

**Key populations  
are being  
left behind in  
universal health  
coverage:  
landscape  
review of health  
insurance schemes  
in the Asia-Pacific  
region**



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# Executive summary

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## Background

Universal health coverage is guided by the principle that individuals and communities receive the services they need, including essential good-quality health services, without suffering financing hardship (1). The establishment or expansion of government-sponsored health insurance is often promoted as the main vehicle to finance universal health coverage. For people living with HIV and people from key populations (sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs, people in prison) living with or at risk of HIV, universal health coverage is considered a health-for-all solution for countries to integrate all HIV services, including prevention.

Once insurance schemes are in place and benefits defined, individuals should have access to insurance and the services they need. This is not always the case, however, for people living with HIV and people from key populations. Exclusions may exist (e.g. for people who inject drugs), people may not want to reveal information about themselves, the services needed may not be covered, or the right providers may not be contracted.

This is a pressing issue in the Asia-Pacific and other regions, where the HIV epidemic is concentrated among key populations, and people from key populations and their partners account for 98% of all new infections (2). The universal health coverage commitment provides an opportunity to understand how well health insurance schemes are working and where governments can focus their efforts in health systems strengthening to ensure easier access to services for people living with HIV and people from key populations.

This report examines three key objectives to understand how well existing health insurance schemes are working for key populations in the region:

- ▶ Health insurance coverage and access to health insurance for people from key populations.
- ▶ Types of services covered in health insurance, including prevention services for people from key populations.
- ▶ Mechanisms adopted for maximum service coverage for people from key populations.

Evidence is drawn from a landscape review of six countries in the region—Cambodia, India, Indonesia, the Philippines, Thailand and Viet Nam. A rapid review of the literature, including desk-based research, country deep dives and key informant interviews, informed the report. Based on this research, the report sets out a way forward to support positioning of the HIV response within universal health coverage.

## Key findings

- ▶ Domestic resource mobilization is an ongoing challenge as development partner funding is declining, particularly for key populations. About 80% of domestic financing is spent on HIV treatment services. HIV prevention and outreach rely on development partner funding, which saw a 63% decline between 2010 and 2019. Government-sponsored or compulsory health insurance accounts for a third or more of health financing in Indonesia, the Philippines, Thailand and Viet Nam. Cambodia and India have hybrid systems, with insurance schemes in place for certain groups. Out-of-pocket payments account for 50% or more of current health expenditure in Cambodia, India, the Philippines and Viet Nam. External sources of financing are highest in Cambodia, accounting for a fifth of current health expenditure. Financial hardship remains a challenge in the region.
- ▶ To meet universal health coverage goals, national health insurance schemes have expanded population coverage to include poor and vulnerable people. These schemes are at different stages of development in the region. Recent changes include the expansion and consolidation of schemes in all six countries (Table 1).
- ▶ All the schemes cover HIV treatment. All countries except for Indonesia have an explicit benefits package that lists all services covered in the health insurance scheme. Indonesia uses a small negative list for services not covered, so the benefits package is implicit.
- ▶ Coverage of HIV prevention services is absent, except for some services in Thailand. Civil society and community-based organizations and development partners fill the gaps for people without any financial protection.
- ▶ Barriers impede enrolment of people from key populations. Barriers include lack of awareness, complicated administrative processes, documentation requirements, co-payments or facility fees, stigma and discrimination, mixed success with sensitization training, and weak data privacy systems. These barriers compound issues around data collection and reporting to understand the depth and breadth of coverage of key populations in national health insurance schemes.
- ▶ Data on total health insurance coverage are available, but there are no data on coverage of key populations. For four of the six countries, population coverage varies from 66% (Philippines) to 99% (Thailand). Two countries (Cambodia, India) are in the infancy of health insurance coverage. Insurance coverage for people living with HIV is available only in Thailand and Viet Nam (respectively, 271 704 and 142 604 people on antiretroviral therapy in 2019).
- ▶ Use of evidence informed the inclusion of HIV-related services in the benefits package. In Viet Nam, the estimated cost of delivering HIV treatment services informed the Government's decision to include them in its social health insurance scheme. In Thailand, an evidence-based approach is institutionalized and informs decisions around benefits package inclusion and reimbursement.
- ▶ Legislation can be a powerful tool to create buy-in, but its impact varies:
  - ▶ Health insurance coverage is offered to all citizens, including foreign workers with valid work permits, as part of single schemes in Indonesia, the Philippines and Viet Nam. In Thailand, schemes are defined separately for selected groups. In Cambodia and India, the schemes target poor and vulnerable people. For people living with HIV and people from key populations, only certain services are

covered. These examples demonstrate tension between laws that mandate enrolment of citizens and other laws that prohibit coverage of certain conditions or interventions.

- ▶ In the Philippines, legislation is in place for people living with HIV and people from key populations to enrol; denial of enrolment is unlawful. Separate legislation specifies that all Philippine people are automatically enrolled and entitled to benefits of the national health insurance programme. Challenges exist, however, because some private health insurers impose exclusions.
- ▶ Criminalization policies in Cambodia and Indonesia exclude people who inject drugs from joining the schemes.
- ▶ Federated structures can be a challenge for governance and coordination. This is due in part to vertical delivery of national programmes, which rely heavily on development partner funding for prevention services. This split in government oversight and vertical programme delivery impedes linkages to care and financial integration of programmes:
  - ▶ In India, the National AIDS Control Organization oversees prevention and treatment, but the health insurance scheme covers HIV-related inpatient care.
  - ▶ In the Philippines, implementation depends in part on local government priority-setting, which may not align closely with central government policies.
- ▶ Civil society and community-based organizations contribute to the decline in HIV incidence in the region, but community-led delivery and social contracting are not at scale. Social contracting where civil society and community-based organizations are reimbursed with support from national programmes or development partners is seen in India, Indonesia and Viet Nam. Reimbursement via health insurance is under way or in the pilot phase in the Philippines and Thailand, and in the early stages of consideration in Cambodia. Civil society and community-based organizations inform the benefits package in the Thai health insurance scheme, where this feature is unique.

**Table 1.**Key features of the HIV financing landscape<sup>a</sup>

| Country     | Development of scheme  | Coverage of eligible population | Coverage of people living with HIV and key populations                | Benefits basket includes HIV prevention | Co-payments or fees  | Health insurance social contracting with civil society and community-based organizations |
|-------------|--|---------------------------------|---|---|--|--|
| Cambodia    | Started in 2000<br>Expanded to people living with HIV in 2019            | 500000 in 2020                  | Data not available<br>People who inject drugs excluded                | No                                      | Fees US\$1–25  | Early stages of planning with health insurance   |
| India       | Started in 2008<br>Expanded to people living with HIV in 2018            | 2% in 2020                      | Data not available  | No                                      | US\$7000 annual cap, then out-of-pocket payments                               | Not with insurance<br>Only with national programmes and development partner support      |
| Indonesia   | Consolidation of schemes in 2014   | 83% in 2019                     | Data not available<br>People who inject drugs excluded                | No                                      | Out-of-pocket payments<br>Local government may subsidize catastrophic expenses | Not with insurance<br>Only with development partner support                              |
| Philippines | Started in 1995<br>Automatic enrolment of people living with HIV in 2019 | 66% in 2017                     | Data not available  | No                                      | US\$600 annual cap, then out-of-pocket payments                                | Piloting with health insurance   |
| Thailand    | Started with inclusion of people living with HIV in 2002                 | 99% in 2019                     | 271704 people living with HIV received antiretroviral therapy in 2019 | Some aspects                            | None   | Yes, but not at scale  |
| Viet Nam    | Started in 1992<br>Expanded to people living with HIV in 2014            | 80% in 9 provinces in 2018      | 142604 people living with HIV received antiretroviral therapy in 2019 | No                                      | 20% co-payment being addressed via cross-budget subsidization                  | Not with insurance<br>Early stages of piloting with development partners                 |

<sup>a</sup> Data are for most recent years available.Source: Vannakit R, Janyam S, Linjongrat D, et al. Give the community the tools and they will help finish the job: key population-led health services for ending AIDS in Thailand. *J Int AIDS Soc.* 2020;23(6):e25535.

## **A way forward to support positioning of the HIV response within universal health coverage**

The recommendations set out below support an agenda around the HIV response as part of the goal of achieving universal health coverage. The recommendations target existing health insurance schemes and then look more broadly at health systems strengthening to ensure easier access from a fiscal perspective and a partnership approach.

### **Improve scope and legislation regulating health insurance schemes: benefits package responses**

Governments should prioritize the following to improve existing health insurance schemes:

- ▶ Comprehensive coverage, including prevention services, should be provided for people from key populations.
- ▶ Legislation and legislative tools should be strengthened and used to ensure people from key populations are entitled to health insurance.
- ▶ A harmonized approach to the insurance basket should be reflected at subnational government levels.

### **Governments working with civil society and community-based organizations should:**

- ▶ Ensure explicit inclusion of people living with HIV and people from key populations with confidentiality concerns.

### **Governments working with civil society and community-based organizations and development partners must:**

- ▶ Address knowledge gaps in health insurance eligibility and the rights of people living with HIV and people from key populations to access schemes.
- ▶ Sustain efforts for sensitization training.

### **Ensure sound financing strategies for easier access: fiscal responses and financial incentives**

Governments should target their fiscal responses in the following areas:

- ▶ Central governments should work closely with subnational governments to ensure alignment in fiscal responses, providing a clear central steer.
- ▶ Financial integration of vertical programmes in HIV prevention and treatment and as part of universal health coverage should be planned and supported.

### **Civil society and community-based organizations should be partners at the decision-making table:**

- ▶ Civil society and community-based organizations should inform the fiscal response.

### Development partners should:

- ▶ Ensure the HIV response is part of the wider fiscal conversation around common goods for health.

### Governments working with civil society and community-based organizations and development partners should:

- ▶ Explore innovative approaches for greater community-led service delivery through social contracting such organizations.

### Partnership responses

Governments should:

- ▶ Adopt a cross-government, multisectoral approach to safeguarding privacy of people living with HIV and people from key populations.

### Governments working with civil society and community-based organizations and development partners should:

- ▶ Sustain and scale up delivery models of these organizations to improve outreach to key populations.
- ▶ Create a policy space platform for civil society and community-based organization delivery models to share learning and maximize service coverage for key populations.
- ▶ Ensure future transition and sustainability planning uses a a multistakeholder model including civil society and community-based organizations from the start.

# Introduction

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Achieving universal health coverage, including provision of and access to good-quality health services needed by the population and financial protection, is one of the targets of the Sustainable Development Goals (SDGs). Health insurance schemes, including government-funded, social health and private insurance, are positioned in many countries as a vital tool to finance achievement of universal health coverage.

When planning for service provision, the specific needs of key populations are not always salient when the needs of the general population are being considered. Key populations include sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs and people in prison. People from key populations are at increased risk of acquiring HIV, in part due to discrimination and social exclusion. In the Asia-Pacific region, 98% of new infections are among people from key populations and their partners (2).

Most universal health coverage indices measure percentage coverage or absolute numbers of people who have (or do not have) access to services. Unless the needs of key populations are separately flagged and addressed, and provision of services specifically monitored, it is likely that they may be ignored when planning for universal health coverage. As key populations lack political power, it is likely that denial of services would not be noticed by stakeholders at large.

The COVID-19 pandemic has accentuated access-related challenges for vulnerable people who face mobility restrictions and livelihood challenges due to lockdowns and their effects.

This report undertakes a rapid review of the health insurance schemes in six countries in the Asia-Pacific region—Cambodia, India, Indonesia, the Philippines, Thailand and Viet Nam. The focus on health insurance is necessary because it is envisaged to be the main source of health financing in these countries. The review examines coverage for people living with HIV and people from key populations, considers the types of services covered, and identifies barriers to access for people from key populations.

The report is based on key informant interviews with stakeholders with expertise and knowledge about health insurance schemes in the region, complemented by a rapid review of the literature.

