CONSEIL NATIONAL DU SIDA
25-27 RUE D'ASTORG
75008 PARIS
T. 33 [0]1 40 56 68 50
F. 33 [0]1 40 56 68 90
CNS.SANTE.FR

REPORT INTERNATIONAL EN

2007 FEBRUARY 15TH REPORT ON FREE ACCESS TO TREATMENT AND CARE

TABLE OF CONTENTS

REPORT by the International Commission of the Conseil national du sida

Members of the International Committee:

- François Bourdillon;
- Samir Hamamah;
- Danièle Juette;
- Chantal Lebatard;
- Claude Le Pen;
- William Lowenstein;
- Marc de Montalembert;
- Jean-Luc Romero;
- Willy Rozenbaum, President;
- Muriel Vray.

Report produced by: Marc Dixneuf; Anthony Poncier.

SUMMARY Since the end of the 1990s, the epidemic of HIV infection has occupied an ever more important place on the global agenda. In 1997, France declared itself in favour of access to antiretroviral therapy (ART) for people who are infected with HIV in developing countries (DCs) and, after much reluctance, notable progress was made. The number of persons being placed on treatment has increased. However, the proportion of persons being treated remains low in comparison to the needs and access varies according to regions. As such, in some countries less than 5% of persons with a need for medication have actually access to treatment. For this reason, in 2006, the member States of the United Nations declared themselves in favour of a universal access to treatment, care and support services by 2010. This is the only means of controlling the epidemic and its consequences upon individuals and societies, and therefore a direct way to achieve Millennium development goals (MDGs).

Despite these advances, there is currently a financial barrier preventing people who are infected with HIV from accessing care. In developed countries, access to care without direct payment is considered to be an essential requirement of effective treatment and care. Nowadays, scientific findings have shown that the effectiveness of treatment and care in developing countries is linked to free access, without out-of-pocket expenses at the point of delivery, provided that this treatment forms part of a global treatment and care in the long-term. The effectiveness of free treatment is found on several levels. It is, of course, of an individual and medical nature, but the economic and social nature is also to be taken into account. Moreover, it can contribute to the strengthening of health systems as a whole. As a consequence, in the name of international solidarity, support for global free provision of care for persons infected with HIV constitutes an ethical obligation.

Free treatment was first advocated by the *Free by Five* declaration issued in November 2004. The report by the *Conseil national du sida* (*CNS*) is intended to emphasize the individual and collective benefits of free treatment and care while at the same time taking into account the difficulties that providing such treatment presents. One of the first difficulties is the fear of destabilising health care systems – fears that negate the universal advantages that can be obtained from increased access due to its free provision. The second difficulty lies in the actual idea of "free services for the people", which occasionally loses sight of what actually funds these services, namely: collective financing of health care expenditure. Providing this free access is difficult, but resolving the problems that it presents must contribute towards structuring the health care systems as a whole and reinforcing their funding mechanisms.

The first part, "Free access to care: a global benefit", concerns the balances to be achieved between, on the one hand, the implementation of free long-term treatment and care for people infected with HIV and, on the other, the health care systems weakened by their various structural shortcomings. Given the benefits that this element represents on an individual level, its free nature is essential. Expanding this service to a wider audience must also represent an opportunity to emphasize the global benefits that can be drawn from this significant change.

The first chapter, entitled "Profitable change to health care systems" focuses primarily on the reluctance that exists towards free access to these services (*the contested benefit of free access to care)*. As evidence against its relevance and feasibility, the two points most commonly put forward are the re-examination of the cost financing model promoted by the Bamako Initiative (BI) and the fragility of the health care systems themselves. The BI was a response to the failures of the primary healthcare policy and put forward a model that made it possible to secure part of the health care funding and the involvement of the users in their own health care system. Apart from a few exceptions, the BI has not facilitated wider access to medication and the States used it primarily to limit their commitment in terms of health care financing, while at the same time supporting the financial burden of hospital management through health care products. The BI thus cannot be used as the standard for a model that

would have earned success. The structural weaknesses in health care systems are undeniable. The implementation of free access exposes difficulties in relation to adaptation to scale and the upkeep of financial involvement for other diseases is already raising problems.

That said, these difficulties must not represent justification for a *status quo*, but rather form part of the elements that will guide the modalities of the implementation of free access to treatment and care. Secondly, this chapter will look at the advantages that can be gained from providing services free of charge (*The way of structuring the health care system).* The considerable volume of funding dedicated to HIV compared to other sectors of health care gives rise to criticism. This preferential treatment for HIV needs to be harnessed in order to improve the structure of the health care system by developing sector-wide approaches that allow hospital-based services to be coordinated and also to reinforce the health care systems. With the premise of increasing the number of people receiving treatment and care, free access is also the opportunity to strengthen the links between public and private sector services, be they associative, denominational or company-based. These exchanges must go beyond treatment and care by favouring the pooling of means of procurement and reinforcing the exchange of expertise.

The second chapter, "The advantages of free access to treatment and care at individual and collective level" illustrates that treatment and care must be free if they are to be effective. This effectiveness is in the first instance on an individual and medical level (*Individual, effective treatment and care).* The publications available indicate that free treatment and care facilitate better access to services and to better results in medical terms. At the same time, the package of care offered must include all the necessary aspects of that care and not be limited solely to antiretroviral therapy. These contributions form an overall concept that can be achieved gradually with an increase in the level of funding available. This package certainly includes screening, the initiation of treatment and monitoring of its effectiveness in virological terms. It should also embrace the financing of complications associated with the disease or its treatment. Ultimately, although apparently far from being a medical service, it is important for this package to include reimbursement of hospitalisation costs, transport costs and nutrition, which are essential when being placed on treatment.

The second chapter also looks at the economic and social efficiency of free access to treatment and care (*A broader collective benefit*). From the health care system point of view, free access to treatment and care allows the burdens of co-payment to be eliminated and the iniquity of the system to be reduced. From a global perspective, the individual benefit of being placed on treatment is also a social benefit insofar as it contributes directly to the maintenance of social structures, be they familial or local. Ultimately, free access to treatment and care generates a doubly positive economic impact by avoiding the slide into poverty resulting from excessive health care costs and also by allowing companies to sustain their workforce. More generally, free access contributes towards the upkeep of a level of productive activity that is favourable to growth.

The second part, "The financial issues of free treatment and care", discusses the modalities of financing this free access, looking at international aid and national resources. Financing of this free access requires a global increase in the funds allocated to it.

The third chapter, "Improving the context of aid", addresses the essential developments of the relationship between donors and recipients in order to make the best possible use of external funding. The *Paris Declaration* on the effectiveness of aid and the *Three Ones principles* of the UNAIDS provide the outline for these improvements: Ownership of policies by the States, alignment of donors on national policies, harmonisation of donors' practices and sustainability of aid according to the results. The increase in financial aid required for the provision of free treatment and care for people infected with HIV means boosting the States' capacities (*Relative autonomy of national policies*). Currently, there are multiple constraints confounding the management of health care policies. External finance is difficult to control and government expertise is inadequate in the fields that are essential for defining choices, such as epidemiology. Of course, the support contributed by donors allows these shortcomings to be compensated. However, the activities of external contributors are not always fully cohesive with the demands of national policies.

These principles of alignment and ownership must also be envisaged at global level (*Constraining international policies*). International policies can, in fact, put a stranglehold on the management of aid. Governments in developing countries remain partly dependent on macroeconomic models that could be established, and donors do not always align their multilateral economic policies with the declared directions of their aid policies. International organisations recognise the need for greater investment in health care policies, but countries struggle to free themselves from automatic actions that are imposed when structural adjustments occur. Contradictions continue in other respects within the context of the procurement of health care products. While remarkable, for example in terms of drug prices or flexibility in the application of laws governing intellectual property, the degree of progress remains inadequate. Products are prevented from being bought at lower cost due to technical difficulties or to practices undertaken by non-public-sector players.

The fourth chapter, "Strengthening the funding of national health care systems" emphasizes the options for financing at national level through the State's budget or through the development of mechanisms for risk sharing. The leeway in terms of budget is limited (*The challenges of State budget management*). States need to manage financial flows and their decentralisation with reduced means. At the same time, they grant tax exemption on health care products in order to make access to them easier, but the State's income is reduced accordingly. At the same time, the fight against the wastage of funds is essential, whether this wastage results from difficulties of governance or as a consequence of embezzlement.

The development of insurance-based mechanisms (*The prospects offered by the risk sharing*) represents one possible route for financing health care in developing countries. In terms of financing the treatment and care of people infected with HIV, however, this prospect seems rather a long way off. The financial capacities of mutual benefit societies or micro-insurance for health are too limited to cover the needs of treating HIV. Moreover, development of the health care risk sharing demands legal structures that are

still poorly developed and human resources that are still insufficient in number. However, mutual benefit societies offer a means of creating a basis for mechanisms relating to health care risk sharing. One intermediary solution between budgetary funding and that of an insurance-based type is that offered by purchase funds. These funds can be topped up from various sources, budgets, external aid, and can be used to purchase a specific package of care. Being distinct from the State budget, they are more flexible and represent a solution that can be deployed quickly.

France has been present at each of the stages in the battle against the epidemic in developing countries: It has promoted access to treatment, then put in place the structures that facilitated the first treatment and care programmes. France now makes a major contribution to the Global Fund and has opted to use the innovative financing method of Unitaid to finance the purchase of drugs.

The goal of universal access to screening, treatment, care and support services by 2010 can only be achieved if the free provision of these services is extended. France needs to advocate this progression to the member countries of the European Union and international organisations, but implementing it is not without its own difficulties. The principles for improved utilisation of the aid on offer and greater efficiency of national policies in the fight against AIDS highlight the countries' need to own their policies. To do this, countries must increase their expertise in areas as varied as epidemiology, procurement of health care products, implementation of flexible agreements on intellectual property and development of insurance-based mechanisms. France's commitment must therefore also involve the maintenance, development and reinforcement of policies of bilateral support for developing countries.

INTRODUCTION

In 2005, at the close of the G8 summit in Gleneagles and during the General Assembly of the United Nations in 2006, the countries represented pledged their commitment to "universal access to prevention of infection by HIV, treatment, care and support for people living with HIV (PLHIV) by 2010[1]"." This pledge is supported by the African Union, which represents the region's countries that are most affected by the epidemic, with 24 million people living with HIV out of a world population of 38 million[2]. The epidemic of HIV infection is having a serious impact and may continue to do so for some time in social and economic terms, particularly in Africa. It destroys families, social networks and societies' economies. In Africa, 12 million children are regarded as AIDS orphans. When they are not left to fend for themselves, they have to be taken in by their grand-parents or their older siblings[3]. Depending on the country, the proportion of men and women of working age who are living with HIV varies, but it can sometimes represent up to 25% of a particular age category. The decrease in GDP growth rates can thus reach up to 3%[4]. In the corporate sector, the impact of HIV has been reckoned as a "tax" representing up to 6% of the total workforce caused by employees dying and the consequent impact on companies' performance. It is therefore essential to ensure that the greatest number of people possible receive treatment and care in order to allow them to survive and thus maintain their country's social cohesion and productivity.

In developing countries, there are numerous factors preventing access to treatment and care and their extension. The fear of stigmatisation discourages people from wanting to find out their status and delays their entry into the health care system. As a result of various forms of discrimination, populations that are particularly at risk are not receiving treatment and care, namely: men who have sex with men, displaced populations and sex workers. Merely being a woman also represents an obstacle to accessing care[5]. Ultimately, the human resources crisis in the health care system is one of the structural barriers to this access[6].

There is another common barrier for all people infected with HIV in developing countries: that of out-of-pocket expenses for care. Effective treatment and care requires medication, but also regular consultations and the carrying-out of biological examinations. Added to these medical expenses are the costs of travel associated with actually getting to the consultation, or expenses incurred for proper nutrition to help keep the infection at bay. People infected with HIV therefore have to shoulder a number of significant expenses. Direct payment for this care, even if it is only partial, has a negative impact on access to care and the continuation of treatment, and thus on the effectiveness of the treatment and care package overall. It is now scientifically recognised that people who have free access to services at the point of delivery enjoy a greater life expectancy and better medical results.

It therefore seems essential to broaden free access to treatment and care for people infected with HIV, understood as the abolition of out-of-pocket expenses at the point of delivery. Realising the goal of universal access to treatment and to care by 2010 does not seem to be particularly likely unless this fundamental change takes place. This change is also in line with a model that has been proven to be effective. In developed countries, access to care without out-of-pocket expenses, particularly for long-term illnesses, is considered to be an essential requirement for effective treatment and care. This report will focus solely on the financial aspect of the barrier to access to treatment and care. Access for people who are discriminated against for reasons of gender or social rank will not be discussed here, however a reduction in the financial barrier may help alleviate this discrimination.

The individual issues of free treatment must not obscure those of financing it collectively. The prospect of free treatment coupled with universal access raises the issue of the increase of funds allocated to health by the States and international donors. For the entire fight against the epidemic in 2008, the evaluated available resources will be no more than 10 billion dollars[7], whereas the estimated demand for 2008 will be 22 billion dollars[8]. The volume of external aid therefore needs to increase, as must the governments' allocation of funding to the health care sector. The issues from this point of view depend as much upon the strengthening of national systems as upon the development of international aid policies.

---

[1] General Assembly of the United Nations, *Resolution adopted by the General Assembly, political declaration on HIV/AIDS*, A/RES/60/262, 2 June 2006, paragraph 20. G8 summit in Gleneagles, *Presidential Declaration*, 8 July 2005. G8 summit in Gleneagles, document on Africa, paragraph 18d. Access to health care services is considered universal when 80% of the total number of people requiring urgent treatment effectively receive it. UNAIDS, *Report on the Global AIDS Epidemic: A UNAIDS 10th anniversary Special Edition*, Geneva, UNAIDS, 2006, p. 255.

[2] African Union, *Gaborone Declaration on a roadmap towards universal access to prevention, treatment and care*, CAMH/Decl.1 (II), Gaborone, Botswana, 10-14 October 2005. African Union, *Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by a United Africa by 2010*, Africa's common position to the UN general assembly special session on AIDS, Sp/Assembly/ATM/3(I) reve.2, Abuja, Nigeria, 2-4 May 2006. African Union, UNAIDS, WHO, *Brazzaville Commitment on Scaling Up Towards Universal Access in Africa*, Brazzaville, Republic of Congo, 8 March 2006. UNAIDS, *Report on the Global AIDS Epidemic* 2006, op. cit,p. 14.

[3] Appaix O, Dekens S, *Pour un plan d'action en faveur des orphelins et enfants vulnérables*. Volume 1 Analyse de situation, Orphelin sida international, May 2005.

[4] International labour office, *HIV/AIDS and work: global estimates, impact and response*, The ILO Programme on HIV/AIDS and the world of work, 2004.

[5] UNAIDS, *Report, op. cit.*, pp. 175-176 and pp. 188-189.

[6] Conseil national du sida, *The Human Resources Crisis in Southern Countries: A Major Obstacle to the Fight Against HIV*, 6 July 2004.

[7] Kate J, Lief E, *International Assistance for HIV/AIDS in the Developing World: Taking Stock of the G8, Other Donor Governments and the European Commission*, The Henry J. Kaiser Family Foundation, July 2006, p. 16.

[8] UNAIDS, *Resource needs for an expanded response to AIDS in low- and middle-income countries*, UNAIDS, August 2005, p. 3. Clinton HIV/AIDS Initiative, *Global ARV demand forecast*, overview, 9 June 2006.

There is reluctance over the prospect of developing of a supply of free treatment and care at the point of delivery. In the first instance, free treatment appears to raise issues over the principles of cost recovery. Secondly, the provision of free treatment and care for HIV at a given point coupled with the charging for treatment for other serious diseases at this same point appears difficult to justify. The attention that the international community gives to HIV must provide the starting point from which to contemplate a particular effort for HIV, but with the aim of structuring all health care systems. The increase in resources must strengthen the system with the perspective of a link through health care insurance.

Financing the response to the epidemic of HIV infection also illustrates the issues of reciprocal dependence between donors and recipients in the context of the epidemic. The richest countries must contribute towards the fight against the pandemic in developing countries, but the recipient countries also need to consider their responsibility with regard to the international community as a whole. The expression of international solidarity is a reciprocal process that anticipates transformations in the practices of both the countries receiving the aid and the donors providing it. The *Paris Declaration* which advocated an improvement in aid provides the framework in which it is possible to increase the volume of aid and improve its utilisation[9]. This need for change is also stressed by the contact group created recently following the *High-Level Forum on the Millennium Development Goals* (MDGs)[10].

This report does not intend to evaluate France's foreign policy in terms of the fight against HIV or health care cooperation policy. Several reports published recently in France analyse these policies and offer suggestions for their development[11]. The objective of this report is to highlight the challenges to the implementation of free access to treatment and care for HIV infection, but also the need for this advance. France was the first country to pledge its support for access to treatment in developing countries, against the opinions of developed countries but also international organisations. In 1998, the creation of the FSTI (International Therapeutic Solidarity Fund) was the first step towards establishing an international fund dedicated to the fight against the epidemic of HIV infection. The development of hospital-based cooperation with the ESTHER (Network for Therapeutic Solidarity in Hospitals) organisation marked commitment to a specific boosting of national expertise. France's tremendous commitment is demonstrated by its investment in the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the creation of Unitaid, which perpetuates the funding of drug purchasing. Based on this report, the relevant French political figures are invited to take a new, pioneering step.

The *Conseil national du sida*'s mission is "to offer its views on the problems faced by society as a result of AIDS and to make useful suggestions to the government". In 1998, the CNS submitted its first statement in which it advocates access to antiretroviral therapy in the countries of sub-Saharan Africa. Since then, access to treatments in the Southern countries has been defended by the CNS on numerous occasions. It has also spoken out about the ethical issues of research in developing countries, about the treatment and care of pregnant women and certainly more recently about the human resources crisis. The CNS's ongoing concern for international health care policies is clearly reflected in its missions. In this report, the International Commission of the *Conseil national du sida* will continue its thoughts on the expansion of treatment and care for people infected with HIV in developing countries. Despite the particular features of the epidemic as experienced in each country, national responses are interdependent. The epidemic of HIV infection in developing countries is a problem for French society insofar as it is impossible to abandon these countries to face the pandemic on their own. The challenges that these countries face are also shared by developed countries. In the name of international solidarity, support for free, universal treatment and care for people infected with HIV represents an ethical obligation.

To prepare its report, the Commission interviewed around thirty individuals involved with international policies aimed at fighting AIDS and who hold a very wide range of positions and roles. Their contributions allowed the Commission to draw up a detailed description of the situation regarding access to treatment in developing countries and to discuss the relevance and feasibility of providing such services free of charge. The Commission would like to thank these individuals for their contribution to its work[12]. The information received during the interviews was supplemented with information obtained from publications that provided background on the points raised, namely: medical literature, health economics publications or publications on policies for public development aid. Grey literature on health care financing and the fight against HIV was also used.

The report has a three-pronged objective: firstly, it defends the benefit of free treatment and care for HIV infection, which relieves people living with HIV of the obligation to pay out-of-pocket for their care. HIV is a long-term illness, but one which it is possible to live with. The epidemic is a phenomenon for which governments need to agree to define responses that facilitate the greatest

---

[9] *Paris Declaration on Aid Effectiveness, Ownership, Harmonisation, Alignment, Managing for results and Mutual accountability*, Paris, March 2005. United Nations, *Report of the International Conference on Financing for Development*, A/CONF.198/11, Monterrey, Mexico, 18-22 March 2002. *Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors*, Final report, 14 June 2005, UNAIDS, Geneva.

[10] *Report on the scaling up for better health (Post-HLF) initiative*. First meeting of the steering committee, Paris, France, 25-26 September 2006. www.hlfhealthmdgs.org.

[11] Conseil économique et social, *La coopération sanitaire française dans les pays en développement*, avis présenté par Marc Gentilini, Official Journals, Paris, 2006. Morange P, Kerouedan D, *Rapport au Premier ministre. Evaluation de l'action de la France en faveur de la réalisation des Objectifs du Millénaire pour le Développement dans le domaine de la Santé. Articulation et coordination des aides bilatérales et de la participation de la France aux programmes multilatéraux du secteur de la santé*, June 2005. Kourilsky P, *Optimiser l'action de la France pour l'amélioration de la santé mondiale. Le cas de la surveillance et de la recherche sur les maladies infectieuses*, Rapport au gouvernement, 27 March 2006. Moreover, the analysis of foreign health care policies is a field of research that remains as yet little explored, see Drager N, Fidler D P. Foreign policy, trade and health: at the cutting edge of global health diplomacy. *Bulletin of the World health organization* 2007; 85(3).

[12] See the list of individuals interviewed in the appendix.

possible effectiveness in the long term, both for the individuals and the society as a whole. The first part of the report will underline the multiple benefits of supplying free treatment and care as a response to the epidemic, as well as the benefits for the entire health care system. The report will then look at the challenges associated with funding this free treatment. Insofar as there is a need for increased aid, one of the challenges facing funding is an improvement in its management. Countries need to become more autonomous in their administration and international policies need to be organized more coherently with the issues of the global response to the epidemic. The increase in funding allocated to the treatment and care of people infected with HIV also calls for a strengthening of capacities for budget management. Health insurance is not a short-term solution and there is a need to develop alternative mechanisms, such as purchase funds. The second part of the report will thus evaluate the opportunities and challenges of financing free access to treatment and care. Finally, this report acts as the basis for a statement by the CNS followed by a series of recommendations for the French government aimed at providing direction for supportive actions for developing countries in the field of HIV.

PART I FREE ACCESS TO CARE: A GLOBAL BENEFIT

The prospect of a health care delivery provided without out-of-pocket expenses, combined with the goal of universal access, must bear in mind the current mechanisms involved with financing health care systems in developing countries. The framework of access to treatment and care is defined by the Bamako Initiative (BI) and is based on the financial involvement of the system's users.

In this context, recourse to medical care depends on individuals' capacity to afford direct expenditure. This method of paying for care is the most widespread in developing countries, but it is one that the poorest people find difficult to cope with, thereby reducing their use of health care services[13]. These costs can reach a level whereby, in relation to total household expenditure, they can become "catastrophic" when they lead to money being diverted from other expenditures. The World Health Organisation (WHO) estimates that health care expenditure is catastrophic when it exceeds 40% of the income remaining after basic needs have been paid for[14].For populations with very low incomes, even a minute level of health care expenses is a catastrophic health expenditure[15]. In general terms, out-of-pocket payment is an impoverishing factor and a source of iniquity. It comes on top of the indirect costs essential for good treatment and care, such as transport or nutrition.

