

What does Universal
Health Coverage
mean for People
Who Use Drugs:
A Technical Brief

Introduction

Universal Health Coverage is defined as health coverage that ensures that

- all people and communities have access to the promotive, preventive, curative, rehabilitative and palliative health services that they need,
 - care is of sufficient quality to be effective, and
 - use of these services does not expose the user to financial hardship
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On 23rd of September, 2019 the United Nations General Assembly will hold a High-Level Meeting (HLM) on Universal Health Coverage (UHC). The theme of this meeting is *“Universal Health Coverage: Moving Together to Build a Healthier World”* and ostensibly aims to accelerate progress towards universal health coverage. Given the political momentum generated due to the upcoming HLM on UHC, and the potential for country-level action towards realising universal health coverage, it is important for all drug user rights advocates to stay informed.

This INPUD Technical Brief explains how Universal Health Coverage (UHC) can be both an opportunity and a concern for the health and rights of people who use drugs.

UHC as a concept is not new. In fact, its origins date back to the WHO Constitution of 1948 and the ground-breaking Alma-Ata Declaration from the 1978 International Conference on Primary Health Care, urging governments to promote the health of all people. This principle is enshrined in the Universal Declaration of Human Rights.¹

Through sustained diplomacy and negotiation at the political level and strong and concerted advocacy from civil society and communities, UHC is now prominent in the Sustainable Development Goals (SDGs). It is specifically referenced in Goal 3.8 which calls for members to *“Achieve Universal Health Coverage, including financial risk protection, access to quality essential health care services and access to safe and effective quality and affordable essential medicines and vaccines for all.”*

The principle of the SDGs is ‘leave no one behind’; this should be taken to mean that those on the fringes of society are accorded the same rights to health and wellbeing as the most privileged. People who use drugs, along with other criminalised and marginalised populations, clearly fit into this category. Therefore, for ‘leave no one behind’ to be more than empty rhetoric, the poorest, most marginalised and vulnerable - including people who use drugs - must be centred in the conceptualisation, formulation

1 Ruben et al. (2019) *HIV and the High Level meeting on Universal Health Coverage: What’s at stake – key populations blog*. Found at <https://www.poz.com/article/hiv-high-level-meeting-universal-health-coverage> April 11 2019

and implementation of UHC. UHC must be founded on the understanding that health is not a commodity or a privilege, but a fundamental human right for all.²

What is Universal Health Coverage?

As emphasised above, the World Health Organisation states that “*Universal Health Coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.*”³

Within this definition there are three main objectives:

1. **Equity in access to health services** – this means everyone who needs services should get them, not only those who can pay for them
2. **The quality of health services** – should be high enough to improve the health of those receiving services
3. **People should be protected against financial risk** – ensuring that the cost of using services does not put people at risk of financial harm

What People Who Use Drugs Need From UHC

1. Equity

Equity is the bedrock on which the concept of UHC has been developed. For the right to health of people who use drugs to be respected, access to comprehensive harm reduction programmes, including overdose prevention, needle and syringe programmes and drug consumption rooms is crucial. In order to achieve health equity, member states must also consider removing legal barriers to inclusion and access to health services: criminalisation of people who use drugs is well-demonstrated to drive harms to health of people who use drugs, and this is compounded by stigma and discrimination. States have a duty and obligation to protect and uphold the health, social inclusion and rights of their citizens.

