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OPINION FOLLOWED BY RECOMMENDATIONS

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STATEMENTS FOLLOWED BY RECOMMENDATIONS ON FREE ACCESS TO TREATMENT, CARE AND SUPPORT FOR PERSONS INFECTED WITH HIV IN DEVELOPING COUNTRIES

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STATEMENTS ON FREE ACCESS TO TREATMENT, CARE AND SUPPORT FOR PERSONS INFECTED WITH HIV IN DEVELOPING COUNTRIES

Since the end of the 1990s, the HIV infection epidemic has occupied an ever more important place on the world agenda. In 1997, France declared itself in favour of access to antiretroviral (ARV) medicines for developing countries (DCs) and, after much reluctance, notable progress was made. The number of persons receiving 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[1]. 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's development goals.

In spite of these advances, there currently exists a financial barrier for persons infected with HIV to access to care. And yet, treatment is effective if it is made freely available, without direct payment at the point of delivery, and if it becomes part of a global care in the long run. The effectiveness of free treatment is found on several levels. It is, of course, of an individual and medical nature, but it also depends upon economic and social factors. Moreover, it can contribute to the strengthening of health systems as a whole[2]. 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.

AN UNSUITABLE FINANCIAL SET-UP FOR HEALTH CARE

In 1987, the Bamako Initiative (BI) fashioned the present framework for financing the health care system in DCs, most notably by having users of the health care resources participate financially. This participation was to help overcome the failures of international health care policies of the preceding years which had not been able to offer universal access to basic health care needs. Thanks to direct contributions from patients, health care centres have their own financing[3]. In return, users can participate in the centre management and the quality of services can improve.

At the time the BI was implemented, few people took into account the epidemic extent of HIV infection in DCs, in particular in sub-Saharan Africa. Today, its impact is profound and lasting. The countries of sub-Saharan Africa have 24 million of the 38 million people living with HIV (PLHIV) worldwide and the highest prevalence rates with an average of 6% of people infected in the population. In some African regions, PLHIVs sometimes represent 20% to 30% of the population. On this continent, the average life expectancy has decreased, falling from 62 to 43 years of age. Women represent 57% of PLHIVs and this feminisation of the epidemic could lead to the life expectancy of women being lower than that of men from 2008[4]. The HIV infection epidemic destroys families, social networks and the economy of societies. On this continent, 12 million children are considered as AIDS orphans and

[1] UNAIDS, *Report on the global AIDS epidemic. A UNAIDS 10th anniversary special edition*, Geneva, UNAIDS 2006. The Conseil national du sida has expressed an opinion on the following subjects on several occasions: *Report and recommendations towards a new solidarity* for access to antiretroviral treatments for persons living with HIV in sub-Saharan Africa, 10 December 1998. Report and proposals for a general access to treatments relating to HIV/AIDS, 7 November 2000. Communiqué on the occasion of the resumption of proceedings instituted by thirty-nine pharmaceutical companies in Pretoria against the South African government, 17 April 2001. Communiqué on the threats posed by the Bangui Agreement to health in Africa, 8 February 2002. Communiqué on the new threat to access to treatments in poor countries, 16 January 2003. Notification followed by recommendations 'Promoting access to antiretroviral treatment for pregnant women living with HIV in Southern countries', 24 June 2004. Notification on the human resources crisis in Southern countries, a major obstacle to the fight against HIV, 6 July 2004.

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

[3] The only exceptions to the recovery of costs are the treatment of tuberculosis and leprosy.

[4] United Nations Development Programme, *Human development report 2006*, UNDP, p. 266. *Perspectives démographiques mondiales*, Nations unies, 2005.

they have to be cared for by grandparents or older siblings[5]. Depending on the country, the proportion of women and men of working age living with HIV varies, but it sometimes represents up to 25% of that age range. The decrease in GDP growth rates can thus reach up to 3%[6]. At the business level, the impact of HIV is calculated like a 'tax', representing up to 6% of the wage bill due to employee deaths and their consequences upon business performance.

For a family, it is believed that the maximum average cost of health care amounts to 100 euros per year for all family members. In that context, access to care depends on the ability of people to cope with an immediate charge. It is difficult to bear for the poorest and prevents them from seeking health care services. These expenses can reach such a level in relation to income that they are said to be 'catastrophic'[7] For populations with very low incomes, even a minute level of health care expenses is a catastrophic health expenditure[8] The direct payment for health care provisions by the user is an obstacle to access to care and can be a factor of impoverishment and a source of iniquity.

