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**XVII International AIDS Conference
Financing for Sustainable National Health Care
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ALAN WHITESIDE, PH.D.: -This session. Alright ladies and gentlemen. I would like to welcome you all to the session on Financing for Sustainable National Health Care. I think the lack of people in this room does not reflect the importance of the topic. It is extremely important. As we move forward with this AIDS epidemic, it can only become more important.

This is a special session to explore the various models of health care financing at national levels and to look at donor approaches in working in partnership with resource-limited governments and civil society.

My name is Alan Whiteside. I have been working in HIV for 20 years. I am most closely involved with the countries of Swaziland and South Africa and for me that is the contrast between a country, which can afford sustainable development and a sustainable health and one which clearly cannot, as indeed is the case in many of the parts of Southern Africa and Africa more broadly.

We have a distinguished panel and I believe the role of the chair is to introduce and to keep time and that is exactly what I will do. So, without any further adieu, I should like to invite Chris van der Vorm, the Director of the Health Insurance Fund, a foundation which provides private health care insurance to low-income groups in Sub-Saharan Africa to take the microphone and give us your presentation on health insurance

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schemes for the working poor. In fact that is what is in the program but I see the title is different.

CHRIS VAN DER VORM: Welcome distinguished guests, ladies and gentlemen. My colleague Professor [inaudible] was unable to come to the conference, which means that I am replacing him. Now I realize that it is very difficult to replace [inaudible] but I promise you I will do my best to communicate what he had intended to say during this session.

The title of the presentation, I have changed slightly compared to what is written in your programs. It is "Breaking the Deadlock Using Private Health Insurance Schemes." It is slightly more provocative compared to the title that you have suggested.

First of all, the report from UNAIDS marked the latest statistics for 2007 on HIV/AIDS shows some encouraging results for the cost of the fight against HIV/AIDS. The startling impact of the epidemic is, of course, no means under control and much remains to be done.

Again, it is evident from the numbers that Africa, which hosts two-thirds of those infected, is hit most severely and proves to be most vulnerable for this disease. The International community has introduced some impressive commitments to bring HAART to resource-poor settings. Some of these milestones are shown on this slide. One striking is, of course, the commitment of the U.S. government and despite so

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much unpopular actions and decisions, it must be said at the present has shown very impressive pledge towards the fight against the HIV/AIDS pandemic.

However, HIV/AIDS, as we all know, does not stand on its own. It is also general health care we are concerned about in exactly these geographies. General health care, which covers the basic infections and the often-fatal opportunistic infections. Currently, the AIDS response creates an island of sufficiency in a swamp of inefficiency. In referring to this diagram, which has been produced by Gorik Ooms, I believe, is in this room and I asked his permission during lunch and he agreed.

This is clearly illustrated in this diagram. It shows how the vertical approach reaches beyond the surface of what is required leaving behind still at an unacceptable depth, the level of general health care. The patients of general health care and access to general health care will, over time, determine the success of these vertical interventions. It is therefore crucial that we view HIV/AIDS and other major diseases in the context of general health care.

In providing access to general health care, we are still faced with some major challenges. These challenges apply most fundamentally to the African continent and the millions of poor and vulnerable people.

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Remember that in Africa, with only 14-percent of the world's population bears 44-percent of the global burden of communicable diseases. In Africa, local governments still have limited capacity to deliver the required medical services and the required quality of care in a [misspelled?] transparent and accountable way, the last percent is for out-of-pocket expenses, leads to financial shocks.

[Inaudible] in 2007 determined that approximately 150 million people annually suffer from catastrophic health expenditures as a result of being uninsured. Out-of-pocket expenses is the least efficient and least inclusive form of health care financing and it also limits the investment climate as a result of the unpredictable nature.

In 2004, for example, the IFC committed \$5.6 billion U.S.D. in direct launching guarantees. Of these investments, less than two-percent went to the health sector, which none to Africa. No investment is a restraint of capacity and quality improvement. This means that people are not willing to pay for the current services provided.

Crowding out, of course by many of the current donor programs, means replacement of current resources instead of in addition. So, how could some of these challenges be overcome? How can the deadlock that currently exists be broken? What can we learn from historic developments in the OCD [misspelled?] countries?

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Introducing health insurance in communities was the first critical step in the establishment of health care systems in many of the OECD countries.

Interesting references, for example from the developmental insurance system in the Netherlands can be drawn from papers by Hans [inaudible] and Veena [inaudible] but the key principles starting with risk pooling, the principle of insurance introduces the concept of risk sharing between groups and individuals within groups. It also limits the financial shock effect when people fall ill and who would otherwise be in danger of falling into the poverty trap.

Prepaid financing introduces predictable revenue streams, which enhances the investment climate. This allows for an improvement in quality and capacity, which in turn, will increase people's willingness and capacity to pay for health care services, the concept of prepayment of stimulating empowerment.

Insurance also limits crowding out effects by enhancing use of the existing high percentage of out-of-pocket expenses for prepayment of health insurance. On this basis, the health insurance was established in 2005. Initiative of [inaudible], if it is a foundation-based [inaudible] and it aims to set up going to health insurance schemes for low-income community workers in Africa using local HMOs and insurance companies. The Board of the fund is chaired by [inaudible], former CEO of AHOM

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[misspelled?] one of the largest insurance companies in the world.

Other members include a former Dutch minister and CEOs of the largest insurance and banking organizations in the Netherlands. PharmAccess, a Dutch NGO specialized in HIV/AIDS treatment and general health care programs in resource-limited settings is the main implementing partner of the fund.

In 2006, the Dutch government made an impressive commitment of 100 million EURO to the fund to set up community health insurance programs in four African countries over a period of five to six years. Currently, the fund is working with the World Bank to expand the program in Nigeria and in a similar way; the fund is working with the U.S.A.I.D. to combine the vertical HIV/AIDS response with this general health care program.

So, the vision of the Health Insurance Fund is to set up sustainable health systems of health care delivery and financing by introducing private health insurance coverage for HIV/AIDS, malaria, and tuberculosis, for people with a low and medium income in Africa and through this, to fund and to contribute to the achievement of the Millennium Development Goals. So, what are the key characteristics of the Health Insurance Fund? How can we limit some of the major challenges?

