



UNIVERSAL HEALTH COVERAGE: HOW TO FINANCE IT?



This year is a key moment in the global journey towards achieving Universal Health Coverage (UHC). As countries debate how to make progress, many of these conversations are happening without meaningful participation from communities and civil society.

Frontline AIDS is deeply committed to ensuring community-based organisations and civil society are able to engage with and contribute to these global and national policy dialogues.

A common challenge is that community and civil society are not seen as experts on health financing – one of the three core dimensions of UHC policy. Frontline AIDS has developed this discussion paper to try to demystify and explain the concept of pooled financing for health so that civil society and community groups are able to engage with UHC policy-making nationally.

This paper focuses on pooled financing and the economic impact of health expenses on individuals. It doesn't cover the other challenges to improving access to health care or the quality of services.

The paper does not present Frontline AIDS position on UHC but is a contribution to provoke further dialogue on options available to countries to finance healthcare. Below are a few questions to consider while you engage with this discussion paper.

- **Should and can healthcare be free at the point of access for everyone? Does this affect the quality of services?**
- **In each of the outlined models of financing healthcare, who might be excluded from accessing healthcare?**
- **What are the challenges of co-existing healthcare systems?**
- **Who sets the guidance as to what services should be covered by a pooled financing system?**
- **Can UHC effectively work to reduce financial hardship without social protection mechanisms?**
- **How can we address the concerns felt by marginalised or even criminalised people who often feel the need to pay out of pocket in order to ensure confidentiality and safety when accessing healthcare services?**

There are no simple answers to these questions. They are all context- and country-specific. We attempt to explain some of the issues, but the answers need a more detailed and nuanced analysis by country.

WHAT IS UHC AND WHY DOES IT MATTER?

According to the World Health Organization (WHO), UHC means that “all people have access to the health services they need (prevention, promotion, treatment, rehabilitation and palliative care) without the risk of financial hardship when paying for them. This requires an efficient health system that provides the entire population with access to good quality services, trained health workers, good quality medicines and technologies. It also requires a financing system to protect people from financial hardship and impoverishment from health care costs. Equitable access to health services ensures healthier people; while financial risk protection prevents people from being pushed into poverty. Therefore, universal health coverage is a critical component of sustainable development and poverty reduction, and a key element to reducing social inequities.”¹

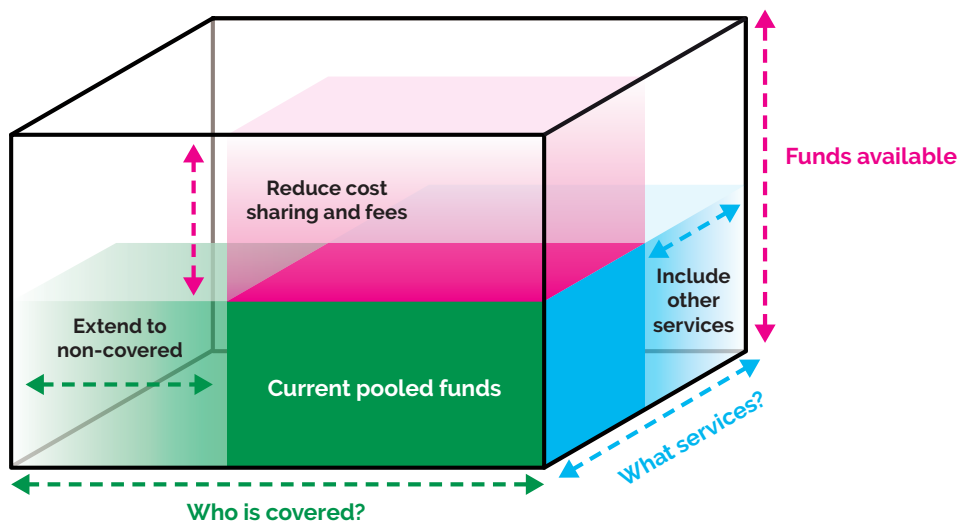
This description may sound straightforward, but its interpretation is nuanced and will need to be debated in each country context. Some questions include: what is meant by “need”, who decides what’s included in that “need”, using which criteria and who should be included in the policy-making process? How do we define and measure “access to” or “good quality of” health services, and which threshold should we use to determine “impoverishment” of a given household?

