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# Health for all? Pasts, presents and futures of aspirations for universal healthcare

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ABSTRACT

In this special issue, we bring together anthropological and historical work that considers successive aspirations towards 'health for all': their pasts, their futures, and their diverse meanings and iterations. Across the world, hopes for providing 'health for all' were central to nation building in the long 20th century, and for international relations, particularly after the second world war and the establishment of the WHO. Health became seen as a fundamental good by citizens of North and South and has remained a central force shaping global and national politics until today. But what does 'health for all' actually mean, and how did it come to matter? In this introduction we approach 'health for all as a situated, multi-faceted phenomenon, that - while having a shared aspiration towards universality of access and equality of care - comes into focus in partial, diverse and contentious policies, programmes, projects and practices. Beyond homogenising narratives that frame 'health for all' in terms of either success or failure, the special issue highlights the diverse iterations that 'health for all' has taken on the ground for different subjects and groups of people, exploring exclusions and limitations as well as dreams and aspirations.

## 1. Introduction

When the Covid-19 pandemic arrived in 2020, it encountered public healthcare systems under strain across the world, after decades of austerity. The pandemic exposed well-worn fault-lines of socio-economic inequality between countries and regions, and within states. It underlined how injustices along racial, class, gendered and geographical lines remain entrenched, and in many places have worsened - drawing attention to questions of who gets sick, who dies, who is vulnerable, and why (e.g. Carney et al., 2022). The pandemic also made apparent extensive failures in attempts to provide healthcare to all. Just as the 2014–2016 Ebola epidemic was a symptom of a larger global health crisis, in large part due to a lack of investment in health systems on the African continent (Packard, 2016), so the Covid-19 pandemic exposed the fragile state of health systems and the unequal access to healthcare around the globe, including in some of the world's wealthiest economies. The medical and economic havoc caused by the virus refocused attention on health systems, and highlighted the vital role of both public healthcare, and arguments for creating truly universal, publicly-funded health services that reach and include everyone (see Yates, 2020; Whittall, 2020).

Under these conditions, there is reason to pause and consider successive aspirations towards 'health for all': their pasts, their futures, and their diverse meanings and iterations. Across the world, hopes for providing 'health for all' were central to nation building in the long 20th century, and for international relations, particularly after the second world war and the establishment of the World Health Organization (WHO). Health became seen as a fundamental good by citizens of North and South, and has remained a central force shaping global and national politics until today. But what does 'health for all' actually mean, and how did it come to matter?

The WHO's Constitution of 1946 is a good place to start (World Health Organization, 1946). Here, the WHO affirmed a broad definition of health: asserting that health is a basic right, regardless of race,

*Abbreviations:* UHC, Universal Health Coverage.

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religion, political belief, economic or social condition; and that governments have an obligation and responsibility to ensure the health of their peoples. This utopian vision of a post-WWII world was famously re-asserted in the 1978 Alma Ata Declaration, seen by many as revolutionary document which combined global health policies with criticism of global economic injustice (Packard, 2016). In the declaration, 134 countries committed to a comprehensive goal of ensuring primary health care (World Health Organization, 1978, 14). They also recognised the necessity of including the views and needs of the people concerned in a participatory manner.

These moments and their broad optimism feel distant from the present. But although they went largely unrealized, the aspirations articulated by the Alma Ata declaration, and the 1970s as a period of political progress and decolonization, continue to have contemporary significance, beyond merely nostalgic references towards 'health for all' in a post-colonial world. The language of health for all promises everyone the possibility of a healthy life regardless of class, race, gender, financial means or geographical location. If in some locations, particularly in the USA, this aspiration has gained very little traction (Castañeda and Mulligan, 2018; LaRusso et al., 2022), in other regions – for example in Latin America or Northern Europe – it has a long history, and persists within political rhetoric and welfare state arrangements, despite ongoing austerity measures and discrimination (Kehr, 2019, 2020; Kehr, 2022; Pushkar, 2019; Birn, 2020). Meanwhile in many post-colonial states, it remains a promise that gestures towards a more expansive and inclusive citizenship.