First of all, people must be offered packages, health care packages that they are willing to pay for in which covers

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not only primary health care but also basic secondary care including hospitalization.

Introducing subsidy will make these services affordable to lower income people, will stimulate the amount at the same time. As the willingness and the [inaudible] to pay increases, co-payments are expected to increase. Also as the volume of the number of people insured increases, economies of scale will contribute.

There is a paramount importance that the service providers can deliver the quality services. This means that a network of private and public service providers used are subject to an elaborate upgrading program, medically, financially, and administratively. A baseline is established and ongoing monitoring and evaluation measures and controls the quality and capacity improvement of these providers.

An output-based contract with the local HMO insurance company assures for accountability and transparency. The local implementing partner is paid on the basis of its performance and is subject to external audits carried out by recognized international accountancy firms.

Local embedding is key to the success of the program. First of all, the local implementing partner is responsible for the execution of the program. Secondly, the communities that are offered the insurance must take ownership of the program. In Nigeria, special steering group committees are established

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to manage the schemes and assist with the marketing and education. Without support from these local people, the programs are doomed to fail. Equally important is the coordination of the local public programs in order to harmonize and achieve complementarity. In Nigeria, the program was launched by former President [inaudible] in close collaboration occurs with the governor of [inaudible] who is also chairman of the governor firm of Nigeria.

Then collection of actuarial data, medical and financial is crucial for evolution of the program but also the other programs. Currently, there is hardly any data available on consumption making it very hard to determine the associated risk of insurance and tailor the program to the need of communities.

Impact evaluation for operation research is carried about by the Center for [inaudible] Related Communicable Diseases and Amsterdam Institute for International Development. These institutions are contracted by the Fund and exploit large-scale research programs on the biomedical, socioeconomic aspects of the program. So, where do we stand in terms of execution?

Nigeria was the first country in which a program was launched for 75,000 farmers in Quera [misspelled?] state and 40,000 marked [misspelled?] women in Legus [misspelled?]. Of those, currently more than 40,000 are enrolled after a period

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of 18 months. In addition, two programs are developed. Again, one in Quera [misspelled?] for 70,000 farmers and one in Legus [misspelled?] for 30,000 ICD workers. Both programs are expected to be launched by the end of this year.

The expense in Quera [misspelled?], interesting, is an initiative of the governor of Quera [misspelled?] state himself. He has expressed his enthusiasm for the program and has committed to the gradual takeover of the financial burden over a period of five years. This means that after five years, the program will be fully supported out of local resources.

The expansion in Legus [misspelled?] [inaudible] is a slightly higher income group and is financed by the Royal Bank of low and medium-income workers in the ICD sector.

Of the 23 private and public clinics servicing these groups, 14 have been upgraded or partially upgraded. Three rounds of monitoring, evaluation have so far taken place of all contracted service providers. [Inaudible] but this approach is not meant to be the Holy Grail. It is based on principles and results from OCD countries, extensive literature and all experience gained by PharmAccess and many others in developing countries.

As mentioned in the presentation, the program is closely monitored through extensive impact evaluation studies, which will give us invaluable information not only for the program evolution, but also for other programs, and approaches.

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This is an example of one of the clinics contracted before upgrading and this is after upgrading. It is a clinic in Shunga [misspelled?]. Interestingly enough, the number of patients' visits in this clinic has increased from 20 per month to more than 1,500. This is one of the villages in Quera [misspelled?] state, a village where nearly all were insured, showing their insurance card proudly as we travel through Quera [misspelled?] state in April this year.

I would like to make special acknowledgment, first of all, to the Board of the Health Insurance Fund, some of you are present here in the room today but also representatives of PharmAccess, HIGIA [misspelled?] HMO, the local implementing partner in Nigeria, the Quera [misspelled?] state government, and the operational [inaudible] organizations and of course, the Dutch Ministry of the [inaudible] Corporation. Thank you very much for your attention and I look forward to answering your question either during this session or afterwards. There is a booth on the second floor and you are very welcome, I will be there this afternoon my colleagues. Thank you very much.

[Applause]

ALAN WHITESIDE, PH.D.: Thank you very much Chris. I would like to invite our second speaker to take the microphone. Carissa Etienne is the Assistant Director General for Health Systems and Services at the WHO. She will be presenting to us on the international health partnership and related

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initiatives. I must just warn you I do not think that clock is set at 15 minutes. I think it has been set at 20 minutes. Yes, it is set at 15. Good. Excellent.

CARISSA ETIENNE, M.D., M.SC.: Okay. Thank you, Mr. Moderator and good afternoon. Thank you for inviting us to share on the international health partnership and related initiatives, better known as IHP-plus. You will wonder what is WHO doing. I am presenting on this partnership. WHO and the World Bank have been given the joint responsibility for insuring the day-to-day management and the coordination among partners for the international health partnership.

This partnership, which was launched in September of 2007, aims to facilitate better coordination and increase funding for health based on country-led processes for improved results. It represents a renewed effort to support countries in achieving their health MDGs, their health 1B4, 5, and 6 through a single harmonized in-country implementation effort with scaled-up financial, technical, and institutionalized support for the health MDGs.

There are now 32 signatures to the global compact, ten ministers from developing countries, nine international organizations, 11 bilateral donors, and two other donors.

The truth is that one of the main reasons behind the formation of the launching of the IHP-plus is the disproportionate correlation between global disease burden and

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health financing. Investment in health is insufficient. Developing countries themselves, it is important to note, do not invest sufficient resources in health as shown here by the poor progress on meeting the budget targets for health spending. The blue represents those that have met those targets and you will agree with me that the blue is sparse indeed.

The second reason for the IHP-plus is that international funding is unpredictable. We can see the great volatility in the international funding. They are often also based on donor rather than the recipient budget schedules.

Failure to give predictable aid on budget has serious implications, as governments try to plan for the future, particularly when considering financing gaps in health, and the need to address core constraints such as insufficient health care workers and yes, support to countries is also inefficient.

This is maxed [misspelled?] by a lack of coordination and also harmonization between key development partners. This has led to overburdened country teams with numerous mechanisms for accounting, reporting, monitoring, and evaluating inputs and outputs.

As a result, increased aid for health has led to increased transaction costs on the part of recipient countries and overall greater inefficiencies.