The report is structured as follows:

- ▶ The methodology set out by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and further details on the approach and limitations are outlined.
- ▶ The landscape findings regarding policy challenges in health insurance coverage for people from key populations are discussed, including access, services and mechanisms to maximize coverage.
- ▶ Country deep dives in India, the Philippines, Thailand and Viet Nam highlight current challenges and recent innovations.
- ▶ A way forward to support positioning of the HIV response within universal health coverage is set out to improve coverage, scope, financial protection and access for people living with HIV and people from key populations. Mechanisms towards health systems strengthening and partnerships to ensure easy access and sustainable health outcomes are discussed. Recommendations are proposed in three areas: benefits package responses, fiscal responses and partnership responses.

# Methodology, approach and limitations

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In the context of people from key populations, this review examines health insurance coverage and access; the basket of services covered in health insurance, including prevention; and mechanisms adopted for maximum service coverage.

It looks at the extent of coverage of health insurance schemes and access for people from key populations. It specifically considers the benefits of the schemes, such as outpatient visits and hospitalization-related services, and whether primary care components are built in or linked so that people can access primary care without financial hardship.

HIV treatment services tend to be included to some extent in universal health coverage packages, such as antiretroviral therapy and prevention of mother-to-child transmission. Explicit benefits packages are analysed to examine whether prevention and promotion services for people from key populations are included, such as condoms, needles and syringes, opioid substitution therapy, pre-exposure prophylaxis (PrEP) and basic clinical services.

The review examines the purchasing mechanisms of health insurance schemes. It considers whether contracting with civil society or community-based organizations is possible to provide services for people from key populations, and whether there are barriers to such mechanisms.

The review provides a quick landscaping of health insurance in six countries in the region—Cambodia, India, Indonesia, the Philippines, Thailand and Viet Nam. A deep dive is carried out into the situations in India, the Philippines, Thailand and Viet Nam. These four countries provide a useful comparison of health insurance schemes. The criteria used to select these countries included the size of the schemes, coverage of people from key populations, and specific innovations.

The findings of this review aim to inform the narratives around universal health coverage, and the integration of prevention services currently provided by vertical programmes into the universal health coverage support package. General health facilities fall short in provision and access to services for people from key populations. This review considers how financial incentives support integration for people from key populations. The discussion considers how schemes, financial incentives and delivery of services can be better aligned to meet the needs of people from key populations. Recommendations on integrating or including key population-specific services in current insurance schemes and universal health coverage packages will emerge.

The methodological approach included:

- ▶ A desk review drawing on recent national and international reports and secondary data to assess health insurance schemes.
- ▶ In consultation with the UNAIDS Regional Advisor and country directors, identification of stakeholders at the country level to participate as key informants.
- ▶ A questionnaire for key informants to complement the desk review by identifying services delivered and gaps and challenges in meeting the HIV response as part of universal health coverage.

Efforts were made to gather the most recent evidence and relevant information, but a systematic literature review was not conducted. Key sources of information were used to complement the key informant interviews as part of the desk-based research. This provided contextual information that may not be readily available in publications to inform and influence policy and implementation.

Annex 1 outlines the terms of reference.

# Landscape findings and policy challenges

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## Key messages

- ▶ Insufficient government funding is devoted to health in all the landscape countries. Countries are dependent on development partner funding, particularly for people from key populations.
- ▶ Universal health coverage should increase with a country's level of income, but some countries do not follow this trend. These differences suggest that how the health system is managed and how resources are allocated are equally important.
- ▶ Out-of-pocket payments form a significant share of current health expenditure. Financial hardship remains a challenge in the region.
- ▶ Challenges related to COVID-19 led to service disruption, drops in use, foregone care, and drops in insurance claims. Weakened government fiscal positions threaten universal health coverage and domestic resource mobilization with mounting debt.

## Fiscal picture

The HIV epidemic in the Asia-Pacific region is concentrated, with relatively low prevalence rates, but reducing the HIV burden has had mixed progress. There was a 12% decline in new infections in 2019 (3). The epidemic in the region is concentrated among people from key populations and their partners, accounting for 98% of all new infections. There are rising infection rates among gay men and other men who have sex with men, accounting for just under half (44%) of all new infections (2).

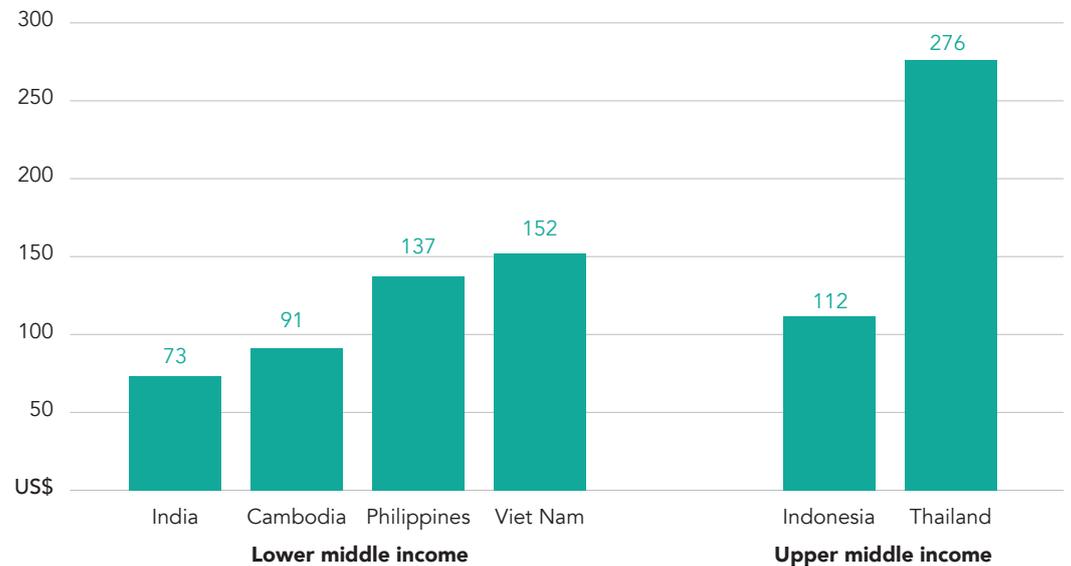
The region has seen a decline in new HIV infections since 2010, but this masks country differences (2). New HIV infections have risen sharply in the Philippines, with 16000 estimated new infections in 2019 (2, 4).

Several factors contribute to the differences in outcomes in the region, including epidemiology, the design of HIV programmes, and financial and sociopolitical factors. Of particular concern is the fiscal picture in these countries and the extent of provision of access to appropriate services and financial protection for people from key populations.

Between 2010 and 2018, there were generally small fluctuations in health expenditure as a share of gross domestic product (GDP), ranging from 6% in Cambodia to less than 3% in Indonesia (5). The Philippines, Thailand and Viet Nam have seen small increases in share of GDP, and Cambodia and Indonesia small decreases. India's share of GDP has remained stagnant.

**Figure 1.**

Current annual health expenditure per capita, 2018



Lower middle income: US\$1026–3995; upper middle income: US\$3886–12375.

Source: Global Health Expenditure Database, 2018.

Current annual health expenditure per capita varies across countries, with the lowest in India (US\$73) and the highest in Thailand (US\$276) (Figure 1). Per capita health spending is not necessarily correlated with country income levels (6).

All countries have embarked on universal health coverage agendas. Universal health coverage aims for all people to receive the health services they need, including public health services designed to promote better health (e.g. tobacco information campaigns and taxes), to prevent illness (e.g. vaccinations), and to provide treatment, rehabilitation and palliative care (e.g. end-of-life care) of sufficient quality to be effective, while at the same time ensuring use of these services does not expose users to financial hardship (7).

SDG 3.8 sets a target to support progress towards universal health coverage.<sup>1</sup> Two SDG indicators provide the framework to monitor progress and are measured together to provide a more complete picture:

- ▶ Indicator 3.8.1: coverage of essential health services, defined as the average coverage of essential services based on tracer interventions (reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; service capacity and access) among the general population and the most disadvantaged populations.
- ▶ Indicator 3.8.2: proportion of population with large household expenditure on health as a share of total household expenditure or income (7).

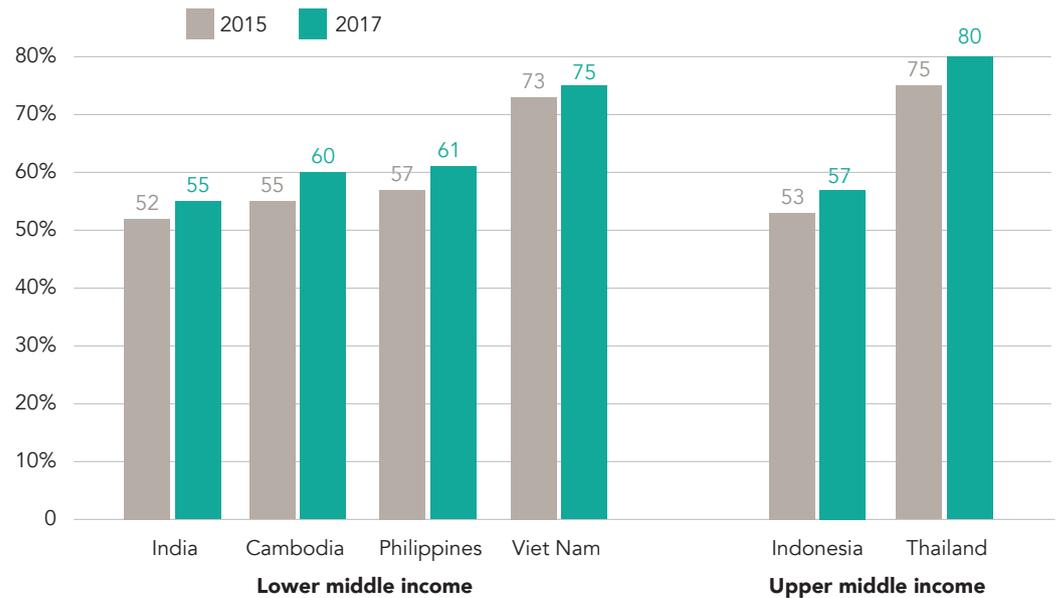
The universal health coverage index between 2015 and 2017 increased for all countries (Figure 2). Indonesia has a lower universal health coverage index than Cambodia and the Philippines, even though it is an upper middle income country (7, 8). Resources are

<sup>1</sup> "Achieve universal health coverage, including financial risk protection, access to good-quality essential health-care services, and access to safe, effective, good-quality and affordable essential medicines and vaccines for all" (7).

spent differently in different countries. For example, India and Thailand finance most of their HIV responses, but Thailand's budget execution rate (113.6%) is more than the overall health budget execution rate (89.4%) (9). Taken together, fiscal capacity and allocation of the level of health spending matter for countries at all income levels.

**Figure 2.**

Universal health coverage, 2015 and 2017



Source: Global Health Expenditure Database, 2018.

Chronic low funding of health systems in some countries, such as India, has contributed to shifting the financial burden on to low-income people facing high out-of-pocket payments and little financial protection. Across key health financial indicators, public health spending ranges from 1% of GDP in India to 2.9% of GDP in Thailand (Table 2). Out-of-pocket payments as a share of current health expenditure are highest in India and lowest in Thailand (Figure 3). All countries are at different stages of health financing. The health financing transition explains the trajectory from earlier stages where health spending is low and primarily out-of-pocket, to later stages where health spending is higher and primarily pooled.

