



Universal Health Coverage & The experience with Publicly Funded Health Insurance (PFHI)

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Political Declaration of UN-HLM on UHC , Sept. 2023

PHM welcomes many features of the declaration but notes that Progress is NOT on course to meet objectives of UHC 2030

1. Coverage of services stagnates- since 2019
2. Worsening of financial protection- increased impoverishment due to healthcare
3. Setbacks to most disease control programs too due to covid and other reasons

PHM understanding:

- Not poor implementation- but poor strategies and inadequate budgets.
- In formal policy-text UHC is not equated with insurance and privatization, and there are also formal denials – but *de facto* across most LMICs, introduction of “PFHIs” have become the major feature of UHC.
- Fragmentation- integration of UHC with the vertical disease control programs is also weak.



PHM's caution, 2012

Quote from Call to Action Adopted at Third Peoples Health Assembly, Cape Town, on July 12th, 2012:

“ While we welcome the recent surge in interest in the concept of universal health coverage, we oppose the idea that this be achieved through the promotion of a **minimalistic insurance model** that would offer **‘basic packages of care’** and would operate within a **market-based system of healthcare**. We oppose attempts to use this approach to **dismantle or undermine the public health system** to **promote corporate interests** in health care delivery. Universal health coverage must be achieved through organized and **accountable systems** of **high quality public provision** of **comprehensive primary health care** and of a **fully functional referral system governed by need of care.**”



PHM's caution- 2023 on the UN political declaration

“ Behind the flow of rhetoric around UHC is a deep tension between two models of healthcare delivery:

universal access to healthcare through publicly funded and publicly administered healthcare services

versus

'universal coverage' (meaning publicly sponsored health insurance with *strategic purchasing* of a 'basic package of essential services' from a mix of service providers) complemented by a market place of private health insurance plans and private providers for services beyond the package.”



Problems of PFHIs in LMICs

ACCESS

1. **Availability a huge problem**- same premium for all- but facilities and services are in urban areas. (Philippines- India- most African nations)
2. **Mandatory premium approach** covers too small a package- and 60% unable to sustain contribution- or afford a second package: (The South Korean/Croatia problems,)
3. **Rationing Care**- Budget is fixed and can pay for only a limited number of procedures- denials disguise the rest
4. **Not an Entitlement**: Cherry-picking: Empanelled hospital does not offer care to all who are eligible. Impossible to enforce access as an entitlement with pvt providers
5. **Eligible but not Registered**: a Significant proportion of eligible population fail to get registered or are unaware of benefits.

FRAGMENTATION

- **No Coverage** for
 - ambulatory care at secondary and tertiary level
 - primary healthcare coverage,
 - rehabilitation and palliative care
- **In secondary and tertiary care**- limited to select procedures within a treatment plan- eg bypass surgery- not coronary artery disease.
- **Referral linkages weak** and no accountability for continuity of care...at same level or between levels.

POOR REGULATION

1. **Double-billing and over-billing**- many studies show unabated catastrophic health expenditure and a discount price instead of cashless services
2. **Provider induced utilization**- high level of unnecessary procedures-eg *hysterectomies, knee replacements*, often leading to reservation to public providers.
3. **Weak regulatory environment**- problems of quality and fraud

PFHIs funding of public providers

Developing trends in India.

EARLIER SCENARIO

- Hire insurance agencies to empanel hospitals, process claims & payments
- Select insurance agencies based on lowest quote for premium.
- PFHIs focus was on recruiting private providers- most of the utilization went to private providers .
- Public Services funded by line-item budgets- often inadequate and rigid