To move toward UHC, a country would need to consider a number of things including: Who is covered? Which services are covered? What proportion of the cost should be covered through the pooling systems?² Pooling systems will be further discussed in the next section. The aim of a pooled system is to ensure that no one individual carries the burden of paying for healthcare needs, and to prevent financial hardship aspect.

These dimensions are usually represented in a cube-shape graph like the one below.

Three dimensions to cover when moving towards universal coverage

Source: WHO Universal Coverage – Three Dimensions



To understand the rationale behind the financing dimension of UHC and its complexities, it's important to learn how the dynamics of the healthcare market work.

1. See Questions and Answers on Universal Health Coverage https://www.who.int/healthsystems/topics/financing/uhc_qa/en/
 2. See Health financing for universal coverage: https://www.who.int/health_financing/topics/pooling/en/

BASIC DYNAMICS OF HEALTHCARE MARKET

Healthcare is unlike any other basic product available in the market³. When we go to the supermarket, we choose to buy food, drinks or cleaning products based on their price, the price of their alternatives, our income and our preferences as well as the quality of the product and its availability.

If we like oranges, the amount of oranges we'll buy depends on:

- How expensive they are: the higher the price, the less we will buy and vice-versa;
- How much other fruit we also like costs: the cheaper pears or bananas are in comparison, the fewer oranges we buy, and vice-versa;
- What our budget is: the higher the income, the more oranges we'll buy;
- Our preferences: if we like oranges more than any other fruit, we'll buy them even if the price increases (until a certain limit). Preference is also influenced by 'the law of the diminishing benefit of repeated consumption': if we've been eating oranges quite often lately, we may prefer other fruit;
- Availability: if there's a stock out of oranges, the price is immaterial.

These are the characteristics of most common products (not all) we consume every day. The demand for those commodities will vary depending on how these factors are modified, especially their price. In other words, the demand for those products is sensitive to its price, an economic law called 'price elasticity'.

This is not what happens in relation to the demand for healthcare:

- Even if the price of healthcare increases, most households will still need to buy it: to avoid disease, recover quality of life (to be able to work, for instance) and save family members' lives.
- Households can't easily buy effective, evidence-based alternatives to healthcare.
- Demand for healthcare is less affected by income. Families tend to use their income, savings and assets, even if they are low, to pay for life-saving healthcare for their family.
- Healthcare demand is not usually modified by repeated or continuous consumption: it depends how much it is needed at that time.

This is why demand for healthcare is seen as less sensitive to price than other commodities: changes in its price have little effect on its demand. In economic terms, the demand for healthcare is 'inelastic'.

Two other factors need to be considered:

1. Uncertainty: The demand of healthcare is uncertain. Most of the time we don't know when we'll need healthcare, to what extent and for how long. Only when a disease is diagnosed or a trauma has taken place, can doctors provide a prognosis.
2. Asymmetric information: When we demand healthcare, we don't usually know exactly what we need. We may know little about the disease, and how it should be treated. We expect healthcare providers to have that expertise, and rely on their knowledge and experience to take the right decisions for us.

3. To better understand the basic economic concepts used here (demand, elasticity, substitutes), please, refer to <https://courses.lumenlearning.com/boundless-economics/>

However, not all demand for health is equally inelastic: it depends on the existence and prevalence of competitors offering a particular service or commodity and the availability of good substitutes. For instance, if a medicine is off-patent and many manufacturers offer it as generic, the consumer will be sensitive to its price increase, because they have other options. The same is true for health products that have good substitutes: a price increase in ibuprofen might lead people to buy other painkillers such as paracetamol, for example.

The price inelasticity of healthcare demand can affect patent-protected medicines, generic medicines with few competitors, specialised medical services, and basic health services with little regard for other circumstances (such in geographical areas where the number of doctors and other healthcare workers is very low).