Harm reduction is a pragmatic human-rights based public health approach. Although well documented, evidenced and acknowledged as effective in reducing the harms to health and society that can be associated with drug use, funding remains very limited and significant barriers to service access remain. For example, low- and middle-income countries experienced an estimated 90% shortfall in funding for harm reduction services (NSP and OST) in 2017, despite these services being proven to be highly cost-effective interventions that reduce mortality and morbidity.⁴ Worryingly, the majority of harm reduction services, especially in low- and middle- income countries remain dependent on external funding sources, with governments reluctant to invest domestic resources to support programmes for a criminalised and highly

2 GNP+ (2019) *Universal Health Coverage: Putting the Last Mile First*. Found at <https://www.gnpplus.net/universal-health-coverage-putting-the-last-mile-first/>

3 World Health Organisation (2019) *What is Universal Health Coverage* – WHO webinar series April 2019-. Found at <https://www.who.int/primary-health/PHC-webinar-series/>

4 Cook C, Davies C. (2018). *The Lost Decade: neglect for harm reduction funding and health crisis among people who use drugs*. London. Harm Reduction International

stigmatised community. The potential risk of UHC is that funding for harm reduction services may be reduced further, due to a reduction in domestic funding for disease-specific programming, such as HIV, hepatitis C and tuberculosis. At the same time, UHC provides the opportunity to both address these gaps, if member states commit to including harm reduction interventions within national health benefit packages.

It must be noted, however, that increasing spending on services alone for people who use drugs is not sufficient. The right to health for people who use drugs will not be realised unless fundamental issues of social justice are addressed for this community. Criminalisation is a significant barrier to UHC: if UHC is to be a reality for people who use drugs, states must intensify national efforts to create enabling legal, social and policy frameworks in each national context in order to eliminate stigma, discrimination and review and reform punitive laws that criminalise and socially exclude people who use drugs.

Unless UHC commits to “putting the last mile first” and reaching the poorest and most marginalised in society – including people who use drugs – it will never achieve its stated goal of universal equity in health care.

2. Quality-Driven, Community-Based and People-Centered Care

Both a community-based and people-centred approach are essential for UHC to work and achieve its goals. Community-based systems for health complement and strengthen hospital and clinic based services. As with other key populations, people who use drugs bring unique added value: their lived experience, their ability to reach and be accepted by the most marginalised of communities, their unique skills and knowledge and their ability to respond immediately to challenges makes them valuable stakeholders and contributors to health care quality. The space for the involvement of people who use drugs in health responses is already limited and constrained. It is difficult to imagine, as the world refocuses on UHC, that things will change significantly for the better; and yet community monitoring for accountability and quality of services are essential if quality of health services are to continue to improve under UHC.

The world over, the space for civil society is shrinking. This not only reduces opportunities to influence policies and legislation but also reduces options for engaging in discussions about improving quality of health services. For example, as more countries transition out of Global Fund support, Country Coordination Mechanisms, one of the important spaces where people who use drugs can engage on quality of service issues, will disappear. As UHC moves away from disease-specific policies and programming, National AIDS Commissions, with dedicated

seats for community constituents, will be dissolved, further reducing the opportunity for people who use drugs to engage in national health policy and programme discussions.

To address this shrinking civic space and maintain essential opportunities for people who use drugs, and other marginalised communities, to engage in quality of health care discussions, states must be pressured to create, or build on existing multi-sectoral platforms. This requires investing in national, regional and international networks and consortia that convene and are led by the communities that are most marginalised, enabling the channelling of rights-based, evidenced information to assist states in improving health services to their populations. This will open up means of access for people who use drugs to bring an understanding of how health service policies, guidelines and protocols are translated at point of delivery, and what changes should be made to ensure that adoption of UHC principles will deliver the improved health care it is designed to achieve.

Movements such as those around HIV, sexual and reproductive health and rights, women's health and mental health have been driven by the leadership of communities to expand equitable access to health. It is communities who innovate and deliver services to the most marginalised and hardest to reach. It is communities that will be critical in ensuring health service quality under UHC is optimal and addresses the needs of the poorest, and most vulnerable first. Maintaining and expanding platforms, fora and mechanisms to enable people who use drugs and other marginalised communities to engage with and inform the discussions on quality of health services under UHC is essential. Putting communities at the centre of UHC will not only ensure quality of services but also that truly no-one is left behind.

