

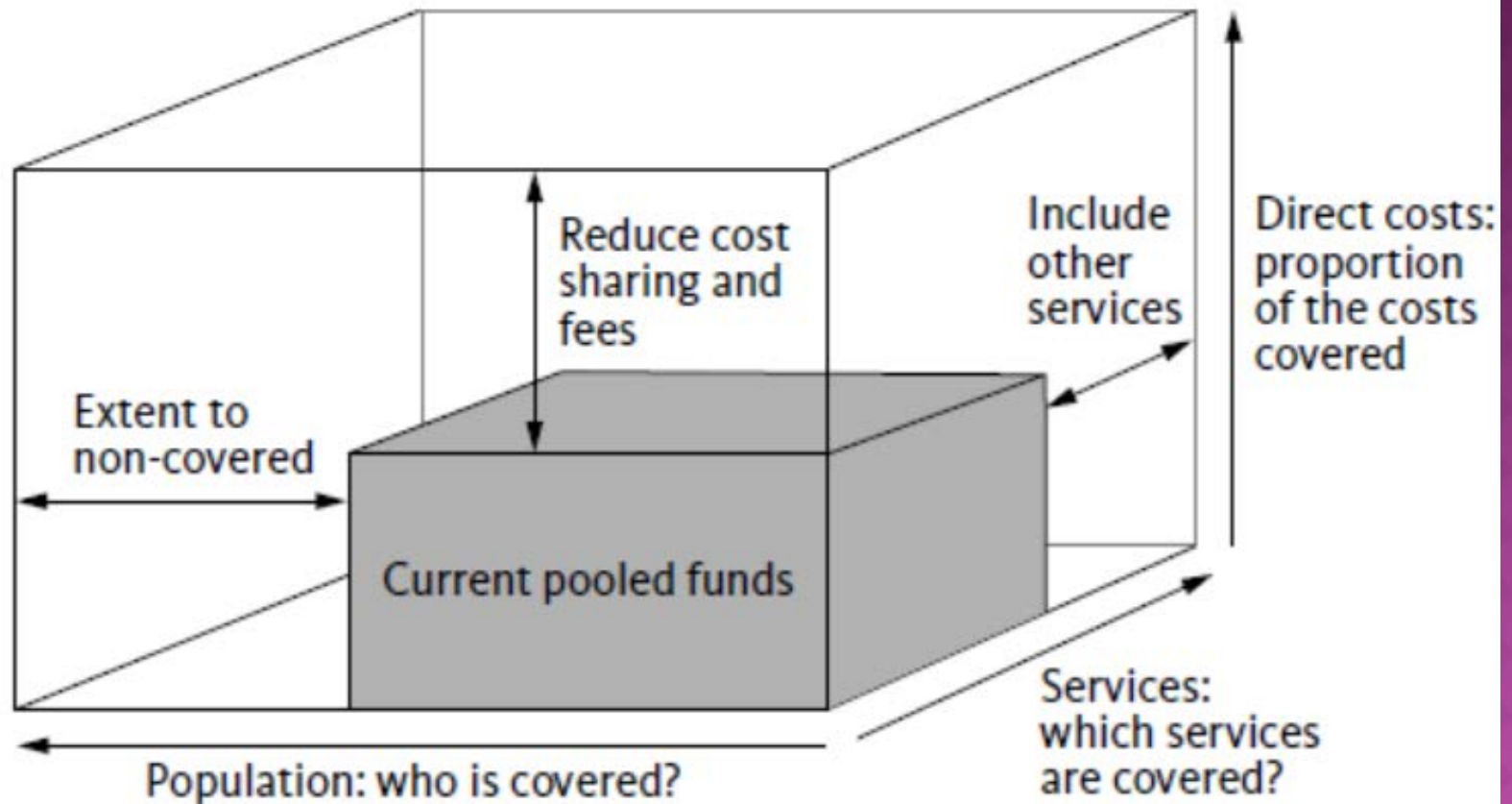
PRIMARY HEALTH CARE AND UNIVERSAL HEALTH COVERAGE: UNDERSTANDING THE CHANGING DISCOURSE AND DIRECTION OF HEALTH SECTOR REFORMS

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PHM-IPHU on Action for Equitable Health Systems: Advancing
Comprehensive Primary Health Care in Pandemic Times

