ENDING HOSPITAL DETENTION FOR NON-PAYMENT OF BILLS:

LEGAL AND HEALTH FINANCING POLICY OPTIONS

World Health Organization

HEALTH SYSTEMS GOVERNANCE AND FINANCING POLICY NOTE

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CONTENTS

Key messages

- **The position of the World Health Organization (WHO) is that no person should be detained in a hospital against their will for non-payment of bills and user fees. Nor should the remains of a deceased patient be withheld and not released for unpaid hospital bills and user fees.**
- The practice of hospital detention for non-payment of bills is contrary to international human rights laws and to universal health coverage (UHC) objectives.
- Deficits in the legal system and weaknesses in the health financing system can lead to uncompensated care.
- Legal options are available to end the practice of hospital detention for non-payment of bills and user fees, including: prohibiting the practice of hospital detention; recognizing international human rights in national legislation; committing to UHC in domestic laws; ensuring proper implementation and enforcement mechanisms; and establishing information and reporting mechanisms.
- There are short-term measures to address and prevent uncompensated care at the level of health care providers, including: mobilizing additional funding; creating a specific fund to cover high-cost treatments; expanding, adjusting or reviewing existing user fee exemption mechanisms; and adjusting enrolment conditions of existing health insurance schemes. In the long term, more substantive health financing reforms will be needed.
- Much greater attention is required both from country policy-makers and the international community on the need to ban hospital detention.
- It is necessary to raise public awareness on the issue of hospital detention and that the practice is illegal. At the same time patients have to be aware of benefit entitlements, co-payment requirements and exemption policies.
- The international community should provide specific support – including financial resources – to countries whose people suffer from hospital detention to assist in stopping the practice immediately.

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1. INTRODUCTION AND PURPOSE

Uncounted numbers of people are detained in public and private hospitals around the world for non-payment of hospital bills, despite the fact that hospital detention is both a human rights violation and inconsistent with efforts towards universal health coverage (UHC) (*1, 2*). Hospital detention for non-payment of bills occurs when hospital staff refuse to release patients after medical discharge is clinically indicated, because neither the patient nor their family can pay the bill. Another form of hospital detention is refusal by hospital staff to release the bodies of deceased patients to their families when bills remain unpaid (*3*).

Hospital detentions have been reported in various countries for some time (*4–6*). Data on hospital detention is not systematically collected, and thus there is limited evidence on the scope and scale of the practice and its negative impact on patients and their families. Available Studies indicate that hospital detention occurs mainly in health systems in low- and middle-income countries. Based on the limited academic research available, Yates, Brookes & Whitaker estimate that hundreds of thousands of people could be affected every year, mostly in specific countries in sub-Saharan Africa and a few countries in Asia (*2*).

It is clear that these countries are struggling to find practical solutions to end hospital detention, despite legal provisions prohibiting the practice and national commitments to work towards UHC. UHC means that all people receive needed health services of sufficient quality, without fear that access to those services will expose the user to financial hardship. The objectives of UHC include utilization of health services in line with need (i.e. equitable access), quality of health services and financial protection (*7*). The international community has committed to achieving UHC as part of the 2030 Agenda for Sustainable Development (*8*).

The purpose of this paper is to present options to help to end the practice of hospital detention for non-payment of bills and user fees. The paper first explains why the practice is contrary to international human rights laws and UHC objectives. It then explores legal and policy options that can be applied in the short/medium term to address the underlying causes of hospital detention, as well as broader law reform efforts to help to end the practice. Next, the paper discusses short-term health financing measures as well as broader long-term health financing reform options to prevent and address uncompensated care, with the aim to develop more sustainable financing mechanisms for health services.

The paper is based on a review of published articles and grey literature, including press articles, identified by searching PubMed and Google using the search term “hospital detention”. The literature review was supplemented with insights from WHO policy advisory and technical work on health financing in countries, and from a

self-administered questionnaire to WHO country offices. Overall, available literature on hospital detention is scarce; very few published articles were found, and relevant information was largely contained in newspaper reports.

The paper has an implicit focus on public hospitals in relation to health financing policy options, given that many private hospitals ask for an upfront payment or deposit before admitting a patient. The paper does not explore the issue of people not seeking care due to lack of financial means, nor the issue of denial of care. These issues require detailed exploration in a separate paper.

