$2.5 trillion (around 2.2% of the global GDP) if the same models of care continue to be used. The care cascade for hypertension is worse than that of diabetes, he added.⁹⁵ A study of 44 LMICs found that hypertension control levels are around 20% in Latin America and the Caribbean and as low as 10% in countries in South and East Asia and Sub-Saharan Africa. This highlights a major challenge in relation to the effectiveness of care people are receiving under and the inequities that exist both between and within countries.

5.2.3 Transforming health systems to achieve universal health care

Clearly, UHC is not enough to ensure health outcomes said Atun. When considering universal health care, much of the discourse has focused on entitlements in relation to financing or insurance coverage. But without efficient and effective health systems, universal health care and the targeted health outcomes will not be achieved. In order to achieve universal health care through UHC, a balance must be struck between multiple health system objectives. Health care should be highly effective, efficient, responsive to the needs of all, and equitable. UHC must be reframed in terms of both value-for-money (effectiveness and efficiency) and value-for-many (responsiveness and equity). Fighting global inequalities will require inclusion, investment, and innovation, as well as rethink-

ing the societal values that shape the concept of UHC. Investments should address both the social and structural determinants of health to rectify the global society's failures, which have particularly impacted the most neglected populations with the lowest income, education level, and socioeconomic status and further contributed to widening inequalities. Again, UHC will not be sufficient to address these challenges.

UHC must be transformed to deliver not just universal coverage but universal care in order to achieve universal health by ensuring equitable health outcomes, not just access to equitable health care services. This will require redesigning and integrating public health and health systems by re-considering organizational design—e.g., separating public health functions from functions that produce health services at the individual level. Multisectoral action through integrated networks must simultaneously focus on population health as well as individual health. Transitioning toward integrated financing for health systems, public health, and the social sector will ensure that in addition to healthcare delivery issues, more upstream social and structural determinants of health are also addressed. Service delivery requires not only supply-side solutions, but also targeted demand-side solution that mitigate barriers to access to effective health care services, particularly for those who struggle to access care due to cost, geography, or other barriers, even when services are available. Services need to be affordable and accessible to all individuals at the time they need them. Atun concluded that "...going forward, we have to redefine UHC from universal health coverage to universal health care to actually achieving universal health outcomes—that is the challenge for global health."

5.2.4 Discussion

5.2.4.1 On solutions to the challenge of care

Kleinman pointed out that Atun's presentation noticeably avoided issue of quality. No direct

⁹⁴ Manne-Goehler et al 2019

⁹⁵ Geldsetzer et al 2019

measures of the quality of health care are used to evaluate health systems, he said; rather, institutional efficiency is measured and used in lieu of measures of quality. He conceded that reason quality is not measured in health systems is very complex and likely beyond the scope of Atun's presentation. Julia Walsh, retired professor of maternal and child health and international health in the school of public health at University of California, Berkeley, applauded Atun's descriptions of the challenges and barriers to UHC, but she was disappointed that he did not propose specific solutions to those challenges. Kleinman agreed and further considered the issue of the cascade of care for hypertension, raised by Atun. In the US, around 75% of hypertension patients do not adhere to the treatment regimen. This challenge cannot be addressed, or even described, by evaluation merely in terms of efficiency and responsiveness. Mary Bassett, New York City health commissioner, added that from a public health point of view, consuming excess dietary sodium is a major contributor to hypertension. As the food supply in developing countries has become increasingly commercialized and dominated by transnational corporations, the diets in those countries have shifted and given rise to the same health challenges faced in more developed nations. It is critical to address these and other drivers of noncommunicable diseases in the context of individualized care, she said. Kleinman commented the public health discourse too often gives short shrift to the clinical components of care—in fact, the prioritization of care is what distinguishes social medicine from public health. Bassett agreed that care is crucial and that access to care is among the social determinants of health. She criticized Atun's implication that rising inequality is a natural phenomenon rather than calling out the social policies that have led to it. Audrey Chapman, professor of community medicine and health care and Joseph M. Healey Memorial Chair in medical ethics and humanities at University of Connecticut School of Medicine, said that another impediment is the global shortage of trained health care professionals, particularly in Africa and other settings where there have been efforts

to expand coverage, but no efforts to increase the supply of professionals to provide care.

5.2.4.2 A critique of the technocratic perspective

Anne-Emanuelle Birn, professor of critical development studies (UTSC) and of social and behavioural health sciences (Dalla Lana School of Public Health) at the University of Toronto, described Atun's presentation as eminently technocratic and apolitical, which illustrates the perils of depoliticizing health policy discussions. Atun mentioned the structural determinants of health but did not delve into their significance; moreover, he did not mention the impact of profiteering, which is a crucial factor. For instance, his use of Gini coefficient data failed to highlight that since 2000, certain Latin American countries such as Brazil, Uruguay, and Bolivia have decreased inequality through concerted redistributive policies. Cate Oswald, chief policy and partnership officer at Partners In Health, reflected on the remarks given by Eric Sawyer, founding member of ACT UP, in relation to Atun's presentation. Sawyer described the importance of collaboration across multiple domains and disciplines—from activists to technocrats—in order to work toward Atun's aims of multisectoral action, integrated networks, and innovative financing. Joel Curtain, director of advocacy at Partners In Health, commented that the collective rights framework was absent in Atun's discussion of health. He proposed that the solution to many of the public health challenges of the global South lies in reverting the flow of \$2 trillion per year to the global North in illicit tax flows. These challenges cannot be addressed using only the currently domestically available funds in the global South. Interim strategies based on prioritization are merely a stop-gap measure that allow wealthy governments to claim they have taken action while actually maintaining the global status quo.

Ray praised her younger colleagues for taking up the struggle to relieve the global South. She noted that in order to address issues of quality it is necessary to consider why health care providers are not delivering high-quality care. The people's health movement has highlighted

the need for synergy between communities and health workers. Communities must value and hold service providers accountable for the quality of services provided; furthermore, health workers will provide better care if they feel valued. This synergy can result in better health outcomes. In Southern Africa for instance, health care professionals work hard, but they often do not feel rewarded, valued, or recognized. Given their poor work environment, it is unreasonable to expect these health workers to provide high-quality care. This pattern can be reverted through community activism to bring greater recognition to health workers. Kleinman agreed, pointing to the work done in India to evaluate the true quality of both public and private care.⁹⁶ This research evaluated the drivers of care as well, and its findings corroborate Ray's comments and presentation. He further remarked that the quality of care in developed and wealthy nations is poor and in decline; this poor quality of care may need to be evaluated independently. He highlighted the importance of compensating family-based care. In the US, the vast majority of care is delivered by families, but this care goes uncompensated, either in terms of status, cognitive resources, or remuneration. For instance, a family that provides routine care for a family member with diabetes may know the optimal regimen for that patient's diabetes, yet they cannot access a pharmacy without going through a physician, who is unlikely to have better knowledge than the family about the optimal regimen for that particular patient. Richard Cash, senior lecturer on global health in the department of global health and population at the Harvard T.H. Chan School of Public Health, affirmed that a large proportion of care for many diseases, including hypertension, diabetes, diarrhea, and tuberculosis is delivered through home-based care. An investigation into the quality of care delivered by health systems is warranted, but the quality of home-based care must also be studied and improved in order to improve the overall quality of care. He also commented that there have been many successes and improvements in public health. He dismissed the alarmist attitude toward the state of health,

suggesting that further improvements can be made through the study of past successes.

5.3 INTERPRETATION AND UHC

Joia Mukherjee, associate professor of medicine and associate professor of global health and social medicine at Harvard Medical School, highlighted the challenges facing those who cannot access medical services and argued for system-wide health reform at the primary, secondary, and tertiary levels. She connected the issues of health care to the struggles for liberation in the global South, and she highlighted the need for activism to bring about the societal changes to improve health. Her presentation was followed by a brief discussion.

5.3.1 Human impact of UHC policies

Mukherjee opened by drawing attention to the real people whose lives and families are impacted by health policies such as UHC. She shared the story of a man named Marshall, who worked as a motorcycle chauffeur and broke his leg when he was a 45-year-old father of five children. He did not believe that health services would be available to him. When he started shivering from the complications related to his injury, his family contacted community health workers who brought him into a Partners In Health public facility. Marshall had a minor open fracture of his tibia, but by the time he received care he had gangrene. Because the nearest hospital that could perform orthopedic surgery was 16 hours from Marshall's home, he died from his injury. She argued strenuously that this type of outcome is unacceptable in the 21st century and that the faces of those who are suffering around the world are not being recognized at UNGA and other settings where health policy decisions are made. She cautioned against seeking technocratic solutions that fail to account for the suffering in peoples' lives—the decisions made around UHC directly impact whether people like Marshall will live or die. For Marshall, his wife, and his five children, these decisions are immensely significant. Marshall's children will need support; his wife is likely to live in poverty or

96 Das et al 2012

to trade sex for food and protection for her children. Discussions of health insurance, financial coverage, and basic sets of interventions must be grounded in such realities of people's lives.

5.3.2 Need for comprehensive health services at all levels

Mukherjee pointed out that the care that would have saved Marshall's life was not included in the interventions promoted at the UNGA meeting. During discussions about the UHC declaration at the UNGA meeting, Mukherjee intervened on the floor to raise issues around Marshall's death, along with the needs of women who require c-sections and children who need neonatology. She reported that one member of the UNGA said that, given the opportunity and funds, African nations would divert funds to build tertiary care. She countered that primary care is not mutually exclusive from secondary and tertiary care. Health systems in the impoverished global South are collapsing due to the burdens of inadequate resources. Primary care clinics often serve over 100 people per day. She characterized the services provided at such clinics as more similar to triage on a battlefield than PHC services. In many places in the global South, there is a massive flow of need; without investment in primary care, secondary care, tertiary care, medical and nursing schools, the battle will be lost. Mukherjee acknowledged that vaccination, vitamin A, and oral rehydration will save lives, but she rejected the notion that provision of such basic services are an adequate solution to the global health needs of 21st century. She praised the work of HIV/AIDS advocates, as described by Sawyer, and she asserted that longitudinal care is a basic right.

Mukherjee explained that water collection in places like Haiti, Malawi, and India, water is still collected from a central water pump. She considered the lionization of John Snow, who removed the handle of the water pump during the 1854 cholera epidemic in London—yet his breakthrough did not provide an alternative source of clean water. In the 21st century, the foundational challenge of clean water has still not been

adequately addressed in discussions of global health. Prevention of disease is essential, said Mukherjee, but the prioritization of prevention should not preclude the treatment of those with disease. Furthermore, the treatment of disease must include addressing the social factors that contribute to disease, such as food and housing. In Malawi's Neno district, 6% of children suffer from acute malnutrition; nutritional supplement interventions notwithstanding, these children will die unless they are given food.

The Astana Declaration proclaimed that PHC is the most inclusive, effective, and efficient approach to enhance people's physical and mental health, as well as social wellbeing. It further asserts that PHC is a cornerstone of sustainable health systems for UHC and achieving the SDGs.⁹⁷ Mukherjee explained that she and Partners In Health have fought against this type of exclusive focus on PHC. PHC must be linked to community participation; community health workers alone cannot solve this problem, but they can be of great help if they are supported within a system of primary care. The need is vast for other higher-level services, such as surgery, treatment for schizophrenia, and many other eminently treatable conditions that could be addressed through investment in comprehensive health services, yet in global health, there is a greater focus on innovation than health systems themselves. She remarked on the frequent discussions of technological innovations in artificial intelligence, data systems, telemedical, and mobile devices. However, without adequate investment in health systems themselves, these innovations will not be effective. For instance, drones are used in Rwanda to deliver blood to a hospital, but a drone will not fix the challenges that led to Marshall's death. Furthermore, the technocratic approach and the fixation on technological innovation obscures the underlying problem of global health: systemic impoverishment linked to histories of colonialism, slavery, racism, and neoliberalism. She shared an image of a small closet with an empty bookcase and a rolling cart with several dozen pill bottles. This room was the pharmacy of a

⁹⁷ World Health Organization 2018

district hospital that served 350,000 people. The lack of resources in a hospital setting cannot be tolerated merely because tertiary care is seen as a lower priority than primary care. Some have argued that the problem in low-resource settings is demand creation, yet Mukherjee argued that the perceived lack of demand simply reflects the poor supply of care.

