

Health Sector Responses to HIV/AIDS and treatment access in southern Africa: Addressing equity

EQUINET
DISCUSSION
PAPER **10**



Regional Network
for Equity in
Health in Southern
Africa

In co-operation with



Oxfam

By
David McCoy



**Health
Systems
Trust**



Editors: R. Loewenson, C. Thompson

October
2003

HEALTH SECTOR RESPONSES TO HIV/AIDS AND TREATMENT ACCESS IN SOUTHERN AFRICA: ADDRESSING EQUITY

David McCoy
Health Systems Trust



Regional Network for Equity in Health in Southern Africa
(EQUINET)

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This paper has been produced with the support of
DfID (UK) and IDRC (Canada)

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Executive Summary

'Disparity is a shocking reality that we cannot hide from. This is a global injustice. It is a travesty of human rights on a global scale.'

Nelson Mandela on the lack of access to antiretroviral drugs at the International AIDS Society Conference in Paris, July 2003

'Health equity cannot be an apolitical, acultural, "technocratic" concept restricted to the domain of healthcare and public health. Health equity is best thought of not as a social goal in and of itself, but as inherently embedded in a more general pursuit of social justice.'

Peter and Evans, in Challenging Inequities in Health, 2001¹

This paper discusses a set of complex, inter-connecting issues related to the moral imperative to increase access to HIV care and treatment in southern Africa, with a particular focus on antiretroviral therapy (ART). However, it does this with an equity lens. An equity lens seeks not just to look at improving access to care and treatment for the millions of people who currently lack it, but rather seeks to reduce the gap in access to health resources between different population groups. Underlying this view is an explicit argument that the current inequities in access to treatment are related to differentials in power and political influence between different population groups over the manner in which resources for accessing care and treatment are distributed.

It is argued in the paper that an equity-oriented approach is necessary not only from a moral and humanitarian perspective but also for public health reasons. Unless attention is paid to the redistribution of available resources and to the relative and absolute levels of disempowerment amongst individuals, communities and countries, we run the risk of failing to achieve the Millennium Development Goals and the targets that have been set for increasing access to ART.

The Southern African Regional Network for Equity in Health (EQUINET) and Oxfam (GB), in cooperation with IDRC and DfID, have commissioned a series of technical papers on equity in health sector responses to HIV/AIDS in southern Africa. The programme, initiated in February 2003, aims to identify policy issues and options to strengthen equity in health sector responses to AIDS. A regional workshop and review panel identified the key areas for analysis at country and regional level. In line with this framework, EQUINET and Oxfam have commissioned a series of country studies from four countries in southern Africa plus theme papers on HIV/AIDS equity issues in relation to health personnel, to food security and nutrition and gender equity. This paper explores the regional dimensions of equity in health sector responses to AIDS, drawing on the country and theme papers.

All people with HIV/AIDS should have equal opportunity to access effective and appropriate treatment. Access to treatment is, however, only beneficial if it is translated into improved health outcomes. In the context of existing social and health inequities, widespread poverty, high rates of new HIV infections, famine and budgetary constraints, increasing access to HIV care and treatment must be organised in a manner that balances HIV prevention and treatment efforts; HIV interventions and the broader strengthening of the health system as a whole; and HIV care and treatment with other public health and social needs.

Equity in access to HIV care and treatment needs to be assessed across groups (particularly gender, socio-economic status, age and race) and at various levels, including the household, community, country, regional and global levels.

Section 1 describes the current state of the HIV/AIDS epidemic in southern Africa and explains how the epidemic is undermining the broader state of socio-economic development in the region. The epidemic is patterned on a range of underlying social and economic inequities, and results in a further deepening of those same inequities. Unless interventions are deliberately set to break this vicious cycle, HIV/AIDS worsens aggregate socio-economic and health indicators and unfair and unacceptable disparities. This requires more than just a pro-poor approach to development and treatment initiatives, but an approach that intervenes in these socio-economic and health disparities.

Section 2 presents and discusses the broader context of increasing access to care and treatment. Current levels of health expenditure in many countries are insufficient to meet basic public health and healthcare needs, let alone complex and relatively expensive treatment programmes. The push to increase treatment coverage cannot be planned in isolation of broader socio-economic reform, including of the global trade and investment regimes that currently act to keep poor countries poor. Inadequate levels of official development assistance and slow progress towards debt relief are markers of a lack of global commitment towards addressing poverty and the HIV epidemic, and represent issues around which the global public health community should rally. Section 2 also highlights the extreme difficulty African governments face in allocating scarce resources across multiple priority health and social needs. Concerns are raised about the possible over-medicalisation of HIV/AIDS interventions to the cost of the underlying economic and food security needs of the poor, particularly as the latter are necessary for them to realise the benefits of clinical and behavioural interventions. The paper highlights areas where there is room for enhancing equity in resource allocation and public policy decisions within the region, both nationally and within multilateral and regional frameworks.

Section 3 discusses pricing of medicines from an equity perspective. Although cheap medicines will not automatically result in effective treatment, especially for the poor who lack access to effective, accessible and affordable health services, the issue of drug pricing has taken on an important symbolic function. Efforts to exempt poor countries from patent regulations and differential pricing



policies are only partial solutions to making medicines more affordable. Beyond this are issues of how society manages patents and intellectual property, how research and development of new medicines and vaccines is funded, and how fair and sustainable pricing is ensured. The current intellectual property regime and market structure is inefficient, acts as a barrier to scientific cooperation and undermines equity.

Section 4 highlights ways in which the organisation and management of the health system matters when it comes to expanding access to care and treatment for HIV/AIDS. Without adequately skilled health personnel, regular supplies of medicines, community-based support and laboratory services, effective, efficient and sustainable treatment programmes are not possible. Although it will be possible to create 'islands' of effective treatment through dedicated 'special' projects, even in the most under-resourced setting, any hope of achieving sustainable and widespread coverage requires a health system that is functional at the country level.

Much needs to be done to develop appropriate and equitably organised health systems. There needs to be an explicit commitment to equity and to expanding HIV/AIDS treatment *as part of* a broader set of health system priorities. The focus on expanding access to HIV/AIDS treatment could either take the route of least resistance and implement treatment interventions that are built on the current pattern of inequities; or it could consciously set out to use the impetus around expanding HIV care and treatment to reduce inequities, *preferentially* target the poor and systematically uplift the healthcare infrastructure of the most under-resourced areas in a country. The latter requires a broad-vision approach to the expansion of HIV/AIDS treatment, which includes a sustained engagement with various health systems policy questions. These include the way the health system is financed and organised; how health resources (government, donor and private) are distributed; how ministries of health fulfil their governance and stewardship functions; how the public and private sectors interface with each other; and how concepts of equity, redistribution and rights to health are accepted and reflected within the health system.

Within this context, **Section 5** discusses the policy and operational considerations of treatment programmes themselves, including the need to:

- balance the rapid expansion of access to treatment with the need to develop basic healthcare infrastructure
- optimise the balance between HIV treatment and other healthcare services
- optimise the balance between HIV prevention and treatment
- ensure that the burden of care and treatment is equitably shared between the commercial, for-profit sector and the public and not-for-profit NGO sector
- ensure that criteria for rationing care and treatment are optimal, transparent and equitable
- promote a policy and regulatory environment at a country level that balances the need for minimum standards of care and treatment with increasing access.

Unless treatment programmes are carefully and appropriately planned and organised, they may worsen inequities and result in inefficiencies and unwanted outcomes. More could be done to carefully develop context-specific plans for the expansion of treatment in a way that will not aggravate inequities or result in the inappropriate withdrawal of resources from other health interventions or from other parts of the health system.

This demands coordinated strategic planning and strong public health leadership. It places an obligation on donors to ensure that their plans are sustainable and integrated within long-term strategies to improve health systems. The danger that quick-fix, vertical and multiple top-down approaches will fragment the already fragile health systems of southern Africa and lead to a worse outcome in the long-run should not be discounted lightly. It is, therefore, important that appropriate and realistic targets are set for the expansion of treatment and that treatment is expanded only in a way that strengthens the health system's capacity to provide ART and comprehensive PHC in the long run.



1. Introduction

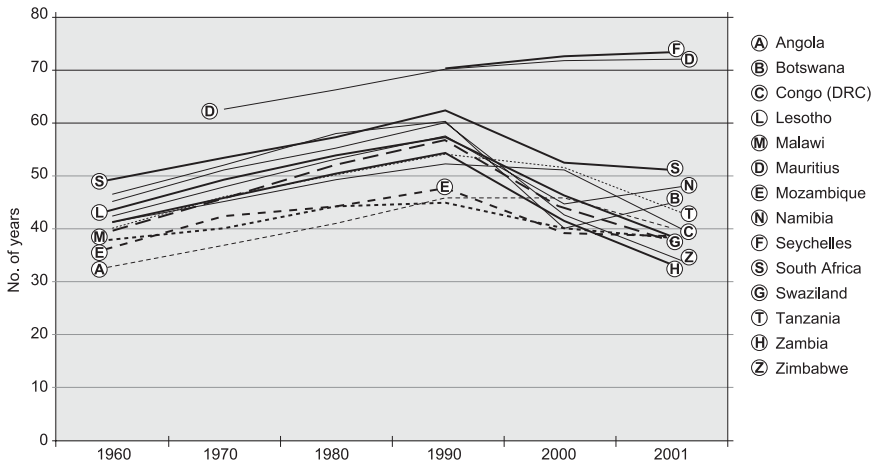
1.1 Background to the HIV epidemic in southern Africa

The HIV prevalence and mortality rates in southern Africa read like a horror story. The SADC countries, with a combined population of only 3.5% of the world's population (approximately 207 million people), account for 35% of people living with HIV/AIDS and about a half of all infections in Africa, with an average adult HIV prevalence of 13.7%, compared to 9% for sub-Saharan Africa (SSA) as a whole. In four countries HIV adult prevalence has reached rates previously thought impossible (Botswana 38.8%; Lesotho 31%; Swaziland 33.4%; and Zimbabwe 33.7%).ⁱ

These prevalence rates translate into approximately 15 million adults and children currently infected with HIV in the SADC region. To date, close to 10 million people are estimated to have died of HIV/AIDS-related diseases in the region, with over 1 million HIV/AIDS deaths in 2001. The cumulative *affected* population, including spouses, children and elderly dependents, is estimated at 125 million, or 60% of the total population of the region.ⁱⁱ

Under-five child mortality, which had been falling over the past few decades in most countries, is now on the rise. In Zimbabwe, the infant mortality rate is estimated to be 72% higher than it would be without AIDS.² In several countries, life expectancy has dropped to levels that were typical of the 1950s (Figure 1). The Human Development Index (HDI) has dropped in Botswana, Swaziland, Namibia, Lesotho, Zimbabwe and Zambia. Although there are many reasons for this shocking picture of regression, it is clear that HIV/AIDS is one of the primary factors.