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UNIVERSAL HEALTH COVERAGE



Evolution of UHC

INITIAL PHASE

- ◉ World Bank's 'Investing in Health' report in 1993- stratified health insurance, private/voluntary healthcare delivery, tax-funded 'benefits package'
- ◉ **World Health Report 1999** Making a Difference - New Universalism
- ◉ Executive Board December 2004 document on 'Social Health Insurance' - Pressure by USA and World Bank to include "health insurance"
- ◉ First mentions of UHC- **WHO EB Resolution A58.33 (2005)** calling on member states to 'ensure that health-financing systems include a method for prepayment of financial contributions for health care' to share risks, avoid catastrophic health expenditure and impoverishment

- ◉ International agencies rallied behind UHC in response to rising catastrophic health expenditure and impoverishment due to debilitating impact of SAPs on public health systems and increasing privatisation.
- ◉ **BUT** instead of strengthening public health systems, discourse shifted from how services should be provided to how services should be financed (under UHC).
- ◉ WHO (M Chan 2006) shifted from primary health care to an increasing focus on universal health coverage.
- ◉ **World Health Report 2010 Health Systems Financing: The path to universal coverage** - Strongly influenced by World Bank; framework that normalised role of private providers and private health insurance in healthcare delivery

UHC: 2015 ONWARDS

- ◉ **SDGs- UHC** became one sub-target (3.8); No mention of PHC
- ◉ Initial UHC indicator - “Number of people covered by health insurance or a public health system per 1,000 population” changed to “Proportion of population with large household expenditures on health as a share of total household expenditure or income” through civil society action
- ◉ UHC-2030 (multistakeholder org) formed in 2016
- ◉ UN HLM on UHC 2019
- ◉ Upcoming UN HLM in 2023

GLOBAL CONFERENCE ON PHC FROM ALMA-ATA TOWARDS UHC AND THE SDGS (ASTANA DECLARATION) 2018

- ◉ UHC as a financial strategy and social protection mechanism became “a fait accompli” and a broader development goal to pursue, to which PHC was relegated a supporting role.
- ◉ Definition of PHC as care at the first level of contact with the formal health sector

What becomes evident:

- ◉ Lack of coherence in how WHO and public health experts see the interrelation between UHC and PHC
- ◉ UHC is a sharp divergence from comprehensive PHC approach

Key concepts in the UHC discourse

- ◉ **New Universalism** - a belief that in healthcare provision the ownership and nature of provider (private or public) do not matter and instead efficiency, quality, competition, and provision are key (World Health Report 1999- Making a Difference)
- ◉ **Provider-purchaser split** - Private sector to provide services and government's main role would be in regulation, stewardship and funding

- ◉ **Strategic Purchasing** - “Purchasing” or “contracting” services from private providers seeks to mitigate the market failure and also seen as a way to regulate them in LMICs (World Health Report 2010-Health Systems Financing: The path to universal coverage)
- ◉ Emphasis on (single payer) **public financing** but not on public provisioning

WHAT IS THE PROBLEM WITH THIS?

COVERAGE VS CARE

"The term coverage rather than care either suggests a limited scope of care or is being used to suggest enrolment in an insurance scheme.....Involving the for-profit private sector in providing health care has allowed for funding imbalances and provider capture, with more funds from these public schemes going into the private health sector, thereby reinforcing existing health inequities. Insurance-based models of UHC risk being promoted at the expense of funding PHC and other public health programmes." (Sanders et al 2019)

Focus on financial risk protection and service coverage, while neglecting other crucial elements of a health system. Eg. health workforce

UHC in implementation

STRATEGIC PURCHASING FOR UHC THROUGH PUBLICLY FUNDED HEALTH INSURANCE SCHEMES: KEY CHARACTERISTICS (1)

- ◉ New wave of insurance schemes different from social health insurance in HICs
- ◉ Rationale: To reduce financial burden on healthcare expenditure through efficiency, quality, competition (for providers), choice (for people)
- ◉ Explicit objective of favoring/engaging the for-profit private sector or promoting commercial interests
- ◉ Over-reliance on digitalization and information technology (IT) systems
- ◉ BUT most models non-transparent and lack public accountability

STRATEGIC PURCHASING FOR UHC THROUGH PUBLICLY FUNDED HEALTH INSURANCE SCHEMES: KEY CHARACTERISTICS (2)