**Table 2.**

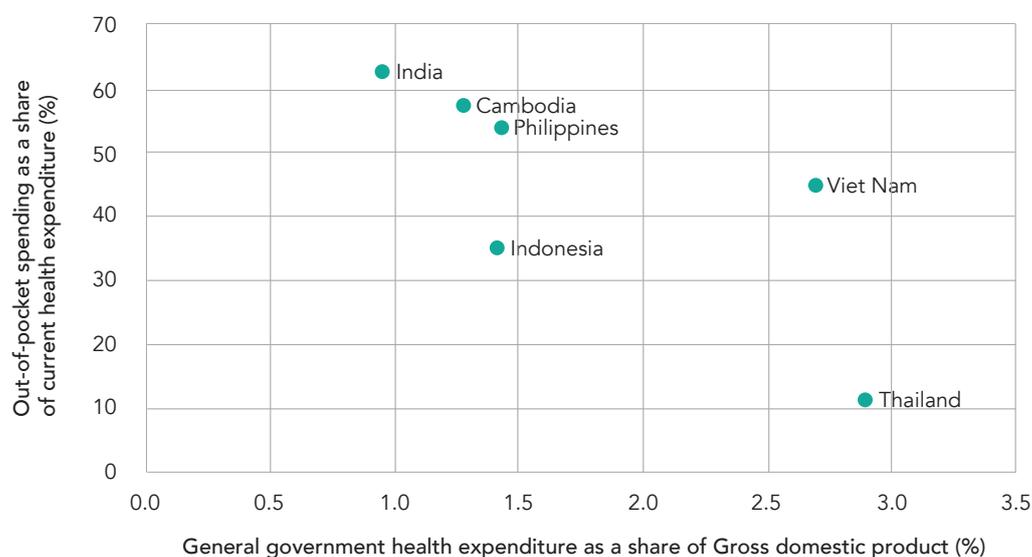
Health financing indicators, 2018

|   | Cambodia | India | Indonesia | Philippines | Thailand | Viet Nam |
|---|----------|-------|-----------|-------------|----------|----------|
| Public health spending as % GDP   | 1.3      | 1.0   | 1.4       | 1.4         | 2.9      | 2.7      |
| General government health expenditure as % general government expenditure | 5.2      | 3.4   | 8.5       | 6.6         | 15.0     | 9.3      |
| General government health expenditure per capita (current US\$)           | 19.3     | 19.6  | 55.1      | 44.6        | 210.4    | 69.1     |
| General government health expenditure as % current health expenditure     | 21.3     | 27.0  | 49.3      | 32.7        | 76.3     | 45.6     |
| Out-of-pocket spending as % current health expenditure                    | 57.5     | 62.7  | 34.9      | 53.9        | 11.0     | 44.9     |
| External as % current health expenditure                                  | 20.5     | 0.7   | 0.4       | 0.8         | 0.3      | 1.8      |

Source: Global Health Expenditure Database, 2018.

**Figure 3.**

Public and out-of-pocket health expenditure, 2018



Source: Global Health Expenditure Database, 2018.

All countries have focused on expanding coverage and access to national health insurance schemes to meet their universal health coverage goals. Government-sponsored or compulsory health insurance accounts for a third or more of health financing in Indonesia, the Philippines, Thailand and Viet Nam. Cambodia and India have hybrid systems, with insurance schemes in place for certain groups (Box 1, Figure 4). Out-of-pocket payments account for half or more of current health expenditure in Cambodia, India, the Philippines and Viet Nam. External sources of financing are highest (a fifth of current health expenditure) in Cambodia. Financial hardship remains a challenge in the region.

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**Box 1****Health financing framework and definitions**

Health financing schemes are the main building blocks of the functional structure of a country's health financing system. These are the main financing arrangements through which health services are paid for and through which people can access health care, such as government schemes, social and voluntary insurance, and direct payments by households. Health financing is analysed through financing schemes, the revenue sources of each scheme, and the institutional units (financing agents) managing the schemes.

Participation in a scheme may be compulsory or voluntary (10, 11). In compulsory schemes, coverage of the population is automatic and universal for all citizens or residents (e.g. a national health service). Participation (with contribution payments) is mandatory by law for the population or for defined groups within the population (e.g. social health or compulsory private insurance).

In voluntary schemes, coverage of individuals or groups is at the discretion of individuals or firms (e.g. individual- or group-based voluntary health insurance).

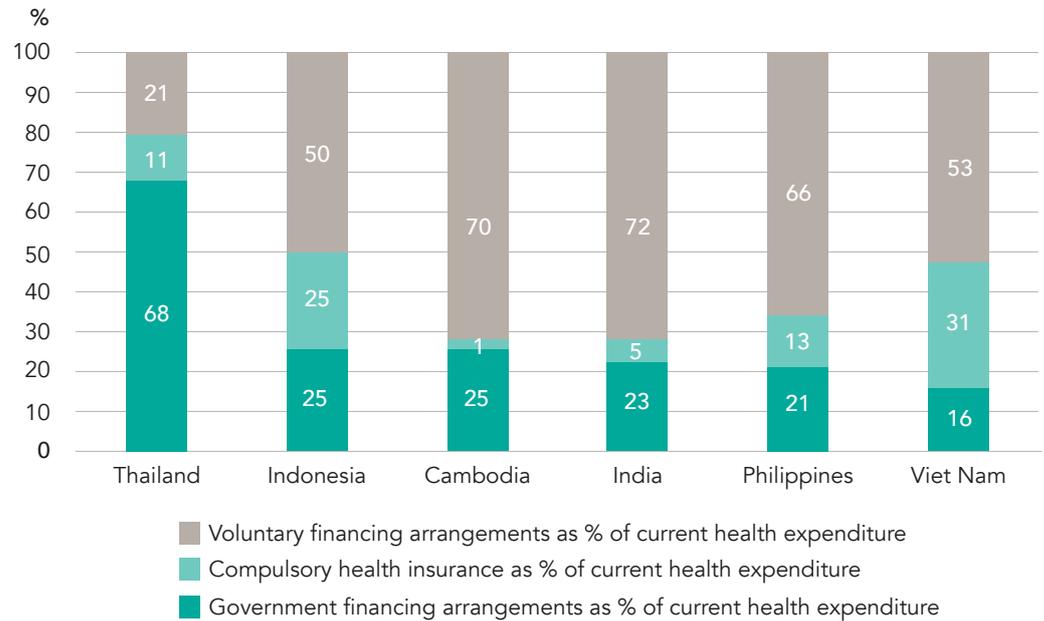
Access to the health services under a financing scheme may be non-contributory, contributory or discretionary. Non-contributory access is defined by constitution or law (e.g. citizens, residents, or defined individuals or groups within the country) and not linked to a specific contribution payment.

Countries face complex choices in how they raise, pool and use funds to ensure the availability and use of good-quality services. Health system financing is an essential component of universal health coverage, but progress towards universal health coverage also requires coordinated actions across the pillars of the health system.

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**Figure 4.**

Sources of financing, 2018



Source: Global Health Expenditure Database, 2018.

In the Asia-Pacific region, on average 81% of domestic financing is spent on treatment services because domestic resources prioritize HIV treatment. HIV prevention and outreach tend to rely on development partner funding. Between 2010 and 2019, there was an overall 63% decline in development partner funding in the region, affecting HIV prevention services for people from key populations (2).

Donor financing can mitigate only some of the access and out-of-pocket payment issues. Financial sustainability remains a challenge. There is mixed progress on domestic HIV financing for people living with HIV and people from key populations (2). This suggests financial protection remains a challenge in the region. Viet Nam is an example of a country where budget pooling led to increased mobilization of domestic resources (Box 2).

## Box 2

### Expansion of coverage drawing on budget pooling and cross-subsidization

In October 2019, Viet Nam had an estimated 211981 people living with HIV, of whom 142604 were on antiretroviral therapy. Before 2014, antiretroviral therapy was provided almost exclusively by donors. In the context of declining donor funding for HIV programmes, the Government of Viet Nam pursued a strategy to sustainably finance its HIV response with domestic resources. The Government has integrated HIV services into its social health insurance scheme since 2013. With funding from central and provincial government budgets

and social health insurance contributions, Viet Nam increased use of domestic resources for HIV from less than 25% in 2014 to 53% in 2020. In addition, since 2020, 56 of the 63 provinces in Viet Nam have used their local budgets to cover social health insurance premiums or antiretroviral co-payments for people in need (12).

Information on the size of key populations living with or at risk of HIV is limited, and there are issues around the availability of recent data, data collection, reporting and quality (Table 3). Lack of readily available and accessible data on key populations compounds the problem of understanding the impact of health insurance. The existing data show only part of the picture (3).

**Table 3.**  
Estimated HIV prevalence

| Country     | Prevalence (%) |   |                         |                    |                  |
|-------------|----------------|---|-------------------------|--------------------|------------------|
|             | Sex workers    | Gay men and other men who have sex with men | People who inject drugs | Transgender people | People in prison |
| Cambodia    | 2.3            | 4   | 15.2                    | 9.6                | 1.6              |
| India       | 1.6            | 2.7   | 6.3                     | 3.1                | 2.1              |
| Indonesia   | 5.3            | 25.8  | 28.8                    | 24.8               | 1                |
| Philippines | 0.6            | 5.0   | 29                      | 3.9                |                  |
| Thailand    | 2.8            | 11.9  | 20.5                    | 11                 | 1                |
| Viet Nam    | 3.6            | 10.8  | 12.7                    |                    |                  |

Sources: 2020 global AIDS update: seizing the moment—tackling entrenched inequalities to end epidemics. Geneva: Joint United Nations Programme on HIV/AIDS; 2020.

UNAIDS data 2020. Geneva: Joint United Nations Programme on HIV/AIDS; 2020 (<https://www.unaids.org/en/resources/documents/2020/unaids-data>).

AIDS Data Hub database.

There are issues concerning the extent to which health financing and expenditure data capture the sources and financing, limiting country comparisons. In this report, country deep dives provide qualitative and contextual information, giving a fuller picture of efforts to increase coverage and access for people from key populations.

The COVID-19 pandemic has led to service disruptions, a drop in use, foregone care, and a drop in insurance claims (11). The pace of transition from donor financing support is not certain. The challenge is to ensure programmes are funded and

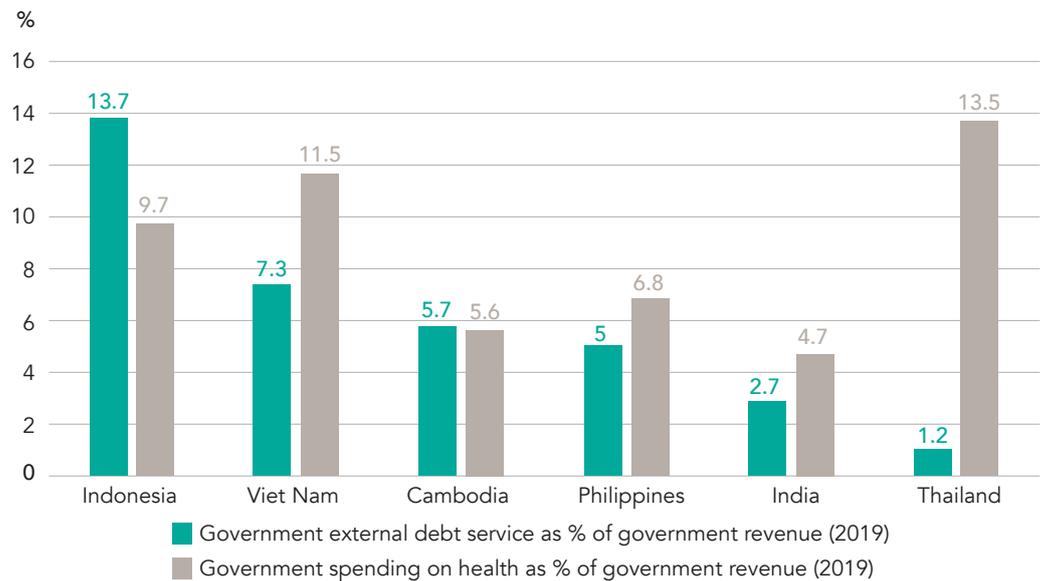
expenses not shifted to individuals in the form of out-of-pocket payments at the point of care (13).

Economic growth in the region is trending downwards. The extent of negative impacts on the global economy, government revenues and jobs in the formal and informal economies are uncertain (14).

Health spending as a share of government revenue ranges from 4.7% in India to 13.5% in Thailand. Except in Indonesia, all health spending as a share of government revenue exceeds the proportion spent on external debt payments (Figure 5).

**Figure 5.**

Comparison between government health spending and debt service payments, 2019



Sources: Sixty-four countries spend more on debt payments than health. Worcester, UK: Jubilee Debt Campaign; 2019 (<https://jubileedebt.org.uk/press-release/sixty-four-countries-spend-more-on-debt-payments-than-health>Jubilee Debt Campaign).

