Chapter 5: Universal Health Coverage and Socioeconomic Actions in TB

SUMMARY

New strategies focusing on socioeconomic actions are required to achieve the 90-(90)-90 targets and end TB. Ministries and agencies across government, beyond the ministries of health and the public health sector, must collaborate in order to have maximum impact on the TB epidemic. Universal health coverage (UHC) must be at the heart of such strategies, with the goal of making TB programmes high-quality, accessible and affordable. People affected by TB need the support of social protection policies and programs to help them recover from sickness and manage any disability or loss of function that results from TB without suffering catastrophic financial loss or other avoidable hardships.

PRIORITY ACTIONS

Governments:

- Fulfill commitments made in the UN political declaration on UHC, including the commitment to strengthen efforts to address TB by advancing comprehensive approaches and integrated service delivery, ensuring no one is left behind.

- Implement nonmedical interventions in parallel to medical services, including social protection, poverty alleviation and urban regeneration strategies.

- Assess barriers to accessing TB services and to address them in national UHC agendas. Ensure TB services are included within social benefit packages.

- To create a multisectoral response at the national level, consider establishing a national TB coordination council, similar to a national AIDS board.

- Implement patient cost surveys to understand the drivers of TB patient costs, and use the findings to improve financial and social protection policies.

Advocates:

- Equip parliamentarians and decision-makers with evidence showing how focusing on TB will also improve performance in tackling other national priorities including other UN Sustainable Development Goals.

- Engage and enroll new potential allies outside of the traditional TB community, including those working in social welfare, labour, housing and urban regeneration, agriculture and other relevant sectors.

Health programs:

- Ensure health care staff treating people with TB understand social protection policies and the associated programmes for which people with TB are eligible.

- In the course of pursuing UHC, ensure the right balance of integrating TB care into primary healthcare and maintaining specialized TB managerial functions.

- Ensure operational research is used to guide and improve the implementation of social protection programs.

Researchers:

- Strengthen the body of evidence showing the links between socioeconomic actions and progress made against TB.

Even though free TB diagnosis and treatment are at the heart of global TB efforts, individuals and families affected by TB often still struggle with other associated costs. Those costs can even be catastrophic. When the costs become too great, it creates a powerful disincentive that prevents people from accessing TB care. On a population level, the high costs associated with TB suppresses access to care, creating a barrier that stands in the way of ending the disease.

Ending TB requires a holistic approach that incorporates a broad range of medical and nonmedical interventions carried out across a range of sectors. Compared with older approaches to "controlling" TB, the End TB Strategy has increased the focus on poverty alleviation and social protection as critical pieces of a holistic, multisectoral effort. Combined with urban regeneration, these interventions have the potential to enhance prevention, improve access to care, and prevent TB-related catastrophic costs.

Implementing these measures will require greater involvement with the private sector, civil society and community health workers. However, the need for nonmedical *interventions* means that a greater range of nonmedical *actors* must be engaged. Planning and investing to end TB is not solely the task of health ministries, but also of other ministries and government agencies, including those responsible for social welfare, finance, labour, housing and urban regeneration, agriculture and others. Engaging finance ministries, with national TB programmes and advocates from across sectors participating strategically in national budget process, is crucial to seeing more resources flow toward a multisectoral TB response.

Improving medical services: Universal Health Coverage

TB and UHC efforts go hand in hand, as roughly 40 percent of people with TB do not have access to appropriate treatment as of 2018. In fact, given the huge global burden of TB, combined with the potential to strengthen health systems by building on health infrastructure originally established for the purposes of delivering TB care, expanding TB efforts provides an important pathway toward UHC. At the same time, the global push towards achieving UHC provides an opportunity for TB services to scale up, become more affordable and accessible, and improve in quality. For these reasons, social protection and UHC are core components of the End TB Strategy. Pillar Two of the strategy seeks to ensure that health and social sector policies work jointly to address the social determinants of TB.

After years of neglect, UHC is now high on political agendas again. In September 2019, the UN General Assembly (UNGA) convened the High Level Meeting on Universal Health Coverage. The political declaration endorsed by the UNGA reaffirmed the commitments made in the UN political declaration on ending TB. The declaration also committed to strengthen efforts to address TB by advancing comprehensive approaches and integrated service delivery, ensuring no one is left behind.