So, given this context, the IHP was designed to be country-focused and country-led to ensure ownership to build on

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existent structures, mechanisms, and country health plans, to provide long-term predictable financing for results-oriented national plans and strategies and to ensure mutual accountability for delivering on commitments.

When countries sign up the global compact, they agree to establish a country compact. A country compact is a negotiated and signed time-bound agreement in which all partners agree to implement and uphold defined national health priorities outlined in appraised and validated country health plans.

Priorities outlined in this country health plan are primarily targeted at meeting the health-related MDGs but also at other priorities as decided by country teams. It ensures that there is one country health plan with clear performance benchmarks for all parties that are monitored and evaluated in an open and transparent way to hold all parties accountable. So, one country national health plan, one results framework, one policy matrix, one budget, and one monitoring and evaluation mechanism.

Importantly as well, all countries' stakeholders should contribute to a compact. That means government and development partners including local non-state actors and civil society to be exact. Compacts are linked to existing in-country processes such as joint reviews. In countries where SWOT [misspelled?] already developed, the IHP process works with those countries

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to utilize the SWOT process and so decrease the time period between which, within which we can produce a national health sector plan.

What are some of the compact timelines? Countries are moving pretty quickly with the first compacts. Ethiopia has completed its first compact and is ready to be signed. It has gone to some of the developmental partners. Other countries, Malawi [misspelled?], Mozambique, Nepal, and Zambia aim to have their compacts signed by the end of December.

The IHP process also includes a significant level of interagency work. This interagency work has involved the development of compact guidance notes, also civil society engagement, we have ensured that civil society is represented on the steering committee or the [inaudible], which is a scaled-up reference group, both on the business [inaudible] but also in the broader steering committee group.

We are continuing efforts to work with countries to ensure that civil society organizations are fully represented in the process for national health plan development, monitoring, and evaluation.

The interagency group is continuing work on a common country-based appraisal validation process and also a common approach to monitoring performance and evaluation. There has been a review as part of the annual review that is recommended for the IHP and this report is expected in September. This

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review evaluates all parties in terms of their adherence to the commitments made in the compacts.

What are some of the challenges and expectations? You will certainly expect that with this level of paradigm shift towards greater alignment and harmonization, there are significant challenges and expectations. The IHP process is raising expectations for more predictable funding and new behaviors among development of partners. The question is can it deliver on this?

The IHP process should not allow national stakeholders to move away from existing commitments such as universal access to HIV/AIDS. The country level implementation requires well-functioning interagency teams working with government and civil society. There has been a significant level of difficulty with the degree of coordination and collaboration within this interagency country teams. There seems to be a level of disconnect between the central agencies' decisions and intent and certainly the action and messages of country-based staff.

Also there is an issue of the full involvement of civil society at the country level and also a question as to how do you ensure that the civil society representatives on these country teams do in fact, are in fact, representative of civil society organizations in the country.

In conclusion, therefore, we believe that the international health partnership provides the opportunity to

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enhance aid effectiveness to ensure this level of alignment and harmonization around one country national plan, around commonly agreed [inaudible] the national health priorities and it can influence positively both donor and recipient country behavior.

We think and we hope that this will, in fact, pan out, that the IHP provides the opportunity to attract more predictable financing to health, to improve the impact of collective efforts, and to strengthen the response to HIV/AIDS and chronic care. Thank you. [Applause]

ALAN WHITESIDE, PH.D.: Thank you very much indeed and well done for keeping to time the first two speakers. It is my pleasure to introduce to you Dr. Mauricio Hernandez-Avila who is the Undersecretary of Disease Prevention and Health Promotion. For those of us who are not Latin Americans, coming to this country and seeing the amazing work that is being done here in health and also in social transfers has been a real privilege. So, we move from what is inspirational to what is practical. Thank you.

MAURICIO HERNANDEZ-AVILA, M.D., M.P.H., PH.D.: Thank you very much. I want to thank the organizers for the invitation and I hope you are enjoying a very good conference. Thank you very much.

Well I want to share with you our experience with the retroviral program. First I will give you some context regarding Mexico on the health structure, some issues regarding

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a study on retrovirals by [inaudible] from the National Institute of Public Health and then discuss some of the challenges that we are facing in Mexico.

Our current expense in health is around 6.6-percent of our gross domestic product and we are targeting by the end of this administration to go to seven-percent.

Mexico is a country that has 100 million inhabitants and is fractionated in 32 states that has also contributed to the fractionated health services that we have. We are a population, [inaudible] is more on the side of the jungle population.

Now the health system, as you can see in these complex graphs, is fractionated. We have very short presentation of the population, which is in commercial, private insurance, which is three-percent. The insurance for formerly employed, which is by [inaudible], which is 40-percent, [inaudible], which is HMO for garment employees is between seven and nine-percent. Recently we have implemented a health reform for the poor, which has been covered until now 25-percent and we hope to accomplish covering the rest by the end of this administration. We still have three-percent of the population who lives in remote areas, which have no coverage.

Now the way that the system is financed, we have the sickness and maternity insurance, which is known as the Institute de Mexicana [inaudible] sociale, which is financed by

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three [inaudible] there, the worker, which does a prepayment, employer who is also contributing and the state. Also, the Este [misspelled?], which is the medical services for the federal employees. One portion is from the employee or the two portions are by the federal government both as employer as the state fee.

Finally. We have the popular insurance, which is the new reform that was implemented in the last administration, which is basically a family contribution. However, this insurance is directed to the lower income of the population. So, most of the families we insure provide no contributions. So, most of the finance comes from the state.

So, if we estimate the different populations, we will have, in Mexico, closet to an estimate of 30-percent uninsured and close to 40-percent, which have complete insurance and 21-percent who have limited coverage, do not buy the popular insurance.

So, most of the funding that comes for the retroviral program, as you will see, comes from the federal funding. Now in terms of the strategies that have been proposed to obtain affordable medicines, I mean in this case, antiretrovirals, this is based on the work by [inaudible]. We have differential prices. We have generic competition both of these we have been using them in Mexico. We have voluntary licensing flexibility with agreements that they are not used

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yet in Mexico. High volume fortresses that are starting to be used, local production, and probably the one needs an important mention, is the last one, which is import restriction, which was announced by President Calderon in the opening ceremony, which eliminates the restrictions for imports of generics, which is a very important announcement.