- ◉ Strategic purchasing agency operating outside Ministry of Health, with participation of corporate/for-profit private sector and global actors. Eg. National Health Authority in India; Philippine Health Insurance Corporation
- ◉ Support by global actors (eg. Gates Foundation), global health academia, and global institutions (eg. WHO, World Bank, ADB) on developing capacities for “strategic purchasing”
- ◉ Failure of PFHI schemes is seen mainly in its dominant model of “purchasing” clinical care from the for-profit private sector. Experiences of countries such as India (AB-PMJAY), Indonesia (JKN), and Philippines (PhilHealth) exemplify this.

What have been the
consequences of PFHI
schemes for people and
health systems?

UTILISATION

- ◉ Utilisation increased in some schemes, but it has been inequitable
- ◉ Inequitable access based on geography, regions, rural-urban, and social groups (indigenous populations)
- ◉ Pattern of unnecessary procedures, tests and drugs under insurance. Eg. Hysterectomies, C-section in India
- ◉ Selective services being provided, especially by for-profit private providers who engage in cherry picking
- ◉ Large number of needs remain unmet. For e.g. injuries, chronic diseases

Private provisioning destroys any and all advantages of public funding

FINANCIAL PROTECTION

- ◉ Studies show such schemes have **not led to financial protection**. Eg. Indonesia, Philippines, Vietnam, Morocco, Kenya, Nigeria
- ◉ Mixed evidence from Ghana
- ◉ Most private facilities continue to **charge extra** despite insurance coverage promising zero co-payments
- ◉ Extra billing leading to **Out of Pocket Expenditure (OOPE)**

Evidence of government funded insurance schemes in Asian countries shows that there is coverage without financial protection

IMPACT ON PUBLIC AND PRIVATE HEALTH SECTORS

- ◉ Private providers are the biggest beneficiaries of such schemes as they get bulk of the claim amount
- ◉ Funds reduced for public sector
- ◉ Dual practice by government doctors- conflict of interest created and collusion between private and public sectors increased
- ◉ Provider and regulatory capture by the private sector seen in many countries
- ◉ Expansion of healthcare markets and increased commercialisation of healthcare

Insurance as mode of financing and incentivising hasn't worked in public sector and has exacerbated problems faced by people going to for-profit private sector

OFT-QUOTED SUCCESSES OF STRATEGIC PURCHASING: SETTING THE RECORD STRAIGHT

- ◉ Thailand portrayed as a successful “strategic purchasing” model
 - BUT Thailand’s health system neither relies on private sector provisioning, nor is it based on principles of “competition” and “choice”
- ◉ Costa Rica model resembles Thailand in terms of its reliance mainly on the public sector for provisioning (Hernández and Salgado 2014)
- ◉ Ghana relies mainly on faith based non-profit organizations

“Keep awakes”:
Recent developments in
UHC and PHC

“STRATEGIC PURCHASING” FOR PHC

- “Operational Framework for Primary Health Care” by the WHO and United Nations Children's Fund (UNICEF) that uses the same narrative of “strategic purchasing” for primary health care (WHO and UNICEF 2020)
- Walking the Talk: Reimagining primary health care after COVID-19 (World Bank 2021)
- The Lancet Global Health Commission on financing primary health care: putting people at the centre (2022)



Purchasing and payment systems

Delivery of integrated health services with primary care and public health at the core

Purchasing and payment systems that foster a reorientation in models of care for the PHC-oriented purchasing and payment systems aim at fostering the implementation of PHC-oriented models of care (see Section 3.1). When supported by adequate resource flows in support of PHC and driven by PHC-oriented models of care, purchasing and payment systems increase the accessibility of priority interventions to the entire population and the integration of services with primary care and public health at their core. Strategic purchasing – including benefits design, provider payment methods and contracting arrangements – can strengthen the PHC orientation of models of care and promote the integration of health services while advancing other health system objectives.

