B1 | THE UNIVERSAL HEALTH COVERAGE/PRIMARY HEALTH CARE DIVIDE

Introduction

Universal Health Coverage (UHC) has become one of the major health strategies pursued by countries and global health actors. UHC policy and its discourse are driven by the World Health Organization (WHO) and the World Bank (WB) and have become embedded in the Sustainable Development Goals (SDGs). The genesis of UHC was discussed in *Global Health Watch* (GHW) 4 and 5 (Chapters B1 in both editions), including how its principles have become firmly embedded and accepted as basis for health sector reforms. Notably, these analyses highlighted the difference between a Primary Health Care (PHC) approach versus a UHC policy orientation. The Alma-Ata PHC discourse incorporates a focus on building and supporting the PHC sector, including a prominent role for community health workers and community involvement. The PHC approach envisages health systems working closely with their communities on the social and environmental determinants of health. In contrast, the UHC policy approach focuses on financial protection and argues explicitly for public, single payer financing, but not necessarily single provider (public) care. It commits to health systems strengthening and stresses the importance of primary care but doesn't address issues of community engagement, nor is it critical about the role of private providers in driving up costs or posing a barrier to equitable access for all:

> The term coverage rather than care either suggests a limited scope of care or is being used to suggest enrolment in an insurance scheme …. Involving the for-profit private sector in providing health care has allowed for funding imbalances and provider capture, with more funds from these public schemes going into the private health sector, thereby reinforcing existing health inequities. Insurance-based models of UHC risk being promoted at the expense of funding PHC and other public health programmes. (Sanders et al. 2019)

This chapter traces UHC global policy developments and processes implemented during the period 2015–2020 and reflects on the implications in driving the global health agenda. It touches on the impact of the COVID-19 pandemic, and how it risks derailing efforts to implement UHC, notably in low- and middle-income countries (LMICs). It then assesses in more detail and in a critical manner how UHC is being implemented in a number of countries, notably the problematic approach of "purchasing" services.

Universal Health Coverage and the Sustainable Development agenda

In the development of what became the SDGs, the WHO and UN commissions argued for UHC to become the main health goal (Leadership Council 2013). It became eventually just one of the 13 sub-targets (3.8) for SDG 3 that has the umbrella goal to "Ensure healthy lives and promote well-being for all at all ages" (see GHW5 Chapter A1 for a critique of the SDGs) (UNDESA 2016). Target 3.8 is to "achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (ibid.).

With UHC having only a relatively marginal role in the SDGs and PHC not being mentioned specifically as a strategy to attain UHC, it became clear soon after adoption of the SDGs that the right to health as a principle for human capabilities and development, and the role of healthcare services therein, was not prioritized as such. This probably has to do with other pressing global challenges such as climate change, biodiversity loss, and growing economic inequities (see Chapter A1). Analyses of global health governance in the context of the SDGs indicate that the subsequent focus on increasing domestic financing to improve healthcare systems implied an acceptance that many low-income countries (LICs) would have difficulty securing essential health services for their citizens (Van de Pas et al. 2017). Shared responsibility and solidarity by states for attaining the right to health are neglected in the actual policy implementation of the SDGs; instead, the dominant principle is that governments are domestically responsible to finance UHC for their constituencies (ibid., 4). In a study on financing health systems to achieve the health SDGs in 67 LMICs, WHO estimated that an additional $274 billion of annual spending on health would be needed by 2030 to make progress towards the SDG 3 targets (progress scenario). In the ambitious scenario, $371 billion would be needed to reach health system targets, the equivalent of an additional $41 (range 15–102) or $58 (22–167) per person, respectively, by the final years of scale-up (Stenberg et al. 2017).

A major question, then, is what would be a global strategy to attain these essential health system needs? WHO and the World Bank, since the release of the 2010 World Health Report 2010, have jointly pursued a strategy of expanding UHC in LMICs based on the three consecutive strategies of domestic resource mobilization, pooling of funds, and strategic purchasing (Etienne et al. 2010). WHO continues to argue the primacy of UHC, that it "is the target that underpins and is key to the achievement of all the others" (World Health Organization 2015a, 196) while remaining oddly silent about its earlier-lauded PHC approach.

The WHO's close collaboration with the World Bank led to their first joint annual UHC monitoring report which appeared in 2015 (World Health Organization 2015b). They applied tracer indicators to monitor UHC progress in countries using coverage of a number of health service indicators (e.g., immunization services and antenatal care) and financial protection indicators

(e.g., catastrophic health expenditure). Although coverage is thus reported on in the report, inequities in coverage are not. Both organizations regard UHC as having equity "hardwired into it" and, thus, it is a somewhat secondary concern to trace, albeit recognizing a need for "global monitoring" (World Health Organization 2015a, 59). That general coverage of health service and financial protection indicators prevail in monitoring is an accountability weakness because *average* coverage numbers may mask important, and increasing, health and financial risk inequities at the country level.

The primacy of UHC

In 2016, formally as a transformation of the International Health Partnership + Network, the UHC2030 was formed as a multi-partner initiative, with the secretariat jointly hosted by the WHO and World Bank. After an initial consultation in Geneva with its several international partners (International Health Partnership 2016a) the UHC2030 global movement (now known as the Compact) was announced, articulating a model UHC approach that:

> … includes strengthening multi-sectoral and multi-stakeholder policy dialogue and coordination of health system strengthening efforts at global and country levels, which should be reflected in country compacts or equivalents as appropriate; fostering political will, nationally and globally, for sufficient, sustainable and equitable investment in health systems for UHC; and facilitating monitoring and accountability for equitable progress towards UHC so that no one is left behind. (International Health Partnership 2016b)

It is important to stress the multistakeholder approach the Compact is taking, as it aligns with the SDG "partnership" ideas, legitimizing a "new universalism" thinking and "private providers" engagement in advancing the UHC agenda (multistakeholder and private-public partnerships are becoming increasingly ubiquitous across the WHO and UN system, with criticisms of this trend found in several GHW6 chapters). UHC2030 provides technical advice to WHO member states and development partners on several themes relevant to UHC policy implementation, including public financial management, UHC in fragile settings, financial sustainability, health systems assessment, and multi-sectoral action. It intends to function as the international mechanism to bring actors, finance, and leadership together to advance the UHC agenda, and includes a civil society alliance, the UHC2030 Civil Society Engagement Mechanism (CSEM).[1] Despite its lofty goals, it seems difficult for the UHC2030 movement to really make a difference in securing access to essential services globally, as both international and domestic public finance and attention to health systems strengthening and UHC has stagnated over the recent years.

