

People's Health Movement



Priority Setting for Universal Health Care

PHM Position Paper

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The PHM is a global network bringing together grassroots health activists, civil society organizations and academic institutions from around the world. PHM works on various programmes and activities and is committed to Comprehensive Primary Health Care and addressing the Social, Environmental and Economic Determinants of Health.

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Priority setting for universal health care

Summary

This paper reviews contemporary policy debates regarding priority setting for universal health coverage (UHC) in the context of instabilities in the global economy and the neoliberal program for managing those instabilities.

PHM recognises the importance of universal health coverage (UHC) although our endorsement is qualified because of the diversity of interpretations of UHC circulating, some of which, such as the World Bank's multi-payer, stratified access, mixed delivery model, PHM does not support.

PHM endorses the need for equity and efficiency in the allocation of resources for health care and population health programmes including in the implementation of UHC. Health system design (funding and delivery configuration) is the major determinant of equity and efficiency in resource allocation and health care delivery. More specific approaches, discussed below, include: first, the use of 'defined benefit packages' in insurance dominated systems; and second, the methods and mechanisms through which equitable and efficient resource allocation can be promoted in tax-funded, public delivery systems.

While it is easy to define 'benefit packages' in terms of a list of 'interventions', it is a huge and costly administrative task to ensure that benefit payments are restricted to interventions that are used in accordance with clinical guidelines (assuming that clinically authoritative guidelines for that environment exist). The opportunity costs of implementing the defined benefits package strategy with integrity are particularly high in the context of private insurance and private practice.

Resource allocation in tax-funded public delivery systems can be efficient and effective; critical elements include: adequate funding, planning and budgeting at the district

health system level, the role of senior clinicians in budget management and guidelines implementation at the clinical level, and community accountability with respect to both funding and administration.

The marketisation of UHC undermines the implementation of comprehensive primary health care. Reducing PHC to arbitrarily defined 'interventions' limits and distorts the analysis of needs and priorities; precludes effective community accountability; ignores public and community action around the social determination of health; and prevents best use of limited resources.

Contemporary policy debates around UHC are framed by macroeconomic instabilities globally and the neoliberal policies being put in place to manage those instabilities. Widening social and economic inequalities associated with neoliberal economic policies contribute to the fraying of social solidarity and consequently weaken political support for single pool single payer systems. Transnational corporations, as the principal conduits of foreign direct investment, are driving a race to the bottom with respect to tax policies (through tax competition) with increased restrictions on public funding of health care as a consequence. Neoliberal pressures to open new markets for corporate investors through health system privatisation (supported by trade in services provisions and investor protection provisions in contemporary trade agreements) contribute to the privileging of market models in health policy debate.

Not only are the policies of neoliberalism exacerbating the global economic crisis but they are driving inequity and inefficiency in health care delivery through marketisation and privatisation. Health policy makers should be fully aware of the perverse influence of the neoliberal program in debates around UHC, including around priority setting.

PHM calls upon policy makers to approach UHC with full consideration of the benefits of single payer financing and publicly managed health care delivery, including equitable resource allocation for efficient, safe and high quality care.

PHM recognises the importance of universal health coverage (UHC) but our endorsement is qualified because of ambiguities associated with the different interpretations of UHC

PHM appreciates the emerging consensus regarding universal financial protection against health care costs. Financial barriers to accessing health care and health care induced poverty are serious health hazards in many countries (Xu, Evans et al. 2003, McIntyre, Thiede et al. 2006, Meessen, Van Damme et al. 2006).

However, our support for the UHC slogan is qualified because of the diversity of interpretations of UHC circulating (O'Connell, Rasanathan et al. 2014), some of which, such as the World Bank's multi-payer, stratified access, mixed delivery model (World Bank 1993, Preker, Sheffler et al. 2007, Kim 2013), PHM does not support.

In proceeding from the principle of universal health coverage to its implementation there are two broad sets of choices: first, regarding financing, and second, regarding service delivery.

Financing

WHO has been cautious about specifying any particular health financing system for UHC but has emphasised the need for community-wide pooling in terms which implicitly endorse single payer systems:

Multiple pools, each with their own administrations and information systems, are also inefficient and make it difficult to achieve equity. Usually, one of the pools will provide high benefits to relatively wealthy people, who will not want to cross-subsidize the costs of poorer, less healthy people. (World Health Organization 2010)

Forms of financial risk protection that pool funds (through tax, other government revenues, and/or insurance contributions) to spread the financial risks of illness across the population, and allow for cross subsidy from rich to poor and from healthy to ill, increase access to both needed services and financial risk protection (WHO 2014).