Health financing arrangements provide the fuel for health systems: they establish the amount of resourcing available and the way in which risks are shared among those who are ill and those who are well, the ways that funds flow through the system to frontline providers, and the payment systems that create incentives for providers. Together, these arrangements shape the equity, effectiveness, and efficiency of PHC. The way in which health systems are financed can also drive changes in how services are delivered—for example by encouraging new models of provision and service delivery that are more people-centred than existing models. The design of health financing arrangements is not merely a matter of technical decisions: it is also deeply influenced by the political, social, and economic contexts. Spending more on PHC means spending less (in relative or absolute terms) on hospitals and specialists, which might then be favoured by the growing urban middle class. Prioritising PHC therefore requires a societal consensus, as realised through a political process.

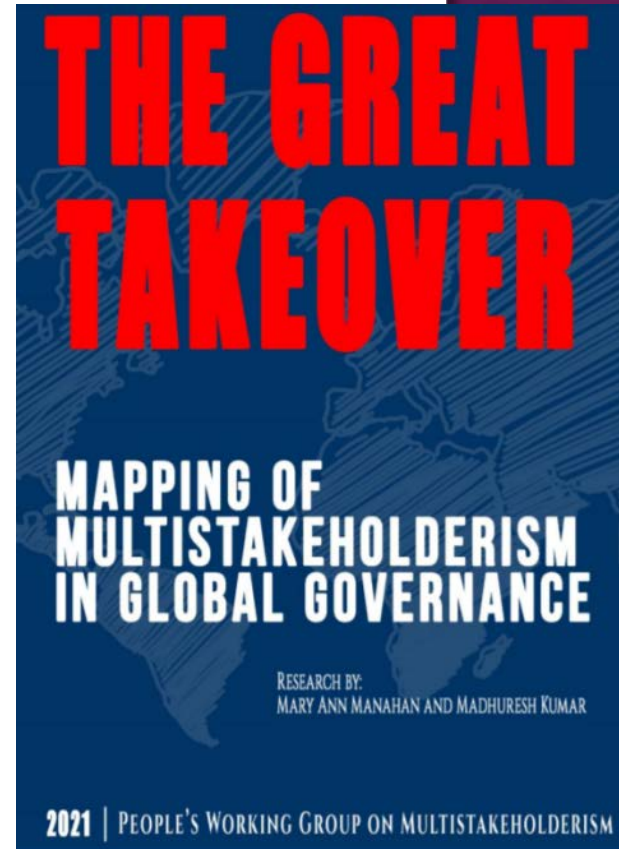
GLOBAL HEALTH GOVERNANCE

New systems of governance
(multistakeholder institutions)
being set up even at global levels
to pursue such interventions,
leading to corporate capture and
private interests in governance
mechanisms

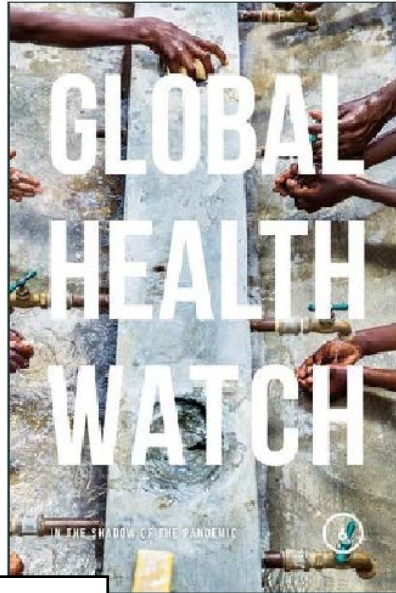
Eg. UHC2030

Influential Institutions: WHO; UNICEF (UN Bodies);
World Bank (IFI); World Economic Forum
(Business/Industry); BMGF (Philanthrcapitalist);
GAVI, Vaccine Alliance (Others); OECD etc.

Funded by IFIs/DFIs; Northern donor govts, UN
bodies



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WHAT CAN WE DO?

- ◉ **Remain vigilant** while documenting and scrutinizing the evidence and policy push towards PPPs, PFHI schemes, and other purchasing arrangements under UHC.
- ◉ **Examine and critique dominant narratives** that put profit before people and intervene wherever these dialogues get captured by the private sector, including in global institutions.
- ◉ **Demand higher public investment and strengthening of the public sector** to provide secondary and tertiary health services along with primary level health care, and strengthening regulation of for-profit providers.
- ◉ **Demand expansion of public employment**, especially in LMICs, which would be beneficial both for the workers and for society
- ◉ Scholars, academics, NGO workers, health activists and social movements must **build solidarity** around this issue

Thank You