Global Health Expenditure Database, 2018.

One analysis predicts that severe drops in tourism, trade, and domestic consumption and investment in developing countries in Asia due to COVID-19 may lead to economic losses amounting to US\$42billion (0.5% of GDP) (15). The International Monetary Fund projected a contraction of -2.2 for the region, in part due to sharper contraction in countries such as India and the Philippines (16, 17). The pandemic has led to falls in commodity prices, the main export income for many countries, huge capital flight, and an increase in future borrowing costs (18). A weakened government fiscal position threatens universal health coverage and domestic resource mobilization with mounting debt.

There are barriers to increasing HIV spending, including fiscal space due to the global economic slowdown. Other challenges that existed before the pandemic remain, such as political will to invest in HIV and stigma and discrimination against people from key populations. Political inertia has led to missed opportunities to increase funding for key population programmes and to increase involvement with civil society and community-based organizations. Health insurance may bring opportunities to catalyse social

protection and social contracting to further HIV outreach. There are opportunities to improve resource allocation and remove fragmentation in delivery and financing of HIV programmes so the needs of people from key populations are firmly embedded in universal health coverage.

### Fiscal picture: key points

Legislation may exist to allow people from key populations to access insurance, but in practice barriers impede access of people from key populations to health insurance schemes, and there is a lack of coverage for prevention services. Barriers include:

- ▶ Complicated administrative processes.
- ▶ Requirements for documentation that people from mobile populations may not have.
- ▶ Co-payments or facility fees.
- ▶ Stigma and discrimination.
- ▶ Weak data privacy systems.

In this review, examples of government legislation in the Philippines and Viet Nam explicitly include access to insurance for people living with HIV and people from key populations, but many people from key populations are unaware of their eligibility (19).

All schemes are plagued with difficult processes, and joining is not straightforward. Providing evidence of residency and supporting documentation is a challenge for people from key populations, many of whom are mobile and do not have a permanent place of residence. For example, three months residency is required in Indonesia to provide proof of residency, but people from key populations may not have this proof and are unable to enrol. In Viet Nam, there are restrictions on accessing schemes in different provinces; if a person moves out of a province, their insurance eligibility and access are not guaranteed in another province.

The level of premium contributions depends on the type of membership. In Indonesia, the head of the household pays the premiums for all family members as part of family membership of the scheme. If a person living with HIV moves from the family address to another address, they need to join the scheme and pay as an individual.

Co-payments continue to hinder access for people living with HIV (19, 20). Financial protection is not sufficiently available for people from key populations. Private health insurance may not be available because it is unaffordable or exclusions are in place. Development partners and civil society and community-based organizations continue to play an important role in provision of HIV-related services.

Stigma and discrimination remain a barrier. In Cambodia and Indonesia, people who inject drugs cannot access health insurance due to criminalization of drug use. Sensitization training for providers is not always taken up and requires further scale-up. People from key populations expressed concern over identity safeguarding in all the countries reviewed. In Viet Nam, the updated Health Insurance Law allows sharing of data with third parties, but details on how the data will be protected are unclear. Data privacy measures are not sufficiently in place to encourage people from key populations to join the schemes.

## Population and key population coverage

In this review, national health insurance schemes in the region are at various stages of development. Some countries established health insurance schemes many decades ago, but the most significant developments relate to population expansion and the inclusion of HIV-related services supported by more recent legislation.

The Philippines and Viet Nam introduced social health insurance in the first half of the 1990s, but these schemes did not cover the entire population. Early in the 2000s, Cambodia introduced coverage for poor people through support of nongovernmental organizations rather than an established government-sponsored scheme. Thailand established a universal scheme that included HIV-related services in 2002. Near the end of the 2000s, India introduced a national health insurance scheme for poor and vulnerable people. Indonesia moved to consolidate its schemes in the 2010s (21).

Recent important changes include the expansion and consolidation of schemes in India, Indonesia, the Philippines and Viet Nam, and inclusion of HIV treatment services in the benefits basket (Figure 6, Table 4).

Gaps remain, particularly for people from key populations. Health insurance benefits baskets typically cover treatment services such as antiretroviral therapy, viral load testing and HIV-related complications. Prevention services and opportunistic infections tend to be missed. People living with HIV and people from key populations face stigma and discrimination and high out-of-pocket payments for non-HIV needs (e.g. cancer, surgery). Data on people from key populations accessing schemes typically are not readily collected for reporting purposes.

Of particular concern, data are not readily available and disaggregated on people from key populations living with or at risk of HIV with respect to enrolment, coverage, access to services, and level of financial protection. This review requested breakdown of people from key populations accessing and enrolled in national health insurance schemes, but this was not provided. Key population organizations do not readily have this information.

There are barriers to enrolment, such as identity requirements, residence documentation and certificates, which some people from key populations do not have. Lack of data privacy compounds data collection and reporting issues in understanding the depth and breadth of coverage of people from key populations.

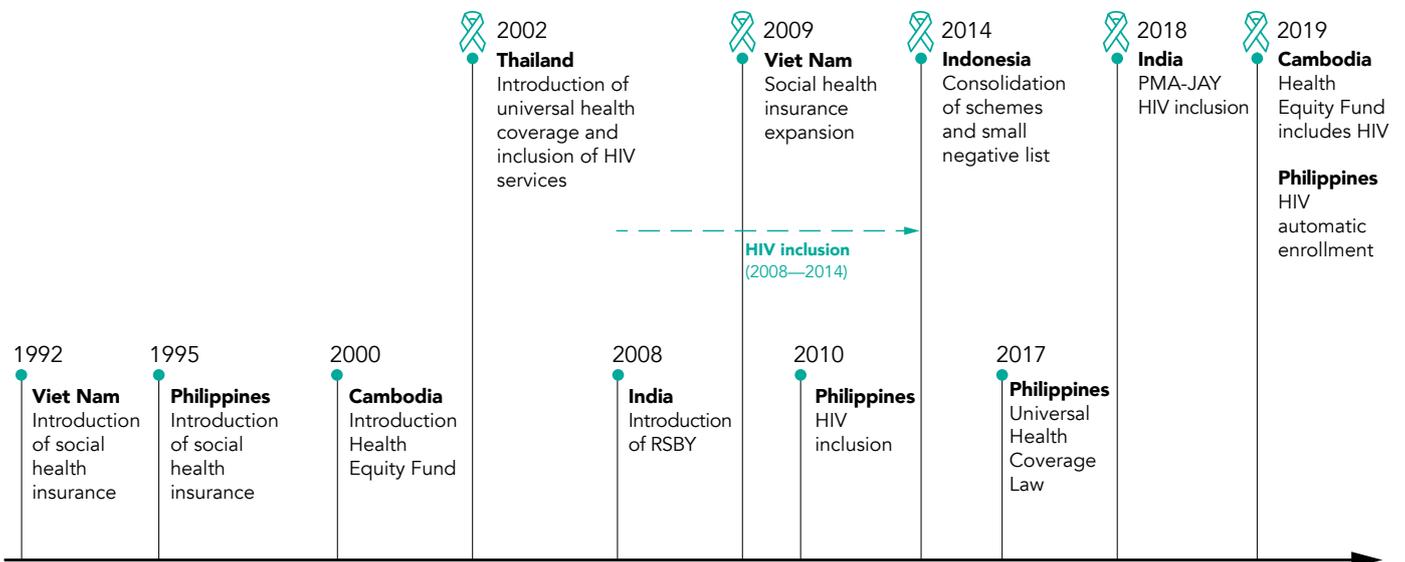
HIV prevention services may be supported in part by development partners working with country national programmes. Prevention and treatment services are not well integrated in the primary care package. Services tend to operate in silos without continuation or referral of care across primary and inpatient care settings. Civil society and community-based organizations continue to fill gaps in access and funding of preventive and treatment services. Social contracting with health insurance schemes is not well established, but it does operate in Thailand and is in early piloting stages in the Philippines.

### Population and key population coverage: key points

- ▶ To meet universal health coverage goals, national health insurance schemes have expanded population coverage to include poor and vulnerable people, including people from key populations living with or at risk of HIV.
- ▶ Schemes include HIV treatment services.
- ▶ Gaps include prevention, opportunistic infections and non-HIV-related needs.
- ▶ HIV services are fragmented, with prevention typically under national or donor programmes. Civil society and community-based organizations provide gaps in HIV prevention and treatment services to people without financial protection.
- ▶ Barriers discourage people from key populations from joining national health insurance schemes. Barriers include complicated administrative processes, requirements for documentation that people from mobile populations do not have, co-payments or facility fees, stigma and discrimination, and weak data privacy systems.
- ▶ Data on insurance coverage of people from key populations are not available. Thailand and Viet Nam have data on coverage of people living with HIV.

**Figure 6.**

Inclusion of HIV treatment in national health insurance schemes, selected countries



**Table 4.**

Key features of the HIV financing landscape

| Country     | Eligible population coverage | Insurance coverage of people living with HIV and people from key populations | Benefits basket includes HIV prevention | Co-payments or fees  | Health insurance social contracting with civil society and community-based organizations |
|-------------|------------------------------|--|---|--|--|
| Cambodia    | 500000 in 2020               | Data not available<br>People who inject drugs are excluded                   | No                                      | Fees of US\$ 1–25  | Early stages of planning with health insurance   |
| India       | 2% in 2020                   | Data not available   | No                                      | US\$7000 annual cap, then out-of-pocket payments                               | Not with insurance<br>Only with national programme or development partner support        |
| Indonesia   | 83% in 2019                  | Data not available<br>People who inject drugs are excluded                   | No                                      | Out-of-pocket payments<br>Local government may subsidize catastrophic expenses | Not with insurance<br>Only with development partner support                              |
| Philippines | 66% in 2017                  | Data not available   | No                                      | US\$600 annual cap, then out-of-pocket payments                                | Piloting with health insurance   |
| Thailand    | 99% in 2019                  | 271704 people living with HIV received antiretroviral therapy in 2019        | Some aspects                            | No co-payments in Universal Coverage Scheme                                    | Yes, but not at scale  |
| Viet Nam    | 80% in 9 provinces in 2018   | 142604 people living with HIV received antiretroviral therapy in 2019        | No                                      | 20% co-payment recently addressed via cross-budget subsidization               | Not with insurance<br>Early stages of piloting with development partners                 |

Data are for most recent years available.

Source: Vannakit R, Janyam S, Linjongrat D, et al. Give the community the tools and they will help finish the job: key population-led health services for ending AIDS in Thailand. *J Int AIDS Soc.* 2020;23(6):e25535.

# Landscape highlights

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## Cambodia

In Cambodia, the health financing system for poor people was initially led by nongovernmental organizations but is now government-sponsored. The Health Equity Fund provides coverage for poor and vulnerable people via the IDPoor programme, which has recently included HIV services. People who inject drugs face exclusions.

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The Health Equity Fund provides access to health services for members of households identified in the IDPoor registry and certain categories of informal workers who do not access contributory schemes (22, 23). The IDPoor registry identifies poor and vulnerable households (500000 registered in 2020) (23). Over half of people living with HIV who qualify for an IDPoor card do not have one (24). The Health Equity Fund was piloted in 2000 and funded by local nongovernmental organizations to ensure access to health services for poor and vulnerable people. The Cambodian Government is the largest funder, with partner support.

In 2019, the Cambodian Government designated all people living with HIV as a high-priority population to be covered by the Health Equity Fund and expanded its benefits package to include HIV services. A policy circular set out the Government's commitment to increase financing for HIV through the Health Equity Fund, contract with civil society organizations, use facility funds for HIV, and better integrate HIV within the health sector (13).

The National Social Security Fund covers private-sector workers. A law was passed in 2019 to include self-employed people but is still to be implemented (23). The National Social Security Fund benefits package includes 14 chronic illnesses and outpatient and inpatient services, but HIV services and medicines are not reimbursed (25).

A case study on Cambodia and other countries shows trends towards integration of HIV in health systems using analyses based on the World Health Organization (WHO) framework for health systems (26). Cambodia's system was characterized as "partly integrated" in terms of HIV policy and governance, service delivery, human resources, and strategic investments and efficiency, but "not integrated" in terms of commodity supply chain, strategic information, and health information system levels (27).