One of the principles of UHC is that people must have access to care without financial hardship, said Mukherjee. The UN has reported that 800 million people spend at least 10% of their household budget on health care. The majority of this spending, she suggested, is on catastrophic expenditures, such as lengthy treatment for drug-resistant TB. People who are already poor are most likely to have catastrophic health events, underscoring the need to understand the wide-ranging personal impacts of these events and to ensure that people have access to surgery, medicine, and physicians. Often patients must travel great distances to seek care because their local health facilities are unable to offer needed treatment. The burden and costs of travel exacerbate the hardships faced by people who experience these catastrophic health events and their families. In the case of TB treatment, treatment for drug-resistant cases is often not offered due to the higher costs of such treatments; rather, a designated set of interventions, DOTS, is the only option offered to TB patients in many facilities. DOTS does not include the provision of food or mental health support, and it only recently began to include screening for HIV.

Again, primary care alone cannot address these needs—instead, primary care must be offered in addition to other services and efforts to address the social determinants of health. She considered the notion of selective primary care, which recommends the prioritization of some preliminary services in lieu of comprehensive care. She argued that within this approach, the packages of services that are offered are in many ways

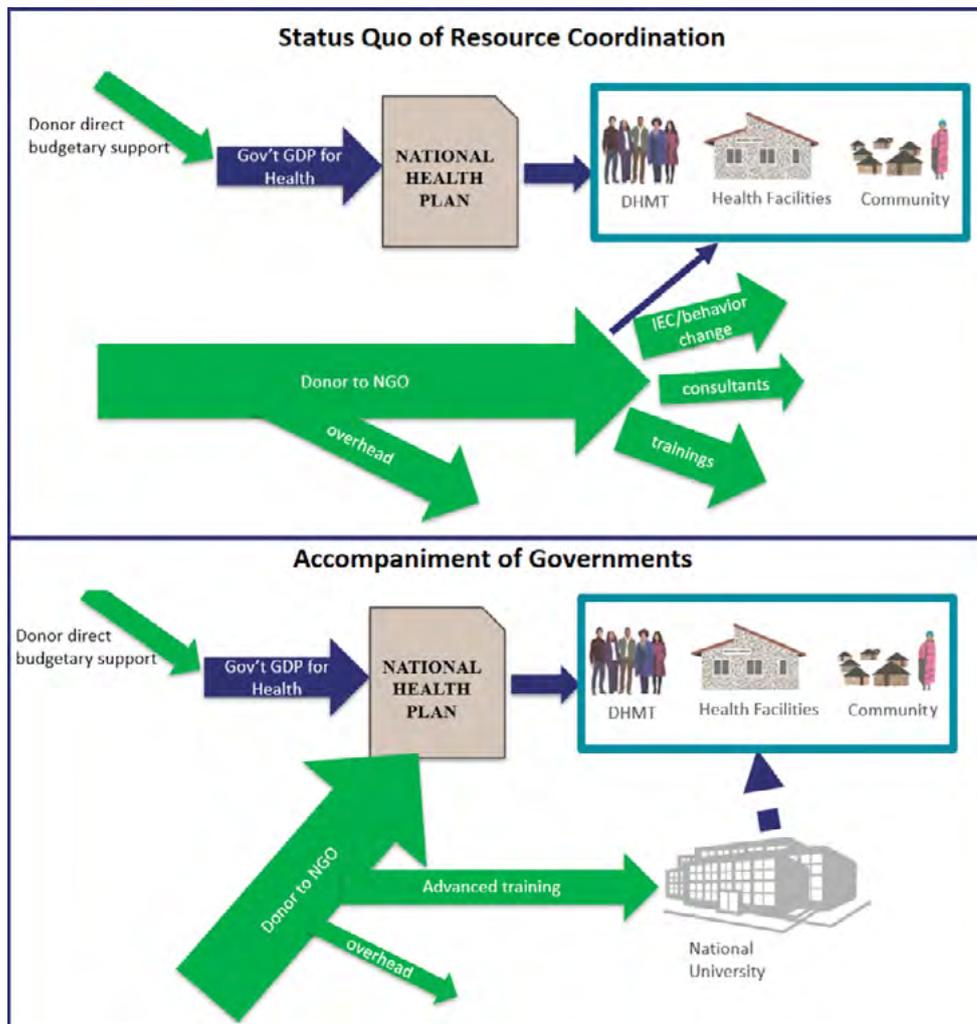
defined by racism. She presented evidence from the 2016 Global Burden of Disease study, which found that cardiovascular diseases presents the greatest burden of disease globally.⁹⁸ People around the world are dying from rheumatic valvular disease because they do not have access to penicillin. But in addition to penicillin, these individuals should be able to have their valves fixed—this is a stark injustice.

5.3.3 Government accompaniment instead of vertical funding

Mukherjee called for a shift from the status quo of resource coordination to strategy of government accompaniment. She noted that there is more money in the global South than often presumed, but it is structured in a way that does not provide healthcare. To illustrate, she shared a visual representation of the flow of health resources in many countries (see Figure 4-1). In many cases, vertical programs are established through donor funding that 1) does not pay government salaries, 2) does not compensate government health workers, 3) relies on volunteer health workers, and 4) addresses only one disease. If this funding can be diverted toward established national health plans, then billions of dollars of funding would be available to ministries of health to realize their national health plans. The mindset that domestic resource spending must be used for specified sets of interventions will perpetuate this status quo, she warned. The bulk of donor funding currently goes toward behavior change programs, educational programs, consultant salaries, and trainings at capital cities with costly per diems that allow funders to claim that they have trained a certain number of people. Alternatively, through accompaniment of governments, the bulk of funding could be directed toward the realization of national health plans, advanced training could be conducted at national universities, and total overhead costs could be greatly reduced.

Figure 5-1: Status quo of resource coordination versus accompaniment of governments

⁹⁸ For more information, see <http://www.healthdata.org/policy-report/findings-global-burden-disease-study-2017> (accessed February 15, 2020)



Source: Mukherjee presentation

Notes: GDP = gross domestic product; NGO = nongovernmental organization; DHMT = district health management team

5.3.4 Model of national health reform

Mukherjee described an intervention in Lesotho that used Partners In Health's national health reform model to improve health outcomes. The program's approach focuses on strategies of service delivery to achieve UHC, strengthening health system management, and developing a professionalized village health worker program. These strategies primarily included paying all health staff, improving supply chains, and renovating facilities. The delivery of quality services was achieved through the establishment of health centers as the population-based

hub for the progressive realization of UHC. This strategy is based on an understanding of the disease burden of the population covered by the health center and the alignment and assurance of key inputs including staff, supply chain, and infrastructure to achieve UHC. The burden of disease was mapped and key targets were calculated for each catchment area. These targets were coupled with facility assessments to determine staffing, supply, and system and infrastructure inputs required. District and health center management ensured that health centers had appropriate supplies and provided access to quality care through supervision and data monitoring. Health center performance

was measured regularly against UHC targets. The strengthening of health systems management was achieved through the reorganization of the district health management team structure and the diversion of resource allocation and decision-making powers from the central to the district level. Partners In Health provides ongoing leadership and management training, mentoring, and support for these teams, empowering them to set targets, develop district plans, allocate and coordinate partners and resources, and accurately monitor progress and performance of each facility in their districts. These practices improve performance and enable district health management teams to access performance-based financing, which can be used to address resource gaps to further improve coverage. Partners In Health actively engages national-level health officials to build capacity and support data-driven national plans and policies, which empowers ministry of health leadership and helps them understand resource needs and coordinate partners and funding in line with those needs. The professionalized village health worker program strategy promoted comprehensive training and performance-based payment for village health workers. These health workers conducted community-based demand creation activities, such as village outreach campaigns, patient identification, and accompaniment and tracking of patients in need of support. Oversight and supervision for this program came from health centers, which assured that village health workers covered key interventions for a defined population. Traditional authorities, community health councils, local officials, and community members were fully engaged in planning, monitoring, and evaluating community health intervention.

Mukherjee explained that this model of reform led to an increase in the utilization of care, including increases in HIV enrollment, vaccination, and facility-based delivery. This increase in utilization, was not due to the selection of a set of services or interventions, but to the improvement of the health system itself. This model led to increased demand, access, and quality of services, along with improved linkages between the community, health center, district

hospital, and tertiary hospital. Three nurses in the community chose to deliver their babies in a community health center—which is notable because the community health center had previously been considered a place for poor people to receive care, not professionals. This speaks to the sense of solidarity that was promoted by the national health reform model. Additionally, this model improved the fill-rate in the health system.

To further bolster the need for health system strengthening, Mukherjee highlighted the challenge of finding patients with TB, which is a hallmark of the failure of modern health systems. The burden of TB disease among adults has eclipsed that of HIV because a strategy of prevention has been implemented to the exclusion of other strategies. Generally, only smear-positive, drug-sensitive pulmonary TB is routinely treated, in most cases, through vertical programs. TB cases will only be found through investment in health systems and community engagement, she asserted, not through campaigns narrowly focused on TB. In Liberia, health system strengthening led to an increase in TB case finding and they were subsequently able to achieve universal coverage of TB case finding and treatment.

5.3.5 Liberation movements and global health

Mukherjee presented images of health revolutionaries Kwame Nkrumah, Patrice Lumumba, and Amílcar Cabral. These revolutionaries promoted equity, justice, and the right to health care for their people. The movements for equity, health, and justice represent long lasting struggles, particularly in Africa. Each year, \$192 billion flow out of Africa, as shown in Figure 5-2. Much of this money serves global corporate interests, rather than the interest of the African people. For instance, Liberia has one of the largest diamond mines in the world, yet it is the home of some of Africa's poorest, least healthy people. These diamond mines were the epicenter and catalyst of Liberia's civil war, despite the fact that Liberians receive little of the wealth created by the diamonds mined in Liberia. Africa's natural resources have become a tax on Africans, she said, which is borne in the form of ill health and short life expectancy. The African people

capture little, if any material gains from their nations' resources. The revolutionary struggles in Africa have primarily focused on the notions of resource ownership, the redistribution of wealth, and basic social and economic rights. These struggles and the battle for health cannot be won without a fight, she said. Corporate

power, neoliberal agendas, and the underlying racism that justifies the current distribution of resources must be challenged globally in order to win such a fight. Mukherjee closed by imploring the audience and participants to join the fight.

Figure 5-2. Financial outflows, costs, and inflows in Africa



Source: Mukherjee presentation, Sharples et al 2014

5.3.6 Discussion

Bassett noted that the concept of “primary health care” and “primary care” are conflated in the Declaration of Astana. She suggested that Mukherjee’s critique was mainly aimed at the notion that all people need is primary care rather than comprehensive health coverage—an argument made by David Sanders in his last published work.⁹⁹ However, “primary health care” as conceived in the Declaration of Alma-Ata is embedded in a comprehensive health system that includes referrals and

other services. She advised that a careful use of language is necessary to avoid that type of conflation. Mukherjee agreed and added that this conflation has contributed to the movement toward technocratic solutions and the types of ineffectual interventions promoted at the UNGA.

Aaron Shakow, director of the Initiative on Healing and Humanity at the Center for Global Health Delivery, Harvard Medical School, explained that in 1979, USAID endorsed the Declaration of Alma-Ata and the PHC approach as their strategy for health care in Africa because it was deemed to be the most cost-effective solution.

⁹⁹ Sanders et al 2019; World Health Organization 2018

Consequently they identified certain health issues and hazards for programmatic support (e.g., infectious and parasitic diseases, rapid population growth, malnutrition) as higher priority than health concerns identified by the people in Africa themselves (e.g., cancer, cardiovascular disease, and other chronic diseases) that are becoming increasingly prevalent in more developed sectors of the population and among the elderly. He noted that the debate at Alma-Ata did have a component of liberation, but the authors still maintained that treating these types of prevalent diseases was not necessary. He asked how to take Mukherjee's powerful call for action on a comprehensive set of health issues and "make it stick" in a way that catalyzes action by the centers of policy-setting power.