Scrutinising the language of universality and inclusion draws our attention to the partiality of universalist goals – to exclusions, limits and frictions that have sometimes comprised, or even been integral to aspirations of 'health for all'. Questions of who gets access to which services or is afforded rights, and who is left out and why, train our focus on differentiation and exclusion (Basilico et al., 2013). Such questions become more pressing in a world where many people are on the move, forced to leave home and country by wars and discrimination, climatic and economic crises. Moreover, there are substantial arguments that 'health for all' can never be achieved in a fundamentally unequal world and within capitalist societies as currently structured, in which the aims of equity, egalitarianism and inclusion are fundamentally at odds with a socioeconomic and political system built upon profit-making, inequality and division. Without a radical politics that addresses inequalities, so this argument goes, all that will be produced will be a watered-down reform (Gorz, 1967; Therborn, 2007).

Cognizant of these unresolved debates and tensions, in this special issue we attend to various iterations of 'health for all', and how it has been translated into troubled and partial realities in African, European, Middle-Eastern and South Asian settings. We attend to the diversity of 'health for all' pasts and presents, exploring how 'health for all' has been aspired towards and put into practice at different moments in time, and in various geographical locations (see Brazelton, 2022; Gaudilliére et al., 2022). These range from top-down approaches that materialise in the formation of national insurance coverage schemes or national health services, hypothetically universal in access and free at the point of use (Kehr, 2022), to more participatory and bottom-up (yet also partial and fragmented) approaches, where communities and non-state actors play a central role in shaping access to healthcare on the ground (Gaudilliére et al., 2022; Mladovsky, 2022; Wintrup, 2022).

Dreams and aspirations, frustrations and disappointments, frictions and tensions have been, and continue to be, an important part of this story (see Geissler and Tousignant, 2020). Even if success continues to be elusive, as aspirations to 'health for all' have often been side-lined or ignored, one can also observe the possibilities, opportunities and trajectories that some partial failures have opened up or set in motion (Muinde and Prince, 2022; Prince, 2022). Thus we also explore what these aspirations might produce in themselves, in terms of creating solidarities, relations, collectives and politics at different scales. We ask what these interventions have left behind, their remains and legacies, as well as what they may engender beyond their immediate or long-term goals (see Geissler et al., 2016; Tousignant 2018; McKay 2020; Prince, 2020b).

Where prominent, the language of 'health for all' often goes hand in hand with idioms of human rights, social justice, and solidarity. But how has this language been interpreted and translated (Cerón and Jerome, 2019)? Aspirations to 'health for all' are refracted by political and economic relations and enacted through specific technologies, policies, networks, infrastructures and actors. By attending to diverse iterations of 'health for all' – as hopes, dreams, and partial and troubled realisations with important historical and geographical differences – the various contributions to our special issue look at both global aspirations and situated manifestations. We attend to languages of universalism that have been taken up in different contexts to expand access to healthcare, and look at the affective, political and social registers through which limitations and frictions are expressed, as well as the many possibilities, hopes and imaginaries that the notion of health for all affords. We show how 'health for all' as an idea brings people together, creates relationships, collectives and solidarities, spaces for technological innovation and for political debate, even as it generates tensions.

## 2. Histories of 'health for all': Aspirations, realisations and frictions in the long 20th century

Interventions to improve health and expand healthcare have been tied to different political and economic ideas - about the place of the state, the market, the medical profession, the role of citizens and 'the community', as well as of non-governmental and international organisations. Approaches have oscillated between a focus on medical technologies and a focus on systems and people, the former having an important contemporary traction. Health and healthcare interventions have often been dependent on economic models, including ideologies of healthcare financing based on demands for efficiency and marketization. Finally, they have been caught up in wider historical processes including the development of capitalist and socialist states, Cold War and world systems conflicts, colonialism, nation-building, decolonization, and the unstable consolidation of neoliberalism.