The Health Equity Fund has been extended to reimburse facilities for the provision of outpatient consultations for HIV testing and counselling at health centres and voluntary counselling and testing centres at referral hospitals, with referral to pre-antiretroviral therapy and adult and paediatric antiretroviral therapy services (consultation, investigations and medicines) (28). Service fees of US\$2.50 may be applied at facilities.

External funds cover HIV testing, antiretroviral medicines and viral load testing. Non-HIV-related needs may require out-of-pocket payments if not covered by the Health Equity Fund or the National Social Security Fund.

### **Cambodia**

- > Services covered: HIV testing, counselling, and adult and paediatric antiretroviral therapy services.
- > Population coverage:
  - > 500000 in 2020.
  - > People who inject drugs are criminalized and face exclusions.
  - > Coverage of people living with HIV: unknown.
  - > Coverage of people from key populations: unknown.

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### **India**

India's relatively new national health insurance scheme aims to cover 500 million poor and vulnerable people. The vertical programme delivery for people living with HIV sits outside the health insurance scheme, and linkages to care remain a challenge.

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Only 18% of the urban population and 14% of the rural population are covered under any health insurance plan (29). Government-funded health insurance schemes have not succeeded in wide population coverage. After 8 years of implementation, the national health insurance programme, Rashtriya Swasthya Bima Yojana, reported to have enrolled 41 million families (30), but out-of-pocket payments were not significantly reduced (31).

In 2018, Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) was launched as a major step to move India closer towards universal health coverage and subsumed Rashtriya Swasthya Bima Yojana (32). The aim of PM-JAY is to provide hospital coverage for the 40% of India's population that is poor or low-income. This tax-financed national health insurance scheme only covers inpatient care. PM-JAY has identified 500 million people eligible to join the scheme, and 10 million beneficiaries were registered in 2020 (33).

Antiretroviral medicines and viral load monitoring are not covered as these are provided through the national AIDS programme. No data are available on coverage of people living with HIV or people from key populations. The National AIDS Control Organization, part of the Ministry of Health and Family Welfare, is responsible for HIV prevention and treatment. The programme adopts a multisectoral response, including partnerships with civil society and community-based organizations and the private sector in service provision alongside Government facilities and standalone clinics. The Ministry of Health and Family Welfare's recent initiative is to revamp existing primary health facilities into health and wellness centres. This is not coordinated with PM-JAY, and ensuring linkages of care remains a challenge.

## India

- > Services covered: inpatient care with specific HIV-related benefits packages that cover management of HIV, complications and opportunistic infections.
- > Population coverage:
  - > 2% (10 million people) in 2020.
  - > Coverage of people living with HIV: unknown.
  - > Coverage of people from key populations: unknown.

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## Indonesia

Indonesia has moved to consolidate its scheme but defined only a small negative list. An implicit benefits basket is a challenge, and people who inject drugs face exclusions.

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Indonesia consolidated various insurance schemes in 2014 with the introduction of national health insurance (Jaminan Kesehatan Nasional, JKN) into a single national scheme managed by a semiautonomous public agency, Badan Penyelenggara Jaminan Sosial-Kesehatan (34, 35). Population coverage is 83% (223 million people), but 70 million people, mostly in the informal sector, are still uninsured (36, 37). The scheme stipulates mandatory participation by all poor and vulnerable people. People in the informal sector can join voluntarily. People who inject drugs face exclusions.

The benefits basket is implicit. A small negative list specifies what is not included (38). In practice, the Ministry of Health determines the benefits basket, but the Social Health Insurance Law does not specify responsibility. Indonesia recently implemented minimum service standards, and local governments are expected to commit sufficient funding to meet health targets (13). Currently JKN covers facility-based voluntary screening and treatment for sexually transmitted infections, facility-based consultations for HIV testing, antiretroviral therapy, palliative and other therapy for advanced HIV and AIDS and related comorbidities, and routine biochemistry-related laboratory tests, but it does not include prevention (39).

There is no social contracting between JKN and civil society and community-based organizations, although they are involved in the HIV prevention response, which is mostly funded by development partners (40).

## Indonesia

- > Services covered: benefits package is implicit, with a small negative list. Facilities are reimbursed for counselling, HIV testing, antiretroviral therapy and HIV complications.
- > Population coverage:
  - > 83% (223 million people) in 2019.
  - > People who inject drugs are criminalized and face exclusions.
  - > Coverage of people living with HIV: unknown.
  - > Coverage of people from key populations: unknown.

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## Philippines

The Philippines embarked on health insurance in the 1990s. There have been recent introductions of the Universal Health Coverage Law and automatic enrolment of people living with HIV. Piloting of social contracting with health insurance is under way.

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PhilHealth, the national health insurance programme, was created in 1995. In 2010, the Government included HIV-related treatment services in the benefits package, but Philippine people were not automatically part of the scheme (41–43). Passage of the Universal Health Coverage Bill 5784 in 2017 means all Philippine people are automatically enrolled and entitled to benefits of the national health insurance programme (44). The programme had 66% coverage in 2017, but coverage estimates do not necessarily capture people entitled to a premium subsidy (45). The programme accounts for a small share of current health expenditure, and there are substantial out-of-pocket payments.

The HIV Law passed in 2019 allows for people living with HIV to be automatically enrolled into the scheme (46). Private insurers tend to put in exclusions, however, so people living with HIV cannot access coverage. A technical working group is looking into this.

The scheme includes an outpatient care package for people from key populations, covering up to US\$600 annually. The benefits package covers antiretroviral therapy, laboratory viral load monitoring and testing, but it excludes baseline testing and opportunistic infections. There is no prevention package, and key prevention services such as PrEP and condoms are left out.

## Philippines

- > Services covered: HIV treatment, care, antiretroviral medicines and viral load monitoring.
- > Population coverage:
  - > 66% in 2017.
  - > Coverage of people living with HIV: unknown.
  - > Coverage of people from key populations: unknown.

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## Thailand

Thailand expanded coverage to poor and vulnerable people, with inclusion of HIV prevention and treatment services in the benefits basket. Proposals for reimbursement of key population-led services for HIV testing and PrEP have not been implemented.

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Thailand has four health insurance schemes: a scheme for civil servants, a scheme for private-sector employees, the Universal Coverage Scheme introduced in 2002 for the 47 million Thai citizens not covered by the other two schemes, and a cross-border migrant scheme.

The Universal Coverage Scheme is financed from general taxation, and premiums are not imposed on the informal sector. When the scheme was started, the Ministry of Public Health did not have sufficient funds to cover poor and vulnerable people, and the Thai Government covered the shortfall of 30 billion Thai baht from general tax funding. Key enablers include reimbursement practices for budget setting, political commitment and health system readiness. For provider payment, reimbursement through capitation (per head) and diagnosis-related payments (case-based) within global budgets supported efficient budget setting (47). Political commitment has continued despite changes in government leadership and receives broad public support.

The Civil Registration and Vital Statistics System, which mandates all births and deaths, facilitates identification of people for the scheme.

In 2013, the Thai Government introduced a new policy to cover cross-border migrant workers, who are disproportionately affected by HIV. Civil society and community-based organizations play an important role in the HIV response for key populations. They also inform the benefits package, because civil society has a presence on the National Health Security Office board (48). Social contracting is in place, and civil society and community-based organizations are accredited to deliver HIV services. Since 2016, the National Health Security Office has given US\$6 million to civil society organizations, the majority led by key populations (49). Total population coverage in the Universal Coverage Scheme was 99% in 2019, and 271704 people received antiretroviral therapy (50). The benefits package includes HIV testing, treatment and counselling, opioid substitution therapy, opportunistic infections and non-HIV-related needs (13).

Thailand has recently included PrEP in one of its national universal health coverage schemes funded by the National Health Security Office. Under consideration is for the Office to reimburse key population-led organizations for HIV testing and PrEP distribution (49).

## Thailand

- > Services covered: HIV testing, treatment and counselling, opioid substitution therapy, opportunistic infections, non-HIV-related needs and PrEP.
- > Population coverage:
  - > 99% in 2019.
  - > Coverage of people living with HIV: 271704 received antiretroviral therapy in 2019.
  - > Coverage of people from key populations: unknown.

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## Viet Nam

Viet Nam introduced social health insurance in the 1990s. Progress towards integration of HIV continues, with support from development partners.

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Social health insurance was introduced in 1992 and has undergone a series of reforms and coverage expansion. Population coverage has expanded since it was first introduced, but the whole population is not yet covered—in 2016, 20% of people did not have coverage (51).

Development partners have played an important role in the financing and delivery of HIV-related treatment services and prevention services. The social health insurance package covers treatment services, and 142604 people living with HIV received antiretroviral therapy in 2019 (12, 52). Co-payments up to 20% are applied to HIV treatment under the scheme (53). Financing efforts with development partners to remove such barriers have tried to address this issue; in 2020, 56 of the 63 provinces in Viet Nam used local budgets to cover social health insurance premiums or antiretroviral co-payments for people in need (12).

Antiretroviral therapy, HIV testing, medical services for babies born to women living with HIV, and opportunistic infections are covered under health insurance, but prevention-related services are not (53, 54). Provinces have a provincial AIDS centre or a centre for disease control where prevention services are offered, but these may be hard to access due to their location (only one in each province), stigma and unfriendly services.

## Viet Nam

- > Services covered: HIV treatment, care and testing, antiretroviral medicines and opportunistic infections.
- > Population coverage:
  - > 80% in 2018 in 9 provinces.
  - > Coverage of people living with HIV: 142604 received antiretroviral therapy in 2019.
  - > Coverage of people from key populations: unknown.

# Country deep dives: challenges and innovations

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This section presents findings from deep dives in India, the Philippines, Thailand and Viet Nam, with emphasis on policy challenges and recent innovations. These countries were selected to provide a mix in the development and progression of health insurance towards universal health coverage and the extent to which they include people living with HIV and key populations.

The country deep dives drew on a rapid literature review and validated through key informant interviews. Key informants from health insurance, ministry of health and national programmes, civil society and development partners were identified with support from UNAIDS Country Offices (Table 5).

Key informants who agreed to participate were asked a series of questions covering current health insurance policy context and challenges; performance of health insurance schemes; opportunities to integrate HIV into universal health coverage; role of health insurance in providing financial protection; purchasing arrangements; and role of development partners (see Annex 2 for the full questionnaire and Annex 3 for a list of key informants).

**Table 5.**  
Number of key informant interviews

| Country      | Civil society | Health insurer | Ministry of health or national programme | Development partner | Total     |
|--------------|---------------|----------------|--|---------------------|-----------|
| Cambodia     | 2             |                |  | 1                   | 3         |
| India        | 2             | 1              |  | 3                   | 6         |
| Indonesia    | 2             |                |  | 1                   | 3         |
| Thailand     | 1             | 1              |  | 1                   | 3         |
| Philippines  | 1             |                | 1  | 1                   | 3         |
| Viet Nam     | 2             |                |  | 1                   | 3         |
| <b>Total</b> | <b>10</b>     | <b>2</b>       | <b>1</b>                                 | <b>8</b>            | <b>21</b> |

## Key messages

Legislation is in place for people living with HIV and people from key populations to enrol, and denial is unlawful, but challenges remain when private health insurers impose exclusions (Philippines).

Health insurance coverage is either offered to all citizens under one scheme (Indonesia, Philippines, Viet Nam) or defined for selected groups (Cambodia, India, Thailand).

Federated structures are a challenge for governance and coordination. A federated system requires a governance structure that can integrate and provide funding for preventive services provided by vertical programmes.

Civil society and community-based organizations contribute to the decline in HIV incidence in the region, but community-led delivery and contracting are not at scale. These organizations require accreditation, training and integration into the health system for reimbursement.

## India

The recently established health insurance scheme PM-JAY plans to offer wide population coverage for poor and vulnerable people. The federated system requires a governance structure that can integrate and provide funding for preventive services provided by vertical programmes for better coordination.