Salmaan Keshavjee, Harvard Medical School, Brigham and Women's Hospital, Partners In Health, and Advance Access & Delivery, asked Mukherjee to comment on the contention that some degree prioritization is unavoidable. Mukherjee replied that the common refrain is that "we have to prioritize," but it remains unclear who, exactly, is being asked to do this prioritizing—it is not academia, nor ministers of health and finance who are hamstrung by neoliberal policy constraints (e.g., the government of Ghana was sued by GlaxoSmithKline for trying to import antiretrovirals). Mukherjee herself has never talked to a minister of health who did not want more expansive approach, but they desperately need resources. She remarked, "We have no problem with trillions of dollars going to militaries—interestingly, structural adjustment has never touched military budgets. We need to really rethink what human rights look like in the 21st century."

5.4 COMMERCIALIZATION OF HEALTH SYSTEMS AND THE SUBVERSION OF UNIVERSAL HEALTH CARE

Rama Baru, professor at the Centre of Social Medicine and Community Health in the School of Social Sciences at Jawaharlal Nehru University, discussed the historical and ideological roots of universal health care and coverage, the devel-

opment of health services in post-colonial societies, the varied histories of commercialization in post-colonial societies, and the relevance and importance of the Declaration of Alma-Ata for post-colonial societies. She remarked that the conference's preceding discussions have been both rich but also concerning, in that few of the presenters or participants highlighted the roles of histories and contexts of the issues around universal health care and UHC. Histories, ideologies, and markets have shaped the modern technocratic solutions to health problems. The focus on the social determinants of health is itself, in a sense, a critique of the technocratic approach. She reiterated and affirmed Mukherjee's call for a longitudinal approach to health care. Her presentation was followed by a brief discussion.

5.4.1 Historical and ideological roots of universal health care and universal health coverage

Baru remarked that the concepts of "universal health care" and "universal health coverage" are often used interchangeably in the global health discourse. As a result, there is a lack of conceptual clarity or recognition of the fact that the two concepts have different historical and ideological roots. The former can be traced to the emergence of social medicine in the early part of the 20th century in Western Europe. The latter is the product of the growing commercialization of health care and the need for governments to provide an insurance coverage to needy consumers of increasingly expensive privately provided health care. The core values of social medicine—universality, equity, and comprehensiveness—require state-funded public health services for realizing universal health care, and there was a broad ideological consensus on the ideas and practices of social medicine from the Paternalists to the Marxists. Several European countries invested in public health services during the inter-war and post-World War II periods, and the concept of social medicine that dominated the imagination of public health theory and practice during this period found wide recognition in both Western Europe and the US. An epistemic community of prominent physicians and social scientists subscribed to this

perspective and actively advocated for social medicine. Members of this community were associated with institutions such as the International Health Division of the Rockefeller Foundation, the Johns Hopkins University, and others that were actively engaging with China, India, and several Latin American countries. These people and institutions contributed significantly to the discourse on how to structure health services in developed and developing countries.

Debates regarding the importance of integrating preventive and curative medicine led to the conception of health centers as the primary level of care, Baru explained. This conception was manifested as government policy in Britain after World War I. A Committee headed by Robert Dawson, a senior physician, was convened in 1920 and developed the ethos¹⁰⁰:

Preventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical service must be brought together in close coordination. They must likewise be both brought within the sphere of the general practitioner, whose duties should embrace the work of communal as well as individual medicine.

The Dawson Committee recommended a graded referral system that referred complex cases to secondary health centers, which would be staffed with specialist consultants and closely linked to hospitals. A similar system was proposed and legislated by the health commissioner in New York in 1920. However, this legislation, known as the Sage-Machold Bill, was immediately opposed by the State Medical Society, which testified at hearings that doctors “feared it could prove harmful to the medical profession and that it meant the establishment of ‘state medicine.’”¹⁰¹ As a result, the Sage-Machold Bill was never implemented in New York; this missed opportunity serves as a symbol of resistance to social medicine in the US. The practice of social medicine gained visibility during the post-War experiences of the Soviet Union and China. Henry

Sigerist's work on Soviet Medicine and John Grant's on organizing health services in pre-revolutionary China influenced the theory and practice of social medicine globally during this period.

Baru explained that the work done by John Grant in China as a part of the Rockefeller Foundation's intervention in health care laid the foundation for the development of public health at the Peking Union Medical College for training public health professionals. He also initiated pilot projects for the creation of health stations in rural and urban settings. Grant believed that public health was an integral part of the socioeconomic development of society. He emphasized the need for the integration of preventive and curative services, with the state playing a central role in the financing and provisioning of such services. Grant's role as a leader of the International Health Division of the Rockefeller Foundation in China provided him ample evidence to translate his learnings to other countries, such as India. In 1928, in his address to the annual conference of the China National Medical Association, Grant favored the idea that health care ought to be assured to all through a state-administered system. After the establishment of the People's Republic in 1949, Grant no longer had any influence over, or association with, China's policies, but generations of his students and colleagues occupied influential positions in the Chinese government. Thus, the idea of social medicine found its place within a socialist state. After his involvement with China, John Grant was deputed by the Rockefeller Foundation to set up the All India Institute of Hygiene and Public Health in Calcutta in early 1928. It was his presence in India as a part of the International Health Division of the Rockefeller Foundation that allowed him to participate in the deliberations of the Bhore Committee as an international advisor. The Bhore Committee report influenced thinking on health care in several post-colonial societies in Africa and Asia, drawing attention to the role of social medicine in the development of public health services.

100 Roemer et al 1988

101 Roemer et al 1988

5.4.2 From Alma-Ata to the commercialization: universal coverage or care?

Baru said that the historical inequalities imposed by colonialism and the politics of post-colonial societies impacted health service development and underlined the value of public institutions as a foundation of UHC in these societies. Therefore, the experience of UHC in LMICs and LICs cannot be compared to high-income countries. The Declaration of Alma-Ata was a momentous occasion in the history of public health that brought new life to the ideas of social medicine. This resurgence was largely due to the global failure of disease control programs that had become far too dependent on technology; it was enabled by a global alliance of progressive movements and the growth of community health projects led by civil society organizations. The cumulative result of these factors was the revitalization of interest in the PHC approach, although this revitalization was short-lived. The unraveling of the Declaration of Alma-Ata began in the first decade after its ratification with the assertion of neoliberal ideologies that contributed to growing commercialization, liberalization, and globalization in economic, political, and social sectors. The rapid growth of commercialization altered the terms of discourse—notably, these changes redefined the meaning of “public” in public health. “Public” no longer made reference to community groups; instead, “public” was now used in reference to the consumer. As the power of markets grew, institutional thinking and action were altered; furthermore, this shift in power influenced medical and health practitioners and altered the perceptions of users. During this period, there was a growing reliance on technology, medicines, and hospitals to solve health problems. In the decades since the Declaration of Alma-Ata, the role of public institutions in delivering health services has been fundamentally altered. “Big Capital” is financing not just health provisioning but also pharmaceuticals manufacturing, health technology, education, and research, and it has increasingly assumed stewardship over health care and policy. In developing countries, the nexus between global and national capital produced complex

networks of actors, and their power to influence national policies increased significantly.

Baru explained that the concept of commercialization facilitates a careful examination of the growth of markets and their influence on public health systems, medical practice, and policy. The history and extent of commercialization of health systems varies across countries. Many European and East Asian nations invested in public health systems at a time when most post-colonial societies in the developing world under-invested in health, owing both to competing social and economic demands on governments and the limited fiscal space available to governments in a backward economy. While several African and Asian governments affirmed the notion of UHC, they did not have the institutional and financial wherewithal to realize this aspiration. This resulted in weak public system for provisioning and dependence on multinational companies for investments in pharmaceuticals and medical technology. The process of commercialization proceeded into the 1980s and 1990s with globalization and liberalization. Commercialization was bolstered in this era by health sector reforms, which enlarged the space for the market in both the public and the non-profit sectors. As a result, commercial interests, in mutual alliances with global and national interests, took hold in all sub-systems of national health care systems. Noteworthy consequences of the commercialization of the health system include the increased focus on financing and the provisioning of curative services. These alterations have undermined the principles of comprehensiveness and equity in universal health care. In many LMICs and LICs, a dual system emerged, comprising distinct public and private health systems. The idea of equity was no longer conceived of in terms of social solidarity and community-based approaches; it had transformed into targeted public insurance schemes for the poor with the aim of financing hospital care. In many countries, a weak primary level of care resulted in large out-of-pocket payments for outpatient services. This was antithetical to the idea of comprehensiveness as defined in the Declaration of Alma-Ata. In this era of rampant commercialization, the idea of universal health

care has been subverted and replaced with UHC; thus, coverage has been passed off as care.

The values of human rights, social justice, and redistributive justice are core to the conceptualization of universal health care; these values are antithetical to the notion of health as a commercially provided service. The commercialization of health care in poor societies has required governments to introduce the concept of UHC in lieu of universal health care. It is through a heady mix of populist politics and the SOPs that public subsidies can be given to private market. It is a continuum and a corrective to the health sector reform that pushed for commercialization and privatization of health services across the globe. Country experiences in implementing UHC have demonstrated that UHC is primarily constrained to public insurance schemes with mixed provisioning. Where there is a history of strong public provisioning, it is easier to regulate and control the behavior of the private sector. In several LMICs that have large and diverse private sectors, the ability of the state to regulate is very limited. This is due to the nexus between private interests, medical practitioners, and the political class at local, national, and global levels. In such contexts, the private sector is able to shape policies to their advantage and wrest the public subsidies that are essential for maintaining their profit margins. Many middle-income countries that have nearly universal coverage through social insurance schemes are trying to rationalize rising costs in several ways, such as efforts to redefine the scope, breadth, and height of coverage. In order to reduce hospitalization rates, there is an effort to strengthen primary level care so that it can serve as a gatekeeper to secondary and tertiary levels. China has attempted to maintain costs by investing in primary level care in rural and urban areas. The once-weak community health centers have expanded to provide a range of preventive, curative, and promotive services. The investments made have been in human resources and community-based supportive services that provide integrated care. Such investments are not forthcoming in many LMICs, such as India. The available funding, human resources, and

institutional investments in these settings are not aligned with the hype and hope of UHC.

5.4.3 Discussion

5.4.3.1 On the co-existence traditional and biomedical care in India

Vikram Patel, Pershing Square Professor of Global Health, Harvard Medical School, commented on the issue of power in the Indian framework, where community mobilization is situated within the national health mission to hold healthcare accountable and the now-formalized traditional system of medicine coexists with the powerful position of biomedical practice. Baru replied that it relates to certain degree of leverage of democratic politics. The people's health movement, including the grassroots efforts of civil society organizations, were strong advocates of the national health mission—particularly the national rural health mission—and were involved in its creation in India. These grassroots efforts to promote the national health mission were made with explicit reference to the Declaration of Alma-Ata, focusing on the value of person-centered health care. The current state of the health systems in India, including the co-existence of traditional and biomedical systems mentioned by Patel, reflects the various practices and experiences that contributed to the creation of the national health mission. Through the unfolding of democratic politics within a unique set of circumstances, India's health system came to reflect the influences and interests of civil society engagement, community mobilization, the private sector, and the coalition government in power at the time of these changes. Each of these communities whose interests are represented in the current Indian health system found a certain space to realize their concerns. However, they ultimately found that the government could only be pushed so far.

5.4.3.2 Tradeoffs of commercialization

Walsh commented that the commercialization of health systems has had detrimental impacts—such as the opioid crisis—but it has also been beneficial in some respects, such as vaccine manufacturers who have actively

engaged with child survival efforts by developing new low-cost vaccines that have averted many child deaths through widespread deployment.

David Jones, A. Bernard Ackerman Professor for the Culture of Medicine in the department of the history of science at Harvard University, remarked on the tension within countries that arises from the desire to make all services available and the competing demands on the health system. For example, in India, competing demands within health systems complicate the seemingly straightforward aim of fixing the valves of all patients with rheumatic heart disease. Sophisticated cardiac capacity was developed in a limited number of private and missionary hospitals in the 1950s and 1960s, which expanded rapidly with the commercialization of the private health sector in the 1980s. Today, the best cardiac surgeons in the world are likely to work and reside in India or China. The surgical volumes in these settings are far greater than any other setting, but the entirety of this expanded surgical volume is situated in the private sector. Thus, a subgroup of exceptionally skilled providers is offering care only to a small fraction of the countries' citizens as well as to people who travel to those countries to receive exceptional care.