Finally, the last one, which we tried very unsuccessfully, is purchase in via the international procurement mechanism that is offered by [inaudible] because when Mexico tried to purchase via the system, the pharmaceutical companies denied the purchase.

Now what is the reality of HIV in Mexico so you can have an idea? From 1983 to 2007, we have 150,000 cases. We estimate that we have 64,000 AIDS cases with close to 200,000 living with HIV, which are asymptomatic. The prevalence in Mexico is below one-percent. It is estimated for three-percent and we still have 47,000 cases alive out of them, 43,000 are in our system, which are provided by the government.

We have three providers, social security, which started since the mid-80s, the Minister of Health, which provides limited coverage since 1999, and the Popular insurance, which started with full coverage in 2004.

By 1999, we have 45-percent of persons living with AIDS on insurance and by 2007, we have an estimated coverage of 98-88-percent. Access to antiretrovirals is equal for all

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socioeconomic groups and we have currently 52 specialized clinics all over the country, which compliment the social security institutions.

Our official norms state that patients have the right for prescribing treatment at any facilities or any subsystem. We have been including very rapidly the new generations of antiretrovirals. In these slides, you can see the clinics. We have been building them in the last three years. If you have a chance, you should visit the one here in Mexico known as Clinica Condessa [misspelled?]. It is very close from the area of the hotel.

Now Mexico has been facing some challenges with negotiating prices due to our regulations and limitations for purchasing outside the country. In this study from Paho [misspelled?] in 2000 shows the big inequities that Mexico is facing regarding the price with different countries.

Prices are of second-line generations, are for example, 83-percent higher than in Chile. Being Mexico and Chile, countries of the more or less same gross product [inaudible], 500-percent higher than Brazil. For example, Abbott sales, Kaletra in Brazil at \$90 where in Mexico it is sold \$420.

Now, how is the incorporation of new treatment? We can see that we have been incorporating HAART very rapidly and we are now basically using triple therapy. In terms of the average annual cost has been decreasing since 1999. However, we still

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are very high in terms of 3,000 pesos, \$3,000 per patient per year.

Now patients in regard to Mexico, patients start treatment in advanced stages. We are improving that with increased screening, lab tests, and patients' visits are the largest contributors for treatment cost and many patients have to comply with this with out-of-pocket expenses, which limit the effect of therapy.

Treatments are a higher cost of patients in advanced illness and treatment costs are higher for patients in their last year of life. Now has the increasing costs been? Well in 1995, we have \$49 million investing in the program. Now in 2007, we have an estimate of about \$336 million U.S. dollars, which is close to one-percent of the total health budget.

What is the financial impact? In 2007, in dollars, the cost per patient was almost \$7,000. The total cost for antiretrovirals in 2007, as I mentioned before, was \$326 billion dollars. IF we take in consideration that the average survivor of the patient now [inaudible] 50-point [misspelled?] years, we estimate that the overall cost for patients that are entering in our system, which is estimated of 8,000, will be almost 850 million U.S. dollars. So, clearly, it is a very big load for the health system.

Now what are the challenges for this system, the ability of this program? First, we have heterogeneity in the

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prescription. We have more than 25 combinations and even though that we have a guide for treatment for patients who live with HIV, if physicians are not prescribing according to the guide. So, we need to improve our training of our medical [inaudible]. We have also weak compliance for patients. We also have duplicate coverage because we do not have registry from [inaudible]. So, we estimate that 70-percent duplicate coverage.

Inefficient planning and purchasing because, given the fractionated system, we are purchasing each institution, the retrovirals, which decrease the purchase power.

Finally, we approach this [inaudible] basis according to our [inaudible]. There is a poor link with prevention programs and other health promotion programs that we need to improve.

Now what are the policy recommendations when given what we see in Mexico, we really suggest governments to be realistic about the resource requirements for starting antiretroviral therapy and start very early with industry negotiation and commitment from industry especially with the prices of new drugs. Invest in lab capacity and human resources training.

Countries also should be prepared to shift of the new therapies and challenges that are provided outpatient control, and the need to achieve high [inaudible] and compliance with treatment. Clinicians should clearly understand when to

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initiative and how to monitor patients' therapy and patients should [inaudible] also the benefits of kind [misspelled?] of compliance and behavioral changes to improve prevention.

We also think it is important to estimate in the cost of antiretrovirals, can help countries to plan in terms of their negotiations with drug prices, investing in prevention and in monitoring the cost is a key issue.

We also think that there is a need, very big need for benchmarking of international prices and also clear recommendations from international agencies regarding of prices according to gross product.

Now, what are the next steps for Mexico? First, the public system faces a challenge for the combination of a strategy. We are going to be joining together in the negotiation for price reduction using different mechanisms. We have established a commission, which will be negotiating prices for all the public sector. We have also done and the President and announced, reviewed some reforms that limit the offer of generics in Mexico. These will open also the doors for the use of international mechanisms for purchasing. We also have to work in consolidating a national registry to help us to monitor the impact of the program and also to detect and reduce duplicates.

There is also a group working in mechanisms that will allow an integration of a public fund that will have the

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objective to finance high specialty services and we will begin with antiretroviral and AIDS. This will provide sustainability and will be an important step toward integration of our public health system.

Second, we need to use the international procurement efforts for generics using the mechanism offered by [inaudible] in the region and to consolidate an alliance with promotion and prevention programs and coordination with the Ministry of Education in order to increase our activities in [inaudible]. Thank you very much for your attention. [Applause]

ALAN WHITESIDE, PH.D.: Thank you very much indeed for a very interesting presentation. Our next speaker comes from a part of the world where the eyes of the world are focused, China of course. We hope that the eyes of the world are also focused on the AIDS conference here in Mexico City, So, it is my pleasure to introduce Dr. Guang Shi who is currently the Director of the Health Policy Division at the Department of Health Policy and Regulation in the Ministry of Health in China.

GUANG SHI, M.D.: Thank you Chair. Good afternoon ladies and gentlemen. It is my pleasure to be here to present the health care in China, the achievements, challenges, and the reform in the future. China, as we all know, that is the biggest developing country in the world, with 1.3 billion people in the area of 9.6 square kilometers, is a country with

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two systems. One is a rural area and the other is an urban area.