## Key points

- ▶ It remains to be seen whether the Indian Government will take on the work of development partners in setting out minimum standards of service delivery.
- ▶ States have varying levels of fiscal capacity, budget execution and HIV service provision. There is a need for a more evidence-based approach to address financial and equity issues. Sharing successes for scale-up and innovative approaches to financial risk is needed.
- ▶ A concerted policy effort is needed at all levels of government to educate beneficiaries about the scheme. This also requires capacity at the state and district levels.

## Coordination between the National AIDS Control Organization and the PM-JAY health insurance scheme

The National AIDS Control Organization oversees the HIV response in India. The focus is on outreach, prevention, testing, antiretroviral medicines and treatment. Primary care more generally is under the umbrella of the Health and Wellness Centres Programme, which plans to establish 150000 upgraded centres to provide comprehensive primary care services, free medicines and diagnostic services (31). The extent to which the National AIDS Control Organization and health and wellness centres will work together as part of primary care transformation remains to be seen.

For people living with HIV, coverage through PM-JAY is available for complications and opportunistic infections that require inpatient care (55). The benefits package does not include outpatient care, antiretroviral medicines or ongoing follow-up. PM-JAY plans to put in place an IT system that uses one platform across all states to allow for tracking, identification of beneficiaries, and detection of fraud and misuse. This is part of the

Indian Government's ambitious National Digital Health Mission towards an integrated digital health infrastructure.

Linking primary, secondary and tertiary care with health insurance and universal health coverage is not yet part of the broader health agenda. It remains to be seen how well the National Digital Health Mission will lead to an integrated health infrastructure. Currently, the fragmented approach to prevention and treatment services across the health system creates challenges with respect to linkages of care and integration for people living with HIV and people from key populations.

### Varying policy capacity at state level

Governance, financing and delivery of health services are shared between the central and state governments. At the federal level, the Ministry of Health and Family Welfare has regulatory power over most health policy decisions but is not involved directly in health-care delivery. At the state level, directorates of health services and departments of health and family welfare are responsible for organizing and delivering health-care services to their populations (31).

PM-JAY is a centrally sponsored scheme co-financed by the central and state governments for a minimum standard benefits package of secondary and tertiary health-care services. States have the flexibility to expand their own financing with respect to who is covered, the benefits basket, how much is covered beyond the requirements of PM-JAY, and how to pay for it. States have the option to implement the scheme using a public or private firm (insurance mode), a state department or state implementation agency (assurance mode), or a mixed model (56).

There are big differences in capacity standards at the state level. Despite overall low public funding for health, the states finance the majority (70%) and the central government finances the remainder (30%). Interstate funding for health varies due to state capacity: the lowest per capita spending is in Bihar, Jharkhand, Madhya Pradesh, Uttar Pradesh and West Bengal (616–983 rupees), which is about half that of Kerala and Tamil Nadu (57).

There has been some harmonization in states that have more than one scheme, and some states previously put in place their own health insurance schemes. Some states have added more populations to the coverage using their budgets beyond the central government financing, but expansion is constrained due to Fiscal Responsibility and Budget Management Act rules that limit state deficits to 3%. Previous studies showed public insurance schemes were ineffective (58). Around 37% of the population was covered by any form of health coverage in 2017–2018 (59). As part of PM-JAY expansion, there is an opportunity to build on existing networks of HIV outreach and service provision already established through the National AIDS Control Organization (Box 3).

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### Box 3

#### Civil society and community-based organizations in India's HIV response

In India, the National AIDS Control Organization has contracted out to local organizations since 1996 (60, 61). Targeted interventions have supported the HIV response, particularly for people from key populations. These interventions include needle–syringe programmes and opioid substitution therapy, condom promotion and distribution, and linkages to HIV and sexually transmitted infection testing and treatment services through an outreach-based service delivery model implemented by civil society and community-based organizations (60).

In 2014–2015, 1840 targeted intervention projects that included civil society and community-based organizations reached 5.6 million people, with a coverage of 80% for female sex workers, 68% for gay men and other men who have sex with men, and 75% for people who inject drugs (62), but inequality, stigma and discrimination are still a challenge (63).

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The significant variation in state capacity will have implications on how well health insurance schemes are established in the states in terms of treatment coverage and access for people living with HIV. PM-JAY should support states to meet a certain minimum threshold for coverage and access for people living with HIV and people from key populations. A lack of disaggregated data means that information on access and enrolment of people from key populations is unknown.

#### Learning from state-initiated schemes

In Tamil Nadu, the Chief Minister's Comprehensive Health Insurance Scheme was launched in 2009. Tamil Nadu's income is 11th out of all the states in India with respect to GDP per capita. The state is highly urbanized and has 80% literacy (64). The scheme provides state-financed coverage to over half its population (42 million poor and near-poor people) for inpatient benefits in government and private facilities, with an annual cap of US\$1400 per family. Benefits cover secondary and tertiary care, including diagnostic packages (e.g. cardiovascular diagnostics, magnetic resonance imaging), follow-up packages (e.g. follow-up investigations, medicines) and high-end packages (e.g. implantation, organ transplant). Coverage is generally higher among lower economic groups, so large-scale mistargeting does not appear to be an issue. HIV-related complications are part of the scheme.

Beneficiaries receive a smartcard with a built-in chip that displays a photograph, a unique identification number linked to the family's ration card, and in some cases selected biometric information. The card shows contact details for information and grievance services regarding the scheme and the scheme's public portal. Beneficiaries and their providers can access their medical history and claims records online. Several IT solutions have contributed to a well-functioning scheme to support payments to providers, tracking claims and detecting fraudulent claims (64).

PM-JAY builds on several central and state health insurance schemes that have been implemented in India over the past decade. It also uses a smartcard as part of its scheme. The scheme will continue the packages it offers, including those not currently covered in PM-JAY, such as diagnostic, follow-up and high-end packages.

## Philippines

Legislative changes support the inclusion of the HIV response in health insurance financing along with social contracting, but local government discretion remains a challenge.

### Key points

- ▶ Clients in rural settings have access issues. Many are lost to follow-up or use private clinics. In practice, private health insurance companies exclude people living with HIV and people from key populations.
- ▶ The Philippines is piloting social contracting with civil society and community-based organizations, but accreditation is a lengthy process. There is potential scope for development partners to work with these organizations to support their accreditation work with technical support.
- ▶ Despite central policy decisions, the HIV response depends on local authority discretion.

### Political commitment through legislation

The Philippines has made legislative changes towards integrating the HIV response within universal health coverage. In 2017, the Universal Health Coverage Bill 5784 was passed, which states that all Philippine people are automatically enrolled in and entitled to the benefits of the national health security programme. The Bill distinguishes between people in the formal sector (all people rendering services in government or private employment, business owners, migrant workers, self-employed people), who are obliged to pay a premium, and members in the informal sector, for whom full funding is included in the national General Appropriations Act (65). All senior citizens are mandatorily covered. There is strong political support behind universal health coverage and the national health insurance scheme, PhilHealth, plays an integral role in implementation of the Bill. The Data Privacy Act 2012 ensures privacy of data, but full implementation of this law needs to be strengthened.

The Philippine HIV and AIDS Policy Act passed in 2019 allows for people living with HIV, regardless of risk or diagnosis, to be automatically enrolled in the scheme, including people from key populations. Denial of health, accident and life insurance coverage for people living with HIV is unlawful (66). Only 36% of people living with HIV in the Philippines are receiving treatment. This law aims to improve health insurance coverage and counter stigma and discrimination, but challenges remain. Private insurers still impose exclusions in practice. A technical working group is in place to look at these concerns.

### Social contracting as a strategic purchasing mechanism

In 2018, a key population-led organization was accredited to run a clinic for gay men and other men who have sex with men and to be reimbursed for provision of antiretroviral therapy services (49, 67). Accreditation meant the clinic was in the same category of government-supported clinics that are routinely reimbursed by PhilHealth (68). The clinic

is reimbursed US\$600 (30000 Philippine pesos) annually for each client who initiates and adheres to antiretroviral therapy. The organization estimates that most of its clients are not eligible for PhilHealth insurance, which means it relies on international partners to support the service.

Social contracting is piloted in a few regions with civil society and community-based organizations in universal health coverage implementation sites. These are contracted as treatment facilities to provide outpatient health packages. This should help to further HIV outreach for people from key populations to access treatment services, but prevention services are not included. In the Western Region, the expectation is to increase from 4 to 10 sites. An accreditation process is in place for civil society and community-based organizations to be certified with PhilHealth. These processes can be lengthy, taking six to nine months. The Ministry of Health is working with civil society and community-based organizations to become accredited in universal health coverage implementation sites. At present, only a handful are currently accredited, but they are not providing prevention services. As social contracting continues and matures, there is an opportunity to increase information on people from key populations who enrol and access the scheme.

### National and subnational challenges

The Philippine Government provides an overall steer in setting the HIV policy response, but implementation and delivery lie with local governments. There is a need for ongoing advocacy to influence the local policy-setting agenda in response to changing roles in local leadership. Targeting local health officers and their counterparts is necessary for advocacy to be effective and to inform local priority-setting. Legislation provides guidelines and policies, but these require HIV champions alongside law-makers to support implementation frameworks. Clients have an important role in influencing local decision-making. Empowered clients and support groups should inform local government units of their health service needs.

With the rise in prevalence of HIV in the Philippines, greater national and local government coordination is needed, backed by local political support to sustain outreach activities for people from key populations. It remains to be seen whether clear central oversight will be able to push this agenda and mitigate local government discretion in priority-setting.

## Thailand

Thailand has expanded its health insurance coverage towards wide population coverage, with support of key population-led delivery of services in some parts of the country. Coverage for migrants is a challenge.

### Key points

- ▶ There is a need for the Thai Government to support the integration of key population-led services with endorsement, legalization and institutionalization.
- ▶ Greater coordination of governance is needed at all levels of government to monitor and evaluate service provision for people living with HIV.
- ▶ The generation of evidence and data informs health insurance reimbursement decisions, with support from civil society and community-based organizations.

## Civil society and community-based organizations as part of the HIV response

Key population-led organizations have contributed to the HIV response in Thailand. Their involvement was first funded by development partners. The key population-led health services model was established in 2015 (Box 4). The approach was proposed by key populations, working in close collaboration with the public health sector. The guiding principles of the model include key population-friendliness (non-stigmatizing, confidential), accessibility (flexible service hours, low or no cost, geographically close to workplaces and gathering venues) and quality (adhering to national regulations and standards for health service delivery) (49).

Since 2016, the Thai National Health Security Office has made available US\$6 million to civil society organizations (mainly key population-led) for outreach activities and recruitment of people from key populations for HIV testing (67). Since 2017, a partnership approach with the support of development partners established a certification and training programme for lay providers from key populations (69). Key population-led health service providers undergo training and certification to provide HIV testing, antiretroviral therapy and PrEP for people from key populations (gay men and other men who have sex with men, and transgender people) (67, 70). In 2020, there were 106 certified key population-led providers working in 15 provinces (71). Their involvement contributed to a drop in new infections in Thailand, improved follow-up and earlier treatment initiation (67, 72). This model of delivery relies on development partner support and is not yet integrated. The delivery of prevention services for key populations is largely funded by external partners. The formal integration of key population-led organizations with regard to reimbursement is not well established in the National Health Security Office—the challenge is to expand this model at scale across the country.

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### Box 4 Social contracting in Thailand

Social contracting has matured over time. The transition from donor funding to domestic financing first focused on organizations being politically and legally supported to provide HIV services. A Thai Government regulation permitted nonclinical providers to provide services for HIV and sexually transmitted infections under the supervision of a physician, pharmacist or medical technologist. The development of certification and accreditation schemes for key population-led organizations enabled them to receive government financing, improve the quality of their provision, and follow different financial management and reporting procedures (67). Reimbursement involves a pay-for-performance scheme that pays organizations on a cost per head basis, and grants cover the operational costs of an organization reaching targets or goals (49). This experience is currently being documented for UNAIDS for wider dissemination (67).