Ray remarked on the state of medical tourism in Africa, explaining that in certain cases, people from African countries travel to India for specialist procedures that are covered by employer-based insurance. This begs the question of why countries in Africa do not invest in their health systems so that these services can be provided in-country. India provides these services at very low costs, while surgeons in Africa face higher costs due to their limited customer base and lower surgical volumes. This is a complex situation without an obvious solution, she said. For instance, Botswana is a country whose population is only 2 million, so it cannot realistically be expected to train surgeons and provide all surgical care in-country. Cardiac surgeons, for example, need to work in high-volume facilities in order to deliver high-quality care. In South Africa, some progress has been made toward creating such health facilities in the private sector. However, Ray expressed concern that these

facilities and specialist training are being subsidized by the public sector, yet the middle class is still expected to pay full private-sector prices for the services provided at these facilities.

Baru explained that India's system utilizes public insurance with private provisioning; the public sector pays for all people to access care in private hospitals. Private hospitals in India rely on this public subsidy because it ensures volume; private hospitals cannot be profitable if they are reliant on the middle- and upper-class. Those states that have successfully implemented public health insurance schemes have generally been states with large private sectors. The private sectors in these states supported public insurance, as it was understood that the implementation of public insurance would drive the population of those who could not otherwise afford to pay for services in the private sector into private-sector facilities for government-subsidized care. In this sense, the private sector was influential in bringing about public insurance, and this interaction between the public and private sectors has transformed the perception of health care in India.

5.5 HOW PHC GOT LOST IN TRANSLATION

Socrates Litsios, health historian and retired senior scientist in the Division of the Control of Tropical Diseases at WHO, presented a narrative that depicted the conception of PHC and its subsequent degradation. His narrative explained how the comprehensive vision of PHC was transformed into the modern model, which substitutes coverage in place of care.

5.5.1 Establishing the principles of PHC

Litsios explained that he joined WHO in 1967 as a member of the division of research and Litsios explained that he joined WHO in 1967 as a member of the division of research and epidemiology and communication science. In 1969, WHO turned its attention toward helping countries develop health services. This task was directed by Kenneth Newell, then director of WHO's division of strengthening health

services, who had previously served as the director of research and epidemiology and communication science. Litsios explained that he was brought into Newell's team to prepare

a paper on PHC for the January 1975 session of the WHO executive board. This team specified a set of seven principles of PHC (see Box 5-1).

Box 5-1. Principles of Primary Health Care (1975)

- PHC should be shaped around the life patterns of the population.
- PHC should involve the local population.
- PHC should be maximally reliant on available community resources, while remaining within cost limitations.
- PHC should use an integrated approach of preventive, curative, and promotive services for both the community and the individual.
- All interventions should be undertaken at the most peripheral practicable level of health services by the worker most simply trained for this activity.
- Other echelons of services should be designed in support of the needs of the peripheral level.
- PHC services should be fully integrated with the services of the other sectors involved in community development.

In a paper prepared in 1976, then WHO Director-General Halfdan Mahler defined PHC in a manner that elegantly incorporated these principles, stating that PHC was:

A health approach which integrates at the community level all the elements necessary to make an impact upon the health status of the people. While the development of primary health care was likely to be unique in each country, recurrent features were seen in successful examples: the use of health workers resident in each community; a clearer link between the health worker at the peripheral level and other aspects of community development, the importance of the involvement of all members of the health system in its development, and active involvement of the community and maximum and flexible utilization of existing resources.

WHO's promotion of PHC prompted the Soviet Union to campaign for the convening of an international conference on the subject, which led to the convening at Alma-Ata in September 1978.

In his published reflection on Alma-Ata, Litsios descried the considerable differences of opinion inside and outside WHO regarding the precise meaning of PHC.¹⁰² Still, the Declaration of Alma-Ata defined PHC in a manner that was faithful to the previous definitions from WHO and Mahler:

Essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

¹⁰² Litsios 2002

PHC had been identified as the key to attaining health for all, said Litsios; it would enable people to lead socially and economically productive lives. The Declaration highlighted specific elements that PHC should include which had not been specified in the earlier WHO definitions. For instance, the Declaration called for 1) education concerning prevailing problems and the methods of presenting and controlling them; 2) promotion of food supply and proper nutrition; 3) adequate supply of safe water and basic sanitation; 4) maternal and child health care, including family planning; 5) immunization against the major infectious diseases; 6) prevention and control of locally endemic diseases; 7) appropriate treatment of common disease and injuries; and 8) the provision of essential drugs. Each program fought for inclusion in the Declaration, he explained. The WHO director of mental health, for instance, was successful in getting mental health included in the recommendations adopted by the working committee at Alma-Ata. However, mental health was subsequently removed by WHO senior management and was not mentioned in the final form of the Declaration. In this sense, the Declaration of Alma-Ata was the beginning of PHC becoming “lost in translation.”

5.5.2 From selective care to coverage in the modern era

Litsios explained that by defining PHC in terms of its constituent elements, Alma-Ata was

vulnerable to the criticisms of unaffordability. UNICEF, a cosponsor of the Alma-Ata conference, backed away from its commitment to PHC by joining in the chorus arguing that the goals of health for all were unrealistic. Instead, UNICEF adopted a strategy in 1982 that was designed to spur a revolution in child survival through four basic interventions: growth monitoring, oral rehydration therapy, breastfeeding, and vaccination (GOBI). One critic pointed out that this plan replaced participation with compliance; harsher criticisms asserted that UNICEF had avoided the underlying causes of inequity and poverty. Such criticisms are reflected in political cartoons from the time, shown in Figure 5-3. Mahler’s reaction to UNICEF’s new policies was to support the aim of better and speedier action, but he denounced the fragmented, top-down approach. He categorically rejected initiatives created by those outside of developing nations that included only limited, isolated elements of primary care, which involved parachuting foreign agents into those countries to immunize populations, or that concentrated only on one aspect of disease control without thought for other aspects. Mahler characterized these approaches as red herrings and diversions on the path toward achieving the goal of health for all.

Figure 5-3: Political cartoons critiquing UNICEF policies, circa 1982



Source: Litsios presentation

The debt crises of the 1980s shunted PHC into the background and broadened the appeal of UNICEF's selective approach to child health, said Litsios. This shift in focus was the source of concern for many PHC advocates, and these concerns were expressed in numerous publications throughout the 1980s and 1990s.¹⁰³ Among these publications was Newell's critique of selective primary care proposals as the antithesis of PHC; he suggested that the trend of selective primary care may have originated from the enumeration of specific services in the Declaration of Alma-Ata.¹⁰⁴ Other PHC advocates of the time were critical of user-financing and cost-recovery schemes advocated by UNICEF. For instance, David Werner said that "[J]ust because families are willing to pay for medicines does not mean that they are able to pay for them."¹⁰⁵ PHC was not prioritized by subsequent WHO directors-general until the appointment of Margaret Chan in 2007. She justified for the renewal of PHC as a response to globalization, which was putting social cohesion of many countries under stress, and health systems were clearly not performing as well as they should. Her leadership led to the publication of the 2008 World Health Report *Primary Health Care: Now More Than Ever*,¹⁰⁶ which was rich with analyses, including an account of how the focus of the PHC movement had changed in recent decades. However, careful examination of the history reveals that that what is being portrayed is not a history of primary health care as it was introduced in the 1970s, but rather a history of "primary care" as a set of services instead of than focusing on PHC as a set of values or principles. For instance, the report presented a diagram that depicted primary care as the hub of a coordinated network of services. Along with this alteration, the report introduced a new goal of "universal coverage," addressed in its second chapter, titled *Advancing and Sustaining Universal Coverage*.

Litsios expressed his personal bias against the expression "health coverage," despite its

laudable aims, because it conveys a sense of preserving the status quo. He reflected:

In July 1975, I had the privilege of introducing the seven principles of primary healthcare to the Christian Medical Commission's annual meeting. On that occasion, I expressed the importance of choosing the right words to express an idea and contrasted the goal of "helping people help themselves" ...with that of increasing coverage of the health services. There was life and hope in one; the other sounds like more of the same.

Today, his sentiment is more or less the same when he sees how universal health coverage is defined, said Litsios. To wit:

Universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

To make health for all a reality, we need: individuals and communities who have access to high-quality health services so that they take care of their own health and the health of their families; skilled health workers providing quality, people-centred care; and policy makers committed to investing in universal health coverage.

Universal health coverage should be based on strong, people-centered primary health care. Good health systems are rooted in the communities they serve. They focus not only on preventing and treating disease and illness, but also on helping to improve wellbeing and quality of life.

Although the words "primary health care" are used, they clearly refer more to primary care *services*. As implied by the word "coverage," this definition is a view from above. This perspective stands in stark contrast with the definition provided by Newell's *Health by the People* in 1975, which describes the provision of health care with a view from below.¹⁰⁷ Simi-

103 Chabot and Bremmers 1988; Green and Barker 1988; Heggenhougen 1984; Newell 1988; Reidy and Kitching 1986; Vaughan and Walt 1984; Werner 1993; Wisner 1988

104 Newell 1988

105 Werner 1993

106 Van Lerberghe 2008

107 Newell and World Health Organization 1975

larly, the reference to “people-centered primary health care” further illustrates that the original principles of PHC—that is, people- and community-centeredness—have been lost.

5.5.3 Discussion

Keshavjee commented on the trajectory of PHC from its original conception to Alma-Ata to diversion from Alma-Ata’s conception of PHC spurred by the selective primary care movement. He noted Litsios’ insight that the principles of PHC as framed in at Alma-Ata were already a watered-down version of what the authors had hoped to convey. He asked for Litsios’ thoughts on how this trajectory reverberates today in the move toward advocating for a minimum package that would be covered through purchased insurance. He suggested that this seems antithetical to Litsios’ conception of PHC, particularly given risks inherent in using the private market as the distributor of social goods. Litsios replied that his post-retirement research has focused on elements of health history other than PHC, but his instinct is that the modern approach is flawed.

Michael Knipper, associate professor of history, anthropology and ethics in medicine, and global health at University Justus Liebig, Giessen, remarked that in rethinking or re-conceptualizing Alma-Ata, it is important to study not only the events leading up to Alma-Ata, but also reports and publications from WHO and others to translate this historical knowledge and understand how the events of the last four decades shape the current context. He highlighted several milestones. HIV/AIDS demonstrated the power of social movements and what they can achieve, as well as impacting the history of the human right to health. At the time of Alma-Ata the human right to health was still quite vague, but subsequent work on international law, the development of instruments such as the Availability, Accessibility, Acceptability, and Quality (AAAQ) criteria, and the UN’s General Comment 14 have all contributed to clarifying what the human right to health means and how it can be applied in a practical way. The histories of neoliberalism and commercialization are political developments that have impacted the modern context in the years since Alma-Ata. He added that the

broad exclusion of migrants from UHC—which is not limited to lower-income nations—reflects how today’s context is very different than the past. It would likely have been unimaginable in the 1970s that wealthy democracies with strong health systems would exclude migrants from universal access not only to health care, but also the social determinants of health.

Knipper also commented that the Declaration of Alma-Ata was a strong critique of the medicalization of health. Mahler cautioned, for example, that ministers of health are often in fact “ministers of medicine” rather than health. This underscores the need to invest in educating medical and public health students as well as the public at large, that health is a comprehensive issue that extends beyond the technical concerns of medicine itself. Further, Knipper recommended emphasizing the importance of care in education as well as in the political domain. In addition to the social determinants of health, there is an emerging notion of the political determinants of health, given that social inequities are a result of political choice. Bringing political determinants of health into the discourse would help to link the challenges we face today to the historical experience of the last four decades, he suggested. Litsios added that the role of medical doctors is fundamental. Both Mahler and Newell were critical of the medical professions and historically, physicians have not generally been the frontline proponents of PHC for a variety of practical reasons. The links between medical schools and public health schools are weak, with many public health schools becoming research-oriented rather than focusing on the promotion of health services and the training of health workers. Meanwhile, medical schools train physicians only to provide medical services. This leaves an enormous void in terms of PHC that will not be addressed through an exclusive focus on the social determinants of health, which governments simply will not act upon.