In many ways, the practice of direct payment represents a barrier to the effective treatment and care of people living with HIV[16]. The goal of universal access and the out-of-pocket expense scheme contradict each other. Treatment and care of infection with HIV is a long-term matter. It is financially burdensome, even if expenditure only concerns the treatment of opportunistic infections and laboratory investigations. This financial burden is not sustainable in the long term for the vast majority of people who need treatment. Due to a lack of free access to care, the global benefits of treatment and care for people infected with HIV – namely an improvement in their health and a response to the epidemic's social impact – will not be achieved.

Balances need to be found for the implementation of free, long-term treatment for people infected with HIV in health care systems weakened by various structural shortcomings. Given the benefits on an individual and collective level, free treatment is essential. It also offers an opportunity to provide the entire health care system with access to the funding associated with the treatment and care of HIV.

CHAPTER 1 PROFITABLE CHANGE TO HEALTH CARE SYSTEMS

The implementation of treatment, care and support schemes without out-of-pocket expenses requires the numerous weaknesses in health care policy funding to be taken into account. Reluctance over the free provision of treatment is voiced due to fears over the disappearance of an imperfect model and the destruction of fragile balances, whereas in fact the prospect of developing a free service can offer a means of dealing with these problems. The options for coordinating supplies of free treatment and care for infection with HIV and for boosting programmes relating to various other diseases to a large degree address the criticisms raised against free treatment.

1.1 THE CONTESTED BENEFIT OF FREE ACCESS TO CARE

The provision of free access to treatment and care implies overcoming the reluctance opposing it with the defence of the current health care financing model and which underlines practical barriers. Health care financing is based on the BI model and on the recovery of costs – a practice that would be confounded by free access to care. As well as this unjustified calling into question of the BI, free treatment would have a pointlessly deleterious effect on fragile health care systems.

---

[13] World development report 2004, *Making Services Work for Poor People*, Washington, World Bank/Oxford University Press, 2003. World development report 2006, *Equity and Development*, Washington, World Bank/Oxford University Press, 2005.

[14] *Designing health financing systems to reduce catastrophic health expenditure*, WHO, Department of health system financing, Health financing policy, Technical brief for policy makers, No.2, 2005.

[15] Su TT, Kouyaté B, Flessa S.Catastrophic household expenditure for health care in a low income society : a study from Nouna district, Burkina Faso. *Bulletin of the World Health Organization* 2006; 84(1): 21-27.

[16] WHO, *The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care*, WHO Working Paper, December 2005. Whiteside A, Lee S. The "Free by 5" campaign for universal, free antiretroviral therapy. *PloS Med* 2005; 2(8):e227.

FREE TREATMENT, AN UNJUST CALLING INTO QUESTION OF THE BAMAKO INITIATIVE?

Faced with the poor results of health care policies following independence and in order to improve access to care, the World Health Organisation (WHO) and Unicef organised the Alma Ata conference in 1978. The strategy proposed at the time was that of primary health care that combines free basic care and universal coverage. This strategy has failed: the care is free, but the health care centres do not offer any medications. In 1987, the Bamako Initiative was touted as a practical solution to the difficulties faced in previous years. In order to enable health care centres to manage their own finances, it obtained financial involvement from users by granting them in exchange a right of input over how their funding was managed. The reservations being expressed today against free treatment are justified by the desire to preserve this model. Nevertheless, it appears to be flawed both in terms of its foundations and its results.

- *Government adherence to the BI, despite mixed results*

In many senses, the Bamako Initiative represented a promising change. Its principles combined improvements in the provision and utilisation of essential medicines, while at the same time strengthening the capacities of local administration systems and ensuring permanent sources of finance that enable the health care units to function. In exchange for this financial input, the community earned the right to have a say in its management. At the time, the recovery of costs appeared to be one means of improving the way the system worked, allowing public funding to be directed towards the people who were deprived of resources. This involvement must also allow the provision of financial remuneration to staff. The BI model offers two main advantages. From the financial point of view, it allows resources to be freed up in order to treat poor people, but also to increase the salaries of health care personnel. From the point of view of how the health care system works, it allows the quality of service delivered to be improved and communities to be involved.

For the States, the benefits of the BI lie in the opportunity it provides for financial disengagement by shifting this burden onto the administrators of the health care centres. In the years that followed its implementation, considering the initial results, medication saw its role as a source of finance stepped up. From being a partial means of financing health care centres, the recovery of costs for medication has become a crutch for hospital finances. Governments' adherence to the BI can thus be explained in part by this choice of method of financing in the hospital sector. This attachment also results from the propagation of this method by international organisations in a global context of structural adjustment. Moreover, certain countries in Africa express limited confidence as regards the prospect of long-term external aid which would compensate the abandonment of the practice of cost recovery[17].

Governments therefore adhere to the BI, which facilitates relative disengagement from health care financing, but questions remain regarding the BI, especially with respect to the health care system. Numerous fears were voiced when the BI was implemented[18]. Firstly, the risk was highlighted of rolling out pilot schemes that were experimental - but limited - too quickly. Secondly, the role attributed to medications as a means of finance was also the subject of debate. The sale of a medicine allows resources to be freed up, but this does not encourage rationalisation of its prescription. From once being a health care product, medicines have become a financial commodity. Ultimately, the recovery of costs was based on the idea that recourse to paid-for care was neither dependent on its price nor people's income. On the other hand, studies have demonstrated a considerable degree of elasticity between supply and demand, with the level of income determining access to paid-for services[19]. The other founding idea is that of giving responsibility to consumers who would be able to exert force on the health care service in order to effect improvements - although this idea has not been verified in practice: the quality of the service provided did not improve by any noticeable degree.

- *The contradictions of the BI given the risks supposedly associated with free access to treatment and care*

One of the BI objectives was to increase equity in access to care – an essential feature[20], and this is one of the arguments put forward against free access. Indeed, it does not guarantee equity in terms of access to care. The mechanisms of exemption are sometimes picked up on by the more well-off. Nevertheless, the research carried out in Mali, Uganda and Burkina show that the poor do not have improved access to care with the BI. Although exemption from payment for poor people is economically viable within this framework, it is rejected on a social level[21]. Vulnerable groups have seen their level of marginalisation increase, as degrees of poverty are identified by the entire population when it comes to suggesting criteria, but those in charge in health care centres claim complexity as a barrier to their use. Health care centres have financial assets, but they are used for investments that do not serve

[17] *Meeting on ensuring universal access: user fees and free care polices in the context of HIV treatment*, WHO, UNAIDS, World Bank, Geneva, 21-23 March 2005.

[18] Ridde V, *L'initiative de Bamako 15 ans après. Un agenda inachevé*, Health, Nutrition and Population, The World Bank, October 2004., p. 6

[19] Cissé B, Luchini S, Moatti J.-P, *Les effets des politiques de recouvrement des coûts sur la demande de soins dans les Pays en développement : les raisons de résultats contradictoires*, GREQAM, Working document No. 03C02, October 2002. Economic literature focuses largely on the pricing effect on the use of health care services and the results are highly discordant, indeed sometimes contradictory. The differences between the initial studies carried out previously can be explained by the different methodologies used. Later on, however, the studies are all based on the same model.

[20] World development report 2006, *Equity and Development*, Washington, World Bank/Oxford University Press, 2005.

[21] Ridde V, Girard J-E.Douze ans après l'initiative de Bamako: constats et implications politiques pour l'équité d'accès aux services de santé des indigents africains. *Santé Publique* 2004; 15(1):37-51.

the interests of the poor. Studies show that equity has been left out in the implementation of the BI[22]. As a consequence, if free access to treatment and care is not synonymous with guaranteed equity, the BI can no longer claim to serve this objective.

What's more, adherence to the recovery of costs does not stop the States from highlighting shortcomings and flaws, be they in the context of the impact on the poorest individuals or the minimal involvement on the part of communities[23]. The Poverty Reduction Strategy Paper (PRSP[24]) underlines the efforts made towards diversifying co-payment[25], and the abolition in certain countries of out-of-pocket expenses for certain populations or diseases[26]. At local level, if there are treasuries in place, the health care financing systems do not benefit from the BI at central level[27]. Salaries, medicine purchasing and the various bribes and back-handers that have to be paid illustrate that this model is ineffective at strengthening the health care system. Free access to treatment and care is thus a constraint for the States that should invest more in health care financing, whereas the BI justified partial disengagement. The theoretical advantages of the BI therefore are contrary to free access, the implementation of which would highlight the lack of investment at government level.

The implementation of free treatment and care of people infected with HIV does not represent a calling into question of the principle of the BI. It is fairly common for different cost recovery systems to coexist in a single health care system, according to the severity of the disease and the burden of its treatment and care. Free access to treatment and care certainly exposes the shortcomings of this model, which it does not unjustly call into question. First and foremost, it does not facilitate the release of resources to ensure care for the poorest individuals, even though this is one of its very reasons for existing. Secondly, free access to treatment and care strips medicines of their role as a financing tool. Consequently, the excessive burden placed upon them appears all the more evident. Whereas the BI allows methods of operation that are detrimental to the health care system and its users to be continued, free access to treatment and care, by forcing this model to be started all over again, allows the financing of the system to be rethought.

A POINTLESS ATTACK ON FRAGILE HEALTH CARE SYSTEMS?

Health care systems in developing countries, in particular sub-Saharan Africa, face numerous challenges that make the provision of free access to treatment and care hard to visualise. Health care systems have been weakened by understaffing, poor infrastructures and a lack of equipment coupled with management problems. Critics claim that, given the diversity of health issues facing developing countries, investment in HIV is disproportionate. Nevertheless, sometimes up to 70% of the patients treated and cared for by internal medicine departments are infected with HIV[28]. One can therefore imagine that free treatment and care would contribute to an improvement in the hospital's overall functioning by avoiding hospital stays for patients with AIDS.

- *Feasible - but not without difficulties*

In some countries, the political authorities have decided to provide free access to certain health care services, for HIV or other needs. Occasionally, the budgetary support has not been planned, and the transition to free access to treatment and care has encountered a number of obstacles. On a background of acknowledged problems and examples of inadequate planning, technical difficulties are sometimes cited as a reason for not offering free health care services. The practical problems that could be accentuated by the free provision of care for HIV have been clearly identified. The issue of feasibility lies for the most part in strict planning of the transition to free access to treatment and care in order to anticipate impacts that are largely foreseeable. The announcement of free access to health care services is often accompanied by a rapid increase in the number of patients registering for treatment. Bearing in mind the human resources crisis which has been discussed in numerous papers, an increase in health care delivery, even with commensurate purchasing of health care products, may seem hard to achieve due to a lack of personnel available to cope with the increase in duties[29]. This global problem is compounded by various hurdles highlighted by the individuals who face them each day: equipment for biological examinations doesn't work, the supply shortage of health care products are frequent and sometimes long.

---

[22] Ridde V. Fees-for-services, cost recovery, and equity in a district of Burkina Faso operating the Bamako initiative. *Bulletin of the World Health Organisation* 2003; 81(7): 532-538. Ridde V, *L'initiative de Bamako 15 ans après. Un agenda inachevé*, Health, Nutrition and Population, The World Bank, October 2004.

[23] PRSP progress report, Burkina Faso 2002. PRSP, Burkina Faso, July 2004.

[24] The Poverty Reduction Strategy Paper (PRSP) was drawn up by the governments of countries with low income in accordance with a participative process involving both national stakeholders and external development partners, including the IMF and the World Bank. The PRSP describes the macro-economic, structural and social policies and programmes which a country will implement over the course of several years in order to encourage growth and reduce poverty; it also illustrates the need for external funding and related sources of finance. The PRSP is essential for providing access to concessional loans from the poverty reduction growth facility or a reduction in debt in the context of highly-indebted poor countries. The PRSP is also the framework in which bilateral donors such as the Nordic countries or the United Kingdom operate.

[25] Cameroon, PRSP, April 2003, Cameroon, PRSP, Joint Staff Advisory Note, March 2006.

[26] Ghana PRSP Progress Report March 2004, Burkina Faso PRSP Progress Report, December 2003.

[27] CNS Interview.

[28] *A High Price to Pay. Detention of Poor Patients in Burundian Hospitals*, Human Rights Watch, September 2003, vol 18, No. 8(A). p. 23.

[29] Conseil national du sida, *Avis sur la crise des ressources humaines dans les pays du Sud, un obstacle majeur à la lutte contre le VIH*, 6 July 2004. WHO, *The world health report 2006 - working together for health*, Geneva, WHO, 2006. A specific response programme for HIV was presented at the Toronto conference (*Treat, Train, Retain:* TTR), see: WHO, *Treat, Train, Retain. The AIDS and health workforce plan. Report on the Consultation on AIDS and Human Resources for Health*, WHO, Geneva, 11-12 May, 2006.

From a more specifically financial point of view, free access to care assumes that the funding of this care has been anticipated, and it has often been the case that this anticipation is either ineffective or indeed difficult. Buying by central purchasing offices, which must involve ARTs, reagents and other health care products, calls for planning a long way upstream. In recent years, the countries' central purchasing offices have experienced serious difficulties caused by late payments from the public purse, whereas they have to pay the entire sum for orders up front several months before the goods are delivered. Adaptation to scale assumes the development of supplies at local level and thus compensation of resources collected by health care centres with contributions from users, especially in remote locations. At regional level, there are bottlenecks even though the link with public finances may be straightforward at central level[30]. Subsidisation is possible, but this assumes the provision of funds very much upstream of the purchase and anticipation of increases in volume[31]. It is also essential to anticipate the coverage of distribution costs (transport, insurance). Due to a lack of evaluation of cost chains, medicines that are free at central level will have a cost at local level and will no longer be within the reach of sick people.

Ultimately, the question arises over the effectiveness of free access to treatment and care when the medication is provided to individuals. Health care personnel draw benefit from the sale of health care products, and it is important to factor this into the calculations of the cost of free access to treatment and care. Medicines subsidised by the German cooperation (GTZ) are thus sold on to sick people whereas they should be dispensed free of charge[32]. The public debates over the "failures of free access" unearth numerous problems that health care systems need to overcome. More than being just an additional weak point, free access to treatment and care represents a favourable factor for the health care system by virtue of the rigorous planning that it necessitates.

- *Creating unproductive competition between diseases*

One of the points most commonly put forward as a means of expressing reluctance over free access to treatment and care is the contradiction between supplying free treatment and care for HIV and paid-for treatment for other serious diseases at the same location. Several aspects of this problem need to be highlighted. From the patient's point of view, it may be difficult to accept this differentiated treatment that sees considerable means being allocated to one infection and little aid being given to cardiovascular diseases, cancer or diabetes, which also constitute a public health problem in developing countries[33]. For some, infection with HIV could become more "desirable" than another disease, thereby diminishing its status as a serious condition and confounding the efforts made in terms of prevention policies.

At health care professional level, there is already a distinction between treatment for diseases from the point of view of the means made available. It sometimes gives rise to paradoxical situations where a brand-new laboratory dedicated solely to infection with HIV exists alongside a laboratory with no means for other diseases – in the same centre. Nevertheless, one cannot consider that these administrative errors represent sufficient motive in themselves for not trying to obtain the maximum benefit from investment in HIV. Health care professionals may fear a negative effect on services other than those that treat PLHIV, causing the flow of staff from one service to another and thereby worsening the human resources crisis. Nevertheless, treatment and care for infection with HIV is not regarded everywhere as prestigious by health care professionals but rather as a risk factor for transmission of the infection and a guaranteed considerable extra workload.

Articles highlight the considerable attention paid to the three diseases to the detriment, say the authors, of other infections that affect the population, whereas numerous infections could be treated for a small cost[34]. Health problems are manifold and, depending on the country and the diseases in question, it appears that the spectrum of diseases also includes respiratory infections or non-transmissible illnesses such as cardiovascular disease. Non-transmissible diseases represent the most significant cause of death[35]. That said, the choice of free treatment and care for HIV is not an indication of indifference as regards other health problems.

Reluctance expressed before the prospect of the implementation of free treatment and care for infection with HIV cannot be considered as brakes to this vital step forward. However, they do represent elements of prudence and reflection that need to be considered in order to guide the implementation of policies that facilitate free treatment and care. They must be integrated into the considerations regarding how to develop the system in order to adapt responses for HIV to other diseases and make the best possible use of financial flows for HIV in order to give them the maximum possible leverage effect. Some of these principles have already been put into practice and tested.

---

[30] CNS interview.

[31] CNS interview.

[32] Exchanges on the e-med list on 5-6 September 2006 on "Fight against AIDS in the Eastern Kasai: costly free treatment" Messages accessible at www.essentialdrugs.org/emed/archives.php.

[33] WHO, *Preventing chronic diseases: a vital investment*, Geneva, WHO, 2006.

[34] Molyneux D H, Hotez P J, Fenwick A. "Rapid-Impact Interventions": How a Policy of Integrated Control for Africa's Neglected Tropical Diseases Could Benefit the Poor. *PLoS MED* 2005; 2(11); 1066, for 0.40 dollar cents per person per year, effect on seven infectious diseases.

[35] Jamison D T, Breman J G, *et al., Disease Control Priorities in Developing countries*, Washington/New York, The World Bank/Oxford University Press, 2006, pp. 30-31.

1.2 THE WAY OF STRUCTURING THE HEALTH CARE SYSTEM

HIV enjoys higher investment than other diseases. This priority addresses field issues and the choices of the global agenda and the donors' visibility. This preference given to HIV, as well as tuberculosis (TB) and malaria, must be regarded as profitable for the entire health care system. Reluctance expressed over free access to treatment and care for infection with HIV call for an improvement in the supply of treatment and care as well as the development of sector-wide approaches in health. The implementation of free treatment and care is an occasion on which to contemplate the links between various health care deliveries for HIV in order to reinforce the service provided in public hospitals. It must also provide an opportunity for vertical programmes to be integrated more effectively and strategies chosen along with health care priorities.

FEEDING STRATEGIC REFLECTIONS ON HEALTH CARE POLICIES

Over the course of the 1990s, the break-up of development efforts and the administrative burden that this imposed on developing countries prompted in-depth analyses of the international organisations[36]. As a result of this re-think, the idea of a sector-wide approach (or *swap*) was developed that could be applied to the health care sector[37]. The normal definition of a *swap* involves the pooling of aid funds, but it also relates to the discussion of health care priorities, the mechanisms of technical support, as well as the strengthening capacities, monitoring and evaluation. *Swap* is the means of creating coherence between national and international support in order to strengthen health care systems[38]. The funds allocated to the response to HIV, TB and malaria can allow sector-wide approaches to be set up. To become reality, these approaches require a government that is relatively stable and structured.

- *The choice in favour of HIV: a pragmatic approach*

Infection with HIV requires complex follow-up which is hampered by the processes of social exclusion and stigmatisation that are compounded with long-term treatment. The epidemic also has a global social and economic impact that merits particular attention. The particular investment that the fight against HIV enjoys aims to address these particular features, although this does not represent negation of the issues of other serious diseases. Given the funding allocated towards the three diseases (HIV infection, malaria, tuberculosis) and knowledge of the links between these infections, combinations with the treatment of malaria and tuberculosis are possible. That said, any specific response for HIV must integrate the health care issues particular to the individual country.

Some countries are facing epidemics of infection with HIV of which the prevalence is lower than that of viral hepatitis, for example. Investment in HIV allows the global health care supply to be improved and needs to take into account the level of prevalence specific to each of the States. Due to a lack of research into possible combinations, the favouritism given to HIV appears to be to the detriment of other diseases. Nevertheless, pregnancies may benefit from improvements brought about by the treatment and care of pregnant women living with HIV. The same goes for medical services that tackle infectious diseases and which take care of numerous PLHIV. Tropical diseases that are being neglected may benefit from the investment in HIV insofar as co-infections can exert a significant impact. Anaemia is one major mortality factor in cases of infection with HIV and it is often consequential to infection by various parasites. The supply of treatment and care for HIV may include treatment that encourages a better response to these infections[39]. In the same way, laboratory facilities can be integrated into an overall service without creating specific, under-used structures.

Ultimately, as the financing given to Malawi by the Global Fund has illustrated, money destined for the treatment and care of people infected with HIV can be deployed in sector-wide health programmes. In September 2005, the Fund demonstrated its allegiance to the sector-wide health care approach, by financing a programme of prevention and care to fight malaria. Then, in August 2006, the fund supported a national response programme to fight HIV that formed part of the health care system reinforcement strategies in the sector-wide approach. Funds destined for the fight against the epidemic of HIV infection can easily be linked to sector-wide health care approach programmes that facilitate the strengthening of health care systems as whole[40].

- *A decompartmentalisation tool to improve efficiency*

Numerous programmes for treating and caring for certain diseases receive external funding destined for vertical programmes, sometimes in specific structures such as for tuberculosis. Free provision must allow the integration of treatment and care and the rounding-off of packages of care offered in accordance with the diseases treated conjointly and the individuals' specific needs. It is necessary to develop medical responses linking HIV and tuberculosis[41].

One of the major problems faced by health care systems is that of procurement. The subsidisation of the purchase of health care products that form part of the HIV care package must be one means of strengthening the global procurement system. The

---

[36] This second point will be discussed in part two.

[37] WHO, *A guide to WHO's role in sector-wide approaches to health development*, WHO, 2006.

[38] WHO, A guide to WHO's role ..., *Idem.*, p. 4.

[39] Hotez PJ, Molyneux DH, Fenwick A, Ottesen E, Sachs SE, *et al.* Incorporating a rapid-impact package for neglected tropical diseases with programs for HIV/AIDS, tuberculosis, and malaria. PLoS Med 2006; 3(5): e102.

[40] This is a project entitled *Health System Strengthening in Malawi*, No. MLW-506-G04-S, signed on 29 September 2006. See www.theglobalfund.org/search/docs/5MLWH_1142_500_ga.pdf.

[41] Reid A, Scano F, Getahun H, *et al.* Toward universal access to HIV prevention, treatment, care and support: the role of tuberculosis/HIV collaboration. *Lancet Infect Dis* 2006; 6: 483-495.

decompartmentalisation of programmes must facilitate better organisation of procurement. The national purchasing offices can increase their turnover and develop technical expertise among their personnel. Moreover, the prospect of free treatment and care for HIV may itself have a positive impact on the administration of health care products such as drugs, reagents or medical equipment. In Senegal, an evaluation of expenditures illustrates the opportunities for rationalising prescribing as a result of free treatment and care[42].