In contrast the World Bank continues to promote multi-tiered health care financing with private insurance for the rich; social insurance for the middle and publicly funded safety nets (based on defined benefit packages) for the poor (World Bank 1993).

Meanwhile, through trade-in-services provisions (in various plurilateral economic integration agreements), the rich countries are opening up health insurance markets for corporate investment while strengthening investor protection provisions in ways which ensure that the privatisation of health insurance will be practically irreversible.

Service delivery

While the WHO remains non-committal regarding service delivery models for UHC, the World Bank argues (Kim 2013) that health care funding in low and middle income countries (L&MICs) must involve mixed delivery because there is already a big private sector in place –commonly referring to informal health care providers and non-profit charitable providers.

However, the Bank, through its International Finance Corporation (IFC), is actively expanding the role of commercial profit-driven health care providers. In 2014 the IFC granted or lent around USD1 billion to private health and education providers, including in Kenya, Brazil and Turkey (IFC 2015, p54). This is described by the President of the Bank as “helping both middle- and low-income countries harness the resources and innovation of the private sector” (Kim 2013).

Having a large private insurance sector is a barrier to the equitable and efficient allocation of resources because it precludes the transfers associated with community-wide pooling; it increases the administrative costs (because of multiple competing pools); and it creates barriers to the regulation of private sector health care delivery to promote efficiency, quality and safety.

The causes of market failure in health care (eg information asymmetry, provider collusion, selfish motivation) are widely acknowledged and a number of commentators have outlined the kinds of regulatory frameworks which would be needed to assure universal access, equity, quality and efficiency in mixed systems (Smith, Brugha et al. 2001, Saltman, Busse et al. 2002,

Busse, Hafez-Afifi et al. 2003, Bloom, Champion et al. 2008, Lagomarsino, Nachuk et al. 2009, Ramesh and Wu 2009). Having a large private sector delivery system adds further barriers to the equitable and efficient distribution of health care resources and to the regulation of quality and adherence to clinical standards.

The experience of the USA casts doubt on the claims that private insurance and mixed delivery systems can be effectively regulated to ensure efficient resource allocation, equitable access and quality and efficiency in delivery. While the regulatory task is complex and expensive, the political barriers associated with powerful commercial lobbies can be insurmountable.

We acknowledge that multi-payer financing systems and private health care delivery are entrenched in many countries. This is an empirical fact which presents policy makers with significant challenges regarding their development paths. Nevertheless, the reality of entrenched private insurers and private providers does not justify WHO's seeming inability to provide meaningful guidance regarding mixed health care delivery. We recognise that the WHO Secretariat is under intense pressure from various bilateral and multilateral donors (including private philanthropies) to remain silent regarding the principles which should be guiding policies for health systems development for UHC.

The World Bank is disingenuous in dressing up its advocacy for private insurance markets and private sector health care provision as contributing to UHC. To the contrary, the Bank's health policy recommendations are shaped in large part by neoliberal macroeconomic orthodoxy including small government, low taxation, and opening up new markets for capital.

PHM endorses the need for equity and efficiency in the allocation of resources for health care and population health programmes and the need for appropriate priority-setting methods to be part of any UHC policies

There are two broad strategies for ensuring equitable and efficient allocation and use of resources in health care: first, structural reform towards a configuration of financing, development and delivery which raises, allocates and uses resources in the most equitable and efficient way; and second, implementing explicit

mechanisms for identifying priorities and for ensuring resources are allocated and used in accordance with those priorities. These are not mutually exclusive alternatives.

In the next section we discuss strategies for improving the equity and efficiency of resource allocation under the following headings:

- Health system design (funding and delivery configuration) as the major determinant of equity and efficiency in resource allocation and health care delivery;
- Explicit methods of priority setting:
 - Defined benefit packages as a strategy for equitable and efficient resource allocation in insurance funded health systems; and
 - Arrangements for equitable and efficient resource allocation in budget-funded public health care delivery systems.