Although they have only occasionally been pushed to the foreground of national or international policy agendas, aspirations and policy shifts towards an expansive and universal 'health for all' constitute some of the major progressive developments of the 20th century, with histories dating back to the 19th century and beyond. But these histories are often intertwined with the emergence of capitalist European nation-states, within an imperial system of colonisation, in which 'progressive' inevitably remains a relative term. In the 19th century, only white citizen-subjects were conceived of as part of national populations in continental Europe, enjoying particular characteristics and rights. As the industrial revolution intensified socio-economic tensions, those metropolitan subjects were increasingly governed "from a social point of view", as part of a collective for whom social politics were framed in terms of entitlements and obligations, the aim being to ensure "social order" as well as "social justice" (Rose, 1999, p. 118). In northern European countries, piecemeal social security policies and interventions were established from the late 19th century onwards, often following popular uprisings and political struggle by pauperized workers against insecurity and poverty, and towards employment, health and education (Esping-Anderson and Gøsta, 1990). Here, systems of welfare and healthcare aimed to stave off what was seen as the threat of socialism, by offering a compromise between capital and labour (*ibid.*). One early example came with the introduction of workers' insurance in the German Reich of the 1880s, a system based on equal financial contributions by workers and employers (proposed as an "anti-socialist" move by Chancellor Bismarck), in what has become known as the Bismarckian model of health insurance. Increasingly from the mid 20th century, such policies were realised through the institutional forms of the welfare state. In this context, citizenship became social in the sense that the state "attempted

to integrate citizens in … a universal realm of equal rights and duties", in which the state fashioned itself as a "guarantor of the common good" (Muehlebach, 2012: 60).

In Western democracies, the rise of universal healthcare as a project is closely linked to this emergence of a social citizenry, the welfare state as a political form, and its ambitions towards redistributive justice and social security – that is, to a social contract between citizens and the state (Espen-Anderson and Gøsta, 1990), consolidated after World War II. In Central Western Europe, Canada, and Japan, a 'Bismarkian' system emerged: here, a mix of public and private providers offer healthcare through varied systems of health insurance, while those without employment are guaranteed social health insurance by the state. National health services financed through general taxation were established in New Zealand and Britain (after the 1942 Beveridge report), the Scandinavian countries, Italy and (much later) in Spain. These offered comprehensive healthcare to all citizens, free at the point of use, at least in theory. Finally, there is the more classically liberal model of health protection, prominent in the USA, parts of Latin America and post-socialist Eastern European countries, in which access to healthcare is publicly financed only under certain conditions of revenue, age and/or emergency situations, while general healthcare is often costly, and accessed through private providers and insurance (Castañeda and Mulligan, 2018; see also Bellanger & Palier, in Fassin & Hauray, 2010, p. 306; Danzon, 2004).

In the socialist countries of the Soviet Union and central/eastern Europe, and in the communist states of China and Cuba, the story of universal healthcare had a radically different trajectory from that of industrialised, capitalist states, where it emerged out of concerns to subdue socialist politics (Birn et al., 2017; Brotherton, 2012; Kirk, 2015; Michaels, 2003; Feinsilver, 2010; Grant, 2017; Solomon, 2017; Vargha, 2018; Whiteford and Branch, 2008; Zhou, 2017, 2020). Despite a greater focus on social medicine and the socio-economic determinants of ill-health, and sharp critiques of the healthcare reformism of the capitalist west, at mid-century the two systems shared, at least in some places, a conceptualization of the social contract between state and citizens as including the provision of universal health care throughout the lifetime (Iacob and Bogdan, 2022; Vargha, 2018). The many varied national and global trajectories of socialist health care form a vital aspect in the history of 'health for all', one which unfortunately lies beyond the remit of this special issue. The same is true for aspirations towards 'health for all' in Latin America, where social medicine in particular has a long history, in contexts where states rarely sufficiently addressed poverty and inequality, despite the development of social protection systems from the 1920s (Birn and Muntaner, 2020; Waitzkin et al., 2001; Brearley, 2016).