THE LEVER OF COMBINING TREATMENT AND CARE SUPPLY

The supply of treatment and care in developing countries is largely based on the public health system. However, there are numerous other types of supply in the private sector that are of a different nature. Private hospital-based services are limited to more well-off sectors of the population. Non profit-making, private offers emanate from humanitarian (*e.g.*: MSF), denominational or associative organisations. Following the recent impetus from the International Labour Office (ILO) and Global Fund, private companies are formalising and developing the supply of treatment and care for salaried employees and their beneficiaries. Depending on the country, the availability of this supply is unequal and of varying reach, but it often represents a better quality of service than the one in the public sector. Communal installations need to have the capacity for development and facilitate transfers of expertise in order to draw the maximum benefit from this supply.

- *The private sector: limited responses, but exemplary ones*

Associative and humanitarian services cannot be anything other than of limited reach given the number of people who need treatment and care. Associations currently serve around 15% of the population that has access to care. Their actions make a significant contribution to the way treatment and care are regarded, most importantly because they offer free treatment and care[43]. A number of people prefer to avail themselves of associative services rather than public ones, despite their limited capacity. The elements of treatment and care such as the provision of food and home follow-up, factors that are not available in the public sector, are what make these associations so attractive. Actions by *Médecins Sans Frontières* (MSF) to promote access to treatment has addressed humanitarian issues as well as the need to illustrate how to obtain this access. The intermingling of actions by MSF and public services highlight the opportunities for cross-over and strengthening, but also the limits of such actions. In Nigeria, MSF is providing free treatment and care to people within public hospitals. However, the NGO has no vocation to remain there, but rather to transfer its activities. The question of withdrawal thus arises, a question whose resolution much depends on whether the country in which the service is provided offers an advanced health care structure, such as South Africa, or still needs considerable support, such as in Nigeria.

Several limitations need to be pointed out. At associative level, the activity is based on the involvement of the community and personal investment by nursing staff. These are often a number of individuals who contribute to the creation, maintenance and subsequent development of efficient associations. These are not models that are easily reproducible. Moreover, the functioning of these associations is backed by external funding that cannot be extended indefinitely, such as the money contributed by Sidaction to Burundi's ANSS (*Association nationale de soutien aux sidéens*). On the other hand, the associations highlight the historical lack of investment by the public hospital sector and the absence of involvement by the State. They are thus faced with the choice of limiting the number of new people who are offered treatment and care. Given their success, they sometimes encounter obstacles of an organisational nature, such as when the prescription or administration of medications is limited to structures or people[44].

The supply of treatment and care from companies also represents an element of response to the extension of free treatment and care for PLHIV. The South African mining communities got involved early on with this line of action due to the high cost of losing their workforce[45]. Since 2003, the responses, previously localised, are more and more coherent thanks to the development of the *Global Business Coalition on AIDS* (GBC), which groups together companies that are either directly involved or which are committed to improving the response to the epidemic. Since then, the Total group has developed a group-wide programme that allows treatment and care to be offered to employees and their families. Despite this, responses from companies can have a number of limitations. Sometimes, employees prefer to receive treatment and care outside company schemes for reasons of confidentiality[46] and screening of employees demonstrates results far removed from local prevalence rates. A screening offer in the port of Abidjan returned a low rate of positive results compared to that known about in the rest of the Ivory Coast's city. The company, for those who work there, is not necessarily the place to receive treatment and care. What's more, companies' structures do not always assure long-term follow-up for workforces that sometimes have a high rate of turnover, or that are not followed-up anymore once they retire. In addition, production may partly be carried out by subcontractors. In turn, the directors of these companies need to be convinced of the importance of a commitment to the fight against HIV. The broadening of the response to communities very much depends on the type of company in question and its location, e.g. whether it is in an urban setting or an area where it is the only point of contact, such as in Areva in Niger. The private sector is nevertheless a powerful medium for disseminating information and raising awareness.

---

[42] Vinard P, Diop K, Taverne B, Etard J-F, *Faisabilité économique de la gratuité complète de la prise en charge médicale des patients VIH au Sénégal*, Conseil national de lutte contre le sida/IRD, June 2006.

[43] AIDES, Réseau Afrique 2000. *Réponses associatives à la lutte contre le sida en Afrique*, Paris, AIDES, 2nd edition, January 2005.

[44] UNAIDS, WHO, Sidaction, *Expanding access to HIV treatment through community-based organizations*, Geneva, UNAIDS, Best Practices Collection, 2005, p. 36.

[45] Rosen S, Simon J, Vincent J R, MacLeod W, Fox M, Thea D M. AIDS Is Your Business. *Harvard Business Review* 2003, www.hu.edu/ghi/HBR%20article%20reprint.pdf. reprint R0302F.

[46] CNS interview.

- *Complementary services to be developed*

Free treatment and care offers to fight against HIV exist. Their methods of funding cannot be extended to the public sector, but they represent starting points from which lessons can be drawn. The NGOs and associations are critical players in public policies and also providers of care that can contribute to the creation of a national health care system. The scope of their services, sometimes determined by legacy, represents an experience that can be adapted to the public sector. It also highlights a sense of responsibility on the part of staff with regard to the people being treated and cared for. In many ways, the associative service is a spur for the public sector, which sometimes turns to the associative sector for advice, as is the case in Burundi. Private treatment and care services are already free and can be intermeshed with public services, either to support part of the public sector services or to transfer expertise to them. Improving the coordination of treatment and care for HIV infection is also essential for simplifying and strengthening purchasing mechanisms for health care products.

The various players can contribute specific expertise or are key agents of health care delivery. Denominational organisations, for example, have considerable expertise in procurement management. They can thus contribute to the coordination of actions between associations and the public sector[47]. In some countries, their hospital and health centre networks form an important part of the treatment and care services. Development of their relationships with international organisations is nevertheless essential[48]. Moreover, companies can also contribute towards strengthening the complementary nature of the individual services. Co-investment, *i.e.* the offer of treatment and care from the company coordinated with the public sector, allows public and private agents to better understand their respective expectations. The companies' skills in administration and strategic planning represent methodological support for health care systems. Relationships exist between governments and private providers for the free distribution of medications, as is the case for tuberculosis. Contractual relationships can be developed between governments and the various agents in the health care delivery sector. The contract stipulates that the provider must respect diagnostic procedures as well as the recommended treatment: medicines must be provided free of charge, treatment must be supervised and rules clearly established to allow the service to be monitored and appraised[49].

CHAPTER 2 THE ADVANTAGES OF FREE ACCESS TO TREATMENT AND CARE ON AN INDIVIDUAL AND COLLECTIVE LEVEL

Several developing countries, such as Senegal, Mali or Cameroon, have been providing free access to antiretroviral medicines for several years now. In other countries, it is private organisations, non-governmental international organisations or national associations that provide free treatment, care and support. Depending on the situation, the extent of the free access to treatment and care varies and includes a package of care of varying degrees of comprehensiveness. These experiences have revealed that free access to treatment and care for PLHIV guarantees its success. In free access schemes, the risk of mortality for people after one year is divided by four, compared to programmes where people pay for their care[50]. Moreover, beyond the direct benefit at individual level for the patient, free access to treatment and care represents a collective advantage both for the health care system and for the society as a whole.

2.1 INDIVIDUAL, EFFECTIVE TREATMENT AND CARE

The available data[51] illustrates the individual benefit of free access to treatment and care. In spite of this, the service provided is often limited to treatments, whereas other aspects of treatment and care are important, including access to these that should also be free. As an article signed by the WHO's HIV department illustrates, free access to care is one of the elements of a public health strategy for developing countries[52].

DATA IN FAVOUR OF FREE ACCESS TO TREATMENT AND CARE

- *Better access to services*

The data available on the relationship between out-of-pocket payment and treatment and care illustrates the benefit of free access for better results, be they in relation to screening, monitoring or more generally mortality and morbidity. The current global context

[47] Global Health Council, *Faith in action. Examining the Role of Faith-based Organisations in addressing HIV/AIDS*, 2005. WHO, EPN, *Multi-Country Study of Medicine Supply and Distribution Activities of Faith-Based Organisations in Sub-Saharan African Countries*, Nairobi / Geneva, EPN/WHO, 2006.

[48] Verspieren P.L'Eglise catholique face à l'épidémie de sida. *Etudes* 2006; 4062: 221.

[49] Lönnrotht K, *et alii.* Hard gains through soft contracts: productive engagement of private providers in tuberculosis control. *Bulletin of the WHO* 2006; 84: 876-883.

[50] The Antiretroviral Therapy in Lower Income Countries (ART-LINC) Collaboration, ART Cohort Collaboration (ART-CC) groups.Mortality of HIV-1-infected patients in the first year of antiretroviral therapy. *Lancet* 2006; 367: 817-824.

[51] Desclaux A, Lanièce I, Ndoye I, Taverne B, *L'initiative sénégalaise d'accès aux médicaments antirétroviraux. Analyses économiques, sociales, comportementales et médicales*, Paris, ANRS, Coll. Sciences sociales et sida, 2002.

[52] Gilks, C F *et al.* The WHO public health approach to antiretroviral treatment against HIV in resource-limited settings. *Lancet* 2006;368(9534): 505-510.

is one of out-of-pocket expenses, even in the form of partial contribution. Bearing in mind the diversity of the care required, the treatment and care of HIV seem particularly fraught with problems, as it requires follow-up which includes regular consultations, daily medication for life and supplementary examinations. The resulting costs quickly become "catastrophic" for household finances. The first step towards treatment of HIV infection is screening. Often, this screening costs money, and its cost is added to the multiple hurdles that result in the delay of awareness over serological status. Experience indicates that offering free screening encourages its uptake[53].

- *More encouraging medical results*

When contributions are requested, the results are interruptions to treatment, with the attendant risk of the development of resistant mutations that this may encourage. Ultimately, this factor makes treatment more complicated. Monitoring is a fundamental element of treatment and care for HIV, which direct payment may limit as a result of the financial constraints that it brings about[54]. A comparative analysis of the results of 18 treatment and care programmes in Africa, Asia and South America shows that mortality rates among people being placed on treatment is lower when they have free access to medications[55]. In the programmes where no contribution is requested, patients are more likely to achieve an undetectable viral load and to maintain it[56]. Conversely, when payment is requested, treatment is interrupted when the individual's finances are exhausted[57].

THE POSSIBILITY OF A WIDER PACKAGE OF CARE

- *The benefits of a global treatment and care*

Free treatment and care are generally limited to a number of services, including treatment. The offer extends progressively to treatment for opportunistic infections or to examinations such as viral load. However, in numerous places, the consultation, biological examinations and other examinations necessary for effective treatment and care are paid for by the patient. Moreover, other expenditure, such as transport, also represents a significant barrier to treatment and care. This barrier is not taken into equal account in the experiments aimed at abolishing out-of-pocket expenses[58].

The prospect of free treatment and care for HIV infection therefore assumes a broad package of care encompassing all the required services. The provision of health care products and services for PLHIV covers a vast spectrum that can either be limited to the follow-up of HIV infection or extended to the treatment, care and monitoring of diseases that may impact on the sufferer's general state of health.

- *A health care delivery that can be progressively extended*

The package of care required to ensure effective treatment and care of adults and children involves various types of intervention. All these interventions can be put together progressively depending on how the health care systems evolve and their level of funding. Treatment and care can be considered effective and complete only when the entire spectrum of interventions is available.

The package of care certainly comprises products and services directly linked with the commencement of treatment and follow-up of the virological response. Screening and diagnosis are essential for inclusion in an ART programme and supplementary examinations are almost always required[59]. Of course, treatment for HIV must be included, but its prescription and follow-up are accompanied by a plethora of services. Free medical consultations are essential at pre-defined intervals or in accordance with need, even when people are not being placed on treatment. CD4 levels are particularly useful for determining the moment at which to initiate treatment. Subsequently, monitoring of effectiveness should be based more on virological follow-up (viral load) than on immunological testing (CD4). This must be complemented with a biological assessment to gauge tolerance[60]. It is important, given the limited resources, to ensure improved monitoring of the effectiveness of treatment with conduction of viral load counts. Clinical follow-up alone is insufficient for measuring the effectiveness of the treatment and might facilitate the emergence of resistant viral mutants. Ultimately, a change in treatment would involve recourse to second-line treatments, for which the cost is significantly higher than first-line treatments.

---

[53] Thielman N.M et al. Cost-Effectiveness of Free HIV Voluntary Counseling and Testing Through a Community-Based AIDS Service Organization in Northern Tanzania. *American Journal of Public Health* 2006; 96(1): 114-119.

[54] Lanièce I, Mounirou C, Desclaux A, Diop K, Mbodj F, Ndiaye B.Adherence to HAART and Its Principal Determinants in a Cohort of Senegalese Adults. *AIDS* 2003; 17(3): S103-S108.

[55] The ART-LINC and ART-CC groups, op. cit..

[56] Ivers L C, Kendrick D, Doucette K. Efficacy of antiretroviral therapy programs in resource-poor settings: A meta-analysis of the published literature. *Clin Infec Dis* 2005; 41(2): 217-224.

[57] The ART-LINC and ART-CC groups, *op. cit.,* pp. 821-822.

[58] Meesen B, Van Damme W, Kirunga Tashobya C, Tobouti A. Poverty and user fees for public health care in low-income countries : lessons from Uganda and Cambodia. *Lancet* 2006; 368: 2253-57. Brikci N Philips M. User fees or equity funds in low-income countries. *Lancet* 2007; 369: 10-11.

[59] These are different biological examination that facilitate, for example, the evaluation of inflammatory phenomena such as the sedimentation rate or the level of CRP (*C-reactive protein*) as well as medical imaging examination such as X-rays, ultrasound, etc.

[60] Investigations of haematological, renal, hepatic and metabolic functions.

The health care delivery must incorporate a range of diseases that require treatment and care, like the prevention of opportunistic infections and the consultations necessary for this prevention[61]. It is also important to treat other diseases that affect the patient's general state of health[62], such as undesirable side-effects of the medications he or she is taking[63]. Adjuvant treatments also need to be taken into account[64]. This package also embraces care such as hospital stays as well as expenditure that sometimes seems external to issues of health, such as transport costs to consultations or appointments for examinations, time off work and so on. Ultimately, some interventions are crucial to the success of the initiation of treatment and its follow-up, and must be integrated into the free package of treatment and care. Nutrition is one area that requires development, along the lines of the resolution by the WHO in January 2006[65]. Support to monitoring and adherence to a course of treatment, without which the overall treatment and care package is destined to failure, is also essential.

2.2 A BROADER COLLECTIVE BENEFIT

Collective financial investment in treatment and care that is freely accessible to the population will enable the costs that the epidemic represents for societies to be addressed. Health care funding still often appears as an expense, but it more appropriately represents a long-term investment, as the Commission on Macroeconomics and Health has illustrated[66]. Funding of mechanisms that facilitate access without out-of-pocket expenses is one means of improving certain aspects of the health care system and addressing the economic costs of the present and future epidemic. Some parties are keen to point out that the investment in treatment and care in developing countries is an advantage for the security of industrialised countries[67].

IMPROVED MANAGEMENT OF TREATMENT AND CARE SUPPLY

In a health care system where human and financial resources are scarce, the efficiency of a programme is important. It is acknowledged that access to free treatment and care allows access programmes to be more efficient and consume fewer resources.

- *An opportunity for a fairer system*

Equity in terms of access to care is a constantly-affirmed objective and represents a key element of the architecture envisaged by the Bamako Initiative (BI). It is based on the financial involvement of the user, with exemptions for the poorest people. In reality, exemptions are not actually granted[68], either because the exemption procedures are not clear or the exemption mechanism represents a non-covered cost for the funds collected through financial participation[69]. The poor therefore do not benefit from the measures aimed at allowing them access to care. Therefore, out-of-pocket expense represents an obstacle to access to care for those who are supposed to afford it without actually providing access for those who are entitled to specific exemption measures.

- *Restricting workloads for administrators*

Early experiences of access to treatment in sub-Saharan African countries highlight the limitations of implementing financial contributions from patients adjusted according to their supposed revenues. The Senegalese initiative of access to antiretroviral drugs (Isaarv) implemented from 1998 onwards offers a platform for gathering long-term experience. Over time, the principle of partial, controlled contribution has been progressively abandoned in favour of free access[70]. The mechanism of controlling co-payment was based on a process of selection for subsidisation. Three committees selected which people could benefit from access to ARTs and the amount of their contribution[71]. Over time, the levels of contribution have fallen from seven to three, and finally disappeared. The lowest level of contribution was eight dollars per month. In Senegal, the reasons for progression towards free access to treatment and care for all are two-fold. The first one is of a medical nature. The financial burden is one of the obstacles to monitoring for a

[61] The most common opportunistic infections include: Candidiasis, herpetic infections, bacterial lung infections, septicaemia, Kaposi's sarcoma and toxoplasmosis.

[62] Such as malaria, digestive parasites, acute or subacute respiratory infections and bacterial diarrhoea.

[63] Such as dyslipidaemia, diabetes and cardiac disease.

[64] Chiefly anti-anaemia and anti-diarrhoeal medications.

[65] Resolution adopted by the General Assembly of the United Nations, *Political Declaration on HIV/AIDS*, UNGASS 2 June 2006, point 28 encouraging a package of care that includes nutrition, A/res/60/262. WHO, *Nutrition and HIV/AIDS, report by the secretariat*, A59/7, 4 May 2006. WHO, fifty-ninth World Health Assembly, *Nutrition and HIV/AIDS*, WHA59.11.

[66] Sachs J D, *Macroeconomics and Health: Investing in Health for Economic Development*, Report of the Commission of Macroeconomics and Health, Geneva, WHO, 2001.

[67] Drummond D, Kelly R, *The economic cost of aids: a clear case for action. Poverty and Marginalization Primary contributors*, TD Economics, Special Report, August 8, 2006.

[68] Ridde V, Girard J-E, *op. cit.*

[69] Desclaux A., 2004. Equity in access to AIDS Treatment in Africa : pitfalls amongst achievements, *in* Singer M., Castro A. (eds). *Unhealthy health policy : a critical medical anthropology perspective*. Lanham, Altamira Press, pp. 115-132.

[70] Desclaux A, Lanièce I, Ndoye I, Taverne B, *op. cit.*

[71] Various case evaluation committees have been set up: A medical technology committee (examination of medical files), a technical committee for social aspects (evaluation of monitoring and payment capacities) and an eligibility committee (for determining the contributed sum).

large number of patients, and it is therefore unlikely that it will be kept. The second one is of an organisational nature. The increase in the number of people receiving treatment and care over time has equated to a significant workload in terms of categorising patients. At the same time, the number of poor patients included in the schemes has increased and the rate of recovery has been poor. Therefore, the time spent on categorisation procedures and the cost that this generates relative to the recovery of costs has quickly led to the abandonment of processes that no longer seemed relevant to those administering the programme.

A WORTHWHILE INVESTMENT

- *A response to the epidemic's social and economic costs*

The epidemic of HIV infection represents a burden for societies. The number of men and women of working age living with HIV varies from country to country, but this number represents a significant percentage of the active population, up to 35% in Southern Africa[72]. At corporate level, it has been possible to calculate the impact of HIV as a "tax" representing up to 6% of the workforce. Treatment programmes thus represent a means of reducing this financial burden[73]. This benefit has been demonstrated from a case study which included periods of time during which the cost of treatment was much higher than it is today[74].

What's more, the initiation of treatment encourages a return to employment and productivity[75]. The same study also illustrates that the time spent working by children filling in for their parents decreases. The burden of the epidemic also represents a social cost that treatments reduce, but any contribution towards these treatments impacts on household budgets. The provision of care without payment at the point of delivery thus appears to support the family economy and makes a direct contribution towards development by avoiding child labour. In the best case scenario, it is common for parents living with HIV to apportion money for the child's schooling to the detriment of payment for treatment[76]. Free access would mean that such choices would no longer have to be made.

- *An investment for long-term treatment and care*

Treatment and care are a cost-effective investment[77]. Good treatment and care limit the problems of monitoring, and therefore the risks of resistant mutation selection are reduced and the long-term prognosis is better. Poor follow-up might cause more rapid changes of treatment, treatment that is also more complex and more expensive. Underinvestment in treatment and care with first-line treatments might quickly lead to an increased need for second-line treatments. Their cost is significantly higher than that of first-line medications and the problem of financing them is more acute, even in countries which have well-organised health care systems[78].

The burden that expenditure on treatments other than ARTs represents is sustainable, as the study carried out in Senegal on the proportion of expenditure on ART medications and other health care products illustrates[79]. The long-term effectiveness of investments made in access to treatments therefore calls for additional effort, but the proportion remains poor compared to the costs of treatment already being delivered.

Freedom of access to care must be regarded as a rational solution aimed at ensuring the best possible results from treatment. In the opposite case, international and national funding will be dedicated to treatments whose efficiency will be limited by the barrier created by out-of-pocket expenses on the part of PLHIV.

PART II THE ISSUES OF FINANCING FREE ACCESS TO TREATMENT AND CARE

Free access to treatment and care for people infected with HIV costs money, and it involves greater amounts of funding being allocated to health care. The issues of financing free treatment are not simply to increase resources, but rather to consolidate existing sources such as external aid and national structures.

Increased international funding for treatment and care of people infected with HIV must be associated with improved administration of public development aid. The general guidelines for improved efficiency are defined in the *Paris Declaration* of March 2005, which sets out the terms of a greater efficiency of development aid. Based on the idea of reciprocal responsibility, it outlines the principles which the partners must follow. The recipient States must assume their responsibility in the planning and implementation of their

[72] ILO, *HIV/AIDS and work: global estimates, impact and response*, Geneva, 2004.

[73] Rosen S, Simon J, Vincent J R, MacLeod W, Fox M, Thea D M, *op. cit.*

[74] Eholie S-P, Nolan M, Gaumon P, Mambo J, Kouamé-Yebouet Y, Aka-Kakou R, Bissagnene E, Kadio A, Antiretroviral Treatment can be Cost-Saving for Industry and Life-Saving for Workers: a Case Study from Côte d'Ivoire's Private Sector, *in*, Moatti J-P, Coriat B, Souteyrand Y, Barnett T, Dumoulin J, Flori Y-A, *Economics of AIDS and Access to HIV/AIDS Care in Developing Countries. Issues and Challenges*, ANRS, Paris, 2003.

[75] Thirumurthy H, Graff Zivin J, Goldstein M, *The Economic Impact of AIDS Treatment: Labor Supply in Western Kenya*, NBER Working Paper No. 11871, December 2005.

[76] CNS interviews.

[77] Goldie SJ, Yazdanpanah Y, Losina E. Cost-Effectiveness of HIV Treatment in Resource-Poor Settings. The Case of Côte d'Ivoire. *N Engl J Med* 2006; 355: 1141-53.