Health system design (funding, delivery configuration and planning) is the major determinant of equity and efficiency in resource allocation and health care delivery

Health system design (funding and delivery configuration) is the critical determinant of equity and efficiency in resource allocation and efficiency and quality in health care delivery. A proper exploration of options for improving resource allocation must give full consideration to the broad issues of health system design.

In multi-payer systems the lack of community wide pooling (and the associated transfers) sustains inequity and inefficiency in resource allocation. The autonomy of private insurers and private providers constitutes a high barrier to implementing effective clinical governance. Fully marketised systems, as in managed care in the US, carry huge administrative costs, in part as a consequence of the complex regulatory functions required; inequity and inefficiency are intrinsic to this model. The other side of 'inefficiency' in such systems is the profit which flows to insurers, suppliers and private providers. From the corporate perspective this is their great advantage. The World Bank's advocacy for stratified health care funding reflects an acceptance of, and contributes to, unequal access. The Bank's mantra of 'reducing poverty' translates into

safety nets for the very poor but acceptance and exacerbation of inequality.

Global private-public partnerships promote inefficiency through fragmentation of service delivery, lack of accountability, high coordination costs, competition for staff, and inequity and inefficiency through arbitrary access boundaries.

Publicly funded, publicly delivered health care programs are inefficient when under-funded, under-staffed and badly managed; they are inequitable and inefficient when dominated by large hospitals and when comprehensive primary health care is neglected. However, with proper stewardship and community accountability, public financing and delivery yields equity, efficiency and quality more reliably and at lower cost than private sector dominated systems (Mackintosh and Koivusalo 2005).

What is possible is shaped by what has gone before. In countries which have inherited a strong public sector delivery system and expectations of public financing, PHM would urge close consideration of a strengthened public sector service delivery, based on comprehensive PHC and community accountability and funded through progressive taxation.

In countries which have inherited a mixed service delivery model and multi-payer funding, moving towards a publicly funded and publicly delivered model may not be feasible in the short to medium term. In such circumstances PHM would urge moving towards a single payer system with regulatory and funding reforms directed to progressively strengthening the public system and bringing private and voluntary providers into a single unique/unified system.

Single payer arrangements enable strategies such as population based capitation payment for primary health care and capping expenditure on inpatient services through funding contracts which specify volume limits. By themselves these strategies do not guarantee equity and efficiency but they can be part of a progressive system reform to this end.

Stepping back from questions of financing and service delivery it is important to recognise the influence of system wide planning on resource allocation and implicit priority setting. Thus human resource planning (e.g. decisions about the role of community

health workers) has huge implications for patterns of resource allocation. Likewise the distribution of capital resources between tertiary hospitals and district health systems including primary health care will have a continuing impact on utilisation and servicing patterns.

While structural reform should take precedence over administrative mechanisms for priority-setting, there are periods when funding and delivery structures are frozen in place and the introduction of explicit methods for priority setting (and regulation) may be needed. However, methods for priority setting need to be evaluated in relation to the specific circumstances; tailored to the specific barriers and circumstances of different systems.

A wide range of explicit methods of priority setting are available

A wide range of explicit methods for priority setting are available. In this section our focus is on two specific approaches: first the use of 'defined benefit packages' in insurance dominated systems; and second, the methods and mechanisms through which equitable and efficient resource allocation can be promoted in tax-funded, public delivery systems.

Defined benefit packages

The discourse of defined benefit packages involves reducing the health care process to a commodified 'intervention' with clear boundaries and a price and apparently no institutional infrastructure. Accordingly the discussion of priority setting is reduced to the 'cost-effectiveness' of the commodified intervention.

This intervention-based model of health care is limited in many respects; health care is much more than the sum of a defined set of standardised interventions; the boundaries which define the intervention are always arbitrary and open to debate and distortion; and effectiveness in practice in very diverse settings is much more complex than efficacy in research.

Benefit packages involve more than a list of interventions to be funded; they also include, by implication, the clinical guidelines which qualify the use of such interventions.

Effectiveness of the intervention in practice depends on provider capacity, including diagnostic capacity and capacity to deliver the intervention, as well as the condition of the patient. Research based clinical guidelines for therapeutic interventions depend on particular standards of diagnosis (and diagnostic resources) and on particular standards for delivery of those interventions. Research based clinical guidelines for diagnostic interventions are always contingent on the availability of a particular mix of technologies, on prevailing epidemiological patterns (incidence levels determine the likelihood of false positives or false negatives) and on particular patterns of clinical presentation. The cost of developing and reviewing clinical guidelines which are seen to have clinical authority and which fully reflect local conditions is high in the industrialised countries; the opportunity costs of doing so in L&MICs is significant.

