

Universal Health Coverage in the Global South: New models of healthcare and their implications for citizenship, solidarity, and the public good

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In 2010, the World Health Organization (WHO) released a call for all countries to move towards ‘Universal Health Coverage’ (UHC). The WHO defines UHC as “ensuring that all people can use the promotive, preventative, curative and rehabilitative health services they need, of sufficient quality to be effective, while ensuring that the use of these services does not expose the user to financial hardship”. UHC is described by the WHO’s director as “the single most powerful concept public health has to offer” and is included under the Sustainable Development Goals. The move towards UHC offers a unique opportunity for interdisciplinary research to study how governments, policy makers, health workers, patients and citizens in various countries are addressing questions of health equity, economic inequality, social solidarity and the public good. In this article I outline the issues at stake in the policy focus on UHC and argue that UHC opens up a challenging new research field in medical anthropology.

From social solidarity to commodification of health care

The past three decades which have elapsed since the 1980’ies have seen fundamental shifts in the relationship between the public and the private in the financing and distribution of health-care services worldwide. There has been a decisive movement away from the post second-world-war social contract, of state provision of public health-care and protection of the public’s health towards a more fragmented distribution of responsibility across public, private for-profit and not-for-profit organizations (1–6). During this period, pressure from global financial institutions pushed many low-income countries to privatize health-services, and cut state support for health-care. Public health systems have become increasingly enmeshed with market-based solutions to health-care and the privatization of health-care

services, while the introduction of user-fees has pushed the burden of health-care financing onto the poor (7–10). Across the globe, health is being converted from being a right and entitlement to being a privately purchased commodity. Economic inequality remains a key and increasingly urgent issue that undermines equitable access to quality health care (11).

Growing recognition of the detrimental consequence of these policies in face of health crisis and epidemics of disease, and an upsurge in rights discourses, including health as a human right (12), led to the rise of “global health” initiatives. Focusing on the Global South and particularly on African countries, organizations such as the Global Fund for HIV/AIDS, TB and Malaria, the US Presidential Fund for AIDS Relief (PEPFAR), and the Gates Foundation seek to address the abandonment of the poor to market forces and provide free HIV/AIDS, TB and malaria medicines, and bed-nets to poor populations.

While spectacularly successful in terms of numbers on treatment, global health initiatives have been criticized for bypassing government health care systems in favour of non-government organizations, of producing enclaves in a sea of under-resourced public health facilities, of promoting technical solutions and vertical disease programmes in place of supporting national health systems and of packaging health-care in a specialized, technical assemblage rather than a durable network of care (13–15). The recent Ebola crisis threw a spotlight onto these issues, exposing the chronic neglect of national health systems in West Africa and the limitations of a humanitarian, NGO-dominated response (16, 17).

In this context, debates about and arguments for a more progressive, comprehensive approach – to invest in public health systems and ensure that the poor are not excluded by the cost of healthcare – are gaining currency. Universal Health Coverage in particular is moving up the policy agenda. In 2010 the WHO Assembly released a declaration urging member states to “aim for affordable universal coverage and access for all citizens on the basis of equity and solidarity” and a report on achieving Universal Health Coverage (1,2).

The WHO has, as mentioned above, defined UHC as “ensuring that all people can use the promotive, preventative, curative and rehabilitative health services they need, of sufficient quality to be effective, while ensuring that the use of these services does not expose the user to financial hardship” (1). The director of WHO regards the UHC as the “single most powerful concept that public health has to offer” (3). A number of low and middle-income countries (e.g. Brazil, Ghana, Mexico, Rwanda, Turkey and Thailand) are implementing reforms to make health care universally available. India

and China are pursuing universal health coverage, and more than 80 countries have asked the WHO for implementation assistance.¹ (2, 18)

In the Global South, Universal Health Coverage moves countries away from cost-sharing policies, in which the cost of health care was disproportionately borne by the poor, towards universal access to free or heavily subsidized health care. It focuses on the state's obligations to its citizens, marking a shift away from the Washington consensus towards policies aimed at addressing inequality through social redistribution.

Crucial to the introduction of UHC are questions of financial risk protection, of how to raise funds (through taxes or required prepayment) and pool risk so that the rich subsidize the poor and the healthy subsidize the sick (19, 5). Attempts to reform and extend (national) health insurance form a hallmark of UHC policies (1, 20). In European welfare states, national health insurance and free or subsidized healthcare provided the kernel of the social contract between the state and its citizens and have been a cornerstone of citizens' concepts of 'the good society' (21).

By contrast, in the majority of low or middle-income countries, state social protection has until recently been limited to groups such as civil servants or people in the formal economy. Existing forms of health insurance are a patchwork of commercial insurances and employment-related insurances, pre-paid and voluntary schemes. Extending coverage means including people in the informal economy (in many countries the majority population) whose incomes are precarious, the unemployed and the poor (22). Moves towards UHC therefore open up issues of redistribution, social solidarity and the public good, and potentially redefine the role and responsibility of the state.

What kind of society is envisioned in debates and efforts to extend UHC? Despite its progressive goals, the ways UHC addresses such issues, remains unclear. UHC highlights questions of inclusion and recognition of the state's responsibility, appearing to push against 'the death of the social' (6). Yet UHC could also be interpreted and applied as a solution offering a minimalist biopolitics that assuages political agitation and confers state legitimacy in the face of widening social inequality.

