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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. Fragmentation- integration of UHC with the vertical disease control programs is also weak.

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.

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 and make payments
- Select insurance agencies based on tendering process- lowest quote for.
- 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

- 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 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

1. ADEQUATE INVESTMENT IN PUBLIC HEALTH INFRASTRUCTURE AND HUMAN RESOURCES,

2. COMPREHENSIVE PACKAGE- ONLY EXCLUSIONS ARE SPECIFIED

3. UNIVERSAL COVERAGE IS LEGAL ENTITLEMENT EMBEDDED IN REGISTRATION INTO A COMPREHENSIVE PRIMARY HEALTH CARE NETWORK.

4. AND SO IS REIMBURSEMENT OF PROVIDERS- BUDGETS MUST PAY FOR UTILIZATION- (*14% OF TPE*)

5. OVER 95% OF PROVIDERS ARE PUBLIC PROVIDERS- PRIVATE PROVIDERS LARGELY IN BANGKOK AND IN HIGH END PROCEDURES- PAID ON MARGINAL COSTS

6.EFFECTIVE COMMUNITY ENGAGEMENT & GRIEVANCE REDRESSAL AT MANY LEVELS

7. EFFECTIVE FIELD LEVEL INTEGRATION OF 5 RISK POOLS- CIVIL SERVANTS, SOCIAL INSURANCE, UCS,, STATELESS, MIGRANTS

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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