PROVIDING DENTAL CARE FOR PEOPLE LIVING WITH HIV AND PEOPLE WHO USE DRUGS⁴

Data from WHO European Region⁵ countries show that the poorest households tend to experience less price elasticity for demand for medicines than for dental care. We can interpret this as indicating that, in this population, medicines are valued as life-saving or quality of life sustaining, while dental care is not. When household budgets are constrained, the substitute for full dental care (accessing only basic dental checks or even nothing) is preferred.

Even many advanced public health systems do not include dental care in their basic package of services, or only for certain populations (children) or for very basic services (infected tooth extraction). But this is especially the case for poorer populations, or people who are prone to oral health problems, such as people who use drugs and people living with HIV (as a number of studies have demonstrated that people living with HIV⁶ are at an increased risk for various dental health challenges).

When households are willing to buy healthcare even if it means that they are pushed into poverty, it is called 'catastrophic health expenditure'. However, if a household runs out of income or assets, or they consider the price too high for the potential benefits, the healthcare won't be purchased, and the health needs will remain unmet.

WHY WE NEED POOLING SYSTEMS

One way to avoid incurring catastrophic health expenditures or leaving a health need unmet is to participate in a pooling finance mechanism. In this system participants provide money to a centralised account at a fixed period: for instance, 100 USD per month. That money is kept by someone referred to as an insurer that uses it to buy healthcare when one of the pooling participants needs it. Insurers can be public or private.

Pooling mechanisms are a way to deal with both the uncertainty of healthcare needs (when, which type, for how long) and the limited capacity of households to cope with high health costs in a short period of time.

In pooling mechanisms, the entitlement to receive healthcare is not linked to the participant's monetary contributions. Neither can the participant decide under which conditions such healthcare should be provided: this is decided by the insurer on behalf of all pooled participants.

4. The examples described in the boxes are extrapolated from real examples to discuss likely scenarios related to HIV, although some of the arguments may be supported by specific references.

5. Cerezo, J. WHO Barcelona Office for Health Systems Strengthening, based on Universal health coverage: financial protection country reviews: <http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/clusters/universal-health-coverage-financial-protection/universal-health-coverage-financial-protection-country-reviews>

6. See https://www.who.int/oral_health/action/communicable/en/

Pooling mechanisms are usually of three types:

1. Generalised public mandatory mechanisms
2. Private voluntary mechanisms
3. Public or private mechanisms linked to employment status.

Generalised public mandatory mechanisms

In generalised public mandatory mechanisms, the insurer is a public body that collects the participants' contributions regardless of their willingness to do so. The collection is usually done through taxes or levies (on income, sales, corporate benefits, or consumption of specific products such as fuel, alcohol or tobacco). Those taxes are mandatory in the sense that the contributor cannot refuse to pay, or will face legal consequences if they do so. This is key for the sustainability of the system: if made voluntary, younger and healthier people may opt not to contribute for the time being, while older and less-healthy people will require increased healthcare services, leading to an economic collapse of the system.

The main challenge with these mandatory pooling mechanisms is when a large portion of economic activity is informal or the public authority is not able to collect sufficient taxes. For instance, non-declared sales, labourers without legal contracts, or corporate benefit concealment. In such circumstances, those who do contribute may feel unequally treated.

CAN INCOME FROM SEX WORK CONTRIBUTE TO HEALTHCARE FINANCING

One way to ensure that public mandatory mechanisms of healthcare are well financed is by enlarging the fiscal space of a country⁷. This can be done if the largest segments of informal economic activity enter the regulated area and start contributing significantly to public budgets. However, some citizens may not be able to or see benefit in contributing to these mechanisms because their economic activity is prohibited or not regulated.

Sex work is one of many examples where this may occur. In countries where sex work is not regulated, sex workers will likely not be paying tax on their income, not because they don't want to but because they're not allowed to. This means that they are not able to contribute finances through income tax to the healthcare system. When accessing healthcare, they may be treated in a stigmatised and discriminatory way because of their HIV status or their choice of work and be excluded from the system. Others may perceive they're not entitled to access healthcare because they don't directly contribute to its sustainability⁸.