China used to be a closed up [misspelled?] planning economy since the foundation People's Republic of China in 1949. It was not until 1978, Mr. [inaudible], the late senior leader opened the door of China to the outside world and launched the [inaudible] reform, which results very fast development in social and economic sectors.

So, the annual growth rate of GDP is 9.7-percent in the past three decades. Now China is the fourth largest economy in the world with \$2.24 trillion U.S. and the two trillion reservation [misspelled?]. It was only \$226 in terms of the average income. Now it is \$2,000 U.S. dollars. Due to the capacity of the economy and social development, China now can hold the Olympic games and the day after tomorrow will be the opening ceremony for the 29th Olympic games. So, welcome all of you to China. [Applause]

We also made big progress in achieving the goal of the Millennium Development Goals. In 1978, 250 million people were living under the poverty line but now declined into 24 million. The infant mortality rate was about 50 per thousand live births in 1991 but now it reduced to 15 per thousand live birth and the mortality rate has the same kind of trends. It was 80 per 100,000 live births in 1991 but now is only 36 per 100,000 live births. The TB and HIV are also under control.

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Furthermore, the average life expectancy at birth is also increased greatly compared with 35 years old in 1949 but now is 73. All the achievements in the health sector are contributed to the expansion of health insurance and the availability of health resources in China. Five years ago, only 30-percent of people have any kind of health insurance but now 80-percent of the people have health insurance schemes.

The biggest health insurance scheme is for the rural residents that is contributed mostly by the government body [misspelled?] and the rural household can contribute 20-percent of the [inaudible]. Now it covered 800 million residents in the rural area.

The second biggest housing insurance is the basic house insurance for the [inaudible] employee especially for those employees in the formal sector and the premium is about eight percent of their salary and shared by the employer and the employee but now it covers 180 million people.

From 2007, the government of China initiated health scheme for the rural residents, which covered 47 million people now. We also set up the medical assistance scheme for the poor and we also promoted the commercial insurance for the rich.

As for the health results, we also see very quick increase compared with 1978, the hospital beds increased by 64-percent and health [inaudible] also increased by 87-percent. As

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for the total health expenditure in China, it is at the moderate level compared with other low-income countries.

In 1978, the total health expenditure accounted for three-percent of GDP but now is about five-percent. At that time, the average house spending per capital is only \$3 U.S. but now it increased to about \$100 U.S. Let us pay close attention to the share of the out-of-pocket for health spending.

In 1978, it only accounted for 20-percent due to the marketization of health sector, the out-of-pocket counted more and more in terms of the total health expenditure. It increased to 60-percent in 2000 but now the trend is reversed.

So, as we can see that China is at a very critical period and it is in the very fast development period and a very fast transition from planning economy to marketing economy. From the agriculture country to a modern industrialized country and from a young society to an aged society.

So, in 1978, the old people above 65-years old account only five percent. In 2000, it accounted for seven-percent, which means that we are an old society now. It is predicted that in 2040, 20-percent of the people are old people.

So, this will let us face the very big challenge of the chronic disease and infectious disease. According to a survey in 2002, the prevalence of hypertension in the adult is about 18-percent, 18.8-percent, which is above 31-percent increase

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compared with that of 1991. We also have these kind of trends for diabetes, obesities and overweight. We also recall the SARS outbreak in 2003, which resulted the cost is about five times of the terrorist attack September the 11th in the United States and we also faced the risk of HIV and AIDS. By 2007, 220,000 cases are reported.

It is estimated by the U.N. AIDS and WHO and Ministry of Health of China that the prevalence is about 700,000. The other headache for us is the cost escalation the unit cost for the visit for outpatients and the episode of the in-patients is increased more than ten times compared with 2006 and 1991.

We also have the additional distribution of hospital beds. It used to be the share of the hospital beds in the rural area, used to increase to 60-percent in beds in 1980s but now it declines to 30-percent.

We also face very big disparities in terms of the health spending and health insurance beneficiaries and the health outcomes. This shows that the health spending for the urban area is about three times that of the rural areas.

In terms of the health insurance, it is not entitled to everyone in China. It is based on the occupation of the place you live. So, for the urban health insurance, the contribution is about 1,500 [inaudible]. For the rural new [inaudible] medical scheme, the contribution is only 50 [inaudible]. As for the reimbursement rate for the urban employee is about 60-

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percent but for the rural residents, it is only 30-percent. We also have this disparity in terms of the infant mortality rate. It is two times for the rural residents compared with those in the urban areas.

So, we have to depend reform of health sector in China and the state council has set up taskforce to formulate the health reform framework and the Premier [inaudible] held a seminar and workshop, discussed about the health reform, goals, and strategies and policies. So, the health reform in China will be value-driven. I think that health is the fundamental of human rights and the government committed to provide health care to everyone and they are focused on the equity and the risk protection and efficiency and this is the pre-condition of the harmonious society, which is the government raised [misspelled?].

So, this is the vision for health reform in China. The goal is health for all. We have to guarantee the equitable exercise to public health including [inaudible], HIV/AIDS prevention, and MCH we also established the health delivery system, which focused on the allocation efficiency and we also set up the universal coverage for health and insurance and all this will be driven by the transparent accountable regulation system.

So, for the strategic framework of health reform in China, we have four main pillars. Health insurance system,

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health care delivery system, public health system, and we also established the essential drug policy, which guarantees the safety, efficacy, and affordable basic drugs for all the people.

So, we will do a lot of things to achieve the goals including improve the Ministry [inaudible] and the regulation structure. We will improve the operation system of the public hospitals and improve the financial policy pricing regulation and establish the monitoring, evaluation system, invest more in the research and development and the manpower and establish the information system and legal system.

So, in the future, let me say in 2020, we will have a unified health insurance, which have equitable contributions and the beneficiaries for all the people. We also integrate the health delivery system, which have very high capacity and we also have established the referral system, which improved the allocated efficiency of health care. Thank you for your attention. [Applause]

ALAN WHITESIDE, PH.D.: Thank you very much indeed Dr. Shi. It is my pleasure to introduce, shifting continents now, to Africa; it is my pleasure to introduce Dr. Daniel Ngamiye from Rwanda where he is the Coordinator of the Project Management unit of all the global Fund projects and also of the Multisectoral HIV/AIDS Project for the World Bank in Rwanda.