Whether insurance or tax based, health systems around the globe remain selective in terms of coverage. Historically, in western industrialised nation states, citizens' social rights and moral duties co-developed within inegalitarian, imperial economies. While welfare arrangements of the late 19th and mid-20th century sought to develop 'protection' against natural, social, economic and work 'risks' under capitalist modernity, using the language of solidarity and liberal rights (Donzelot, 1994), they did so only outside the colonies and their exploitative structures, palliating the risks of industrial capitalism primarily for a white, metropolitan citizenry, and only partly so.

In the colonized world, aspirations for healthcare and welfare, although forcefully articulated in many places under colonial rule, only gained sustained political traction in newly independent states (Cooper, 2014). As formal colonialism was replaced by independence from the late 1950s, newly independent citizenries hoped for a protective state that would make health and health care one of its core social projects (Chakrabarti, 2013; Prince and Marsland, 2013; Geissler, 2014; Tousignant, 2018; Geissler and Tousignant, 2020; Bagchi, 2022). Such hopes were given impetus by the Universal Declaration of Human Rights (1948) and by an optimistic belief that formerly colonized countries would be able to implement their own visions of progress. In line with the dominant ideologies of state-led healthcare and development at the time, the 1960s and 70s were a period of state investment, funded by loans from the western and eastern blocs. But interventions focused largely on urban and tertiary healthcare infrastructures. Rural healthcare remained fragmentary and basic; in many African countries, it was provided largely by religious mission organisations. Beyond national governments, international health efforts focused almost entirely on targeted disease and vaccination programmes (Packard, 2016).

Out of this situation, the Alma Ata conference and Declaration of 1978 stood as a moment of change, as governments committed themselves to the comprehensive goal of primary health care, to be realised by including the views and needs of people and communities in a participatory manner - health "by the people". Promoted by the USSR and hosted in the Soviet republic of Kazakhstan, the Alma Ata Declaration constituted a point of temporary convergence between polar Cold War visions of justice in health (Brown et al., 2006, 2019; Chorev, 2012; Birn and Krementsov, 2018). But the primary health care movement faltered due to inadequate financing, lack of consensus concerning what PHC should be, and naive ideas of what communities are and how they function. Resources remained focused on urban centres and governments did not seriously address lack of access to basic needs, like clean water, housing or nutrition (Justice, 1986; Packard, 2016). Although primary healthcare systems were developed locally in this period (Packard, 2016, p. 246; Beaudevin et al., 2022; Gaudilliére et al., 2022), these were rarely successfully scaled up. From the 1980s, structural adjustment policies were imposed on governments of the 'developing' world in the form of spending cuts, privatization of healthcare, and the introduction of user fees, effectively shrinking public healthcare infrastructure (Turshen, 1999; Jaffre and Olivier de Sardan 2003; Foley 2009; Pfeiffer and Chapman, 2010; Pfeiffer, 2014). With the end of the Cold War, this neoliberal hegemony became further entrenched. Many national health systems turned away from the aspirations of expansive and inclusive public health services embodied by the Alma Ata Declaration (Prince and Marsland, 2013).

Approaching the present, the austerity policies imposed on Latin American and African countries in the 1980s and 1990s prefigure developments in Europe during the past 15 years (Kehr, 2018; Knight and Stewart, 2016; Powers and Rakopoulos, 2019; Rakopoulos, 2018; Ribera-Almandoz, Olatz, and Mònica Clua-Losada, 2020). Here, substantial cuts have been imposed in national health care systems, with public resources channeled towards private providers (Harrington, 2009). This has been a significant move away from universalism and inclusion towards the marketization of healthcare. Meanwhile, Europe's borders and its politics of inclusion have become more volatile or openly hostile, reinforcing increasingly differentiated health policies and practices. Vulnerable groups, including economically precarious immigrants and undocumented migrants are subject to further exclusion, as they become the targets of partial measures rather than full coverage and inclusion (Mladovsky, 2022; Probst, 2022). Both trends have been met with intensified healthcare activism, even where the effects of this on shaping policy remain to be seen (Pushkar, 2019; Sahraoui, 2020).