Private voluntary mechanisms

In private voluntary mechanisms, unlike public systems, participation is not mandatory. Voluntary Health Insurance (VHI) can be offered by for-profit companies or may be community- or faith-based, not-for-profit schemes. In all these cases, the individual is free to decide whether to take up the offer or not. VHI normally implies a legal obligation for the user to pay a certain amount periodically (called a "premium") and in return the provider will offer health services to be used when needed under certain conditions.

7. Fiscal space is commonly defined as the budgetary room that allows a government to provide resources for public purposes without undermining fiscal sustainability. According to the International Monetary Fund, fiscal space exists if a government can raise spending or lower taxes without endangering market access and putting debt sustainability at risk. See *What is "fiscal space" and why does it matter?* https://www.who.int/health_financing/topics/fiscal-space/why-it-matter/en/

8. Sex workers may contribute to the public health system through sales taxes (every time they purchase something), but social perceptions of those contributions are less evident than income tax contributions.

For-profit VHI has several limitations:

- Individuals who are more in need of healthcare, or think they will be (like older people), tend to buy insurance, while the healthier and younger individuals will not, a phenomenon called 'adverse selection'. This threatens the viability of the insurance scheme, unless those in need or at higher risk are charged higher premiums. Since less healthy individuals tend to be poorer⁹, they risk having to pay a higher premium which will represent a far higher proportion of their household income than for other groups. This usually leads to lower-income users not contracting VHI, a phenomenon known as "market exclusion". This also affects users with previous health conditions that are considered too costly, when the company may refuse to provide insurance at all, not even with high premiums.

To address the exclusion of marginalised people in VHI markets, governments may decide to subsidise VHI for certain population groups, but this doesn't solve the problem of adverse selection¹⁰.

- VHI providers set limitations to the type, quantity, proportion or covered time of healthcare, depending on the value of the premium paid. For instance, they may provide cancer treatment but only cover first-line therapies, or only until spending has reached a certain limit, or only a percentage of the cost, or only for a given period of time. Outside those circumstances, the user must pay and be excluded from the pooling system benefits.

Community-based health insurance schemes are common in low-income countries. They usually offer a basic health package for a flat rate. However, this approach has only proven to be effective in facilitating health access and avoiding catastrophic health expenditure to a limited extent because the user still needs to pay for the services not covered and the poorest and most vulnerable will still be excluded¹¹.

HIV DIAGNOSIS AND VOLUNTARY HEALTH INSURANCE

A VHI holder may be diagnosed with HIV and discover that the insurance conditions could limit the healthcare they can receive: only certain, less expensive HIV medications are included; the number of monitoring tests (CD4 and VL) may be limited to once a year; the therapy of certain opportunistic infections may be excluded; the period of coverage is fixed; only a percentage of services and medications are financed; or HIV healthcare needs are not covered at all. Or they may be told by the insurer that their premiums have increased significantly, precisely when an HIV diagnosis might lead to a reduction in their income because of losing their job or dealing with the associated stigma and discrimination.

Private or public mechanisms linked to employment status

In many countries there are pooling mechanisms to finance healthcare that is linked to employment status. Occasionally the mechanism is voluntary – the employee is given an amount intended to buy the health insurance of their preference. In such circumstances the same challenges will occur as with general VHI. Most often, however, those mechanisms are mandatory: both the employer and employee have an amount deducted from their benefit or salary which is used to finance the healthcare they're entitled to. These insurance mechanisms may be private or public, but even when they're public, they restrict access to

9. See "Chronic Diseases and Poverty" at https://www.who.int/chp/chronic_disease_report/part2_ch2/en/

10. The US Affordable Care Act or "Obamacare" tried to solve that problem by requiring all US citizens to have a VHI or risk a penalty. This policy has proven to have had a limited effect in increasing the number of healthy, young people buying an insurance in the US, as the cost of the penalty is much lower of that of the increasing premiums.

11. See "Characteristics of community-based health insurance (CBHI) schemes" https://www.who.int/health_financing/topics/community-based-health-insurance/key-characteristics/en/

those participating in the scheme and their families. If an individual loses their job, they and their family are no longer entitled to this healthcare.