5.6 DISCUSSANT REMARKS

In response to the session’s presentations, discussant Robert Yates, director of the global health programme and the executive director of the Centre for Universal Health at Chatham

House, shared his perspective on the aims and strategies of UHC. He focused on the need for action and greater political will. His comments were followed by a general discussion.

5.6.1 Discussant: Rob Yates

Yates noted the panel's focus on the semantic distinction between universal health *care* and universal health *coverage*, remarking on the sometimes excessive focus on terminology in public health, which gives rise to a "cocktail of acronyms" that is not always matched with a focus on action. He commended Allen's call for public health to engage with other sectors and make the case for a health system that provides everyone with the health services they need. While abstaining from discussing the distinction between universal care and coverage, he acknowledged that the global health agenda care is currently being driven by universal health coverage. The battle for UHC is worth fighting for, said Yates, but care must be taken to ensure history does not repeat itself. He highlighted several components of the definition of UHC presented by Litsios: universality, access to a range of services without financial hardship, the need for individuals and communities to have control of their health and access to skilled health workers, and the need for people-centered PHC as a part of UHC. He acknowledged that this conception of UHC does not adequately address the determinants of health and suggested that imaginative thinking about the determinants of health will be required to integrate this agenda into UHC. He suggested that the lion's share of need being addressed by UHC has to do with health services, and that many of these services can be designed to address the determinants of health. These services should be allocated according to need and with financial protection, as it would be unacceptable for access to such services to push people into poverty. This definition of UHC—founded on rights, equity, and fairness, with everyone getting the services they need—could be described as resurrecting the ideals of Alma-Ata and the health-for-all movement.

This approach to UHC can only be achieved if those who are healthy and wealthy subsidize

those who are sick and poor; thus, UHC must be publicly financed. Under such a financing scheme, wealthy people must pay in more than poor people and the poorest people pay indirectly. Such a model challenges certain ideologies that have been prominent in the language used to describe UHC. For instance, the notion of "community financing," which calls for maximum reliance on available community resources while remaining within cost limitations, implies an opposition to the idea that the healthy and wealthy should pay for health care for the sick and poor. If the goal of UHC is to be achieved, he said, reliance on community financing is not acceptable. The question of whether a mandatory social health insurance model or a tax-financed model is used adds another layer of complexity; however, both of these models are effectively tax-based and any health system aiming for UHC must be tax-financed.

Throughout the panel and the conference there has been criticism of the technocratic approach to UHC, Yates remarked. Atun's presentation in particular was critiqued for its overtly technocratic tone. In defense of this approach, Yates pointed to the need to spend money wisely. Health systems must be strengthened, and it is necessary to demonstrate that money is being spent efficiently. Baru demonstrated that UHC is not associated with health insurance. This perspective is a huge worry, particularly considering the impact of recent Indian health reforms, which have led to the growth of private hospital insurance that has diverted many people to private hospitals for care. The modern movement for UHC must not be captured by the notion that UHC means universal health *insurance*. "Coverage" in UHC refers to the provision of health services and of financial risk protection, not merely to the expansion of health insurance coverage. The bottom line was emphasized by Mukherjee, he noted: we need more money for virtually all services. In some settings, greater domestic funding is required, while other settings need external financing or aid. This raises the major question of how financing will be acquired.

The reality is that political will is necessary to increase funding for health services, said Yates. The public health community must become more

strategic and skillful in generating the political will to finance health services by rallying behind UHC. Politicians and populations understand the notion of state-financed UHC and it is a relatable, clear objective that populations can demand of their politicians. He added that there are opportunities to improve the pitch for UHC. Public health advocates are adept at demonstrating the health benefits of UHC; however, they are less skilled at advocating for its economic benefits. Furthermore, the political benefits of UHC are largely neglected in terms of advocacy. The politicians who instate UHC can expect to benefit politically from its successful implementation—this potential benefit should be harnessed to advocate for UHC. In the UK, for instance, NHS funding is often used as a political tool to appease the dissatisfaction of the British people. In other settings, however, politicians seem not to be aware of the political gains they can realize by improving their countries' health systems. UHC advocates should rally around politicians to promote UHC and hold politicians accountable to bringing about real UHC, but they should also make politicians aware of the many benefits of UHC for themselves and their countries.

5.7 GENERAL DISCUSSION

5.7.1 Moral considerations and strategic approaches to advocating for global health

Kleinman remarked on the power that lies beneath the technologies and technicalities of an economy. He noted that Adam Smith's *The Wealth of Nations* was a moral text. Smith's conception of market forces and the "hand of the market" is rooted in—and dependent on—the moral and religious domains; he makes clear that infiltrating religion in the moral domain with the market is untenable and unacceptable.¹⁰⁸ Kleinman considered how the moral domain could be incorporated into politics in order to bring about changes to health financing. For instance, he explained that a group of his colleagues at Harvard University have identified climate change as the fundamental existential threat

of our time, thus they have called upon Harvard University to stop investing its endowment in fossil fuels. He suggested that if climate change threatens human existence, then Harvard should reorient all its efforts to be relevant to addressing this key issue. Similarly, if poor health is an ongoing existential threat to human life, then a claim can be made for allocating resources in a commensurate way. He asked Yates whether this kind of argument can be made within the framework of political economics. Yates agreed upon the importance of developing tactical strategies for advocating for health, because endless analysis and conceptualization will not lead to action or change. He suggested that Kleinman's proposed argument should be reversed, however. Rather than frightening politicians with the threat of poor health, advocates should highlight the benefits of improving health. This is a particularly important tactical consideration when the consequences of a threat will not be realized for a long time. If politicians understand that acting on health care will solve a problem and bring about benefits and improvements, they are more likely to act. Health systems are susceptible to rapid improvements and this can translate into quick political wins that can elevate politicians who invest in UHC into national heroes.

5.7.2 The shortcomings of political arguments for UHC

Ray commented that many discussions about reforming health services and garnering political will fail to account for the burdens of colonial policies in African and Asia. The allure of political gains or becoming a national hero will not enable politicians in these countries to overcome their abject lack of resources. She suggested that this tactic might be used to sway politicians in the West to find some way of repaying their ill-gotten gains to former colonies in Africa and Asia, thus allowing those countries to build their own health services. However, unless the entire system is restructured, Ray was concerned about paying such reparations to the current governments of certain countries that received HIV/AIDS funding that ultimately had a destruc-

¹⁰⁸ Smith 1776

tive impact on those countries' PHC services. Changing the system would require the type of large-scale movement used by HIV/AIDS activists to address economic injustices through spirited, disruptive campaigns, rather than insular academic debate over the semantics of coverage versus care, for example. Academia should take a leading role in this effort, rather than relying on civil society to do the work. She argued strenuously that the first step should be to begin rectifying the economic injustices perpetrated by the former colonial powers that have stolen money from nations around the world. Birn commented that in Canada, which has achieved UHC, the types of political benefits described by Yates were realized by the Canadian politician who fought for that achievement. But in spite of this achievement, Canada has the highest child poverty rate among OECD countries, excluding Mexico, and there are great disparities in health between First Nations indigenous people and the general population. Canada does offer coverage to migrants, including migrant farm workers, but sick migrants are often deported. She maintained that if we continue to focus on UHC without coming to the crystallization of the Alma-Ata Declaration—i.e., a new international economic order—then “we are simply deluding ourselves.”

Regarding political will, Patel said the contention that healthcare-oriented political agendas win elections was not the case in India's recent elections. The dramatic improvements in health brought about by national investment in India's National Rural Health Mission are unparalleled, yet India's National Congress Party, which brought about this investment and improvement in health, lost the recent election. He suggested that the political value of healthcare might not translate across all cultures. Baru distinguished between political agenda and the will of politicians. She said that the politics needs to be unpacked from considerations of health and pointed out that healthcare in India is being shaped by the actions of both state and central actors. Some states in India have been innovative in their approach to health, the appropriateness of their approaches notwithstanding; for instance, the insurance-based approach to coverage emerged from the actions of India's

southern states, not the central government. These innovations were developed to address the inequities in these states. The conceptualization of these approaches is often mixed with populist politics, and the spirit of the political aspects of this mix is to identify policies or approaches to health that will help politicians win elections. This spirit has been a boon to the insurance sector, as the expansion of insurance coverage tends to capture the votes of a particular segment of the general population. She attributed the success of the National Congress Party, in part, to the fact that it was a political coalition. Coalition politics creates space to leverage new ideas. She raised the question why the National Rural Health Mission enlisted longstanding community health proponents into the committees and decision-making processes of the program, yet community health advocates are not being invited to meetings at the ministry of health in Delhi. India is now likely to be led by a majoritarian government for the next decade, she said, and the space for democratic engagement is likely to reduce during this period. The politics of these situations and the political alignments that influence health systems must be analyzed and contextualized globally. This trend toward majoritarianism is not unique to India; similar trends can be observed in Turkey, Russia, and the US. These trends seem to be connected to broader historical movements and to be here stay for some time.

5.7.3 Activism, ideology, and the role of academia in bringing about change

Kleinman asked whether UHC aims to achieve economic and social justice, which includes the reformulation of systems of care, or aims to transform and strengthen health systems through PHC as a locus of change. Mukherjee commented that not all people must be activists, but many academics should be (and are) activists who are engaging with—rather than waiting for—civil society to bring about change. Academics are often the beneficiaries of inherently unequal wealth and may even be actors that contribute to these problems. Beyond disruption and activism, development of knowledge bases

and social strategies are also critical for bringing about change. Many of the conference's participants do work that can be used in activism, while others may be involved in implementation that demonstrates what changes can be made in existing health systems. Mukherjee rejected the Ray's claim that HIV/AIDS funding destroyed PHC systems. In many countries, HIV/AIDS funding was the sole source of health funding. The effectiveness of health aid is largely dependent on the people working on the ground. These discussions often revolve around social determinants of health, but there are social forces at play that are not just deterministic; these forces have magnitude, direction, and long historical tails. Policies are needed to push against and change the vector of these forces. She compared global action on climate change to global action on health, suggesting that the disparity in global political concern between these two issues is related to a disparity in action. Therefore, specific actions should be taken to address the intersectionality between climate, health, education, and economics. Although activism is critical, it is dependent on convergent action across academia, implementation, and clinical practice.

Baru noted that alliances are often driven by ideological considerations. Within any large national health program, the perception of what is required at the community level varies from the doctor down to the frontline workers. Mid-level health workers are more likely to acknowledge the real lives and circumstances of the people they serve, with higher-level management less likely to be interested in those considerations. A creative approach is needed to develop alliances or professional organizations among clinicians and other professionals whose voices are not currently represented or mobilized effectively. She added that commercialization is one of the greatest challenges. India, for instance, has a strong corporate presence that largely determines the definitions of health as well as the kinds of partnerships that are built with technology to deliver and redefine what is required in terms of universal health coverage.

Litsios commented on the role of history and instructive examples to energize and promote activism. For instance, the Declaration of Alma-Ata was intended to create health by the people, but the films that were presented to illustrate primary health care were ludicrous—e.g., promoting food that was not available locally. He noted that the publications that come out of health meetings often present success stories that should be highlighted and promoted in a broader way to attract more attention. Kleinman noted the importance of considering the unintended consequences of purposive social action, first developed by Robert Merton¹⁰⁹ and illustrated by the barefoot doctor movement in China. Barefoot doctors were so incompetent as caregivers, but useful as public health workers, that people in China still seek care in tertiary facilities instead of primary care facilities.