Figure 1: Life expectancy trends in southern Africa 1960-2000



ⁱ HIV transmission in the region is mainly heterosexual (92% of all infections).

ⁱⁱ This figure is derived from a calculation of the number of people currently living with HIV plus 10 million who have already died from HIV/AIDS, multiplied by a factor of 5 to represent the numbers of those directly affected.

In addition to the direct effect on mortality and life expectancy, HIV has a number of devastating *indirect effects*.^{3,4,5} The epidemic has torn away at the social fabric of families and communities. A study in Zambia revealed that 65% of households in which the mother had died had dissolved.⁶ The region now has millions of orphans (470,000 in Malawi; 660,000 in South Africa; 810,000 in Tanzania; and 780,000 in Zimbabwe).⁷

At the household level, HIV/AIDS can lead to the total impoverishment of an entire family as a result of reduced or lost earnings due to the breadwinner(s) being ill or dying; and from efforts to pay for healthcare. The effect of a fatal and prolonged illness can be catastrophic for the poorest households but also for the non-poor. Paradoxically, the availability of antiretroviral therapy (ART) 'at cost' may result in a growing proportion of the non-poor impoverishing themselves at the household level as income and assets are used to pay for medicines and consultations.

With its concentration amongst the economically productive adult population, HIV/AIDS will negatively affect social and economic development. One analysis asserts that in Africa's worst-hit countries, HIV has already reduced GDP by 1%⁸ and studies have forecast that by 2015 the economies of Botswana and Swaziland would grow by 2.5 and 1.1 percentage points less because of the epidemic.

The health sector is affected by health workers themselves being ill and dying from HIV/AIDS, or having to cope with the effects of death in their families and communities. Malawi and Zambia, for example, are reported to be experiencing 5–6 fold increases in health-worker illness and death rates. In addition, HIV/AIDS increases the demand on the health system as hospital beds are occupied by an upsurge in AIDS-related illnesses. The increasing incidence of tuberculosis and diarrhoeal diseases also places a significant additional strain on primary level health services. This simultaneous effect of increasing demand and weakening capacity has the potential to tip health systems that are already dysfunctional into a state of collapse.

Effects are also noted in other sectors. For example, in the education sector a reduced intake of students is being experienced due to children from impoverished HIV-affected households not being able to afford to go to school, or having to stay at home to look after sick adults. It is projected that by 2010 there will be a 20% and 25% reduction in primary school age population in Zambia and Zimbabwe respectively.⁹ In Swaziland it has been estimated that an extra 7000 teachers will have to be trained over the next 17 years just to keep services at their 1997 levels. In the agricultural sector, HIV/AIDS will also affect household food security and agricultural productivity.

1.2 HIV and equity

Equity is an ethical and value-based concept that is grounded in principles of fairness and distributive justice.^{10,11} From a health perspective, it can be defined as the absence of *unfair* health disparities or inequalities.^{12,13,14,15,16} What is typically considered unfair is the presence of *avoidable* health inequalities or disparities (or in the distribution of the determinants of health) between groups of people with different levels of underlying social advantage or disadvantage (for example, in terms of wealth, power, access to public resources and prestige). Health inequities therefore point to the phenomenon of groups of people who are already socially disadvantaged being systematically placed at a further disadvantage with respect to their health.¹⁷

The term 'social' is used to embody a range of political, economic and cultural factors that are mediated by society, as distinct from natural or biological factors that may result in health disparities, but which are not considered unfair or unjust. For example, certain health disparities that exist between young adults and the elderly would not be considered unfair, nor would health differences that result from individual biological variations. Social vulnerability to health can be spread unequally and unfairly across socio-economic, racial, ethnic, religious, gender, geographical, age and sexual orientation groups.

An equity approach stands in contrast to a 'basic needs approach' or 'poverty approach' which focuses on the poor and the disempowered without relating their condition to the rich and the powerful. Equity implies an approach that gives more to those who have little, and thus less to those who have much. Rather than the allocation of equal shares, equity implies the allocation of fair shares.¹⁸

The notion of equal opportunities to be healthy is also grounded in the human rights concept of non-discrimination and the need for governments (or the organised representation of society) to take the necessary measures to eliminate the unfair health consequences of social disparities. Judging whether a process is equitable depends on the definition of what society accepts as an equal right of all.¹⁹ Some emphasise inequalities in health *outcomes*; others emphasise the *opportunities* for good health outcomes.

Power and influence are often central to considerations of equity. Those who are in positions of power often determine what is equitable and what is not. In some settings, those in power may seek to justify avoidable racial, ethnic and gender disparities in health.^{20,21} Power may also determine the allocation of health resources and the manner in which public policies and institutions respond to inequalities.

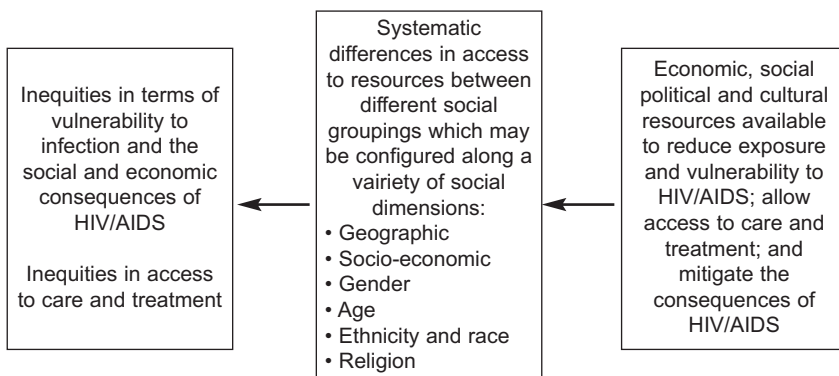
1.3 The social inequalities of HIV / AIDS

The relationship between HIV and social disparities emerges at three stages (illustrated in Figure 2). These are firstly, vulnerability to HIV infection; secondly, the opportunity to receive appropriate and effective treatment and care; and thirdly the consequences of HIV infection. At each stage, the ability to protect and maintain health and to minimise the consequences of HIV infection will be determined by the availability of and access to a range of different resources.

These resources exist at different levels of society and have been described in several ways by sociologists and political economists.^{22,23} They include political influence and the economic wealth of countries at the global and national level; the social and cultural capital of communities and households; and the ability of individuals to mobilise economic and social resources to reduce vulnerability and access treatment. Systematic differences in access to these resources by different groups, mediated by different degrees of social advantage, wealth, power and freedom, results in the unfair disparities associated with vulnerability to HIV/AIDS and access to appropriate and effective treatment and care (Figure 2).

For example, we know that poverty places individuals and communities at a higher risk of vulnerability to infection through a number of different pathways, including the lack of access to treatment for sexually transmitted infections (STI) and to barrier methods of contraception; a lack of access to education and knowledge; psycho-emotional states of being that increase risky behaviour; and reduced levels of immune protection as a consequence of malnutrition. Once infected, poverty reduces the ability to access healthcare and treatment, as well as to withstand the social and economic consequences of HIV/AIDS. Illness or death due to HIV/AIDS can push vulnerable households into choices that may result in further negative outcomes such as taking children out of school and selling remaining assets. On top of this, the relationship between poverty, increased susceptibility to HIV infection and a diminished capacity to deal with the consequences of HIV/AIDS is bi-directional, placing poor countries, communities, families and individuals in a vicious cycle.

Figure 2: HIV/AIDS and inequity



Although poverty is a major engine driving the epidemic in southern Africa, other underlying factors must also be highlighted; many of which are unevenly distributed in a way that can be considered unfair and unjust. For example, gender relations play a pivotal role in shaping vulnerability to HIV infection. In many countries, women are disempowered for social and cultural reasons, leading to a relative lack of employment opportunities, poor access to education, training and information, and vulnerability to disease. Their inability to protect themselves from unprotected intercourse and sexual violence makes them more vulnerable to HIV infection, as reflected in their higher infection rates.^{24,25,26,27} Disempowerment and poverty, and the subsequent bartering or selling of sex as a livelihood strategy, further increases young women's vulnerability.^{28,29} Because women are also more vulnerable to HIV infection for biological reasons, they are affected by a triple set of social, economic and biological vulnerabilities.

Children are also relatively disempowered. In spite of child rights activists demanding a 'first call on children', the reality is that African children remain vulnerable to poor health. As with women, poverty compounds the effect of this social disempowerment. Young children living in poverty are forced into behaviours that place them at increased risk of HIV/AIDS. Infants of impoverished HIV-positive mothers are at risk of either HIV infection through breastmilk or of diarrhoeal disease and malnutrition from unsafe formula feeding practices.

Resources at the community or societal level that are differentially distributed also contribute to the unfair distribution of the burden of HIV/ AIDS. These resources include 'features of social life, networks, norms and trust, that enable participants to act together more effectively to pursue shared objectives'³⁰ and widen people's access to other economic, material, psycho-emotional and cultural resources. Communities and countries with reduced social cohesion and solidarity as seen in times of civil conflict, war and displacement are more vulnerable to HIV/AIDS, as are communities affected by high levels of migrant labour and a disruption to traditional family and community structures.

The HIV/AIDS epidemic is, therefore, fuelled by a multiplicity of factors that lie on a continuum from the 'macro' material-social environment; to socio-cultural factors of lifestyle, behaviour, attitudes and values; to 'micro' individual factors of knowledge, psycho-emotional coping capacities and biological susceptibility. All of these factors need to be looked at through an equity lens.³¹ They are also inter-related: Ensuring equitable access to treatment for HIV/AIDS is one way to mitigate the social inequalities that arise from disproportionate levels of vulnerability to and burdens from HIV/AIDS.

2. The context for access to HIV care and treatment

2.1 The global context

The distribution of HIV prevalence at the global level shown in Figure 3 reveals the fact that the HIV/AIDS epidemic is largely super-imposed upon a world of pre-existing socio-economic and health disparities.

Figure 3: Global distribution of HIV/AIDS



Table 1 provides some data on the relationship between HIV, health and socio-economic development. What is striking is the degree of *absolute* poverty (millions of people living below the poverty line) as well as the disparity between rich and poor countries. While the per capita GDP of sub-Saharan Africa (SSA) is 16.5 times less than that of the high-income OECD countries, its HIV prevalence is approximately 25 times higher. When some of the poorer countries of SADC are compared to the high-income OECD countries, the socio-economic disparity is even larger. For example, people in the high-income OECD countries are 53.2 times richer than the people of Malawi.