Thus, while the aspirations, political rhetoric and language of the Alma Ata declaration, including concepts such as solidarity, inclusion, social justice, and health as a human right, continue to circulate, particularly among activist groups like Global Health Watch, much of current global health policy and financing remains focused on market-based approaches to healthcare. These distinctively imagine healthcare as a commodity. The solutions and planning approaches promoted are primarily technical, often delivered not through governments but through public-private partnerships, philanthropic funders, and NGOs, while health care in general is left to be delivered through privatization and market competition (Birn, 2014; Erikson, 2015; Hunter and Murray, 2019). While this hegemony has not gone unquestioned and has been accompanied by alternative models and political contestation in many places, it remains the dominant framework of healthcare policy (McGoey, 2014; Farmer et al., 2013; Keshavjee, 2014; Schrecker and

Clare, 2015).

An example of these contradictions can be seen in the 'universal health coverage' (UHC) agenda, which increasingly dominates contemporary discussions about 'health for all'. Promoted by the WHO and World Bank, and incorporated into the Sustainable Development Goals in 2015, UHC proposes a situation where "everyone has access to the healthcare they need without suffering financial hardship" (Rodin and de Ferranti, 2012; World Health Organization, 2010; 2015). UHC initially appeared to buck the neoliberal trend, as it positions healthcare as central to the social contract between citizen and state, appearing to embrace progressive goals of social justice and equity, and the need for more comprehensive, universal, inclusive health systems (Chan, 2012; Lancet Editorial, 2012; Medcalf et al., 2015). However, the argument that healthcare costs should not create "financial hardship" neatly skirted issues of free, subsidised, and primary healthcare (Evans and Ariel Pablos-Méndez, 2016; Stigler et al., 2016). There is ample criticism of the neoliberal cooptation of UHC, its technical "delusions and dilutions" (Birn and Nervi, 2019), which point to the lack of clarity about terms such as "universal", "coverage" and "health/care" and the ways its language of progressive universalism masks crucial issues of social justice, including forms of exclusion and differentiation, as well as the quality of care (Prince, 2017; Abadía-Barrero et al., 2019; Kittelsen and Fukuda-Parr, 2019; Prince, 2020a; Muinde and Prince, 2022). While initially appearing to interrupt the neoliberalisation of healthcare in the global south, in many cases UHC policies have seemed to foster it, promoting not an expansion of healthcare but a continued marketization (Oxfam, 2014).

## 3. Iterations of 'health for all'

Authors of this special issue ask, from their respective historical and ethnographic fieldsites: how have universalist aspirations to 'health for all' been put into practice locally, with which limitations, debates, exclusions and disappointments, but also hopes and desires? How have these visions fed into arguments about what is necessary for healthcare to be accessible and just? The articles collected here examine how 'health for all' has been imagined and attempted in Africa, Europe and India from the 1960s to the present, and also which exclusions accompany its aspirations. The case studies attend to the situated particularity of 'health for all', which resist a homogenization of this universalist approach. As anthropologist Lila Abu-Lughod argues, writing about particularity does not mean to "disregard forces and dynamics that are not locally based". (Abu-Lughod, 1991, p.150). Rather, our collection underlines how the "effects of extralocal and long-term processes", be they global technologies, international economics, or national health policies and programmes, "are only manifested locally and specifically" (ibid.). In this vein, authors explore firstly how 'health for all' has been and is imagined to be, and what it might engender or leave behind. Secondly, authors examine the programmes, infrastructures, technologies and innovations, state-market relations, models of citizen consumers, and imaginaries of the public through which diverse actors have attempted to realise 'health for all' on the ground. Thirdly, authors make us aware that imaginaries and attempts to implement 'health for all' also produce exclusions and marginalizations. Below, we discuss the contributions to these three arguments in turn.