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DANIEL NGAMIJE, M.D., M.P.H.: Thank you Mr. Chair. I want to thank also the organizers of this meeting to give me this opportunity to share the experience of my country, Rwanda, in the health sector system.

The outline of my presentation, as you can see it on the screen, is that without being a [inaudible] country or a [inaudible] country, why Rwanda decided to introduce a community-based health insurance. What are the objectives? What are the results currently and what are the challenges that we have in order to sustain this system?

So, Rwanda is a small country with 9.3 million inhabitants located in Central Africa. In 2001, when the government decided to go for universal access with the community health-based insurance, our economic and health situation was really bad. The income per person per year was \$235 U.S. with a low level of poverty. Sixty-percent of our population, according to the World Bank criteria [misspelled?] were declared poor. A small country with high density and the majority of the population are active in agriculture.

In health systems, really where with a very high level of under five mortality, 196 per 1,000 when the mortality rates, the maternal mortality was 1,071 by 100,000 live [inaudible]. At this time and up to now, the majority of, the main causes of morbidity were malaria, respiratory infection, and others. One of the issues again was that the former

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[inaudible] had already insurance and it was not equitable that the government have the majority of the population without access to the health insurance.

Lastly, it was two years after the implementation of the pilot system with this community-based [misspelled?] insurance. So, our health system is built with six pilots for the [inaudible] of institutions. In the middle, you can see that the health care financing is one of the big pilots of these systems. My presentation actually is showing what the government has done to build this pillar.

So, the government decided to go for universal access with community based [misspelled?] insurance because it was very low-level of utilization of services.

The second reason was that the health facilities have a lot of depth especially after the progressive withdrawal of post-genocide health donation in 1999. There was the problem of equity as I said with the launching of insurance for the former sector and the last reason was that the country, it was discovered that the population was not involved in the management of their health facilities.

So, the objective of this community [inaudible] insurance was to improve the health status for the population by supporting financial access to the health service, to improve the financial capacity of the health facilities with this predictable fund so that they can be used at health

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facilities correctly. The last one, it was to involve the population in the management of their own facilities.

So, this community health insurance is organized with three levels. The first level is health centers. The health center is the primary level. The second one is the district hospital. The third one is the referral hospitals.

The first level, administratively speaking, it would have the sector level. After the sector level, you have the district level and then the national level with the Ministry of Health. So, each level has its responsibilities. The first level must take in the voluntary contribution for the population as a premium to be a member of the community-based [misspelled?] insurance per year. This area is also taking some donation at this level.

The second level, which is really critical for this system to open correctly, to function correctly, is district pooling risk with donor whose funds coming from donors, the national pooling risk, is contributing at this level, the district revenue, and the sections for the community-based [misspelled?] insurance at the health center. There is a contribution that they must give at this pooling risk every year.

There is this third level for the national pooling risk where contributions are coming from the Ministry of Health's budget, 13-percent of his budget, annual budget, civil

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insurance, private, and military insurance, and other private insurance, of course, some donors.

So, how is this community-based insurance financed? So, [inaudible] in the village is required to pay \$2 per year and if he is sick [misspelled?], he is paying \$0.4 U.S. by episode and if he is transferred at the hospital level, he must pay ten-percent as co-payment for the hospital bill. Then the pooling risk, the budget plan for each member is \$2 and this \$2 are generated through contribution coming from \$0.4 from the district and the health center and \$1.02 from donors and the national pooling risk. This pooling risk managed to pay the bill from the hospitals. The national pooling risk is paying also at the national referral hospital, the bills from the patient who has not been treated at the district hospital but who have been referred to the national referral hospital and the budget is planned for one U.S. dollar by member and this is coming from national and public insurance and the Minister of Health's budget as I said.

So, what we are expecting to our partner for this scheme is the technical assistance, the mobilization of the fund, and I want to take this opportunity to give the example with the Global Fund with [inaudible] round five when we have been supported with \$33 million with two objectives. The first one was to pay membership for very poor persons and to

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contribute to the district pooling risk and also pay the membership for people living with HIV and the orphans.

The second objective was to improve the quality of services by [inaudible] capacity for [inaudible] people in service, reviewing policies but also helping some crucial achievement like solar energy. What are the main results after seven years of implementing this scheme? As you can see from 2003, we are now with 83-percent of [inaudible] who are now with their community health insurance.

We can now compare the active and passive contribution to the community health-based insurance. Fifty-five-percent of this population who are members are contributing with their own money, when donors are contributing 45-percent. Within these donors, there are also some public funds like when the government is supporting people who are not poor or indigent because they are participating like mediators or tribunal judge in [inaudible] special court for genocides.

So, remember that one of the objectives to establish this system was to give funds to help financially the health system and the health centers. You can see that in 2006, faith-based facilities, their health care had been covered by 61-percent, when in 2007 the coverage of this health care costs is now 84. For the public health facilities, we are now with 90 costs that are covered by this scheme. The consequence of this

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is actually the utilization of the health services, which is increasing, as you can see from 2001 up to 2007.

This is to compare how the utilization of services is increasing, when the morbidity of malaria is reducing due to the good treatment and access to other measures for the prevention.

The impact with other measures, of course, not only the community health insurance, is how the infant mortality had been reduced from the 2,107 up to 62. According to the [inaudible] under five mortality from 196 up to 103.

Look how the delivery, the percentage of mothers who are delivering now in their facilities increasing. Now we are with 45-percent. That means all of these financial barriers are progressively removed and we can expect that this will contribute in the reduction of maternal mortality. In 2000, it was 1,071. In 2005, we have now 650.

So, what are the requirements for the sustainability of this community health insurance? First for the government must keep the goal for universal access to this community health insurance. Secondly, they are critically [inaudible] that must be conducted especially to mobilize this fund from private insurance and some public institution to contribute to the pooling risk.

There are some studies that must be conducted in terms of knowing quality, what are the real costs of the health

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services that you are provided. For the development partners, we are expecting to develop partners, a strong commitment to sector wide approach in health and also be open to some projects that are addressing issues like community-based health insurance like the Global Fund did. Other partners are also asked to contribute on this.