Box 5.1 Key TB Commitments in the United Nations Political Declaration on Universal Health Coverage

*Reaffirm the strong commitments made through the political declarations adopted at the High-level Meetings on ending AIDS, on tackling antimicrobial resistance, **on ending tuberculosis**, and on the prevention and control of non-communicable diseases, as well as the General Assembly resolutions entitled "Consolidating gains and accelerating efforts to control and eliminate malaria in developing countries, particularly in Africa, by 2030";*

*Strengthen efforts to address communicable diseases, including HIV/AIDS, **tuberculosis**, malaria and hepatitis as part of universal health coverage and to ensure that the fragile gains are sustained and expanded by advancing comprehensive approaches and integrated service delivery and ensuring that no one is left behind;*

It is critical that TB programmes seize the opportunity created by this high-level political attention on both TB and UHC, and actively engage in efforts to secure greater access to TB care through national efforts to achieve UHC. Depending on the country context, in order to be part of the UHC and health insurance initiative, TB programmes may need to restructure their budgets, service delivery mechanisms and data collection methods.

Health care financing has become a prominent aspect of global efforts towards UHC, and health insurance schemes are increasingly being rolled out in many low-income countries. However, many people at risk for TB lack health insurance coverage. UHC must therefore not be limited to health care financing, but must also include the expansion of critical health services. As discussed in Chapter 4, community health workers can help reach the "missed" millions of people in need of TB care by reaching out to communities, tracing contacts of people impacted by TB, and educating family members.

Box 5.2
Universal health coverage (UHC) is defined as ensuring that all people can use the health services they need, that these services are of sufficient quality to be effective, and that the use of these services does not expose the user to financial hardship.[1] Sustainable Development Goal 3 ensures healthy lives and promotes well-being for all at all ages. This goal focuses on achieving UHC, which includes financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

Integrating TB into poverty alleviation and social protection activities

There is an extensively documented, strong positive correlation between poverty and TB across all age groups. A new review of children's susceptibility to TB described the relationship between paediatric TB and poverty as "overwhelming," with poverty being the

[1] What is universal coverage? Geneva: World Health Organization; 2019 (http://www.who.int/health_financing/universal_coverage_definition/en/).

leading factor that puts children at risk of being exposed to TB, being infected, developing disease and experiencing poor outcomes.[2] A recent statistical modeling exercise conducted by experts from WHO, the London School of Hygiene & Tropical Medicine and other universities found that ending extreme poverty and expanding social protection coverage would result in a 84.3 percent reduction in TB incidence by 2035.[3]

In addition to the direct health costs of seeking TB care, many households also incur significant related expenses, including costs for travel, food, and childcare, and loss of income. These costs can be catastrophic for families, as their spending on health care can exceed 40% of their disposable income.[4] Income loss accounts for, on average, 60% of the costs incurred by people with TB, with 25% attributed to direct costs such as tests, medicines, and hospitalization.[5] Addressing these costs is especially relevant in the fight against TB, since the disease disproportionately affects families who are impoverished and malnourished.

Evidence shows how social protections, particularly those focused on treatment adherence, can improve TB outcomes and operational results.[6] Many social protection programmes have used conditional cash transfers to incentivize participation. This model has been employed to improve public health in many low and middle-income countries, notably Brazil and more recently India (see Box 5.3: India's National Direct Cash Transfer Programme).

Box 5.2 What is social protection—and what have governments committed to do about it?

Social protection can be understood as a set of public actions that address not only income poverty and economic shocks, but also social vulnerability. Social protection takes into account the interrelationship between exclusion and poverty. Through income or in-kind support and programmes designed to increase access to services (such as health, education and nutrition), social protection helps to realize the human rights of children and families.[7]

By endorsing the UN political declaration on UHC, governments have committed to:

[S]top the rise and reverse the trend of catastrophic out-of-pocket health expenditure by providing measures to assure financial risk protection and eliminate impoverishment due to health-related expenses by 2030, with special emphasis on the poor as well as those who are vulnerable or in vulnerable situations.[8]