These socio-economic disparities underline health disparities. While a woman can have an 88.8% chance of reaching the age of 65 years in a high income OECD country, only two out of five women can expect do so in Malawi. Tanzania's under-five mortality rate of 165 per 1000 live births, means that every sixth child born alive will die before the age of five years; in contrast, in the high income OECD countries, every 167th child dies before the age of five.



Table 1: Selected socio-economic, health and HIV indicators

	GDP per capita (PPP US\$)	% adults (15–49) living with HIV/AIDS	Number of people living with HIV/AIDS	% population living <\$2/day 1990–2001 (1993 PPP US\$)	Under-five mortality rate 2001	Life expectancy at birth (years) 2001
Sub-Saharan Africa	1690	9.0	28.5 million	-	172	46.5
OECD countries	23,569	0.28	-	-	14	77.0
High income OECD countries	27,848	0.36	-	-	7	78.1
Malawi	615	15.0	850,000	76.1	183	38.5
Tanzania	523	7.8	1,500,000	59.7	165	44.0
Lesotho	2420	31.0	330,000	65.7	132	38.6
Zambia	780	21.5	1,000,000	87.4	202	33.4
Zimbabwe	2280	33.7	2,000,000	64.2	123	35.4

Source UNDP 2003 and UNAIDS 2002

The data do not just reveal a large disparity between rich and poor countries, but also show a trend over the last 50 years of *growing inequities*. Over the last few decades, an increasing proportion of global wealth has been accumulated by the richer countries, with the fifth of the world's people in the highest-income countries having 86% of world GDP in 1999, compared to 1% in the fifth in the lowest income countries.

The *growing socio-economic disparities* are also reflected as widening disparities in health indicators. For example, in spite of starting with lower mortality rates in the 1970s compared to SSA, the OECD countries have demonstrated faster rates of improvement as shown in Table 2. Between 1970–75 and 1995–2000, the life expectancy of SSA increased by a mere 3.5 years from 45.3 to 48.8. Life expectancy in the OECD countries, on the other hand, rose from 70.4 to 76.4 years, demonstrating again a growing divergence in health indicators between rich and poor countries.³²

Table 2: Comparison of child mortality rates over time

	Under-five mortality rate 1970	Under-five mortality rate 2000	% reduction in under-five mortality rate 1970 - 2000	Infant mortality rate 1990	Infant mortality rate 2000	% improvement in infant mortality rate 1990 - 2000
Sub-Saharan Africa	135	107	20.7	223	174	21.1
OECD countries	40	12	70	53	14	73.6
High income OECD countries	20	6	70	26	6	76.9

Source UNDP 2002

These illustrations underline the importance of *not* just looking at whether the socio-economic and health indicators of poor countries have improved, stagnated or worsened, but to look at them relative to those of the richer countries. This is important for several reasons. One is that the differential of wealth can create a vicious cycle of the rich getting richer, and the poor becoming poorer. An example of this is with the phenomenon of the global 'brain drain' which has seen thousands of skilled human resources flowing from Africa to richer countries, reinforcing inequities whilst undermining Africa's capacity to develop itself.ⁱⁱⁱ

In the 1980s, the doctor: population ratio was 1:10,800 in sub-Saharan Africa, compared to 1:1,400 in all developing countries and 1:300 in industrialised countries. Since then, the situation has deteriorated. In the 1990s the doctor: population ratio in Malawi, Mozambique and Tanzania was 1:30,000 or more, and in Angola, Lesotho, Zambia and the Democratic Republic of Congo it was 1:20,000. The knowledge and skills loss from the poorer to the richer countries is a form of reverse (poor to rich) subsidy.³³

Looking at southern Africa's health and HIV burden in relation to the health and wealth of the rich countries also points to the structural factors that keep many African countries in poverty within the global political economy.

The control and regulation of trade through the World Trade Organisation and various other bilateral trade agreements, provide particularly glaring examples of the double standards that maintain and accentuate the disparities between rich and poor. Although the Doha Round of negotiations has been hailed as a 'development round' that would better serve the needs of developing countries, the evidence from the collapsed negotiations in Cancun suggests otherwise.

ⁱⁱⁱ For specific discussion of the brain drain see Padrath et al (2003) in EQUINET discussion paper 3 on the maldistribution of health personnel in southern Africa and the paper on HIV/AIDS and health personnel in this EQUINET series on Health sector response to HIV/AIDS.



While poor countries are expected to open up their markets to competition, the richer countries are able to pick and choose where and when 'protectionism' and public subsidies are acceptable. The agricultural subsidies of the European and North American farmers are but one example of how poor countries are forced to compete unequally and are victims of double-standards. Furthermore, declining terms of trade have undermined the natural advantage some developing countries have had in certain markets. For example, in 2000, prices for 18 major export commodities were at least 25% lower in real terms than in 1980.³⁶

Many African countries have been further hamstrung by the imposition of damaging economic policies. Many of the macro-economic prescriptions of the Washington Consensus imposed upon African countries have simply failed to work. The World Bank and IMF continue to plough a line of economic liberalisation that will further concentrate wealth in fewer hands, shrink the role of government, increase the preponderance of market failures and entrap thousands more people in poverty.^{37,38}

Part of the challenge of responding to the structural and ideological causes of under-development lies in promoting a greater recognition that the social and economic development of the poorest peoples and countries is contingent on a greater *sharing* of global opportunities and resources, and not just on the creation of *additional* opportunities and resources for the poorest countries. The ecological limits to economic growth; increasing mechanisation and unemployment; and the growing concentration of wealth and power point to the need for an active process of socially-guided redistribution and the creation of a fairer and more robust multi-lateralism centred on human development and the fight against poverty. This challenge and resource demand contrasts with a relative lack of commitment and progress towards improved levels of official overseas development assistance (ODA) and debt relief.

Despite the fact that OECD countries are wealthier, the level of ODA has been falling. While wealth per person in the OECD countries more than doubled between 1961 and 2000, the amount of aid given dropped by four times over the same period.³⁹ Between 1990 and 2001 ODA fell from about 0.33% to 0.22% of donor countries GNP, the lowest ever level.⁴⁰ Furthermore, ODA has declined most in the regions and countries of greatest need. Of the 49 least developed countries, 31 receive less aid today than in 1990.⁴¹ Furthermore, much ODA continues to be poorly coordinated, badly used and tied to the economic and political interests of the donor countries.

In the health sector, although the Global Fund has generated new resources for the fight against AIDS, TB and Malaria, there are signs that the targets set for resource generation will not be met. As of March 2002, the projected annual costs of the Fund were less than the pledges received from donor governments and corporations,⁴² and the money promised by the donors at the end of this year is \$1,371m less than the money that the Fund needs. Furthermore, some of funds raised seem to have been diverted from other sectors such as education and agriculture.⁴³

As far as debt relief is concerned, annual debt service payments from Africa has risen by 39% from 1990 to 1999 (Jubilee Research) and SADC governments as a whole spend more on debt servicing (average of 4.1% of GDP in 2001) than they do on providing basic social services such as health (average of 2.8% of GDP in 2000).⁴⁴ In terms of the total debt stock of poor countries, the amount that has been written off to date is a mere \$36.3 billion; less than one third of the \$110 billion promised in 1999 and not much more than 10% of the conservatively estimated \$300 billion of unpayable debt owed by a group of 53 countries that have been identified as very poor and indebted.⁴⁵

Finally, although the establishment of the Global Fund has generated new resources for the fight against AIDS, TB and Malaria, there are already signs that the amount of money required will not be raised. As of March 2002, the projected annual costs of the Fund were less than the pledges received from donor governments and corporations,⁴⁶ and the money promised by the donors at the end of this year is \$1,371m less than the money that the Fund needs. Improvements in debt relief and ODA could form a core set of issues around which the global health community can rally and highlight the fundamental need to address the underlying global economic and political determinants of poverty, social justice and health.

2.2 The regional and national context

At the southern Africa level, the breadth and depth of poverty leaves governments and societies with immensely difficult resource allocation and public policy choices. From the narrow perspective of treatment for AIDS, it means that treatment and care for HIV/AIDS would be unaffordable to most individuals and households. In Malawi, the cost of ART is approximately twice the average monthly per capita income. Even if medicines are free, the cost of accessing treatment can be considerable. In one setting in Malawi where all public health facilities are within 6 km of the population and where care is provided free-of-charge at the point of delivery, it was found that that on average, patients spent US\$13 and lost up to 22 days work accessing a TB diagnosis. For the non-poor this was equivalent to 124% of their total monthly income. For the poor this amounted to 248% of monthly income or 584% after food expenditure.⁴⁷

Furthermore, in southern Africa where the social and development needs outstrip the basket of resources available, HIV/AIDS is but one humanitarian and development priority. In the recent past, more than 14 million people have been at risk of starvation in Zimbabwe, Zambia, Lesotho, Swaziland, Malawi and Mozambique.⁴⁸ Resources are also required to meet the unmet needs of education and nutrition; roads and irrigation systems; local agricultural systems; and industrial and technological development to compete in the global market.

Because of the relationship between HIV/AIDS, the broader economy and the other sectors of development, it is hard to tease out the relative cost-benefit and cost-effectiveness of HIV/AIDS interventions compared to other interventions. For example, treatment programmes designed to keep people healthy and productive may be seen equally as a key intervention for the agricultural and education sectors.

On the other hand, various non-health sector interventions can have a considerable impact on the health of people living with AIDS. It is argued, for example, that nutrition plays a critical role in both the prevention and progression of infectious diseases.⁴⁹ Another example of the value of placing clinical interventions within a broader context has been with the promotion of formula feeding as an intervention to reduce vertical transmission. Failure to balance the benefits of formula feeding against its dangers – when there is a lack of access to clean water and to resources required to purchase, prepare and store formula milk safely – can result in an intervention that benefits the well-resourced strata of society but harms the poor.