[78] The World Bank, Thailand Ministry of Public Health, *Expanding access to antiretroviral treatment in Thailand*, December 2005.

[79] Vinard P, Diop K, Taverne B, Etard J-F, *Faisabilité économique de la gratuité complète de la prise en charge médicale des patients VIH au Sénégal*, Conseil national de lutte contre le sida/IRD, June 2006.

public policies, a principle designated by the term "ownership". For their part, donors must align their actions with the framework of national policies, a principle designated by the term "alignment". They must also improve the harmonisation of their practices by developing similar procedures for the granting of aid, its monitoring and its assessment. Ultimately, administration of this aid is centred on its results and assumes monitoring and assessment of the funds invested[80]. The policies specific to the HIV epidemic benefit from the framework of the "*Three Ones*" put forward by UNAIDS: a common framework at country level aimed at coordinating the partners' activities; a coordinating body at national level that offers broad and multi-sector representation and a single system of monitoring and assessment. In June 2005, the global task team on the coordination of aid for HIV/AIDS[81] set forth a number of recommendations that are incorporated into the framework of the *Paris Declaration* and the *Three ones*[82]. More recently, in September 2006, a group of international organisations proposed a programme aimed at supporting the stepping-up of health care responses in Africa given the few results that had been achieved[83]. The *Programs Assistance Facilitation for Health* (PAFH) aims to help improve health care policies in developing countries.[84].

At State level, covering the cost of free access to treatment and care requires reinforcement of national funding structures. As well as defining sector-wide approaches in health care, States also need to step up their budgetary commitments. For several years, the cost of extended care has been included in the needs assessments, but investments are needed in their infrastructures such as the building of facilities, logistics and the upgrading of laboratories[85]. Moreover, the health care risk sharing is a growing area of interest and the subject of numerous experiments of varying scale. Insurance-style structures appear to be the solution of the future. Nonetheless, they do not seem to have been adapted to the level of demand for treatment and care of people infected with HIV. On the other hand, the development of purchase funds seems more promising.

CHAPTER 3 IMPROVING THE CONTEXT OF AID

The increase in financial aid required for the provision of free treatment and care for people infected with HIV means boosting the States' capacities and improving alignment of donors' practices with their issues. The financial issue of improving aid lies in the increased coherence between the practices and representations of the various partners, primarily those of the governments and the most significant donors. Alignment, coordination and harmonisation are the guiding elements for the actions of donors, but these are ignored outside the framework of health care policies toward the planning of which governments contribute directly. These principles of alignment and ownership must also be envisaged on a global level. International policies can, in fact, put a stranglehold on the management of aid. Governments of developing countries do not always seize the opportunities offered by changes in the positions of international organisations and donors do not align their multilateral economic policies with the declared objectives of their aid policies.

3.1 THE RELATIVE AUTONOMY OF NATIONAL POLICIES

States' ownership of health care policies implemented in their own countries is one of the declared objectives in the international texts on improving public aid for development. However, numerous constraints make this ownership difficult. Furthermore, the coordination of donors and alignment of external programmes with national policies remain inadequate[86].

DIFFICULT NATIONAL PLANNING

UNAIDS has identified the obstacles that limit the States' ownership capacities: needs are poorly understood; priorities are not always clearly defined at State level; the players are poorly coordinated[87]. The implementation of a policy of free access calls for

[80] *Paris Declaration on Aid Effectiveness*, March 2005. The text is available at the following address: www.oecd.org/dataoecd/11/41/34428351.pdf.

[81] Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, Geneva, UNAIDS, Final Report, 14 June 2005, p. 9.

[82] The recommendations are presented in four categories: Empowering inclusive national leadership and ownership; Alignment and harmonisation; Reform for a more effective multilateral response; Accountability and oversight.

[83] *"Tackling the barriers to scaling up in health... a coordinated response" Programs Assistance Facilitation for Health. A Joint Action Framework for the African Region*, final draft 23 September 2006, African Development Bank, UNICEF, World Bank, World Health Organization, Brazzaville September 2006. Document available at: www.hlfhealthmdgs.org/September2006Mtg.asp.

[84] Idem. Among the problems that the programme pledges to resolve is that of the disproportionate allocation of resources to certain priorities such as HIV. Furthermore, the High-level forum for the Health MDGs launched the Scaling up for better health initiative, whose aim is to accelerate progress toward the health MDGs.

[85] UNAIDS, *Resource needs for an expanded response to AIDS in low and middle-income countries*, UNAIDS, August 2005, p. 17 and 19. It states: The resource needs for treatment and care cover more than antiretroviral treatment and include: provider initiated testing, treatment and prophylaxis for opportunistic infections, antiretroviral therapy, including nutritional support, laboratory testing and palliative care.

[86] Commission for Africa, *Our Common Interest. Report by the Commission for Africa*, March 2005, p. 356: A study carried out for the Commission drew the following conclusions: aid is not aligned with national budgetary cycles; the priorities of donors take precedence over those of the beneficiaries; all in all, disbursement procedures are constricting and ponderous.

[87] UNAIDS, Making the money work through greater UN support for AIDS response. The 2006-2007 Consolidated UN Technical Support Plan for AIDS, Geneva, UNAIDS, March 2006.

improved and sustained expertise on the part of the States within the context of a partnership with external players. The strengthening of national capacities is essential for improving aid administration and its effectiveness. Countries therefore have a significant need for technical assistance.

- *Uncertain financial steering*

Often, the weakness of the State's administrative capacities is cited as a reason for the limited impact of external aid. From a macro-economic perspective, the influx of aid is actually liable to the creation of negative effects[88]. Some States may encounter difficulties with managing external funds, especially in terms of using them effectively. The State's internal redistribution structures can sometimes exhibit inadequate capacities. It may be necessary to anticipate channels of funding that guarantee the preservation of funds destined for health and to create reserve funds when a problem arises over absorption capacity. That said, the limits that States encounter in planning their policies can have an external origin. In terms of absorption capacity, several observers note that it would be better to talk about a problem of disbursement capacity on the part of the donors[89]. In certain cases, the donor is slow to come up with the anticipated funds, only to then issue hasty disbursements. In parallel to these administrative difficulties, there is the problem of understanding real flows. A study on Ghana shows that the inputs of financial flows are not well known in the health care system. The government's knowledge does not reflect the effective diversity of incoming flows. From this point of view, poor evaluation of the sums available reduces the State's capacity to plan health care financing efficiently[90].

In order to partly overcome these difficulties, certain agents, be they donors or representatives of recipient countries, would like to see an increase in the proportion of financing for programmes and a reduction in that for projects. This allows actions to be planned for a longer period and resources regrouped more effectively for the same objective[91]. The guarantee of long-term external aid is one of the factors involved in better planning. Nevertheless, the issue of financial sustainability is sometimes based more at institutional level[92]. The arguments relating to the absorption capacity or disbursements that are too slow, the unpredictability of aid or institutional shortcomings are often contradictory. It seems that, when put together, these structural weaknesses make planning more uncertain than specific failures on the part of one or other of the partners. In all cases, it is not the State's level of development that shapes the absorption capacity for external financing and its utilisation[93].

- *A need for technical expertise in public health policies*

In many ways, States most urgently need technical expertise. The problems listed in some documents are indicative of this: needs are poorly assessed; leadership at national level is inadequate and hampers the definition of needs in terms of technical support; funds are not allocated to scale; coordination between technical agencies, providers and financing bodies is poor; capacities for technical support at regional and local level are not used[94]. Technical support does not have to be solely administrative or medical. In order to define the directions of their treatment and care policies for HIV within the framework of global health care policies, States need to have access to the required expertise in epidemiology. Services provided by the WHO offer this support, but their ownership assumes expertise at national level that can interact and negotiate more effectively with international organisations and their donors. UNAID's third principle is planning the creation of a shared system of monitoring and appraisal on a national scale with standardised parameters[95]. There again, States need to benefit from technical support aimed at transferring expertise and not just providing assistance, even over the long term.

Ultimately, the technical support provided by developed countries needs to integrate the issues of free treatment and care for HIV in the various sectors of intervention. The technical cooperation scheme with Germany makes all its staff aware of the issues of HIV, including those who don't work in the health care sector. This facilitates coherence with the expectations of international organisations with regard to countries that require them to take account of the epidemic in all sectors of public intervention[96]. Management of strategic planning and procurement represent significant challenges for governments and national programmes aimed at fighting AIDS[97]. France supports drug policies in various ways by supporting the WHO's pre-qualification programme for generic ARTs and

---

[88] CNS interview.

[89] CNS interview.

[90] CNS interview.

[91] CNS interviews.

[92] Vinard P, Diop K, Taverne B, *Comment financer la gratuité ? Le cas de la prise en charge médicale complète des Personnes Vivant avec le VIH/sida au Sénégal*, Dakar, Conseil national de lutte contre le sida, Institut de recherche pour le développement, Alter Santé internationale et développement, January 2007.

[93] Chunling L, Michaud C M, Khan K, Murray C J L. Absorptive capacity and disbursements by the Global Fund to Fight AIDS, Tuberculosis and Malaria: analysis of grant implementation. *Lancet* 2006; 368: 483-488.

[94] UNAIDS, *Making the money work through greater UN support for AIDS responses. The 2006-2007 Consolidated UN Technical Support Plan for AIDS*, Geneva, UNAIDS, March 2006.

[95] UNAIDS, *The "Three Ones" in action: where we are and where we go from here*, UNAIDS/05.08F, 2005, p. 8.

[96] Unaids, The World Bank, UNDP, *Mainstreaming HIV and AIDS in sectors & programmes. An implementation guide for national responses*, September 2005. Holden S, *Mainstreaming HIV/AIDS in Development and Humanitarian Programmes*, Action Aids, Oxfam Gilbert Barbier and Save the Children UK, 2004.

[97] Republic of Chad, Public Health Ministry, Supervisory Mission for Activities against AIDS. 19-29 September 2006. Mission report, National Programme against STIs/HIV/AIDS. Document available at www.pnls-tchad.org.

contributing to the drawing-up of national policies or backing central purchasing offices. These represent an important element in health care policies and they must be supported if they are to have the expertise required to respond to the requests from the various purchasing agencies at national level.

AN ALIGNMENT OF DONORS WITH NATIONAL POLICIES TO BE APPLIED MORE CLOSELY

The various external players in the funding of treatment and care for HIV do not always operate within the framework of national policies. Support from donors to the State can have ambiguous consequences. As a report by the UNCTAD states: "The large number of donors, all with increased aid programmes, overwhelms the weakened bureaucracies in recipient countries due to a proliferation of negotiating, reporting and supervisory procedures"[98]. More efforts therefore need to be made to reconcile the interests of the various stakeholders. Moreover, the role of non-governmental organisations also needs to be discussed. By virtue of the funds that they contribute and the innovations that they generate, these NGOs are the key players in the policies of access to care, but they must also align themselves to best possible effect with the national framework[99].

- *The uncertain reconciliation of local and donors' interests*

There is no shortage of criticisms voiced by recipient countries towards donors: donors would be impatient towards the countries' organisational difficulties without helping to face these shortcomings. The objectives set by some of the donating countries do not match those of the country. Donors collaborate amongst themselves, but they do not demonstrate transparency vis-à-vis the country and do not respect national choices. Aid sometimes remains only as promises and some countries are neglected while others are very much favoured[100]. The aid policy may be a source of constraint for States, as numerous reports have pointed out[101]. The problem lies with effectively implementing coordination that often remains at formal level[102].

The countries are also responsible for organising relations between the stakeholders, and these relations can be either particularly confused or clearly organised[103]. From the donors' perspective too, coordination input is essential, with the coordinating bodies affiliated to various IGOs in one country being manifold[104]. What's more, the fields of expertise of the various international organisations do not always appear to be clear, a factor that can hamper the State's actions[105].

The assessment and monitoring required must not give rise to endless duties or procedures as the States' administrative capacities are limited. The demands of donors, in particular with regard to ensuring the correct use of their funds, can generate difficulties if procedures are not accompanied by support. Bureaucratic demands hamper the State's functioning while donors sometimes lay off local personnel[106]. One solution that is sometimes held onto is to pass on the aid and implementation of action to NGOs. However, although this may serve the interests of the donors, who are in a better position to ask for accounts from a private organisation, this solution limits the efforts implemented by central bureaucracies aimed at improving their expertise and hampers any ownership. Strengthening of their capacities is essential for the countries[107]. National pharmaceutical policies with respect to external intervening bodies are a good example, especially considering the procurement needs for health care products which represent a significant proportion of expenditure. Treatment and care practices vary according to the investor and can increase central purchasing offices' administrative procedures. Sometimes, the international agencies appealed to have differing levels of performance. Criticisms were raised against the choice of the Global Fund, which chose to sometimes finance programmes in which procurement was carried out by international organisations. In some countries, the presence of these latter is essential. In others, the difficulties faced by the local offices of these organisations have impacted on national purchasing offices, which were able to offer similar services at a lower cost and were requested to compensate the shortcomings of these large organisations. In some countries, these shortcomings have led to permanent interruptions to procurement.

---

[98] UNCTAD, *Economic Development in Africa. Doubling Aid: Making the "Big Push" Work*, United Nations, New York and Geneva, 2006, p. 55.

[99] See for example the document entitled: UNAIDS, WHO, Sidaction, *Expanding access to HIV treatment through community-based organizations*, Geneva, UNAIDS, UNAIDS Best Practices Collection, 2005. AIDES, Réseau Afrique 2000. Associative Responses to the Fight Against AIDS in Africa, Paris, AIDES, 2nd edition, January 2005.

[100] UNAIDS, The "Three Ones" in action, op. cit., p. 33.

[101] UNCTAD, *Economic Development in Africa, op. cit.*, p. 5: "Another major source of the inefficiency and ineffectiveness of much aid is the lack of coherence among donors and their objectives and requirements, and a failure to reconcile these with the needs, priorities and preferences of the countries receiving assistance. The sheer multiplicity of donoros, with different outlooks, accounting systems and priorities have created a landscape of aid that, at best, can only be described as chaotic. This has in turn stretched the administrative capacities of the recipient countries to breaking point". Commission for Africa, *Our Common Interest, op. cit.* UNAIDS, *Report on the Global AIDS Epidemic 2006, op. cit.* UNAIDS, *The "Three Ones" in action, op. cit.*

[102] UNAIDS, *The "Three Ones" in action, op. cit.*, p. 17.

[103] UNAIDS, *Idem.*, p. 20 and p. 25.

[104] Zimmermann F, Drechsler D, *Integrating Global Programs with Country-led National Programs*, Ghana Country Survey, OECD Development Centre, 8 August 2006.

[105] Shakow A, *Global Fund – World Bank HIV/AIDS Programs. Comparative Advantage Study*, prepared for The Global Fund to Fight AIDS, Tuberculosis & Malaria and The World Bank Global HIV/AIDS Programs, January 19, 2006.

[106] UNAIDS, The "Three Ones" in action, op. cit., p. 35.

[107] Gupta S, Powell R, Yongzheng Y, *The Macroeconomic Challenges of Scaling Up Aids to Africa*, IMF Working Paper, WP/05/179, September 2005, p. 31.

However, developments demonstrate better integration of international solutions with the national capacities' needs for reinforcement. The money from Unitaid allows the shortfalls from certain areas to be covered. Recourse to agencies such as the *Clinton HIV/AIDS Initiative* (CHAI or Clinton Foundation) has raised concerns over choices that are contrary to the reinforcement policy in the pharmaceutical sector in developing countries. The example of the signature on 26 January 2007 of a memorandum of agreement between the CHAI and the Ministry of Health of Cameroon, however, based on finance from Unitaid, facilitates the integration of this progress into the framework of central purchasing offices at national level. Nevertheless, these organisations and donors need to ensure that the benefit of their contribution on a large scale does not also become a hindrance to the States' capacity for autonomous administration. In this sense, the Cameroon memorandum is a model example.

- *The place of civil society*

The health care delivery offered by civil society needs to be meshed with the offer from the public sector, although there is often mutual mistrust between governments and associations[108]. Civil society's role is to make plain its dissent towards the views of the authorities when required. This raises the issue of aligning these organisations with national policies. Various fairly different perspectives need to be taken into account. The international NGOs can have enough autonomy to allow them to implement their own programmes. Alignment is not necessarily sought, because they are in an intermediate position between the critical organism and the partner structure. They sometimes associate themselves closely with national structures, as in the example provided by the MSF organisation in Malawi[109]. The question of the level of alignment with national policies does not arise in this type of configuration where collaboration is highly advanced. Some parties defend the development of the NGO's activities within the framework of increased formalisation by contract with the States[110]. However, this involvement throughout the length of the action is not necessarily a shared one. It actually appears in contradiction to the vocation of the humanitarian NGOs, which provide temporary assistance before withdrawing when local structures have been strengthened. Therefore, for large international NGOs, the question of alignment does not really arise as they support programmes that are well integrated into national structures.

At country level, the successes of local associations have sometimes given them the role of driving force behind the implementation of responses, which conversely has highlighted the inadequacies on the part of public authorities. They are therefore key partners for international donors, but their relative weakness leaves them vulnerable to political manipulation. The support provided by donors neither has to be a means of bypassing the State nor represent a risk of weakening the associations. Donors can obtain a means of exerting pressure on national policies through the associations. The United States prefer to bypass the State, notably by financing religious organisations within the President emergency program for AIDS relief (Pepfar) scheme. The support policy for civil society is in this case reinforcement of it. On the other hand, in Cameroon, the World Bank has divided the civil society sector by supporting fake organisations. Donated funds have disappeared and are completely lost to associations that could have used them appropriately[111]. The representative character of the organisations retained as partners of the donors is another problem. The French Development Agency (AFD) has chosen to involve civil society in the discussions about aid in countries, but due to a lack of consensus on the legitimacy of the organisations, the benefit of their participation is limited. The response to the epidemic of HIV infection is largely provided by the associative sector. Civil society therefore needs to be supported by ensuring that it respects the framework of national policies, but also the expertise and legitimacy of the existing organisations.

3.2 DETERMINING INTERNATIONAL POLICIES

The financing of health care systems depends on external flows and choices defined at global level. This external support for the State is essential, especially since demand will grow and developing countries need to face a number of challenges. Nevertheless, it sometimes sets the limits or braking points for reinforcements of national systems. These constraints, linked to the international framework, take two forms. When defining budget trends, governments sometimes tend to respond more to the presumed expectations of donors than seizing emerging opportunities. In parallel, they have to face the complexity of the international commercial framework of trading medications with limited means.

THE QUEST TO CONFORM TO DONORS' EXPECTATIONS

Health financing and the global development agenda have evolved in recent years, but governments of developing countries remain cautious as regards opportunities for change in terms of their direction[112].

- *Positive development of paradigms in aid policies*

The framework of development policies, and therefore the framework of health care policies, is largely determined by the Washington Consensus set out at the start of the 1980s[113]. Further to the report by the WHO on Macroeconomics and Health in 2001,

[108] Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, Final Report, 14 June 2005, p. 10.

[109] CNS interview.

[110] Ooms G, Derderian K, Melody D. Do we need a world health insurance to realise the right to health ? PloS Med 2006; 3(12): e530.Ooms G, Derderian K, Melody D (2006) Do we need a world health insurance to realise the right to health? PloS Med 3(12):e530.

[111] Rossert H, Pelletier V, Trenado E, Mission report, Cameroon (Yaoundé, Douala, Bafoussam) from 22 to 29 January 2005, AIDES. p. 16-18.

[112] UNAIDS, *The "Three Ones" in action, op. cit.*, p. 9 and 11.

a baseline strategy for health care finance reform was put forward and is responsible for the developments to date[114]. The definition of the Millennium's Development Goals, in which health occupies an important position, was added to this report and helped develop representations on the benefit of investing in health.

In 2002, the Monterrey conference on development financing and its follow-up also represent progress. In the Washington Consensus, it is outlined, among others, that financial markets in these countries need improvement. Nevertheless, this conference also provided an opportunity to emphasize the need for an increase in public aid for development in order for poor countries to be able to grow. More recently, the follow-on discussions from this conference looked at the difficulties posed to health care policies by the application of certain principles set down in the Washington Consensus. Point 46 in the summary of the high-level dialogue in June 2005 states[115]:

> *Macroeconomic policy design and advice by the Bretton Woods institutions for developing countries did not always contribute to achieving the Millennium Development Goals, according to a number of participants - for example, in caps on health spending, usually deemed necessary to avoid inflationary pressures. Several ministers also pointed out that international obligations and conditionalities imposed by the Bretton Woods institutions tended to constrain the policy space in a way that stifled some initiatives to foster development.*

Most of the publications of intergovernmental organisations now suggest greater flexibility in the implementation of macroeconomic policies. They set forth the room for manoeuvre that both recipient States and donors enjoy in order to improve health care services and strengthen the aid coherence. More significant financing requirements in health care were highlighted in two of the latest reports by the World Bank on human development[116]. They advocate changes in macroeconomic policies in a more subtle way, without actually marking any rupture. The States' responsibility in the provision of essential services and their good quality is asserted. At the same time, however, privatisation must not be regarded as a solution to be applied across the board and in all economic sectors, in particular in terms of health care insurance[117].

- *National policies influenced by models of structural adjustment*

Thanks to international discussions on development funding, the brakes that the models of the international organisations could constitute tend to be lessened. Nevertheless, the practices adopted tend to persist at country level. It is difficult to transform practices established from the hammering-out of a paradigm that now represents an accepted standard[118]. The example of the Poverty Reduction Strategy Paper (PRSP) illustrates fairly well the difficulties that countries experience in integrating the fight against HIV and all their health care policies into global strategic planning. The PRSP describes the macroeconomic, structural and social policies and programmes that a country will be implementing over the course of several years in order to encourage growth and reduce poverty. They allow the planning and budgeting of national plans, thereby representing important tools for national planning in countries with low and medium incomes. The PRSP facilitates eligibility for funding and the partners and donors operate within the guidelines that the PRSP sets down. In theory, the various State-level stakeholders are involved in the drafting of this document, as well as the International Monetary Fund (IMF) and the World Bank.

In the chapters dedicated to health, the PRSP often makes reference to the recovery of costs and formulates suggestions for developing health care insurance. In so far as these documents are aimed at promoting the interests of the poor, this idea of taking contributions from the poor in order to overcome their inability to pay for care seems somewhat surprising. Generally speaking, the position accorded to health in these documents is relatively superficial; they scarcely address the issues of inequality in health care

---

[113] The ten points of the Washington Consensus include growing openness of economies and free competition, with it being possible to divide the measures into two groups: a series of measures for stabilisation and a series of structural measures. The measures for stabilisation are aimed at: budgetary stringency in order to avoid inflation and to limit debt generation; reduction of public expenditure rather than increasing fiscal pressure; action on interest rates that must be fixed by the market; devaluation of the currency or depreciation thereof to encourage exports. The structural measures envisage: liberalisation through suppression of barriers to commerce and deregulation to open up the markets; the lifting of restrictions on direct foreign investments; privatisation of companies; fiscal reform in order to increase the number of ratepayers (enlargement of the tax base, VAT, reduction in marginal tax rates); the right of ownership in order to promote private wealth creation.