Yates clarified that UHC is not intended to be sufficient to solve all health problems, let alone greater societal problems. Addressing the economic issues related to the distribution of wealth, taxation, and colonial policies could have profound impacts on health. Still, he affirmed the importance of incremental action and taking “big steps that work.” UHC is a major step that is known to work and to have benefits that extend beyond the health sector. Galvanizing a health system and moving it from a very low public spend to spending 2% of the GDP to cover the entire population is not only a wise way to spend money, but it catalyzes transformative processes that can reduce income inequalities; this has been demonstrated in Thailand, Japan, and Korea. Academia can play an important role in engaging and exciting high-level politicians—and even heads of state—about the extent to which UHC can be a “game-changer” for governments through the benefits to be reaped by UHC in terms of health, economics, and beyond.

Mukherjee remarked that influencing heads of state should be one part of a broader strategy. The world is still operating on the post-World War II human rights framework that leaves each nation-state “as a tub on its own bottom.” As such, we have accepted, within human rights,

109 Merton 1936

what countries can afford. We have also largely accepted the Universal Declaration of Human Rights, but that is really about what a nation-state does or does not do for its people based on its resources. This framework does not account for the fact that globalization has both beneficiaries and victims—for example, with respect to the free transport of capital. In this era of globalization, we must re-examine how we construct society and who is responsible for human rights. Some have argued that Haiti should increase its health spending to provide certain services based on a claim to human rights, but that is not the fatal flaw of the Haitian health system. Haiti is trillions of dollars in debt if accounting for the World Bank, colonialism, slavery, and the economic embargo led by the United States starting from the time of Thomas Jefferson.

5.7.4 Global challenges of aging populations

Kleinman considered the example of Japan, which has one of the best long-term health care systems in the world. However, by 2040, an estimated 40% of the Japanese population will be aged ≥ 65 years and it will be impossible for Japan to maintain its existing health care system as its population ages. The aging population of China will represent an even greater burden, which Kleinman asserted will be impossible to address through health spending. Yates argued that these countries will be faced with the inevitable political decision to increase the proportion of GDP spent on health. It has been demonstrated in the US that large proportions of GDP can be spent on health, the efficiency of that spending notwithstanding. He rejected the notion that there is some inherent barrier that will preclude politicians from making the choice to spend more on health, affirming the primacy of political choice in determining the extent of funding. Mukherjee noted that elder care in the US is largely provided by people from poor countries, which again highlights the dichotomy between beneficiaries and victims of globalization. “We cannot think of the nation-state alone,” she argued, “We have to think about

our core collective responsibility to health in a cosmopolitan way.” Kleinman agreed, but he was concerned that utopian thinking may not lead to change. “Can we actually have these things happen? It is much more likely that the world will continue to be the world we are accustomed to, but with additional constraints...How will we face a world with additional constraints where even the idea of planetary health may diminish in the face of environmental health emerging as the great existential issue,” he remarked.

5.7.5 Foreign aid, privatization, and the technology-driven global health agenda

Patel raised the issue of donor foundations, particularly in the least-resourced countries in the world, who distort health agendas by contributing funds not to governments to increase their per capita health spending but to specific health agendas dictated by the global North. Baru said that the interests of corporations who back these donors need to be analyzed. Technology is forced into health policies as part of the Northern agenda in Southern contexts; the use of vaccines in global health programs is a particular case of this phenomena that should be discussed. Kleinman concurred, pointing out the Bill and Melinda Gates Foundation operates with technological discovery as a primary basis for its activity.

Mukherjee raised two interrelated problems with the manner in which foreign aid is dispensed: 1) the innovation- and technology-driven approaches to aid, and 2) the push for privatization led by the US and donor foundations. Beyond the problem of privatization itself, there is an underlying assumption that the captains of capital are inherently smarter than other actors in the health space and that they will somehow alleviate the burdens of over 200 years of impoverishment and a broken system by developing some novel app or gadget. This approach and its fixation on quick fixes has a certain arrogance, she said. Regarding privatization, the US is still working under the framework set forth in the Foreign Assistance Act of 1961¹¹⁰, which founded USAID and called for

¹¹⁰ For more information, see <https://www.usaid.gov/ads/policy/faa> (Accessed February 15, 2020)

1) “buy American”, 2) open markets in the US, and 3) do not support big government in other countries. Thus, the shortcomings of programs such as PEPFAR are not caused merely by the provision of funds to support HIV care; they are caused by the US government’s demand that foreign aid cannot pay for the salaries of government workers in other countries. This demand creates brain drain and a secondary cadre of a parallel health system that pays non-government workers to provide HIV services. The US government demands that funders not purchase generic drugs; rather, they must support pharmaceutical companies through their foreign aid spending. They also demand that funders focus on religious organizations. These demands, based on the Foreign Assistance Act of 1961 create the narrative—and actuality—of privatization, even in the realm of NGOs. There has been a proliferation of NGOs implementing vertical programs on contract. Altogether, this situation reflects a neoliberal paradigm of foreign aid, and until this paradigm and the narrative of privatization are discarded, it will not be possible to develop the needed systems of care.

Yates cited an example that illustrates the problems with flashy, technology-driven programs that are ineffectual or damaging. A health financing app called M-TIBA was developed for use in

Kenya.¹¹¹ The app promises to provide affordable healthcare with mobile-based payment. Yates pointed out the absurdity of this app’s approach to health financing, which does not include any form of pooling or sharing. The app’s only function is to facilitate mobile payment for users who are able to pay for their own health services and, perhaps, health services for their family or friends. This app is of no value to a poor villager without a mobile phone or without an immediate contact who is willing to pay for their health services. This approach to financing is fundamentally incompatible with UHC, yet M-TIBA was praised by the World Bank president in a speech given at the UN. The international community must be vigilant, he said, highlighting the lamentable track record in terms health financing.

Litsios considered the role of civil society and WHO in these issues. In the 1970s, civil society organizations were key advocates of PHC; the PHC NGO group interacted with WHO and country leadership and coordinated their activities in an effective manner. The role of WHO and civil society needs to be re-evaluated going forward. It will likely fall to the NGO and civil society community to pressure WHO to move toward the kinds of health policies action discussed at this conference.

¹¹¹ For more information, see <https://www.m-tiba.com/> (Accessed February 15, 2020)

6 Reflections on health for all and paths forward

This chapter summarizes the conference's final session. It featured closing remarks, which reprised key themes of the conference and addressed other essential considerations related to the agenda of health for all: the tension between addressing determinants of health and the provision of health services; the role of the technocratic perspective in making health policy decisions; the redress of injustice as an end unto itself; and the need for health advocates not be limited in scope and aim by existing budgetary constraints. The conference concluded with a collaborative discussion that was framed around a brief consideration of history, conceptual frameworks, and action. During this discussion, participants explored examples of health systems and health policies from around the world, examined the critical need to translate discussion into action, considered the requirement that health services must be publicly financed, and affirmed that these ideas should be conceived of as a critique of the existing UHC agenda intended to bring about systemic transformation.

6.1 CLOSING REMARKS: VIKRAM PATEL

Vikram Patel, Pershing Square Professor of Global Health, Harvard Medical School, opened by discussing the work of Noshir Antia, who was an Indian plastic surgeon and author and a source of personal inspiration to Patel. Antia's book *People's Health In People's Hands* reflects his experiences working with the marginalized population of leprosy patients in India.¹¹² The book highlights the role of social injustice as a driver of health inequalities. In addition to being inspired by work such as Antia's, Patel's own career has also been influenced by the technocratic perspective through his work with the Disease Control Priorities initiative, for example. He drew

upon his experience in both of those "camps" to reflect on the proceedings of the conference.

Patel suggested that we have been presented with a Faustian bargain in the choice between focusing on social justice or health services, yet both are critically important determinants of human health as well as the inequities in how human health is experienced between populations and within subgroups of the population. Further, social justice is not an issue limited to the present, as evidenced by the impact of historical trauma. In his work in the area of mental health, it is impossible to understand people's mental health problems without understanding their lives and social conditions, along with the lives and social conditions of their ancestors. This gives rise to the fundamental question of how a frontline provider in a health center can be expected to deal with this broader social construction of ill health. Patel maintained that the reason for addressing social determinants is not to improve health alone; the redress of societal injustices is an end in itself. The consequent benefits to human health, particularly for historically disadvantaged subgroups of populations, are worthy of celebration in addition to the fact that these injustices are, in and of themselves, something that everyone of any professional persuasion must combat throughout their lives. He added that these considerations are distinct from the discourse around UHC and its equity. He described the concept of UHC as conceived at Alma-Ata as a grand vision that has been progressively dismantled since its inception; it has now been displaced by a narrow, technocratic view of what should be provided under the guise of UHC.

Patel considered how the chipping away of UHC and the emergence of the technocratic approach has influenced his own work in the area of mental health. Although the SDG era has popularized the slogan that no one should be left behind,

¹¹² Antia and Bhatia 1993

people with mental health problems and disabilities have always been left behind. As early as the 1960s, it was already clear that this was a historically disadvantaged group of people in every community. The disadvantages they faced were often deeply intertwined with social factors, including historical trauma and the trauma is related to actually experiencing enduring mental illness. Patel recalled that his work took a significant turn in 1998. The Global Burden of Disease study had revealed that mental health conditions were among the leading causes of the burden of disease, in part because they are states of health are least valued by communities.¹¹³ Armed with this clear evidence of human suffering, Patel presented these findings to the World Bank and explained that mental health illnesses are not only linked to poor health status, but are also considered to be the most burdensome diseases. Although the economists at the World Bank were receptive to these findings, they were primarily concerned with whether there were cost-effective interventions for addressing these mental health illnesses. This motivated Patel to investigate and gather evidence about how to support people living with mental illnesses such as schizophrenia, dementia, and autism in ways that can also be applied to palliative care and to other chronic enduring health conditions. That is, people with these types of enduring conditions need more than the narrowly defined health or biomedical interventions that are most likely to be formally evaluated. They often need better housing, a combination of interventions that addresses physical and mental health comorbidities, and other forms of support. However, this kind of comprehensive approach cannot be accommodated or evaluated within the cost-effectiveness framework used by implementing and funding organizations. For instance, this framework led to the narrow redefinition of the intervention for schizophrenia that included only antipsychotic drugs. This echoes today, as what is being promoted under the guise of UHC for serious mental illness is access to the

cheapest antipsychotic drugs available, which would never be prescribed in the West today.

Even though mental health conditions are not inherently lethal, people with serious mental health illnesses tend to die between 20 and 30 years earlier than they should because they do not benefit from the UHC as originally envisioned. This because the modern paradigm of UHC completely fails to capture the broad biopsychosocial nature of mental health problems and other chronic health issues, said Patel. The term “biopsychosocial” refers to the idea that understanding any health condition requires taking into account all three dimensions of human wellbeing: biological makeup, psychological makeup, and the social world. The modern paradigm of UHC has become narrowly fixated on the biological component to the near-complete exclusion of the psychological and social components of health. Consequently, the work of addressing people’s psychological and social needs has essentially been farmed out to the patient’s family or to NGOs, charities, or religious organizations operating under the guise of charity. Those families are not well supported and generally left to their own devices to provide this care for their loved one. In fact, he estimated that in most parts of the world, virtually the entire burden of care for cancer, palliation, and a wide range of chronic disabilities and enduring conditions is placed upon families, because these needs do not fit in to the narrow view of what types of care should be financed.

To illustrate the extent to which the vision of UHC has drifted since Alma-Ata, Patel reported that at a recent meeting of WHO’s independent high-level commission on NCDs, a colleague with a narrow, technocratic view of NCDs argued that the recommendations for countries on NCDs and mental health should prioritize the usual strategies (e.g., smoking and exercise interventions) and the only care intervention should be treatment of hypertension. Care, risk reduction, or treatment for diabetes and cancer, for instance, were excluded because they did not

¹¹³ Participant evaluations are one factor used to determine the weighting of disease burdens. Participants are asked to compare various health states; disability values are allocated and used to calculate the burden of each disease. For instance, schizophrenia was valued as the worst health condition to have; participants considered it worse to have schizophrenia than to be paraplegic.

fit into the model. The pressing issue now is to find ways to mobilize more resources for health, said Patel. He rejected the pervasive assumption in public health that the envelope is fixed—e.g., that the \$32 in Ethiopia will always be \$32, rather than an elastic number that can be expanded. Countries like India, which are no longer reliant on external assistance to fund the health sector, need to use the funding allocated for health in a way that is more sensible and efficient way, but also maximizes quality of care.