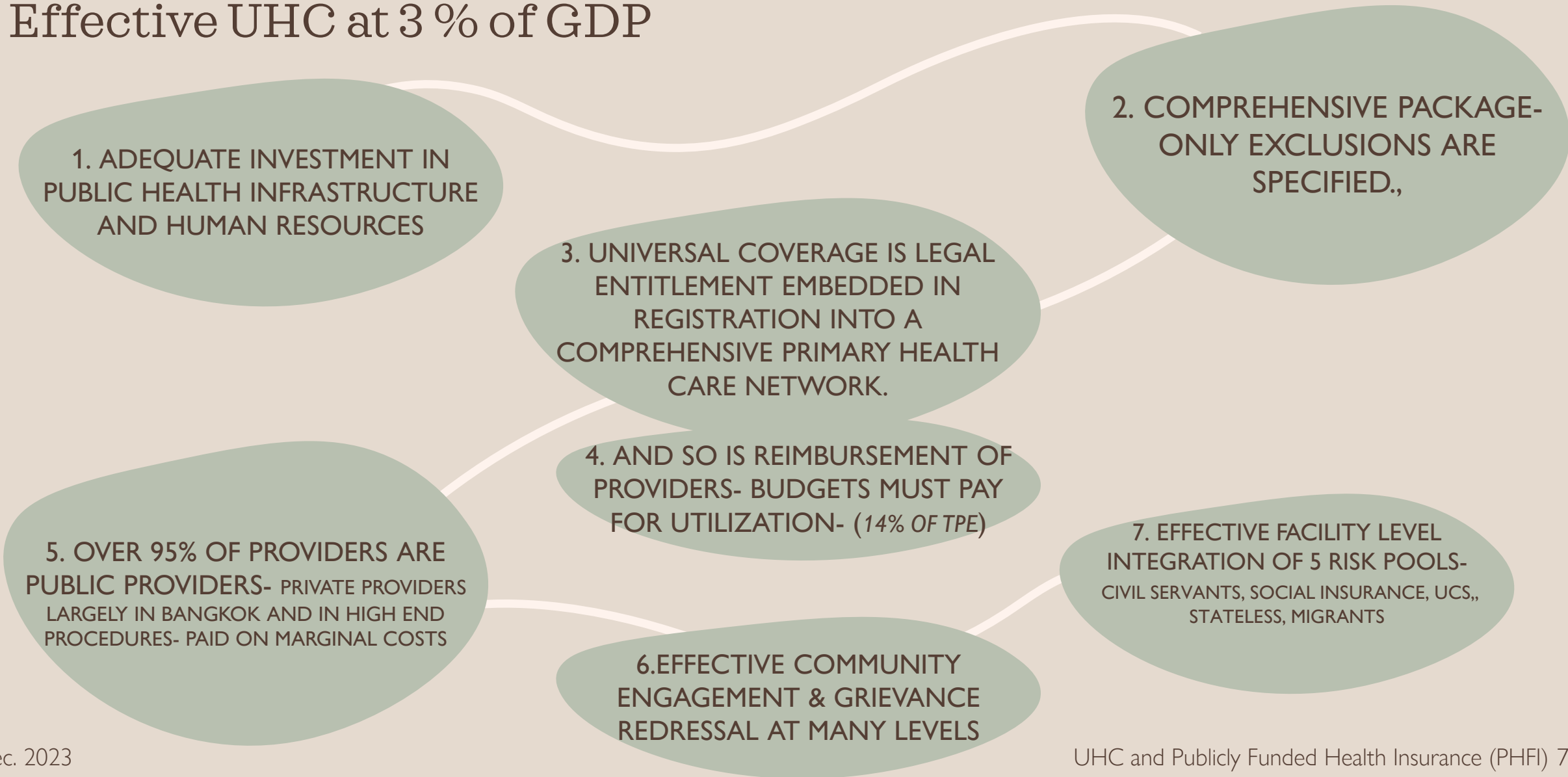
DEVELOPING TRENDS (IN A NUMBER OF STATES)

- Shift to assurance mode-no insurance company- managed directly by semi-autonomous govt body- or hybrid of insurance and assurance.
- Associated with high cost-over-runs-.
- Increasing reservation of packages to public provider
- Increasing exit of private providers- marginal costs vs price foregone

IS THIS MODE OF FINANCING DESIRABLE?

- PROs: Decentralized flexible funds, Increased volume, quality and mix of public services, stabilizes prices in the private market, builds institutional managerial capacity, has promoted digitization and e-records.
- CONs: greatly increase administrative work, expanding services without staff and infrastructure- adverse impact on health workers and quality of care; introduces commercial behaviors into public services, exclusions on identity basis threatens....

The Thailand Universal Coverage Scheme (UCS) Outlier-Effective UHC at 3 % of GDP



Designing Health Insurance for UHC: 6 directions of change

PROVIDERS

Strengthen public health services & not for profits- purchase from private sector to supplement in critical areas; better regulation in private sector.

PACKAGES

Move towards assured comprehensive services- only exclusions need be justified. HTA valuable for choice of technology- not for selective care.

PAYMENT MECHANISMS

Ring fence clinical decisions from monetary incentives- move away from fee for service to “requirement responsive” global budgets

BUDGETS

Tax Based: Reimburse all providers the costs of services they have provided-: will need tax reforms and larger outlay- but it is affordable

INTEGRATION

Organizational strategies to ensure continuity of care, public health integration and community engagement

CORE VALUES

Healthcare as Public Goods: Based on Trust & Solidarity- Not as market commodities



thank you

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