While it is easy to define 'benefit packages' in terms of a list of 'interventions', it is a huge administrative task to ensure that benefit payments are restricted to interventions that are used in accordance with clinical guidelines (assuming that clinically authoritative guidelines for that environment exist). It is likewise a huge administrative task to assess for approval the exceptional cases for benefit payment in relation to interventions which are not included in the standard benefit package.

The opportunity costs of implementing the defined benefits package strategy with integrity are high in single payer mixed delivery systems; they are particularly high in the context of private insurance markets and private practice. The difficulty of monitoring adherence to clinical guidelines in private practice in the industrialised countries is well known. The cost of prospective utilisation review / utilisation control in the USA is a significant contributor to the very high cost of health care in the US. Likewise the administrative cost of approvals for exceptional cases is high. These high administrative costs in the rich countries translate into huge opportunity costs in L&MICs.

It is self-evident that the use of the defined benefit package for priority setting requires monitoring to ensure that providers conform to the guidelines associated with each intervention. Such monitoring can be seen as quite invasive by clinicians and, if it is identified as the interference by 'bean counters' in the professional practice of medicine, it can be seen as lacking legitimacy and invite gaming or

sabotage. Accordingly, it is important that utilisation review methods are embedded in comprehensive clinical governance arrangements explicitly focused on quality and safety as well as efficiency. As noted earlier, the broader system configuration can facilitate or obstruct this. For example the collection of prescribing indications from private sector practitioners is difficult whereas drug and therapeutics committees in public hospitals are generally accepted as a legitimate part of clinical governance arrangements.

Resource allocation in tax-funded public delivery systems can be efficient and effective; critical elements include: adequate funding, planning and budgeting at the district health system level, the role of senior clinicians in budget management and guidelines implementation at the clinical level, and community accountability with respect to both funding and administration

In budget funded health care, priorities are set in the hierarchical process of budget development. Managers at various levels exercise judgement in making choices between competing claims. Developing district health systems (Segall 2003) enables the integration of a range of considerations in priority setting including outcomes, quality, safety and efficiency. It also enables the integration of prevention and rehabilitation into the work of the health system. One of the established tools for priority setting in such settings is the use of program budgeting with marginal analysis (PBMA). This is a method which brings together stakeholder judgement and evidence regarding health outcomes (Mooney 2005, Peacock, Richardson et al. 2007). The core idea of PBMA is to allocate budget priority to those programs where the marginal dollar buys the greater health outcomes.

A critical aspect of public sector delivery systems is the role of senior clinicians as budget holders, bringing together budget responsibility and clinical authority. In such situations formalised clinical guidelines can be modified in practice in accordance with local circumstances. Clinical judgement in such settings may be a more reliable approach to priority setting than centralised exclusion/inclusion decisions. Certainly it is likely to be much cheaper.

Clearly it is essential that such decision making is accountable, including in terms of established clinical guidelines. The advantage of public sector health care delivery is that utilisation review is embedded in comprehensive clinical governance arrangements so that inappropriate use of resources is considered in the same setting as clinical review of quality and safety.

Public funding and public sector delivery are not without challenges. In highly unequal societies there is always pressure from the rich to buy their way out and to reduce a universal public system to a residualised safety net. Resource mobilisation is always a challenge, particularly in situations of rampant corporate tax evasion and tax competition. Accountability and probity require continuing attention, including through strong community involvement.

PHM endorses the importance of capacity building for priority setting; noting that as well as technical capacity, it includes community capacity and norms and structures to support dialogue and accountability

PHM endorses the need to include capacity building for priority setting in programs for health systems development; this includes community capacity as well as technical capacity, and includes also the norms and structures needed to support professional and community dialogue.

There is a wide range of actors with a material interest in the outcomes of resource allocation decisions and the often fierce contestation for resources in health care. The ground rules regarding resource allocation will arise out of a dialogue which, while giving appropriate weight to technical measures, must also work towards professional and community consensus regarding such principles. Whilst suppliers and providers have a right to participate in such a dialogue, their participation should be transparent in the sense that their material interests are recognised and they are not in a position to determine outcomes.