2. HOSPITAL DETENTION IS A HUMAN RIGHTS VIOLATION AND CONTRARY TO UHC OBJECTIVES

Detention periods can vary greatly from days to months and, in rare cases, to more than a year (*4, 9*). There are reports of detained patients being locked in a room or handcuffed to a bed. Detainees often have to rely on their families, or begging, for food (*9, 10*). There are also reports of highly abusive and degrading treatment during detention (*2*), including sexual abuse and psychological harm (*3*). For example, it has been reported that women have been pressured to have sex with hospital staff in exchange for cash to pay bills. (*2*). Hospital detention also has serious ramifications from a clinical viewpoint. It negatively impacts on the physical and/or mental health of detainees by exposing them to hazards due to, for example, overcrowded hospitals and increased risk of infection. It can trigger psychological trauma because of fear, the conditions of detention and the separation from family members (*3*).

Hospital detention directly conflicts with the objectives of UHC. It prevents patients from accessing needed health services for fear of detention, it is contrary to patient-centred quality care, it exposes patients to financial hardship and, through affecting the most vulnerable, it is contradictory to equity in service use. Hospital detention for non-payment of bills primarily affects the poorest and most vulnerable population groups which have the weakest voice. Women and children are disproportionality affected. In the case of women, medical detention for non-payment of bills can occur for deliveries and related complications. Hospital detention also happens in relation to high-cost treatments, such as cancer treatment for children (*5*). Furthermore, the practice of hospital detention can have a deterrent effect, by preventing patients from seeking care if they do not have sufficient means to pay for treatment. Hospital detention for non-payment of fees also creates situations of significant hardship for detainees, who face poor and degrading conditions during their forced stay.

3. HOSPITAL DETENTION REVEALS WEAKNESSES IN LEGAL SYSTEMS

3.1. INTERNATIONAL LAW PROHIBITS HOSPITAL DETENTION FOR NON-PAYMENT OF BILLS

The practice of hospital detention for non-payment of bills is contrary to international human rights laws.

First, hospital detention contravenes a number of fundamental civil and political rights protected by the 1966 International Covenant on Civil and Political Rights (ICCPR). The ICCPR guarantees specified civil rights and freedoms and, together with the International Covenant on Economic, Social and Cultural Rights (ICESCR), it enacts – in a binding framework – the rights outlined in the 1948 Universal Declaration of Human Rights (*11–13*). Two articles from the ICCPR prohibit detention for non-payment of bills: Everyone has the right to liberty and security of person and "[n]o one shall be subjected to arbitrary arrest or detention" (article 9(1)). Moreover, "[n]o one shall be imprisoned merely on the ground of inability to fulfil a contractual obligation" (article 11); this provision prohibits the deprivation of personal liberty for failure to pay a debt, either by a creditor or by the State.

Second, hospital detention contravenes the right to health protected by the ICESCR. The right to the enjoyment of the highest attainable standard of physical and mental health was first articulated in the 1946 WHO Constitution, which defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The WHO Constitution further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". The 1948 Universal Declaration of Human Rights also includes health as part of the right to an adequate standard of living (article 25). The right to health was reaffirmed as a human right in the ICESCR in 1966 (article 12). Since then, other international human rights treaties have recognized or referred to the right to health or elements of it, such as the right to medical care. The right to health is relevant to all countries: every State has ratified at least one international human rights treaty recognizing the right to health. Moreover, countries have committed themselves to protecting the right to health through international declarations, domestic legislation and national policies.

The Committee on Economic Social and Cultural Rights,[1] General comment no. 14, states: *"The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health"* (*14*). Hospital detention, therefore, violates the right to health as it interferes both with detainees' right to autonomy and their entitlement to equal opportunity in accessing health care. As hospital detention disproportionately impacts vulnerable groups, it also follows that the practice is inherently discriminatory and as such is in direct conflict with the right to health. Furthermore, General comment no. 14 states that: "Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups" (*14*).

Hospital detention also contravenes the right to be free from torture and cruel, inhuman or degrading treatment, which is protected explicitly by several international and regional conventions. Protection against cruel, inhuman and degrading treatment applies to treatment in health facilities (*15*). Being detained for non-payment of hospital bills is a degrading treatment and as such is a serious violation of this right.