[114] Report of the Commission on Macroeconomics and Health, Sachs J, *Macroeconomics and health : Investing in Health for Economic Development*, Geneva, WHO, 2001. The strategy can be summarised in six stages: increase in tax revenues destined for health care; increase in support from donors in order to finance public assets and access to essential services; conversion of direct payment expenditure to mechanisms of prepayment, including programmes of community-based financing supported by public funds whenever possible; reinforcement of the reduction of debt for countries that are heavily in debt; efforts aimed at surmounting existing shortcomings in the allocation of resources; reallocation of public expenditure dedicated to non-productive expenses and subsidies towards the social sector with an accent on the poor.

[115] United Nations, *Summary by the President of the General Assembly of the High-Level Dialogue on Financing for Development*, A/60/219, New York, 27-28 June 2005.

[116] World development report 2004, *Making Services Work for Poor People*, Washington, World Bank/Oxford University Press, 2003. World development report 2006, *Equity and Development*, Washington, World bank/Oxford University Press, 2005.

[117] World development report 2006, *op. cit.*, p. 12.

[118] Hibou B, *The Political Economy of the World Bank's Discourse : From Economic Catechism to Missionary Deeds and Misdeeds*, [March 1998], Paris, Les études du CERI, No. 39, January 2000.

and analyses of excessive payment for care are rare, as indeed are analyses looking at the protective role of the health care system[119]. The PRSP must allow the place of AIDS to be defined in the processes of budget planning. However, the analysis reveals somewhat poor integration: the content for AIDS remains poor and is poorly linked to poverty, while needs are not assessed[120].

There is a lack of harmonisation at budgetary process level between the PRSP and the budget. The PRSP refers to the Medium-Term Expenditure Framework (MTEF[121]), but since needs are not specified for HIV, it is not possible to be specific about the allocation of resources from the MTEF. There is tension between the need to mobilise additional resources in order to back HIV policies and integrating them into medium-term expenditure plans and governments' annual budgets. Resources are released through the initiative to help heavily indebted poor countries and provide direct budgetary support. But in order to integrate them into the increase in funding in governmental budgets for HIV campaigns, the public expenditure management system needs to be improved. Technical support is essential for reinforcing the procedures of allocating and monitoring resources[122].

Strengthening of technical capacities is sometimes mentioned, but previous adjustment policies have created what is perceived as the standard by the bureaucracies of developing countries. This heaviness is lamented by some who are able to support the financing of salaries or technical assistance. This is the case, for example, for the Global Fund, but the financing offers to reinforce the health care system are not part of the package of aid requested by countries. The United States devote some of the funds they allot to the Fund to technical assistance[123]. Technical support for the strengthening of capacities at national level in order to integrate AIDS into the PRSP has often been specific, badly planned and fragmented. Sometimes, investment at government and civil society level explains the lesser importance given to AIDS[124]. Funding emanates from extra-budgetary resources, a fact that does not encourage governments to integrate AIDS policies into their national tools for development[125]. Faced with the need to take account of the cross-section problems, the PRSP needs to be harmonised with the programmes at national and international level (food, other health care problems such as malaria, the health of the mother and child, etc.). Depending on the country, AIDS must be contextualised within global frameworks such as the MDGs and diseases linked to poverty[126].

DRUG PROCUREMENT REMAINS COMPLEX

The price of health care products represents an important issue for administrative strategies, since it affects governments' margins for financial manoeuvre. Low prices allow more patients to be included in a programme or allow a broader package of care to be offered. The problem of medicine prices for antiretrovirals has prompted numerous debates and led to the implementation of various solutions, ranging from prices negotiated with brand-name drug manufacturers, within an *Access* framework or not, to copies and generic drugs. The agreements negotiated within the framework of the World Trade Organisation (WTO) have allowed the polemics arising from the application of patent law to be diminished, although this has not alleviated the difficulties the countries face. The prospect of increasing the number of people being placed on treatment therefore calls for the views of donors to be steered towards universal access with a multilateral commercial framework[127].

- *The failed adjustment of the multilateral commercial framework*

It is essential for developing countries to receive support from developed countries in order for them to follow reductions in price. Indeed, although the agreement on the Trade Related Intellectual Property Rights (TRIPs) for drugs has provided a solution, it is not entirely satisfactory and there is a need to provide technical support to the States in order for them to get the most out of the multilateral commercial framework.

The controversies over the application of the agreement on TRIPs for drugs were the subject of debates at global level after the publication by the WHO and MSF of guides allowing countries to make better use of the TRIPs' flexibilities[128]. These arrangements allow the price of medicines under patent to be reduced by issuing voluntary or compulsory licences[129]. In parallel to the

---

[119] Brouillet P in Dussault G, Fournier P, Letourmy A, *L'assurance maladie en Afrique francophone. Améliorer l'accès aux soins et lutter contre la pauvreté*, Washington, World Bank, Health, Nutrition and Population Series, 37149, 2006, p. 534.

[120] UNAIDS, World Bank, Pnud, *Integrating AIDS into national development tools and processes. Review of experiences*, Geneva, UNAIDS, December 2005, p. 6-7.

[121] The object of the MTEF is to establish a link between policies, planning and budgeting.

[122] UNAIDS, World Bank, Pnud, *Mainstreaming AIDS in development instruments and processes at the national level. A Review of Experiences*, Geneva, UNAIDS, December 2005, p. 11-12.

[123] CNS interview.

[124] UNAIDS, World Bank, Pnud, *Integrating AIDS. op. cit.*, p. 10.

[125] *Ibid*, p. 9.

[126] UNAIDS, World Bank, Pnud, *Integrating AIDS. op. cit.*, p. 12.

[127] Krikorian G, *L'accès aux génériques. Enjeux actuels et propriété intellectuelle*, AIDES, 2006, pp. 1-2.

[128] Correa C, *Implications of the Doha Declaration on the TRIPS Agreement and Public Health*, Health Economics and Drugs, EDM Series No. 12, June 2002. Correa C, *The Uruguay Round and Drugs*, WHO, February 1997. Velasquez G, Boulet P, *Mondialisation et accès aux médicaments. Les implications de l'accord ADPIC/OMC*, 2nd Ed., WHO, January 1999.

[129] Voluntary and compulsory licences maintain the allocation of rights (royalties) to the patent holder. In the first case, the manufacturer accepts to negotiate rights less than those to which he claims entitlement. In the latter case, the country issuing the licence arbitrarily sets the sum of compensation paid to the patent holder.

discussions held within the WTO[130] which led to the Doha Declaration (November 2001) and the statement known as the "August 30th decision" (2003), the generic competition has allowed prices to fall. The arrival on the market of generic drugs, produced chiefly by India, has led to brand-name drug manufacturers lowering their prices. The production of generics in Brazil has provided reliable data on production costs and thus highlighted the significant margins being achieved[131].

The Doha Declaration of November 2001 recognises the opportunity for countries that have production capacities to issue an obligatory licence in order to produce generic drugs, regardless of the disease for which they are intended. The "August 30th, 2003 decision" completes the Doha Declaration for countries that are unable to manufacture drugs. The importing country and the exporting country both issue obligatory licences defining the volume of products and their packaging. What's more, the governments of African countries need to take into account the framework of the African Intellectual Property Organization[132] which supplements the TRIPs.

The reduction in price and the negotiations within the framework of the WTO are certainly progress, but they are inadequate in many ways. On the part of developed countries, the implementation of legislation allowing the export of generic drugs to developing countries does not seem adequate. Canada and the EU have legislated to integrate the provisions of the August 30th decision, but there are still obstacles. Under Canadian law, for example, drugs must have been approved for marketing in the country, a fact which is not the case for combinations of several antiretrovirals manufactured in India. In Europe, legislation is reserved for WTO member countries, which excludes 18 least developed countries (and 32 countries that are not members of the WTO in total). In developing countries that have no production capacities, the August 30th 2003 decision is not applied due to the ponderous nature of the procedures that would need to be implemented. The technical support that the WTO can offer, financed by France[133], is nowadays inadequately known by States that would need it. This decision needs to be promoted through the training of central administrative personnel and technical follow-up.

- *Persisting problems*

Given the growing need for access to second-line antiretroviral therapy, difficulties are going to arise with regard to procurement in developing countries or the maintenance of policies implemented in intermediary countries such as Brazil or Thailand[134].

Despite this significant progress, problems persist, in particular the tense relations between countries and manufacturers. The price of certain drugs falls only when a government creates the possibility of issuing an obligatory licence[135]. In November 2006, Thailand thus anticipated issuing an obligatory licence for Efavirenz in order to be able to produce it locally and save some 24 million dollars. At the start of February, Merck announced that it was able to lower the drug prices thanks to improvements in the manufacturing process. In India, the government is facing a legal procedure instigated by Novartis, which is contesting the application of a clause in India's patent law to one of their anti-cancer products. As India is one of the key suppliers of antiretroviral generic drugs, the challenge of a clause allowing the production of generics is creating concern[136].

Other legal reasons also sometimes hamper the import of generic drugs. For example, a drug that can improve patients' treatment and care or save money may not be registered in the country. Sometimes, agreements signed within the framework of the *Access* programme prohibit the import of the brand drug generic version that was the subject of the preferred tariff agreement. Ultimately, health care products other than medicines are protected by patent, such as reagents that allow biological examinations to be carried out. Within the framework of the WTO agreements, it is also essential to anticipate to what extent their price can be adjusted to developing countries' capacities.

CHAPTER 4 STRENGTHENING THE FINANCING OF NATIONAL HEALTH CARE SYSTEMS

At national level, the funding of care provided free of charge can take two forms. The first is derived from the State's budget by increasing the allocation of funds to health care and improving the efficiency of their use. The other form is the development of pre-payment through mechanisms of risk sharing. These two methods need to be explored and adapted in terms of their implementation given the urgency of the need for the development of free care services for people living with HIV.

---

[130] The World Trade Organisation is therefore responsible for implementing the multilateral trade agreements that it creates: General Agreement on Tariffs and Trade (GATT); General Agreement on Trade in Services (GATS); Agreement on Trade Related Intellectual Property Rights (TRIPS).

[131] See appendix.

[132] The CNS has highlighted the difficulties that the Bangui Agreement would pose to procurement: *Communiqué sur la menace que font peser les accords de Bangui sur la santé en Afrique*, CNS, 8 February 2002.

[133] For the period between 2006 and 2008, France gave € 600,000 to the WTO for technical support. The envisaged aims include strengthening of capacity for negotiation in the field of international trade agreements and for the creation of legislation incorporating the safeguard clauses provided by TRIPS Agreement in favour of public health.

[134] Coriat B, Orsi F, d'Almeida C. TRIPS and the international public health controversies: issues and challenges. *Ind. Corp. Change* December 2006; 15: 1033-1062.

[135] Thailand threatens to produce more copycat drugs, Reuters, 12 February 2007.

[136] MSF, Le recours de Novartis contre la loi indienne sur les brevets risque de compromettre l'accès aux médicaments, New Delhi / Geneva, press release, 26 September 2006. See also: www.msf.fr/site/actu.nsf/actus/petitionnovartisfaq201206?OpenDocument&loc=au.

4.1 THE CHALLENGES OF MANAGING THE STATE BUDGET

At budget level, the governments' margins for manoeuvre are limited. The balances in favour of health are delicate, since they presume the simultaneous addressing of significant external flows and internal adjustments. Moreover, part of the action must involve efforts in favour of greater efficiency of utilisation for the available funds at State level in order to limit their wastage.

PRECARIOUS BALANCES

The States' commitment to increase allocation of funding to HIV, or health care in general, is based on fragile balances. The processes of centralising access to treatment involve a financial dimension that has been little addressed. Choices in favour of access to treatment involve measures of tax exemption, which reduce even more the State's income and compound the suppression of out-of-pocket expenses.

- *Managing the flow of funding and sustainability of funds*

The significant increase in global aid over recent years is not linked solely to investment in the fight against AIDS, which only represents between 5 and 25% of the total aid provided, depending on the country. However, in some of these countries, the funding for HIV represents a very significant proportion of health care costs[137]. The sole risk is of not using the money wisely, due to a lack of being able to use it at all. In reality, the trickiest problem for a government is to know of the different flows of aid and their destinations.

Flows effectively entering countries can be poorly known of due to the great diversity of the donors and to the fact that there is no system in place for gathering data. The result is a very patchy overview at government level of how health care is financed in reality. A recent study on Ghana, carried out by the OECD development centre, highlights this discrepancy. The ministry of health takes three sources of financing into account: household expenditure, the State budget and external aid. In reality, these flows are more dense and intricate, with inputs from NGOs, support from international donors to the State budget, direct project funding, etc.[138]

Another difficulty for governments is ensuring the decentralisation of funding to health care centres located far away from major cities. There are guides for managing stocks for regional pharmacies, but financial management can represent a sticking point. Decentralisation needs progressive implementation and it took five years for it to be effective in Senegal[139]. Health care centres have been able to exploit the Bamako Initiative in terms of strengthening their management capacities, therefore the transition to free treatment means monitoring them as they move towards this status.

The potentially negative impact of external aid on national policies essentially depends on poor predictability[140]. If aid is durable and predictable, it becomes easier for governments to plan the major changes in programme funding, such as that of free access to care for infection with HIV. The sustainability of taxes is particularly significant during a period in which aid is being scaled up. The development of sustainable aid financing mechanisms such as Unitaid or the International Finance Facility facilitate better planning of funding for free treatment and care[141].

- *Using tax systems*

One of the solutions for freeing up financial resources at State level is to develop the tax system. At the High-Level Meeting on MDGs on Health in Abuja, the idea of fiscal space was put forward as a means of increasing health care funding. Fiscal space can be defined as the margin of manoeuvre that allows a government to provide resources for a specific objective. There are various means of increasing fiscal space: The margin freed up by reduction of debt, reallocation between sectors, increases in internal taxation and improvements in the tax collection. The idea of sustainable tax refers to the government's ability to support expenditure for a designated objective over the course of the anticipated period without compromising the State's financial position. Economic growth remains the most reliable means of increasing the State's revenues.

The increase in health care allocations needs to take account of the tax losses that can result from measures taken in favour of providing free access to care. Indeed, in order to ensure free medications and other health care products, taxes need to be waived – a concept that would mean losses for the State's budget. Nevertheless, other taxes can be created within a framework in line with public health objectives, such as taxes on alcohol or tobacco[142].

---

[137] CNS interview.

[138] Drechsler D, Zimmermann F, *New actors in Health Financing : Implications for a Donor Darling*, OECD Development Center, Policy brief No.33, pp. 14-15.

[139] e-med messages, from 21-25 July 2006, available at www.essentialdrugs.org/emed/archive/200607.

[140] The Landau report begins with the unpredictability and volatility of aid, which is often an additional source of instability for recipient countries. This unpredictability also markedly reduces its efficiency. It penalises the investments and programmes that are so essential to development.

[141] See the *International Finance Facility* website: www.iff.coop/

[142] WHO Africa, *The Health of Populations. Report on health in the Africa region*, WHO, Geneva, 2006, p. 76.

TOWARDS BETTER USE OF FUNDS

Health care systems in developing countries, like those in developed countries, suffer from various forms of corruption, whatever the nature of the system[143]. The sums of public funding and diversity of the agents[144] tend to favour undue payment for services, thereby putting a strain on the public purse. The wastage of funds is also caused by their poor usage or imprecise allocation. The funds necessary for financing free HIV care need to be offered added protection against corruption or misuse.

- *HIV funding and corruption*

Health care is an industry particularly prone to corruption. Hospital workers, for example, sometimes demand compensation of a sexual, financial or material nature for provision of their care services[145]. These practices hamper the development of free access to treatment and care. In some countries, patients are detained when they cannot pay[146]. Mindful of the impact of corruption on development, the World Bank has turned the fight against the problem into a global orientation for development policies[147]. The fund allocation mechanisms used by international donors need in fact to be the object of attention. The World Bank is itself committed to monitoring its own practices. In the past, projects supported by the World Bank in the fight against HIV have been subject to misappropriation[148].

Taking account of the increase in funds required to finance free treatment and care and the fraudulent practices already in existence, the funding of free treatment and care needs to be accompanied by security mechanisms. Experience gathered by the Global Fund is helpful in this regard. The Fund's local agent, who ensures the appropriate financial management of the project in a particular country, can suspend payments in the event of problems[149]. The Global Fund has suspended its payments three times. The parameters used to monitor performance are negotiated by the stakeholders and include the programmes' progress. Adjustments and support are possible. It is therefore easier to determine which problems relate to governance and which relate to wilful misuse, as the collaboration between the Global Fund and Uganda has illustrated. In August 2005, the Global Fund suspended payments to Uganda, which subsequently set up a commission of inquiry. The result of the inquiry was that misuse of the funds had been fostered by administrative weaknesses on the part of the agency in charge of managing them. For its part, the Global Fund recognised weaknesses in its own procedures[150]. In some countries, these weaknesses involve varying levels of the policy administration in the fight against HIV. The forms of fraud are manifold and have a direct impact on the number of people who are given access to treatment[151].

- *Funding that is sometimes misused*

A reduction in the efficiency of allocated funds can lead to many problems or failings, be they at the level of the donor organisation or at government level. From the international organisations' point of view, problems can result from discrepancies between local issues and those of the organisations. The fact that the performance of a donation or loan can be evaluated by the rapidity of its disbursement encourages donors and recipients to sometimes allocate funds without due care[152]. Problems can also arise from the lack of investment from the representatives of the donors in steering structures at State level, such as the Global Fund's Country Coordinating Mechanism (CCM). The CCM's mission is to draw up subsidy proposals and to supervise the implementation of programmes. Strengthening of the CCM forms part of the challenges that the Global Fund is pledging to resolve in order to align itself better with countries and harmonise its action with those of other donors[153].

---

[143] Transparency International, *Corruption and health, global corruption report* 2006, p. 4.

[144] The agencies in health care can be divided into the following groups: government regulators (ministries, parliaments), disbursers (social insurance institutions, private insurance firms), care providers (hospitals, doctors, pharmacists), consumers, providers (of medical equipment, drug companies).

[145] Transparency International, *op. cit.*, p. 105.

[146] Human Rights Watch, September 2003, vol 18, No. 8(A), op. cit..

[147] IMF, World Bank, *Strengthening bank group engagement on governance and anticorruption, Development Committee* (Joint ministerial committee of the boards of governors of the Bank and the fund on the transfer of real resources to developing countries), DC2006-0017, September 8, 2006.

[148] Rossert H, Pelletier V, Trenado E, *op. cit.* Page 17 states: "Funds are transferred via a mechanism that allows a significant proportion of the subsidies intended to the associations to be hijacked (this mechanism is known about by all and we cannot believe that the World Bank is unaware of it)".

[149] CNS interview.

[150] Press releases from the Global Fund: 24 August 2005, Global Fund suspends grants to Uganda; 31 August 2005, Joint Press Statement by the Global Fund and the Government of Uganda on development relating to the Global Fund grants; 10 November 2005, Global Fund Lifts suspension of Uganda Grants; 2 June 2006, The Global Fund welcomes Ugandan corruption inquiry report.

[151] Tanui K, Ng'ang'a N, "Corruption in Kenya's National AIDS Control Council", in Transparency International, op. cit., p. 112-115.

[152] Transparency International, *op. cit.*, p. 107. UNCTAD, *Economic Development in Africa. Op. cit.* p. 69. "Various indications also give rise to the suspicion that certain donors, in their haste to pay out their money, may have been guilty of excess optimism in their evaluations of the processes and of budgetary governance."

[153] CNS interview.

At country level, it is difficult to identify how much mismanagement is deliberate and how much is related to structural problems. The funds helped purchase generic drugs that are not pre-qualified by the WHO or another recognised agency. Procurement is not always correctly planned, so products have to be destroyed. Sometimes, breaks in procurement are caused by failures on the part of the field IGOs[154].

The disbursements by the Global Fund form part of clear procedures for monitoring and assessment. These latter facilitate learning of how to manage aid and the Monitoring and Evaluation guidelines. The Ugandan experience illustrates that it is possible to overcome difficulties associated with disbursements by reinforcing structures at all levels. The recriminations sometimes expressed by recipients are justified by the lack of human resources, but it is fair to ensure that the money is being used for access to care in accordance with previously-agreed criteria. Further to the adoption of procedures for subsidy continuation based on performance, the most meticulous countries can benefit from extending financing and greater autonomy in terms of evaluation

4.2 PROSPECTS OFFERED BY THE RISK SHARING MECHANISM

For several years, governments and international donors have been supporting the development of insurance-like mechanisms to partly finance the health care system in developing countries. They are the subject of works that are presented as practical guides[155] and enjoy the involvement of the International Labour Office with the programme entitled Strategies and Techniques against Social Exclusion and Poverty (STEP)[156]. However, their development is very limited and requires structural reinforcement. Financing treatment and care of PLHIV therefore calls for more immediate responses and the implementation of mechanisms that will allow the preparation of a basis for future sickness insurance providing extended, if not universal, coverage.

LIMITED IMMEDIATE IMPACT FOR THE TREATMENT AND CARE OF PEOPLE INFECTED WITH HIV

The countries of sub-Saharan Africa are resolutely committed to the path of developing various insurance-based mechanisms. However, with the prospect of providing a rapid response to the financial needs of treatment and care for HIV, these tools are inappropriate either as a result of their poor ability to generate funding or as a result of the time required to implement them effectively.

- *Assets for treatment and care despite current weaknesses*

Since 1999 in Africa, there has been a network between development actors for mutual benefit societies entitled "La Concertation". Various experiments have been carried out on varying scales, addressing salaried workers, farmers and informal workers. The number of people registered with mutual benefit societies in French-speaking Africa is one and a half million beneficiaries for 200,000 members out of a population of 300 million people. The mechanisms tested or developed take the form of mutual benefit societies where membership is voluntary or health insurance where premiums are obligatory. In the first case, insurance mechanisms can adapt to the informal sector that is clearly more developed than the formal sector required for health insurance. Mutual benefit societies can be put in place in the formal or informal sector, in cities or in rural locations. The main brake to their development is the low rate of penetration among the population on fairly low incomes. The coverage rate is less than 1% of the population[157]. For those who enjoy fairly regular income, the ability to pay remains poor and the risks covered are small. Even adapted to poorer populations, mutual benefit societies remain inaccessible to the worst-off. Sometimes, the accelerated development of mutual benefit societies' premiums can lead to hard-to-sustain expenses when these premiums, which are in theory voluntary, are imposed. The ability to pay cannot exceed 2% of the household income[158].