In the field, different pooling mechanisms coexist

In many low- and middle-income countries, all three pooling mechanisms coexist. For instance, in countries where mechanisms linked to employment status are prevalent, it is usual for government to create parallel healthcare systems financed with public funds for those who are unemployed, working informally, or working in the public sector (if they're not covered by a specific insurance scheme). In addition, VHI may be bought by wealthier individuals to complement existing options.

The main challenge in this coexistence is ensuring the quality of those services provided with public financing. If the publicly-funded healthcare is only used by low-income, little or non-contributing individuals, it will tend to be less resourced, leading to fewer treatment options, worse equipment and infrastructure, longer waiting times. It may also mean lower-paid staff, who are either less qualified or have higher absenteeism rates if they are simultaneously working in the private sector¹².

ENSURING HEALTHCARE QUALITY FOR TRANSGENDER WOMEN

Healthcare quality is not only affected by financial factors¹³. Levels of expectation regarding the quality of services also affect the system response: the lower the expectation, the less pressure to provide quality services. When healthcare services are separated according to direct monetary contribution (accessible through VHI or insurance linked to employment status) and non-direct monetary contribution (accessible through public subsidies), patient expectations are different.

In some countries, transgender women are excluded from the formal labour market and from VHI markets. Instead they use subsidised public services where they confront stigma, discrimination and verbal abuse. Their capacity to influence and improve the quality of those services is limited by their reduced social and political capital as well as their low expectations of the services. Fearing degrading treatment, they tend to use the services only when absolutely necessary, which in turn reduces their ability to demand improvements.

HOW MUCH SHOULD PEOPLE PAY DIRECTLY FOR HEALTHCARE

When there's no pooling mechanism to cover healthcare financing, users have to pay the full cost of healthcare at the point of service or commodity purchase. Similarly, when the pooling mechanism doesn't cover 100% of healthcare services, the rest has to be paid by the user at the point of service or purchase. These are known as 'out-of-pocket' (OOP) expenditures.

OOP spending penalises the poorest and sickest individuals. The lower the income and assets, the higher the proportion of household expenditure that needs to be dedicated to healthcare. In addition, the proportion of household income used will be higher when the treatment is more complex or prolonged. As discussed above, this leads to catastrophic health expenditure and household impoverishment¹⁴.

12. See The Mixed Health Systems Syndrome. <https://www.who.int/bulletin/volumes/88/1/09-067868/en/>

13. See Understanding and measuring quality of care: dealing with complexity for a review of the most prevalent factors and their complex intersection. <https://www.who.int/bulletin/volumes/95/5/16-179309/en/>

14. See Out-of-pocket payments, user fees and catastrophic expenditure https://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/

There is international consensus that health OOP payments should be reduced to increase equity in healthcare access. But what should be the threshold? Different measurement methodologies, such as the one used by WHO and the one adopted by the Sustainable Development Goal (SDG) indicator system, offer different interpretations of the threshold for catastrophic health expenditures¹⁵. This makes it more challenging to define a clear target for advocacy and policy purposes.

Should the threshold be zero, which means no OOP at all? Should it be zero for everything and for everyone? The implications for each type of service and commodity may be different. There is evidence that user fees (OOP at the point of service) are a barrier to access healthcare, particularly in low-resource settings¹⁶. It should be noted however that in those settings user fees should not be eliminated without first strengthening the healthcare system. Without this there is a risk they will collapse or substantially reduce in quality. In middle- and high-income countries with public or semi-public pooled mechanisms, inequity caused by user fees depends on its design and the existence of exemptions or caps (for lower-income individuals or those with chronic conditions)¹⁷.

In the case of health commodities, and particularly medicines, most countries have established co-payments (fixed amount to be paid when accessing an insured service) for many of these, which are prescribed through the primary healthcare system. Evidence shows that co-payment mechanisms, even when they include exemptions and caps for most marginalised groups, still lead to increased inequity and reduced use of vital medicines¹⁸.

CAN PREP BE OFFERED FREE OF CHARGE TO MEN WHO HAVE SEX WITH MEN?