Within the broader community there will also be differences of opinion regarding the broad parameters for priority setting and it is important that the public discussion be conducted in a way which

works towards consensus based on principles of equity and social solidarity.

Broad consensus around the ground rules, community awareness and administrative transparency set the conditions for the accountability of officials and practitioners regarding resource allocation decisions and clinical practice.

PHM is particularly concerned that the marketisation of UHC (driven by the Bank, accepted by WHO) undermines the implementation of comprehensive primary health care. Reducing PHC to arbitrarily defined 'interventions' limits and distorts the analysis of needs and priorities; precludes effective community accountability; ignores public and community action around the social determination of health; and prevents best use of limited resources

Comprehensive primary health care (CPHC) has been re-affirmed as the basis for health policy by WHO member states. However, such progress as has been achieved in implementing PHC since the 1980s has focused largely on its medical care elements.

The dominant approach ('selective' PHC) is characterised by the neglect of promotive and preventive aspects of care and the exclusion of inter-sectoral collaboration, community participation and sustainable district level structures. UNICEF's GOBI package for child survival privileged a few selected interventions, allowing donors and governments to avoid tackling inequalities and the social determination of ill-health (SDH).

Reducing comprehensive PHC to a set of commodified interventions funded through benefit packages disembowels the Alma-Ata vision of PHC (WHO 2009). In particular, it precludes systematic stewardship regarding the social determination of health, including the engagement of local PHC staff in working with communities in relation to the SDH. Thus community education about hand-washing may be included in the benefit package but supporting community action around improved water supply and sanitation is excluded from consideration. It is worth recalling the WB's conclusion in 1993 that expenditure on clean water and sanitation is not cost-effective (a conclusion reached by assigning

the full cost of water and sanitation to the health sector and ignoring inter-sectoral benefits).

A further consequence of the application of benefit packages in PHC is that services which are outside the essential 'package' are necessarily funded by direct user charges and provided by the private sector, thus further supporting private medical care. Private practice and fee for service reimbursement make it much harder to realise the vision of comprehensive PHC.

PHM insists on a recognition that health policy debates around UHC are framed by macroeconomic instabilities and the neoliberal policies being put in place to manage those instabilities

The global economy is on a perilous path with imbalances driving the economy away from stability, equity and sustainability. These imbalances are also driving the relentless progression of global warming; the floods of refugees in all parts of the world; and widening economic inequalities, as well as in the global health crisis. These crises reflect in part the direct effects of economic imbalances; they are also driven by the neoliberal policies being put in place by the global governors to manage the economic crisis.

The global economy faces a rolling crisis of over-production, under-consumption and over-accumulation (Kotz 2008, Tabb 2012). 'Over-production' refers to the fact that, with globalisation and technology, the big corporations can now produce for bigger and bigger markets using fewer and fewer workers. However, people who don't have jobs can't buy stuff (and many of those who have money already have too much stuff). This is why PHM also speaks of 'under-consumption' as the other side of over-production: slack demand due to lack of buying power. The corporations respond to stagnant demand and declining profit by: replacing labour with technology; replacing high wage with low wage labour; externalising the cost of production to the environment; increasing market share through mergers and acquisitions; avoiding tax; and searching for new markets. Reducing labour costs might improve the profits for those corporations who survive but across the economy as a whole they further choke off buying power (Bello 2006).

The search for new markets involves several strategies: opening up countries who were trying to develop their own industries; creating new products through technical innovation and sophisticated marketing; marketising family functions which had previously been outside the market economy, such as meals and recreation; and privatising public services including education, health insurance and health services.

The other side of this crisis of over-production is the rising tide of profit with nowhere to go because of reduced opportunities for new investment in real productive capacity. This is the crisis of 'over-accumulation' and this is what lies behind the extraordinary expansion of the financial sector over the last 30 years. Money which might have been invested in productive enterprise goes into speculation, debt-funded consumption and financial churning with the remorseless extraction of fees. The global financial crisis of 2007-9 was the inevitable result of speculative borrowing and asset inflation (Keen 2011, Grabel and Gallagher 2014) but when the asset bubble burst it was the big banks who were bailed out and the taxpayers and 'sub-prime' borrowers (in the US) and the pensioners, the sick and the unemployed (in Greece) who were forced to pay.