3.2. DOMESTIC LAWS INSUFFICIENTLY IMPLEMENT INTERNATIONAL HUMAN RIGHTS

As with all international human rights, implementation and enforcement of the rights and entitlements established by the ICCPR and the ICESR depend on legislative and judicial action at the national level. Through their ratification of the ICCPR and the ICESR, States parties assume obligations and duties under the two covenants. Specifically, States parties to the ICCPR are required to take the "necessary steps … to adopt such laws or other measures as may be necessary to give effect to the rights recognized in the present Covenant" (article 2(2) of the ICCPR) (*11*). Furthermore, States parties to the ICESR are required to *"take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, to achieve progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures"* (article 2(1) of the ICESR) (*12*).

More than 70 countries recognize the right to health in their national constitutions, and a far greater number legislate various aspects of the right to access health services in their domestic laws. In addition to laws that provide for the right to access health services, some countries have also passed laws or issued government directives to expressly prohibit the practice of hospital

[1] The Committee on Economic, Social and Cultural Rights (CESCR) is the body of independent experts that monitors implementation of the International Covenant on Economic, Social and Cultural Rights by its States parties. The Committee was established under ECOSOC Resolution 1985/17 of 28 May 1985 to carry out the monitoring functions assigned to the United Nations Economic and Social Council (ECOSOC) in Part IV of the Covenant.

detention. For example, the Philippines passed the Hospital Detention Law in 2007, which "declares that the act of detaining patients in hospitals is illegal" and introduced sanctions, in the form of fines and/or imprisonments, for non-compliance with the law (*16*). Kenya is working on a new law, very similar to the Philippines law, that would ban hospital detention for non-payment of fees and impose fines when the law is broken. The federal government of Nigeria announced in 2016 that "hospitals did not have the right to detain patients for non-payment of hospital bills", and Zimbabwe has issued an official directive against the detention of patients (*2*).

Finally, courts in a number of countries have ruled that detention for non-payment of fees is arbitrary and illegal. In Kenya, for example, the courts have ruled that hospital detention is an illegal practice and that unpaid bills are debts that should be recovered through court action and civil debt recovery processes (*17*).

3.3. IMPLEMENTATION PROBLEMS AND KNOWLEDGE GAPS

Despite the existence of international human rights laws and national legislations, the practice of hospital detention still persists in some countries. Several factors help to explain why legal measures are ineffective and insufficient in stopping the practice. Some health care providers are not fully aware of their legal obligations and seem not to know that hospital detention is illegal. Moreover, even in countries where the practice is illegal or contrary to government policy, detainees face barriers to making complaints or seeking legal redress. Detainees are often unaware of their legal rights and have limited access to health complaints mechanisms, the courts or other means of challenging the legality of their detention (for example, through complaint to an independent officer such as an ombudsperson) (*2*).

Implementation of legal provisions also faces challenges related to dispersed governance, especially in decentralized systems. Policies and legislation made at national level need some degree of consistent delivery at subnational level; this can be difficult when subnational governance mechanisms have a separate degree of political authority. A related challenge is inadequate collaboration between agencies; anything other than the simplest legal or policy measures require continuous collaboration with a host of local "downstream" implementation actors such as patient rights groups, frontline health workers and a range of local service agencies. If such collaboration does not occur, then implementation of a law prohibiting hospital detention will likely fail.

4. HOSPITAL DETENTION REVEALS WEAKNESSES IN HEALTH FINANCING SYSTEMS

Hospital detention would not occur in a well-functioning health financing system that ensures equitable access to health services and effective financial protection. Although this is not an explanation or a reason for the detainment of patients, the existence of hospital detention reveals significant weaknesses in a health financing system.

4.1. WEAK REVENUE RAISING, POOLING AND PURCHASING ARRANGEMENTS

First, the overall level of public funding for health is insufficient in many low- and middle-income countries due to weaknesses in revenue raising and overall budget constraints. Moreover, the share of public spending allocated to the health sector is relatively low. A low level of prepaid funding for health services goes hand-in-hand with high out-of-pocket expenditure. Second, a low level of prepayment also means low levels of pooled funds. This is often aggravated by severe fragmentation in the pooling function, which limits redistributive capacity and thus leads to inequitable access and inadequate financial protection, in particular for lower income groups. Third, with limited prepaid and pooled funds available, budget allocations and/or provider payments are often insufficient for the provision of promised benefits. Moreover, line-item budget allocations constrain providers in efficiently using their resources according to needs and priorities. In addition, government-funded and provided health services often come with an insufficient or vaguely defined benefit package, delays in budget release and a general disconnect between budget and needs. In short, inadequate revenue raising, pooling and purchasing arrangements lead to insufficient funding at provider level and/or lack of financial protection of patients.