There are, moreover, different models of moving towards UHC. Some are based on introducing a comprehensive, national health insurance fund, while others are limited to 'community-based' and voluntary insurance schemes (18). The envisioned role of the state, while prominent, is also variable, with NGOs playing a role in several pilot schemes already under

1 http://www.who.int/universal_health_coverage/universal-health-coverage-access-pr-20141212.pdf?ua=1

way (18). Many interest groups have stakes in the introduction of UHC, including commercial insurance companies and other business interests (23). Countries have different mixes and relationships between public and private sectors in health-care, while NGOs, and transnational donors and organizations play various roles. National politics is another important factor, and UHC can be employed within different political ideologies (24–26). Importantly, the question of what is universal in UHC is a matter of negotiation. The aim of UHC is not necessarily to make all health care services available and accessible to all citizens within a national space (27). UHC reforms rest on decisions about which health services should be made accessible to which population groups. Although triage is used in all health-systems, in ‘resource-poor’ countries UHC means an extremely circumscribed range of services. UHC is therefore not a universal model but a forum for experimentation and contestation.

UHC and debates about social protection in the Global South

UHC is part of a broader interest among governments in the Global South, international organizations and policy-makers in social protection policies, as a means of tackling issues of poverty (if not inequality). Governments in the Global South – particularly in Mexico, Brazil, South Africa, and Namibia – are experimenting with what James Ferguson describes as “new kinds of welfare systems” (28). Post-apartheid South Africa, for example, has introduced a myriad of social grants such that 44% of households were receiving at least one government grant by in 2014 (28). Cash Transfer schemes, based on the argument “just give money to the poor”, are being piloted and rolled out in many low and middle-income countries. Departing from dominant approaches to development and poverty-alleviation, these direct payments avoid a large bureaucracy and they do not aim to educate, transfer skills, technology, empowerment or participation to the poor. While the amounts being transferred are small compared to European welfare transfers, they have been described as “a development revolution from the South” (29).

Similarly, Universal Health Coverage appears to represent a new approach and new ways of thinking about poverty and redistribution, the state and citizenship, health and development. UHC is innovative in its approach to social protection in relation to health, firstly, in its ambitions concerning social solidarity, and secondly, in its vision of the central role of the state. UHC represents a move away from market-based model of health care toward a more central role for the state, and a recognition of the need for new ways of tackling inequality and inequity.

In European welfare states, national health services funded by health insurance or taxes are institutions that lie at the heart of the social contract between state and citizens. As schemes that “announce solidarity” (30), they are central to the entitlements of citizenship. Moreover they form the basis of many citizens’ concepts of the ‘good society’ and the public good. They are also building blocks of state legitimacy. In many postcolonial societies, where historically there has been extremely limited systems of welfare, and where several decades of Structural Adjustment and the Washington Consensus has incapacitated state support for health care, UHC seems to propose a radically different future. Indeed, the WHO’s call to achieve UHC worldwide by 2030 is being hailed as the most progressive policy objective since WHO’s 1978 call for ‘Health for All in the Year 2000’ through investment in primary health-care systems (4, 31).

Yet here is paradox. While appearing to return to some key post-war values concerning public health for all, UHC takes shape in a very different world from the 1970s. In Europe, welfare is being cut back and state services retrenched under austerity policy. Worldwide, resources are increasingly concentrated in the hands of the wealthy, while public resources are dwindling. Social inequality and exclusion are growing, as unemployment is increasingly recognized to be a permanent rather than temporary condition. In an era of labour surplus, poor and marginal populations the world over have “very little relevance to capital” (28: 11); they are abandoned as redundant or ‘surplus’ (32), while being urged to consume and becoming entrenched in debt (33, 34). Neoliberalism as a political and economic project appears ever more entrenched.

In this context, the “new welfare” of social protection programmes in the Global South hardly poses a radical challenge to the status quo. There is, in fact, a strong argument that welfare policies such as cash-transfer schemes are a cheap way of managing poverty. Like humanitarian interventions, they offer a minimalist intervention – a biopolitics not of care but of ‘bare life’ (32, 35). Indeed, social protection may underwrite the social costs of an aggressive neoliberal growth strategy, offering a band-aid as wealth disparities widen (36). While UHC appears progressive and even radical, there are many ways of implementing UHC and a large degree of interpretation over what kind of care the population have a right to access. The fact that the World Bank has become avid proponent of both UHC and Cash Transfer Schemes, suggests that these are not incompatible with neoliberal policy agendas.

While acknowledging these critiques, anthropologist James Ferguson maintains that the debates and movements towards social protection by

governments in the South are shifting the grounds of political possibilities and that they should be taken seriously for several reasons. First, they reveal a shift away from an obsession with immaterial conditions (such as the rhetoric of ‘participation’ and ‘empowerment’) in the pursuit of development and democracy, and a shift towards material livelihoods and material redistribution (37). Second, new models of social protection and distribution move away from patronizing notions of welfare as charity or state benevolence. They are explicitly framed by arguments about justice and the ‘rightful share’ of citizens, conceived as active recipients. Third, they signify the recipient as a member of the nation-state in postcolonial contexts where recognition of membership is often absent (38). According to Ferguson, social protection policies thrust “a specific condition of presence –the specifically social (not biological) fact of being not only alive but here and among us in a way that implicitly demands at least minimal forms of recognition and obligation” (28: 215). These forms of social protection and assistance thus indicate a turn away from attenuated forms of ‘biological citizenship’ (39) or ‘therapeutic citizenship’ (40) – in which the criteria for inclusion into programmes of care is based on biological condition or disease status (for example, being HIV-positive) – towards a system where inclusion and access to free or subsidized care is based upon membership of society. They also indicate the reinsertion of the state into questions of care.

Despite such arguments, it is clear that UHC, like social protection policies, can serve very different social and political agendas (24, 26). It can also fit into opposing critical arguments: dismissed as part of the architecture of neoliberalism, or dismissed as being utopian and unrealizable. Such paradoxes render the debates about and movements towards UHC particularly interesting sites for examining issues of redistribution, inequality, and solidarity, as well as for exploring the social and political collectives that are forming around forms of public health. These paradoxes also suggest that we can take for granted neither the ‘universal’ in Universal Health Coverage nor the universality of notions of obligation, solidarity and the public good that are ‘pulled along’ with UHC reforms. The current focus on UHC in global health policy, among organizations such as the WHO, the World Bank and the Rockefeller Foundation, and among national governments, provides an opportunity for scholars to examine these questions by examining both UHC policy and how it is being implemented.