The development of universal health insurance is a slow process that calls for expertise in a number of sectors beyond medicine. In European countries, it has often been the case that more than a century has gone by before a universal system has been set up[159]. Health insurance is too underdeveloped to allow it to be envisaged as a means of financing HIV treatment and care. HIV risk coverage is not offered by private insurance companies. Large transnational companies set up in Africa need to take care of the financing of treatment themselves, with their health insurers only now agreeing to discuss the possibility of covering this risk[160]. Some countries, such as the Ivory Coast, saw the development of mutual benefit societies in the tertiary sector a few years ago. An

[154] MSF Switzerland, Communication 25 January 2006, Le Honduras en manque d'ARV, la société civile se mobilise et MSF approvisionne en urgence…

[155] Gottret P, Schieber G, *Health financing revisited. A practitioner's guide*, Washington, The International Bank for Reconstruction and Development/ The World Bank, 2006.

[156] Following the international labour conference in June 2001, it was decided to extend social security coverage to those who need it. The global campaign for social security for all was launched in June 2003.

[157] Séry J-P, Letourmy A *in* Dussault G, Fournier P, Letourmy A, *op. cit*, p. 206. For more detail, see Letourmy A, Ndiaye P, Pavy-Letourmy A, Galland B, Hautet E, *Inventaire des SAM en Afrique: synthèse des travaux de recherche*, Dakar, La Concertation, October 2004. See http://www.ilo.org/gimi/concertation/ShowMainPage.do. Letourmy A, Pavy-Letourmy A, *La micro-assurance de santé dans les pays à faible revenu*, Paris, Agence française de développement, notes and documents, No. 26, December 2005, pp. 124-125.

[158] CNS interview.

[159] The number of years passed between the first law on health insurance and the last one for universal insurance is 118 years in Belgium and 127 in Germany. Carrin G, James C, *in* Dussault G, Fournier P, Letourmy A, *op. cit*, p. 458.

[160] CNS interview.

optional product was offered at the time to cover HIV[161]. In Mali, mutual benefit societies are able to reinsure themselves through the UTM *(Union Technique de la Mutualité Malienne)* for HIV risk. Corporate mutual benefit societies need more detailed information on expenditure related to the infection.

The social networks that arise thanks to these mechanisms can lend support to the policies involved in the fight against the HIV epidemic by circulating information about prevention. Opportunities do however exist for combining the mutual benefit societies from the informal sector with the free treatment and care of HIV. The treatment and care of malaria or opportunistic infections might also be envisaged. Mutual benefit societies directly support part of the treatment and care of people living with HIV, since they do not choose their members and treat opportunistic infections[162]. Mutual benefit societies have the advantage of behaving as purchasers of care, thereby allowing them to influence the availability and quality of services.

- *A long-term development that needs to overcome numerous obstacles*

Numerous technical obstacles need to be overcome before the development of insurance-based mechanisms covering a large population on a voluntary basis with mutual benefit societies or on the basis of a health insurance model. According to the estimation carried out at the start of the new millennium, the number of mutual benefit societies is 619, but only 366 are considered as operational[163]. The challenges that need to be overcome are technical and political. These programmes are even more limited in their reach and call for expertise and human resources that are still lacking in developing countries, particularly in Africa. The technical requirements for developing health insurance limit its rapid evolution. A "critical mass of actuaries, health care economists specialising in finance and advisory clinicians" is needed[164]. Health insurance is based on a contract between a care purchaser and a care provider. One can imagine that the negotiation of the contract will help improve the quality of the service provided. Currently, difficulties remain at various levels, either due to administrative shortcomings or mistaken expectations on the part of members arising from a lack of clarity in their relations with the mutual benefit societies[165]. Data on the services offered is scarce, making an evaluation of costs difficult. The legal framework is not always sufficient to allow the development of health insurance and recourse in the event of the non-compliance with contracts[166].

Care purchasers should be able to negotiate prices and act on quality. The problem is the rate of penetration, which shapes their power of negotiation. Development of contractualisation calls for upstream activity with care providers who can reject the criticisms formulated by insurers who are relaying the complaints of insured parties[167]. There is no mechanical link between the creation of a mutual benefit society or health insurance and an improvement in the services provided. Contractualisation can put an end to out-of-pocket expenses – an important source of revenue in hospitals for all personnel.

Civil society will have to be able to become a partner to the health care system and be represented in obligatory insurance management agencies. Therefore, it must be structured and the representative organisations must emerge and be recognised both by the State and by all social partners. The State needs to agree not to intervene in this management. The governments have an important responsibility to exercise choices that can turn out to be restrictive for them. In fact, the development of health insurance, from the point of view of obligatory insurance aimed at universal coverage, means investing in the training of qualified personnel, creating a specific legal framework and granting autonomy from the State for the management of health insurance. Insofar as the State, through its public service, is a service provider, it must report to the health insurance company. Therefore, governments must invest funds in the development of a mechanism which, *in fine*, will cast a critical eye over its health care delivery[168].

POSSIBLE CHANNELS OF TRANSITION

Despite the current limitations, health insurance appears to be a useful mechanism to set up, but the prospect of this remains somewhat far-off. It is therefore crucial to find channels of transition to respond to the immediate issues of financing free access to treatment and care and to prepare the development of insurance-based mechanisms. The development of micro-insurance companies could be one means of quickly building up civil society's expertise in the negotiation of health care delivery. Nevertheless, these assets required for the future development of health insurance will not help finance the treatment and care of people infected with HIV. From a financial perspective, development of the principle of purchase funds in the form in which it is envisaged or implemented in some African countries seems to be the best solution for rapidly channelling external funding and making the demand for care solvent[169].

---

[161] CNS interview.

[162] CNS interview. *Expert meeting on Microfinance and HIV/AIDS. An initiative of Hivos in cooperation with EIBE university of Nyenrode, Share-net and the PSO knowledge center*, 15 April 2004, Amsterdam, Royal Tropical Institute.

[163] Séry J-P, Letourmy A, *in* Dussault G Letourmy A, *op. cit.*

[164] Dussault G *in* Dussault G, Fournier P, Letourmy A, *op. cit.*, p. 8.

[165] Huber G, Hohmann J, Reinhard K, *Mutuelles de Santé – 5 années d'Expérience en Afrique de l'Ouest. Débats, Controverses et Solutions Proposées*, Eschborn, GTZ, 2003, p. 36 and p. 40.

[166] Preker AS, Velenyi EV, *in* Dussault G, Fournier P, Letourmy A, *op. cit.*, pp. 94-96. Séry J P, Letourmy A, *in* Dussault G, Fournier P, Letourmy A, *op. cit.*, p. 198.

[167] Criel B, Blaise P *in* Dussault G, Fournier P, Letourmy A, *op. cit.*, pp. 365-366.

[168] Huber G, Hohmann J, Reinhard K, *op. cit.*, p. 56.

[169] CNS interview.

- *Micro-insurance as a structuring tool*

Micro-insurance can serve various objectives, including the fight against poverty, improvements in the health care sector and an extension of the insurance market, for example[170]. It targets excluded individuals and the informal sector[171]. Works on health insurance or mutual benefit societies underline the limits of these mechanisms given the populations' incomes. The mutual benefit societies set premiums that are sometimes inaccessible as they are defined outwith the needs of the local population. This is however not the case for mutual benefit societies developed in rural settings or in the informal sector[172]. Studies show that members of mutual benefit societies form part of the more favoured categories because there has to be an ability to contribute[173]. Micro-insurance allows the development of an autonomous and structured civil society to be encouraged. Transaction costs may be high, but the definition of the package of treatment and care by the community can improve health care delivery and thus benefit HIV.

Micro-insurance does not allow financing of the treatment and care of HIV, but it does offer financial resources in care centres thanks to pre-payment. It facilitates the setting-up of local solidarity that helps excluded individuals. The negotiation of covered care allows the offer to be adjusted to best effect. Micro-insurance allows the practices of risk-sharing to be anchored on the scale of small communities and favours the processes of learning for care purchasers and providers from a development point of view[174].

- *Purchase funds: an answer to the financing needs*

The prospect of effective health insurance is a long way off. To get to that point, the various means of paying for expenses will have to be explored. In Senegal, several possibilities have been assessed and purchase funds appear to offer the most attractive prospects. The following takes up the key themes of the document published in January 2007 by Philippe Vinard, Karim Diop and Bernard Taverne entitled "*Comment financer la gratuité ?*"[175].

Numerous types of financing for treatment and care are possible at national level, involving external donors or not. Financing by procurement of products has been able to work for the procurement of ARTs thanks to State financing or funding provided by international donors. However, the change of scale runs the risk of hampering its management. ART drugs or reagents must be managed separately from other health care products that remain paid-for. What's more, this prevents the delivery of ARTs in private dispensaries. Most importantly, the responsibility of the health care structure manager is not involved in the good management of procurement insofar as he can offload this responsibility onto the agent organising the subsidy. On the other hand, management by a central purchasing office facilitates greater autonomy[176]. Another mechanism is financing by equipment, a method favoured by donors who prefer investment. However, maintenance of this equipment represents a significant financial burden while it has been implemented for long-term aid. First and foremost, laboratory equipment raises a logic of use far removed from its initial function. Equipment financing is aimed at facilitating the free carrying-out of examinations necessary for the treatment and care of HIV infection. It is however possible to carry out tests within the context of other types of treatment and care that are charged for. CD4 counts are free, while other tests are intended to free up funds. Laboratories often carry out more paid-for tests, sometimes for an exaggerated sum, than those for which they have been equipped[177]. The result is a concentration of laboratory activities on paid-for activities.

An increase in budgetary allocation could be kept aside to finance programmes. In Senegal, the free care announced for the elderly is financed in this way. The problems arise at the level of decentralisation as a result of the slow nature of disbursements. Health care centres do not receive the funds in time and funding problems develop[178]. Ultimately, another method is the reimbursement of invoices by a third party. In some regions of Senegal, this payment is taken care of by NGOs. Elsewhere, donors pay individuals' premiums to mutual benefit societies, which allow them to receive care. For its part, the State takes charge of invoicing care declared free, such as Caesarean sections or the treatment and care of the elderly as announced recently. However, there are certain sections in the central health government that manage these payments, although they are not supposed to pay for these expenditures and their staff are not trained to do so.

The limits of these various mechanisms lead the authors of the study to suggest the development of purchase funds. This fund takes the form of a pot of money to be managed separately from the State budget and whose function is to pay the bills presented by care providers[179]. The management and monitoring of this mechanism can benefit from the involvement of PLHIV and financial

[170] Letourmy A, Pavy-Letourmy A, *op. cit.*, p. 16.

[171] Dror D M Jacquier C.Micro-Insurance: Extending Health Insurance to the Excluded. *International Social Security Review* 1999; 52(1).

[172] CNS interview.

[173] Letourmy A, Pavy-Letourmy A, *op. cit.*, p. 130-131.

[174] Gommans C, Gatera C, *Report of the Workshop HIV/AIDS and Microinsurance in the Microfinance Sector in Africa*, Addis Ababa, 25-27 April 2005, Africa microfinance network, HIVOS, p. 28.

[175] Vinard P, Diop K, Taverne B, *Comment financer la gratuité ? op. cit.*

[176] *Idem.*, p. 8.

[177] *Ibid.*, p. 9.

[178] *Idem.*, p. 10.

[179] *Idem.* Synthesis. The characteristics are as follows: "They [purchase funds] are inspired by the logic of insurance in the purchase of a package of defined services (contractualisation and accreditation), by the sector-wide approach (by "pooling" public, private and international

backers, as well as representatives of the State and care providers. As for the development of insurance-based mechanisms, it is crucial to develop expertise for accreditation. Insofare as there is a specific fund for HIV, the extent of expertise is less because it covers services in the package of care specific to the treatment and care of PLHIV. There has to be a regional hierarchy to accompany decentralisation. Funds for financing treatment and care can emanate from external donors for whom the fund provides a mechanism that allows them to better control the use of granted funding and to be more aware of the number of people receiving treatment and care[180]. This fund, to which donors would contribute, facilitates a sectorial approach to health care and increased coherence in the donors' action. The advantage of the fund is that it preserves and strengthens the structures' administrative autonomy. It seems that, in the short term, the payment of bills by a separate purchase fund is the solution. The fund is separate from the budget. Its management will not hamper the work of the central government. Furthermore, it can be topped up from various sources and can purchase services. This is one solution for the perpetualisation that is often presented as a financial problem, but which is in fact more of an institutional issue. The work involved with accrediting health care structures authorised to raise invoices helps the development of health insurance.

CONCLUSION

The commencement of treatment for persons infected with HIV is effective if it is freely accessible and if it forms part of a long-term, global approach. The effectiveness of this free treatment and care is felt on several levels: certainly on a personal and medical level, but also at an economic and social level. Moreover, it can contribute to the strengthening of health systems as a whole [fn] . As a consequence, in the name of international solidarity, support for global free provision of care for persons infected with HIV in developing countries constitutes an ethical obligation.

Implementing this free access to treatment and care is a difficult task. By partially breaking with the model of financing health care systems that prevails currently, it has raised criticism. By highlighting the need for increased external aid, it makes the adherence of development partners to the principles they have been advocating for several years for improved use of this aid essential. These obstacles are not prohibitive. On the contrary, the efforts to overcome them can provide an opportunity for improving the structure of health care systems both at strategic orientation level and at the level of financing mechanisms.

Following an initiative by the French President, governments that have come to power in France since the end of the 1990s have undoubtedly contributed towards steering international policies in the fight against AIDS towards universal access to treatment. The last initiative put forward, Unitaid, is the concrete representation of the promises of perpetualisation of financing dedicated to public development aid. This document provides the basis for a number of suggested ideas for France's foreign policy in the fight against HIV. France is resolutely committed to the fight against the epidemic of HIV infection in developing countries. The multilateral financial contributions from France, to the Global Fund or Unitaid, make it one of the key contributor countries to the fight against HIV. Free treatment and care needs to be sustained at the level of European institutions and international organisations to provide the stimulus necessary to make universal access to screening, treatment, care and support services possible.

France's commitment must also involve the maintenance, development and reinforcement of policies of bilateral support for developing countries. At multilateral level, France's financial input has been considerably stepped up. Nevertheless, bilateral aid remains essential since it allows States to be given the capacities they need to respond to requests by donors and international organisations. The principles for improved utilisation of the aid on offer and greater efficiency of national policies in the fight against AIDS highlight developing countries' need to own these policies. In order to do so, countries need to have their own expertise to define their health care strategies, for example in the field of epidemiology. Procurement of health care products requires the development of national structures or the reinforcement of those that already exist. Countries also need the human resources and technologies essential for implementing the TRIPs' flexibilities. Support policies for the pharmaceutical field must be followed up. All technological personnel providing support to these countries therefore need to be made aware of the challenges posed by HIV. Ultimately, health care funding is based on the development of health insurance in the short or long term and on budgetary basis. For now, the solution that would be quickest to implement for financing free access to treatment and care would be that of purchase funds.

---

resources), by financing based on results (a payment for the service rendered) and by independent management of public budget bottlenecks (with involvement of civil society)."

[180] *Idem.,* pp. 13-14.

APPENDICES

ACRONYMS

AFD: *Agence française de développement* (French Development Agency)

ANRS: *Agence nationale de recherche sur le sida et les hépatites virales* (French National Agency for AIDS and Viral Hepatitis Research)

ANSS: *Association nationale de soutien aux sidéens* (National Association of Support to People Living with AIDS) (Burundi)

ART: Antiretrovirals therapy

BI: Bamako Initiative

CCM: Country coordinating mechanism

CHAI: Clinton HIV/AIDS Initiative

EU: European Union

GBC: Global Business Coalition on AIDS

GFATM: Global Fund against AIDS, Tuberculosis and Malaria

GTZ: *Deutsche Gesellschaft für Technische Zusammenarbeit* (German Society for Technical Collaboration)

HIV: Human Immunodeficiency Virus

IGO: Intergovernmental organisation

ILO: International Labour Office

IO: International organisation

IRD: *Institut de recherche sur le développement* (Research and Development Institute)

ISAARV: *Initiative sénégalaise d'accès aux médicaments antirétroviraux* (Senegalese initiative of access to antiretroviral therapy)

LFA: Local Fund Agent

M&E: Monitoring and Evaluation

MDG: Millennium Development Goal

MSF: *Médecins sans frontières*

MTEF: Medium-Term Expenditure Framework

NASA: National AIDS Spending Assessments

NGO: Non-governmental organisation

OECD: Organisation for Economic Cooperation and Development

OI: Opportunistic infection

PAFH: Program of Assistance Facilitation for Health

PEPFAR: Presidential Emergency Program for AIDS Relief

PLHIV: people living with HIV

PRSP: Poverty Reduction Strategy Paper

STEP: Strategies and Tools against social Exclusion and Poverty

SWAp: Sector-Wide Approaches

TB: Tuberculosis

TRIPS: Trade Related Intellectual Property Rights

TTR: Treat, Train, Retain

UNCTAD: United Nations Conference on Trade and Development

UNGASS: United Nations General Assembly

WHO: World Health Organisation

WTO: World Trade Organisation

LIST OF PERSONS HEARD

The Conseil national du sida expresses its sincere thanks to the people who kindly agreed to contribute to its thoughts within the framework of its interviews:

- Yves Souteyrand, World Health Organisation, HIV Department, Coordinator for 'Strategic information and research', 15 December 2005.
- Prof. Alice Desclaux, Anthropologist, Université Paul Cézanne of Aix-Marseille (UPCAM) / Research Centre for Cultures, Health, Societies (CReCSS), 16 March 2006.
- Dr. Bruno Galland, International Centre for Research and Development (CIDR), in charge of developing health microinsurance, 16 March 2006.
- Prof. Jacky Mathonnat, Economist, Centre for Studies and Research in International Development (CERDI-CNRS), Université d'Auvergne, 16 March 2006.
- Alain Letourmy, Health economist, Researcher at the Research Centre for Medicine, Science, Health and Society (CERMES-INSERM), 27 April 2006.
- Didier Gobbers, Public health consultant, 27 April 2006.
- Dr. Alliou Sylla, Leader of the national programme for the fight against AIDS, Ministry of Health, Republic of Mali, 4 May 2006.
- Dr. Hélène Rossert, Director General of AIDES, 4 May 2006.
- Prof. Jean-Paul Moatti, Economist, Université de la Méditerranée/U379 INSERM, Institut Paoli Calmette, Marseille, 18 May 2006.
- Prof. Michel Kazatchkine, Ambassador for HIV/AIDS and transmissible diseases, 19 June 2006.
- Dr. Michel Lavollay, 12 October 2006.
- Olivier Vilaça, Co-investments manager, Global Fund to fight HIV, Tuberculosis and Malaria, 12 October 2006.
- Eric Fleutelot, Director of international programmes, Sidaction, 12 October 2006.
- Serge Barbereau, Caroline Damour, Pharmacists, Réseau médicaments et développement (ReMeD), 26 October, 2006.
- Johannes Jütting, Denis Drechsler, Felix Zimmerman, Henri-Bernard Solignac Lecomte, Organisation for Economic Co-operation and Development (OECD), Development Centre, 27 October 2006.
- Landis McKellar, Consultant 27 October 2006.
- David Dror, Hon. Prof. of health insurance, Erasmus University, Rotterdam, 14 November 2006.
- Jean Dussourd, Unitaid special consultant, Ministry for Foreign Affairs, 24 November 2006.
- Annick Hamel, Médecins sans frontières (MSF), 15 December 2006.
- Dr. Bernard Kouchner, President of the Network for Therapeutic Solidarity in Hospitals (ESTHER), 15 December 2006.
- Dr. Anne Petitgirard, Director of the Network for Therapeutic Solidarity in Hospitals (ESTHER), 15 December 2006.
- Catherine Ferrant, Director of Social Innovation and Diversity, Dr. Jean-Pierre Gardair, Doctor, Total, 17 January 2007.
- Dr. Duncan Earle, Team leader Operational Partnerships and Country Support, Global Fund to fight HIV, Tuberculosis and Malaria, 26 January 2007.
- Dr. Badara Samb, World Health Organisation, HIV Department, coordinator for 'strengthening health care systems', 26 January 2007.
- Philippe Vinard, Health economist. ALTER santé internationale, Department of Infectious Diseases, Faculté de médecine of Montpellier, 26 January 2007.
- Guilherm de Lemos, Antonio Ortiz, Ministry for Foreign Affaires, Department for co-operation, social development, health office, 31 January 2007.
- Pascal Brouillet, Project leader, French development agency, 31 January 2007.