4.2. INADEQUATE FUNDING OF HEALTH PROVIDERS

There is ample evidence for the underfinancing of hospitals in many low- and middle-income countries (*18, 19*). As a result of inadequate prepaid funding, health service providers rely on direct out-of-pocket payments as an important source of revenue. Providers who receive a major share of their funding from direct payments

have limited possibilities to compensate unpaid care through other sources. Out-of-pocket payments are often the only funds over which hospitals have some discretion and autonomy, either formally or informally. Facilities use these funds to cover operational costs (for example, medical supplies) or to provide bonuses for health workers, as well as to cover night shift costs or daily allowances for outreach workers. As such, health workers may have a direct interest in increasing the collection of out-of-pocket payments.

4.3. INADEQUATE USER FEE EXEMPTION MECHANISMS

Hospital detention affects poor or near-poor patients in particular. Compared to formal sector employees, people in the informal economy are less likely to be protected by a health insurance scheme and, therefore, their access to health services is contingent upon paying user charges directly out-of-pocket. In addition, their ability to pay such regressive user fees is also much lower (*2*).

In various countries where user charges are in place, exemption mechanisms have been introduced. These operate either ad hoc at the point of use, following an assessment by health workers of a person's ability to pay; or, poor households are given some form of official document granting exemption from fees. However, this form of exemption mechanism based on direct targeting often does not work well for a variety of reasons, such as a lack of clarity in policy on who is eligible, a lack of guidance on how to determine eligibility, or noncompliance with exemption rules (*20*). Inadequate identification of beneficiaries can lead to patients falling through the safety net. Likewise, people just above the threshold for exemption may not benefit and nor do they have the resources to afford health care or insurance premiums.

More recently, a number of countries have introduced broader "free health care" policies. Such policies aim to eliminate formal fees at the point of service, either for all services (mainly at primary health care level), for selected population groups, for selected services for everyone, or for selected services for specific population groups. Selected population groups are usually defined and identified using medical or economic vulnerability criteria based on easily observable sociodemographic characteristics. Frequent examples of free health services include antenatal care, assisted deliveries, caesarean sections and health services for children below a defined age (often 5 years) (*20*). However, even countries with user fee exemptions or a free health care policy in place have failed to prevent detention of patients unable to pay for services not included under the exemption/policy (*6*).

From the perspective of service providers, a big concern about exemption mechanisms and free health care policies is whether funds are provided to compensate for the foregone revenue from user fees, even if the overall amount collected is small. Health workers could be reluctant to grant user fee exemptions or waive user charges if there is no compensation for foregone revenues (*20*). Moreover, lengthy procedures for compensation and exemption may reinforce providers' concerns that they will not recover their costs, as well as patients' concerns that they will not be able to afford health services (*2*).

5. LEGAL MEASURES TO END HOSPITAL DETENTION

5.1. PROHIBITING THE PRACTICE OF HOSPITAL DETENTION

In countries with no pre-existing legal prohibition on hospital detention, domestic laws should be passed to prohibit the practice of detaining patients, and the bodies of patients, in hospitals for non-payment of bills. Box 1 proposes some content for a domestic law to prohibit the practice of hospital detention.

Box 1. Proposed content to include in a law to prohibit hospital detention

The law should explicitly prohibit hospital detention for financial reasons.

1. The law should contain a clear definition of the term "hospital detention for financial reasons" to explicitly describe the situations(s) where detention is unlawful. For example: "Hospital detention for financial reasons means refusing to discharge a patient after medical discharge is clinically indicated, or refusing release of bodies of deceased patients, for reasons of non-payment in part or in full of hospital bills or medical expenses".
2. The law should clearly distinguish circumstances where detention in hospital may be clinically justified and expressly authorized by law for public health reasons (for example, where a person is being confined to prevent the spread of a dangerous disease) from situations where there is no clinical justification for detention.
3. The law should provide mechanisms for recourse to the courts or some other national authority to make a determination of whether a detention is unlawful and to provide for court-ordered release of patients, or the release of the bodies of deceased patients. This mechanism should ideally be government-funded, free-of-charge and easy for patients and their families to use, to ensure access to quick and simple redress and release.
4. The law should provide for sanctions (such as fines) against defined parties, hospital staff and the owners/operators of a hospital to act as a deterrent to the practice of hospital detention. Fines should be set at a high enough level to effectively deter the practice.
5. The law could include a provision that prohibits health facilities and health workers from refusing to treat patients, on financial grounds, in the case of medical emergency.