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### Outreach to non-Thai migrants is insufficient

The Universal Coverage Scheme covers almost all Thai citizens. The scheme was designed to expand coverage to Thai citizens who were not already covered by the civil service or private-sector employee schemes. Non-Thai citizens and migrants, however, are not permitted to be part of the scheme. In 2001, the Thai Government established a separate scheme for migrants that required migrant workers to pay premiums. Migrant health volunteers supported the delivery of health services to migrant workers (47). There is a high risk of HIV infection among migrants: HIV prevalence among migrants to Thailand from neighbouring countries was found to be up to four times higher than among the general population in 2014 (2, 73). Most sex workers are migrants from villages who use the work to support their families in their home communities. Those in low-income places appear to be at particularly high risk of HIV (74).

In 2013, the Thai Government announced a policy to provide health insurance for registered and unregistered cross-border migrant workers not covered by social security (75). The scheme includes outpatient, inpatient, health promotion and disease prevention services, including HIV treatment and other high-cost care, but excludes renal replacement therapy for chronic renal failure and treatment for psychosis and drug dependence (76). The migrant scheme has low coverage and in 2016 covered only 35% of the 3.4 million migrants and their dependents (77). There have been discussions on whether the Thai Government should fund health services for migrant workers (78). Lack of clear policy direction and slow verification processes impede implementation of the scheme (76). Those left out of the scheme face out-of-pocket payments for their HIV health needs. Recent efforts with a voluntary non-profit-making health insurance scheme mitigate some of these negative effects but are not sufficient (79). Expansion of coverage, enrolment and access to the scheme remains a challenge for migrants from key populations.

### Evidence-based approach for inclusion in the benefits package and reimbursement

The Institute of HIV Research and Innovation has been involved in evidence generation to inform the reimbursement of key population-led organizations. The Institute advocates for key population-led health service providers to perform HIV-related services to increase availability, access and quality and provides evidence to inform pricing decisions.

The Institute's recent work has looked at HIV testing and PrEP distribution. This involved gathering data in three provinces with high rates of HIV among sex workers, transgender people, and gay men and other men who have sex with men. The pilot sites were key population-led health services for HIV testing and PrEP distribution, positive testing, offer of PrEP, acceptance of PrEP, how to retain clients in service, and how to create better linkages to care. The clinical work and data-gathering provided a costing analysis to the Thai Government for reimbursement, which showed that use of PrEP was higher in key population-led clinics. A multistakeholder approach was necessary to support this work to establish stakeholder buy-in. At the time of writing, the Government had approved the plan for the National Health Security Office to reimburse key population-led organizations for HIV testing and PrEP distribution, but this has not been implemented.

## Viet Nam

There has been progress in the integration of the HIV response into health insurance in Viet Nam, but challenges remain.

### Key points

- ▶ People from key populations find it difficult to navigate the system due to the switch in provision via the health insurance system and restrictions in coverage in different provinces.
- ▶ Evidence generation with support from development partners contributed to the Vietnamese Government's decision to include HIV treatment services in the health insurance basket.
- ▶ It remains to be seen whether changes to the Health Insurance Law will safeguard the privacy and confidentiality of people from key populations.

### Political support for legislative changes

A series of legislative changes have led to the establishment of Government-sponsored health insurance, consolidation of provincial schemes into a single health insurance fund, and expansion of population coverage and the benefits package. A compulsory scheme was set up in the 1990s for civil servants and pensioners. The Ministry of Health oversaw the scheme implemented by the Vietnam Health Insurance Agency (51). A key change in the 2000s led to the transition of the Health Care Fund for Poor People into a compulsory scheme, with premiums funded by the Government. The benefits package in 2014 included HIV treatment, which coincided with the reduction of international aid (80, 81). In 2015, the Health Insurance Department was established in the Ministry of Health to oversee and provide governance.

The Health Insurance Law is undergoing draft changes for implementation planned for 2022–2023. One proposed change will allow third parties to discover clients' HIV status, including administrative staff who enter information into the system. It remains to be seen whether changes to the draft law will protect the confidentiality and privacy concerns of people from key populations.

### Contribution of civil society and community-based organizations

Integrating vertical HIV programmes into a single health insurance fund required a multistakeholder approach. Civil society and community-based organizations supported this transition, particularly by promoting awareness among people from key populations living with or at risk of HIV, such as sex workers and people who inject drugs (53). This involved training of counsellors to work with people living with HIV in community-based health facilities (12).

Some charities provide financial support to subsidize health insurance premiums, but affordability and access to services remain barriers for people from key populations. In 2019, the city of Ho Chi Minh committed funding to subsidize social health insurance premiums and antiretroviral medicine co-payments for people living with HIV unable to pay (13).

Social contracting with the Government is being considered. Civil society and community-based organizations do not have the required legal status to spend Government funds or be contracted by the health insurance scheme. A pilot programme in a clinic in the province of Nghe An with development partner funding

provides counselling, condoms and clean needles. Further work is needed to understand how this could be scaled up to consider accreditation of civil society and community-based organizations and payment mechanisms for reimbursement.

### Transition of HIV financing from development partners to health insurance

Initially, development partners—in particular, the United States President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)—financed the provision of HIV services, including prevention. As donor funding declined, the Government planned for increased domestic funding, management and implementation of HIV programmes (12), but only for treatment. With funding from the central and provincial government budgets and social health insurance scheme contributions, Viet Nam increased use of domestic resources for its HIV response from less than 25% in 2014 to 53% in 2020 (82). As of 2020, 56 of the 63 provinces in Viet Nam use their local budgets to cover social health insurance premiums or antiretroviral medicine co-payments for people in need (12).

Ongoing collaboration with development partners supports the transition from donor-funded HIV programmes towards domestic financing as part of the country’s universal health coverage response. The United States Agency for International Development (USAID) has worked with the Government of Viet Nam to support this transition, including generating evidence to estimate the cost and feasibility, working with civil society and community-based organizations to improve outreach efforts, and enrolment into the scheme. USAID supported integration of donor-funded HIV clinics within the scheme and reimbursement for procurement of antiretroviral medicines. Integration of donor-funded HIV-clinics involved providing technical assistance to provincial departments of health and HIV clinics to qualify for social health insurance contracts. At the national level, this was complemented with a monitoring tool to assess progress towards integration. The social health insurance scheme was designed for the reimbursement of medicines rather than advanced procurement of medicines. A central unit was designated and established with a legal basis to oversee the administrative roles and responsibilities for procurement of medicines (12).

# Key messages

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This study set out to determine the extent to which existing health insurance schemes cover people from key populations and their access to insurance; the types of services covered by health insurance, including prevention for key populations; and mechanisms adopted to maximize service coverage for people from key populations.

The following key messages emerged:

- ▶ All the schemes cover treatment, but none includes comprehensive coverage for prevention services. This is due in part to the vertical delivery of national AIDS programmes in the countries considered, which for key populations rely heavily on development partner funding and sit outside the main health service delivery platforms and financing schemes.
- ▶ Barriers to enrolment in schemes include lack of awareness among people living with HIV of their eligibility to join; administrative requirements preventing some people from key populations from joining; lack of confidentiality and privacy safeguards; and mixed success with sensitization training.
- ▶ Data on total health insurance coverage are available, but coverage of key populations is not known. In four of the six countries, population coverage varied from 66% (Philippines) to 99% (Thailand). Two countries (Cambodia, India) are in the early stages of coverage. Coverage for people living with HIV is available only in Thailand and Viet Nam (271704 and 142604 people on antiretroviral therapy, respectively).
- ▶ Use of evidence informed the inclusion of HIV-related services in the benefits package. In Viet Nam, the estimated cost of delivering HIV treatment services informed the Government's decision for the social health insurance scheme to include HIV treatment services. In Thailand, an evidence-based approach is institutionalized and informs decisions around inclusion and reimbursement in the benefits package.
- ▶ Legislation can be a powerful tool to create buy-in, but its impact varies. In some countries, health insurance coverage is offered to all citizens, including foreign workers with valid work permits (Indonesia, Philippines, Viet Nam). In other countries, schemes are defined separately for different groups (Thailand) or target only poor and vulnerable people (Cambodia, India). For people living with HIV and people from key populations, coverage is only for certain services. Criminalization policies in Cambodia and Indonesia exclude people who inject drugs from joining the schemes. These examples indicate tension between one law that mandates enrolment of citizens and another law that prohibits coverage to people from certain groups or of certain conditions or interventions. In the Philippines, legislation contributed to the explicit inclusion of people living with HIV to be entitled to health insurance where denial is unlawful. Legislation exists that specifies all Philippine people are automatically enrolled and entitled to

the benefits of the national health insurance programme, but challenges remain when private health insurers create barriers and exclusions. There is therefore inconsistency in implementation of the law between the Government and private insurers.

- ▶ Federated structures can be a challenge for governance and coordination in programme implementation. Top-down policies work well only if they are implemented locally and aligned with local government priorities. Typically, health insurance schemes and national AIDS programmes are run separately. In India, the National AIDS Control Organization oversees prevention and treatment, but the health insurance scheme covers HIV-related inpatient care, which impedes linkages in care and financial integration of these programmes.
- ▶ Civil society and community-based organizations contribute to the decline in HIV incidence in the region, but community-led delivery and social contracting are not at scale. Social contracting has a longer history in some countries, with support from national programmes and development partners (India, Indonesia, Viet Nam). In other countries, reimbursement via health insurance occurs on a small scale or is in a pilot phase (Philippines, Thailand) or under consideration (Cambodia). Civil society and community-based organizations inform the benefits package in the Thai health insurance scheme, where this feature is unique.

# A way forward to support integration of HIV responses in universal health coverage

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This review set out to understand the challenges around access and coverage for people from key populations in health insurance schemes in the Asia-Pacific region, and the associated enablers and barriers. The region has a concentrated HIV epidemic that requires a targeted approach for key populations. This report recommends that national governments provide clear oversight and support innovative approaches to further HIV outreach at the subnational and local levels for well-coordinated service provision.

An explicit place for civil society and community-based organizations in policy planning is needed in upstream policy and downstream implementation. With development partner funding falling, the risk of key populations being left behind is significant, particularly when health insurance schemes are planned and launched as an approach to achieving universal health coverage. Future transition planning is necessary to ensure financial protection and easier access to services for people from key populations.

The recommendations set out below support an agenda around the HIV response as part of the goal of achieving universal health coverage. The recommendations target existing health insurance schemes and then look more broadly at health systems strengthening to ensure easier access from a fiscal perspective and a partnership approach.

## **Improve scope and legislation regulating health insurance schemes: benefits package responses**

Governments should prioritize the following to improve existing health insurance schemes:

- ▶ Provide comprehensive coverage to include prevention services for people from key populations. All insurance schemes fall short on prevention. None of the insurance schemes goes far enough in prevention coverage. Universal health coverage as a goal provides an opportunity to ensure prevention is given equal importance to enable linkages in care. A comprehensive prevention package should include counselling, condoms and lubricants, opioid substitution therapy and PrEP.
- ▶ Use legislation and strengthen legislative tools to ensure people from key populations are entitled to health insurance. Legislation has progressed the HIV response as part of universal health coverage, but the legal framework

and criminalization policies should not exclude people from key populations. Legislation should be explicit to include people from key populations in health insurance.

- ▶ A harmonized approach to the insurance basket should be reflected at subnational levels of government. There is a need for clear steering and enforcement from central governments to ensure services for people living with HIV and people from key populations are accessible at the local level. Some insurance schemes currently fall short in enrolment of people living with HIV and people from key populations, and local government discretion shifts local priorities that may not align with the central government.

Governments working with civil society and community-based organizations should:

- ▶ Ensure explicit inclusion of people living with HIV and people from key populations. This should be balanced with ensuring confidentiality, addressing issues around identification, and lacking documentation for verification. Privacy policies should stipulate anonymization of data, who can access data, and conditions where identification of individuals may be necessary. Lack of assurance around data protection hindering enrolment and access was a common theme in the key informant interviews. Better privacy safeguards would contribute to improving data collection on key populations.