Lastly the conclusion is that for the health insurance for all, there is a need for a right choice at the right time. The population who are low-income and medium-income, this population must contribute to their own health. For those who are very poor, there is a need for solidarity for them. This is a message that was delivered in each health center. In one night, you can spend by drinking this local beer when you could take this money to buy you a card for all day [misspelled?]. Thank you very much. [Applause]

ALAN WHITESIDE, PH.D.: Thank you very much. As an economist, I love your second to last slide showing the opportunity cost of drinking. So, thank you for that. I now like to invite Dr. Susan Cleary to join us. Susan is the Director of the Health Economics Unit of the University of Cape Town. So, please, Susan.

SUSAN CLEARY, PH.D.: Good afternoon ladies and gentlemen. The title of my presentation is "Equity in National Health Care" and in giving this presentation, I will be taking

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the perspective of a citizen reflecting on her own country's health system 15 years after the end of apartheid.

By way of background, South Africa has 17-percent of the global HIV burden. We also have the world's largest treatment program. However this program has been characterized by delays in starting treatment, ongoing issues of AIDS leadership in government and unnecessary disputes about the efficacy and toxicity of antiretroviral treatments.

All of this has led to a number of battles between civil society, academia, and government, which has diverted crucial energy from the urgent task of responding to the world's worst HIV crisis.

Prior to 2004, the HIV treatment strategy in the public health system consisted of a program of treatment and prophylaxis of opportunistic and HIV-related infections. Given how little individual health gains such a program offers, it is likely that coverage of those in need was very low.

In 2003, the government developed an operational plan that proposed first and second-line antiretroviral treatment for patients with CD4s less than 200 or AIDS and this plan contained a target of universal access to antiretroviral treatment by 2009 but inexplicably, the government subsequently denied any knowledge of the existence of this target despite it being explicitly outlined in its own operational plan.

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More recently, we have developed a national strategic plan for HIV and AIDS but now we are only aiming on achieving universal access by 2011. According to this document, by 2007, South Africa was only providing antiretroviral treatment to 20-percent of people developing AIDS during that year. So, the gap between coverage and need in 2007 was still very large.

Treatment for HIV in South Africa for health economists is a classic example of resource allocation in the face of highly constrained budgets. HIV is a new disease primarily affecting prime age adults. This is a [inaudible] in society that ordinarily one could rely on to be relatively well in comparison to children and the elderly.

We are talking here about an additional half a million people in need of this treatment each year for the foreseeable future. So, effective scale-up in South Africa means that millions of South Africans could be receiving antiretroviral treatment in the not too distant future.

So, we [inaudible] talking here about marginal changes in the scale of an existing program. To scale-up, we are going to need investments in infrastructure including new health facilities, drug procurement and delivery systems. We also crucially need to increase our training of health professionals both through university education and through on-the-job training.

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The key point is that without careful planning one wonders whether it will ever be possible to achieve equitable access to antiretroviral treatment in South Africa and whether this could ever be sustainable.

Moving now to financing, South Africa spends about 7.7-percent of GDP on health care. On the face of it, this is very respectable. It is comparable to the level spent in the developed world and very high in comparison to countries of similar economic development as South Africa.

However, this figure marks a massively unequal distribution of resources. In terms of overall funding, the majority poor, that is 85-percent of the population, access health care in the public health system to the value of only \$200 per annum while the minority rich about 15-percent of the population access health care by insurance in the private health system to the value of \$1,260 per annum. That is more than a six-fold difference. The distribution of human resources is even worst. There is one general doctor for 590 people in the private sector in comparison to one per 4,200 people in the public sector. This is a seven-fold difference.

Even worst still, there is a 22-fold difference in access to specialists with one specialist for every 500 people in the private sector in comparison to one for every 11,000 people in the public sector.

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So, given these levels of inequity between public and private, a key constraint to achieving equity in HIV treatment is that the vast majority of HIV-positive South Africans are dependent on the public sector.

So, what exactly is the magnitude of the cost and outcomes of HIV treatment? This table shows the results of a cost effectiveness analysis, where costs and outcomes are presented on an individual basis. I am showing three mutually exclusive HIV treatment interventions here. The first is no ART. Remember, I explained that that used to be the government's treatment strategy prior to 2004.

The second is first-line ART only, which is the strategy that is currently being pursued by Malawi and other countries in Africa that have far fewer resources than South Africa. The third, first and second-line ART is South Africa's current treatment strategy in the public sector.

Now obviously if you look at the lifetime cost per patients, these increase as a lifetime [inaudible] increase but if you consider the incremental cost effectiveness ratio of only \$1,625 per [inaudible] gained, first and second-line ART still looks like a very good buy for South Africa especially if you consider that we have a GDP per capita of around \$3,000.

The problem with this is that considering costs and outcomes on a per patient basis, unfortunately, hides the very high costs that we would face if we were to move towards

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universal access to either of the antiretroviral treatment interventions shown.

This figure shows the annual costs of providing universal access over a ten-year period to either first-line ART, that is the red bars or first and second-line ART, the blue bars. Obviously during the first year, it is only about \$250 million U.S., which seems quite reasonable for South Africa.

However, as more and more people enter care into this quite effective form of treatment, costs increase rather dramatically and by the tenth year, we would need between two and \$3 billion per annum and to put this into context, this is around a third of the 2007 funding channeled to the entire world by the global health initiatives.

Let us now try to put this into the context of the level of resources in the South African public health system. If we assume that it might be reasonable and this might be a heroic assumption, to dedicate about a third of our public resources to HIV treatment, then by the fourth year of universal access, we would already be facing constrained budgets and issues of sustainability and this is true for either of the antiretroviral treatment interventions under consideration.

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However, if we could draw on the entire South African health system for HIV treatment, even after ten years of universal access, treatment could still be sustainable.

So, if we were to think through, as a country, how we should prioritize over the next ten years, what should we do? Firstly, if we do only have a third of the public sector resources at our disposal and we were following a first and second-line treatment strategy, the best we could do would be to gain about 9.4 [inaudible], that is this bar over here for which we could cover about 80-percent of the patients in need over this ten-year period.

The sad thing here is that like our poor neighbors in the rest of Africa, if resources are constrained more good can be done through restricting individual health gains to first-line antiretroviral treatment only. So, these two kind of gray bars are showing that.