5.2. ADDITIONAL LEGAL AND REGULATORY MEASURES

Depending on the possibilities offered by their legal systems, Member States should recognize international human rights (see section 3.1) in their national legislation; for example, the ICCPR could be mentioned in a country's constitution. Through this recognition of human rights in national laws, hospital detention will be implicitly prohibited.

In addition, countries that have committed to moving towards UHC may concretize this commitment by legislating the right to access a defined set of health services. A domestic law could be established to formalize access to a package of essential health services, selected in accordance with national priorities and circumstances.

Further regulatory provisions can complement these legal tools. For example, licensing requirements or contracts between service providers and public purchasers, such as health insurance agencies, can prohibit hospital detention. Such contracts may also include financial and other sanctions on providers, such as loss of license or contract annulment. The purchaser or the health ministry could also collaborate with the legal sector to ensure that providers are held accountable and that appropriate legal and financial sanctions are enforced.

5.3. IMPLEMENTING AND ENFORCING LAWS

In some countries, legal measures already exist to prohibit hospital detention; however, the laws are not implemented or enforced and so fail to prevent detentions. This highlights the importance of not only ensuring that a well-designed law is in place, but also the need for well-resourced institutions to implement the law, to monitor ongoing compliance and to take effective action to enforce the law should this be required. In addition, access to impartial dispute resolution bodies and processes for patients and families is needed to help to enforce patient rights.

Ensuring that such institutions, bodies and processes are in place is an SDG commitment. Member States have committed to a legal doctrine called the rule of law under SDG target 16.3: "Promote the rule of law at the national and international levels and ensure equal access to justice for all". Specific functions of the rule of law and its relationship to development under the SDGs are increasingly recognized. The 2030 Agenda for Sustainable Development recognizes the rule of law as essential for development, as an end in itself, and as a cross-cutting enabling factor for a wide range of other development goals – including achieving UHC (target 3.8). SDG 16 promotes the rule of law, accountable institutions, inclusive decision-making, equal access to justice for all, and public access to information. It calls for non-discriminatory laws and policies for

sustainable development, to ensure that the SDGs leave no one behind[2]. Rule of law approaches focus on three main actions to strengthen laws: building legal institutions (for guiding, making, administering and enforcing laws); empowering people; and engaging non-state actors (including the private sector[3]) through a balanced set of rights and responsibilities formalized in law.

5.4. INFORMING ALL STAKEHOLDERS AND ESTABLISHING REPORTING MECHANISMS

The legal measures described above need to be accompanied by information provision to ensure that all stakeholders are aware of and know the legal situation regarding hospital detention. It is equally important to ensure that efficient reporting and monitoring mechanisms are put in place. This might require a multisectoral approach involving, for example, social workers or local authorities outside of the health sector. Hospital supervision committees could also play a role. Parliaments or human rights bodies can support such initiatives by requesting information and holding government and hospitals accountable. Collaboration with other actors, especially social workers and nongovernmental organizations, can contribute to informing patients as well as to holding hospitals accountable.

Finally, governments need to ensure that patients and their families have access to advice and assistance, as well as to mechanisms for reporting and resolving breaches of rights; for example, through the courts or through an independent body such as an ombudsperson.

[2] SDGs 13, 14 and 15 call for action on climate change, biodiversity loss and desertification, while other SDGs highlight the importance of planet issues to achieve goals on poverty, food security, gender, water, energy, sustainable economic growth, infrastructure, cities, sustainable consumption and production.

[3] For example, see the United Nations Global Compact on the SDGs, a voluntary initiative based on companies' commitments to implement universal sustainability principles and to take steps to support United Nations goals (https://www.unglobalcompact.org/).

6. HEALTH FINANCING OPTIONS TO PREVENT AND ADDRESS UNCOMPENSATED CARE

6.1. EXPLORING SHORT-TERM HEALTH FINANCING MEASURES

This section presents some short-term or interim health financing measures to prevent uncompensated care. These approaches have been implemented in various countries with the aim of compensating hospitals for unpaid medical bills. A combination of several options is possible, and may be necessary. At the same time, wider health financing reforms over the medium- and long-term will be needed (see section 6.2).