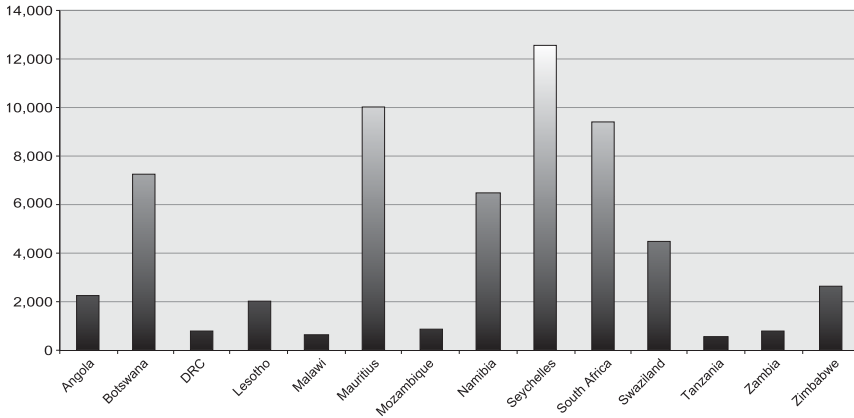
However, in the current global context of insufficient levels of development assistance, economic stagnation and limited public sector capacity to implement a wide array of social sector programmes, there is a danger that the focus on treatment for HIV/AIDS could divert attention away from other equally important issues. For example, in spite of the significant inter-relationship between HIV/AIDS, nutrition and poverty, the tendency has been to emphasise clinical and behavioural interventions targeting individuals, rather than interventions aimed at the more upstream determinants of vulnerability to infection (and capacity to benefit from treatment), such as household food security.⁵⁰ In southern Africa last year, there was a decline in the number of requests for donor assistance on food security interventions as well as a decline in the promotion of the baby-friendly hospital initiative.⁵¹ An explanation offered for this is that political and administrative attention has been diverted away from household food security towards HIV/AIDS.⁵²

The over-emphasis on treatment at the expense of other development needs may represent both 'over-medicalisation' of the HIV/AIDS epidemic, and a reflection of the difficulty of instituting a broader, multi-sectoral approach that deals simultaneously with the socio-economic and political determinants of health and poverty. Those poor countries that have succeeded in achieving good health outcomes highlight the importance of synergistic, multi-sectoral action and the value of comprehensive, as opposed to selective, approaches.^{53,54} These approaches are also important from an equity perspective as more often than not, the poor are unable to benefit from isolated interventions (even when they have access to them), when they face multiple deprivations and barriers to meeting their basic needs.

2.3 Inequities at the regional level

Socio-economic inequity also exists between countries within the region. Whilst most countries in southern Africa are poor, there is a 25-fold difference between the richest and poorest (see Figure 4).

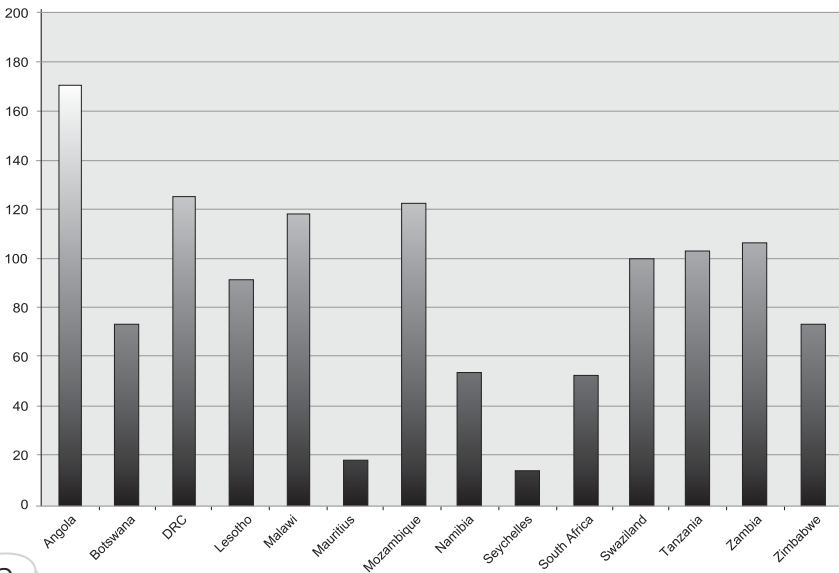
Figure 4: Per capita GDP of SADC countries, 2000



Source: UNDP, Human Development Report 2002

There is also a considerable degree of variation in health status and life expectancy within the region (See Figures 5 and 6).

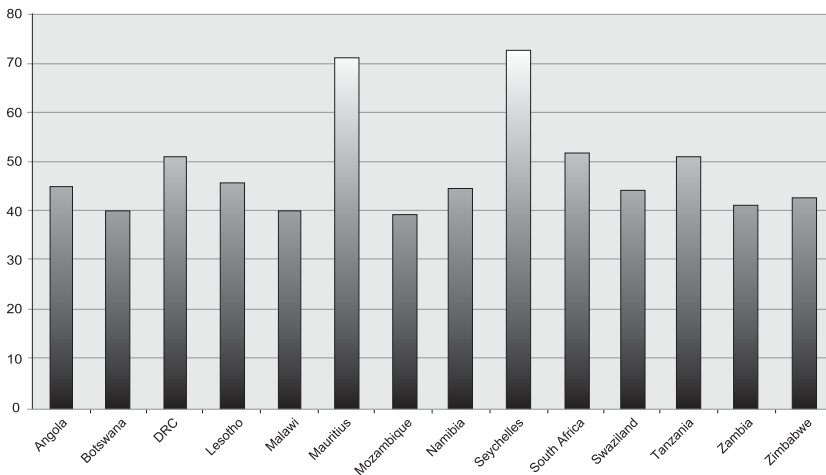
Figure 5: IMR of SADC countries, 2000



Source: UNDP, Human Development Report 2002



Figure 6: Life expectancy of SADC countries, 2000



Source: UNDP, Human Development Report 2002

There is also a large variation in the level of health expenditure (see Table 3), with up to six-fold differences in health expenditure per capita across the region. The variation in health systems capacity is particularly marked with respect to health personnel. For example, South Africa has approximately 400 doctors per 100,000 people, nearly four times higher than the next SADC country (Mauritius), and significantly higher than the regional average of less than 20 doctors per 100,000 people.

When total per capita health expenditure is assessed against the AIDS patient load, there is no obvious correlation. Some countries with a high AIDS burden, such as South Africa and Botswana, have relatively high levels of total healthcare expenditure (Table 3). However, for countries like Zambia, Tanzania, Malawi and Mozambique, a very low level of per capita health expenditure accompanies a high prevalence.

Table 3: Healthcare expenditure and ARV treatment in southern African countries 2000

	Total per capita health expenditure (PPP \$US) 2000	Estimated number of people requiring ARV treatment
Angola	52	24,000
Botswana	358	26,000
DRC	-	120,000
Lesotho	100	25,000
Malawi	38	80,000
Mauritius	315	Neg.
Mozambique	30	60,000
Namibia	366	13,000
Seychelles	749	Neg.
South Africa	663	360,000
Swaziland	195	12,000
Tanzania	27	140,000
Zambia	49	120,000
Zimbabwe	170	200,000

Source: UNDP Human Development Report 2003, sourced from WHO

The inequities between SADC countries suggest the need for a regional response to development and the HIV/AIDS epidemic. The existence of a Southern African Development Community to promote development and economic growth and to alleviate poverty is already one step in that direction. The process of regional integration to evolve common or complementary political values, systems and institutions provides a foundation for interventions to enhance regional solidarity and equity. SADC leaders have endorsed an integrated regional HIV/AIDS policy and strategy that includes a commitment to harmonising policies and legislation relating to HIV, coordinating resources in the region and creating mechanisms for the bulk purchase of medicines and the manufacturing of generic drugs.⁵⁵

The promotion of equitable access to care and treatment for HIV/AIDS within the region will, however, require more than just common policies and a pooling of resources. It would also require a preferential distribution of the available resources to the poorer countries of the region. One example of an intervention to promote equity at a regional level has been the decision of South Africa to prevent the in-flow and migration of scarce health personnel from the rest of sub-Saharan Africa so as to avoid worsening the inequitable distribution of health personnel staff in the region. As far as the donor community is concerned, the significant socio-economic and health inequities that exist within the region should lead to a more strategic targeting of aid allocations to those countries in greatest need.

Finally, inequities also exist *within* countries. As Table 4 indicates, in none of the SADC countries shown did the poorest 20% of the population share more than 7% of the total national income/consumption. In Namibia, Lesotho and South Africa, the poorest 20% of the population consumed 2% or less of the total national income.



Inequalities exist across race, geographical area and gender. In South Africa, of the 65% of the population who live below the poverty line, almost all are black⁵⁶ and 72% of the poor live in rural areas. Females have lower access to education and lower literacy rates in most SADC countries (see Table 4). These wider social determinants of health imply that interventions outside of the health sector need to complement those within the health sector if equitable access to treatment is to be sustained.

Table 4: Selected indicators on economic and social inequality, SADC Region

	Share of poorest 20% in national income or consumption	Richest 10% to poorest 10%	GINI index	Ratio of girls to boys in primary education 2000–01	Ratio of girls to boys in tertiary education 2000–01	Ratio of literate females to males 2001
Angola	Not estimated	-	-	0.88	0.64	-
Botswana	2.2%	77.6	63.0	0.99	0.89	1.09
DRC	Not estimated	-	-	0.9	-	0.86
Lesotho	1.4%	117.8	56.0	1.02	1.74	1.19
Malawi	4.9%	22.7	50.3	0.96	0.38	0.76
Mozambique	6.5%	12.5	39.6	0.77	0.79	0.63
Namibia	1.4%	128.8	70.7	1.0	1.23	1.04
Seychelles	Not estimated	-	-	0.97	-	-
South Africa	2%	33.6	59.3	0.94	1.24	1.0
Swaziland	2.7%	49.7	60.9	0.95	0.88	1.02
Tanzania	6.8%	10.8	38.2	1.0	0.31	0.95
Zambia	3.3%	36.6	52.6	0.93	0.46	0.95
Zimbabwe	4.6%	22.0	56.8	0.97	0.6	0.97

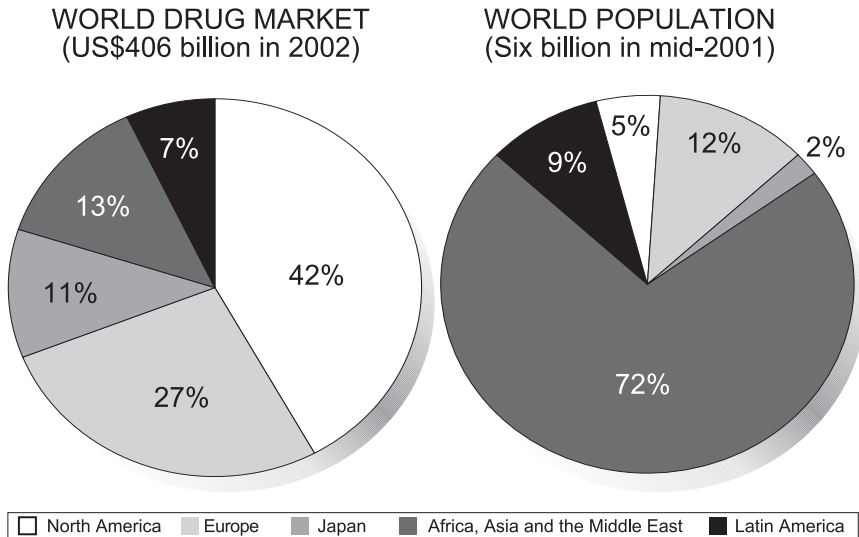
Source: UNDP 2003

3. Medicines – patents, profits and affordability

While cheap medicines for antiretroviral and opportunistic infection treatment will not by themselves provide equitable access to HIV/AIDS care and treatment, the issue of drug pricing has become an important litmus test of the global community's commitment to a fair and humanitarian response to HIV/AIDS. The profits generated by the pharmaceutical industry, the subsidies they receive from tax breaks and publicly financed research, their influence on governments and international institutions, and the current inequitable pattern of medicine consumption (see Figure 7) has made pharmaceutical profits and intellectual property rights the focus of treatment campaigns.