Despite lower prices for antiretroviral medicines, annual treatment costs around 150 euros for one person, which is more than the total annual health care costs for a whole family. The treatment of HIV infection incurs other costs like consultations, medical examinations, etc. In Senegal, for example, the total cost for treatment and care exceeds 400 euros per year[9] For many reasons, the direct payment for care constitutes a brake to good treatment[10] and it conflicts with the objective of universal access. Taking into account household incomes and the costs of long-term treatment, it is impossible for people to make contributions over the long-term, however small they are. Consequently, the free treatment of persons infected by HIV appears to be the only solution to achieving the objective of universal access by 2010 and this must, therefore, be imposed upon nations[11]

FREE PROVISION AS AN EFFECTIVE MEANS TO ACCESS TREATMENT

Access to treatment enables an immediate improvement in the PLHIV's health and alleviates considerably the burden on hospitals and health care personnel. In developed countries, the implementation of antiretroviral multitherapy in 1996 enabled a reduction of almost 80% in new cases of AIDS and opportunist infections. Thanks to these treatments, hospitalisation has decreased by similar proportions[12]. Today in Africa PLHIVs represent the largest proportion of hospitalised people.

Data available on the relation between direct payment and treatment show the advantage of free access for better results whether it be for screening, observation and, more generally, for mortality and morbidity.

The first step towards treating HIV infection is taken with screening. More often than not there is a charge for this and its cost adds to the various barriers that delay the obtaining of the serological status[13] A fundamental aspect in the effectiveness of medicines, the adherence to treatment is limited by the constraints of paid access[14] When payment is demanded, treatments are interrupted when the person's finances are depleted, which increases the risks of resistant mutant selections. In the long run, treatment becomes complicated. In contrast, the analysis of results from around twenty programmes shows that mortality rates among treated persons

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[5] 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.

[6] International Labour Office, *HIV/AIDS and work: global estimates, impact and response*, Geneva, ILO, 2004.

[7] *Designing health financing systems to reduce catastrophic health expenditure*, WHO, Department of health system financing, Health financing policy, Technical brief for policy makers, n°2, 2005. Health care costs are catastrophic when they exceed 40% of revenues remaining after basic needs have been met.

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[9] 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, p. 15.

[10] WHO, *The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care*, WHO Working Paper, December 2005.

[11] WHO, Unaids, *Guidance on ethics and equitable access to HIV treatment and care*, WHO, 2004.

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[14] Laniece I, Ciss M, Desclaux A, Diop K, Mbodj F, Ndiaye B, Sylla O, Delaporte E, Ndoye I, Adherence to HAART and its principal determinants in a cohort of Senegalese adults. *AIDS*.2003Jul;17Suppl3:S103-8.

are less when they have access to free medication[15] Other studies show that the best results for controlling viral load are those obtained from patients who have been included on free access programmes[16]

Treatment favours the return to work and people infected with HIV can carry on with their activities and provide for the needs of their family. Moreover, the time spent working by children, who then act as substitutes for their parents, decreases and they can return once again to school[17]. Free access at the point of service delivery thus seems to support family economics and contribute directly to development by avoiding child labour. In the best case scenario, it is commonplace that parents living with HIV choose to pay for the child's education at the detriment of treatment[18] Free access will mean no longer having to make such choices.

THE FINANCING OF FREE TREATMENT IN FAVOUR OF THE STRUCTURING OF SYSTEMS

Financing free access to care for PLHIVs has to meet two challenges. On the one hand, the loss of revenues generated by the direct recovery of costs must be compensated for. On the other hand, the increase in needs must be anticipated to achieve the objective of universal access. For the fight against the epidemic in 2008, the resources available are estimated to be only 10 billion dollars[19], whilst the estimated needs will increase to 22 billion dollars in that same year[20] The volume of external aid must therefore increase as well as the allocation for health care in the government's budgets. The issues from this point of view depend as much upon the strengthening of national systems as upon the development of international aid policies.

Developing countries face numerous sanitary challenges with health care systems weakened by structural limitations. The sums necessary for the implementation of free treatment worldwide are significant. These finances must therefore be part of a sector wide approach in order to benefit the health system as a whole. Thus, support given for the reinforcement of antiretroviral supply channels must serve all health care products. Maternity hospitals can benefit from improvements carried out for the treatment of pregnant women living with HIV. The same is true for medical facilities that deal with infectious diseases and who treat numerous PLHIVs.

The Paris declaration and the 'Three principles' promoted by UNAIDS set out guidelines for a better use of aid and for improving policies for the fight against AIDS[21] The application of these principles must allow funds allocated to HIV to contribute to health care policies as a whole. Governments of developing countries must benefit from a drive to strengthen their capacities for management and financing of their health care systems. At their level, international donors must contribute to facilitating the management of states and to the appropriate use of the funds put at their disposal.