Across the world, national publics are debating UHC, while some governments are experimenting – some very tentatively – with different models of UHC. There is a growing body of comparative work on the roll-out

and implementation of UHC reforms, conducted by researchers in the fields of health policy, health systems strengthening, health economics and political science (19, 25, 41). This literature analyses issues surrounding the implementation of UHC, pursuing questions of what works and how, including the merits and drawbacks of different models of health insurance (compulsory vs voluntary, national vs community-based) (18, 42). It examines quality of care issues amidst expanding coverage (43), the role of private health-services in the 'public good' (44), politics (5), solidarity and obligation (36, 45), and the contradictory demands placed on health workers as they implement reforms (46). This literature also offers in-depth country-focused and comparative studies, with journals such as *The Lancet*, *Health Policy and Planning*, and *PLOS Medicine* devoting special issues to the progress towards UHC.

The thrust of this work is pragmatic, pursuing questions of what works and how. I propose something different: to explore how UHC reforms are shaping new collectives of care and citizenship, forms of obligation and solidarity, and a re-evaluation of the role of the state and of national health care systems.

Based on my own immersion in the discipline of social and medical anthropology, I suggest that the following four bodies of anthropological and social science scholarship can give inspiration and directions for future research on Universal Health Coverage: a) scholarship on 'the public good'; b) scholarship on poverty, inequality, and obligation; c) critical medical anthropology and global health; d) anthropological work on the state, policy and bureaucracy.

a. UHC and studies of the public good

i) Studies of utopian social movements: Derived from Thomas More, the concept of utopia is usually conceived as a 'non-place', removed from society, thus a site for re-imagining and re-constituting a new social order. As anthropologist Henrietta Moore points out however (47), utopias are often both real and imagined, and social anthropology has a long history of interest in utopian visions and the movements that grow up around them – from millenarian movements and cargo cults to more recent social movements and experiments with democracy and social ecology. While utopian thought has come to denote that which is idealistic, naïve or even impossible, utopias both imagined and real shaped 19th and 20th century political and social projects, practices and visions of the 'good life' (47). Whether directed at transforming gender relations, inequality or relations of production and reproduction, utopian goals were indeed not aimed at a non-place but at a

better society; they offered not merely dreams outside reality but sought to shape a new reality. It is precisely because utopian 20th century goals concerning equality, employment and inclusion seem to have lapsed into ‘cruel optimism’ (48) in our current era that scholars should pay attention to visions of social progress and transformation.

However, the question of whether UHC should be approached as utopian is debatable. Compared to current trends towards minimalist biopolitics in humanitarian interventions (14), UHC certainly offers a vision of societal transformation. It is utopian, I contend, to the extent that UHC appears to “announce solidarity” (30), to offer a better life to all, and to be directed towards ideas about a ‘good society’ or the public good. For its proponents, UHC is both idealistic goal *and* attainable (4). Significantly, Richard Titmuss, key proponent of the United Kingdom’s National Health Service (NHS) (established in 1948) argued that the NSH would function as “a practical utopian community, participation in which would educate patients in the values of solidarity and altruism” (49:393). In *The Gift Relationship*, Titmuss argued that altruism could be socially engineered and that the National Health Service would foster a sense of mutual responsibility and social growth. For many UK citizens, the NHS continues to embody the values of social solidarity and thus to hold a deep emotional pull. Yet since the 1990s neoliberal values have infused its services, offering “a new utopia, of the market, free bargaining and choosing” (49). Similar contradictions surround UHC. It is a struggle to formalize social protection at the same time as health-care is increasingly being privatized and the free market promoted as the means of improving quality of services and customer choice. Solidarity and neoliberalism are not necessarily uncomfortable bedfellows; indeed, solidarity has a prominent role in ‘free market’ ideologies (50).

ii). An ‘anthropology of the good’. In recent years, anthropologists have been interested in what has been termed “the suffering subject” (51). Moving away from its earlier focus on cultural difference towards a concern with connection and common humanity, anthropology has sought a more direct engagement with political and economic exclusion, war, colonialism, structural violence and precarious living and working conditions, often through a methodology of ‘empathetic connection’ and ‘moral witnessing’ (51). Joel Robbins argues that, while addressing crucial problems of our age, this approach stays within the limits of the present. Suffering is foregrounded, while the concern to explore the organization and values of a better society, which underpinned earlier comparative cultural anthropology, faded. In recent anthropological concern with morality, care, hope, and time, however,

Robbins discerns a shift towards ‘an anthropology of the good’ which engages with people’s attempts to build better ways to live or to foster the good, attending to morality and values, imaginations and aspirations, and struggles for a better future.

The debates and struggles around UHC offer ideal ground, I contend, for an exploration of the ‘public good’ and the politics of the possible. This is not a utopian proposal. UHC can throw light onto how progressive politics and policies, while being put in place in contexts of neoliberalism and advanced capitalism, may not be limited by them and may be used to contest them. Here, anthropologist Anna Tsing’s anthropology of ‘global universals’ remains an inspiration both in its approach and methodology (52). Following Tsing’s call for ‘utopian critiques’, a study of UHC debates and reforms allows us explore how the central problematics of solidarity and inequality are negotiated and debated by policy makers, health workers and citizens. In order to do this, the literature on poverty and inequality, obligation and mutual support, provides a useful resource.

b. Poverty, inequality and obligation: How can we approach questions of solidarity?