The WHO in the meantime was making the case that UHC is the essential financial strategy to advance PHC (Chan 2017). It celebrated 40 years of the PHC Alma-Ata declaration in 2018 by convening a global meeting in Astana.

The 2018 Astana declaration made it clear that for WHO and its member states "PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals" (Global Conference on Primary Health Care 2018). UHC as a financial strategy and social protection mechanism became "a fait accompli" and a broader development goal to pursue, to which PHC was relegated a supporting role. This decision indirectly endorsed the public–private financing and collaborative discourse of UHC, neglecting to consider countries' different health systems and contexts. UHC has become the de facto international strategy for financing health services. The implication of this is institutional acceptance and legitimation of policies that encourage private health actors and private insurance providers to take active roles in resource mobilization, pooling, and purchasing of services with the assumption that national governments would then regulate and govern the health financing domain and actual performance of actors.

One step forward, two steps backwards

Such strategies might work well in countries where government capacity and fiscal space is considerable, but they are likely to be counterproductive and likely to undermine health equity in states where this capacity is not available, as the empirical cases described later in this chapter show. In a WHO technical briefing on building the economic case for PHC (background for the Astana conference), there is surprisingly little attention on the interrelation between PHC and UHC. Although the briefing identifies three ways in which PHC provides economic benefits (improved health outcomes, health systems efficiency, and health equity), UHC as an outcome is not mentioned as such (World Health Organization 2018). This suggests, first, a lack of coherence in how WHO and public health experts see the interrelation between UHC and PHC. Second, and more critically, it indicates that UHC is not so much a continuation of the principles and values of the comprehensive PHC approach as defined in 1978 but, 40 years onwards, a rather sharp divergence from it. There are marked differences between the Alma-Ata and Astana declarations on how they describe the economic development goal to be pursued by countries. Where the Alma-Ata declaration spoke about "Economic and social development, based on a New International Economic Order (NIEO)," the Astana approach focuses on the SDGs and attaining the UHC target. There is a huge difference between calling for a NIEO and supporting the SDGs:

> PHC was considered unlikely to succeed without the establishment of a NIEO based on ensuring the rights of states and peoples under "colonial domination" to restitution and full compensation for their exploitation and that of their resources; regulation of transnational corporations; preferential treatment for low-income and middle-income countries (LMICs) in areas of international

> economic cooperation; transfer of new technologies; and an end to the waste of natural resources. With the 1980s rise of neoliberal economics, the UN-supported NIEO was abandoned. (Sanders et al. 2019)

Indeed, replacing the lodestar of PHC with UHC threatens to be one step forward and two steps back for advancing Health for All.

Peak UHC: not so much …

The zenith of the UHC movement occurred in 2019, when a UN High-Level Meeting (UN-HLM) on UHC was convened alongside the Annual UN General Assembly in New York. This led to a UN-HLM political declaration on UHC (UN General Assembly 2019). Two reflections on this declaration and outcome merit attention. In a side-event before the actual declaration, the WHO presented the 2019 UHC global monitoring report "Primary Health Care on the road to Universal Health Care" (World Health Organization 2019). This report states that while there has been progress in the UHC service coverage, measuring progress on SDG indicator 3.8.1, from a global average of 45 (of 100) in 2000 to 66 in 2017, progress has slowed since 2010. The poorest countries are especially lagging far behind. With current trends, it is projected that only 39% to 63% of the global population will be covered by essential health services by 2030, which basically implies a stagnation from where coverage stands today. Worryingly, and one of the reasons that the UHC approach needs to be so critically scrutinized, the figures indicate that the incidence of catastrophic health expenditure (SDG indicator 3.8.2), defined as large out-of-pocket (OOP) spending in relation to household consumption or income, *increased continuously* between 2000 and 2015, with about 930 million people spending more than 10% of their household income on healthcare in 2015. Overall, financial protection is deteriorating, although countries with more public investments in health tend to fare better (UN General Assembly 2019). A major reason for this impediment is the overall socioeconomic environment and the prevalence of weak health systems, including human resource gaps, poor quality services, and low trust in health practitioners. Even as the WHO argues for a PHC approach, albeit only as a means to achieve UHC and not as an end in itself, it falls into the global financing line that argues for the need for domestic investments in healthcare of around $200 billion a year.

> The key is to improve domestic tax and revenue performance in line with the Addis Ababa Action Agenda, to increase government revenues. All countries should immediately allocate or re-allocate at least an additional 1% of GDP [gross domestic product] to primary health care. UHC is, after all, a political choice. (ibid.)

This conclusion that UHC is a political choice, reiterated by the UN-HLM leaders and major actors, means that UHC is a choice countries can opt for

domestically, something for which international partnerships and investments and multistakeholder partnerships may be options but not necessarily essential (Kirton and Kickbusch 2019). But this focus on investment is a crucial fallacy if one does not consider structural economic conditions and their governance arrangement. To stay with the words of Greta Thunberg, spoken during the UN climate summit held around the same time, "all you can talk about is money and fairytales of eternal economic growth" (Van de Pas 2019a) (see also Chapters A1 and A3). Many countries do not have the political and economic choice to opt for UHC. They find them themselves (by choice or obligation) enmeshed in systems-deep economic globalization. As part of the international economic conditions and structural arrangements (trade rules, debts, austerity, and monetary policies), many LMICs simply do not have the domestic fiscal space to finance and invest in inclusive UHC by the 2030 target date, unless more heterodox economic approaches in public investment are considered (Rowden 2019). As for the international solidarity enunciated in the UN-HLM political declaration, that seemed to be a hollow shell from the onset (Van de Pas 2019b).

UHC meets the pandemic

Only four months after the UN-HLM and the political declaration on UHC, WHO declared the COVID-19 outbreak a Public Health Emergency of International Concern (PHEIC) (World Health Organization 2020). Since then, the global public health community, leaders, and societies alike have been in the grip of the COVID-19 pandemic. What is striking is that the UHC discourse, and broader SDG agenda, was quickly neglected and replaced by international calls for emergency public investments for the preparedness and response to the SARS-CoV-2 and future pandemics. The SDGs and UHC (social protection) approach, in essence, appeared to be irrelevant in dealing with a pandemic. However, economic disruption will be felt most strongly in LMICs, and more than 80 LMICs have demanded financial help from the International Monetary Fund (IMF) to deal with the economic impact of the crisis. The eventual impact on health outcomes and health systems will be much deeper and lasting than that of the viral disease itself (Van de Pas 2020).