6.2 COLLABORATIVE DISCUSSION REGARDING OPTIONS MOVING FORWARD

César Ernesto Abadía-Barrero, assistant professor of the anthropology department at the University of Connecticut, presented a framework to orient the discussion of strategies for moving forward toward health for all. He began by presenting three images to spur discussion on three themes. The first image was a photograph of demonstration held by the Latin American Social Medicine Association during the signing of the Declaration of Astana. Protestors held a large sign that read “in order to advance our right to health we have to say ‘no’ to universal health coverage.” This image highlights the concern over the distinction between care and coverage. The second image was of the opinion piece presented by Jean Claude Mugunga, *Partners In Health*.¹¹⁴ In this piece, Mugunga described how the selection of health services is not being made by those who will be receiving those limited services. This arrangement can be characterized as the technocracy serving the interest of donor states over the interests of the recipient states. Abadía-Barrero reiterated Mugunga’s invocation of the adage “nothing about us, without us” and the relevance of this message moving forward. The third image was from an article titled *Protests rage around the world – but what comes next?*¹¹⁵ The piece highlighted massive revolts around the world and prevailing sentiment that society is on the verge of collapse. With these

three images in mind, he proposed an agenda for moving forward framed by three themes: colonial and neocolonial history in health; a framework for achieving justice; and creative strategies that challenge, transgress, and invert power.

6.2.1 Colonial and neocolonial history in health

The conference adequately demonstrated the significance of the history of health for all and the numerous reinterpretations of the Declaration of Alma-Ata, noted Abadía-Barrero. As a historical document, Alma-Ata can be characterized in two very different ways: 1) as a gold standard, inspirational, practical foundation for action on comprehensive health care or 2) as a minimizing, colonialist document that used and continues to use the global South for post-colonial racist experimentation by for-profit global health policy and global health sciences. “The importance of this historical piece is not to think back, but to think about what it means in the present and how we can continue with a rationalized global policy assessment of what we should be doing,” he said. This is the major challenge of technocracy—how to think about history in a way that acknowledges and confronts the neocolonial and neo-imperial configurations of global health as we move forward.

6.2.2 Framework to achieve justice

Abadía-Barrero noted the continual struggle to define in a meaningful way the concepts of equity and justice in health. Even the utility of certain agreed upon concepts has been challenged, as many of these concepts are easily co-opted by emergent neoliberal platforms—for example, the co-opting of PHC by UHC. Developing a framework offers the opportunity to unpack concepts that are often taken for granted, such as catastrophic expenses and the meaning of political will within our global neoliberal economy and imperialist agenda. Even the concepts of suffering, health, care, and health care are being constantly redefined in context-specific

114 For more information, see <https://www.devex.com/news/opinion-the-un-political-declaration-on-uhc-undermines-health-as-a-human-right-95675> (accessed February 15, 2020)

115 For more information, see <https://www.theguardian.com/world/2019/oct/25/protests-rage-around-the-world-hong-kong-lebanon-chile-catalonia-iraq> (accessed February 15, 2020)

ways. The conference included specific ethnographic and qualitative examples of sexual and reproductive rights, mental health, and other concepts that demonstrate the importance of context-specific consideration. The idioms of social justice mobilization presented by Sarah Willen illustrates that there are many ways to advance this platform. However, he noted that other idioms are restrictive, such as reduced, vertical approaches that stand in contrast to comprehensive and more expansive approaches towards health. He proposed that progressiveness may help promote idioms of social justice and mobilization, but it will require defining progressiveness itself in technical or political terms. To advance a political discussion of progressiveness, however, the technical must be subverted under the political

6.2.3 Creative strategies that challenge, transgress, and invert power

Next, Abadía-Barrero considered strategies for moving forward. Throughout the conference, speakers remarked on the need to reallocate budgetary priorities at the national and global level. For health care services must be effective, efficient, and responsive at all levels of care, the international economic order will need to be redefined using creative strategies to challenge, transgress, and invert structures of power. For instance, within the social medicine tradition, Brazil has been successful in negotiating the costs of antiretrovirals, promoting a strong national generics platform, and even breaking patents in the service of Brazil's health. A counterpoint is the catastrophic devastation of healthcare and other epistemologies of care in Colombia under privatization. He argued that health care does not need to be expensive; rather, it has been made expensive by the for-profit sectors that benefit from providing care. Costs are not fixed, but are social constructions based largely on profit, which warrants careful consideration of the margin of profit that is acceptable within a global emancipatory agenda around global health. He suggested that the answer to these challenges lies not in the technocratic rationing of resources, but in the redistribution of power and resources. It lies not in the rallying for

political will and global solidarity, but in tackling colonial and neocolonial reparations. It is also important to consider who should be engaged in making these decisions. State actors and international institutions will likely play a role, but community-based strategies and new global actors will be critical. Upstream social determinants of health are not the greatest historical determinants of health and the inequalities—it is the history of colonialism that has been the most powerful force. The strategic plan should involve tactics such as eliminating the patent system and removing the element of profit from health care. It would also be helpful to consider de-colonial theory, which holds that the same strategies that created these problems will not solve them. With these themes in mind, he opened the floor for discussion about the path for moving forward.

6.2.4 General discussion

Richard Cash, senior lecturer on global health in the department of global health and population at the Harvard T.H. Chan School of Public Health, asked why Cuba is not at the forefront of these discussions, given that they have achieved UHC and they have one of the largest medical schools in the Americas. He asked how Cuba's experience could contribute, particularly in the Latin American context. Abadía-Barrero said that Cuba has been a focal point of the Latin American social medicine movement, tradition, and ideology. Issues of coverage do not need to be addressed in nations with robust, publicly funded health care systems that bridge every level of care. Cuba offers an example of these kinds of social systems that have persisted despite the political embargos and under very harsh conditions.

6.2.4.1 Translating discussion into action: role of academia in the path forward

Randall Packard, William Henry Welch Professor of the History of Medicine at the Institute of the History of Medicine at Johns Hopkins University, remarked that much of the discourse of the conference involved very familiar ideas that have been discussed at length in other conferences and publications. This raises the question of how to break out of cyclical discus-

sions and bring about action, but there is no clear strategy for going forward. He shared an anecdote from his experience in South Africa. In the 1990s, labor historians who were very critical of the government explained to him that the government did not interfere with their radical work because they stayed within their academic circles and thus posed no threat. It was only if they actually engaged with laborers and activism that the risk of government suppression and violence became a real threat. While academics in the global health discourse are not facing the same physical risks as those historians in South Africa, he suggested that they should be moving along the same trajectory as those historians—toward activism. Transitioning toward activism, forging connections outside of academic, and expanding the network of global health allies should be core components of the strategy for advancing health for all.

Mukherjee considered the appropriate role of academics in inverting power structures. From her perspective as both a practicing clinician and an academic, she suggested that academics in positions of power and privilege should work with communities of people who are suffering and oppressed while considering how to leverage that power and privilege. They should engage with activists to ask *them* how academics such as themselves can be useful tools in the movement. Gaining those types of perspectives is powerful and transformative, because it inverts the power structure: the academic's skillset is being used for the benefit of the people who most need it, rather than for the academic's benefit or for the benefit of merely generating knowledge. Richard Cash, senior lecturer on global health in the department of global health and population at the Harvard T.H. Chan School of Public Health, suggested that doctoral students should no longer be allowed to conduct their research using other people's data. If everyone who received a doctoral degree had to conduct their own fieldwork, they would be better acquainted with the realities of what is happening on the ground.

Robert Yates, director of the global health programme and the executive director of the Centre for Universal Health at Chatham House, encouraged engagement in the current debate

in South Africa, where the health system has an opportunity to become more equitable. South Africa currently spends 8% of GDP on health, but half of that spending is spent by the 16% of the population with access to private insurance. The remaining population must seek care in underfunded segments of the health system. Efforts are ongoing to protect the vested interests of private hospitals, pharmaceutical countries, and insurance providers; these stakeholders are lobbying the South African government to preserve the status quo. The South African press has been exposing these inequities and there is an opportunity to transform the South African health system. Yates said that the South African government would welcome engagement from academics who can argue for the benefits and virtues of creating a more equitable health system. Academics should be looking for countries where policymakers are amenable to health systems transformation to engage with these policymakers and help bring them across the finish line in such policymaking efforts.

Jon Shaffer, doctoral candidate in sociology at Boston University, suggested drawing upon examples of transnational social movements to provide insights into pursuing the right to health by using the tools of social theory to analyze social movements from structural, cultural, and ideological frames. He also distinguished between activism and community organizing. Activism is loud, momentary, visible, and punctuated; community organizing is slow, deliberate, strategic, and often occurs under the radar. He suggested analyzing grass roots organizations as vehicles that create spaces and opportunities for strategic activism; the Social Medicine Consortium might be a useful ally in such efforts going forward.

Patel pointed out that great power has been vested in the medical communities across the globe, particularly in the private sector, but they are rarely engaged as allies in global health efforts. For instance, as the opioid epidemic in the US unfolds, much blame is placed on pharmaceutical companies that did not write a single prescription for an opioid drug. The now-disbanded American Pain Society was a dominant force in the medical field

and its legacy remains a testament to the collusion of medicine as an organized system in its own right, within the medical system. Those who are members of both the global health and medical communities should engage with the medical community, he suggested.

Anne-Emanuelle Birn, professor of critical development studies (UTSC) and of social and behavioural health sciences (Dalla Lana School of Public Health) at the University of Toronto, agreed that those who are able to work in the global North or in accommodating institutions in the global South should act in solidarity and in service of those with less power. Scholar activism is the only ethical way to engage in academia, she said. She highlighted the example of Cuba, which evolved its health system by first prioritizing poor and rural communities and engaged in South-South cooperation. Cuba worked in Algeria to rebuild its health care system following its liberation struggle. Cuba, with its small GDP, has managed to single-handedly counter the brain drain caused by the US, the UK, and Australia. This lesson in horizontal cooperation—putting the agenda of the cooperant first—has great value moving forward. She called for engaging in the struggle for global health equity “without a passport”; advocates of global health should be involved in speaking truth to power wherever they are. In Canada, for instance, the people’s health movement, which comprises clinician activists, academic activists and community activists, is advocating against the extractivism of transnational mining companies who are free to extract resources in foreign countries without judicial recourse. All academics can find opportunities for action in their home countries, she said.

Keshavjee remarked that along with the privilege and luxury of discussing these issues from a distance, academics bear some responsibility to bring about action and work with people on the ground. He cited the ongoing transformation in TB care. The Academy of Sciences challenged the longstanding notion that only one form of TB should be treated, which led to the creation of new programs and the treatment of all forms of TB with policies of active case finding, treatment of latent TB, and patient supports. He suggested that there are similar challenges to

the status quo to be made in the UHC discourse. For instance, proponents should explain that achieving UHC requires access to pharmaceuticals at a fair, reasonable price and probably requires a highly regulated, perhaps state-financed pooled risk mechanism. A substandard, unsatisfactory conception of UHC has been set forth and should be publicly challenged, he said. Even the watered-down versions of principles of UHC as originally conceived at Alma-Ata are now fundamentally at risk by moving forward with the current plan. For UHC to be realized, there are dimensions that will need to change: the voices of the people who are suffering because of these policies need to be in the rooms where policies are made; drug supplies will need to be available, and the fallacy of the closed envelope needs to be dispelled. Failure to address those dimensions is tantamount to the double-truth doctrine described by Shakow—doublespeak in which everyone is plugging for human rights, but some humans still receive substandard care because their country has an envelope of only \$35.