i) From the perspective of citizenship and social justice: Proposals for extending or introducing UHC, including forms of national health insurance, present opportunities for examining the social contract – the extent and content of obligations – between the state and its citizens and well as among citizens themselves. Bronwyn Harris and colleagues (36) argue that national health insurance reforms in South Africa “aim to transform the existing and inequitable contracts between people and institutions, and challenge the boundaries of social justice that limit how much inequality is acceptable in any society” (36: 180). Changing the social contract requires active public participation and involvement (5). Simply creating a new financing bureaucracy does not guarantee equity and universal access in a health system, because it does not tackle “social fractures” between people or change relationships and identities, “the *social* part of solidarity” (36: 180). One approach to solidarity is thus to explore the *willingness* of people to contribute according to their means. Methodologically this implies finding innovative ways to operationalize difficult concepts such as solidarity, vertical and horizontal equity, progressive and proportional contributions. It also means exploring the levels of trust people have in state services; and the reasons they may prefer private facilities and services.

ii) From the perspective of obligation and mutual support: Whereas Harris and colleagues approach questions of redistribution and solidarity at a so-

cietal scale, anthropologists seeks to ground questions of poverty and obligation in local socio-cultural values and practices, thus highlighting fields of obligation and claim-making that exist outside welfare and development interventions. For example, drawing upon fieldwork in Malawi, Harri Englund attends to the specific claims and aspirations that inform variable experiences of being poor and argues that moral obligations are not external to social being and thus a matter of ethical choice, but are “constitutive of relationships and subjectivities” (37, 53). He calls for ethnographic research to “conveys ways in which human beings, including mutual strangers, come to have obligations towards each other” (53: 288). While interdependence and obligation form the texture of social relations, they should not be romanticized; they are often a burden, but they are something people live with rather than choose.

iii) From the perspective of informal associations of mutual help, distribution and social protection: There is a lively body of scholarship within anthropology and African studies on multiple forms of informal mutual support and voluntary associations— including burial societies, savings societies and rotating credit associations based on women’s groups, neighbourhood or religious/church networks, and even global diasporic Pentecostal churches – which exist in the absence of state support (54). Most of this work focuses on low and middle-income countries, and I am most familiar with the literature in African studies, but there are also studies from Europe (50). Economic anthropologists shows how state-regulated and formal arrangements interpenetrate with those less visible and regulated (55, 56), how they draw upon both old and new forms of solidarity and interdependence as well as market logics and entrepreneurship, and how they are reshaping kinship and social relations (57). While in the past, mutual help societies were embraced mainly by people who were excluded from state-or job-related access to credit and to social protection, with rise of precariousness in post-Fordist economies, middle classes are also turning to these informal associations. Meanwhile, amidst the ‘financialization’ of the economy (58), commercial insurance companies are increasingly targeting people depending on informal livelihoods. Particularly in South Africa, aggressive marketing has encouraged people to take out several insurance schemes simultaneously and anthropological studies of insurance are emerging (59–64).

c. Medical anthropology and critical global health

i) Medical anthropology and critical studies of global health offer some critical resources for thinking about and designing a study of UHC. Recent studies grapple with reconfigurations of the private and the public, new

terrains of the biopolitical and novel assemblages of science and biomedicine. Concepts such as structural violence, governmentality and biopower (65–67), and discussions about the social collectives forming around health issues, captured in terms such as ‘biological citizenship’, ‘therapeutic citizenship’ and other biosocial collectives, are particularly relevant (39,40, 68).

Structural violence is a term introduced by Johannes Galtung and developed by Paul Farmer to capture the mechanisms whereby large-scale social, political and economic forces become embodied as disease and disability among the poor and vulnerable; how suffering is ‘structured’ by historically given social forces that constrain agency. A related term, social suffering, similarly seeks to capture the forms of social violence that constitute inequity (69). Forms of structural violence often structure norms, for example, when poor are blamed for their condition, or patients for their illness. The concept could provide useful insights into how various groups and individuals (e.g. policy-makers, bureaucrats, health-workers, patients and publics) perceive inequality. However one could also take the more radical approach of Baer, Singer and Susser (70) who argue that the pursuit of profit and economic growth in capitalism is fundamentally at odds with any pursuit of equity.

Governmentality and biopower: Any health-care or welfare reform does not enter a vacuum but is inserted into a complex historical, political, social and economic space of power, contestation and negotiation. The clinic constitutes a space of governmentality, where various forms of power and authority may coexist. Especially in post-colonial settings, the clinic embodies complex layering of power/knowledge: hierarchies, identities and divisions inflected by colonial and post-colonial legacies and ‘imperial debris’ (71) alongside new regimes of consumer choice, patient power, self-care and ‘responsibilization’, transparency and audit (72, 73). Paternalistic, authoritarian and punitive relations coexist with policy initiatives that strive for democratic participation and patient’s rights.

The terrain of global health interventions – which, in many resource-poor countries in the Global South, is increasingly fragmented by a bewildering array of NGOs and transnational organizations working in various relations with national government – adds another level of biopolitical complexity. New kinds of collectives, both larger and smaller than the nation-state, and new forms of ‘biosociality’ are forming around health issues. For example, in Kenya, where I have conducted research, biological conditions, such as being HIV-positive, open access to forms of care not available to other citizens, producing an uneven landscape of care and entitlements. While celebrated in terms of increasing global access to AIDS

drugs, these programmes produce a fragmented landscape of care, in which having HIV/AIDS ensures access to care while other diseases or episodes of ill-health do not (35, 74).

