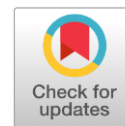


Healthcare Without Follow-Up: Why Access to Diagnosis Alone Cannot Deliver Universal Health Coverage

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Universal health coverage is often assessed through visible indicators: the number of people screened, clinics constructed, diagnostic technologies introduced, and patients enrolled in public health programs [1]. These achievements matter, but they can create a misleading impression of progress when health systems fail to ensure what happens after diagnosis. A patient who is told that they have hypertension but receives no sustained treatment, a woman with an abnormal cervical screening result who cannot obtain confirmatory testing, or a child diagnosed with malnutrition who is never reassessed has technically accessed healthcare. Yet none has received effective care. Diagnosis is not the endpoint of healthcare. It is the beginning of a clinical responsibility. The central promise of universal health coverage is that all people should receive the health services they need without financial hardship. This promise cannot be fulfilled through isolated encounters. Healthcare becomes meaningful only when diagnosis is connected to treatment, monitoring, referral, rehabilitation, and long-term support. Without these elements, access may be recorded administratively while preventable illness continues clinically [2,3].

The Growing Gap Between Detection and Care: Many health systems have expanded screening and diagnostic capacity more rapidly than their ability to provide continuity of care. Community campaigns identify

diabetes, hypertension, hepatitis, tuberculosis, cancers, mental health conditions, and maternal risks. However, patients frequently disappear between screening, confirmation, treatment initiation, and subsequent monitoring. This gap is especially damaging in chronic diseases. Conditions such as diabetes and hypertension require repeated assessment, medication adjustment, laboratory monitoring, and support for adherence. A single consultation cannot establish long-term control. When patients are diagnosed but not followed, disease progression continues silently until complications become severe, expensive, and difficult to reverse [4].

The same problem affects infectious diseases. Identifying an infection without ensuring treatment completion may leave the patient unwell, allow transmission to continue, and contribute to antimicrobial resistance. In cancer care, a positive screening test without timely diagnostic confirmation and treatment may increase anxiety without improving survival. In maternal healthcare, recognizing a high-risk pregnancy is of limited value when referral systems, transport, specialist review, and delivery planning are unavailable. The absence of follow-up therefore converts diagnostic expansion into an incomplete intervention [5].

Why Patients Are Lost After Diagnosis: Patients do not simply “fail to follow up.” In many cases, health systems lose them.

Follow-up may require repeated travel, long waiting times, unaffordable laboratory tests, inconsistent

medication supplies, or consultations at distant facilities. Referral instructions may be unclear, paper records may not reach the receiving clinic, and patients may have no reliable method of contacting healthcare providers [6]. Those with limited income must often choose between attending an appointment and earning a day's wages. Fragmentation also contributes to the problem. Screening programs may operate separately from primary healthcare facilities. Hospitals may discharge patients without communicating with community clinicians. Diagnostic laboratories may issue abnormal results without a mechanism for clinical review. Specialists may recommend treatment without verifying whether patients can obtain or afford it [7].

Digital health systems have improved communication in some settings, but technology alone does not guarantee continuity. A text-message reminder cannot replace medication availability, affordable transport, clinical accountability, or a functioning referral pathway. Digital tools are helpful only when they are embedded within accessible services capable of responding to patients' needs [8].

Diagnosis Without Treatment Can Deepen Inequality:

The consequences of poor follow-up are not distributed equally. Wealthier patients can often seek second opinions, travel to specialist centers, pay for investigations, and purchase medicines privately. Poorer patients are more likely to remain trapped between diagnosis and treatment. As a result, diagnostic access may expand while outcome inequalities persist or worsen. A health system may report high screening coverage even though only a small proportion of patients with abnormal results complete treatment. Such reporting rewards activity rather than health improvement [9].

Financial protection must also extend beyond the initial consultation. A free screening test offers limited protection when confirmatory investigations, medicines, transport, rehabilitation, or repeated monitoring require substantial out-of-pocket expenditure. Universal health coverage should not be judged by whether patients can enter the healthcare system once, but by whether they can remain in care for as long as clinically necessary [10].

Follow-Up Is a Core Clinical Intervention: Follow-up should not be treated as an optional administrative function. It is a clinical intervention that influences adherence, complication rates, treatment effectiveness, patient safety, and survival. A functional follow-up system should identify patients requiring review, assign responsibility for their continued care, communicate results promptly, arrange referrals, track missed appointments, and facilitate re-entry into care [11]. High-risk patients should not depend solely on their own ability to navigate complex services. Primary healthcare must play a central role in this process. Strong primary care teams can coordinate chronic disease management, provide medication refills, monitor treatment response, reinforce

preventive advice, and determine when specialist input is required. Community health workers can further support continuity by tracing vulnerable patients, addressing practical barriers, and connecting households with formal services [12].

However, continuity cannot depend entirely on individual commitment. It requires staffing, interoperable health records, reliable supply chains, referral feedback, protected financing, and clear institutional accountability [13].

Measuring What Happens After Diagnosis: Health systems should move beyond counting consultations and tests. Performance indicators must capture the full care cascade. For hypertension, measurement should include treatment initiation, retention in care, and blood pressure control. For diabetes, systems should monitor follow-up attendance, access to medicines, glycemic assessment, and screening for complications. Cancer programs should report the proportion of patients progressing from screening to diagnosis and treatment within appropriate timeframes. Maternal programs should assess whether identified risks lead to specialist review and safe delivery planning [14].

These indicators reveal where patients are lost and where reforms are needed. They also discourage systems from presenting diagnostic volume as a substitute for effective care. Data collection must lead to action. A registry that identifies missed appointments is useful only when someone is responsible for contacting patients and resolving the reasons for non-attendance. Accountability should therefore extend across the entire patient pathway rather than ending when a diagnosis is recorded [15].

Redefining Universal Health Coverage: Universal health coverage should be understood as universal access to completed, coordinated, and effective care. This requires a shift from encounter-based systems toward relationship-based care. Policy makers should finance complete care pathways rather than isolated services. Essential benefit packages must include confirmatory testing, medicines, monitoring, referrals, rehabilitation, and palliative care where appropriate. Health facilities should establish clear responsibility for reviewing results and arranging subsequent care. Referral systems must provide feedback to the original clinician, and patients should receive understandable instructions about what will happen next [16].

Most importantly, health systems must regard loss to follow-up as a quality failure rather than an inevitable feature of patient behavior. The true measure of healthcare access is not whether a person reaches a clinic, receives a test, or leaves with a diagnostic label. It is whether the health system remains connected to that person until the necessary care has been delivered. Universal health coverage cannot be achieved through diagnosis alone. A diagnosis without treatment is unfinished care. Treatment without monitoring is unsafe care. Referral without

coordination is fragmented care. Healthcare becomes universal only when patients are supported throughout the complete course of their illness not merely until the moment their condition is named [13-17].

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