Many middle-income countries are considering including pre-exposure prophylaxis (PrEP) as part of the basic package of prevention offered to men who have sex with men. This trend follows the WHO recommendation that "*people at substantial risk of HIV infection should be offered PrEP as an additional prevention choice, as part of comprehensive prevention*"¹⁹. In parallel, some better off men who have sex with men in those countries have reported accessing PrEP medication through private purchasing – even before national policy to provide it had been adopted. Once PrEP is included in national HIV strategies, a discussion may be needed about to what extent it is offered free of charge – to all men who have sex with men who are at substantial risk of HIV infection, or only to those who cannot afford it? Intermediate options may include setting different percentage subsidies according to the social and financial situation of the user (starting from 100% subsidy for individuals who are most vulnerable and less able to pay).

15. See Catastrophic health spending in Europe: equity and policy implications of different calculation methods <https://www.who.int/bulletin/volumes/88/1/09-067868/en/>

16. See The impact of user fees on health service utilization in low- and middle-income countries: how strong is the evidence? <https://www.who.int/bulletin/volumes/86/11/07-049197/en/>

17. See the European country reports available at Universal health coverage: financial protection country reviews <http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/publications/clusters/universal-health-coverage-financial-protection/universal-health-coverage-financial-protection-country-reviews>

18. See Effect of co-payment policies on initial medication non-adherence according to income: a population-based study <https://qualitysafety.bmj.com/content/27/11/878.long>

19. See Pre-exposure prophylaxis <https://www.who.int/hiv/topics/prep/en/>

WHO IS COVERED BY POOLING MECHANISMS AND HOW ARE THEY PROTECTED AGAINST FINANCIAL HARDSHIP?

Pooling mechanisms can protect against financial hardship related to healthcare needs by potentially reducing the use of OOP expenditure. But not all schemes protect to the same extent.

As discussed previously, VHI only covers those who voluntarily participate in their schemes, and doesn't necessarily cover every health need or their full extent. Increasing the number and services provided by VHI will require intensive public subsidies for individuals who are most sick and on lowest incomes, which is less attractive to governments. On the other hand, insurance linked to employment excludes those who are unemployed or working in the informal sector and it requires the development of a parallel, public funded, usually less-resourced network of health services to fill the gap.

Also, the fact that the predominant pooling mechanism in a given country is public and mandatory doesn't mean it covers everyone. Many high-income countries, for example, restrict access to healthcare for people without legal residency, either according to their personal characteristics (for example, exemptions are made for children or pregnant women) or to their health needs (for example, enabling access to emergency healthcare)²⁰.

As discussed above, the fact that the population is covered by a pooled financing system or insurance is not per se an indicator of financial protection against catastrophic health expenditures. Measuring the percentage of household income spent on health costs is a better indicator of this. Countries that link entitlement to healthcare to user payment and that lack effective tax collection systems demonstrate the gap between universal coverage and protection against financial hardships related to healthcare needs²¹.

Finally, there is the question: to what extent UHC can effectively work to reduce financial hardship without social protection mechanisms. People with ill-health may not be able to work, leading to financial hardship. In many countries, individuals unable to work don't receive any financial support or what they receive is too low to meet their basic needs. This problem affects not just the person who's sick, but others who depend on the lost income^{22 23}.

WHAT DO POOLED MECHANISMS COVER AND HOW?

As quoted earlier, WHO states that UHC means that "*all people have access to the health services they need (prevention, promotion, treatment, rehabilitation and palliative care)*".

But who decides, and how, which services are needed for a particular person? In the case of private pooling mechanisms, that is usually defined in the contract between the insurer and the insured. In the case of public-held systems, this is in principle decided by the national health authorities. In theory, national health authorities are responsible for determining which treatment for a particular disease or which services for a specific population group will be covered by the public system (and under which conditions) with the resources available. In practice, healthcare services offered in many low- and middle-

20. <https://www-bmj-com.sire.ub.edu/content/350/bmj.h2681.full>

21. <http://www.euro.who.int/en/health-topics/Health-systems/health-systems-financing/universal-health-coverage-financial-protection>

22. <https://thl.fi/en/web/thlfi-en/research-and-expertwork/projects-and-programmes/eu-social-protection-systems-programme-eu-sps/research-on-social-protection/social-protection-and-universal-health-coverage-uhc>

23. Being affected by tuberculosis is one of the classic examples of the need of social protection mechanisms to make UHC effective <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001693>

countries can be more the result of political priorities or vested interests than a rationale, evidence-based choice based on preferred health outcomes or cost-effectiveness. Progressing towards a comprehensive and sustainable UHC model will require reviewing and rationalising the healthcare services provided in a given community²⁴.

