The Role of Financing in Ensuring Access to Essential Drugs

External assistance and pharmaceutical financing

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First, I would like to thank the organizers of this Workshop, WHO /WTO. The quality of the programme and the questions raised give us the opportunity to discuss in depth important matters, at that moment.

I would like also to express my recognition to the Norwegian government which is always supporting such useful initiatives.

Second, two months before the special session of the General Assembly of the United Nations on Aids, it is very interesting to see such a large mobilization on access to care for the HIV infected persons. In 1997, France was a precursor and this goals seemed unreachable. Today, it is feasible and the pragmatic approach proposed here has been always our concern.

My contribution will be a down to earth approach and I will report only the lessons learnt from the French experiences.

Since the Bamako initiative, all partners try to provide essential drugs at the primary level, and "financing of these molecules" which is the theme that I have to discuss, was an issue. But before going into details in this matter, even if my colleagues have already reaffirmed it, I want to stress again that "financing drugs is a necessary but not a sufficient measure".

We all know the example of measles immunization: we have the vaccine, it is not expensive, UNICEF is used to distributing it freely and even in such conditions, the percentage of cases is still high in Africa. A number of other examples which are cost/effective have already been mentioned.

Therefore, let me recall you the main issues of our classic bilateral aid. It's purpose is to participate to the reduction of inequities within the OCDE framework.

Strengthening health systems is our first priority. Fifty millions out of one billion of FF each year are focused on national drug policies but we don't have any special budget dedicated to pharmaceutical financing. Our major comitment is solidarity, and some principles are required : strong national health engagement, government plan coordination of the different actors with complementary actions, regionalisation and decentralisation, when necessary.

The programmes on drug policy are conducted in close relations with WHO and UNAIDS and we can notice significant progresses over the last 10 years. Nevertheless, the cost of drugs still remains too expensive in a many of countries. One third of the population still has

no access to drugs, only 5% of the population benefit from health insurance. The cost of a prescription could represent 8% to 70% of the official monthly minimum salary. From a country to another, the differences of cost of a prescription could represent a gap from 1 to 18. As a result of that, the medicines are not or partly bought with the side effects we all know.

In an attempt to lower the prices of drugs, a number of States have adopted measures to promote generics, but the sales in the private sectors are still insufficient (7% in Cameroon, 8% in Ivory Coast, 30% in Mali of GROSS sales in 98). In the public sector, they are missing most of the time because of administrative difficulties. At the same time, illicit market is rather flourishing.

Coming back to the "economic accessibility of drugs", 3 steps are to be considered : identification of needs, economic environment management, financing mechanisms.

I- Identification of the needs

Bamako initiative allows us to concentrate our efforts on essential drugs. As far as the AIDS epidemic is concerned, focusing on key medicines means focusing on treatment of opportunistic diseases, prevention of mother to child transmission, and to know the immunological status of the HIV patients to decide ARV prescription.

Epidemiological data will allow to define the necessary volume for treatment of adults and children. The next step is to identify the most cost/effective products. We all know the gap of prices of ARV. Transparency on prices as proposed by UNAIDS could help countries to better negotiate them. We have already positive experiences on tiered prices for vaccines followed up by UNICEF and WHO, and it must be possible for drugs if we are able to avoid reselling of rebated HIV drugs.

II- Economic environment

Because the African market is rather small and rarely solvent, the manufacturers are not interested in it.

The in capacity for the patients to pay for drugs is also to be considered. The Government will discuss with the manufacturers for an equitable price. But even with low prices, it remains an obstacle for the poorest as demonstrated in Ivory Coast in the project financed under the international therapeutic solidarity funds. At the beginning of our demonstrative project, a patients' contribution of 5000 CFA was requested and revealed to be a real obstacle for the women. Once reduced to 1000 CFA the attitudes change and the women accepted to come into the project.

Even if you pay attention to this issue, the tarification policy risks to exclude a number of patients. This effect is difficult to be measured and very often the national mechanisms to avoid this exclusion are not well defined (no clear criteria of poverty) and so, difficult to manage.