Figure 7: The global pattern of pharmaceutical drug consumption

Sources: IMS Health/Population Reference Bureau



In recent months, the struggle to make life-saving medicines affordable for the poor has been fruitful. The price of antiretrovirals has decreased considerably as a result of political, legal and moral pressure and, more significantly, as a result of competition from generic manufacturers. However, medicines will soon all under the rules and regulations of the TRIPS agreement.^{iv} One of the effects of this will be to protect new, patented medicines from generic competition for a period of 20 years.

^{iv} The TRIPS agreement defines the international rules set up to protect intellectual property rights and patents under the auspices of the WTO.

The November 2001 Doha Declaration on the agreement on Trade Related aspects of Intellectual Property Rights (TRIPS) and recent WTO negotiations provide member states with the authority to issue compulsory licenses and import generic medicines in response to public health emergencies. However, certain governments and pharmaceutical companies are pushing for strict limitations on the situations under which countries may be exempt from TRIPS for public health reasons. A review of the US government's bilateral policies on patents and medicines conducted in 2002 found that the US government was using bilateral trade and patent agreements, as well as the threat of sanctions and associated diplomatic pressures to undermine countries that produce generic medicines and/or consider importing them.⁵⁷ The review concluded that the US government was 'heavily influenced by the narrow commercial interests of the giant pharmaceutical companies seeking to stave off generic competition for lucrative patented drugs'.

A central argument of the pharmaceutical giants is that the current intellectual property rights and patents regimes are necessary to provide a reward system that will promote the innovation and high quality research and development that is required to produce new and better medicines.

Implicit in this argument is the view that not-for-profit and publicly financed mechanisms for developing new drugs or vaccines are inefficient and ineffective. However, there are in fact many examples of innovation and scientific enterprise operating in the not-for-profit sector and built largely on public financing. The Human Genome Project has shown that it is possible to deliver high quality products in the public domain, on academic salaries and with a no-profit motive.⁵⁸ With good management and leadership; clear plans and goals; regular inter-action between funders, managers and technical experts; a competitive atmosphere with peer review; and open data and information exchange, innovative and high-quality scientific developments can flourish for the benefit of all.

In addition, there is a growing recognition that the current regime of patents and intellectual property rights, as it applies to the pharmaceutical industry, has become distorted, inefficient and ineffective. One paper⁵⁹ notes six ways in which patent protection can lead to wasteful and harmful 'rent seeking behaviour' within the pharmaceutical industry:

- ◆ Although patent protection can reduce prices by providing competition, it encourages an over-emphasis on the production of copycat drugs, which add little value to health outcomes because companies are forced to compete with each other. A study commissioned by the Pharmaceutical Manufacturers and Researchers of America said that copycat drugs may account for more than 70% of all research spending.
- ◆ Patent rents provide firms with a large incentive to persuade doctors and patients to use their drugs, and the industry now employs nearly twice as many people in sales and marketing as in research and development. There is also evidence that, on occasion, research findings that suggest the unsafety or inefficacy of products are kept secret.



- ◆ Restricting the dissemination of research findings in order to protect a competitive edge in the market is also a source of inefficiency. The financial incentives to prevent the disclosure of research findings until patents are filed slow down scientific progress.
- ◆ The legal costs associated with securing and enforcing patents, and which can include side payments to generic producers to keep competition out of the market, have become considerable.
- ◆ Political lobbying for the protection and extension of monopolies is also costly. The pharmaceutical industry ranks near the top in campaign contributions, and spends considerable amounts financing 'grassroots' lobbying efforts by people afflicted with specific diseases.
- ◆ The existence of large patent mark-ups provides a strong incentive for the production of unauthorised versions of drugs.

The costs associated with the rent-seeking behaviour of companies seeking to extract larger and larger profit margins results in higher prices and lower levels of access, leading some researchers to conclude that publicly-financed research and development could result in net savings as a result of eliminating the patent-induced inefficiencies and distortions.⁶⁰

There is clearly now a need for a change in how society applies patents and intellectual property, and how the research and development of new medicines and vaccines is financed and priced. The 'Drugs for Neglected Diseases Initiative' and the aims of the International Alliance for Vaccine Initiatives are two other examples of alternative models set up to develop new medicines and vaccines based on cooperation, information sharing and non-profit motives. They are also a response of the industry's failure to develop any effective drugs or vaccines over the last few decades for the diseases affecting millions of people in the South has necessitated such new initiatives.^v

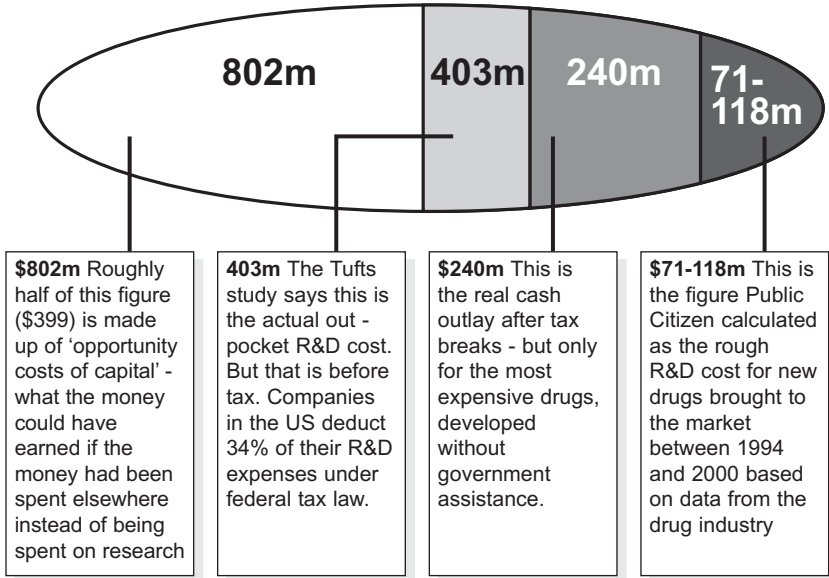
Added to this is the growing concern that the 'rewards' for the development of new pharmaceutical products have become disproportionate and unjustifiable. Remuneration packages for the CEOs of pharmaceuticals of over 11 000 times the average earnings of the world poor have fuelled public discontent. Such discontent is increased by reports of unethical marketing and deliberate inflation of research and development costs, as shown in Figure 8.⁶¹

^v Between 1975 and 1999, 1393 new chemical entities were marketed, of which only 13 for tropical diseases.

Figure 8: Distribution of costs of drug production

How much does it really cost to manufacture a drug?

In November 2001, the Tufts Centre for the Study of Drug development, which is 65% funded by the industry, came out with a figure of \$802. Public Citizen, a consumer organisation, did a detailed analysis of the figure and concluded that it was inflated by about 75%. In addition, none of the 68 drugs Tufts considered had been developed with the help of government money, unlike the case with many other medicines.



Source: Guardian special supplement, March 2003; based on research conducted by Public Citizen

These points have relevance to the use of differential pricing as a solution to making medicines affordable for poor countries. Differential pricing offers a partial solution to the problem of high process in developing countries by getting the consumers in the rich countries to subsidise low prices in poor countries (through higher out-of-pocket payments, insurance premiums or taxes). It does not, however, address the economic inefficiencies of the industry, the excessive profits, the need for a greater role for public and not-for-profit financing of research and development, the regulation of the private sector, nor the authority of developing countries to implement the Doha Declaration and exercise the flexibilities of the TRIPS agreement without restriction.

4. Health systems and expanding access to treatment

The organisation and management of the health system matters when it comes to expanding access to care and treatment for HIV/AIDS. Without a functional health system capable of providing adequately skilled health personnel, regular supplies of medicines, community-based support for people living with AIDS and laboratory services, treatment programmes that are effective and efficient are simply not possible. While it will always be possible to create 'islands' of effective treatment through dedicated 'special' projects, even in the most under-resourced setting, any hope of achieving sustainable and widespread coverage requires a health system that is functional at the country level.

The way in which a health system is organised also affects equity. Rather than helping to reduce the health divide between rich and poor, many health systems aggravate existing disparities by being inequitable themselves. The current focus on expanding access to HIV/AIDS treatment and care in Africa can take one of two routes. It could take the route of least resistance and implement treatment and care interventions on top of existing social and health systems inequities, and result in a worsening of inequities. Alternatively, it could set out to use the impetus to reduce inequities, *preferentially* target the poor and systematically uplift the healthcare infrastructure of the most under-resourced areas in a country.

This, however, requires a broad-vision approach to the expansion of HIV/AIDS care and treatment and a more sustained engagement with various health systems policy issues, such as the way the health system is financed and organised; how health resources (government, donor and private) are distributed; how ministries of health fulfil their governance and stewardship functions; how the public and private sectors interface with each other; and how concepts of equity, redistribution and rights to health are accepted and reflected within the health system.

4.1 The financing and organisation of health systems

One of the biggest issues about the expansion of HIV/AIDS treatment in Africa is the question of who will pay for it – not just for the medicines, but also for the healthcare infrastructure that is required. If the responsibility for financing is left entirely to individual households and individuals, this will lead to poor households being unable to afford care and treatment for their health needs, or accessing care at the expense of meeting other needs.