The failure of national measures can prejudice the global response. The states as a whole, whatever their level of development, have a global responsibility in relation to the HIV infection epidemic which is a transnational threat. Governments of developed countries must provide the necessary support to countries that are in need of it. The governments of developing countries are responsible as regards their population and the world as a whole for the implementation of effective policies for the fight against HIV and for a strict management of allocated funds.

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[16]Ivers LC, Kendrick D, Doucette K, Efficacy of antiretroviral therapy programs in resource-poor settings: a meta-analysis of the published literature. *Clin Infect Dis*. 2005 Jul 15;41(2):217-24.

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[18] CNS interviews.

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

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

[21] The Paris declaration on the effectiveness of aid on development, March 2005, lays down principles of relations between donors and recipients. Donors must coordinate their aid and bring it into line with national policies; recipient States must take over developmental policies by defining strategic directions; aid is managed according to the results obtained. The Declaration can be read here: www.oecd.org/dataoecd/11/41/34428351.pdf. The three principles of UNAIDS are a plan of action against AIDS which forms the basis for the coordination of the activities of member states; a national authority for coordinating the fight against AIDS; and a system for monitoring and assessing adapted to each country.

RECOMMENDATIONS FOR FREE ACCESS TO TREATMENT FOR PERSONS INFECTED WITH HIV IN DEVELOPING COUNTRIES

1 THE FREE PROVISION OF HEALTH SERVICES AS A MEANS OF ENSURING GOOD TREATMENT AND CARE FOR PERSONS LIVING WITH HIV

For persons infected with HIV, the only way to remain in good health, to avoid AIDS and to play an active part within society, is to benefit from antiretroviral treatment and from all the other care necessary. Moreover, the receipt of treatment helps have an impact upon the prevention of transmission.

It has been demonstrated that this benefit is real, but particularly if the persons infected with HIV have free access to treatment, *i.e.* without direct payment at the point of service delivery.

The principle of direct payment of part of the care and treatment of persons infected with HIV is an obstacle to this access and goes against the effectiveness of treatment access policies.

THE CARE OFFERED MUST BE THAT OF A GLOBAL APPROACH

Services offered freely to people must constitute a coherent programme which is not limited to treatment alone but which covers screening, diagnosis, monitoring and treatment with all the necessary facilities. The extent of care offered must be adapted to suit local situations, but its evolution should tend towards global treatments and care.

2 TOWARDS FREE PROVISION OF CARE IN THE HEALTH SERVICE

FINANCING THE FREE PROVISION OF HIV TREATMENT CONTRIBUTES TO STRUCTURING THE HEALTH CARE SYSTEM AS A WHOLE.

The implementation of free provision of treatment for persons infected with HIV must allow the consolidation of national purchasing offices and the logistics of supplying health care products.

Hence, through its missions, the global fund to fight HIV, Tuberculosis and Malaria contributes to making a link between the three pathologies. This implementation must make it possible to go beyond this, by developing programmes which associate policies for combating HIV with measures adapted to highly prevalent infections in those countries.

ALL THE INTERNATIONAL AND NATIONAL PLAYERS IN HEALTH CARE POLICIES MUST SUBSCRIBE TO A STRATEGY OF PROVIDING FREE HEALTH CARE SERVICES

As recommended by the Paris declaration and the 'Three principles' set out by UNAIDS, countries must define the general directions of their health care policies. The financing of the free provision of access to care must be integrated into the framework of national health care policies in order to benefit from as many spin-offs as possible.

The projects and programmes supported by international donors must be consistent with national health care policies. International organisations, programmes supported by Unitaid, private foundations, companies who offer free treatment to employees, their families and sometimes neighbouring communities, must bring themselves into line with national policies.

The actions of the different players in health care policies and the fight against HIV must be coordinated and harmonised.

The monitoring and evaluation of programmes and their financing according to the results must be supported and developed along the lines of the global fund's procedures that have demonstrated their relevance and effectiveness.

3 TOWARDS PERPETUAL FINANCING OF FREE HEALTH CARE PROVISION

TOWARDS UNINTERRUPTED FREE FINANCING

The countries are reluctant to implement free treatment due to the uncertainty regarding the longevity of external aid. A long-term financial commitment on behalf of France and other donors is required.

In order to ensure free provision without jeopardising purchasing offices, from now on the necessary funds for supplies must be provided. The permanent financial aid mechanisms, such as Unitaid or the *International Finance Facility* (IFF), must ensure the immediate implementation of free access to treatment.

