



World Health  
Organization

# WHO DISCUSSION PAPER: THE PRACTICE OF CHARGING USER FEES AT THE POINT OF SERVICE DELIVERY FOR HIV/AIDS TREATMENT AND CARE

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## INTRODUCTION

The global movement to expand access to antiretroviral treatment for people living with HIV/AIDS as part of a comprehensive response to the HIV pandemic is grounded in both the human right to health and in evidence on public-health outcomes. However, for many individuals in poor communities, the cost of treatment remains an insurmountable obstacle. Even with sliding fee scales, cost recovery at the point of service delivery is likely to depress uptake of antiretroviral treatment and decrease adherence by those already receiving it. Therefore, countries are being advised to adopt a policy of **free access at the point of service delivery** to HIV care and treatment, including antiretroviral therapy. This recommendation is based on the best available evidence and experience in countries. It is warranted as an element of the exceptional response needed to turn back the AIDS epidemic.

With the endorsement by G8 leaders in July 2005 and UN Member States in September 2005 of efforts to move towards universal access to HIV treatment and care by 2010, health sector financing strategies must now move to the top of the international agenda. Rapid scale-up of programmes within the framework of the "3 by 5" target<sup>1</sup> has underscored the challenge of equity, particularly for marginalized and rural populations.<sup>2,3,4</sup> It is apparent that user charges at the point of service delivery "institutionalize exclusion" and undermine efforts towards universal access to health services.<sup>5</sup> Abolishing them, however, requires prompt, sustained attention to long-term health system financing strategies, at both national and international levels.

## UNIVERSAL ACCESS TO HIV TREATMENT AND CARE AS A PUBLIC HEALTH PRIORITY

The "3 by 5" target was inspired by a strong global consensus that universal access to antiretroviral treatment and care is an ethical imperative. Access to treatment is also emerging as a necessity to promote public health and safeguard economic and social development.

*Public savings.* Industrialized countries that guarantee universal access to treatment and care have seen dramatic reductions in AIDS-related mortality and morbidity. This has the potential to generate substantial net public savings brought about by reduced burden on health facilities (direct medical costs).<sup>6,7</sup> In Brazil, a middle income country which has guaranteed free universal access to ART since 1996, savings for public health expenditures from the national programme were estimated at \$1.1 billion (\$200 million net) over the period 1997-2001.<sup>8</sup> Ensuring that all

members of the community are able to benefit from HIV treatment and care is an investment that appears to pay economic dividends.

*Public health.* Antiretroviral therapy has not yet been available for long enough in most poor, highly affected countries to assess the relationship between treatment coverage and the epidemiology of HIV. However, recent experience in developed countries supports the hypothesis that universal access can have important benefits for population health. In Taiwan, China, a programme guaranteeing universal ART access was implemented in 1997, after which the estimated rate of HIV transmission decreased by more than half.<sup>9</sup> In this instance, ensuring the widespread availability of ART has therefore altered the course of the epidemic. Moreover, dismantling barriers to access helps to forestall the emergence of drug resistance as an outcome of poor adherence.

*Development.* Recent macroeconomic models suggest that AIDS can cause far greater long-term damage to national

economies than previous analysis had suggested.<sup>10,11</sup> According to these models, failure to respond comprehensively can so deplete “human capital” that progressive economic collapse within a few generations is a real possibility. The current consensus among economists is that the macroeconomic damage caused by AIDS will be multiplied over time in the hardest hit countries. The preservation of social capital and productive labour is a net gain to the economy, and removing barriers to treatment access is therefore a critical component of sound economic planning at the national level.

*Social cohesion and stigma.* Universal access to treatment can also help to maintain social cohesion in high burden settings. Stigma associated with HIV/AIDS has long been recognized as a significant barrier to the success of public health interventions. The threat of ostracism or violence discourages many people from being tested, let alone treated. In settings of very high incidence, stigmatization of people living with HIV/AIDS can also bring with it severe economic costs and undermine social cohesion. It worsens the exclusion of already marginalized groups, in particular women and girls.

It has been recognized that “promoting hope by...providing ARV treatment to those who are medically eligible” is a critical component of any comprehensive AIDS intervention.<sup>12</sup> By removing a powerful rationale for exclusion or fear of people living with HIV, the availability of treatment can significantly diminish stigma and its negative effects. However, inequitable access to HIV treatment and care may underscore inequalities of class and gender, and therefore worsen stigma. Defeating stigma is another powerful argument for universal access as a basic tenet of treatment, care and prevention.