How can this be done? When deciding which drugs should be made available to their citizens, governments and health advocates can refer to the WHO List of Essential Medicines²⁵, updated every two years. But when it comes to adopting a defined package of healthcare services for a disease, category of diseases or population group, it's not that simple. WHO will have recommendations for prevalent conditions in terms of prevention, diagnosis, care and treatment, if they exist, but it's up to each government to decide how those recommendations are incorporated as national policies, technical norms, regulations and guidelines. Beyond those recommendations, the range of potential services will tend to expand when evidence becomes available about their benefit for the healthcare users. This perpetual process of considering new services puts pressure on the financial viability of the health system, even in high-income countries²⁶: public systems face increased healthcare demand while resources allocated to finance them are never sufficient.

One way to deal with health system stress is by prioritising the availability of these new health services. Since not all services provide the same benefits and the resources to run them are always limited, countries need to decide which interventions come first and which can wait. This can be done by just adding new services to those already existing, or by defining an Essential Package of Health Services for each disease or population group that will update or replace those previously offered. Either way, the decision to modify or enlarge the services or to adopt a defined service package is usually made in one of three ways:

1. Arbitrarily: national health authorities decide which services are made available without using a standardised procedure;
2. Based on cost-effectiveness: priorities are set according to the cost-effectiveness of the interventions, either using international references²⁷ or by undertaking context-specific analysis (or a combination of both);
3. Through a participatory process: the list of services covered is defined following consultation with concerned stakeholders²⁸

Each of the three approaches may prove problematic. Deciding arbitrarily on healthcare services covered may lead to increased expenditure but not to better health outcomes. Using only cost-effectiveness analysis to prioritise health services, apart from the methodological controversies involved²⁹, may not take into consideration other relevant principles, such as equity or societal preferences. Finally, participatory processes may end up with services being prioritised based on the level of political influence of specific stakeholders, regardless of their cost-effectiveness or their impact on equity.

24. See Universal Health Coverage and Essential Packages of Care <https://www.ncbi.nlm.nih.gov/books/NBK525285/>

25. See WHO Model Lists of Essential Medicines <https://www.who.int/medicines/publications/essentialmedicines/en/>

26. See Defining a Health Benefits Package: What Are the Necessary Processes? <https://www.tandfonline.com/doi/full/10.1080/23288604.2016.1124171>

27. See for instance Disease Control Priorities 3. <http://dcp-3.org/>

28. This method is one of the advocacy pillars of the Civil Society Engagement Mechanism for UHC2030 (CSEM) <https://csemonline.net/advocacy/>

29. See Cost effectiveness analysis in health care: contraindications <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1124387/>

ACCESS TO QUALITY HEALTHCARE SERVICES

The Sustainable Development target for UHC (number 3.8) calls for the world to “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all³⁰”.

“Access to quality health services” is a gradient that starts from availability followed by accessibility, acceptability, utilisation and then, finally, quality³¹. Each of those elements require specific actions as part of a comprehensive UHC policy. But the ultimate indicator of effective access to quality health services and of the most efficient use of the limited resources available is the improvement in the health outcomes of the population.

This is vital in countries where national health systems distinguish between health service holder and health service provider. For instance, in a predominantly public health system, the public authorities (national, regional or local governments) are the holders of the service, but not necessarily the providers. Even when the provider is also a public entity, it is usually functionally and administratively separate from the public service holder. Through this arrangement, the public health service holder can hire the services of a given provider (public, for-profit private or non-for-profit private, faith-based, community-based) according to their needs and the price-quality relationship of the services the provider offers in a competitive process. While the inclusion of for-profit providers in the public health systems is controversial and may require strong regulation and oversight³², other types of provider also need to be accountable – not only in terms of financial management and service quality provision, but also in terms of health outcomes achieved.