Optimistically, the pandemic may lead the global health community to reflect on how to strengthen health financing, primary health care, and essential public health functions in a balanced matter, recognizing that public investments, shared financial responsibilities by governments, strong public regulatory governance, and accountable service provisions are required to provide social and human security (Assefa et al. 2021). It is not sufficient to focus on resilient health systems only (Kutzin and Sparkes 2016); health systems need to become transformative as part of broader socioeconomic reforms that are inclusive, equitable, and respecting of the globe's ecological barriers. In the post-pandemic period, the

public–private partnership approach to UHC policy should be replaced by a solidarity vision and strategy that supports human dignity and secures essential healthcare services globally. This becomes obvious when we consider how the UHC story has so far played out in many LMICs globally.

Box B1.1: Universal Health Coverage and the neglect of health workforce employment

With UHC policies focusing so much on financial risk protection and service coverage, they take as a given the other crucial elements of a health system. A major bottleneck in many countries for the provision of essential healthcare services is the availability of a skilled, decently employed, and well-remunerated health workforce. Moreover, power relations embedded in existing social inequalities such as gender, class, caste, migrant status, and ethnicity have been profoundly shaped by global and country-level health workforce policies, leading to more precarious and exploitative conditions for those at the lower levels of the health workforce hierarchy, such as community health workers, nurses, and auxiliary health workers (see Chapter A2) (Writing Group for PHM 2021). The WHO estimated in 2015 that 18 million health workers' jobs, 12 million of them in LMICs, are missing relative to the numbers required to provide the essential health services needed to attain the SDGs (Scheffler et al. 2018).[2] Despite more than 15 years of health systems strengthening (HSS) approaches via global health initiatives and other mechanisms such as WHO's Working for Health program, it has proven difficult for many countries to expand fiscal space for health workforce development, with some notable exceptions like Rwanda, Ethiopia, Thailand, Ecuador, and a few others. This difficulty is related to the overall political economy of health and global economic governance that provides the macro-economic conditionalities (and limitations) for generating resources and financing health employment. The WHO acknowledged the financial gap and proposed a $1 billion healthcare investment fund aimed at increasing access to PHC through investing in infrastructure (health facilities and educational institutions) and job creation. The proposal was presented at the 2019 UN-HLM on UHC (ILO-OECD-WHO 2021).[3]

The COVID-19 pandemic has brought to the fore how crucial the health workforce is in providing emergency care, providing essential public health functions such as epidemic surveillance, and conducting vaccination campaigns. The WHO designated the year 2021 as the International Year of Health and Care Workers (ILO-OECD-WHO 2021). Despite all the applause and vocal support for the health workforce, it remains to be seen

whether any of this translates in actual new financing and job creation. The prevailing global economic orthodoxy considers health workforce salaries a recurrent economic cost that should be financed via domestic budgets, and not by international development finance, a utopian impossibility for many LMICs. Moreover, economic conditionalities and austerity measures have restricted critical public employment in the lead-up to the COVID-19 crisis. Of the 57 countries identified by the WHO as facing critical health worker shortages, 24 received advice from the IMF to cut or freeze public sector wages in the past three years (Hyde 2020).

In reaction to persisting global austerity measures (see Chapter C1) and a neglect of public sector care roles, Action-Aid published some clear and excellent recommendations on how gender responsive public services should be financed:

- Governments should pursue expansionary macro-economic policies and countercyclical investments … resisting the IMF cult of austerity and wider constraints to public financing.
- Governments should invest more in non-military public sector personnel – particularly investing in public sector care roles that are presently underpaid and undervalued.
- Governments of developing countries should set ambitious targets for increasing tax to gross domestic product (GDP) ratios in a progressive way to ensure a long-term sustainable resource base to deliver gender responsive public services.
- Governments should renegotiate existing debt and push for new and independent debt workout mechanisms.
- All governments should factor progress of human rights and SDGs, including unpaid care and domestic work, into national economic measurements and targets, moving away from the simplistic focus on GDP and towards a care economy (see Chapter A3).
- Governments should focus on rebuilding the national social contract around public services, resisting the ideological push for privatization and public–private partnerships (PPPs) (see Chapter B3) (Ambrose and Archer 2020).

UHC in implementation

While in the UHC discourse there has always been an emphasis and consensus on public funding in order to ensure financial protection, in its provisioning, it has been influenced by "new universalism" – that is, a belief that in healthcare provision the ownership and nature of provider (private or public) do not matter and instead efficiency, quality, competition, and provision are key. A provider–purchaser split is envisaged. The state is supposed to play a role not so much in providing services but instead in stewardship, funding, and establishing systems

to purchase services from private providers. Purchase or service contracts are also seen as a way to regulate the private sector in LMICs.

In many LMICs, such arguments and narratives have been built under the UHC discourse, favoring public funding for private provisioning, thereby providing opportunities for PPPs, publicly funded health insurance schemes, and further commercialization of healthcare. These privatization initiatives are being undertaken under the paradigm of "strategic purchasing for UHC," under the pretext of achieving efficiency and quality by opening the door to competition (for providers) and choice (for people) and by "engaging" with the for-profit private sector.

Most of the models of "strategic purchasing" from the private sector under UHC include the explicit objective of favoring the private sector or promoting commercial interests; there is over-reliance on digitalization and information technology (IT) systems, creating opportunities for data mining by the for-profit sector. However, most models are non-transparent with little public accountability (see Chapter B2). In most instances we find that a strategic purchasing or facilitating agency is set up, operating outside the Ministries of Health and promoted in partnership with the for-profit private sector and global actors. The National Health Authority in India and the Philippine Health Insurance Corporation are examples of such arrangements that also open the door for corporate capture, creating possibilities for conflicts of interest. Global actors such as the Gates Foundation, global health academia, and global institutions (WHO, World Bank, and the Asian Development Bank, for instance) have been proactively offering support to health (and finance) ministries, academic institutions, and resource agencies of various countries for "strategic purchasing" (Tichenor and Sridhar 2017; Kelley and Cashin 2018); the Strategic Purchasing Africa Resource Centre (SPARC) is one example.[2]

The dangers of "purchasing" from the for-profit private sector

In many countries, especially in LMICs, UHC is often conflated with coverage by publicly funded health insurance (PFHI) schemes. These schemes have recruited the private sector to provide healthcare services using public funding. Evidence from around the world shows that these schemes, especially in countries which engage the for-profit private sector, may not have led to financial protection from healthcare expenses, nor universal access, and may in fact have exacerbated existing health inequities. The experiences differ greatly if healthcare delivery is by the public or non-profit private sector (Garg 2019).