In the context of such fragmentation and amidst the state's neglect of health-care and the politics of nostalgia therein (75–77), anthropologists are becoming attuned to citizens' and patient's desires for belonging and inclusion, for state protection and care. It is in this context that debates about UHC are emerging. For example, in countries such as Tanzania or Kenya, debates about UHC take place on the terrain or 'debris' of earlier visions and struggles surrounding public health as a public good that took place in the 1960s and 1970s. Yet conceptions of the public good may diverge widely as other moral economies and values jostle for space (78–80). As Rebecca Marsland and I suggested in our recent book, in many African countries, public health a matter of contestation and tension, "an open, even experimental arena, the future trajectories of which remain unclear" (76: 115).

ii) Studies of Universal Health Coverage and health insurance: There is a large comparative literature on the implementation of UHC reforms in specific countries, pursued by scholars working in public health and health policy (81). Specific issues addressed include the merits and drawbacks of different models of health insurance (compulsory vs voluntary, national vs community-based); how to ensure quality of care while seeking to expand coverage; the private-public mix of services, and the role of private health-services in the 'public good'; as well as the experiences of the bureaucrats, health workers and patients involved. Although the focus tends to be on a limited set of outcomes and questions of implementation, some innovative work also deals with questions of solidarity and the contradictory demands placed on health workers as they implement health reforms (36, 46). This literature also offers in-depth country-focused studies, with journals such as *The Lancet* devoting special issues to the progress towards UHC, allowing for comparison between countries as well as in-depth focus on a single country.

As mentioned above, various models and schemes for (universal) health insurance form the backbone of UHC. There is the potential for collaborative work here, particularly as insurance is a new topic of anthropological research. A recent issue of the journal *Medical Anthropology Quarterly* devoted to "the social life of health insurance" identifies a new anthropological research agenda (60). Meanwhile in the field of economic anthropology, studies of commercial insurance are emerging (59, 82). Key questions that future research could address on a country-by-country or comparative ba-

sis, are a) how health insurance is organized within UHC schemes; b) what kind of values and practices it supposes or seeks to install; c) the broader landscape of insurance, including health insurance and commercial insurances; d) the habits and actions and values of citizens and patients, providers and regulators, and bureaucrats. This brings us to the question of bureaucracy and the state.

d. Anthropological approaches to studying the state, policy and bureaucracy:

Universal Health Coverage is envisioned, by-and-large, as a state-orchestrated policy. The WHO's call for UHC forms part of its push towards strengthening national health systems in view of the fact that only the state has the geographical reach and durability to organize the health care system. WHO is working with national governments to implement UHC (even where UHC is envisioned as the expansion of 'community-based' health insurance) and to promote the notion of health-care as a 'collective good'. Bureaucrats and bureaucracy play a prominent role. How could we get a handle on this arena of policy making and implementation? If we study the implementation of UHC in countries across the world, we will need to study the state.

States in the Global South, particularly African states, are often described by political scientists and in the media in terms of corruption, venality and inefficiency. By contrast, anthropologists approach the issue from the ground-up, exploring plural cultural logics and social practices of statecraft and citizenship. If we take African countries as the example, again, there is much evidence that, despite the erosion of state capacity since the 1980s, and the widespread problems of corruption and inefficiency, concerns for the public good are not absent among civil servants (83–85). Research on the 'moral economies' informing bureaucracy and the often-conflicting obligations state officials face, explores the contradictory space of the 'public good' (86), challenging assumptions about bureaucrats as being corrupt or indifferent. These studies explore the everyday life of the state, offering insights into how contradictory 'public goods' may translate into inaction (87, 88). The office, with its meetings, plans, documents and files, emerges as an important ethnographic site for examining how law gets translated into practice and how the state functions.

Some of these issues are taken up the 'anthropology of policy', an emerging field which tracks processes from policy to planning to implementation, challenging assumptions about unified logics to explore how planning and practice emerge out of multiple interests (89).

The anthropology of development, too, scrutinizes policy and practices, offering insights into the unintended consequences of development interventions (90). Recent approaches move beyond critiques of development towards engagement with development's multiple effects (91).

James Ferguson (92) makes a similar move in relation to neoliberalism, arguing that neoliberal governmentality should be approached as a contradictory space rather than a coherent set of policies and practices. When policy is a "vast experimental field" (93), UHC may be, as Ferguson suggests in relation to Cash Transfer Programmes, "inventing arts of government adequate to our times" (28). This suggests that we should explore how UHC, while being engaged in the contexts of neoliberal government, may not be limited by it. The questions of what kind of state UHC policies imagine and shape, and of UHC's relation to neoliberalism, must be left open for empirical exploration.

UHC reforms should be situated within this complex framework of governmentality. In many postcolonial contexts, the state is not a predictable, monolithic power (75) and transnational agents (from global health organizations to commercial insurance and pharmaceutical companies) are creating enclaves and exclusions (94, 95). In these contexts, forms of power, knowledge and the public good are hotly debated in the public sphere (96). We could therefore approach state bureaucracy as a complex arena filled with conflicting values and practices and explore how state officials or civil servants actually engage with 'the public good'. The point is to explore how 'universal' concepts and values are engaged; how they travel and are embedded in national histories as well as in local socio-cultural fields, and the frictions that are generated therein.

Conclusion: A new research field for medical anthropology

Social inequality and the widening gap between public and private health-care services are major challenges of our time. In many low-income countries, health-care is polarized between optimized privatized services catering to the wealthy and insured, and minimal interventions and packages designed for the poor and delivered through global health, humanitarian and NGO structures, while government-supported national health care systems are neglected. There is an urgent need for rethinking this model of health care and the kind of society it creates and upholds. All the major global health funders and organizations, as well as international organizations and national governments are discussing ways of implementing UHC.

While extensive research is being done on UHC, much of it focuses on pragmatic issues concerning implementation. In this article, I have argued

that, if we want to take UHC seriously as one of the most progressive policies since the Declaration of Alma Ata in 1978, we should explore the values of solidarity, obligation and the public good that it seems to call forth (97, 98), and study whether and how these values are put into action, through comparing countries and initiatives.

I have advocated for a medical anthropology approach to studying the relations between UHC policy and practice and its engagements with citizenship, the state and the public good. Anthropological research is uniquely positioned to explore these issues, given its capacity to move between sites of policy-making and implementation, and to capture the perspectives and practices of different actors and organizations. An anthropological approach is especially called for because, given the plurality of its forms, Universal Health Coverage is less as a concrete object than a vision. Its effects should thus be measured not only against their realization but in relation to the debates and social processes UHC engenders.