HIV COMMUNITY OUTREACH SERVICES AND HEALTH OUTCOMES

Community-based organisations (CBOs) that provide HIV services financed by donors or domestic funds are also health service providers and as such they have to be held accountable for their results. They receive funds to provide services that will lead to better health outcomes. But this is not always the case. In some countries, HIV testing offered to marginalised communities through community-led outreach activities have generated lower positivity yields (the number of new HIV positive cases detected against the total number of HIV tests performed) than those offered through fixed, public testing sites³³. Traditional outreach by peers from marginalised communities has exhausted outreach capacity once the third level of personal connections is reached (the friend of the friend of my friend). In fact, some communities may prefer discreet, user-friendly, onsite services with evening open hours to being tested through outreach, where they are uncertain about confidentiality. Innovative approaches are needed to design distinct service models for marginalised communities.

30. See SDG 3: Ensure healthy lives and promote wellbeing for all at all ages <https://www.who.int/sdg/targets/en/>

31. See Human resources for health and universal health coverage: fostering equity and effective coverage <https://www.who.int/bulletin/volumes/91/11/13-118729-ab/en/>

32. See Does Ownership Matter? An Overview of Systematic Reviews of the Performance of Private For-Profit, Private Not-For-Profit and Public Healthcare Providers <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4249790/>

33. Based on confidential reports the author has produced as HIV program evaluator.

Another area for discussion is essentiality of the services. For many diseases prevalent in low- and middle-income countries, including HIV³⁴, the WHO recommends the basic package of services and commodities that needs to be available for a specific condition. But all national health systems, including those in high-income countries, experience a tension between their available resources and the healthcare coverage requirements. Managers have responsibility for allocating the limited resources available. They do this through the health system components, where criteria related to the burden of disease and cost-effectiveness of health interventions may play a role, but are not the only considerations. Other elements may influence that decision including personal interests, system inertias, political priorities, donor preferences, or the influence of different stakeholders, including patient advocates³⁵.

FUNDING HIV IN THE CONTEXT OF TRANSITION TO DOMESTIC FINANCING

Globally, HIV still gets the highest share of financial support from the Development Assistance for Health (DAH). As many countries upgrade from low- to middle-income status, however, the proportion of the national AIDS responses being financed by domestic funds is increasing, not without some challenges³⁶. Governments in transitioning countries have to target funds towards multiple health challenges affecting an increasingly ageing population. In this new scenario, the ultimate power does not lie with donors anymore but with the local emerging middle-class who are core contributors to the domestic budget. Among them, the idea that other growing health challenges, such as non-communicable diseases, should be prioritised is gaining support.

The reality is that in many of these countries, the burden of HIV is less than for other conditions³⁷. In this context, traditional strategies that call for a vertical national AIDS response may no longer resonate with public opinion. The move towards UHC is a great opportunity to ensure well-resourced national health systems. However, the challenge will be to ensure that these systems serve the needs of people most affected by HIV, including marginalised communities.

ABOUT FRONTLINE AIDS

Frontline AIDS wants a future free from AIDS for everyone, everywhere. Around the world, millions of people are denied HIV prevention, testing, treatment and care simply because of who they are and where they live.

As a result, almost 2 million people were infected with HIV in 2017 and almost 1 million died of AIDS-related illness.

Together with partners on the frontline, we work to break down the social, political and legal barriers that marginalised people face, and innovate to create a future free from AIDS.

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34. See Guidelines and policy briefs on HIV <https://www.who.int/hiv/pub/guidelines/en/>

35. For an illustration of the complexity of health budget allocation decision-making and the role different stakeholders play in a high-income country (UK), see the Documentary Movie "The Price of Life". <http://www.adamwishart.info/the-price-of-life>

36. See Financing Global Health 2017: Funding Universal Health Coverage and the Unfinished HIV/AIDS Agenda <http://www.healthdata.org/policy-report/financing-global-health-2017>

37. See the database Global Burden of Disease Compare <https://vizhub.healthdata.org/gbd-compare/>