Among LMICs, Thailand is falsely portrayed as a successful "strategic purchasing" initiative by proponents of that model in order to make it a case. Thailand's health system neither relies on private sector provisioning, nor is it based on principles of "competition" and "choice." In Thailand, nearly 89% of hospitalization care and 86% of outpatient care are in the public sector, something which most global commentators fail to mention (Tangcharoensathien et al. 2018). The other successful experiences in PFHI schemes often quoted

are those of Ghana and Costa Rica. The Costa Rican model resembles that of Thailand in terms of its reliance mainly on the public sector for provisioning, with facilities having greater autonomy (Hernández and Salgado 2014). The Ghanaian health insurance scheme relies mainly on faith-based non-profit organizations. However, these organizations recently seem to be working more in semi-urban and urban areas instead of the remote or more vulnerable areas where they were traditionally located (Grieve and Olivier 2018). Ghana's PFHI scheme has shown some impact on financial protection, however OOP expenditure still exists (Okoroh et al 2018).

The biggest failure of PFHI is seen in its dominant model of "purchasing" clinical care from the for-profit private sector. Experiences of countries such as India, Indonesia, and Philippines exemplify this.

Indonesia: Indonesia has had a PFHI scheme for outpatient and in-patient health, called the Jaminan Kesehatan Nasional (JKN)/National Health Insurance. Studies show that while the coverage is high and utilization of health services increased, it has not had a significant effect on OOP expenditure or catastrophic health expenditure (Darius 2018). Moreover, there is inequitable access to health services as the health facilities are urban-centric and health services do not reach remote areas, with indigent populations facing several barriers in access (Salaheddine and Karasneh 2020). The Indonesian government has also been increasing the share of premium to be paid by people (non-poor). The insurance model has also led to funding imbalances between the public and private sectors with around three-fourths of the insurance funds going to the private sector.

Philippines: The Philippines has been implementing health insurance for many decades, though currently the Philippine Health Insurance Corporation (PHIC) is located within the UHC narrative. The scheme promotes both private healthcare and insurance sectors. While enrolment figures have increased, there is a lack of financial protection as it mandates co-payments for people availing services, leading to OOP expenditures (People's Health Movement 2019).

Morocco: In Morocco's PFHI scheme, problems such as cost escalation, over-billing, and patients having to make additional payments have been documented. The scheme has led to imbalances in financial flows between the private and public sectors, with 90% of the claims going to the private sector, leaving fewer funds for the public sector. This has debilitated the public sector further with health workers shifting to the rapidly growing private sector (Mathauer 2017; Dkhimi et al. 2017).

Kenya: In Kenya, the National Health Insurance Fund was set up as a separate organization to act as "purchaser." However, it has failed to promote quality, efficiency, or equity and there is a pro-rich pattern of utilization of health services, inequity in enrolment and financial protection, and geographical inequity in the distribution of hospitals (Munge et al. 2018). There is very little consumer engagement, and feedback or grievance-redressal systems are not established (Mbau et al. 2018).

Box B1.2: AB-PMJAY. The largest PPP in health initiated by the Indian Government

In 2018, the National Health Insurance Scheme, or RSBY, was expanded (in terms of population and annual amount coverage) through the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). PMJAY is considered to be the largest PPP initiated by the Indian government, as a strategy to achieve UHC and the SDGs (Nandi 2021). But the scheme has not enabled free hospital healthcare, and patients continue to incur very high OOP costs and catastrophic health expenditures, mainly in the for-profit private sector (Garg et al. 2020). This is due to illegal payments demanded by private hospitals, for which families face huge financial hardships, often being forced to pay from savings, loans, or the sale or mortgage of jewelry, land, or other assets.

The private sector has captured the market under the PMJAY and in most states a larger proportion of the claims amount has been going to the private sector (Nandi 2021). For example, up until August 2020, 75% of PMJAY money went to the private sector. The PMJAY itself has seen huge increases in its budget, relegating important programs such as primary health care, disease control, immunization, women's and children's health, etc. to a lower priority with reductions of their respective budgets in real terms. It has also led to the under-funding of the public sector that mainly caters to women, the poor, and other vulnerable communities, thereby further exacerbating inequity in access. Moreover, funds meant for marginalized groups in under-served and rural areas are appropriated by the private sector which is located in urban centers and less vulnerable regions. The insurance scheme has failed to provide protection or access during the COVID-19 pandemic. Under India's scheme, the institutional and governance arrangements for PFHI were modified with the formation of the National Health Authority (NHA) which bypasses the Ministry of Health. The NHA has people from the corporate sector on its Board, thereby legitimizing the role of the for-profit private sector in scheme governance. The NHA is now also implementing the National Digital Health Mission, illustrating the convergence of corporate and private interests. The digital mission's plans have been criticized by People's Health Movement (PHM) India over concerns regarding data privacy, selling sensitive medical data to commercial entities for profit, exclusions, etc. (ibid.).

PHM India (Jan Swasthya Abhiyan) is providing resistance through evidence building and documentation. It is gathering testimonials and along with statements, position papers, and demands incorporating perspectives of health and other activists. PHM India is putting them forward in public meetings and in submissions to government. It is circulating these positions

through media and other publications within India. The global PHM's Health Systems thematic circle is bringing together similar experiences internationally.

Global financing for healthcare: boosting the private sector

Below we look at three examples of healthcare financing, including by countries of the Global North, that promote the private sector in health directly or through "technical assistance" in the Global South. The examples below highlight the damage that PPPs are doing to countries' health systems, including increasing financial burden and health inequity.

Dutch Aid & Trade in Health: Wemos, an advocacy organization focusing on access to health in LMICs, studied the Dutch Aid and Trade (A&T) agenda and the Dutch government's official development assistance (ODA) mechanisms regarding healthcare in Africa in terms of its characteristics and (potential) impact from a health equity and UHC point of view (Wemos 2019; 2020). They found that in sub-Saharan Africa there had been a significant increase in Dutch A&T instruments in healthcare in the past five years, including (mainly) ODA and some non-ODA instruments (Wemos 2021). The primary objectives of A&T in healthcare were to promote private sector development and improve the business climate. In health in Africa, A&T "stimulates private (enterprises in) healthcare and health insurance, research & development of health products, innovations in public or private healthcare infrastructure, and technical assistance for private sector contracting in the public sector" (ibid.). Dutch A&T matched funds for development of relatively expensive public healthcare infrastructure that was mostly at the higher/tertiary levels and more suitable for big (multinational) companies. Tanzania, which has a limited health budget, had to finance its half of the funds through deferred payments to the contracted company (ibid.). Various financing modalities are used with the explicit purpose of furthering Dutch business interests in the healthcare sector through the promotion of PPPs. In Kenya, A&T provided financial support for Dutch businesses along with funding for technical assistance and studies for the fast realization of PPPs in public healthcare (with a role for Dutch companies). However, most A&T projects in healthcare lack "an evidence-based Theory of Change as to how to reach universal and equitable access to health services" which was "also reflected in a lack of monitoring, evaluation and impact assessment in terms of progress towards universal access to health without financial barriers" (ibid.).

