

Universal health coverage and HIV in resource-constrained countries: a critical juncture for research and action

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AIDS 2013, **27**:2173–2175

Keywords: Africa, AIDS, financing healthcare, free healthcare, HIV, social protection, universal health coverage

Introduction

The recent publication in *The Lancet* of a series of articles in favor of extending universal health coverage (UHC) in resource-constrained countries reflects international consensus on this topic [1]. UHC can alleviate impoverishment caused by healthcare costs, it promotes access to care, and, more broadly, it promotes health and social development [2].

However, the methods and resources that must be implemented to achieve this are far from being clearly defined [3]. For 30 years, studies conducted on social protection in resource-constrained countries have struggled to identify unambiguous models; they reveal the wide range of possible pathways for achieving universal medical coverage in these countries [4].

Therefore, operational research must still be conducted to assess the mechanisms to protect against the financial risk of disease that are best adapted to resource-constrained countries. These studies must take into account numerous payment exemption initiatives to treat specific populations (the poor, children under 5, the elderly), specific health situations (obstetric care, mother-and-child health,

renal failure), or specific diseases (onchocerciasis, tuberculosis) [5]. Several contributions on payment exemption policies in west Africa (Burkina Faso, Niger and Mali) concluded that conducting operational studies before, rather than after, policy implementation was critical to avoid major strategic miscalculations [6].

Until now, very little research has been done in this area in connection with HIV, as reflected in paucity of presentations on this topic at the July 2012 International AIDS Conference in Washington [7]. How can this lack of research be explained despite the fact that there are so many reasons for conducting systematic and comparative operational research on this topic in resource-constrained countries and, particularly, in Africa?

Why has there been so little research on payment exemptions for HIV in resource-constrained countries?

The dearth of research on payment exemptions for HIV treatment in resource-constrained countries can be explained primarily by the goals set by research sponsors.

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Received: 23 January 2013; revised: 21 February 2013; accepted: 10 March 2013.

There appears to still be a preference for developing new drugs or innovative treatment strategies compared to conducting public health studies aimed at optimizing the available therapeutic options. HIV research in developing countries is still driven by the hope for a medico-technical solution – a magic bullet – from a perspective that fails to fully consider the deficiencies in the healthcare systems, the barriers to treatment access for patients, or the structural issues at the root of social inequalities in healthcare.

The lack of research can also be explained by the perception among promoters of social protection systems that HIV infection is an exceptional risk. This perception is partly due to the history of access to antiretroviral drugs and their initially exorbitant prices as well as a failure to accurately estimate treatment costs, leading to over-estimates. Fears about excessive costs worry managers of social protection systems, causing them to exclude HIV treatment from comprehensive social protection systems in the belief that HIV treatment should be managed independently through specific measures. This position is further encouraged by the vertical organization of programs and specific funding that has removed HIV from general healthcare management systems.

Payment exemptions for HIV in resource-constrained countries, a critical study topic

How to integrate HIV risk into the UHC systems that will be implemented in developing countries is a key question with no immediate response, even though this option is now supported by UNAIDS, which recommends the development of ‘HIV-sensitive rather than HIV-exclusive (approaches)’ [8]. Only operational research that is able to evaluate the constraints and challenges of this integration could specify how to achieve it.

HIV treatment programs are a critical topic for operational research on the implementation of payment exemptions:

- (1) The impact of payments for drugs and care by patients has been documented, and its effects have been shown in terms of limiting access to care, treatment drop-out, and a decline in treatment adherence that all lead to treatment failure as well as the spread of viral resistance that hastens the transition to the more expensive second-line treatments and will ultimately incur higher costs;
- (2) After evaluating access to care in the area of HIV, WHO recommended a payment exemption for drugs and treatment in 2005 and 2006 and presented this measure as one of the pillars of the public health approach for poor countries [9];
- (3) Initiatives have already been implemented: payment exemption for antiretroviral drugs has been extended to all countries in Africa, and this measure has had a

significant impact on the dramatic increase in the number of people receiving antiretroviral treatment. Several empirical experiences built on a humanitarian platform in which payment was completely exempted – for example, Médecins sans frontières in Africa or Partners In Health in Haiti – could serve as models;

- (4) Provisions for individual and collective coverage are now properly codified through international recommendations that are regularly updated and implemented at the country level; they can define which medical services are necessary and accurately evaluate the cost of care.
- (5) Several middle-income countries around the world have integrated HIV services into UHC (for example, Thailand and Brazil); analysis of these experiences demonstrates that they cannot be reproduced exactly in resource-constrained countries, but, nevertheless, they inspire systems that could be tested in Africa [10].

These various components provide the necessary groundwork to implement studies on payment exemption mechanisms and to document their precise impact. These studies will make it possible to explore the benefit to society when HIV-related costs are covered, assessed through an in-depth economic analysis of healthcare costs for patients and the health system; diverse funding models that are better adapted to the needs of users, including public–private partnerships; new funding mechanisms (for example, funding the demand for care); and new forms of governance for health that actively involve civil society and play a greater role in strengthening the health system, based on quality-of-care criteria. By using HIV as a starting point, these studies contribute to research on ‘health financing and the organization of healthcare delivery,’ essential prerequisites for implementing UHC [2].

Recently, UNAIDS recognized that ‘investments in social protection are necessary to achieving the vision of zero new HIV infections’ and stated that ‘it is now time for HIV experts to work more closely with social protection experts to ensure that national social protection strategies are responsive to individuals and families living with and affected by HIV’ [8]. A common interest is emerging between the UHC advocates and heads of AIDS programs around operational research on payment exemption mechanisms for HIV treatment. It is time to take advantage of this critical juncture and fund the research that will make UHC a reality for people living with HIV.

Acknowledgements

B.T. and A.D. wrote the first version of the article. E.D., I.N., A.M.C.S., and F.B-S. critically revised the article and added substantial information; they agreed to the

resubmission. The authors acknowledge Sharon Calandra who translated the article and edited the final version.

No specific funding has been granted for this work.

Conflicts of interest

There is no competing interest for the authors.

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