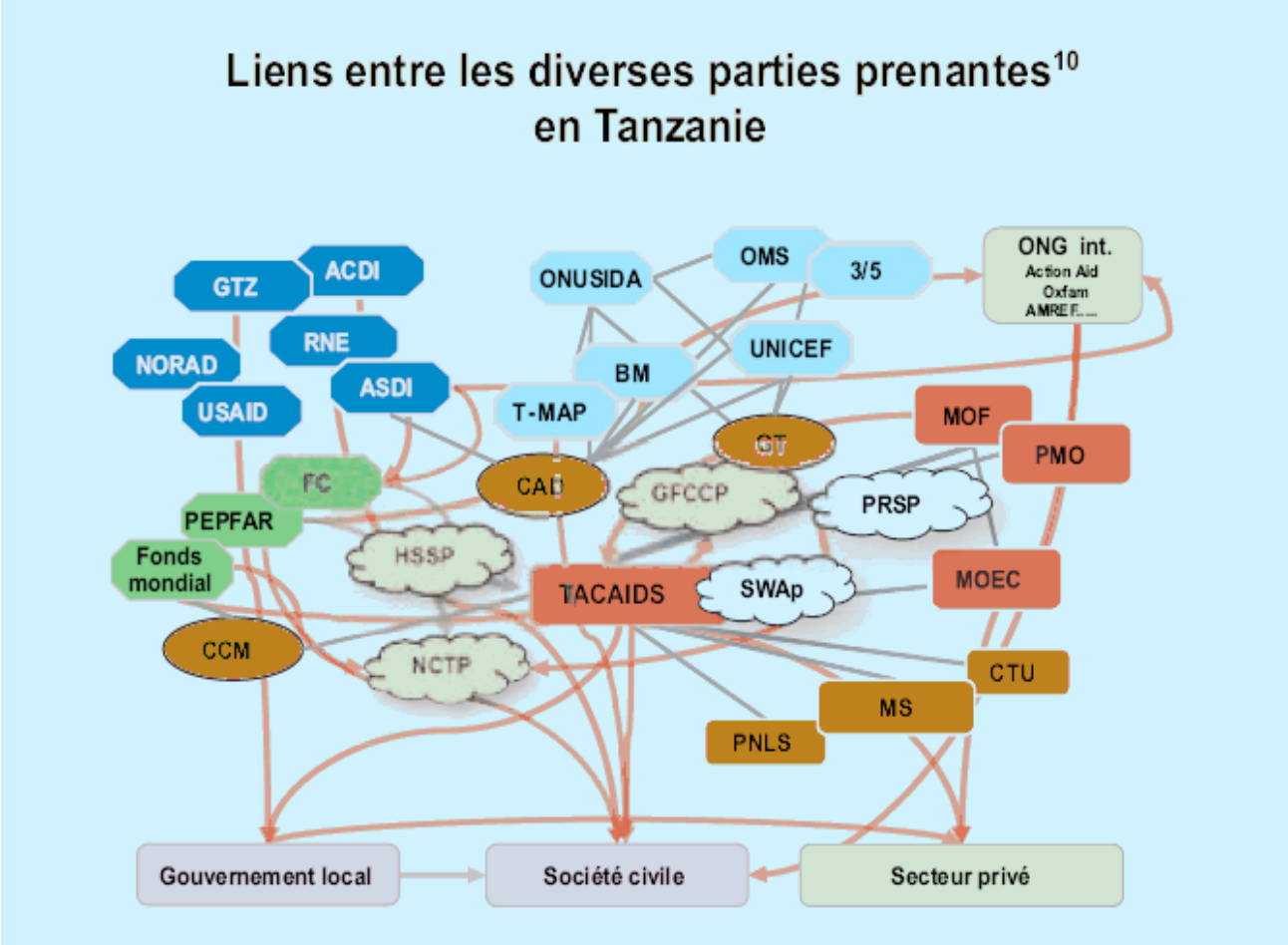
Thanks are also due to the following persons for making themselves available: Carinne Bruneton; Véronique Collard; Lydia Kawangizu; Dr. Christian Mouala; Marie-Claire Outtara; Dr. Jean-Loup Rey; Sophie-Marie Scouflaire; Dr. Elisabeth Girrbach; Michel Etcheparre; Bernard Taverne.

TABLES AND FIGURES

STAKEHOLDERS: THE CASE OF TANZANIA

Diagram taken from: UNAIDS, *The "Three Ones" in action: where we are and where we go from here* , UNAIDS/05.08F, 2005.

http://data.unaids.org/Publications/IRC-pub06/JC935-3OnesInAction_fr.pdf



THE ACTORS IN HEALTH CARE FINANCING: THE CASE OF GHANA

Diagram taken from: Drechsler D, Zimmermann F, *New actors in Health Financing: Implications for a Donor Darling*, OECD Development Center, Policy brief No.33. Available at: www.oecd.org/dataoecd/27/6/37903846.pdf

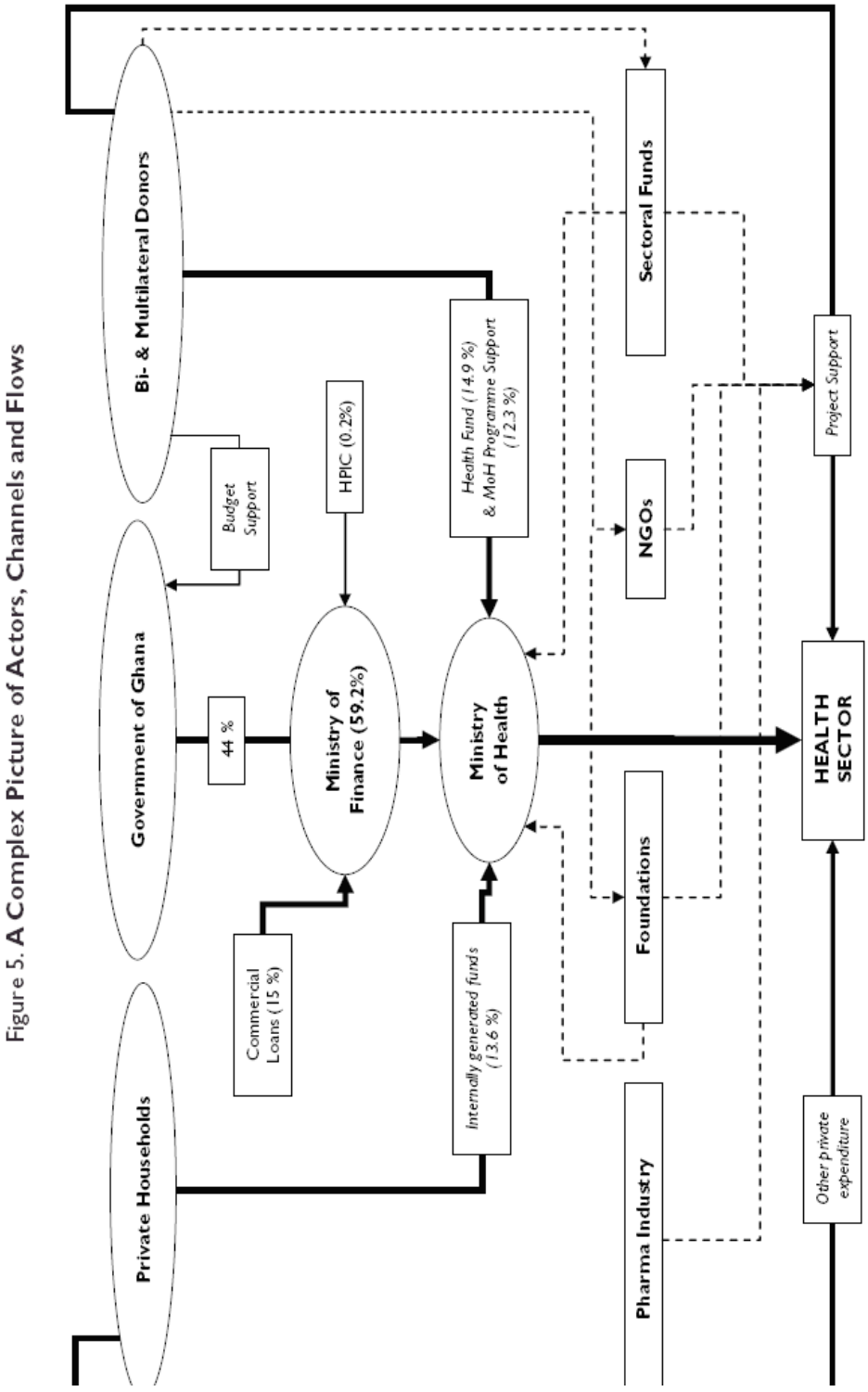
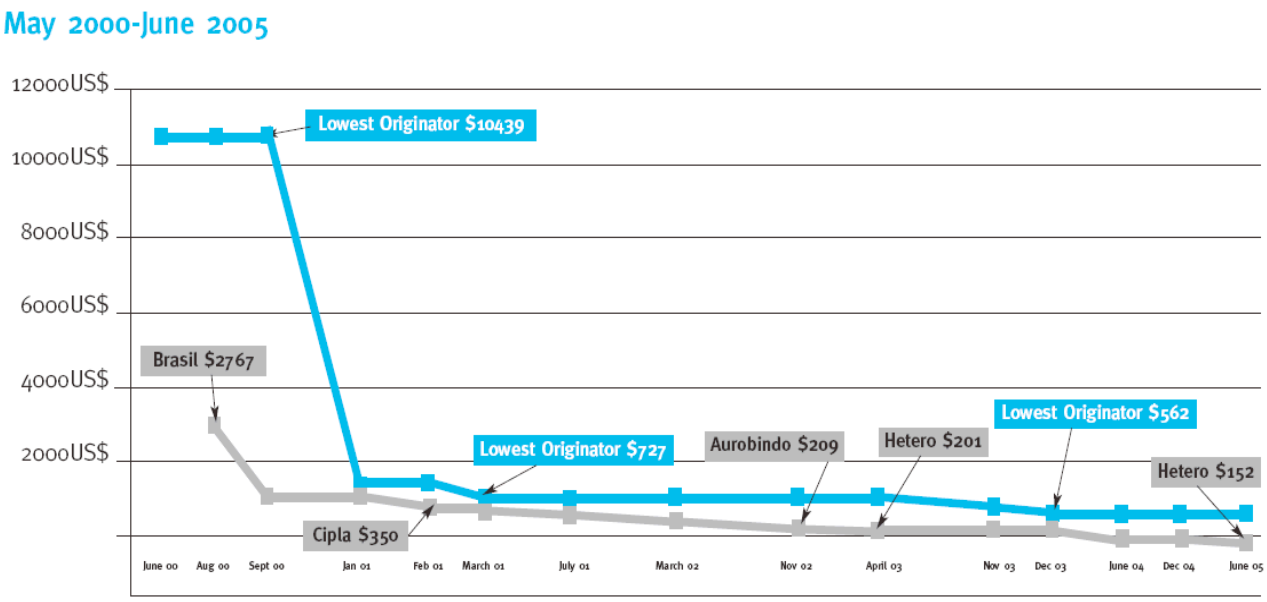


Figure 5. **A Complex Picture of Actors, Channels and Flows**

Authors' illustration. Percentages are derived from MoH (2006*a*) and concern 2005.

THE EFFECT OF GENERIC COMPETITION

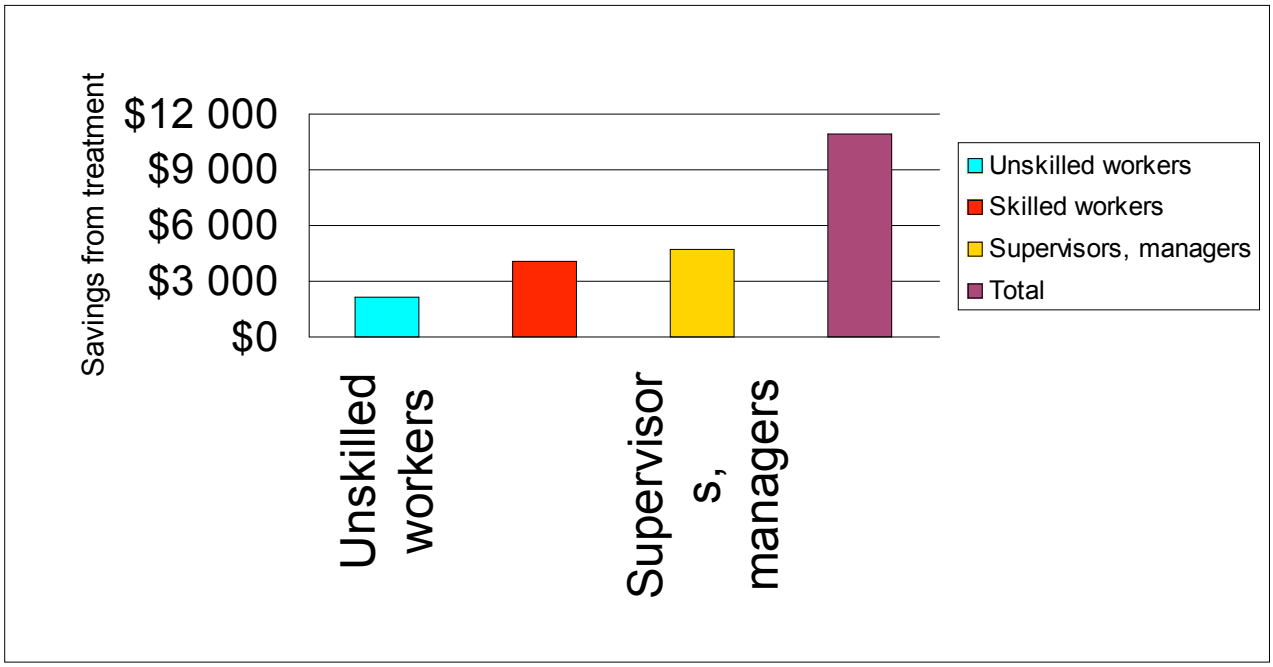
Table taken from *Untangling the web of price reduction*, MSF, available at www.accessmed-msf.org



Sample of ARV tiple-combination: stavudine (d4T) + lamivudine (3TC) + nevirapine (NVP). Lowest world prices per patient per year. Generic competition has shown to be the most effective means of lowering drug prices. During the last four years, originator companies have often responded to generic competition.

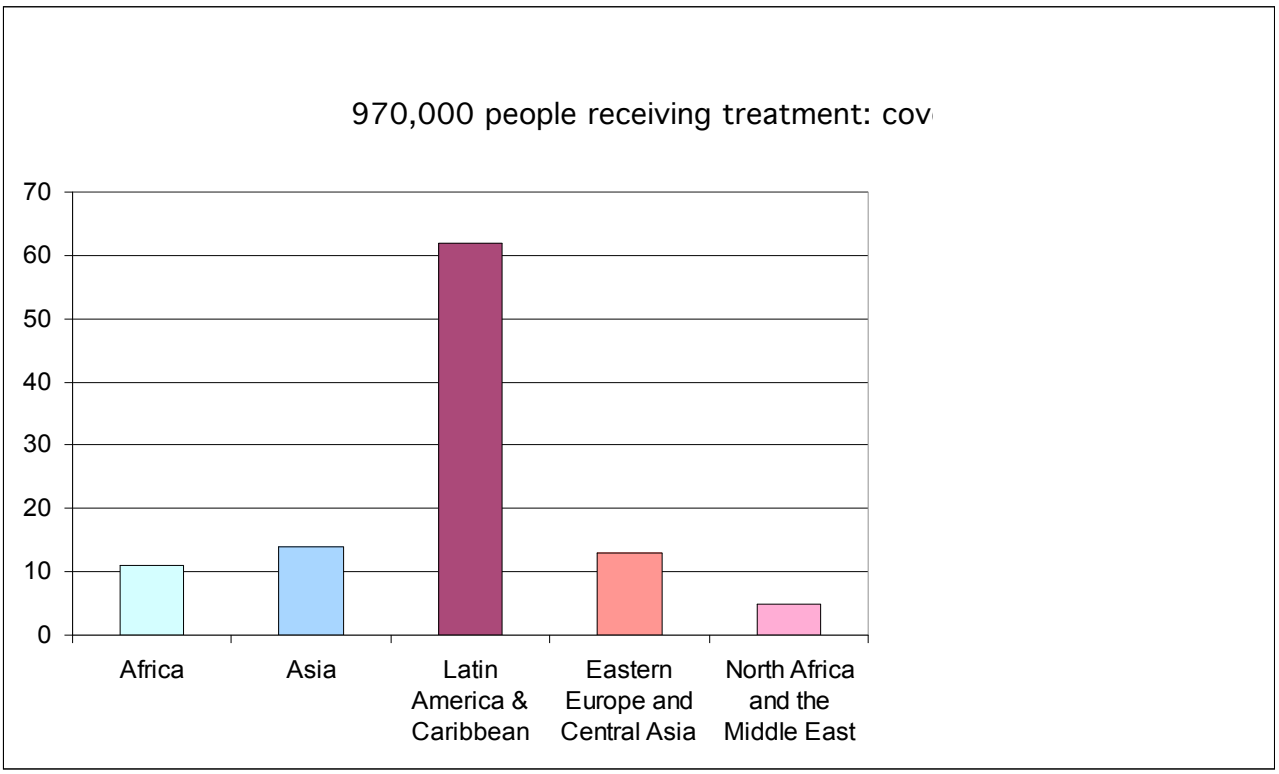
REDUCING THE AIDS "TAX": THE BENEFITS OF TREATMENT

Rosen S, Simon J, Fox M, MacLeod W, Vincent J, Thea D, Investing in the Epidemic: The Cost of AIDS to Businesses in Africa, Center for International Health Boston University School of Public Health, July 2002. See: http://sph.bu.edu/index.php?option=com_content&task=view&id=427&Itemid=526



COVERAGE OF ADULTS WITH ANTIRETROVIRAL THERAPY, JUNE 2005

Table created by the WHO and UNAIDS (2005). Wider access to antiretroviral treatment across the world: Update on the "Treat 3 Million by 2005" Initiative. www.who.int/3by5/june2005report_fr.pdf



BIBLIOGRAPHICAL REFERENCES

INTERNATIONAL HEALTH POLICIES

GREY LITERATURE AND OFFICIAL REPORT

- French institutions

CNS, *Avis sur la crise des ressources humaines dans les pays du Sud, un obstacle majeur à la lutte contre le VIH*, 6 juillet 2005.

CNS, *Avis suivi de recommandation « Promouvoir l'accès aux antirétroviraux des femmes enceintes vivant avec le VIH dans les pays du Sud »*, 24 juin 2004.

CNS, *Communiqué sur la nouvelle menace dans l'accès aux traitements des pays pauvres*, 16 janvier 2003.

CNS, *Communiqué à l'occasion de la reprise à Prétoria du procès intenté par trente-neuf compagnies pharmaceutiques au gouvernement d'Afrique du Sud*, 17 avril 2001.

CNS, *Communiqué sur la menace que font peser les accords de Bangui sur la santé en Afrique*, 8 février 2002.

CNS, *Rapport et propositions pour un accès généralisé aux traitements en matière de VIH/sida*, 7 novembre 2000.

CNS, *Rapport et recommandations vers une nouvelle solidarité. Pour un accès aux traitements antirétroviraux des personnes vivant avec le VIH en Afrique subsaharienne*, 10 décembre 1998.

Conseil économique et social, *La coopération sanitaire française dans les pays en développement*, avis présenté par Marc Gentilini, Paris, Journaux Officiels, 2006.

Kourilsky P, *Optimiser l'action de la France pour l'amélioration de la santé mondiale. Le cas de la surveillance et de la recherche sur les maladies infectieuses*, Rapport au gouvernement, 27 mars 2006.

Morange P, Kerouedan D, *Rapport au Premier ministre. Evaluation de l'action de la France en faveur de la réalisation des Objectifs du Millénaire pour le Développement dans le domaine de la Santé. Articulation et coordination des aides bilatérales et de la participation de la France aux programmes multilatéraux du secteur de la santé*, juin 2005.

Présidence de la République, *Les nouvelles contributions financières internationales. Rapport au Président de la République*, groupe de travail présidé par J.-P. Landau, Paris, La documentation française, Coll. Les Rapports Officiels, 2004.

- International organizations

- *United Nations*

Nations Unies, Assemblée générale, *Déclaration politique sur le VIH/sida*, Résolution adoptée par l'assemblée générale des Nations Unies, 87e séance plénière, 2 juin 2006, A/res/60/262.

Nations Unies, Assemblée générale, *Résumé du dialogue de haut niveau sur le financement du développement, établi par le Président de l'Assemblée générale (New York, 27-28 juin 2005)*, Mise en œuvre et suivi des textes issus de la Conférence internationale sur le financement du développement, A/60/219.

Nations Unies, Assemblée générale, *développer la prévention, les soins, le traitement et les services d'accompagnement an matière de VIH*, Note du Secrétaire général, 24 mars 2006, A/60/737.

Nations Unies, Assemblée générale, *Déclaration d'engagement sur le VIH/sida : cinq ans plus tard*, Rapport du Secrétaire général, 24 mars 2006, A/60/736.

Nations Unies, *Rapport de la Conférence internationale sur le financement du développement*, Monterrey (Mexique), 18-22 mars 2002, A/Conf.198/11.

- *African Union*

African Union, *Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by a United Africa by 2010. Africa's common position to the UN general assembly special session on AIDS*, Sp/Assembly/ATM/3(I) Rev.2, Special summit of African union on HIV/AIDS, Tuberculosis and Malaria, 2-4 May 2006, Abuja, Nigeria.

African Union, *Universal Access to HIV/AIDS, Tuberculosis and Malaria Services by a United Africa by 2010. Resolution of the Ministers of Health on Health Financing in Africa*, Sp/Assembly/ATM/5(I) Rev.3, Special summit of African union on HIV/AIDS, Tuberculosis and Malaria, 2-4 May 2006, Abuja, Nigeria.

Union africaine, *Apercu sur le thème : Une Afrique unie pour l'accès universel aux services de lutte contre le VIH/SIDA, la Tuberculose et le paludisme d'ici à 2010.*, Sp/PRC/ATM/2(I), Sommet extraordinaire de l'Union africain sur le VIH/SIDA, la Tuberculose et le paludisme (STP), 2-4 mai 2006, Abuja, Nigeria.

Union africaine, *Une Afrique unie pour l'accès universel aux services de lutte contre le VIH/SIDA, la Tuberculose et le paludisme d'ici à 2010. Facteurs institutionnels contraignant la réalisation des objectifs poursuivis par l'Afrique, au titre de la prévention et de la lutte contre le VIH/SIDA, la TB et le paludisme*, Sp/PRC/ATM/4(I), Sommet extraordinaire de l'Union africain sur le VIH/SIDA, la Tuberculose et le paludisme (STP), 2-4 mai 2006, Abuja, Nigeria.

Union africaine, *Une Afrique unie pour l'accès universel aux services de lutte contre le VIH/SIDA, la Tuberculose et le paludisme d'ici à 2010. Financement de la santé en Afrique*, Sp/PRC/ATM/5(I), Sommet extraordinaire de l'Union africain sur le VIH/SIDA, la Tuberculose et le paludisme (STP), 2-4 mai 2006, Abuja, Nigeria.

Union africaine, Onusida, OMS, *Engagement de Brazzaville pour l'intensification à une plus grande échelle des interventions visant à réaliser l'accès universel en Afrique*, Brazzaville, République du Congo, 8 mars 2006.

African Union, *Gaborone Declaration on a roadmap towards universal access to prevention, treatment and care*, CAMH/Decl.1 (II), Gaborone, Botswana, 10-14 October 2005.

- *World health organization*

Organisation mondiale de la santé Afrique, *La Santé des populations. Rapport sur la santé dans la Région africaine*, Genève, OMS, 2006.

Organisation mondiale de la santé, *La santé et les objectifs du Millénaire pour le développement*, Genève, OMS, 2005.

Organisation mondiale de la santé, *Le Rapport sur la santé dans le monde 2006 – Travailler ensemble pour la santé*, Genève, OMS, 2006.