Healthcare for all? How UK aid undermines universal public healthcare. A new report by Global Justice Now: Research by Global Justice Now has found that the UK development bank, CDC Group, with a private healthcare portfolio of £420 million, has prioritized supporting private, for-profit businesses over services which reach the world's most marginalized communities

(Global Justice Now 2021). This includes financial support for a series of highly questionable projects, such as the following:

- The now defunct Abraaj Growth Markets Health Fund, the former CEO of which is facing fraud and corruption charges for his involvement in the "biggest collapse in private-equity history."
- Serious allegations of systemic overcharging made against a UK-backed hospital in Kenya. The Nairobi Women's Hospital, unaffordable to many Kenyans, has been accused of overcharging patients, with staff claiming the hospital "resembled a trading floor."
- Hospitals in Bangladesh and Pakistan accused of overcharging patients throughout the COVID-19 pandemic, including Evercare Dhaka and Evercare Lahore which lists its price for a hospital room with a ventilator as approximately £350 a day (over four times the average monthly wage).
- Other UK-backed hospitals face criticism for closing departments during the COVID-19 pandemic or, in the case of Vikram Hospital in Bengaluru, India, being forced to close after refusing to treat government-referred coronavirus patients.
- Investments with no apparent development impact, including a "premium and budget" fitness club chain in Brazil which runs "one of the most expensive fitness centers based in Sao Paulo" (ibid.).

International Specialized Hospital of Uganda (ISHU) PPP at Lubowa, Wakiso District, Kenya (contributed by PHM Uganda 2021): In 2019, the Ugandan Parliament approved a PPP worth 1.3 trillion Ugandan shillings (approximately $379.7 million) with public financing provided to a private sector actor, FINANSI/ROKO Construction SPV Ltd. for the design, construction, and equipping of the International Specialized Hospital of Uganda (ISHU) at Lubowa, Wakiso District. As per the PPP agreement, the private actor will build, operate, and transfer the hospital to the government (the "build-own-transfer" or B-O-T model for PPPs), with the transfer scheduled after eight years of operation.

This expensive tertiary level PPP has poor relevance to the health needs of the majority of Ugandans, as the disease burden centers on diseases such as acute childhood diarrhea, malaria, pneumonia, and HIV/AIDS that are best prevented and treated within communities through comprehensive primary health care. Moreover, the massive costs of the PPP in the face of an otherwise underfunded government health system, leading to long-standing gaps in the health workforce, poorly functioning medical supply chains, corruption in health sector procurements, and neglected health facilities, is criminal. In addition to these concerns, the ISHU PPP entails specific problems related to legal compliance that are typical to many PPPs, identified by the Ugandan civil society as follows:

- The PPP agreement between the Government of Uganda and FINANSI/ROKO Construction SPV Limited is not in compliance with the Uganda

PPP Act (2015). Instead, it was approved based on the advice of the Attorney General, overriding public procedures and positioning the state executive branch as firmly in support of the PPP.

- Cost overruns for the ISHU PPP are not supported by market financial rates. The initial estimate of $345.2 million for the PPP ($249.9m for construction and $95.3m for financing costs) has escalated to $557.9 million, a 61% increase within 18 months of the PPP agreement. Even the Uganda Medical Association has called out the massive cost escalation related to the ISHU facility.
- The Ugandan Ministry of Health, which will be the notional owner of the hospital, will pay an annual fee to cover the provided specialized services over each of eight years of operations to the contractor. This expenditure will take away funds from community health, HIV/AIDS and malaria control, sexual and reproductive health rights, and other essential health services. Therefore, not only is the government financing the initial investment; it is also paying annual from the Treasury to the private partner for health services that the government itself could provide, closer to communities, relevant to people's health needs, and at lower cost.
- The public treasury not only bears 100% of the financing and pays for operating costs; it also bears 100% of the project risk in this PPP, which contravenes Uganda's PPP Act (2015).
- In the event of a dispute, the Investor-State Dispute Settlement (ISDS) provision of the PPP agreement specifies arbitration in the London Court of International Arbitration, rather than in a legal venue in Uganda.
- Finally, government financing for the project adds to its international debt, creating a debt trap that threatens to absorb increasing amounts of the public budget and limits the ability of the government to negotiate favorable terms for financing other health and public services (PHM Uganda 2021).

The ISHU PPP therefore prioritizes the needs of a small, elite segment of the population over the health needs of the majority of Ugandans and diverts health sector funds away from filling nationwide gaps in the health workforce and infrastructure and towards a single, specialized facility. It "normalizes" the democratic deficit surrounding PPP projects in Uganda, with elites in government making decisions about public funds to serve private interests without respect for public health needs, rule of law, or long-term national welfare.

PHM Uganda, working with the Initiative for Social Economic Rights and others, is engaged in developing a coalition to oppose PPPs in Uganda's health system. The aim is to popularize an alternative narrative to PPPs that is people-centered and that promotes enhancement of critical public services including health and healthcare delivery.

Private provisioning destroys all advantages of public funding

The most critical question to be asked is: who should be providing health services if the goal is to achieve universal healthcare and health equity? It is clear from the experiences above that private provisioning destroys all advantages of public funding. However, dominant discourse on UHC has given little emphasis to the importance of public provisioning of healthcare. Instead, "strategic purchasing" and PPP models are promoted, with both public funds and private finance being diverted to the for-profit private sector in the name of healthcare access and UHC (see Chapter B3).

Image B1.1 "Neoliberalism" (2020).