### 3.1. Imaginaries and aspirations

A major theme connecting articles in this collection is a focus on the language, discourses and debates that circulate around aspirations for universal health care, the hopes attached to them, and what these might produce in terms of solidarities, relations and collectives at different scales. How have these aspirations been translated, and what frictions and tensions do they engender? While there is a clear emancipatory impulse here, authors also ask how differently positioned individuals and groups have experienced such universality, and to what extent it has concealed, or been used to conceal, the pursuit of power and privilege. From their respective historical and ethnographic locations, contributors also attend to different local experiences concerning access to healthcare and the questions people raise about what forms justice and solidarity might take, what these terms might mean, and how these goals may be reached.

Kehr's study discusses how healthcare activism in Spain emerged as a pursuit of safeguarding the country's universal public healthcare system, one that is accessible to all. Against the backdrop of a democratic welfare state that emerged in the late 1970s, the introduction of neoliberal policies is considered by activists as a destruction of national healthcare as a public good. Using a moral economy approach, Kehr uncovers the healthcare desires, demands and aspirations of healthcare activists and ordinary citizens, amidst popular moral visions of the state, the public good and the political economy of healthcare. Activists accuse the state of failing the country's universal public healthcare, and consider austerity measures and privatization as illegitimate, illegal and unfair (Kehr, 2022).

From the perspective of memories and historical experiences, Bannister's (2022) contribution explores understandings of fairness in Ghana's past and present national healthcare. Here, notions of fairness vary widely amid competing visions of national healthcare as a public good, manifested across the divergent experiences of different generations since Ghana's independence. While the younger generation frames fairness in terms of rights, older generations compare the immediate independence period of free healthcare with the introduction of structural adjustment policies and the present period in moral terms. Across different generations, historical experiences in terms of modes of paying for healthcare shape competing memories, contemporary perceptions, understandings and aspirations for a just state healthcare system.

With a focus on Senegalese attempts to expand social health insurance through community mutual health organisations (*mutuelles de santé*), Wood's (2022) article examines how improvisation emerges as people wait (hopefully) for state funding. The government of Senegal introduced community-based health insurance in 2013 but has failed to keep its promise of financing *mutuelles,* and enrolment rates remain low. Volunteers who run the *mutuelles* must improvise alternative forms of funding, which they do by seeking precarious forms of patronage from wealthy local people and partnerships beyond Senegal, while artfully drawing upon local values of solidarity. While precarious, such forms of improvisation maintain hopes for more inclusive public healthcare as the *mutuelles* wait for government funding to arrive.

In Kenya, Muinde and Prince (2022) explore how 'ordinary citizens' (*mwananchi*) experienced and evaluated recent moves by the government to expand access to healthcare, which included reforming national health insurance coverage and offering free healthcare services. These developments, clothed in a language of universality and solidarity, generated hopeful expectations for more inclusive healthcare. Yet they encountered a historically fragmented healthcare system, shaped by forms of exclusion and differentiation, a politics of patronage, and class inequalities, all of which worked against universal access. Contradictions between promises of inclusion and realities of exclusion drew people's attention to entrenched forms of neglect, failure, and differentiation, leading them to raise questions about rights to healthcare, state responsibility, solidarity and growing class inequality (Muinde and Prince, 2022).

### 3.2. Partial realizations

Contributions to this special issue also explore the programs, infrastructures, technologies and forms of innovation through which diverse actors have attempted to realise 'health for all' at different historical moments and in different geographical locations.

The historiographic article of Beaudevin, Gaudillière and Gradmann (2022) on primary health care programmes argues that the often-idealised understanding of Alma Ata as the origin myth of 'health

for all' is a retrospective vision that is historically problematic. By showing how PHC materialised differently in Oman, Tanzania and Kerala, India, their article engages with its highly diverse local roots, displacing hegemonic narratives as seen from the WHO headquarters in Geneva. They argue that the roots of 'health for all' policies reside in regional and national practices of PHC rather than in an international Cold-War policy, and that not only ruptures but also continuities with the neoliberal era can be observed.