## THE CHALLENGE OF PROVIDING UNIVERSAL ACCESS TO HIV TREATMENT AND CARE

Even with significant reductions in drug prices, antiretroviral therapy is still very expensive, often many times the local per capita income when all treatment-associated costs are factored in. The long-term sustainability of programmes has therefore become a pressing concern. Because antiretroviral treatment must be sustained for the life of the patient, it is important on clinical, ethical, and public-health grounds that the intervention be supported by adequate and sustained financial resources.

Over the last twenty years, user fees or co-payments have become an increasingly common feature of health system financing, particularly at the district and local levels.<sup>13,14,15</sup>

While the sums collected from end-users may not be large in absolute terms, public-sector decentralization has meant that they play an important role in the solvency of district and local health services or in the motivation of staff—particularly in personnel budgets.<sup>16,17,18</sup> When service fees are abolished without compensating for lost revenues, the results can be counterproductive. End user costs may either be shifted to other services, or recovered informally by providers.<sup>19,20</sup>

On the other hand, for AIDS treatment and care services to have any impact, HIV-infected people must actually be able to access them. When fees are an insurmountable barrier to end users, the economy may experience a large net loss due to ill health, as people are pushed into poverty or prevented from moving out of it. Even if a given individual is able to secure treatment, high out-of-pocket payments can have serious economic repercussions at the household level. A major challenge in financing antiretroviral treatment is therefore to ensure that increased access to treatment does not come at the cost of financial catastrophe for individuals and their dependents.

Balancing the apparently competing priorities of sustainability and access is a significant challenge for government officials and programme managers. Lack of confidence that donors will meet the costs of HIV-related services in the longer term, combined with pessimism that domestic sources cannot suffice for free provision, has led many countries with high HIV prevalence to impose cost recovery policies.

## FREE HIV TREATMENT AND CARE AT THE POINT OF SERVICE DELIVERY: A CLINICAL AND PROGRAMMATIC NECESSITY

The relatively small proportion of total expenses to be gained from end-users in resource-limited settings, combined with high transaction costs and demands on staff time for means testing, suggest that these mechanisms are ill-suited to contribute substantially to overall programme solvency in settings where ART is needed most urgently. In recent years, many individual facilities have come to rely on end user fees to support their personnel budgets and operating expenses. However, serious clinical and public-health concerns raised by fee-for-service models for antiretroviral treatment indicate that cost recovery is poorly suited to the social context of the HIV pandemic. Thus, salaries and working conditions need to be improved through financing schemes that do not involve the recovery of costs from end users at the point of service delivery.

In general, when antiretroviral treatment is provided through the public sector, user charges have been assessed

by sliding scales that try to account for “ability to pay”. But in settings where the median income is well under absolute poverty, estimations of “ability to pay” on the basis of minute variations in subsistence level are unlikely to address barriers to access in a meaningful way. Countries that have imposed cost recovery for ART on end users have often found means testing to be inadequate, with serious implications for programme effectiveness.

Cost is invariably the most frequently cited factor behind failure to adhere to therapy. Senegal’s ISAARV (Initiative Sénégalaise d’Accès aux Antirétroviraux) programme, which has been comprehensively evaluated, included a tiered pricing scheme with seven different income categories. Not only was the exemption system plagued by problems in the selection process, but even when the contribution sought from the patient for drug costs was small, a majority of those who dropped out cited that cost as the most important cause.<sup>21</sup> This finding is consistent with experience in other disease-specific interventions, most prominently those against tuberculosis, where the phase-out of end user fees-for-services has also been called for.<sup>22</sup>

The association between end-user cost and adherence in Senegal has been echoed by data from Uganda,<sup>23</sup> Nigeria,<sup>24</sup> Botswana,<sup>25,26</sup> and Côte d’Ivoire.<sup>27,28</sup> In each case, targeting mechanisms proved inadequate to the task and resulted in a decrease in adherence levels of those already on treatment. When they had exhausted their resources, many patients reported that their initial self-assessment of their ability to pay had been overly optimistic.

In December 2003, as the “3 by 5” strategy was being launched globally, Senegal announced that it was giving up on its attempt to calibrate end-user cost to patient’s incomes, and would offer treatment under the expanded state programme at no charge. A number of countries have now followed suit, including Zambia, Tanzania and Ethiopia.