If finances are collected and pooled at a central level, they can be reallocated and shared out in a way that would support the poor accessing services. If households contribute according to their ability to pay rather than according to their risk of illness or need for healthcare, this would further allow the optimal cross-subsidisation of the poor by the rich and thereby promote equity. The



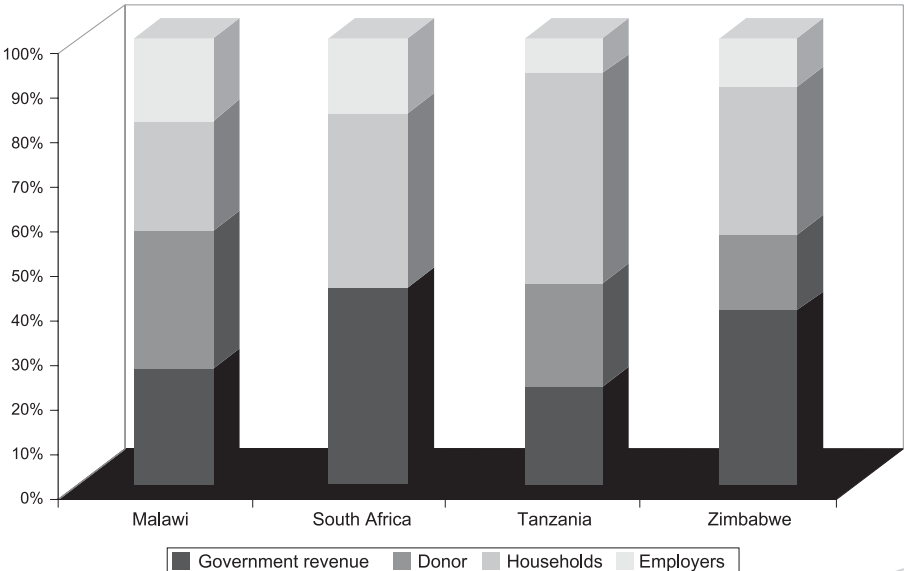
greater the size of the population contributing to a pool of health resources, the greater is the opportunity to cross-subsidise between the healthy and wealthy on the one hand, and the poor and the chronically ill on the other.

The extent to which the rich and healthy should be expected to cross-subsidise care and treatment is fundamental to the issue of equity and is a political and social question that requires further debate. The humanitarian and economic catastrophe of HIV/AIDS points to the need for political, business, religious and civic leaders to mobilise society to accept a need for a greater pooling and sharing of resources to combat the epidemic through the health system.

In order to promote increased access to treatment in a way that is equitable, it is important to understand how healthcare resources are currently financed, pooled and allocated within the broader health system. The World Health Organisation has calculated 'fair financing' scores for countries around the world, and although the report has been criticised, it did reveal that the extent to which healthcare is financed fairly varies considerably within the region. For example, countries such as Angola, Namibia, Zimbabwe and South Africa were found to have much more regressive forms of healthcare financing than Tanzania and Mozambique.⁶³

Figure 9 illustrates the pattern of health financing in four southern African countries and shows the relative contribution of health financing from four main sources: tax, donors, employers and households.

Figure 9: The pattern of health financing in four SADC countries



Financing raised through government taxation and from donors has the biggest potential for the pooling of resources that is required to promote an equitable allocation of health resources. However, raising money from taxation in southern Africa is limited by high unemployment, household poverty and a large informal economy that is not captured by the tax system. As a consequence, government revenue makes a relatively small contribution to an already under-resourced health system in most SADC countries. In South Africa, an improvement in the efficiency of the tax collecting system has resulted in the government being able to raise greater revenue, thereby increasing its capacity to pool public health resources. Looking at how the tax base can be expanded and how it can provide an opportunity for the richer groups of society to contribute progressively towards meeting the health needs of society as a whole, is therefore one route by which the health system can mitigate underlying social and economic disparities.^{vi} Spending a higher share of available public revenue on pro-poor areas of health sector intervention would also make a positive difference.

A second route is to ensure that public health resources are allocated appropriately and equitably. In many SADC countries there are continuing inequities across geographical areas and levels of the health system. For example, in Tanzania urban areas are better served than rural areas and in 2002, government allocation per capita to the regions ranged from US\$0.88 to US\$2.3. In 1995, the ratio of public sector medical officers to the population ranged from 126,518 in Shinyanga region to 6,243 in Dar es Salaam. In Malawi there are also significant urban/rural and regional differences.¹⁶ While the average physician to population ratio is 1:50,000 (compared to the WHO recommendation of 1:12,000), 50% of doctors work in one of the four central hospitals.^{20,16} Plans to devolve revenue generation for health care to local government could further threaten equity in resource allocation.

In many countries, the pattern of health care financing has the effect of segmenting the health system according to socio-economic strata. For example, in South Africa, a relatively small group of the middle and upper class finance a private medical industry through insurance and direct fee-for-service payments, resulting in approximately two-thirds of total health care expenditure being consumed by a socio-economically privileged minority. While social health insurance schemes exist in some countries, such as for civil servants in Tanzania, these are limited to specific subgroups of the population, leaving a health divide between those covered and those not,⁶⁴ with a large share of the population dependant on public and not for profit services.

The private medical insurance industry in South Africa has, for example, not only had a negative effect on equity but has also resulted in rapid cost escalation; poor systems of cross-subsidisation resulting in unaffordable premiums for patients with chronic diseases and for the elderly, the dumping of patients onto the public

^{vi} This would include looking at the relative balance in tax revenue from income and profits and from value added tax. While the former promotes progressive financing (i.e. the bigger the income and profits, the bigger the tax contribution), the latter is more regressive.



sector; and inefficient fee-for-service, supplier-induced demand. The policy of 'individual rating' (with different premiums for different age and risk groups) essentially allowed private insurance companies to "cherry-pick" the lucrative and profitable elements of the health care market whilst leaving the sick and the elderly to be covered, in most instances, by the public or charitable sectors.

This resulted in the government legislating that all private medical schemes could differentiate insurance premiums *only* on the basis of income and the number of dependants, and not on age or the risk of ill-health. In addition, the government made it compulsory for every scheme to cover a defined package of hospital and outpatient services. While these changes will help reduce inequities within the private sector and inhibit the dumping of patients onto the public sector, increasing costs still prevent the bulk of the population from accessing the health resources in the private sector. Other reforms will be required to open up the schemes to a larger low-income market by reducing costs through rational drug prescribing, the generic substitution of brand medicines, more efficient administration and abolishing the fee-for-service reimbursement system to reduce over-servicing.⁶⁵ Central to such reforms will be managing the tension between the role of government to promote the public good and the role of the commercial sector to maximise profits.

The danger of health financing and health delivery systems for the employed and rich segments of society that are segmented from the public or 'charitable' delivery systems of the poor is that 'services for the poor invariably become poor services'. As the influence, aspirations and resources of higher income groups in mobilising and advocating good healthcare become walled off from the needs of the poor, the opportunity for pooling health risks and developing equity-enhancing social solidarity is reduced.^{67,68} The phenomenon of the internal 'brain drain' of doctors from the public sector to the higher-income serving private sector is one example of how a segmented health system reinforces inequity.

While in South Africa a significant proportion of household health expenditure is on insurance premiums, most household expenditure in southern Africa takes the form of community financing schemes or direct fee-for-service payments ('user charges'). User charges in particular have become a more widely used option for financing health care over the past two decades as public sector budgets have declined economic crises and health care reforms have emphasised a greater role for individuals in purchasing of health care. Unless mechanisms to exempt the poor from user charges exist, they can result in untreated morbidity, reduced access to care and long-term impoverishment.⁶⁹ Experience has shown that exemption schemes for the poor frequently do not work.⁷⁰ Reducing the proportion of health financing coming from out-of-pocket payments is thus important to reduce health systems inequities.

Health care reforms have also brought about an increasingly disorganised and pluralistic healthcare market. In many African countries, the weakening of government, reduced public sector budgets and the deterioration of the

public health system has fuelled the growth of a private health sector of variable quality.^{71,72,73} A pluralistic healthcare market of doctors, nurse practitioners, pharmacists, and even grocery shops and street vendors, compete for individual customers who lack the information required to make informed purchasing decisions, as well as the collective bargaining power to ensure ethical provider behaviour. This situation of unregulated 'therapeutic chaos' is likely to lead to further inequity as the poor more commonly use informal and unqualified providers, and be victim to unscrupulous practice.⁷⁴

This private sector market growth has been encouraged by donors, the World Bank and international agreements such as the General Agreement on Trade in Services (GATS),⁷⁵ with corresponding downgrading of the size, authority and value of the public sector. These trends have implications for equity, and thereby for the expansion of HIV/AIDS care and treatment programmes. Increasing private provision and finance of healthcare reduces risk-pooling, minimises redistribution, reinforces divisions between income groups within the health system and accentuates the phenomena of poor care for the poor⁷⁶ (except in those small 'islands of excellence' for the poor which are sustained by NGOs or academic institutions through 'special projects').

Finally, with the exception of South Africa, a significant share of health financing comes from donor aid (in spite of the fact that donor funding is currently inadequate). Together with the cancellation of the current unfair levels of debt, increased and better quality donor funding could help increase the amount of centrally pooled funds and improve the equitable financing of health care. However, the inadequate coordination of a sector-wide approach to health systems support as well as the phenomenon of vertical projects that benefit selected areas and population groups, hampers the effective and equitable use of such resources.

4.2 The culture and ethos of the health system

Given that equity is a social norm, the health system's culture is an important determinant of the extent to which the health system is equitable or fair. Unfortunately there is evidence that poor people frequently face abuse from health professionals and the indiscriminate denial of care. In many instances patients, particularly the poor, receive care that is known by practitioners to be ineffective or unnecessary.^{77,78}

Benefit incidence studies show that public sector health services tend to be preferentially consumed by higher-income groups.⁷⁹ In one study of six sub-Saharan countries, the top income quintile received more than twice as much benefit from government health expenditure as the bottom quintile.⁸⁰ Although part of the reason for this is that higher income groups are better able to overcome the financial and physical barriers to accessing public services, the evidence points to the need for local health providers to pro-actively organise their services in a way that will help overcome the barriers to access for low-income groups. This might involve prioritising community outreach programmes

targeting marginalised communities. In addition, it includes fostering a culture within health systems that does not tolerate abuse and discrimination, and that values equity. In an increasingly privatised and commercialised health sector, and one where the public's capacity for regulation and monitoring is limited, a culture of ethical behaviour may be crucial for the minimisation of exploitative provider behaviour and the phenomenon of over-servicing for financial gain.

It is necessary to bear in mind that the ethical and cultural dimensions of a health system is not merely the aggregation of each individual's motives, values and beliefs. The human constituents of a health system are equally shaped by the values and principles that are embodied at the organisational, systems and societal level. For example, in Zimbabwe and Malawi, a substantial proportion of healthcare to the rural population is provided by non-profit mission hospitals with a reputation for providing effective, equitable and compassionate healthcare that is partially a by-product of their organisational culture and values. In South Africa, the practice of supplier-induced demand and over-servicing is influenced by the profit-making culture of the private sector.