TOWARDS FREE FINANCING IN THE LONG RUN BY DEVELOPING INSURANCE MECHANISMS FOR HEALTH CARE RISKS

The development of free treatment for HIV infection presupposes a growth in finances dedicated to health care. In the long run, countries must be able to put into place mechanisms of an insurance nature which will allow them to better manage capital flow.

4 TOWARDS A FOREIGN POLICY PROMOTING AND SUPPORTING FREE CARE PROVISION

France has become firmly involved in the fight against the HIV infection epidemic in developing countries. France's multilateral financial contributions to the global fund or to Unitaid make it one of the principal contributors towards the fight against HIV. In order that developing countries can benefit at best from these opportunities, it is necessary to defend the idea of free treatment at the level of European institutions, within international organisations and to give countries the necessary technical support.

EMPHASIZING FREE CARE PROVISION WITHIN INTERNATIONAL ORGANISATIONS

FREE PROVISION OF CARE IS THE ONLY WAY TO ACHIEVE THE OBJECTIVE OF UNIVERSAL ACCESS BY 2010.

France must convey the message of free care to international organisations as a necessary stage towards the objective of 2010 for universal access to screening, treatment, care and support services.

French representatives must promote free treatment, for example, at the World Health Assembly, and back the implementation of WHO resolutions on health insurance and the abolition of direct payment.

SUPPORTING SECTORAL APPROACHES LINKED TO HIV FINANCING

French representatives must promote international aid policies concerned with the strengthening of national structures and with the transfer of skills. Countries benefiting from French aid must be encouraged to ask for finance to facilitate strengthening capabilities.

DEVELOPING TECHNICAL SUPPORT FOR HIV TO FACILITATE THE STRENGTHENING OF HEALTH CARE SYSTEMS

France has at its disposal tools which provide useful technical support to countries; like the ESTHER initiative for hospitals or the support for strengthening national medication policies. This technical support must be maintained, developed and reinforced to enable free provision of care to serve as a means of strengthening systems in the context of sector wide approach.

MAKING THE ENTIRE AID ORGANISATION AWARE OF THE STAKES INVOLVED IN FREE CARE PROVISION

In order to strengthen coherence between aid policies and multisectoral efforts to fight HIV in countries, aid personnel, notably technical assistants in fields other than health, must be made aware of the problems posed by the HIV infection epidemic.

French representatives sitting on decision making and coordinating bodies at state level, such as the Global Fund, must fulfil their role wholeheartedly by being present, informed and vigilant.

STRENGTHENING TECHNICAL ASSISTANCE AND BILATERAL AID NECESSARY FOR FREE ACCESS TO CARE

In order to support the concept of national health care strategies and access to free care, technical assistance offered to countries includes:

- *Support for increasing knowledge about the countries' epidemiology*

This knowledge is required to define the public policy guidance.

- *Support for monitoring and evaluating programmes*

The monitoring and evaluation of free access programmes are necessary to ensure that funds are really distributed for the treatment of patients and to possibly modify the programmes. The states must have the necessary personnel to carry out this monitoring so that it is not added to the workload of medical and paramedical personnel.

- *Support for managing the supply of health care products*

Financial support to purchasing offices and to medicine distribution networks must be ensured so that products are actually freely delivered. Personnel in purchasing offices and hospital pharmacies must be prepared for increases in requests for health care products and for risks of supply shortage.

- *Support for implementing flexibilities offered by intellectual property agreements so that they apply to health care products*

Commercial agreements on intellectual property law offer the possibility to adjust the application of patent rights to medication and other health care products according to the needs of developing countries. France must offer support to countries who wish to utilise these flexibilities.

- *Support for budgetary management at a national and decentralized level*

The cancellation of direct payment requires financing to be directed towards health care structures that used to get money out of it. Whilst awaiting the generalisation of health insurance mechanisms, international financing must be collected within a fund run by the states which will enable the purchasing of health care services. Due to the end of direct payment, decentralized health care structures will lose part of their income. The financial channels enabling the supply of funds to these structures must be reinforced. It is necessary to support the training of management personnel responsible for these funds.

- *Support for developing health insurance*

To do so, France and the European Union must provide the necessary support to developing nations so that they can equip themselves with the administrative and judicial systems which may be lacking, and so that they train competent personnel, in sufficient numbers, in order to ensure the management of complex health care systems.

The development of microinsurance appears to be a useful interim solution due to its capacity to favour the mobilisation of civil society and to improve management skills. However, the impact of these mechanisms upon access to care for persons infected with HIV remains slight.

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.
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- 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.
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