Different tarification policy are possible: "fees for services" or "per capita ". For the moment, it seems that a relative autonomy of the pharmaceutical channel simplify the daily "count" and avoid "surprescription".

Nevertheless, cost recovery policy for drugs has side effects: reduction of patients in primary health care and deterioration of the quality of care.

III- Financing mechanisms

Coming back to the financing mechanisms, it is possible now to discuss tiered prices, and for me it is a great step but it is not enough for the poorest countries where AIDS epidemic is major. We have to promote different mechanisms at different levels.

3-1. At the global level, France is participating to PPTE initiative. For example, Cameroon could benefit from some eight hundred millions of FF per year during 10 years, that represent a real issue. Health and education are the two sectors in which this fresh money should be invested and different frameworks (CRSP and C2D) are prepared. 22 countries reached the decision point and it is a very important opportunity to strengthen drug's policy and social protection

Main issue in this matter will be the right link between Ministry of Finance, Ministry of Planification and Ministry of Health - The second issue will also be the absorption capacity. After the relative failure of the structural adjustment, this exercise, conducted under time constraints, has to be a success, and need a mobilization of all partners.

France, besides debt relief, proposed some others mechanisms.

* One is to conduct demonstrative projects of access to ARV. Four projects are actually underway in Senegal, in Ivory Cost, in Morroco and in South Africa. Let us keep in mind that the objective was not to lower the prices of ARV, but to show that such an initiative was feasible. In Ivory Coast, besides the level of the contribution of the patients, the other problem was the resistance of health professionals saying that the ARV were not good. Such experiences show the necessity of an early association as soon as possible of health professionals and the need for social marketing.

* The second is promoted by our Development Bank which just decided to introduce an AIDS component with a global approach in all major works with a risk of spreading of the epidemic within the "debt relief mechanism".

* The third is to use the international development IDA money in an efficient way. As already mentioned in Prague by our minister of Finance, almost 10 billions of dollars from this IDA budget is not used. It is our responsibility to mobilize and use correctly those sums.

3-2. At national and local level

- We are supporting the institutional partners: State participation has to better understand TRIPS and its issues, to be better involved in advocacy, to be better informed for negotiation with international manufacturers and for conducting alliance. As a regulator, the State will fight imitation, encourage generics, strengthen professional capacity to develop best practices in production, distribution and prescription.

- On the other hand, civil society has also a role to play. In this field, we have experiences of promotion of community health units (FSUCOM) and development of community based health insurance (CBHI).

The FSUCOM (Mali, Ivory Coast) have not for first objective to reduce drugs price but to enhance quality of care. Financing of the FSUCOM is being assured for the investment by the donors and the recurrent costs are almost taken in charge by the population.

It's rather too early to study their impacts on drugs'price and there is still discussion around the "optimal" set of benefits to be offered by a CBHI scheme. Experience in some settings suggests that CBHI schemes can, and in fact should, cover high-frequency, low-cost events, such as outpatient care, check-ups and preventive care. For example, a study in China suggested that most people were willing to join a CBHI scheme only when general or "non-risky" diseases were covered under the scheme, and people paid 7% of total income to cover 60% of the cost of these diseases alone.

The issue of trust and its association with the success of CBHI is a recurring theme. In the Senegal study, members and non-members did not differ in terms of their feelings of "trust and solidarity in the villages". But the experiences which are still limited, have to be extended and we have to develop better links between stakeholders to have a legal framework and a snowball effect.

Last, we launched a new project with ILO to try to build bridges between the informal and the formal sector to strengthen Health insurance.

Whatever the mechanism, a number of problems have been identified :

- too small market inducing the necessity of alliance between countries,
- necessity of information and transparency between countries,
- necessity of liaison between public and private sector
- necessity of strengthening good practices
- necessity of a better coordination for health professionals and utilization of AID
- necessity of simplification of procedures.

That is representing a major plan of work. This workshop was an important contribution to it. We will continue to work on all those points during the next few months until December where our project of an intentional meeting on access to treatment will take place. It is another occasion with all like keyholders (donors, developping countries, pharmaceutical firms, NGO'S) to boost the access to drugs for the poorest.

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