In a similar vein, but on the topic of centralised planning and financing, Gorsky and Manton's (2022) contribution looks at how aspirations to 'health for all' have been implemented in the WHO AFRO region, from beginnings in the 1950s up to the 1980s, where there was some limited availability of healthcare provision. The authors show how a historiographic analysis of efforts to widen access to healthcare in the AFRO region decenters WHO's Geneva-based history and deemphasizes Western agency, showing how important regions were in taking situated actions for planning and financing health system development broadly understood, with important regional and national discretions at play.

Also prioritising local experiences in Zambia, Wintrup (2022) looks at one particular program central to aspirations of 'health for all' from Alma Ata to the present, namely community health work. He shows how several 'failures' of earlier CHW programmes have been repeated and lessons lost, due to an orientation towards technofixes rather than social policy, as well as a lack of community participation and the unclear role of community health workers in local settings. He thereby argues for the importance of anthropological studies which follow what does and does not work on the ground, in order to imagine better working programmes and community involvement for the future.

Health system development and the setup of primary healthcare and community health worker programs have been central to efforts to expand access to healthcare in Africa and India. In the last decade, approaches to 'health for all' through digital technology have become more prominent in both regions (see Duclos, 2021). Using the example of a novel digital primary healthcare program in West Bengal, where health assistants work as entrepreneurs in marginalized communities, Bärnreuther (2022) shows how a novel entrepreneurship business model promises alternative models of financing healthcare through the market, while also depending on government funding as well as individuals willing to work under precarious conditions. Her case study shows the affordances of entrepreneurship for particular individuals, but also foregrounds the limitations of an approach in which technology is said to be used for the profit 'of all', while economic profits actually benefit only a few.

While Bärnreuther's contribution foregrounds the possibilities and frictions of novel digital health programs in India, the article by Al Dahdah and Mishra (2022) shows how the Indian state is increasingly making access to healthcare conditional upon digital technologies, like an e-health smartcard, a fact that is at odds with what beneficiaries actually want and need: namely nearby and accessible basic healthcare and welfare services. The authors argue that such digitalization of healthcare and welfare is part of a larger trend towards expanding private healthcare markets in the Global South and beyond, in which attempts to expand coverage are accompanied by an expansion of healthcare markets for profit.

Shifting focus from markets and the state to the desires and imaginaries of medico-scientific actors in the realm of digital diagnostics in Tanzania, Neumark (2022) shows how important digital approaches are for envisioning future health in low-resource settings in efforts to create better healthcare for all. Following urban Tanzanian technologists as they experiment with developing more accessible and practical digital diagnostics for rural populations, he argues that aspirations for expanding healthcare infuse their motivations, reflections and choices concerning accessibility and social relations.

### 3.3. Exclusions

While universal imaginaries, as well as expansive programs, infrastructures and technologies have been central to attempts to realise health for all across the globe from the 1950s to the present, not all communities and individuals have been included equally in such attempts. On the contrary: exclusions, blind-spots, marginalizations and thus absence of healthcare persist in many places and are the focus of the remaining contributions to this special issue. Such exclusions and marginalisation along lines of race, ethnicity, class and gender are often encoded in universalist policies and programmes that nevertheless favour certain individuals and groups over others (Fassin, 2009; Marsland and Prince, 2012; Kehr, 2016; Sahraoui, 2020; Sargent, 2012).

Probst (2022) shows how migrant sex workers from European countries experience and negotiate exclusions from health insurance in Berlin, Germany. Seen from this vantage point, healthcare is no longer a right, but a privilege available only for those conforming to narrow ideas of European citizenship. She thereby reveals a highly restrictive and moralised notion of citizenship at the basis of the German health insurance system, and its underlying racist, classist and gendered assumptions about deservingness and belonging.