Governments and other institutions of society, such as health professional associations, the media and non-government organisations, need to pro-actively play a role in shaping the cultural values and ethos of the health system in a way that promotes equity, ethical provider behaviour and a commitment to providing healthcare for the public good. This may require times when government uses its political and legal leverage to prohibit unethical and exploitative behaviour on behalf of the public and individual patients. Alternatively, health systems' values may be influenced by community 'activist' groups. For example, the Treatment Action Campaign and AIDS Law Project in South Africa have campaigned and lobbied both the public and private sectors to improve ethical standards of behaviour, especially in relation to PLWAs.

The current emphasis on the internal marketisation of the public sector, private sector management tools and the out-sourcing of healthcare activities also carry implications for the social and cultural landscape of public health systems. For example, it encourages the view of patients as customers or consumers; of healthcare as a commodity rather than a service; and that competition within the health system is a greater virtue than cooperation and collaboration. Furthermore, the emphasis on contractual obligations within the health system changes the nature of important informal interactions and understandings that are vitally important in the provision of social services.⁸¹

On the other hand, although there are many examples of sub-standard public sector care, there are also many examples of good, efficient, effective and non-exploitative public sector healthcare provided in poor settings.^{82,83,84,85,86} The groundswell built around the imperative to improve access to HIV care and treatment could be an opportunity to raise the profile of these success stories and to learn from them.⁸⁷

5. Equity enhancing HIV/AIDS treatment and health care

Section 4 argues that a commitment to expanding HIV/AIDS treatment equitably needs to form *part of* a broader set of social and health system interventions. This section discusses the equity-related policy and operational considerations of treatment programmes and services more specifically. These include:

- balancing a rapid expansion of access to treatment with the need to invest and develop healthcare infrastructure and the broader health system
- optimising the balance between HIV treatment and other healthcare services
- optimising the balance between HIV prevention and treatment
- ensuring that the burden of care and treatment is equitably shared between the commercial for-profit sector and the public and not-for-profit NGO sector
- ensuring that criteria for rationing care and treatment are optimal, transparent and equitable
- promoting a policy and regulatory environment at a country level that balances the need for minimum standards of care and treatment with increasing access.

5.1 Balance a rapid expansion of access to treatment with investments in health systems

The resources required to raise the standard of care in southern Africa is far more than that available. The exceptions to this statement within southern Africa are Seychelles (now no longer a SADC member state) and Mauritius – which have relatively high levels of per capita health expenditure and low rates of HIV prevalence. Even in South Africa, in spite of the high level of per capita expenditure and pockets of excellent health care infrastructure, the capacity of the health care system to translate available resources into effective and equitable health care is questionable because of existing health systems inefficiencies and poor capacity.

The uneven degree of health systems capacity within countries creates an equity dilemma for policy makers which may be best explained by an analogy. If health care is analogous to the building of a house, complex and expensive treatment interventions such as ART would be analogous to the construction of a roof, as it is dependent on various elements of health care infra-structure such as trained and motivated health personnel, a pharmaceutical logistics system, and functional laboratories (the foundations and walls of a house).

Those parts of the health system that are analogous to houses with roofs, are typically found serving an elite and fortunate section of society. However, in many parts of southern Africa, the health system amounts to no more than a patch of ground without even a foundation, let alone a set of walls. Access

to HIV treatment is submerged under a broader set of more fundamental needs such as the availability of a functional clinic with regular supplies of antibiotics, or the availability of a labour ward capable of managing an obstructed labour, or even the existence of a doctor within a 50km radius.

In such a situation, efforts to provide roofs for everyone without the necessary foundations could result in poor outcomes, inefficiencies and wasted resources. It could also accentuate inequity if attention is only directed at those who can benefit, or if 'roof building' diverts attention and resources away from plans to build the foundations and walls of the health service, as illustrated by the following quote from South Africa:

'In South Africa, the resources provided for primary care range from around R30 per capita in the worst resourced districts to around R300 in the best resourced districts. Paradoxically there is generally an inverse relationship between health need and resources provided. Districts with the greatest social, economic and health problems have the poorest infrastructure and the lowest level of resource provision. ARVs introduced in a selective way based on the capacity to run programmes and in those districts with the best services, will be given extra resources to run ARVs. This will not only increase inequity directly but also indirectly by attracting scarce human resources. Even if ARVs are introduced everywhere, the likelihood is that there will be good care in some areas and inadequate and sub-standard care in the poorer areas'.⁸⁸

For the poor, an equitable response to expanding HIV/AIDS care and treatment nearly always means putting in place the basics first – building the foundations and a set of walls, and then putting on a roof. However, in the face of an irresistible moral and political force to provide AIDS treatment, the expansion of access to treatment cannot be delayed until everyone has the capacity to benefit. Rather, it is vital to capitalise on the current level of political will to increase access to ART in poor countries in a way that catalyses the broader development of the healthcare infrastructure and the strengthening of basic health services in poorly-served areas.

This calls for plans that will use the additional resources and commitment to expand HIV/AIDS treatment as a lever for developing the broader health system. For example, the managerial skills needed to procure and manage antiretroviral drugs through a logistics system can be used to improve the supply of drugs for other health conditions, and the clinical skills required to diagnose and treat opportunistic infections can be transferred to other clinical areas.

One way to ensure that that this potential synergy is taken advantage of, would be to avoid always taking the easier route of initially providing ART in the 'comfort zone' of academic hospitals and the main urban areas. Instead, by initiating HIV care and treatment in the 'difficult' areas from the very outset, there would have to be a focussed on simultaneous focus on the development of the required healthcare infrastructure, thereby helping to reduce disparities in basic health care.

However, in most countries there is a gravitation towards initiating treatment services in academic and urban centres. At the very least, such plans should guarantee that the expansion of treatment programmes in the urban facilities will not result in a drawing away of resources from the already under-resourced rural and poorer regions *and* ensure that the clinical and programme management skills that are developed through additional resources for ART, will be deployed to build capacity in the rest of the health system.

Further, there is an argument that treatment programmes should be initiated in areas that are currently under-resourced to instigate the development of health care infrastructure in the most deprived areas. Not only would this be fair to currently marginalised groups, there are also questions as to whether roll-outs and trickle-downs from well-resourced areas to deprived areas will ever take place. The *absolute lack of resources* in most southern African countries suggests that this is unlikely. In Malawi, the absolute lack of doctors and nurses may make it either impossible to achieve the initial targets for ART coverage, or that they will be reached at the expense of other areas of healthcare.

Although successful ART programmes in under-served and rural areas have been shown through numerous projects around the world, what remains unanswered is how these successful projects can be replicated on a widescale without the additional resources, external technical support, commitment and enthusiasm provided through academic and non-government support institutions. In Malawi, Medecins Sans Frontieres have implemented a well-designed district-based comprehensive HIV programme in partnership with the local public sector institutions. However, the project budget is in excess of \$1.2 million per annum and has involved the availability of highly qualified technical staff that are in short supply in the rest of the country. Even with this degree of additional financial and human resource support, the district will require further funding to meet the district's HIV/AIDS needs (including prevention interventions). While the project has shown that with good management, public health leadership, technical expertise, and dedicated district health staff, it is possible to implement a comprehensive district-based HIV/AIDS programme, it also indicates that significant levels of financial and human resource investments are required.

Another concern is associated with the rapid timeframes. The comparative advantage of NGOs is that they are able to set up projects and programmes quickly, compared to the public sector which is more bureaucratic and which is also responsible for a wider range of responsibilities and services. Furthermore, because they are not constrained by civil service remuneration policies and human resource regulations, employment in the NGO sector can be made to be more attractive than the public sector. In countries with scarce health resources, the rapid expansion of ART through non-government institutions may result in the depletion of staff from the public sector, thus setting up a vicious cycle of declining public sector capacity and greater reliance on NGOs for the delivery of healthcare services.⁸⁹

A sub-optimal consideration of broader health systems issues is also suggested by the lack of integration between HIV/AIDS plans and programmes with broader health systems changes, such as the devolution of healthcare in Malawi and Tanzania. The high premium placed on achieving rapid coverage, could therefore be coming at the expense of a broader health systems approach.^{90,91}

There are also valid questions about the on-going availability of external financial support to sustain the planned expansion of ART in many countries. In the light of this, there is an argument that targeting the under-resourced areas could result in more long-term benefits if there were a simultaneous commitment to . If ART services are not sustainable, at least the investment in basic healthcare structure could continue to have benefits in terms of improving the capacity to deliver other PHC services. The seriousness sustainability of funding directed at expanding access to ART is especially important in southern Africa where many countries have a poor economic outlook and little prospect of replacing donor assistance with public revenue. The financial support being received from the Global Fund in Malawi, for example, should not be considered as seed money or catalyst money, but as an on-going and indefinite line item of its health budget.

5.2 Balance HIV treatment with other healthcare services

Many government and non-government health facilities are expected to provide a comprehensive range of PHC services, including important preventative services and public health interventions such as childhood immunisations, growth monitoring and promotion; ante-natal care; DOTS for TB; and condom promotion. However, evidence indicates that the current capacity is inadequate to provide these PHC services. For childhood immunisations (considered to be a good indicator of the quality of basic primary healthcare) only two SADC countries (Mauritius and Mozambique) have reached the target of 80% coverage for measles vaccination.³² In Malawi, there is evidence that the maternal mortality ratio (also a good indicator of the basic functioning of the health services) has doubled over the past five years to about 1,200 deaths per 100,000 live births.⁹⁰

Adding a complex treatment programme onto services that are poorly functioning with an inadequate resource base will inevitably result in opportunity costs, and possibly in a reduction in the overall quality and effectiveness of health care. Although in some PHC facilities, efficiency gains are possible, in most parts of the region there is simply an *absolute* lack of resources required to render a basic PHC service. Furthermore, efficiency gains that are possible in theory may be hard to achieve under the current context of demotivated and under-valued staff.

PHC rationing often already occurs in a number of unplanned ways. Some services are simply not offered; others are offered on a periodic basis (e.g. antenatal care on certain days of the week); patients may be turned away and told to come back on another day; clinics may run out of medicines; health facilities may operate without properly trained staff; patient waiting times may be so long that they act as a barrier to seeking healthcare; clinics may give preferential access to patients who are 'willing to pay' something; and

curative care takes place at the expense of preventive care. Front-line health workers may also ration their time on the basis of judgements about the likelihood of survival or cure, or the 'moral worth' of different patients.