Literature

1. WHO report. *Health systems financing: the path to universal coverage*. Geneva: WHO, 2010. <http://www.who.int/whr/2010/en/> (accessed 1st July, 2016)
2. WHO report. *Tracking universal health coverage: first global monitoring report*. Joint WHO/World Bank Group report. Geneva, WHO, 2015. http://www.who.int/health-info/universal_health_coverage/report/2015/en; June 2015. (accessed 1st July, 2016).
3. Chan, M. Best days for public health are ahead of us, says WHO Director-General. Address to the 65th World Health Assembly. Geneva, May 21, 2012
4. Sen, A. Universal Healthcare: the affordable dream. *The Guardian*, 6th January 2015. <https://www.theguardian.com/society/2015/jan/06/-sp-universal-healthcare-the-affordable-dream-amartya-sen> (accessed 5 July 2016).
5. Savedoff, W.D., de Feranti, D., Smith, A.L. & Fan, V. Political and economic aspects of the transition to Universal Health Coverage. *The Lancet* 2012; 380: 924-32.
6. Rose, N. The Death of the Social. Re-figuring the Territory of Government. *Economy and Society* 1996; 25 (3): 327-56.
7. Masquelier, A. Behind the Dispensary's Properous Facade. Imagining the State in Rural Niger. *Public Culture* 2001; 13(2): 261-91.
8. Foley, E. *Your Pocket Is What Cures You: The Politics of Health in Senegal*. Piscataway, NJ, Rutgers University Press, 2010.
9. Pfeiffer, J. and Chapman, R. Anthropological Perspectives on Structural Adjustment and Public Health. *Annual Review of Anthropology* 2010; 39(1): 149-165.
10. Olivier de Sardan J-P. and Ridde, V. (eds) *Une politique publique de santé et ses contradictions. La gratuité des soins au Burkina Faso, au Mali et au Niger*. Paris: Karthala, 2015.
11. Basílico, M. Weigel, J., Motgi, A., Bor, J. & Keshavjee, S. Health for All? Competing theories and geopolitics. In *Reimagining Global Health. An Introduction*, edited by Paul

Farmer, Arthur Kleinman, Jim Yong Kim & Matthew Basilio. Berkeley: University of California Press, 2013, pp 74-110.

12. Amon, J. The “Right to Know” or “Know Your Rights”? Human Rights and a People-Centered Approach to Health Policy. In *When People Come First. Critical Studies in Global Health*. Princeton: Princeton University Press, 2014.
13. Nguyen, V-K. Government by Exception: Enrolment and Experimentality in Mass HIV Treatment Programs in Africa. *Social Theory and Health* 2009; 7, no. 3: 196-218.
14. Redfield, P. Bioexpectations: Life Technologies as Humanitarian Goods. *Public Culture* 201224(1 66): 157-184.
15. Prince, R.J. & Marsland, R. (eds.) *Making and Unmaking Public Health in Africa. Ethnographic and Historical Perspectives*. Athens: Ohio University Press, 2013.
16. Boozary, A.S., Farmer, P. & Jha, A. The Ebola outbreak, fragile health systems, and quality as a cure. *JAMA* 2014; 312(18): 1859-1860.
17. Redfield, P. & Bornstein, E. Forces of Compassion: An Introduction to the Anthropology of Humanitarianism. In: *Forces of Compassion: Humanitarianism between Ethics and Politics*. E. Bornstein & P. Redfield, eds. Santa Fe: SAR, 2011.
18. Lagomarsino, G., Garabrant, A., Adyas, A., Muga, R. & Otoo, N. Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. *The Lancet* 2012; 380(9845): 933-943.
19. Lancet, editorial. The struggle for universal health coverage. *The Lancet* 2012; 380(9845): 859.
20. Saksena, P., Hsu, J. & Evans, D.B. Financial Risk Protection and Universal Health Coverage: Evidence and Measurement Challenges. *PLoS Med* 2014; 11(9): e1001701.
21. Espen-Anderson, G. *The Three Worlds of Welfare Capitalism*. Princeton: Princeton University Press, 1993.
22. Hart, K. Informal economy. In K. Hart, L. Laville and A.D. Cattani (eds) *The Human Economy: A Citizen's Guide*. Cambridge: Polity Press, 2010, pp142-154.
23. Mills, A., Ally, M., Goudge, J., Gyapong, J. & Mtei, G. Progress towards universal coverage: the health systems of Ghana, South Africa and Tanzania. *Health Policy and Planning* 2012; 27 (suppl 1): i4-i12.
24. Funahashi, D.A. Rule by Good People: Health Governance and the Violence of Moral Authority in Thailand. *Cultural Anthropology* 2016; 31(1): 107-130.
25. Reich, M.R., Harris, J., Ikegami, N., Maeda, A., Cashin, C, Araujo, E., Takemi, K & Evans, T.G. Moving towards universal health coverage: lessons from 11 country studies. *The Lancet* 2016; 387(10020): 811-816.
26. Seo, B.K. Patient waiting: care as a gift and debt in the Thai healthcare system. *Journal of the Royal Anthropological Institute* 2016; 22(2): 279-295.
27. Schmidt, H., Gostin, L.O. & Ezekiel, E.J. Public Health, Universal Health Coverage, and Sustainable Development Goals: Can They Coexist? *The Lancet* 2015 <http://dx.doi.org/10.2139/ssrn.2625208> (Published Online June 30, 2015).
28. Ferguson, J. *Teach a Man to Fish. Reflections on the New Politics of Distribution*. Durham: Duke University Press, 2015.
29. Hanlon J, Barrientos, A., & Hulme, D. *Just Give Money to the Poor: The Development Revolution from the Global South*. Sterling: Kumarian Press, 2010.