Source: Greta Acosta Reyes, from the Anti-Imperialist Poster Exhibitions, Cuba. https://thetricontinental.org/review-of-anti-imperialist-poster-exhibition-ii-neoliberalism/

Reliance on the for-profit private sector in the provisioning of healthcare with public funding undermines the public health system, exacerbates health inequities, and increases financial hardship. Public hospitals cater to the more vulnerable groups, which especially include women from poor, rural, and indigenous communities, and are more equally distributed geographically. But, as a result of the diversion of funds through "purchasing" arrangements to the private sector, less funds are available for supply-side financing in the public sector, i.e., to pay for human resources, equipment, infrastructure, medicines, and other supplies. The private health sector mushrooms as a result of such policies, and health workers often shift from public to private sectors or engage in dual practice. Provider and regulatory capture by the private sector are seen in many countries. New systems of governance are being set up at national and global levels to pursue such interventions, leading to corporate capture and infiltration of governance mechanisms by private interests (DAWN 2021; TNI 2021).

Returning to this chapter's theme (the UHC/PHC divide), such schemes have also led to a neglect of PHC, though there are increasing attempts to introduce and expand "strategic purchasing" in primary health care services. This is evident from the new "Operational Framework for Primary Health Care" by the WHO and United Nations Children's Fund (UNICEF) that uses the same narrative of "strategic purchasing" (WHO and UNICEF 2020). The Framework talks about how governments must play more of a "stewardship" role, transforming from the "traditional role of health ministries as providers of services," and that this will require capacity and skills (ibid.). It is a big concern to health movements that bringing primary health care, especially in LMICs, under health insurance or other "purchasing" arrangements involving the private sector will inevitably lead to further privatization and commercialization.

Global evidence shows that countries with strong public health systems and publicly provided healthcare such as Sri Lanka and Thailand have done much better in terms of financial protection and equity in access than countries with a dominant private sector. Given the nature of health markets, "public financing without public provisioning will not adequately address either distribution of services or necessary prioritisation of preventive, promotive and essential curative services" (People's Health Movement et al. 2019). A universal healthcare approach oriented towards strengthening public sector provisioning and "care," not "coverage," can contribute to improving people's health.

Box B1.3: The future is public: cases of remunicipalization and deprivatization

While we are seeing the trend towards privatization of public services, there has also been a steady counter trend of bringing back privatized services into public hands. This is known as deprivatization or (re)municipalization,

which is understood as "the creation of a new public service – municipalisation – or reversals from a period of private management–remunicipalisation" (Kishimoto, Steinfort, and Petitjean 2020, 19). The Transnational Institute along with its partners has documented such cases across sectors. They found that between 2000 and 2019 more than 2,400 cities in 58 countries had brought public services under public control. These moves towards de-privatization starkly illustrate the political and financial failure of privatized and neoliberal models of public services and the failure of healthcare to provide universal and quality services based on environmental and human rights perspectives (ibid.).

A global database of de-privatized municipal services is available on the Public Futures website.[3] Activists and organizations are also invited to submit information regarding new cases on the website. Jan Swasthya Abhiyan Chhattisgarh contributed a case in 2021 of the Chhattisgarh government taking over the Advanced Cardiac Institute in Raipur city. The Institute was previously being operated by for-profit private companies (International Database of De-privatized Public Services 2019).

Conclusion

The failure of the global community to call for and provide assistance to strengthening public sector service delivery is one of the main reasons behind the current crisis in healthcare, which has been made more evident during the COVID-19 pandemic. Health activists and social movements must build solidarities at all levels on this issue and resist it. We must remain vigilant while documenting and scrutinizing the evidence and policy push towards PPPs, PFHI schemes, and other purchasing arrangements under UHC.

We must demand higher public investment in strengthening of the public sector to provide secondary and tertiary health services along with primary level healthcare, and in strengthening regulation of healthcare providers, especially those of the for-profit private sector. We must interrogate and critique the dominant narratives that put profit before people and intervene wherever these dialogues get captured by the private sector, including in the WHO. We must demand labor rights for health workers and other frontline workers, the majority of whom are women, and demand expansion of public employment, especially in LMICs, which would be beneficial both for the workers and for society (Ghosh 2021). It is essential to shift the normative environment in healthcare from a market-based commercialized provisioning of healthcare to a system based on solidarity, human rights, and public accountability, one which ensures financial protection, quality, and equity.

Notes

1 For more information on the UHC2030 Civil Society Engagement Mechanism (CSEM), visit their website at https://csemonline.net/.

2 For more information on the Strategic Purchasing Africa Resource Centre (SPARC), visit their website at www.sparc.africa.

3 To access this database, visit the Public Futures website at www.publicfutures.org.

References

Ambrose, Soren, and David Archer. 2020. "Who Cares for the Future: Finance Gender-responsive Public Services!" ActionAid. https://actionaid.org/sites/default/files/publications/final%20who%20cares%20report.pdf.

Assefa, Yibeltal, Charles F. Gilks, Remco Van de Pas, Simon Reid, Dereje G. Gete, and Wim Van Damme. 2021. "Reimagining Global Health Systems for the 21st Century: Lessons from the COVID-19 Pandemic." *BMJ Global Health* 6 (4): e004882.

Chan, Margaret. 2017. "From Primary Health Care to Universal Coverage – the Affordable Dream." In *Ten Years in Public Health 2007–2017*, 5–12. Geneva: World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/255355/9789241512442-eng.pdf?sequence=1.

DAWN [Development Alternatives with Women for a New Era]. 2021. *DAWN Informs on Public Private Partnerships and Women's Human Rights: Feminist Analysis from the Global South*. Suva: DAWN. https://dawnnet.org/publication/dawn-informs-on-ppps/.

Dkhimi, Fahdi, Inke Mathauer, Olivier Appaix, and Houcine El Akhnif. 2017. "Mixed Provider Payment System in Morocco: Challenges of Alignment." World Health Organization. https://www.who.int/health_financing/events/D1_S2_Akhnif_MoH_Morocco_and_Dkhimi_WHO.pdf.

El Omari, Salaheddine, and Mahmoud Karasneh. 2020. "Social Health Insurance in the Philippines: Do the Poor Really Benefit?" *Journal of Economics and Finance* 45: 171–187.

Erlangga, Darius. 2018. *The Impact Evaluation of Public Health Insurance in Indonesia on Access to Care, Financial Protection, and Health Status*. PhD thesis. University of York. https://etheses.whiterose.ac.uk/23801/.

Etienne, Carissa, Anarfi Asamoa-Baah, and David B. Evans. 2010. *World Health Report: Health Systems Financing: the Path to Universal Coverage*. Geneva: World Health Organization.

Garg, Samir. 2019. "A Study of 'Strategic Purchasing' as a Policy Option for Public Health System in India." PhD thesis. Mumbai: Tata Institute of Social Sciences.