In addition, and as a starting point, hospitals may discuss and offer a delayed payment schedule to patients who are unable to pay fees (the full amount) after discharge. Ideally, social workers or community health workers should support patients in this process or act as negotiators of a delayed payment plan. Clearly, delayed payment is not a viable option for poor households that through the patient's illness have had their livelihoods further constrained and been pushed deeper into poverty.

MOBILIZING ADDITIONAL RESOURCES TO COVER HOSPITALS' UNPAID BILLS

One short-term health financing option is to mobilize additional hospital funding or allow hospitals to use existing funds in a more flexible way. Some hospitals that have been reported to detain patients receive donor funding earmarked for specific activities; increased flexibility in allocating donor funds could allow the hospitals to shift these resources so as to exempt patients from user charges. In Burundi, for example, fee exemptions for maternity services and under-5 children were initially funded through donor support. This policy was an explicit first step towards ending hospital detention (*6*). In some instances, support by aid projects allowed providers to cover uncompensated care (*6, 21*). Aid projects that provide direct funding to hospitals should make such funding conditional upon hospital detention not being practiced. Such an approach does not, however, address any underlying causes of uncompensated care.

INTRODUCING, REVIVING OR SPECIFYING USER FEE EXEMPTION MECHANISMS FOR VULNERABLE INDIVIDUALS

Governments as well as individual hospitals can introduce, revive or further specify user fee exemption mechanisms for vulnerable patients. Such exemptions require a clear

definition of who is vulnerable and hence eligible, as well as which hospital services are eligible for exemption. In the Philippines, for example, hospitals are not allowed to charge co-payments from indigent persons, who are identified by the Department of Social Welfare and Development as those being unable to ensure the subsistence of their family (*22, 23*). Likewise, several low-income countries have introduced free health care policies with a particular focus on maternal and child health services (*20*). However, for user fee exemptions and free health care policies to be functional, adequate financial resources need to be provided and effectively transferred to the facility level. Hospitals need to receive timely and sufficient payments not only to cover the cost of service provision, but also to avoid stock-outs of medicines.

Internal cross-subsidization can be a starting point for hospitals to finance user fee exemptions, although scope for this may be limited as hospitals in low- and middle-income countries often face funding shortages (*19*). Health facilities could also, for example, receive or be required to set aside a designated budget for covering the treatment costs of patients who are unable to settle their bills. Alternatively, the purchasing actor (for example, subnational government or a unit within the health ministry) could hold and manage separate funds and introduce a specific claims mechanism through which providers would be compensated for exempting patients. Providers would then submit a claim to receive payment for patients that were unable to pay the user fees.

In Burkina Faso, for example, a 2006 subsidization and exemption policy for maternal health services foresaw additional funding to providers to exempt the poorest quintile of women from co-payments for deliveries. Health facilities would receive compensation for these exemptions through the district health authorities, based on claims submitted, although implementation challenges remained (*24*). An additional policy was launched in 2009, which aimed to exempt the worst-off people from all user fees for preventive and curative services at government health facilities. It was considered to base fee exemption on "indigence cards" issued by the social action committee; however, identifying those eligible for or in need of exemption was left to service providers and based on vague criteria around patients' livelihoods (*24, 25*). For this full exemption approach, local health committees were requested to reallocate revenue from other cost recovery schemes to cover the exemptions, i.e. the underlying mechanism is cross-subsidization(*25*).

In Chad, social workers at health facilities identify patients to benefit from a fee exemption scheme and fill in claim forms for reimbursement by the Ministry of Public Health; facilities are reimbursed for services and medicines provided. The initial benefit package was launched in 2007 to cover emergency treatment (*26, 27*).[4] Similarly, in Zambia, clinicians can refer patients who are unable to pay user charges to social workers based at government health facilities. The social workers support patients to get exempted from fee payment and help to arrange transport for them to return home once discharged. Hospitals are reimbursed by the Ministry of Health on a case-by-case basis.[5] Overall, the implementation of such policies in these countries has been challenging.

[4] Anecdotal evidence and observations shared by WHO country office staff, collected between March and July 2019, on the occurrence of hospital detention and remedial government measures to address the problem.

[5] Anecdotal evidence and observations shared by WHO country office staff, collected between March and July 2019, on the occurrence of hospital detention and remedial government measures to address the problem.