30. Danzon M. Foreword, pxii. In: Saltman; RB, Busse; R, Figueras J, editors. *Social Health Insurance Systems in Western Europe*. Maidenhead: Open University Press (for WHO), 2004, p. xii.
31. Rodin, J. & de Ferranti, D. Universal health coverage: the third global health transition? *The Lancet* 2012; 380(9845): 861-862.
32. Li, T.M. To make live or let die? Rural dispossession and the protection of surplus populations. *Antipode* 2010; 41:S1, 66-93.
33. Han, C. *Life in Debt. Times of Care and Violence in Neoliberal Chile*. Berkeley: University of California Press, 2014.
34. James D. *Money From Nothing. Indebtness and Aspiration in South Africa*. Stanford: Stanford University Press, 2015.
35. Prince, R.J. HIV and the Moral Economy of Survival in an East African City. *Medical Anthropology Quarterly* 2012; 26(4): 534-556.
36. Harris, B., Nzumalo, N., Ataguba, J., Governder, V., Chersich, M. & Goudge, J. Social solidarity and civil servants' willingness for financial cross-subsidization in South Africa: implications for health financing reform. *Journal of Public Health Policy* 2011; 32(1): 162-183.
37. Englund, H. Extreme Poverty and Existential Obligations. Beyond Morality in the Anthropology of Africa? *Social Analysis* 2008; 52(3): 33-50.
38. Chatterjee, P. *The Politics of the Governed*. New York: Columbia University Press, 2004.
39. Petryna, A. *Life Exposed. Biological Citizens after Chernobyl*. Princeton, NJ.: Princeton University Press, 2002.
40. Nguyen, V-K. *The Republic of Therapy: Triage and Sovereignty in West Africa's Time of AIDS*. Durham: Duke University Press, 2011.
41. Gilson, L., Hanson, K., Sheikh, K., Agyepong, E.A., Ssengooba, F. & Bennett, S. Building the Field of Health Policy and Systems Research: Social Science Matters. *PLoS Med* 2011; 8(8): e1001079.
42. Mills, A., Ataguba, J. Akazili, J., Borghi, J., Garshong, B., Mawawia, S., Meti, G., Harris, B., Macha, J., Meheus, F. & McIntyre, D. Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage. *The Lancet* 2012; 380(9837): 126-133.
43. Stigler, FL., Macinko, J., Pettigrew, L.M., Kumar, R. & van Weel, C. No universal health coverage without primary health care. *The Lancet* 2016; 387(10030): 1811.
44. Mackintosh, M., Channon, A., Karan, A., Selvaraj, S., Cavagnero, E. & Zhao, H. What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. *The Lancet* 2016; 388(10044): 596-605.
45. Harris, B., Eyles, J. & Goudge, J. Ways of Doing: Restorative Practices, Governmentality, and Provider Conduct in Post-Apartheid Health Care. *Medical Anthropology* 2016; 35: 1-17.
46. Walker, L. and Gilson, L. 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa. *Social Science & Medicine* 2004; 59(6): 1251-1261.
47. Moore, H. Visions Of The Good Life: Anthropology And The Study Of Utopia. *Cambridge Anthropology* 1990; 14(3), 13-33.
48. Berlant, L. *Cruel Optimism*. Durham: Duke University Press, 2011.

49. Harrington, J. Visions of utopia: markets, medicine and the National Health Service. *Legal Studies* 2009; 29(3): 376-399.
50. Van Est, D. & Bähre, E. Cash for Care in The Netherlands: Markets, Bureaucracies, and Personal Relations in Post-Cold War Healthcare Reform. *Etnofoor* 2013; 25(2): 99-118.
51. Robbins, J. Beyond the suffering subject: toward an anthropology of the good. *Journal of the Royal Anthropological Institute* 2013; 19(3): 447-462.
52. Tsing, A.L. *Friction. An Ethnography of Global Connection*. Princeton: Princeton University Press, 2005.
53. Englund, H. Poverty. In *A Companion to Moral Anthropology*, edited by Didier Fassin. Malden, Oxford, Chichester: Wiley Blackwell 2015, pp 283-301.
54. Meagher, K. *Identity Economics: Social Networks and the Informal Economy in Nigeria*. Woodbridge, Rochester, Ibadan: James Currey, 2010.
55. Guyer, J. *Marginal Gains. Monetary Transactions in Transatlantic Africa*. Chicago: University of Chicago Press, 2004.
56. Green, M. *The Development State: Aid, Culture and Civil Society in Tanzania*. Oxford: James Currey, 2015.
57. Rodima-Taylor D. & Bähre E. Introduction: Mutual Help in an Era of Uncertainty. *Africa* 2014; 84(4): 507-509.
58. Hull, E. and James, D. Introduction: Popular Economies in South Africa. *Africa: The Journal of the International African Institute* 2012; 82(1): 1-19.
59. Bähre E. The Janus Face of Insurance in South Africa: From Costs to Risk, from Networks to Bureaucracies. *Africa* 2012; 82(1): 150-167.
60. Dao, A. and Nichter, M. The social life of health insurance in low- to middle-income countries: An anthropological research agenda. *Medical Anthropology Quarterly* 2016; 30(1): 122-143.
61. Dao, A. and Mulligan, J. Toward an anthropology of insurance and health reform: An introduction to the special issue. *Medical Anthropology Quarterly* 2016; 30(1): 5-17.
62. Sagli, G., Zhang, J., Ingstad, B. & Fjeld, H. Poverty and disabled households in the People's Republic of China: experiences with a new rural health insurance scheme. *Disability & Society* 2013; 28(2): 218-231.
63. Horton, S. Toward an Ethnography of the Uninsured: Gay Becker's Work in Progress. *Medical Anthropology* 2007; 26(4): 293-298.
64. Horton, S. Abadia, C., Mulligan, J. & Thompson, J. Critical Anthropology of Global Health "Takes a Stand" Statement: A Critical Medical Anthropological Approach to the U.S.'s Affordable Care Act. *Medical Anthropology Quarterly* 2014; 28(1): 1-22.
65. Farmer, P. An anthropology of structural violence. *Cultural Anthropology* 2004; 45(3): 305-326.
66. Rose, N. *The Politics of Life Itself: Biomedicine, Power and Subjectivity in the 21st Century*. Princeton: University of Princeton Press, 2007.
67. Marsland, R & RJ Prince. Introduction: What is Life Worth? Exploring Biomedical Interventions, Survival and the Politics of Life. *Medical Anthropology Quarterly* 2012; 26(4): 453-469.