Organisation mondiale de la santé, *Objectifs du Millénaire pour le développement liés à la santé : mise à jour. Elaboration d'une stratégie de renforcement des systèmes de santé*, Conseil exécutif, 12 décembre 2005, EB117/INF.DOC./2.

Organisation mondiale de la santé, *Prévention des maladies chroniques, un investissement vital*, Genève, OMS, 2006.

World Health organization, *A guide to WHO's role in sector-wide approaches to health development*, Geneva, WHO, 2006.

World Health Organization, African Development Bank, UNICEF, World Bank, *« tackling the barriers to scaling up in health… a coordinated response » Programs Assistance Facilitation for Health. A Joint Action Framework for the African Region, final draft 23 September 2006*, Brazzaville, September 2006.

World health organization, *Background paper on te concept of universal access. Technical Meeting for the Development of a Framework for Universal Access to HIV/AIDS Prevention, Care, Treatment and Support in the Health Sector*, Geneva, WHO/EIP/MHI, October 2005.

World health organization, Eucumenical pharmaceutical network, *Multi-Country Study of Medicine Supply and Distribution Activities of Faith-Based Organizations in Sub-Saharan African Countries*, Nairobi / Geneva, EPN/WHO, 2006.

World health organization, *Health Systems*, Report by the Secretariat, 8 January 2007, EB120/38.

World health organization, *HIV/AIDS. Implementation by WHO of the recommendations of the Global Task Team on improving AIDS Coordination among Multilateral Institutions and International Donors*, Report by the Secretariat, 24 April 2006, A59/8.

World health organization, *HIV/AIDS. WHO's contribution to universal access to HIV/AIDS prevention, treatment and care*, Report by the Secretariat, 4 May 2006, A59/39.

World health organization, *Nutrition and HIV/AIDS*, Report by the Secretariat, 4 May 2006, A59/7.

World health organization, *Proceeedings of a Technical Meeting for the Development of a Framework for Universal Access to HIV/AIDS Prevention, Care, Treatment and Support in the Health Sector*, Geneva, WHO, 18-20 October 2005.

World health organization, *Social health insurance. Sustainable health financing, universal covergage and social health insurance*, Report by the Secretariat, 7 April 2005, A58/20.

World health organization, *Treat, Train, Retain. The AIDS and health workforce plan. Report on the Consultation on AIDS and Human Resources for Health*, WHO, Geneva, 11-12 May, 2006.

World health organization, Unaids, *Guidance on ethics and equitable access to HIV treatment and care*, Geneva, WHO, 2004.

- *Unaids*

Onusida, OMS, Sidaction, *Elargir l'accès au traitement du VIH avec les organisations à assise communautaire*, Onusida, OMS, Coll. Meilleures pratiques de l'onusida, 2005.

Onusida, *Rapport sur l'épidémie mondiale de sida 2006. Edition spéciale 10e anniversaire de l'onusida*, Onusida, Genève, 2006.

Onusida, *Les "Trois principes" en action : bilan et avenir*, Onusida/05.08F, 2005.

Onusida, Banque mondiale, Pnud, *Intégration du sida dans les instruments et processus nationaux de développement. Revue des expériences*, Genève, Onusida, décembre 2005.

Onusida, *Besoins en ressources pour une riposte au SIDA élargie dans les pays à revenus bas et moyens*, Onusida, août 2005.

Onusida, *Faire travailler l'argent disponible grâce à un appui accru des Nations Unies aux ripostes contre le SIDA. Plan d'appui technique consolidé des Nations Unies contre le SIDA 2006-2007*, Genève, Onusida, mars 2006.

Unaids, World Bank, UNDP, *Mainstreaming HIV and AIDS in sectors & programmes. An implementation guide for national responses*, September 2005.

- *Other organizations*

Bureau international du travail, *Le VIH/sida dans le monde du travail : évaluation mondiale, répercussions et réponses*, Genève, OIT, 2004.

Déclaration de Paris sur l'efficacité de l'aide au développement, forum à haut niveau, Paris 28 février-2 mars 2005.

Shakow A, *Global Fund – World Bank HIV/AIDS Programs. Comparative Advantage Study*, prepared for The Global Fund to Fight AIDS, Tuberculosis & Malaria and The World Bank Global HIV/AIDS Programs, January 19, 2006.

World Bank Operations Policy and Country Services, *Enabling Country Capacity To Achieve results. Volume I : Overview*, Washington, The World Bank, 2005.

World Bank, International monetary fund, *Strengthening bank group engagement on governance and anticorruption, Development Committee* (Joint ministerial committee of the boards of governnors of the Bank and the fund on the transfer of real resources to developing countries), DC2006-0017, September 8, 2006.

World Bank, Unicef, *Poverty reduction strategy papers. Do they matter for children and young people made vulnerable by HIV/AIDSD ?*

World Bank, *World development report 2006, Equity and Development*, Washington, World bank/Oxford University Press, 2005.

World Bank, *World development report 2004, Making Services Work for Poor People*, Washington, World Bank/Oxford University Press, 2003.

- **Poverty reduction strategy papers**

PRSP progress report, Bénin, décembre 2002.

PRSP, Burkina Faso, juillet 2004.

PRSP Progress Report, Burkina Faso, décembre 2003.

PRSP progress report, Burkina Faso, 2002.

PRSP progress report, Burkina Faso, 2001.

PRSP, Burkina Faso, mai 2000.

PRSP, Joint Staff Advisory Note, Cameroun, mars 2006.

PRSP progress report, Cameroun, février 2006.

PRSP progress report, Cameroun, avril 2004.

PRSP, Cameroun, avril 2003.

PRSP II 2006-2009, Ghana, novembre 2005.

PRSP Progress Report, Ghana, mars 2004.

PRSP Progress Report, Ghana, fevrier 2003.

PRSP 2006-2007, Lesotho, avril 2006.

PRSP progress report 2005, Madagascar, juin 2006.

PRSP progress report, Madagascar, juillet 2004.

PRSP, Madagascar, juillet 2003.

PRSP progress report, Mali, août 2005.

PRSP progress report, Mali, avril 2004.

PRSP, Mali, mai 2002.

PRSP progress report, Ouganda, mars 2003.

PRSP progress report, Ouganda, mars 2002.

PRSP progress report, Ouganda, mars 2001.

PRSP, Ouganda, mars 2000.

PRSP progress report, Rwanda, juillet 2005.

PRSP progress report, Rwanda, avril 2004.

PRSP progress report, Rwanda, juillet 2003.

PRSP, Rwanda, juin 2002.

PRSP, Sénégal, mai 2002.

République du Tchad, ministère de la Santé publique, *Mission de supervision des activités de lutte contre le sida. 19-29 septembre 2006. Rapport de mission*, Programme national de lutte contre les IST/VIH/SIDA.

GENERAL ITEMS

AIDES, *Réseau Afrique 2000. Réponses associatives à la lutte contre le sida en Afrique*, Paris, AIDES, 2e édition, janvier 2005.

Appaix O, Dekens S, *Pour un plan d'action en faveur des orphelins et enfants vulnérables. Volume 1 Analyse de situation*, mai 2005, Orphelin sida international.

Beck E, Mays N, Whiteside A, Zuniga J, *The HIV Pandemic. Local and Global Implications*, Oxford, Oxford University Press, 2006.

Coriat B, Orsi F, d'Almeida C. TRIPS and the international public health controversies: issues and challenges. *Ind. Corp. Change* December 2006; 15: 1033 - 1062.

Correa C, *Implications of the Doha Declaration on the TRIPS Agreement and Public Health*, Health Economics and Drugs, EDM Series n°12, juin 2002.
Drager N, Fidler D P. Foreign policy, trade and health: at the cutting edge of global health diplomacy. *Bulletin of the World health organization* March 2007 ; 85(3).

Global Health Council, *Faith in action. Examining the Role of Faith-based Organisazations in addressing HIV/AIDS*, 2005.

Hibou B, *Economie politique du discours de la Banque mondiale en Afrique sub-saharienne. Du catéchisme économique au fait (et méfait) missionnaire*, Paris, Les études du CERI, n° 39, mars 1998.

Jamison D T, Breman J G, *et all., Disease Control Priorities in Developing countries*, Washington/New York, The World Bank/Oxford University Press, 2006.

Kaul I, Brunberg I, Stern M, eds, *Global Public Goods. International Cooperation in the 21st Century*, New York, Oxford University Press, 1999.

Krikorian G, *L'accès aux génériques. Enjeux actuels et propriété intellectuelle*, AIDES, 2006

Molyneux D.H, Hotez P.J, Fenwick A. "Rapid-Impact Interventions": How a Policy of Integrated Control for Africa's Neglected Tropical Diseases Could Benefit the Poor. *PLoS MED* November 2005; 2 (11): e336.

Morales K. Funding in Africa is concentrating too heavely on the 'big three'. *BMJ* 2005; 331 : 866.

Rossert H, Pelletier V, Trenado E, *Rapport de mission Cameroun (Yaoundé, Douala, Bafoussam] du 22 au 29 janvier 2005*, AIDES.

Transparency International, *Corruption and health, global corruption report 2006*.

Une santé chèrement payée. La détention des patients sans ressources dans les hôpitaux burundais, Human Rights Watch, septembre 2003, vol 18, n°8(A).

Verspieren P. L'Eglise catholique face à l'épidémie de sida. *Etudes* février 2007; 406(2): 213-225.

DEVELOPMENT AID

Berr E, Combarnous F, *L'impact du consensus de Washington sur les pays en développement : une évaluation empirique*, DT/100/2004, IFREeDE-GRES, Université Bordeaux IV.

CNUCED, *Le développement économique en Afrique. Doublement de l'aide : assurer la "grande poussée"*, New York, Genève, Nations Unies, 2006.

Commission pour l'Afrique, *Notre intérêt commun. Rapport de la commission pour l'Afrique*, mars 2005

Coordination sud, *Lettre des ONG sur la "Déclaration sur les sources innovantes de financement du développement"*, 14 septembre 2005.

Deacon B. Les organisations internationales, l'Union européenne et la politique sociale globalisée. *Lien social et Politiques* 2001; 45.

Maxwell S, *What's Next in International Development ? Perspectives from the 20 % Club and the 0.2% Club*, London, Overseas Development Institute, Working Paper 270, June 2006.

OCDE, *Faire reculer la pauvreté. Le rôle de l'OCDE dans le partenariat pour le développement*, Paris, OCDE, 2005.

ODI Briefing paper, *Scaling up versus absortive capacity : challenges and opportunities for reaching the MDGs in Africa*, May 2005.

Pierru F, Serre M. Les organisations internationales et la production d'un sens commun réformateur de la politique de protection maladie. *Lien social et Politiques* 2001; 45.

Report on the scaling up for better health (Post-HLF) initiative. First meeting of the steering committee, Paris, France, 25-26 September 2006.

HEALTH CARE FINANCING

GENERAL ITEMS

Audibert M, Mathonnat J, de Roodenbeke E, dir., *Le financement de la santé dans les pays d'Afrique et d'Asie à faible revenu*, Paris, Karthala, 2003.

Brikci N, Philips M.User fees or equity funds in low-income countries. *Lancet* 2007; 369: 10-11.

Carrin G. L'assurance sociale maladie dans les pays en développement : un défi permanent. *Revue internationale de sécurité sociale* 2002; 55 (2): 73-89.

Cisse B, Luchini S, Moatti J P. *Equity in Health Care Finance and Delivery : what about Africa*, GREQAM, Document de travail 2006-11, février 2006.

Cisse B, Luchini S, Moatti J-P. Recouvrement des coûts et demande de soins dans les PED. *Revue française d'économie* 2004; 28: 111-149.

Cissé B, Luchini S, Moatti J-P, *Les effets des politiques de recouvrement des coûts sur la demande de soins dans les Pays en développement : les raisons de résultats contradictoires*, GREQAM, Document de travail n° 03C02, octobre 2002.

Designing health financing systems to reduce catastrophic health expenditure, WHO, Departement of health systems financing, Health financing policy, Technical briefs for policy-makers, n° 2, 2005.

Drechsler D, Zimmermann F, *New actors in Health Financing : Implications for a Donor Darling*, OECD Development Center, Policy brief n°33.

Dreschler D, Jütting J, Private Health Insurance for the Poor in developping Countries ?, *Policy insights* n°11, OCDE Development centre, 2005.

Dror D, Duru G, *Stabilising community health financing through re-insurance*, Conférence sur la sécurité sociale, Helsinki, 2000.

Dussault G, Fournier P, Letourmy A, eds, *L'assurance maladie en Afrique francophone. Améliorer l'accès aux soins et lutter contre la pauvreté*, Washington, Banque mondiale, série santé, nutrition et population, 37149, 2006.

Gilson L, McIntyre D. Removing user fees for primary care in Africa : the need for careful action. *BMJ* 2005; 331: 762-765.

Gottret P, Schieber G, *Health financing revisited. A practitioner's guide*, Washington, The International Bank for Reconstruction and Developement/ The World Bank, 2006.

High Level Forum on the Health MDGs, *Fiscal space and Sustainability from the Perspective of the Health Sector*, Paris, 14-15 november 2005.

James C, *et al.* Impact on child mortality of removing user fees : simulation model. *BMJ*, 2005; 331: 747-749.

Jütting J, *Public-private partnerships in the health sector : Experiences from developing countries*, ESS Paper n° 10, Social Security Policy and Development Branch, ILO, 2002.

Lönnrotht K, *et al.* Hard gains through soft contracts : productive engagement of private providers in tuberculosis control. *Bulletin of the World health organization* 2006; 84: 876-883.

Meesen B, Van Damme W, Kirunga Tashobya C, Tobouti A. Poverty and user fees for public health care in low-income countries : lessons from Uganda and Cambodia. *Lancet* 2006; 368: 2253-57.

Ooms G, Derderian K, Melody D (2006) Do we need a world health insurance to realise the right to health ? *PloS Med* 2006; 3(12): e530.

Report of the Commission on Macroeconomics and Health, Sachs J, *Macroeconomics and health : Investing in Health for Economic Development*, Genève, WHO, 2001.

Ridde V, Girard J-E, "Douze ans après l'initiative de Bamako : constats et implications politiques pour l'équité d'accès aux services de santé des indigents africains. *Santé Publique* 2004; 15(1): 37-51.

Ridde V, *L'initiative de Bamako 15 ans après. Un agenda inachevé*, Health nutrition and Population, The World Bank, octobre 2004.

Ridde V. Fees-for-services, cost recovery, and equity in a district of Burkina Faso operating the Bamako initiative. *Bulletin of the World Health Organization* 2003; 81(7): 532-538.

Sachs J D, *Macroeconomics and Health : Investing in Health for Economic Development, Report of the Commisison of Macroeconomics and Health*, Geneva, WHO, 2001.

Singh A, *Building on the user-fee experience : the African case*, Genève, WHO, EIP/FER/DP.03.3, Discussion paper n° 3, 2003.

Smith R, Beaglehole R, Woodward D, Drager N, *Global public goods for health. Health economic and public health perspectives*, Oxford, Oxford University Press, 2003.

Su TT, Kouyaté B, Flessa S. Catastrophic household expenditure for health carre in a low income society : a study from Nouna district, Burkina Faso. *Bulletin of the World Health Organization* 2006; 84(1): 21-27.

Letourmy A, Ndiaye P, Pavy-Letourmy A, Galland B, Hautet E, *Inventaire des SAM en Afrique : synthèse des travaux de recherche*, Dakar, La Concertation, octobre 2004

Letourmy A, Pavy-Letourmy A, *La micro-assurance de santé dans les pays à faible revenu*, Paris, Agence française de développement, Notes et documents, n°26, décembre 2005.

Huber G, Hohmann J, Reinhard K, *Mutuelles de Santé – 5 années d'Expérience en Afrique de l'Ouest. Débats, Controverses et Solutions Proposées*, Eschborn, GTZ, 2003.

Dror DM, Jacquier C. Micro-Insurance : Extending Health Insurance to the Excluded. *International Social Security Review* 1999; 52(1): 87-119.

Gommans C, Gatera C, *Report of the Workshop HIV/AIDS and Microinsurance in the Microfinance Sector in Africa*, Addis Ababa, 25-27 april 2005, Africa microfinance network, HIVOS.

HIV TREATMENT AND CARE

The World Bank, Thailand Ministry of Public Health, *Expanding access to antiretroviral treatment in Thailand*, Decembre 2005.

World health organization, *The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care*, WHO Discussion paper, décembre 2005.

Corbett E L, Steketee R W, ter Kuile F, Latif A S, Kamali A, Hayes R J. HIV-1/AIDS and the control of other infectious diseases in Africa. *Lancet* 2002; 359: 2177-2187.

Forsythe S, Arthur G, Ngatia G, Mutemi R, Odhiambo J, Gilks C. Assessing the cost and willingness to pay for voluntary HIV counselling and testing in Kenya. *Health Policy Plan* 2002; 17(2): 187-195.

Gilks CF *et al.* The WHO public-health approach to antiretroviral treatment against HIV in resource-limited settings. *Lancet* 2006; 368: 505-510.

Goldie SJ, Yazdanpanah Y, Losina E, *et al.* Cost-effectiveness of HIV Treatment in Ressource-Poor Settings – The Case of Côte d'Ivoire. *N Engl J Med* 2006; 355(11): 1141-1153.

Ivers LC, Kendrick D, Doucette K. Efficacy of antiretroviral therapy programs in resource-poor settings: A meta-analysis of the published literature. *Clin Infec Dis* 2005; 41(2): 217-224.

Lanièce I, Mounirou C, Desclaux A, Diop K, Mbodj F, Ndiaye B, *et al.* Adherence to HAART and Its Principal Determinants in a Cohort of Senegalese Adults. *AIDS* 2003; 17(supp. 3): S103-S108.

Reid A, Scano F, Getahun H, *et al.* Toward universal access to HIV prevention, treatment, care and support : the role of tuberculosis/HIV collaboration. *Lancet Infect Dis* 2006; 6(8): 483-495.

The Antiretroviral Therapy in Lower Income Countries (ART-LINC) Collaboration, ART Cohort Collaboration (ART-CC) groups. Mortality of HIV-1-infected patients in the first year of antiretroviral therapy. *Lancet* 2006; 367: 817-824.

Thielman NM, *et al.* Cost effectiveness for Free HIV Voluntary Counseling and Testing Through a Community-Based AIDS Service Organization in Northern Tanzania. *Am J Public Health* 2006; 96(1): 114-119.

Vermund SH, Wilson CM. Barriers to HIV testing - Where next? *Lancet* 2002; 360: 1186-1187.

Desclaux A, Lanièce I, Ndoye I, Taverne B, *L'initiative sénégalaise d'accès aux médicaments antirétroviraux. Analyses économiques, sociales, comportementales et médicales*, Paris, ANRS, Coll. Sciences sociales et sida, 2002.

Desclaux A, "Equity in access to AIDS Treatment in Africa : pitfalls amongst achievements" in Singer M, Castro A (eds), *Unhealthy health policy : a critical medical anthropology perspective*, Lanham, Altamira Press, 2004.

Drummond D, Kelly R, *The economic cost of aids : a clear case for action. Poverty and Marginalization Primary contributors*, TD Economics, Special Report, August 8, 2006.

Haacker M, "Fiscal and macroeconomic aspects of the HIV pandemic", *in* Beck E, Mays N, Whiteside A, Zuniga J, *The HIV Pandemic. Local and Global Implications*, Oxford, Oxford University Press, 2006, pp. 642-659.

Leoni P, Luchini S, *Designin the financial tools to promote universal access to AIDS care*, papier présenté à la Global Finance Conference 2005, Dublin.

Hotez PJ, Molyneux DH, Fenwick A, Ottesen E, Sachs SE, *et al.* Incorporating a rapid-impact package for neglected tropical diseases with programs for HIV/AIDS, tuberculosis, and malaria. PLoS Med 2006; 3(5): e102.

Les partenariats public privé dans la lutte contre le VIH/sida dans les pays en développement. Rapport à la direction du développement et de la coopération technique du Ministère des Affaires Etrangères, Michèle Barzach Santé International, Conseil en stratégie de santé, novembre 2004.

Moatti J-P, Coriat B, Souteyrand Y, Barnett T, Dumoulin J, Flori Y-A, eds, *Economics of AIDS and Access to HIV/AIDS Care in Developping Countries. Issues and Challenges*, Paris, ANRS, Coll. Sciences sociales et sida, 2003.

Rosen S, Simon J, Vincent J R, MacLeod W, Fox M, Thea D M. AIDS Is Your Business. *Harvard Business Review* February 2003l; DOI: 10.1225/R0302F.

Thirumurthy H, Graff Zivin J, Goldstein M, *The Economic Impact of AIDS Treatment: Labor Supply in Western Kenya*, NBER Working Paper n° 11871, December 2005

Whiteside A, Lee S. The "Free by 5" campaign for universal, free antiretroviral therapy. PloS Med 2005; 2(8): e227.

Cellule mondiale de réflexion, *Pour une meilleure coordination entre les organismes multilatéraux et les donateurs internationaux dans la riposte au sida, Rapport final*, Genève, Onusida, 14 juin 2005.

Clinton HIV/AIDS Initiative, *Global ARV demand forecast, overview*, 9 June 2006.

Gupta S, Powell R, Yongzheng Y, *The Macroeconomic Challenges of Scaling Up Aids to Africa*, IMF Working Paper, WP/05/179, September 2005.

Holden S, *Mainstreaming HIV/AIDS in Developement and Humanitarian Programmes*, Action Aids, Oxfam Gilbert Barbier, and Save the Children UK, 2004.

Kate J, Lief E, *International Assistance for HIV/AIDS in the Developping World : Taking Stock of the G8, Other Donor Governments and the European Commisison*, The Henry J. Kaiser Family Foundation, July 2006.

MacKellar L, *Priorities in Global Assistance for Health, AIDS and Population (HAP)*, OECD Development centre, Working Paper n°244, DEV/DOC(2005)04, June 2005.

Vinard P, Diop K, Taverne B, Etard J-F, *Faisabilité économique de la gratuité complète de la prise en charge médicale des patients VIH au Sénégal*, Conseil national de lutte contre le sida/IRD, juin 2006.

Vinard P, Diop K, Taverne B, *Comment financer la gratuité ? Le cas de la prise en charge médicale complète des Personnes Vivant avec le VIH/sida au Sénégal*, Dakar, Conseil national de lutte contre le sida, Institut de recherche pour le développement, Alter Santé internationale et développement, janvier 2007.

Chunling L, Michaud CM, Khan K, Murray CJL. Absortive capacity and disbursments by the Global Fun to Fight AIDS, Tuberculosis and Malaria : analysis of grant implementation, *Lancet* 2006; 368: 483-488.