PUTTING IN PLACE A SPECIFIC FUND TO COVER HIGH-COST TREATMENT

Another short-term health financing option is to set up a specific fund to cover high-cost treatments and catastrophic illnesses. Argentina, Dominican Republic, Mexico, Peru and Uruguay, for example, have separate so-called catastrophic funds, financed through general government contributions, which cover a selection of high-cost treatments that are prone to rapidly create catastrophic health expenditure (*28, 29*). These catastrophic funds are managed by a purchasing agency which operates the claims management and payment process. This option, however, builds on the existence of a functional purchasing agency to manage such a scheme. Clear definitions of the illnesses and population groups to be covered are also required, as well as a sustainable budget. Such specific funds also potentially increase fragmentation in pooling, which might lead to higher administrative costs or other inefficiencies.

ADJUSTING ENROLMENT CONDITIONS OF EXISTING HEALTH INSURANCE SCHEMES TO EXTEND COVERAGE

In countries that have a public health insurance scheme, waiting times for enrolment in the scheme could be waived for coverage of emergency or inpatient care for low-income patients when they newly enrol. For patients this could be attractive, since a hospital bill is usually much higher than several months of insurance contribution. For patients that are eligible to benefit from fully or partially subsidized contributions, a hospital visit could thus provide the entry point to enrolment and help in overcoming barriers to coverage, such as lack of awareness and insufficient information on insurance benefits.

Whatever option countries choose to improve financial protection and reduce financial access barriers to services, it is important that policies are accompanied by sustainable budgets. Lack of timely payments to providers will undermine the credibility of any policy and risk the support of hospitals as well as patients. Moreover, there is need to ensure that additional allocations to hospitals to prevent uncompensated care do not lead to an increased share of resources going to curative care at the expense of preventive or primary health care services. Ministries of health will have to find the right balance, in their given context, to ensure that the services needed by their population are available.

6.2. ENGAGING IN COMPREHENSIVE HEALTH FINANCING SYSTEM REFORMS

Short-term and interim health financing measures to address uncompensated care need to be accompanied by, and placed within, broader health financing system reforms. Comprehensive reforms are necessary to address the health financing challenges and causes of poor performance (discussed in section 4) in order to improve

financial protection and equity in access. Health services need to be adequately and sustainably funded by prepaid financial resources. Specifically, health financing measures that aim to mitigate the risk of uncompensated care need to reduce providers' reliance on out-of-pocket payments as a major revenue source. Such medium- and long-term reforms will take time to be implemented and to show an impact on hospitals' funding.

RELYING ON PUBLIC FINANCE AND REDUCING FRAGMENTATION IN POOLING

First, it is necessary to improve revenue-raising policy with the aim of increasing prepaid funding in an equitable and sustainable way. Countries that have made significant progress towards UHC rely predominantly on compulsory resources, i.e. taxes. Higher government spending on health is generally associated with lower out-of-pocket expenditures (*30*).

Likewise, it is necessary to reduce fragmentation in pooling arrangements in order to increase redistributive capacity, i.e. the potential to redistribute funds from individuals with lower health needs and lower health risks (which refers to the risk of incurring health expenditure) to individuals with higher health needs and risks. Less fragmented pooling arrangements will also reduce dependence on out-of-pocket expenditures and thus increase the share of prepaid funds in overall health spending. There are various pooling reform options to address fragmentation (*31*). As a first step, coverage should be made compulsory or automatic for everybody. In addition, different pools should be merged so that people from the informal sector are in the same pool as formal sector employees, thereby using state budget transfers to finance coverage extension. If merging is not possible, a new specific pool for vulnerable population groups can be introduced by using budget transfers to provide full or partial subsidies to contributions. In fact, over 40 low- and middle-income countries use budget transfers to provide coverage to defined population groups outside the formal sector; in half of these countries, people in the informal economy are in the same pool as contributors (*32*).

MAKING PURCHASING MORE STRATEGIC

The way in which services are purchased is decisive for how efficiently and equitably funds for health services are used. Multiple payment methods need to be aligned so as to set coherent incentives at the provider level to avoid behaviour that is non-conducive to UHC objectives, such as patient "cream skimming" and patient shifting. In other words, payment methods and rates should be the same for all people – whether they contribute or whether they benefit from subsidized coverage.