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[2] Roy R, Whittaker E, Seddon J, Kampmann B. Children and *Mycobacterium tuberculosis:* a review of susceptibility and protection. Lancet Infect Dis. 2019;19(3):e96-e108.
[3] Carter D, Glaziou P, Lönnroth K, Siroka A, Floyd K, Weil D, Raviglione M, Houben R, Boccia D. The impact of social protection and poverty elimination on global tuberculosis incidence: a statistical modelling analysis of Sustainable Development Goal 1. Lancet Glob Health 2018;6:e514-22.
[4] Xu K, Evans DB, Kawabata K. Household catastrophic health expenditure: a multicountry analysis. Lancet. 2003;362:111–7.
[5] Eliminating the financial hardship of TB. Geneva: World Health Organization; 2013 (http://www.who.int/tb/publications/UHC_SP_ factsheet.pdf).
[6] Boccia D, Hargreaves J, Lonnroth K. Cash transfer and microfinance interventions for tuberculosis control: review of the impact evidence and policy implications. Int J Tuberc Lung Dis. 2011;15:S37–49.
[7] UNICEF. Social protection (http://www.unicef.org/socialpolicy/index_socialprotection.html).
[8] United Nations. Universal health coverage: moving together to build a healthier world. 2019. Online: https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf

By endorsing the UN political declaration on the fight against tuberculosis, governments have committed to:

- Provide **social protection** for children affected by tuberculosis as well as for their caregivers, particularly women and the elderly.
- Enable and pursue multisectoral collaboration that involves the **social protection** sector.
- Strengthen support and capacity-building in countries that have **social protection** systems with limited resources.
- Help developing countries raise domestic revenues and providing bilateral financial support towards achieving UHC and **social protection** strategies.[9]

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[9] United Nations. United to end tuberculosis: an urgent global response to a global epidemic. Resolution A/RES/73/3. Geneva: World Health Organization; 2018 (https://www.who.int/tb/unhlmonTBDeclaration.pdf)

Social protection efforts require support from health systems and other sectors. Nutritional programmes should collaborate with the World Food Programme and national agencies responsible for food and nutrition. Cash transfer programmes for the poor that often exist under social welfare ministries need to be made accessible to people with TB. Additional operational research can demonstrate impact and identify more effective means of implementing social protection activities.[10]

[SIDEBAR:] In order to maximize their collective efforts toward achieving the health-related SDGs, in 2018 11 of the world's largest international health and development agencies developed a framework for collaboration. *The Global action plan for healthy lives and well-being for all* is built on three strategic approaches: Align. Accelerate. Account. To learn more about how the world's health organizations are working together to accelerate progress toward ending TB, go to: https://apps.who.int/iris/handle/10665/311667

In order to ensure the systematic implementation of social protection programmes, a clear analysis that identifies the socioeconomic factors contributing to vulnerability in specific settings is needed. For instance, in some regions, catastrophic costs may be primarily due to travel costs and loss of income. In others, food security plays a major role in poor treatment outcomes.[11]

Countries are encouraged to undertake an assessment of barriers to accessing TB services and to address them in their UHC agenda. WHO has developed a handbook for conducting TB patient cost surveys that countries can use to assess the drivers of costs for TB patients and their families.[12] Survey findings can then be used to improve financial and social protection policies for families affected by TB. Health care staff treating people with TB should be aware of social protection policies and programmes, such as disability grants, for which people with TB are eligible. In addition, TB services should be prioritized within the social benefit packages that exist within countries.

Antimicrobial resistance and the global health security agenda

The UN General Assembly, the G20, the G7, the BRICS, and the Asia-Pacific Economic Cooperation bloc, as well as ministers from countries across South-East Asia and the African Union have all issued communiques identifying antimicrobial resistance (AMR) as a critical threat to global health security and economic prosperity, pledging action in response. Drug-resistant TB (DR-TB) alone causes almost one-third of all deaths from resistant pathogens, making the effort to end TB the cornerstone of the response to AMR and a crucial piece of the global health security agenda.[13]

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[10] Lutge E, Lewin S, Volmink J. Economic support to improve tuberculosis treatment outcomes in South Africa: a pragmatic cluster-randomized controlled trial. Trials. 2013;14:154

[11] Tanimura T, Jaramillo E, Weil D. Financial burden for tuberculosis patients in low and middle income countries: a systematic review. Eur Respir J. 2014;43:1763–5.