6.2.4.2 Public financing and accountability

Yates commented that if such challenges are to be made, they should unequivocally affirm that UHC can only be achieved through public financing, pointing out that no country in the world has successfully established UHC through a market-driven privately financed system. This should be a key point in the message of UHC and a consensus on this point would have value in bringing the need for public financing to the forefront of the UHC discourse. Mukherjee pointed out the countervailing weight to Yates’ suggestion—NGOs and government agencies within developed nations have positioned UHC as a business opportunity for the private sector. Research in Chocó, Columbia, the poorest Columbian state with a large Afro-Columbian population, revealed that the level of intensive care provided was completely dependent on individuals’ level of private insurance coverage, yet Columbia is touted as an example of achieving UHC. She emphasized that true UHC will not be realized until the language of UHC is used in a consistent and accountable way and

the US-driven consensus on privatization is subverted. Keshavjee agreed that privatization is a major issue. In every sphere of health and medicine, the US pushes for access to markets. He acknowledged the role of markets in some well-functioning health system (e.g., Germany and Switzerland), but noted that systems are highly regulated by the state and the fee structure universal coverage. However, that is not the model used in the US, which is defining what is being recommended for the rest of the world. Regardless of the precise mechanism of distribution, health care must be publicly financed and not distributed on the basis of users' ability to pay or citizenship status—it should be distributed based on need, as fire services are. Mukherjee cautioned that merely calling for public financing is too vague, because it can actually refer to public financing of the private medical sector. The appropriate mechanism of distribution needs to be identified explicitly. In Lesotho, for example, the lion's share of the health budget goes to a private for-profit company and is not being spent to provide care for all people in Lesotho. Patel agreed, noting that in some settings in India, private medical care providers have been known to charge exactly the value of publicly financed insurance premiums for health services. In these cases, as insurance premiums increased, the cost for services were raised to match, and this cycle can rip apart the budget of a publicly financed health system. The private sector needs to be held as strictly accountable as the public health sector in order to level the playing field, he said.

Sunanda Ray, professor of public health medicine in the department of community medicine at University of Zimbabwe College of Health Sciences, pointed out that certain universities have commissioned historical analyses to determine how those universities benefited from the slave trade in order to consider how to attempt reparations. Many universities benefited not only from direct ownership of

slaves but from endowments from slave-owning families. This rationale could be extended to colonial policies and other such practices, she suggested. Ray acknowledged the complications that arise with the discussion of reparations (e.g., preferential scholarships), but she asserted that recognizing how universities have benefited from disadvantaging countries could help to highlight those injustices.

6.2.4.3 Toward revolutionary change

Eric Sawyer, founding member of ACT UP, shared his vision of a global pharmaceutical system that removes the profit incentive for research and development of essential drugs. He expressed his deep outrage that lifesaving drugs are being denied to millions of people on the basis of cost and profit motives. Global control of these commodities should be taken out of the hands of private sector and delivered to people everywhere, he said, and this should be the focal point of a global movement.

Shakow considered whether the current system is amenable to intervention or revolutionary change is warranted. A recurring theme throughout the conference was the need to upend of structures of power. Critiquing the current standard of UHC has great value, but this critique should not be constrained by the assumption that a fundamental transformation of the system is off the table. For instance, it may be the case that, as Sawyer argued, the only way to solve the challenges of supplying drugs to people in need is to separate the profit motive from the pharmaceutical industry. He argued that it would be remiss not to frame the critique in revolutionary terms. Keshavjee agreed, and suggested drawing upon lessons from the environment movement about thinking beyond the bounds of nation-states. The de-growth movement is an example of bold, transformational thinking to forge a new path.

7 References

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8 Appendices

Appendix 1. Conference agenda

DAY 1: Friday, October 25

Session 1: The Roots of Alma-Ata and Selective Primary Care *Belfer Case Study Room*

9:15-12:00pm	Moderator: Allan Brandt, Professor of the History of Science, Amalie Moses Kass Professor of the History of Medicine, Harvard University and Harvard Medical School	
	Speaker: Michael Knipper, Associate Professor of History, Anthropology and Ethics in Medicine, and Global Health, University Justus Liebig, Giessen	“Alma Ata 1978: An unfinished revolution in the history of global health?”
	Speaker: Julia Walsh, Professor, Retired, Maternal and Child Health and International Health, School of Public Health, University of California Berkeley	“Equity, Selective Primary Health Care, and Current Relevance”
	Speaker: Aaron Shakow, Director, Initiative on Healing and Humanity, Center for Global Health Delivery, Harvard Medical School	“A Double-Truth Doctrine? Primary Health Care Between Empire and Emancipation, 1920- 1978”
	Speaker: Christoph Gradmann, Professor, Department of Community Medicine and Global Health, Institute of Health and Society, University of Oslo	“Making Short Shrift of Primary Health Care: Tanzania, Tuberculosis, and Global Health, 1977-1995”
	Discussant: Suman Seth, Professor, Department of Science and Technology Studies, Cornell University	
	Discussant: Anne-Emanuelle Birn, Professor of Critical Development Studies (UTSC) and of Social and Behavioural Health Sciences (Dalla Lana School of Public Health) at the University of Toronto	
12:00-1:00pm	Lunch	Side Room
Keynote Address		
<i>Tsai Auditorium</i>		
1:00-2:00pm	Danielle Allen, James Bryant Conant University Professor and Director, Edmond J. Safra Center for Ethics	“Politics of Rights Expansion”
Session 2: Health as a Human Right		
<i>Belfer Case Study Room</i>		
2:15-6:00pm	Moderator:	

Mary Jo Delvecchio Good, Professor of Global Health and Social Medicine, Emerita, Harvard Medical School

Speaker:
Ezekiel Emanuel, Vice Provost for Global Initiatives, the Diane v.S. Levy and Robert M. Levy University Professor, and Chair of the Department of Medical Ethics and Health Policy, University of Pennsylvania

“Right to Health: Does it Make Sense?”

Speaker:
Ole Norheim, Professor of Medical Ethics, Department of Global Public Health and Primary Care, University of Bergen

“Progressive Realization of UHC and the Right to Health for All”

Speaker:
Audrey Chapman, Professor of Community Medicine and Healthcare, Joseph M. Healey Memorial Chair in Medical Ethics and Humanities, University of Connecticut School of Medicine

“The Contributions of a Human Rights Approach to Achieving Universal Health Coverage”

Speaker:
Sunanda Ray, Professor of Public Health Medicine, Department of Community Medicine, University of Zimbabwe College of Health Sciences

“Sexual and Reproductive Health Rights: Questions of Justice and Human Rights”

Speaker:
Karen Thornber, Professor of Comparative Literature and of East Asian Languages and Civilizations, Harvard University

“Coverage, Care, and Changing Perceptions of Health in East Asia”

Speaker:
Sarah Willen, Associate Professor of Anthropology, University of Connecticut

“Friable Concepts or Imaginative Failures? Ethnographic Reflections on Rights, Equity, and Solidarity in the Contemporary U.S.”

Discussant:
Sarah Zaidi, Co-director, Q Continuum Consulting

Discussant:
Eric Sawyer, Founding Member, ACT UP

7:00pm

Group Dinner

Grafton St. Pub

Mary Jo Delvecchio Good, Professor of Global Health and Social Medicine, Emerita, Harvard Medical School

Speaker: Ezekiel Emanuel, Vice Provost for Global Initiatives, the Diane v.S. Levy and Robert M. Levy University Professor, and Chair of the Department of Medical Ethics and Health Policy, University of Pennsylvania	“Right to Health: Does it Make Sense?”
Speaker: Ole Norheim, Professor of Medical Ethics, Department of Global Public Health and Primary Care, University of Bergen	“Progressive Realization of UHC and the Right to Health for All”
Speaker: Audrey Chapman, Professor of Community Medicine and Healthcare, Joseph M. Healey Memorial Chair in Medical Ethics and Humanities, University of Connecticut School of Medicine	“The Contributions of a Human Rights Approach to Achieving Universal Health Coverage”
Speaker: Sunanda Ray, Professor of Public Health Medicine, Department of Community Medicine, University of Zimbabwe College of Health Sciences	"Sexual and Reproductive Health Rights: Questions of Justice and Human Rights"
Speaker: Karen Thornber, Professor of Comparative Literature and of East Asian Languages and Civilizations, Harvard University	“Coverage, Care, and Changing Perceptions of Health in East Asia”
Speaker: Sarah Willen, Associate Professor of Anthropology, University of Connecticut	"Friable Concepts or Imaginative Failures? Ethnographic Reflections on Rights, Equity, and Solidarity in the Contemporary U.S.”
Discussant: Sarah Zaidi, Co-director, Q Continuum Consulting	
Discussant: Eric Sawyer , Founding Member, ACT UP	
7:00pm	Group Dinner
	Grafton St. Pub

Appendix 2. Participant List

César Ernesto Abadía-Barrero, assistant professor of the anthropology department at the University of Connecticut

Danielle Allen, Director of the Edmond J. Safra Center for Ethics and James Bryant Conant University Professor at Harvard University

Rama Baru, professor at the Centre of Social Medicine and Community Health in the School of Social Sciences at Jawaharlal Nehru University

Mary Bassett, New York City health commissioner

Anne-Emanuelle Birn, professor of critical development studies (UTSC) and of social and behavioural health sciences (Dalla Lana School of Public Health) at the University of Toronto

Allan Brandt, professor of the history of science and Amalie Moses Kass Professor of the History of Medicine at Harvard University and Harvard Medical School

Richard Cash, senior lecturer on global health in the department of global health and population at the Harvard T.H. Chan School of Public Health

Audrey Chapman, professor of community medicine and health care and Joseph M. Healey Memorial Chair in medical ethics and humanities at University of Connecticut School of Medicine

Joel Curtain, director of advocacy at Partners In Health

Ezekiel Emanuel, vice provost for global initiatives, Diane v.S. Levy and Robert M. Levy University Professor, and chair of the department of medical ethics and health policy at University of Pennsylvania

Mary Jo Delvecchio Good, professor of good health and social medicine emerita, Harvard Medical School

Christoph Gradmann, professor in the department of community medicine and global health at the University of Oslo Institute of Health and Society

Salmaan Keshavjee, of Harvard Medical School, Brigham and Women's Hospital, Partners In Health, and Advance Access & Delivery

Michael Knipper, associate professor of history, anthropology and ethics in medicine, and global health at Justus Liebig University Giessen

Natalia Linos, executive director of the FXB Center for Health and Human Rights at Harvard University

Socrates Litsios, health historian and retired senior scientist in the Division of the Control of Tropical Diseases at WHO

Joia Mukherjee, associate professor of medicine and associate professor of global health and social medicine at Harvard Medical School

Ole Norheim, professor of medical ethics in the department of global public health and primary care at University of Bergen

Cate Oswald, chief policy and partnership officer at Partners In Health

Randall Packard, William Henry Welch Professor of the History of Medicine at the Institute of the History of Medicine at Johns Hopkins University

Vikram Patel, Pershing Square Professor of Global Health, Harvard Medical School

Sunanda Ray, professor of public health medicine in the department of community medicine at University of Zimbabwe College of Health Sciences

Eric Sawyer, founding member of ACT UP

Suman Seth, professor in the department of science and technology studies at Cornell University

Jon Shaffer, doctoral candidate in sociology at Boston University

Aaron Shakow, director of the Initiative on Healing and Humanity at the Center for Global Health Delivery, Harvard Medical School

Karen Thornber, professor of comparative literature and of East Asian languages and civilizations at Harvard University

Julia Walsh, retired professor of maternal and child health and international health in the school of public health at University of California, Berkeley

Sarah Willen, associate professor of anthropology at University of Connecticut

Robert Yates, director of the global health programme and the executive director of the Centre for Universal Health at Chatham House

Appendix 3. Lifesaving and low-cost technical interventions used in USAID's Child Survival & Health Grants Program

 Pre-pregnancy/ Pregnancy	 Birth/postnatal	 Infancy	 Childhood
Nutrition counseling	Skilled birth attendant at delivery	Infant and young child feeding counseling	Nutrition counseling; treatment of malnutrition
Newborn tetanus protection	Essential newborn care	Routine and full immunization	Prevention and treatment of pneumonia
Malaria prophylaxis	Immediate breastfeeding	Vitamin A supplementation	Prevention and treatment of malaria
Child spacing	Postnatal visits for mother	Sleep under treated bed nets	Oral rehydration salts, zinc, and increased fluids/food for diarrhea
Antenatal care	Postnatal visits for newborn	Exclusive breastfeeding under 6 months	Sleep under treated bed nets
Handwashing with soap			
Improved drinking water sources and improved sanitation facilities			

Source: Walsh presentation; Kureshy et al 2018



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