Neoliberalism is a program of global economic reform directed to securing the interests of the transnational corporations and the transnational capitalist class in the face of these global imbalances even at the cost of exacerbating the risks to humanity generally which arise from these looping instabilities.

The neoliberal program includes free trade (in manufactured goods – but not agricultural commodities!); opening up trade in services; low quality patenting but high levels of protection; and 'investor protection' provisions to enable TNCs to resist government regulation. It also includes resistance to any effective multilateral tax agreement; resistance to any binding agreement on the human rights obligations of TNCs, and resistance to effective action on climate change.

The neoliberal program exacerbates the global imbalances (of over-production, under consumption and over-accumulation) with devastating implications for the one to two billion excluded and marginalised people for whom this global economy has no place,

except to serve as a threat to those who do have jobs; a stark warning about either accepting lower wages or watching the corporate investment move on to even lower wage platforms.

The effects of the global economic crisis (including the neoliberal program for managing it) frame the policy challenges and permeate the debates regarding health systems, resource allocation and priority setting. If these influences are ignored there is a risk that the policy outcomes of such debates are unduly influenced by the neoliberal program and ideology rather than effectively addressing the conditions for equitable and efficient distribution and use of resources.

In the final sections of this paper we review a number of areas where the global economic crisis and the neoliberal program are framing the health policy challenges and shaping the preferred solutions but are not widely recognised for their influence in this respect.

Insofar as health system challenges reflect the global economic crisis (e.g. equitable access to quality health care) then the solutions to such challenges should include provisions directly addressing the fundamental problems rather than solely adapting to such effects. Insofar as there are health policy options being considered which reflect primarily the neoliberal program for corporate well-being (e.g. the promotion of health care privatisation) then this influence should be taken into consideration in such policy debates.

Widening social and economic inequalities associated with neoliberal economic policies contribute to the fraying of social solidarity and consequently weaken political support for single pool single payer systems

Widening inequalities in wealth and income make it increasingly hard to sustain a strong sentiment of social solidarity in public policy. Widening inequalities contribute to a declining willingness to contribute to single pool single payer systems.

The global crisis of over-production is a major cause of widening inequality. With modern technologies corporations can produce for larger and larger markets with fewer and fewer workers. Between one and two billion people are treated as surplus to requirements by

this system and of course, since they have no waged employment they have very limited buying capacity. Policies of 'austerity' are also driving inequality from structural adjustment in the 1980s to the policies of 'the troika' in Europe from 2012.

If widening inequalities, driven by the neoliberal program, make it harder to implement single pool, single payer systems, the solution should include addressing the fundamental causes of widening inequalities rather than simply accepting them and proceeding to support market based insurance, mixed delivery systems and a safety net approach to UHC.

The TNCs, as the principal conduits of foreign direct investment, are driving a race to the bottom with respect to tax policies (tax competition) with increased restrictions on public funding of health care as a consequence

Tax competition is essentially an auction managed by the TNCs seeking low tax as a condition for their foreign direct investment. Clearly under such circumstances government officials facing reduced revenues are under increasing pressure to privatise health care and move away from publicly funded and single payer systems in implementing UHC.

It is worth contrasting the drive for trade and investment agreements, designed to smooth the path to corporate globalisation, with the failure to negotiate a multilateral tax agreement (or a binding agreement regarding the human rights obligations of TNCs).

Neoliberal pressures to open new markets for corporate investors through health system privatisation (supported by trade in services provisions (e.g., TISA, TPP) and investor protection provisions) contribute to the privileging of market models in health policy debate

The increasing pressure for trade-in-service agreements (e.g., TISA) and chapters (in both the TPP and TTIP) reflects the demand of transnational finance for open access to national financial systems including insurance which includes health insurance. The move from positive lists to negative lists and the increased barriers to withdrawing particular service sectors from liberalisation greatly strengthen contemporary trade-in-service provisions in comparison with the 1994 GATS Agreement.

The pressures to privatise and to open access to foreign investment in services are further supported by the inclusion of investor protection provisions which give foreign investors power to restrict funding policy and regulatory options for health ministries.

The global economic crisis, and in particular the crisis of over-accumulation (and the flush of global cash seeking new markets for investment), are fundamental drivers of the pressure for trade in services and privatisation. From a health policy point of view privatisation of health care is extremely problematic but from the point of view of capital seeking new markets it makes eminent sense.