68. Whyte, Susan R. (ed). *Second Chances. Surviving AIDS in Uganda*. Durham, Duke University Press, 2014.
69. Kleinman A., Das V., Lock, M. (1996), eds. *Social Suffering*. Berkeley: University of California Press.
70. Baer, H., Singer, M. & Susser, I. *Medical Anthropology and the World System*. Westport, CT, Greenwood Publishing, 1997.
71. Stoler, A. L. Imperial Debris: Reflections on Ruins and Ruination. *Cultural Anthropology* 2008; 23(2): 191-219.
72. Mattes, D. 'We Are Just Supposed to Be Quiet': The Production of Adherence to Antiretroviral Treatment in Urban Tanzania. *Medical Anthropology* 2011; 30(2): 158-182.
73. Hull, E. Paperwork and the contradictions of accountability in a South African hospital. *Journal of the Royal Anthropological Institute* 2012; 18(3): 613-632.
74. Prince, R.J. and P. Otieno In the shadowlands of global health: Observations from health workers in Kenya. *Global Public Health* 2014; 9(8): 927-945.
75. Geissler, P.W. (ed). *Parastates and Medical Science. Making Global Health in Africa*. Durham: Duke University Press, 2015.
76. Prince, R.J. & Marsland, R (eds.) *Making and Unmaking Public Health in Africa. Ethnographic and Historical Perspectives*. Athens: Ohio University Press, 2013.
77. Lachenal, G. & Mbodj-Pouye, A. Restes du développement et traces de la modernité en Afrique. *Politique Africaine* 2014 ; 135 :5-22.
78. Last, M. The Peculiarly Political Problem behind Nigeria's Primary Health Care Provision. In *Making and Unmaking Public Health in Africa: Ethnographic and Historical Perspectives*, edited by R. Prince & R. Marsland (eds.) Athens: Ohio University Press, 2013, pp55-74.
79. Marsland, R. Who are the 'Public' in Public Health? Debating Crowds, Populations, and Publics in Tanzania. In *Making and Unmaking Public Health in Africa: Ethnographic and Historical Perspectives*, edited by R. Prince & R. Marsland (eds.) Athens: Ohio University Press, 2013, pp75-95.
80. Olivier de Sardan J-P. A moral economy of corruption in Africa? *The Journal of Modern African Studies* 1999; 37 (1): 25-52.
81. Gilson, L., Hanson, K., Sheikh, K., Agyepong, I.A., Ssengooba, F., & Bennett, S. Building the Field of Health Policy and Systems Research: Social Science Matters. *PLoS Med* 2011; 8(8): e1001079.
82. Mulligan, J. Insurance Accounts: The Cultural Logics of Health Care Financing. *Medical Anthropology Quarterly* 2016; 30(1): 37-61.
83. Iliffe, J. *East African Doctors. History of the Modern Profession*. Cambridge: University of Cambridge Press, 1998.
84. Wendland, C. *A Heart for the Work: Journeys through an African Medical School*. Chicago: University of Chicago Press, 2011.
85. Blundo G. and Olivier de Sardan J-P. (eds.) *Everyday corruption and the state: citizens and public officials in Africa*. London: Zed Books, 2006..
86. Bierschenk, T. and Olivier de Sardan, J-P. (eds.) *States at Work. The Dynamics of African Bureaucracies*. Leiden: Brill, 2014.

87. Mathur, N. & Bear, L. Remaking the Public Good: A New Anthropology of Bureaucracy. *The Cambridge Journal of Anthropology* 2015; 33(1): 18-34.
88. Brown, H. Managerial relations in Kenyan health care: empathy and the limits of governmentality. *Journal of the Royal Anthropological Institute* 2016; 22(3): 591-609.
89. Shore, C. & R. Wilson Anthropology's interdisciplinary connections. In *The Sage Handbook of Social Anthropology Volume One*, edited by R. Fardon. Los Angeles, London, New Delhi: Sage Publications, 2012.
90. Mosse, D. *Cultivating Development: An Ethnography of Aid Policy and Practice*. London: Pluto Press, 2005.
91. Venkatesan, S. & T. Yarrow (eds.) *Differentiating Development. Beyond an Anthropology of Critique*. New York, Oxford: Berghahn Books, 2012.
92. Ferguson, J. The uses of neoliberalism. *Antipode* 2009; 41(1): 166-184.
93. Foucault, M. *The History of Sexuality Vol. 3: The Care of the Self*, trans. Robert Hurley. New York: Vintage Books, 1988 (quoted in 28).
94. Sassen, S. *Territory, Authority, Rights: From Medieval to Global Assemblages*. Princeton, NJ: Princeton University Press, 2006.
95. Peterson, K. *Speculative Markets. Drug Circuits and Derivative Life in Nigeria*. Durham: Duke University Press, 2014.
96. Feierman, S. Struggles for control: The social Roots of health and healing in modern Africa. *African Studies Review* 1985; 28 (1985): 73-147.
97. Titmuss, R. *The Gift Relationship. From Human Blood to Social Policy*. New York: The New Press, 1970.
98. Rakopoulos, T. Responding to crisis: food cooperatives and the solidarity economic in Greece. *Anthropology Southern Africa* 2013; 36(3&4):102-107.

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