3. Health Financing

Equity and health service quality will only be possible within UHC if there is strong political commitment by states to address the challenge of health financing. This means recognising that investment in health significantly contributes to sustainable development, the promotion and protection of human rights and dignity as well as scaling up the services that are delivered and available. However, many health systems remain underfunded and are not sufficiently prepared to implement UHC. High prices for some health products and medication, inequitable access to such products and financial hardship associated with high prices are major impediments to achieving universal health coverage.

To address this, states will need to scale up efforts to ensure there are appropriate spending targets for quality investments in public health services, increased public and private spending on health, and expanded pooling of resources allocated to health. Optimising budgetary allocations on health, with sufficiently broadened fiscal space and prioritising of health in public spending are essential for effective implementation of UHC.⁵

Equitable and quality health care means:

- ◆ No fear of losing your life savings to pay for your health care
 - ◆ That you get the health service that you need
 - ◆ That you are treated as a person – not just as a medical condition
 - ◆ That you have a say in what sort of care works for you
 - ◆ That you are looked at and treated as a whole person
 - ◆ That you are able to discuss other issues such as diet and exercise that may impact on your health.
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5 WHO (2019). *Universal Health Coverage and Health Financing* Found at https://www.who.int/health_financing/en/

As countries move to UHC, state-sponsored health insurance and a minimum package of health services that includes services required by communities of people who use drugs such as opiate substitution therapy and needle and syringe programmes, will be essential if no one is to be left behind in these developments. There is a risk that some countries will opt for a US style system, where health care is now covered by health insurance companies and other private sector corporations. This option would pose a number of challenges for people who use drugs, and other marginalised communities. These include the following:⁶

- Many people who use drugs, particularly those who are unemployed or surviving in a state of impoverishment, are unlikely to have or be able to afford private health insurance. So, without state sponsored health cover, would be left without access to health services
- People who use drugs often face multiple health care issues, and could well be excluded and written out of private sector health insurance schemes

Further to this, both public and private insurance schemes pose substantial risks and concerns for criminalised populations. Enrolment in health insurance schemes – both private and public – requires a permanent address and registration with full personal details, as well as numerous disclosures. For a criminalised population, this raises serious concerns regarding confidentiality: many will feel the risk for accessing health care through health insurance is simply *not worth it*, given it could serve to actually exacerbate difficulty, danger, and – ironically – harms to health.

Even if these challenges can be overcome, it will still be necessary for countries to develop their national health insurance schemes starting from the point of premium waivers (for the poorest and most marginalised) before addressing the level of subsidy to be provided by the wider population. However, many national health insurance schemes are not structured this way. To address this, enrolment should be simple with minimal registration requirements and with confidentiality ensured.⁷

Further to this, it is important for states to invest in increasing the number of health care workers with the necessary skills and knowledge to provide non-stigmatising and non-discriminatory services to the community at large, especially those who are most marginalised, including people who use drugs.

In short, there is no need for states to *re-invent the wheel* to address the needs of people who use drugs within UHC. Building on what is already there and investing in community-based services, for example those run by drug-user led organisations, are not just a cost-effective option, but consolidate what communities already know works for their own health and communities. Moreover, it ensures that communities remain central to UHC; this is essential if ‘leave no-one behind’ is to be a reality.

6 WHO and World Bank (2017). Tracking Universal Health Coverage: 2017 Global Monitoring Report. Found at https://www.who.int/healthinfo/universal_health_coverage/report/2017/en/

7 GNP+ (2019) Universal Health Coverage: Putting the Last Mile First. Found at <https://www.gnpplus.net/universal-health-coverage-putting-the-last-mile-first/>

In summary, financing UHC for people who use drugs means: increasing domestic public spending on health, encouraging private sector spending on health, pooling resources for health investment, developing health insurance schemes with waivers for the poorest and most marginalised, investing in and training of appropriately skilled health care workers and building on and investing in existing community and drug user-led organisations. It is a whole package that is needed if UHC is to work for people who use drugs.