Garg, Samir, Kirtti Kumar Bebarta, and Narayan Tripathi. 2020. "Performance of India's National Publicly Funded Health Insurance Scheme, Pradhan Mantri Jan Arogya Yojana (PMJAY), in Improving Access and Financial Protection for Hospital Care: Findings from Household Surveys in Chhattisgarh State." *BioMed Central Public Health* 20 (1): 1–10. doi: 10.1186/s12889-020-09107-4.

Ghosh, Jayati. 2021. "Why Public Employment Is Crucial for a Healthy, Equitable Society." Scroll.in. January 8. https://scroll.in/article/983340/why-public-employment-is-crucial-for-a-healthy-equitable-society.

Global Conference on Primary Health Care. 2018. "From Alma-Ata towards Universal Health Coverage and the Sustainable Development Goals." Astana, Kazakhstan: World Health Organization and the United Nations Children's Fund. https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf.

Global Justice Now. 2021. "Healthcare for All? How UK Aid Undermines Universal Public Healthcare." January 27. https://www.globaljustice.org.uk/resource/healthcare-for-all-how-uk-aid-undermines-universal-public-healthcare/.

Grieve, Annabel, and Jill Olivier. 2018. "Towards Universal Health Coverage: A Mixed-Method Study Mapping the Development of the Faith-based Non-profit Sector in the Ghanaian Health System." *International Journal for Equity in Health* 17: 97. doi: 10.1186/s12939-018-0810-4.

Hernández, Luis Ortiz, and Diana Pérez Salgado. 2014. "Chile and Costa Rica: Different Roads to Universal Health in Latin America." MSP Occasional Paper

No. 23. Municipal Services Project. https://www.municipalservicesproject.org/sites/municipalservicesproject.org/files/publications/OccasionalPaper23_Hernandez-Salgado_Chile_and_Costa_Rica_Different_Roads%20to_Universal_Health_in_Latin_America_May2014.pdf.

Hyde, Leo. 2020. "IMF Tells Countries Facing Critical Health Worker Shortages to Cut Public Employment Funding." Public Services International. https://publicservices.international/resources/news/imf-tells-countries-facing-critical-health-worker-shortages-to-cut-public-employment-funding?id=10904&lang=en.

ILO-OECD-WHO Working for Health Programme. 2021. *A Review of the Relevance and Effectiveness of the Five-Year Action Plan for Health Employment and Inclusive Economic Growth (2017–2021)*. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO.

International Database of De-privatized Public Services. 2019. "Case Information." Public Futures. https://publicfutures.org/case/1488.

International Health Partnership for UHC 2030. 2016a. "Report UHC 2030 Multi-stakeholder Consultation: Building a Partnership to Strengthen Health Systems." Geneva. https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/mgt_arrangemts___docs/UHC2030_transformation/UHC2030ConsultationReportFinalEN.pdf.

International Health Partnership for UHC 2030. 2016b. "Transitional Steering Committee Meeting: Background Document on the Global Compact." Geneva. https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/About_IHP_/mgt_arrangemts___docs/UHC_Alliance/Official_documents_2017/UHC2030_TSC_Global_Compact_Jan_2017_WIP.pdf.

Kelley, Allison, and Cheryl Cashin. 2018. "3 Shifts are Needed in the Global Health Community's Support for Health Financing to Advance UHC." February 9. https://www.r4d.org/blog/three-shifts-role-global-health-financing-support-advance-uhc-r4ds-two-new-initiatives-sub-saharan-africa-2/.

Kirton, John, and Ilona Kickbusch. 2019. "Health: A Political Choice. Delivering Universal Health Coverage 2030." Global Governance Project. http://www.bit.ly/2019UHC.

Kishimoto, Satoko, Lavinia Steinfort, and Olivier Petitjean, eds. 2020. *The Future is Public: Towards Democratic Ownership of Public Services*. Transnational Institute. https://www.tni.org/files/publication-downloads/futureispublic_online_def.pdf.

Kutzin, Joseph, and Susan P. Sparkes. 2016. "Health Systems Strengthening, Universal Health Coverage, Health Security and Resilience." *Bulletin of the World Health Organization* 94 (1): 2.

Leadership Council of the Sustainable Development Solutions Network. 2013. "An Action Agenda for Sustainable Development: Report for the UN Secretary-General." Sustainable Development Solutions Network. https://unstats.un.org/unsd/broaderprogress/pdf/130613-SDSN-An-Action-Agenda-for-Sustainable-Development-FINAL.pdf.

Mathauer, Inke. 2017. "Mixed Provider Payment Systems: What are the Issues?" April 25. World Health Organization. https://www.who.int/health_financing/events/D1_S2_Mathauer_WHO.pdf?ua=1.

Mbau, Rahab, Edwine Barasa, Kenneth Munge, Stephen Mulupi, Peter K. Nguhiu, and Jane Chuma. 2018. "A Critical Analysis of Health Care Purchasing Arrangements in Kenya: A Case Study of the County Departments of Health." *International Journal of Health Planning and Management* 33 (4): 1–19. doi: 10.1002/hpm.2604.

Munge, Kenneth, Stephen Mulupi, Edwine W. Barasa, and Jane Chuma. 2018. "A Critical Analysis of Purchasing Arrangements in Kenya: The Case of the National Hospital Insurance Fund." *International Journal of Health Policy and Management* 7 (3): 244–254. doi: 10.15171/ijhpm.2017.81.

Nandi, Sulakshana. 2021. "Case Study on the Impact of Public–Private Partnerships through Publicly-Funded Insurance Schemes on Women in India, with Special Reference to Chhattisgarh State." In *DAWN Informs on Public Private Partnerships and Women's Human Rights: Feminist Analysis from the Global South*, by DAWN [Development Alternatives with Women for a New Era]. Suva: DAWN. https://dawnnet.org/publication/dawn-informs-on-ppps/.

Okoroh, Juliet, Samuel Essoun, Anthony Seddoh, Hobart Harris, Joel S. Weissman, Lydia Dsane-Selby, and Robert Riviello. 2018. "Evaluating the Impact of the National Health Insurance Scheme of Ghana on Out of Pocket Expenditures: A Systematic Review." *BMC Health Services Research* 18 (1): 426. doi: 10.1186/s12913-018-3249-9.

People's Health Movement, Partners in Health, Sama, Medicus Mundi International, and Public Services International. 2019. "A Civil Society Assessment of the Political Declaration of the UN High Level Meeting on Universal Health Coverage." https://phmovement.org/wp-content/uploads/2019/09/Civil-Society-Assessment-of-UHC-HLM-declaration_16-Sept.docx.pdf.