## SUSTAINABILITY OF FREE HIV TREATMENT AND CARE AT THE POINT OF SERVICE DELIVERY

The evidence base strongly suggests that even with means testing, user fees at the point of service delivery hinder access by poor people to treatment and care for HIV/AIDS and reduce long term adherence to therapy. Faced with fiscal constraints, however, a number of highly affected countries find it difficult to abolish these fees. Assisting in the resolution of this dilemma must be an urgent priority for international donors and technical agencies such as WHO. Failure to do so would undermine the two core missions of WHO, namely providing

technical support for medical and public health imperatives and advocating for truly sustainable, equitable, efficient and high-quality health systems.

A further key challenge for WHO and the international community as a whole is to help countries and partners develop alternatives to cost recovery policies that are affordable in the short term, and sustainable health financing mechanisms in the long term. Another challenge is to persuade key international agencies that large infusions of funding for health, and for AIDS in particular, can be managed to minimize economic or systemic distortions which may disproportionately affect the poor.

One promising national response is risk pooling strategies that remove cost recovery from the point of service delivery to the population level, in the form of prepayment schemes that take into account ability to pay. Such strategies have been endorsed by WHO’s 192 Member States at the 2005 World Health Assembly.<sup>29</sup> WHO is committed to helping countries to choose appropriate models, roll them out, and monitor their impact on financing for HIV/AIDS interventions.

Yet, national solutions by themselves are insufficient. In many high burden countries, sustainable provision of HIV treatment and care at the point of service delivery will require external funding for the foreseeable future. A concept of sustainability that assesses the feasibility of HIV/AIDS interventions solely on the basis of resources available to countries and localities operating in isolation will lead to unrealistic and potentially damaging policies. Transnational pandemics require a shift from national models of sustainability to an understanding that sustainability is global in scope.

Perennial funding mechanisms proposed for aid to low- and middle-income countries should therefore be encouraged as ways to fund HIV/AIDS interventions in the long term. It is, however, important to ensure that these external resources are used in a way that helps to build health systems in a sustainable manner. To that end, analytical tools and evaluative frameworks that can assist countries to develop their health financing infrastructure must be developed.

The last two years have seen an unprecedented, high-level international commitment to addressing the HIV pandemic. In order to forestall the alarming social, macroeconomic and political repercussions of AIDS, the response must be service- and patient-oriented. While free care at point of service must be managed carefully to minimize negative impact on public health systems, fees recovered from end users have been shown to be a poor solution in the case of HIV/AIDS treatment and care programmes. They can have serious health consequences and may contribute very little to overall sustainability.

## WHO ACTIVITIES TO SUPPORT FREE HIV TREATMENT AND CARE AT THE POINT OF SERVICE DELIVERY

- ▶ Review, monitor, assess and report on the range of health financing strategies and policies across countries particularly with respect to cost recovery from end users at the point of service delivery;
- ▶ Elaborate the policy rationale for free treatment and care at the point of service delivery;
- ▶ Explore the potential consequences of such a policy for public health, equity, and health system and fiscal planning, including the problem of cost shifting to other health services;
- ▶ Coordinate the design and evaluation of model financing mechanisms that are consistent with provision of free treatment and care at point of delivery, at the national and international levels;
- ▶ Ensure adequate technical support to countries considering or implementing free access policies;
- ▶ In all relevant fora, facilitate discussion on appropriate policies for the provision of a package of HIV prevention, treatment and care in national, regional and international fora; on the assessment and decision-making process for policy makers in government, donor agencies, and civil society; and on alternative financing strategies.
- ▶ Document the experience with phase-out of end-user fees for HIV treatment and care services.

## PRINCIPLES FOR FINANCING ART SCALE-UP

- ▶ Because the AIDS pandemic is an unprecedented emergency, with demonstrated potential to cripple social and economic development in high burden countries and to spread across sovereign borders, funding constraints must not be an obstacle to those in need accessing interventions.
- ▶ In order to achieve sustainable and universal access for those in need, HIV/AIDS treatment and care should be available without charge at the point of service delivery.
- ▶ Alternative financing strategies that can ensure sustainable and universal access to HIV treatment and care need to be explored. The design and implementation of such strategies should be prioritized by policymakers at the national and international levels.
- ▶ Equity, quality, efficiency, and sustainability are inter-related and should not be considered in isolation as programmes are scaled up.

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