Global health leaders discuss ‘ending’ AIDS in context of universal health coverage

Image not found or type unknown

From left: Robert Matiru (UNITAID), Khuat Thi Hai Oanh (Supporting Community Development Initiatives), Peter Sands (Global Fund), David Sergeenko (Government of Georgia), JVR Prasada Rao (Global Commission on HIV and the Law). Photo: Charlie Baran.

“Half of the world’s population lacks access to quality health services” and “the world is not on track to reach HIV targets” were two of the opening remarks by World Health Organization Director General Dr. Tedros Adhanom Ghebreyesus (known as Dr. Tedros) during a satellite session at the International AIDS Conference last month in Amsterdam. Dr. Tedros’s objective in the session was to link the dual challenges of ending the HIV epidemic and achieving universal health coverage (UHC), which was the focus of the session , entitled, “Eliminating AIDS epidemics on the road to universal health coverage.”

The high-level session, which took place directly before the opening ceremony of the conference on Monday, 23 July, encapsulated well one of the major themes of the conference, as noted in GFO 340 , that the success of the global HIV response will be tied closely to the success of UHC.

Dr. Tedros described a six-point plan for synchronizing the HIV response with the drive for UHC. First, UHC needs to be informed by the evolution of the HIV and viral hepatitis responses. Second, national HIV

strategies must be integrated into national health-care programs, with the foundation of these programs being stronger systems with a major focus on primary services. Third, countries need to define the quality HIV services to be included in UHC plans. On this point, Dr. Tedros emphasized that, “All people must have access to HIV services no matter who they are.” Fourth, UHC needs to be people-centered. This point harkens to the third principle of the WHO’s UHC call to action of 2017: “Together on the Road to Universal Health Coverage.” Fifth, health systems must have a package of services which are free at point of service, thereby reducing the barrier of out-of-pocket payments. And sixth, “To end the epidemics, we will need new technologies and interventions.”

Dr. Tedros was followed by three presenters with more country-level perspectives, coming from South Africa, India, and Georgia. The first was Aaron Motsoaledi, South Africa’s Health Minister. Mr. Motsoaledi remarked that, “The concept of UHC has arrived at the right time.” He described how South Africa, which has the largest HIV epidemic on earth, functionally has two parallel health systems. “A private one which is superior to any in Europe. And a public one which, just like any other in Africa, is marred by huge inequalities.” From his perspective, the drive for UHC will help diminish the disparity between his country’s health systems.

The next speaker, JVR Prasada Rao of India, continued on Mr. Motsoaledi’s theme of two health systems. According to Mr. Rao, a commissioner with the Global Commission on HIV and the Law, “UHC doesn’t include the private sector.” He appeared to be referring to the fact that the global UHC movement is largely led by governments, NGOs, civil society, and multi-lateral institutions, but does not yet have strong engagement from business or the private sector. This is a problem for Mr. Rao because in India 60% of health services are accessed through the private sector. He described a situation where, just as in South Africa, people who are more privileged have access to the private health system, which offers better quality care, while others are left to suffer the public health system. The distinction itself can inhibit access to services. As Mr. Rao described, “In some developing countries the health system itself is an instrument of stigma for poor people.” Shrinking the gulf between the two will be critical, according to Mr. Rao.

Georgia’s Minister of Internally Displaced Persons from Occupied Territories, Labor, Health, and Social Affairs, Dr. David Sergeenko, spoke next. Universal health coverage is the national policy of Georgia, having been initiated in 2012 and operational since 2013. Dr. Sergeenko allowed that while his country is fairly small, it is nonetheless a great example for other countries to study. While most of his remarks focused on his country’s efforts to control hepatitis C virus (HCV) and HIV, he was able to point to some of the overall benefits of UHC. For example, since 2012, out-of-pocket payments by patients, as a proportion of total health expenditures, have gone down significantly, just as patient visits to public health centers have nearly doubled, signaling more well-visits and treatment-visits, two key indicators of improving health outcomes (see Figure 1).

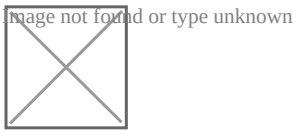

Figure 1. Universal health care program, Georgia; out-of-pocket expenses.

Peter Sands, the new Executive Director of the Global Fund, spoke next, and brought a global perspective back tothe conversation. His remarks followed two major themes: the connection between ending HIV and achieving UHC,and the resources needed to do both. As discussed in GFO 339, Sands reflected: “I think there is a false dichotomy between, ‘should we do UHC or end the epidemics’. We will not succeed in ending the HIV epidemic if we do not build a UHC platform.” Mr. Sands made it very clear that the two go hand in hand from now on. But he acknowledged one of the most lamented risks of UHC, that the marginalized people whom the HIV response has fought to keep at the center, may be left behind by UHC. This cannot be allowed, said Mr. Sands. “A UHC platform that does not include key populations, is not universal.”

Dr. Khuat Thi Hi Oanh, who runs Supporting Community Development Initiatives (SCDI), followed Mr. Sands. In a playful yet poignant jab at the session organizers, Oanh opened with: “I feel really special being the only woman and only civil society on the panel.” SCDI is a Vietnamese NGO that promotes the well-being of vulnerable and marginalized communities. She echoed Sands’ concern about key populations: “The people most affected HIV, TB and HCV are the most likely to be left behind by UHC.” She argued that people living with HIV are desperately in need of UHC, because they are “dying from many other things, such as HCV and overdoses.” Nonetheless, she thinks that the HIV response has much to offer the UHC movement: “I would like to call on my fellow HIV activists to use our experience and know-how and wisdom for UHC.”

Dr. Oanh wrapped up her presentation with a reflection on history, and an idea for how to set up the UHC movement for success. “We don’t want another Alma Ata,” she said referring to the 1978 global health summit that called for universal health coverage by 2000. This year is the 40th anniversary of that aspirational summit, whose main call to action has not nearly been realized to date. “We are 18 years late!” lamented Dr. Oanh. She did boldly articulate one decision that could provide some urgently needed financial and political scaffolding for the UHC movement. Turning to Peter Sands and addressing him directly, she said: “If you can make [supporting UHC] a Global Fund policy, it would have a great impact.”

While the Global Fund Board – not the Executive Director – sets Global Fund policy, Mr. Sands’ comments in this session and elsewhere do suggest that he would support such a policy at the Fund.

Read More