People's Health Movement. 2019. "PHM Philippines: Universal Health Coverage: Everyone, Everywhere – At What Cost to the People?" https://phmovement.org/phm-philippines-universal-health-coverage-everyone-everywhere-at-what-cost-to-the-people/.

PHM Uganda. 2021. "International Specialized Hospital of Uganda (ISHU) PPP at Lubowa, Wakiso District, Kenya." Case study submitted by Denis Bukenya and Ravi Ram for *Global Health Watch* 6.

Rowden, Rick. 2019. "Advocates of the SDGs have a Monetarism Problem." Sheffield Political Economy Research Institute. http://speri.dept.shef.ac.uk/2019/09/09/advocates-of-the-sdgs-have-a-monetarism-problem/.

Sanders, David, Sulakshana Nandi, Ronald Labonté, Carina Vance, and Wim Van Damme. 2019. "From Primary Health Care to Universal Health Coverage – One Step Forward and Two Steps Back." *The Lancet* 394 (10199): 619–621.

Scheffler, Richard M., James Campbell, Giorgio Cometto, Akiko Maeda, Jenny Liu, Tim A. Bruckner, David R. Arnold, and Tim Evans. 2018. "Forecasting Imbalances in the Global Health Labor Market and Devising Policy Responses." *Human Resources for Health* 16 (1): 1–10.

Stenberg, Karin, Odd Hanssen, Tessa T.T. Edejer, Melanie Bertram, Callum Brindley, Andreia Meshreky, et al. 2017. "Financing Transformative Health Systems Towards Achievement of the Health Sustainable Development Goals: A Model for Projected Resource Needs in 67 Low-income and Middle-income Countries." *The Lancet Global Health* 5 (9): e875–e887.

Tangcharoensathien, Viroj, Woranan Witthayapipopsakul, Warisa Panichkriangkrai, Walaiporn Patcharanarumol and Anne Mills. 2018. "Health Systems Development in Thailand: A Solid Platform for Successful Implementation of Universal Health Coverage." *The Lancet* 391 (10126): 1205–1223. doi: 10.1016/S0140-6736(18)30198-3.

Tichenor, Marlee, and Devi Sridhar. 2017. "Universal Health Coverage, Health Systems Strengthening, and the World Bank." *British Medical Journal* 358: j3347. doi: https://doi.org/10.1136/bmj.j3347.

TNI (Transnational Institute). 2021. "The Corporate Capture of Global Governance and What We Are Doing about It." January 22. https://www.tni.org/en/article/the-corporate-capture-of-global-governance-and-what-we-are-doing-about-it.

UNDESA (UN Department of Economic and Social Affairs). 2016. "#Envision2030 Goal 3: Good Health and Well-Being | United Nations Enable." March 3. https://www.un.org/development/desa/disabilities/envision2030-goal3.html.

UN General Assembly. 2019. "Political Declaration of the High-level Meeting on Universal Health Coverage 'Universal Health Coverage: Moving Together to Build a Healthier World.'" United Nations. https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/09/UHC-HLM-silence-procedure.pdf.

Van de Pas, Remco, Peter S. Hill, Rachel Hammonds, Gorik Ooms, Lisa Forman, Attiya Waris, Claire Brolan, Martine McKee and Devi Sridhar. 2017. "Global Health Governance in the Sustainable Development Goals: Is It Grounded in the Right to Health?" *Global Challenges* 1 (1): 47–60.

Van de Pas, Remco. 2019a. "Change is Gonna Come." International Health Policies Blog. September 27. https://www.internationalhealthpolicies.org/featured-article/change-is-gonna-come/.

Van de Pas, Remco. 2019b. "The Universal Health Coverage Divide." September 26. https://www.internationalhealthpolicies.org/blogs/the-universal-health-coverage-divide/.

Van de Pas, Remco. 2020. "The Coronavirus Pandemic and the Irrelevance of the SDGs." Ghent Centre for Global Studies. https://www.globalstudies.ugent.be/the-coronavirus-pandemic-and-the-irrelevance-of-the-sdgs/2/.

Wemos. 2019. "Best Public Value for Public Money: The Case of Match-Funded Multi-hospital Infrastructure Development in Tanzania." Discussion paper. https://www.wemos.nl/wp-content/uploads/2019/11/Wemos_discussion-paper_Aid-for-Trade_Best-Public-Value-for-Public-Money_Oct-2019.pdf.

Wemos. 2020. "In the Interest of Health for All? The Dutch 'Aid and Trade' Agenda as Pursued in the African Healthcare Context." Discussion paper. https://www.wemos.nl/wp-content/uploads/2020/10/Dutch-AT-in-Health-Kenya_Wemos-discussion-paper_Oct-2020.pdf.

Wemos. 2021. "Dutch Aid & Trade in Health: Summary Brief Based on Two Discussion Papers." Discussion paper. https://www.wemos.nl/wp-content/uploads/2021/01/Wemos_Summary-brief-Dutch-Aid-and-Trade-in-Health_Jan-2021.pdf.

WHO and UNICEF. 2020. *Operational Framework for Primary Health Care: Transforming Vision into Action*. Geneva: World Health Organization.https://www.who.int/publications/i/item/9789240017832.

World Health Organization. 2015a. *Health in 2015: From MDGs to SDGs*. Geneva: World Health Organization.

World Health Organization. 2015b. *Tracking Universal Health Coverage: First Global Monitoring Report*. Geneva: World Health Organization.

World Health Organization. 2018. *Building the Economic Case for Primary Health Care: A Scoping Review*. Geneva: World Health Organization. https://apps.who.int/iris/handle/10665/326293.

World Health Organization. 2019. "Primary Health Care on the Road to Universal Health Coverage: 2019 Global Monitoring Report." https://www.who.int/healthinfo/universal_health_coverage/report/uhc_report_2019.pdf.

World Health Organization. 2020. "Statement on the Second Meeting of the International Health Regulations (2005) Emergency Committee Regarding the Outbreak of Novel Coronavirus (2019-nCoV)." https://www.who.int/news/item/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov).

Writing Group for PHM Health Systems Thematic Circle. 2021. "A Political Economy Analysis of The Impact of the COVID-19 Pandemic on Health Workers: Making Power and Gender Visible in the Work of Providing Care." Paper commissioned by the Global Health and Justice Partnership of Yale Law and Public Health Schools. https://law.yale.edu/sites/default/files/area/center/ghjp/documents/phm_commentary_v2.pdf.