Moreover, benefits (including co-payments, where applicable) must be explicitly defined and aligned with patients' needs and their capacity to pay. The poor are more likely to be unable to pay for high-cost emergency treatment. Adequate design of co-payments or user fees is equally important. Evidence shows that financial protection is higher when co-payments are set as a fixed amount rather than as a percentage (*6, 33*). As such, people know better in advance the amount that they will have to pay. Fixed, transparent

and published fee schedules inform patients of the cost of treatment and thus help to avoid informal payments. It is also essential to ensure that patients understand the benefits to which they are entitled. To improve financial protection of the most vulnerable groups, it is necessary to include a cap on co-payments and to prohibit balance billing, i.e. a provider should not be allowed to charge patients above the agreed rate of reimbursement by the purchaser.

ALIGNING PUBLIC FINANCIAL MANAGEMENT RULES

Finally, public financial management rules have to allow the health ministry and purchasers to direct funding for health service provision to where it is needed. This requires predictable health budgets as well as alignment of the health financing system with budget formulation and execution rules. Public financial management systems also need to work effectively to ensure providers receive timely payments (*34*). Payment methods and regulations on the use of funds to recompensate lost revenues from exempted user charges or free health care policies must also allow for sufficient flexibility. A certain level of financial and managerial autonomy for hospitals is critical to allow providers to use and shift resources according to needs and to react to incentives set by payment methods (*34*). This flexibility can allow providers to deal with uncompensated care; for example, through using savings under other cost items to cover uncompensated user fees, or through shifting uncompensated fees to the next budget year. However, increased hospital autonomy has to be accompanied by stronger accountability of providers. The hospital management team should not only follow economic considerations, but also consider the social and public health roles of hospitals.

HEALTH FINANCING REFORMS NEED TO BE ACCOMPANIED BY OTHER MEASURES

In most country contexts, addressing uncompensated hospital care requires a bundle of health financing reform measures rather than work on just one isolated aspect of reform. In Turkey, for example, a ministerial decree successfully outlawed hospital detention by ruling that outstanding bills for uncompensated care could be included in hospitals' budget requests for the following year. Importantly, this measure was part of broader health system reform and was followed by other initiatives, including consolidation of existing health protection schemes, increased funding and improved health service purchasing modalities (*35*).

7. CONCLUSION: HOSPITAL DETENTION MUST END

Hospital detention for financial reasons is a serious human rights violation and should never occur. Persistence of the practice is contrary to countries' commitments to UHC and will put progress towards UHC at risk. Hospital detention threatens UHC because it acts as a deterrent to patients seeking care, is contradictory to patient-centred quality care, violates efforts to ensure financial protection, and is inequitable (as it disproportionately affects the poor, mothers and children). Patients must be able to access the health services they need without fear of abusive or degrading treatment and without financial burden.

In summary, the legal mechanisms for preventing hospital detention include: banning the practice of hospital detention; fully implementing legal measures; ensuring that countries provide legal access rights to health services and products in their constitutions or national laws; making all stakeholders aware of the legal situation related to hospital detention; and ensuring that patients and their families have access to advice, assistance and mechanisms for reporting and resolving breaches of rights (for example, through the courts or through an independent body such as an ombudsperson).

Legal measures, however, will only work in the long term when accompanied with health financing system reforms to address the underlying causes of uncompensated care. Countries where hospital detention takes place need to urgently engage in UHC-oriented health financing reforms. However, as the effects of reform on hospital funding may not occur immediately, short-term measures are also required. It is clear that the feasibility of short-term options depends on the specific health financing context, the political economy around such reform, and availability of support by political actors. Moreover, the public needs to be aware of their benefit entitlements, co-payment requirements and referral rules, as well as of exemption policies.

To expand the evidence base and stimulate further research, questions on hospital detention or denial of care could be added to national household surveys. Such surveys gather information on out-of-pocket payments (36) and on financial copings strategies to pay for health care (37, 38). Countries should explore whether such additional questions can be included in future national surveys. This will also allow better identification of which population groups are most affected by the practice of hospital detention.

In conclusion, UHC can only be achieved if patients can access the services they need without fear of abusive or degrading treatment and without financial hardship. This means that patients should not have to fear being detained in a hospital, and that providers will not deny care to patients upfront. Refusal of care for patients unable to pay is a serious issue that needs to be addressed in any country that wants to progress towards UHC.

Ultimately, the need to ban hospital detention should receive much greater attention from national policy-makers and the international community. The international community is equally asked to provide specific support, including financial resources, to countries whose people suffer from hospital detention to assist in stopping the practice immediately. Moreover, the international community should help countries to implement legal provisions to stop hospital detention practices and monitor their effective implementation.

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