In a similar vein, the contribution by Mladovsky (2022) shows the multiple coverage gaps in mental healthcare services in the United Kingdom. She looks at how marginalized and vulnerable refugees and undocumented immigrants become excluded from mental health care, despite being formally covered within a national health service and despite medical professionals' good intentions. She lays out how social triage and differential racialization plays out in healthcare structures on the ground, leading to informal and contingent coverage. She thereby asks about deservingness in comprehensive healthcare systems and, similarly to Probst, questions whether healthcare is truly a right, or not rather a gift that some, but not all, receive.

Brown and Bryder (2022) analyse the shorter life expectancy of Maori communities in New Zealand, despite the existence of a universal, taxpayer funded health system that is, in theory, universal in access. They show that collective attempts to reduce inequity in health outcomes have had little practical results so far, because universal healthcare largely means healthcare provided for the White majority. This fact has been understood since the 1980s as resulting from colour-blind, universalist principles of the welfare state, but little progress has since been made to actually change determinants of health for Maori, which continue to lie outside of the purview of New Zealand's health system.

LaRusso et al. (2022) shift our attention to the United States, where families with children suffering from a poorly understood condition, Pediatric Acute-Onset Neuropsychiatric Syndrome, struggle for access to diagnostics and care. In a system where coverage is highly marketized and where sufficient individual financial resources are needed to access healthcare, they provide an example of coverage exclusions, not only due to limited notions of citizenship, but also due to medical ignorance or blindness concerning emergent conditions. They argue that attempts to expand coverage do not equal aims for universal care, and argue that rather than a rhetoric of expansion, a rhetoric of solidarity should be put forward to achieve "health for all", based on a comprehensive approach to care rather than a notion of coverage.

In all four of these contributions, the reference to 'all' in 'health for all' is never a neutral and inclusive category, a fact that is best understood when working "from the margins" (Tsing, 1994), be it the margins of states, imagined communities or marginal pathologies.

## 4. Conclusion

The contributions to this issue explore 'health for all' through historical and ethnographic methods. Both approaches understand 'health for' all as a situated, multi-faceted phenomenon, that - while having a shared aspiration towards universality of access and equality of care - comes into focus in partial, diverse and contentious policies,

programmes, projects and practices. A fine-grained attention to the dynamic making and unmaking of relations, networks, collectives and solidarities that are generated in its pursuit, and to embedded forms of power and authority, become visible through such historical and ethnographic approaches as well.

The special issue thus highlights the diverse iterations that 'health for all' has taken on the ground for different subjects and groups of people, bringing attention to the nuances of individual and collective stories and desires, beyond homogenising narratives that frame 'health for all' in terms of either celebrative universalism or outright failure. While offering a strong critique of the marketization of health and its unjust outcomes, the contributions push the discussion beyond these familiar narratives through attention to complexity as well as to situated social action (see Closser et al., 2022; Kielmann et al., 2022). They offer insights into the diverse and layered histories within which systems of healthcare provision in various localities have travelled in distinct ways. They also take seriously the legacies of past aspirations that may remain cherished and are available to be reworked, attending to what they may engender beyond their immediate or long-term goals. These include infrastructures and bureaucracies, habits and routines, forms of expertise and identities, collectivities and international networks, as well as ideals such as equality, rights, social justice and solidarity, and imaginations of what could be or should be different.

The situated stories and histories presented here are meant to generate debates about the future direction of healthcare. They offer nuanced perspectives, necessary to evaluate policies and practices in terms of their inclusionary or exclusionary, just or unjust effects. They make us aware of current and historical blind-spots as well as exclusions that favour some people and policies over others. The larger question for our common futures remains whether it is at all possible to achieve egalitarian systems of accessing, giving and receiving healthcare, fundamental to our collective wellbeing, within capitalist, neoliberal and neocolonial systems. This question remains open, in our view. 'Health for all' both implies and requires continuous political struggle, and aspirations for 'health for all' have always been tied to larger political questions about the kinds of societies we wish to live in. Our special issue itself arises from this wider politics of hope. Beyond naive proclamations of 'health for all' as an easy road to travel, the articles collected here underline the continued traction that collective and inclusionary visions of healthcare have for many people across the world.

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