Governments working with civil society and community-based organizations and development partners must:

- ▶ Address knowledge gaps in health insurance eligibility and the rights of people living with HIV and people from key populations to access schemes. Support for increased awareness and education efforts targeting people from key populations, including via social media, is necessary. Several studies cite lack of awareness and education regarding health insurance schemes as a barrier to enrolment, uptake and access (13, 83). This point was reaffirmed in the key informant interviews in all six countries.
- ▶ Sustain efforts for sensitization training. Discriminatory laws impede a supportive culture of sensitization training in service provision, and this was highlighted in the key informant interviews. Even where facilities have undergone sensitization training, quality of services varies. Some facilities are not equipped to ensure services are provided in an environment that assures confidentiality and privacy. Increased efforts in sensitization training are needed to mitigate stigma and discrimination in practice.

## **Establish sound financing strategies to ensure easier access: fiscal responses and financial incentives**

Governments should target their fiscal responses in the following areas:

- ▶ Central and subnational governments should work closely to ensure alignment in fiscal responses, providing a clear central steer. Domestic financing does not sufficiently cover the HIV response as part of universal health coverage. The political commitment to national health insurance schemes provides an opportunity to include domestic financing as part of a well-financed integrated system for HIV prevention and treatment. Governments should continue their efforts in domestic resource mobilization. A well-designed HIV response as part of universal health coverage should align prevention and treatment across care

settings with coordination at subnational levels in procurement and provision of HIV services.

- ▶ Governments should support and plan for financial integration of vertical programmes in HIV prevention and treatment and as part of universal health coverage. There is an unhelpful distinction between individual- and population-based services for HIV. Many insurance schemes regard HIV treatment as an individual-based service and prevention as part of a population-based service (39). National programmes sit outside health insurance schemes, but these vertical programmes require integration in several areas with regard to health system financing—first between prevention and treatment, and then beyond that with integration of financing for HIV and minimum services packages for universal health coverage. These include IT system compatibility for payment, accreditation of facilities for reimbursement as part of financial integration, and appropriate financial incentives for provider payments such as capitation or diagnosis group payments for efficient budget-setting. Other areas of integration that have an impact on financial integration include service delivery, human resources for health, procurement and supply chain management, governance, leadership and accountability, and community participation in health system responses (84).

Civil society and community-based organizations should be a partner at the decision-making table:

- ▶ They should inform the fiscal response. In Thailand, these organizations have a presence on the National Health Security Office board and have an opportunity to inform discussions around the benefits package, but this is unique among the countries covered in this review. The key informant interviews highlighted that civil society and community-based organizations require technical support to enable them to carry out budget advocacy for people living with HIV and people from key populations. Development partners were suggested as a broker to support civil society and community-based organizations with budget advocacy and domestic financing conversations with governments.

Development partners should:

- ▶ Ensure the HIV response is part of the wider fiscal conversation around common goods for health. Development partners should advocate for inclusion of the HIV response in universal health coverage. Given the fragmentation of financing within the health sector, across sectors and among levels of government, the health financing response should try to improve alignment of budget processes, set coherent priorities across sectors and levels of government, and consider innovative risk mechanisms (85).

Governments working with civil society and community-based organizations and development partners should:

- ▶ Explore innovative approaches for greater community-led service delivery through social contracting with civil society and community-based organizations. Social contracting with national programmes began in the 1990s in India and more recently with development partners in Indonesia and Viet Nam. It is in discussion in Cambodia. It is in place as part of insurance schemes in some parts of Thailand, and is in a pilot stage in the Philippines. Existing reimbursement mechanisms for civil society and community-based organizations should serve as a model for government reimbursement systems to support transition towards universal health coverage. A concerted policy effort towards systems

of accreditation, training and certification would support the wider domestic agenda on health insurance scheme outreach, moving the region towards its Fast-Track commitment of a greater share of community-led service delivery.

### **Strengthen systems for health to ensure easier access by embedding a multisectoral approach to governance: partnership responses**

Governments should adopt:

- ▶ A cross-government, multisectoral approach to safeguarding privacy and data-sharing of people living with HIV and people from key populations. The key informant interviews highlighted this in the context of enrolment and access to national health insurance schemes. Discriminatory laws encourage stigma and discrimination. A cross-government approach is needed, working with relevant ministries to safeguard privacy and data-sharing concerns in enrolment, incentives for targets for enrolment, and agreement on data gathering on access and coverage for key populations.

Governments working with civil society organizations and community-based organizations and development partners should:

- ▶ Sustain and scale up these organizations' delivery models to further outreach to people from key populations. Key population-led health services provide strong evidence of well-targeted outreach. Governments should incentivize civil society and community-based organizations delivery models for expansion at scale.
- ▶ Create a policy space platform for civil society and community-based organization delivery models for shared learning to maximize service coverage for people from key populations. Innovations in HIV service delivery continue. These bottom-up approaches show promise for greater scale-up. An approach that coordinates and engages with all levels of government creates a space for networks of learning to tap into and mitigates delivery challenges.
- ▶ Ensure future transition and sustainability planning uses a multistakeholder model, including civil society and community-based organizations from the start. Universal health coverage as a goal requires forward and proactive sustainability planning. Key players, including civil society and community-based organizations, should be part of future sustainability planning. This is essential so that people living with HIV and people from key populations are not left behind in planning, implementation and progress towards the goal of universal health coverage.

# Annexes

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## Annex 1. Terms of reference

Aim: a review of national health insurance schemes in the Asia-Pacific region to assess services and populations covered by them in the context of the HIV response and universal health coverage.

Achieving universal health coverage, including provision of good-quality health services needed by the population and financial protection, is one of the targets of the Sustainable Development Goals. According to the World Health Organization, “Universal health coverage means that all people and communities can use the promotive, preventive, treatment, 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.”

Health insurance schemes, including government-funded, social health and private insurance, are positioned in many countries as a vital tool to achieve universal health coverage. Primary health-care services, an important strategy in achieving universal health coverage, are sometimes subsumed within the insurance programme or provided separately with different sources of financing. In combination, primary care and health insurance programmes are to provide services needed by all communities and people.

When planning for service provision, there is a possibility that services for the most marginalized subpopulations may be ignored as their needs are not salient when the general population is considered. Most indices of universal health coverage measure percentage coverage or absolute number of people who have (or do not have) access to services. Unless the needs of vulnerable and marginalized subpopulations (e.g. sex workers, gay men and other men who have sex with men) are separately flagged and addressed by the package of services, and their provision specifically monitored, it is likely they will be ignored when planning for universal health coverage. As these populations lack political power, it is also likely that denial of service would not be noticed by stakeholders at large.

The COVID-19 pandemic has accentuated challenges in access for vulnerable people, who face mobility restrictions and livelihood challenges due to lockdowns and their effects.

This review aims to examine the extent of coverage of health insurance schemes. It specifically looks at the benefits that the schemes cover, such as health visits and hospitalization services, and whether the schemes have built-in primary care components or are linked to other programmes so that people can access primary care without hardship. If primary care services are provided, the availability of explicit

benefits packages is analysed to see whether prevention and promotion services important for key populations living with or at risk of HIV (sex workers, gay men and other men who have sex with men, transgender people, people who inject drugs, people in prison) are included, such as condoms, needles and syringes, opioid substitution therapy, pre-exposure prophylaxis and provision of basic clinical services. The promise of providing services will be validated by performance reports from the facilities and other secondary sources of information. Where there is no explicit package but a commitment to provide all services needed by the people and the community, there is a need to examine what services are planned to be provided and by whom, and whether they are actually provided.

Another area to be examined is the purchasing mechanisms in place and whether they can contract with civil society or community-based organizations to provide services for key populations, mostly covered by international aid through the Global Fund to Fight AIDS, Tuberculosis and Malaria or the United States President's Emergency Fund for AIDS Relief. If this is not the case, the assessment will analyse the requirements or impediments in setting up such mechanisms.

The findings of this review aim to inform the narratives around universal health coverage and integration of prevention services currently provided by vertical programmes into the universal health coverage package. Recommendations on integrating or including these key population-specific services in current insurance schemes and universal health coverage packages will emerge.

This study provides a quick landscaping of health insurance in six countries in the Asia-Pacific region and a deep dive into the situation in four of these countries. The size of the schemes, coverage of populations and innovations in the countries are the criteria for selecting countries for review.

## Annex 2. Key informant questionnaire

Aim: to assess health insurance schemes with respect to inclusion of HIV and identify opportunities for better integration into universal health coverage.

### Current context and gaps

- ▶ What performance challenges exist in your country in meeting universal health coverage and the HIV response?
- ▶ Can you describe any innovations or successes (e.g. performance-based financing, legislation) in the schemes to include the HIV response in universal health coverage?
- ▶ How has the response to COVID-19 supported or impeded work to include the HIV response in universal health coverage?

### Opportunities to integrate the HIV response within universal health coverage

- ▶ Is there room for health insurance eligibility criteria for people from key populations living with or at risk of HIV?
- ▶ Is there scope to expand the benefits package for people from key populations living with or at risk of HIV?
- ▶ Where can primary care support integration of the HIV response within universal health coverage for people from key populations living with or at risk of HIV?

### Financing map

#### Financial protection

- ▶ What financial protection is in place for people not eligible in the insurance scheme?
- ▶ Do some people from key populations have better protection than others? If so, what are the key reasons for these differences?

### Purchasing arrangements

- ▶ Can the insurance schemes contract with civil society or community-based organizations to provide services for people from key populations living with or at risk of HIV? How well does this work currently? Or is this mostly covered by international aid (e.g. through the Global Fund to Fight AIDS, Tuberculosis and Malaria or the United States President's Emergency Fund for AIDS Relief)?
- ▶ Are there impediments to setting up such purchasing mechanisms through the schemes?

### Other financing streams

- ▶ Is there collaboration with other financing streams and institutions in the country?

### Role of development partners

- ▶ Is there work to integrate vertical programmes into universal health coverage for people from key populations living with or at risk of HIV?

### Performance of insurance schemes

- ▶ How could better performance of the insurance scheme be incentivized?
- ▶ Are there actors that can be leveraged or catalysed?
- ▶ What mechanisms could improve accountability?
- ▶ What mechanisms could improve coordination?
- ▶ How could better programme oversight be implemented?
- ▶ Could you advise on any recent country documentation or resources related to health insurance eligibility, the benefits package, purchasing arrangements and financial protection mechanisms, such as recent information or data on the size of the scheme, inclusion of HIV prevention services in the scheme, or population coverage of key populations living with or at risk of HIV?

## **Annex 3. Key informants**

### **International development partners**

Michael Borowitz, Global Fund to Fight AIDS, Tuberculosis and Malaria

Nandini Kapoor, Joint United Nations Programme on HIV/AIDS Country Office

Somil Nagpal, World Bank

### **Cambodia**

Ms Chhaya, Director, National Social Protection Council

Ouk Somalay, Chair, Excom, National Excom Network

### **India**

Shri Varun Jhaveri, Pradhan Mantri Jan Arogya Yojana, Government of India

Grace Kabaniha, Technical Officer, Health Financing, Universal Health Coverage, World Health Organization

Shri Abu Mere, Member of the National Drug Users Forum

Owen Smith, Senior Economist, World Bank

Shrimati Anandi Yuvraj, Member of the National Network of People Living with HIV

### **Indonesia**

Pandu Harimurti, World Bank

Panji Hutama, Indonesia AIDS Coalition

Aditya Wardhana, Executive Director, Rumah Cemara

## **Philippines**

Robert Figuracion Jr, Community Center Officer, Rajah Community Center

Joseph Michael D Manlutac, Regional AIDS Programme, Department of Health  
Regional Health Office

Kenneth Samaco, HIV Technical Officer Consultant, World Health Organization

## **Thailand**

Dr Phanuphak, Institute of HIV Research and Innovation

Dr Rattaphon, Assistant Secretary General, National Health Security Office

## **Viet Nam**

Nguyen Cam Anh, United States Agency for International Development

Nguyen Anh Phong, Representative of Community of People Living with HIV

Doan Thanh Tung, Representative of Community of Gay Men and Other Men Who  
Have Sex with Men

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**UNAIDS**  
**Joint United Nations**  
**Programme on HIV/AIDS**

20 Avenue Appia  
1211 Geneva 27  
Switzerland

+41 22 791 3666

[unaids.org](http://unaids.org)