[12] Tuberculosis patient cost surveys: a handbook. Geneva: World Health Organization; 2017 (https://www.who.int/tb/publications/patient_cost_surveys/en/)

[13] Tuberculosis—the cornerstone of the AMR threat. TB Europe Coalition; 2017 (http://www.tbcoalition.eu/wp-content/uploads/2015/03/AMR_brochure_spreads.pdf)

Achieving universal access to TB care, while providing patients and families with the social support they need to adhere to quality treatment and prevention, is essential to solving the AMR challenge. Drug-resistant TB has a chance to develop any time a person with TB receives inadequate, substandard, or incomplete treatment. Unfortunately, the living conditions common in low-income settings—especially urban environments where communities lack access to nutrition and quality healthcare—tend to make TB treatment adherence challenging, leading to the emergence of drug-resistance.[14] Today, due to the vast numbers of people who have received such care, the ongoing spread of resistant TB strains is responsible for most new cases of multidrug-resistant (MDR-TB) and extensively drug-resistant TB (XDR-TB). The spread of MDR-TB in particular has become so widespread that a significant burden of people living with latent TB infection are actually living with latent MDR TB infection. A recent modeling exercise estimates that three in every 1000 people globally carry a latent MDR TB infection, with the prevalence around ten times higher among people younger than 15 years.[15]

Ensuring that every person affected by TB has access to the proper treatment and is supported to complete that treatment is essential to ending TB and stopping the danger that TB drug-resistance poses to global health security. Research and development of new tools for diagnosing, preventing and treating TB is also critical and will be discussed in chapter 6.

Improving the urban environment

The majority of the world's population growth is set to occur in urban areas over the coming decades. In many low-income countries, and even in many middle-income ones, urban areas have grown rapidly, but without much planning or resources. This has left the poorest to live in slums. For an airborne disease such as TB that is fueled by overcrowding, poor ventilation, inadequate sanitation, and undernutrition, this development trend has significant implications.

Urban development strategies that improve the physical environment and reduce overcrowding therefore have the potential to make a significant impact in the fight against TB.[16] Well-located health care facilities with respect to housing could enable better links to health services. Improving urban living conditions would also greatly benefit efforts to tackle other diseases such as diarrhoea and pneumonia, which are caused by overcrowding and poor water and sanitation.

Box 5.3: India's National Direct Cash Transfer Programme

BOX 5.3: India's National Direct Cash Transfer Programme for TB

[14] Lange C, Chesov D, Heycknedorf J, et al. Drug-resistant tuberculosis: an update on disease burden, diagnosis and treatment. Respirology. 2018;23:656-673.

[15] Knight GM, McQuaid CF, Dodd PJ, et al. Global burden of latent multidrug-resistant tuberculosis: trends and estimates based on mathematical modelling. Lancet Infect Dis. 2019;19:903-12.

[16] Hargreaves JR, Boccia D, Evans CA. The social determinants of tuberculosis: from evidence to action. Amer J Public Health. 2011;4:654–62.

After India's Prime Minister Narendra Modi announced that he was making TB a national priority, in March 2018 the government of India instituted a direct cash transfer system for people with TB. The cash transfer programme is one of several social-protection and patient-support measures included within the National Strategic Plan for TB Elimination in India 2017-2025. The programme called "Nikshay Poshan Yojana" (NPY) provides direct cash transfers of INR 500 (approximately 8 USD dollars) monthly to bank accounts owned by people with TB or their close family relatives, to be used for nutritional support.

Direct Benefit Transfer (DBT) is a mechanism that can enable targeted and transparent delivery of benefits to citizens through the use of technology. For TB, DBT has been implemented through four schemes within India`s national TB programme:

- NPY
- Honoraria to treatment supporters
- Transportation support to people with TB living in tribal areas
- Financial incentives for TB notification and successful treatment outcomes, provided to private health providers and those who make referrals for TB care

Once a person with TB is notified including his/her bank account details and unique identity number in NIKSHAY—the electronic online TB notification system—this is further linked to the Public Finance Management System (PFMS), which credits the funds to the designated bank account. The same approach is used for treatment supporters and for private providers.

From April 2018 to March 2019 more than 1.5 million beneficiaries received financial benefits of more than US$ 36 million through NPY, while treatment supporters, people with TB from tribal areas and private providers were collectively provided US$ 3 million. Funding for these financial services is supported through India's national TB budget, with funds provided through a loan from the World Bank.

For more details see:
https://tbcindia.gov.in/WriteReadData/India%20TB%20Report%202019.pdf
https://tbcindia.gov.in/index1.php?lang=1&level=1&sublinkid=4802&lid=3316

Creating an enabling environment: Political will and policymaking

Advocacy is key to raising the profile of TB across all relevant sectors. This approach requires a major shift in mindset both within and outside of the community of people working on TB. Engaging and enrolling allies from across sectors, and creating a broad-based, influential constituency that can help drive the response needed to end TB requires a major shift in mindset both within and outside of the community of people working on TB. TB is an urgent societal challenge, and the TB community cannot face it alone.