Community Advocacy

Equity means fairness and for UHC to be fair to all, it must be recognised that health is not a commodity or a privilege, but a human right of each and every person, regardless of their social or political status or their ability to pay. Community advocacy is needed to ensure that UHC adheres to its original principles.

In the context of a peripheralisation of the needs and rights of marginalised communities, people who use drugs should stay informed, promoting knowledge about UHC among their communities and organisations. It is important that they build partnerships with other key populations affected by HIV/AIDS, who are also in danger of being left behind in these UHC discussions, to demand inclusion within their respective countries' UHC agendas.

By demanding a seat at the table, wherever UHC is being discussed, and seeking allies within UN agencies in-country and lobbying them to advocate for the meaningful inclusion of people who use drugs, there is a greater chance that governments can be held to account for their decisions.

Furthermore, advocates should work to promote the *Injecting Drug User Implementation Tool*, or 'IDUIT', as this is recognised by the Global Fund, WHO, UNAIDS and UNODC as normative guidance for people who use/inject drugs.⁸ During negotiations on national health benefit packages, community advocates should refer to the inclusion of buprenorphine and methadone in the WHO essential drugs lists in promoting harm reduction services. This would strengthen national level advocacy for the inclusion of harm reduction services for people who use drugs in public health focused UHC plans.

Conclusion

As UHC becomes a reality, communities such as people who use drugs must be allowed to continue their role as independent watchdogs. Communities must lobby for an accountability framework that enables governments to be held to account.

Stigma and discrimination towards people who use drugs in health care settings must be challenged and addressed through investment and training of appropriately skilled health care workers and other medical staff.

For Universal Health Coverage to truly work for people who use drugs, the following should be taken into consideration: -

8 INPUD, UNODC et al. (2017). Implementing Comprehensive HIV and HCV Programmes with People Who Inject Drugs. Found at <https://www.inpud.net/en/iduit-implementing-comprehensive-hiv-and-hcv-programmes-people-who-inject-drugs>

- Processes must be implemented to remove legal and policy barriers to inclusion and access to health services, including criminalisation of people who use drugs.
- Harm reduction interventions, such as needle and syringe programmes, opiate agonist treatment and naloxone must be included in UHC driven national health benefit packages
- Space for the involvement of people who use drugs must be created in health responses to improve quality of care and ensure community monitoring for accountability purposes
- The financing of UHC must ensure access to quality, comprehensive health care services for all, regardless of ability to pay
- To ensure people who use drugs are not left behind, states must invest in community and drug user-led organisations, building on what already exists and capitalising on the knowledge communities have about what works.
- People who use drugs need to stay informed and find out what UHC platforms for planning and implementation are taking place in their respective countries. Moreover, the building of partnerships with other key populations and allies is needed to demand inclusion within UHC and ensure it addresses community needs and priorities.

UHC *can* work for people who use drugs and *can* be used to ensure people who use drugs are not left behind. But this *will not* happen unless communities are vocal, visible, coherent, knowledgeable and assertive in their demand to be included. It is their right, but this does not mean that it will be automatically respected. As always, communities will have to work and agitate for their rights to be respected.

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The International Network of People who Use Drugs (INPUD) is a global peer-based organisation that seeks to promote the health and defend the rights of people who use drugs. INPUD will expose and challenge stigma, discrimination, and the criminalisation of people who use drugs, and its impact on the drug-using community's health and rights. INPUD will achieve this through processes of empowerment and advocacy at the international level, while supporting empowerment and advocacy at community, national and regional levels. **www.inpud.net**

INPUD is part of Bridging the Gaps – health and rights for key populations. This unique programme addresses the common challenges faced by sex workers, people who use drugs and lesbian, gay, bisexual and transgender people in terms of human rights violations and accessing much-needed HIV and health services. Go to www.hivgaps.org for more information.

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Health and rights  for key populations