If the rhetoric of marketisation and the pressures to privatise reflect fundamental imbalances in the global economy (and the neoliberal response to those imbalances) we should be talking about strategies of global economic reform rather than just accepting the apparent logic of marketisation and privatisation in health care.

'Transparency' provisions in new trade agreements designed to prevent cost-effectiveness considerations from influencing pricing decisions in pharmaceutical subsidy schemes illustrate the wider economic forces opposing efficiency in resource allocation

The inclusion of 'transparency' provisions in modern ('21st Century') trade agreements are designed to prevent the use of cost-effectiveness criteria in determining inclusion and pricing in national pharmaceutical subsidy schemes.

This is a direct challenge to the project of equitable and efficient resource allocation and use in health care and should be high on the agenda of any deliberations regarding priority setting in health care.

Unethical pharmaceutical marketing practices are a major cause of inefficient resource allocation but big pharma (supported by host governments) resists appropriate regulation of marketing

Since 1988, the World Health Assembly has sought to impose restrictions on aggressive and unethical marketing of pharmaceuticals. These initiatives have been opposed by big pharma and its leading host governments. Action by the WHO

Secretariat to implement the non-binding 'ethical criteria' have been unfunded -casualties of the donor chokehold over WHO. The refusal to regulate aggressive marketing of pharmaceuticals has contributed directly to the current crisis in antibiotic resistance. In any discussion of priority setting in health care, full consideration should be given to the political economy and geopolitics which maintain the continuing barriers to effective regulation of pharmaceutical promotion.

Conclusions

The social and political determination of health looms large at this time and comprehensive PHC is a powerful strategy for engaging with such processes. The marketised model of health care, which the World Bank offers under the rubric of UHC, has no strategy for addressing the SDH and would preclude the implementation of PHC. WHO should not be participating in a campaign that has the effect of precluding the implementation of comprehensive PHC.

The regulation of resource flows for equity and efficiency in marketised health systems is complex, expensive and often just not possible. Judgements regarding the effectiveness of interventions require the integration of evidence regarding efficacy with an understanding of that particular health care environment. It is easy to list or delist particular interventions for reimbursement. It is far harder to ensure that listed interventions are only used in clinical situations where they are known to be effective. It is even harder to include workable protocols for considering clinical exceptions for interventions which are not listed.

In publicly owned and managed health care systems equitable and efficient resource allocation can be assured under conditions which are much easier to implement.

Discussions of health system models, including UHC and methods for priority setting, are framed by prevailing ideological currents; in the present period these currents are dominated by neoliberalism. The privileging of marketised models for health care in such discussions reflects corporate pressure to access new markets; tax competition and pressure on public funding; widening inequalities and the weakening of social solidarity.

PHM calls upon policy makers to approach UHC with full consideration of the policy advantages of single payer financing and publicly managed health care delivery, including equitable resource allocation for efficient, safe and high quality care.

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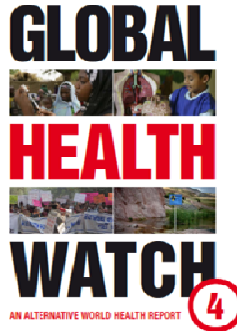
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PHM's Global Programs

Global Health Watch



Global Health Watch (GHW) was conceived in 2003 in response to the need felt for civil society to produce its own alternative World Health Report. The idea of an alternative report developed into an initiative called 'Global Health Watch' (GHW) with the first report launched in July 2005, during the Second People's Health Assembly (PHA2) in Cuenca, Ecuador. The second edition was launched in October 2008, the third in October 2011 and the fourth in October 2014. **Website:** www.ghwatch.org

International People's Health University (IPHU)

IPHU is a short course training program offered by PHM for younger health activists. The program is a face to face short course of 10-12 days under the title, 'The struggle for health', and includes topics dealing with health systems, the social determinants of health, the political economy of health and various aspects of social movement activism. **Website:** www.iphu.org



Democratizing Global Health Governance initiative (WHO Watch)

WHO Watch is a program of engagement with the World Health Organisation. The focus of WHO Watch is on WHO decisions and operations at the country and regional levels as well as in Geneva. As well as directly engaging with global health policy issues WHO Watch seeks to strengthen the links between local and global activism around health. **Website:** www.ghwatch.org