This is not actually an insignificant difference. Here we are talking about an additional .3 [inaudible] million [inaudible] and 13-percent higher coverage. That means that 600,000 more South Africans could be reached over the ten-year period by pursuing a first-line only strategy.

However, if we could draw on the entire health system, only 16-percent of resources would be needed to reach and sustain universal access in the next ten years. We would also find ourselves in the position of being able to do far more

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good for our people. We could consider starting antiretroviral treatment earlier. We could consider offering third-line or salvage treatment. Food support would be freely available for all who needed it and it would even be possible to move the entire health system to a higher level of quality and responsiveness to patient needs.

To conclude, the health system is a social institution and levels of equity in the health system are an important indicator of the levels of solidarity and compassion in society. If this is the case, very little can be said for South African solidarity 15 years after the end of apartheid. What particularly bothers me is that there is a complete lack of discourse in South Africa about equity and immorality of ongoing and actually increasing inequity in South Africa.

Media attention, all too often, focuses on the poor quality of care in the public health system without any acknowledgement of the role that the private sector is playing in draining resources from the public sector.

However, there might be some hope at the moment because the government is currently considering once again putting plans in place for a national health insurance system that would allow for a more equal sharing of resources.

Finally, given the sustainable access to HIV treatment depends crucially on harnessing the resources in the private health system. This might be our best hope as a country to

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improve both equity and solidarity between rich and poor. Thank you. [Applause]

ALAN WHITESIDE, PH.D.: Thank you very much to all the speakers, we do have five minutes. So, if there are one or two people who want to make interventions, please come to the mic but you can only have 40 seconds. You, sir at microphone three?

MALE SPEAKER: Okay. Thank you, Alan. My name is [inaudible]. I am Coordinator of the Africa Public Health Alliance on 15-percent campaign. With the 40 seconds, I appreciate the arguments for private health insurance but I really would want to caution that we should not overemphasize it as a model for health development in Africa. The simple reason is to be able to be with the health system, train and retain the health workers, negotiate the commodities on things like that requires a far more massive scale of health investment than private insurance will ever, ever allow.

So, while it could be useful for small groups of people who, by the way, must have stable incomes not most of the people who have no incomes at all, and the main danger is if we convert out-of-pockets straight to possibilities for sustainable private care and-

ALAN WHITESIDE, PH.D.: Thank you very much.

MALE SPEAKER: It may be a bit of a problem.

ALAN WHITESIDE, PH.D.: Thank you. Microphone number four?

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PAUL CHRIST: Yes, my name is Paul Christ [misspelled?]. I am the President of Vallarta [inaudible]. That is Vallarta confronts AIDS in Puerto Vallarta here in Mexico and we recently received 500,000 Pesos in grant funding from Senceda [misspelled?] and I would like to thank Dr. Mauricio Hernandez very much for that funding. It has allowed us to expand our prevention, outreach, education, and testing, rapid testing programs. My question for Dr. Hernandez is are there any plans to declare a state of public health emergency as permitted under WTO and NAFTA to allow Mexico to import generic medicines and thus bring ARV costs down to a level that would allow Mexico to put people living with HIV on treatment at a much earlier stage of progression as we know that this will [inaudible] with prevention-

ALAN WHITESIDE, PH.D.: Thank you very much microphone number four. Let us move to microphone number one.

SUTURA PACHOUDRE: Okay. Two quick questions in 40 seconds. Chris, the first one to you. My name is Sutura Pachoudre [misspelled?], I work for DFID in London. First question is how does your fund mitigate the potentially negative consequences of introducing a two-tier system of health care, both in terms of access and quality? Second question to Dr. Shi, I am wondering to what extent is the tremendous success in terms of improving health care in China

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due to your rapidly growing economy and if so, if that is the case, then can we generalize your findings to Africa?

ALAN WHITESIDE, PH.D.: Thank you very much. I will take one last question from number three and give the panel a chance to respond.

MALE SPEAKER: Yes? Okay. Hi, my name is [inaudible]. I am studying political science [inaudible] public management and national university and I am from Mexico so welcome to all of you to Mexico and I want to speak in Spanish please if you want to—

ALAN WHITESIDE, PH.D.: I am afraid we are not going to be able to do that because we have very limited time, very quick intervention.

MALE SPEAKER: So, the Director of Ministry of Health. In the new, recent of new law probably [inaudible] how the health of millions of people is [foreign language] with this law is very, a lot of people can [inaudible] la perspectiva of your government [foreign language] thank you.

ALAN WHITESIDE, PH.D.: Thank you very much. Very quick responses from the panel. Dr. Avila, I think you have a number of questions. You have one minute.

MAURICIO HERNANDEZ-AVILA, MD, MPH, PHD: Thank you. There is no reason why to declare emergency with the new statement that was announced by the President. We will have

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access to generics all over the world and that will decrease prices so there is no need for emergency in Mexico.

Second, a lot of people are in favor of the reform of [inaudible] and has nothing to do with the question with what we are discussing here.

ALAN WHITESIDE, PH.D.: Let us move to China and you had a question pointed to yourself Dr. Shi.

GUANG SHI, M.D.: Yes. Thank you for your question and it is very important for us to learn the experience of China. As for the expansion of our experience to African countries, I think we have two points. One is that we have to introduce the market system for the economy sector, which will improve the growth of economy and we see a decentralization and deregulation for this sector.

The second point is that we have to focus on the public policies, which improve the equity of the people after you have achieved the health reform. The SARS outbreak gave us lessons in this area because the SARS outbreak showed us that the bigness of the public health services system in China. Thank you.

ALAN WHITESIDE, PH.D.: Thank you very much and Chris.

CHRIS VAN DER VORM: Very quickly. Very good question. First of all, we work very closely with the public sector to make sure that a two-tier intervention will eventually turn

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into one where we combine resources and initiatives to harmonize.

Secondly, we also focus on groups that are currently not covered by the public sector. Just over time, we can work with the public sector to achieve the national programs but now we are talking in terms of long-term.

ALAN WHITESIDE, PH.D.: Good. Then it only remains for me to thank the people who put this presentation together and the program together, to thank Kristen Newhart who was the behind the scenes person from the International AIDS Society, the presenters for keeping to time and presenting interesting papers, and you all for coming. Thank you very much indeed.

[Applause]

[END RECORDING]

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