When it comes to overseeing multisectoral policymaking for TB that also aligns with national UHC and AMR strategies, one way to ensure the better integration of TB with other programmes

could be for countries to set up a TB coordination council at the national level, similar to a national AIDS board, and to work closer with existing national health committees.

NTP managers are not the best positioned to lead coordinated efforts across several departments and ministries. However, with adequate resources and high-level political support, NTP managers can effectively advise other programmes on how to incorporate TB into their activities. Political will needs to come from a consortium of ministers and high-ranking government officials, even when they need to be spurred to action by advocates, TB survivors and affected communities and their allies, and business and cultural leaders.

The way the argument is framed is also key. Focusing on TB will also improve performance toward achieving other UN Sustainable Development Goals. And social protection interventions are likely to impact multiple diseases simultaneously, making their implementation more valuable and cost-effective.

As TB risk factors are diverse, policy approaches should contain a mix of TB-specific approaches (i.e. interventions that directly reach people who have TB and aim to influence a particular TB indicator) and TB-sensitive approaches (i.e. interventions that reach people who are at risk for TB and can indirectly reduce their vulnerability, such as better housing and ventilation, or agricultural policies aimed at improving nutrition).

Better data on the links between TB and socioeconomic actions should be collected in order to equip decision-makers and parliamentarians with the evidence to change policy and allocate resources for social protection. Addressing TB will require major systemic changes in regulatory capacity (to ensure the rational use of medicines and infection control, among other issues), health care financing (through improved health insurance schemes), and boosting the capacity of health care systems to ensure UHC.

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Box 5.4 Preserving the capacity to end TB: learning from history

In 2002, Raviglione and Pio analyzed the history of WHO policies and guidance going back to 1948. They found that policy approaches shifted several times over decades from vertical, TB-specific approaches toward increasing integration of TB care within general outpatient services. The integration of managerial functions specific to TB followed, driven by the rationale that integration of these specialized functions (e.g., TB training, supervision, logistics and communication) would make their implementation more efficient and cost-effective. The health reform process of the 1980s led to further integration of what had previously been specialized functions of dedicated TB programs.

As a result, national TB programmes were essentially dismantled in many countries. This led to a steep drop-off in TB expertise, weakened support for TB research and large resources gaps just as the HIV pandemic began driving a new epidemic of TB. The need for a urgent TB response led to the rebuilding of specialized TB functions and programs through the 1990s, and the international adoption of DOTS as the standard TB response strategy, followed by another era of integrated approaches at the turn of the millennium.

In reviewing this history, the lessons that emerge are that neither vertical approaches nor excessive integration of TB functions are completely successful. Nor are specialized and integrated approaches mutually exclusive. Instead, the best chance of ending TB is through a mixed approach that continues to maintain specialized functions in some capacities (such as planning, training, disease monitoring, and assessment), integrates service delivery within primary healthcare, enrolls stakeholders from beyond the health sector in efforts to end TB, and relies on effective advocacy to keep TB properly high on national political and policy agendas.[17]

BOX 5.5 JAPAN: Expanding TB care as pathway to UHC

[TK need to consult source material to fact check and strengthen this messaging.]

In 1961 Japan achieved universal health coverage (UHC). In the 1950's TB was the largest killer, popularly known as the "national disease." TB was so prevalent that more than 20 percent of total medical expenditures were allocated to TB.

In 1951, the national TB Prevention Act was enacted, after which the Ministry of Health and Welfare launched a massive campaign against TB, through public health system strengthening, which resulted in a 25 percent decline in the number of people with TB [TK fact check]. TB care was rapidly expanded through:

- Collectively engaging the national government, together with the private sector, community and individuals.
- Creating a dedicated TB budget within national health insurance programs, which was used to expand coverage of TB care and services.
- Engaging the participation of local authorities in the national TB campaign.

The infrastructure, systems and processes put in place during the course of Japan's TB campaign created opportunities for reaching universal health coverage in Japan.

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[17] Raviglione MC and Pio A. Evolution of WHO policies for tuberculosis control, 1948-2001. The Lancet. 2002;359:775-80.