Introducing ARVs could increase this form of indiscriminate rationing which is likely to affect the poor disproportionately. The extension or introduction of ART must therefore be based on a careful assessment of the existing capacity in each health facility; current patterns of utilisation and coverage for other services; and the displacement effect of ART. Ideally, individual facility assessments would be aggregated at the district or sub-district level so that plans to rationalise the use of available resources can be optimised. While it will not be possible to ensure that everyone has access to a basic package of PHC services, district-level planning based on an assessment of available resources and priority health needs can help to ensure that resources are used optimally.

However, the pressure to deliver ART quickly seems to be resulting in the development of a vertical approach and non-integrated approach. For example, in several countries it has been reported that there is even a lack of coordination between ART and PMTCT plans. This lack of integration could aggravate the effects of ART services unintentionally resulting in undesirable and unwanted opportunity costs at the district and health facility level.

5.3 Balance HIV prevention and treatment

A number of studies reviewing the relative cost-effectiveness of different HIV/AIDS interventions indicate that standard HIV prevention interventions seem to be significantly cheaper than treatment interventions in terms of cost per life year gained.^{92,93,94,95} As a consequence, there is an argument that certain preventive interventions (targeted condom distribution, blood screening, nevirapine for the prevention of mother-to-child transmission and STD treatment) and certain treatment interventions (e.g., co-trimoxazole prophylaxis for patients with HIV) should have first call on new funds for HIV/AIDS in Africa.⁹⁶

However, one needs to carefully examine the data before making policy decisions. For a start, the cost effectiveness of any intervention will vary from one context to another depending on variables such as the price of inputs; HIV prevalence; the quality, efficiency and effectiveness of the healthcare system; and the existing pattern of coverage with effective prevention and treatment interventions. For example, where there is good population coverage with effective prevention interventions, ART becomes relatively more cost-effective.

Secondly, the indirect or knock-on effects of various interventions are rarely considered in cost-effectiveness models. For example, the cost effectiveness of PMTCT programmes is usually measured in terms of their effectiveness in reducing vertical transmission but not in terms of reducing horizontal transmission. Some knock-on effects are not even known. For example, no one knows whether ART programmes will result in a secondary decrease or increase in HIV transmission. Finally, cost-effectiveness rankings are not,

on their own, adequate criteria for making resource allocation decisions. Others include the extent to which the intervention is a public good and associated with important externalities; whether it represents a catastrophic cost; and the extent to which the beneficiaries are poor.⁹⁷

Taking all these different considerations into account therefore requires an in-depth understanding of the context, including assessing the current levels of coverage with effective prevention interventions and the potential effect that treatment expansion will have on prevention. According to UNAIDS, access to proven prevention interventions is limited across the world especially in SSA, and are still not scaled up to levels that would have an adequate impact on the HIV epidemic (See Table 5 below).

Table 5: Percentage of individuals globally at risk with access to key interventions

Condoms during sexual intercourse	42%
STI control	24%
VCT	19%
Harm reduction programmes for injecting drug users	12%
PMTCT	5%

Source: UNAIDS 2002

In Tanzania, PMTCT services are currently available in only a limited number of facilities and at variable levels of quality.⁹⁸ It is envisioned that PMTCT services will only cover all regional hospitals and district hospitals in 2006. Zimbabwe has not come anywhere near implementing an effective HIV prevention response. Deep-seated stigma and fear of discrimination remain major barriers to VCT and behavioural change, and many health facilities do not have the medicines required to treat STIs.⁹⁹ In Botswana, although there is widespread coverage of PMTCT services, the uptake of HIV testing and counselling amongst pregnant women remains relatively low.

Although HIV prevention and treatment should be viewed as synergistic elements of a single continuum of healthcare interventions, government and donor officials still have to make resource-allocation decisions between different elements of a comprehensive HIV/AIDS programme that will optimise cost-effectiveness and equity. The issue has a further equity dimension that needs to be considered. HIV-infected people and the NGOs assisting them represent an increasingly influential political force. Because there are comparatively more HIV/AIDS sufferers who are male, educated and economically-active, HIV care and treatment as a public health issue has a relatively higher 'lobbying power' than, for example, improvements in basic child health and reductions in maternal mortality. In contrast, people at risk of infection are a more disparate and less easily organised group, resulting in more resources being made available for identified sufferers than for potential sufferers in the future.

5.4 Ensure equity in the private-public mix towards meeting the burden of care

Equity demands that society looks at how the burden of disease and the costs of healthcare and treatment are shared. This includes looking at how the cost of treating people living with AIDS is shared between the private and public sectors.

Recently, a number of prominent multinational corporations have announced a commitment to fighting the worldwide HIV/AIDS epidemic. These included some of the largest employers in sub-Saharan Africa, such as Coca Cola and Anglo-American. Many companies have undertaken to invest in workplace HIV prevention programmes or to provide treatment, care and social support to employees with HIV illness or AIDS, with the objective of keeping their employees healthy.

However, there are also signs of a systematic shifting of the burden of AIDS from the private sector to governments, not-for-profit NGOs and households.^{100,101} This manifests itself in pre-employment screening to exclude those with HIV from the workforce, reduced employee benefits, restructured employment contracts, selective retrenchments, and changes in production technologies that substitute capital for labour. In addition, firms are increasingly outsourcing work to independent companies (thereby replacing permanent staff with contract workers) in order to minimise their employee obligations. While this shifting of the burden may be understandable for many African businesses struggling to break even in a hostile global economic environment, it is not appropriate for the larger multinational corporations, some of which have an annual turnover bigger than the GDP of entire countries in southern Africa.

Examples of this burden shift include the illegal pre-employment testing of job applicants and screening of applicants to avoid hiring those with risky lifestyles in Zimbabwe.¹⁰² In Botswana, a company reduced the number of days of sick leave that employees are allowed to accrue and adopted a policy requiring anyone with a negative sick leave balance to accept medical retirement. Between 1997 and 1999, the in-house health insurance provider of one large South African employer reduced its ceiling for HIV-related claims from R100,000 per family to R15,000 per family.¹⁰³ In South Africa, a number of large retirement funds reported taking steps to decrease death and disability benefits, cap contributions, or require employees to pay a larger share of premiums for the same benefits.¹⁰⁴ Several other SA firms reported having restructured their healthcare benefits by shifting more of the cost onto the employees, capping company contributions, and/or reducing benefit levels.¹⁰⁵

These practices reduce the share of the economic cost of providing healthcare to HIV-positive individuals borne by private sector employers.¹⁰⁶ However, because of financial constraints, governments will also be forced to pursue strategies to minimise their share of the cost. While the not-for-profit, charitable sector will be able to absorb some of the burden, in the end, it will mainly be households and extended families that will bear the brunt of the costs. Inevitably, poorer households will suffer disproportionately.

Transferring the costs of HIV/AIDS to government, households and the NGO sector is a rational response by profit-maximising businesses, and is not unexpected. However, if governments intervene and demand too much of the private sector, companies may react by relocating their businesses, hasten the transition to capital-intensive technologies and increase the use of contract workers with minimal employee rights. These are all undesirable outcomes – governments would lose tax revenue, employees would lose jobs and communities would lose investment and commercial activity.

Policy makers in sub-Saharan Africa are therefore confronted with a tricky balancing act of doing everything in their power to foster economic growth and retain and create jobs whilst inducing the private sector to do as much as it can to fight the AIDS epidemic.¹⁰⁷ If governments push too hard on the latter, they risk losing ground on the former. They do this in an environment of high mobility of capital and weak regulatory or advocacy systems – globally and nationally – for ensuring corporate social responsibility, especially for the largest and most powerful companies.

5.5 Ensure transparent and equitable criteria for rationing care and treatment

Although clinical criteria for patient eligibility are well established, even for low resource settings without access to CD4 and viral load tests, the criteria for rationing amongst those who are clinically eligible are less well established. In Malawi the goal to deliver ART to 25–50,000 people over the next five years would still result in at least 150,000 people without access to ART. However, there has not yet been an explicit and frank discussion about rationing and how policies and procedures will be put in place to determine who will and will not receive treatment. Rationing at a local level will be inevitable even within single treatment projects or programmes.

Without clear criteria or an explicit strategy for the rationing of treatment, access to treatment will tend towards reflecting underlying socio-economic inequities and social biases. Ideally, rationing should be based on the achievement of clear public and social goals, and include a pro-active strategy to reduce inequitable barriers to access. For example, ART projects and programmes should determine how they will mitigate inequitable cultural barriers to access, such as female disempowerment. In addition, they need to determine the extent to which patient selection procedures will incorporate elements of community

involvement, as well as the investments required to ensure effective and appropriate community involvement. In some projects, community structures have also been established to ratify and legitimise decisions about patient selection, as well as to act as a buffer to the development of local patronage or even corrupt practices (which would tend to discriminate against the poor).

The use of community structures to assist with patient selection decisions can also be of use in applying quasi-clinical selection criteria. For example, some projects have devised criteria that are considered to be predictors of good adherence to treatment and follow-up. These might include pre-therapeutic evidence of regular clinic attendance and evidence that the patient has taken steps to improve his/her own level of treatment literacy.

Arguments can also be made for targeting certain groups of people rather than individuals. For example, it has been suggested that all mothers accessing PMTCT services be eligible to receive ART. This could act as an inducement for pregnant women to request HIV testing, redress any gender imbalances and potentially reduce the number of HIV orphans. On the other hand, there are concerns that this could result in HIV positive women becoming pregnant in order to access ART. In addition, treating a mother and not her partner could result in women being abused by their partners or their treatment confiscated or shared out with others. Others suggest targeting patients with TB because the treatment adherence regimes that are established for TB medicines can be easily converted to support ART adherence.

A second way in which population groups are 'selected' for eligibility is by limiting the availability of services geographically. Those who are unable or unwilling to travel or relocate geographically would thereby be excluded from access to treatment. As argued earlier, the choice to initiate treatment programmes in the urban areas will effectively discriminate against rural populations.

Finally, a third form of targeting population groups is in relation to certain occupational groups. For example, in some countries there have been suggestions that health workers, teachers and agricultural workers are targeted for preferential access because of their importance to society more broadly. The challenge of targeting occupational groups is that it would imply the capacity to provide treatment services across a wide geographical area. If health workers are identified as a group that should be targeted for preferential access to treatment, but services are only available in urban facilities, this could aggravate the current disparities in the availability of health personnel between rural and urban areas.

What is important about the establishment of selection criteria is the removal of primary responsibility from front-line health providers and the creation of transparency and clarity on an issue that could potentially become very difficult. Donors, governments, clinicians and activists need to take a more pro-active stance in stimulating discussion about patient selection criteria and avoiding a default first-come, first-served pattern of patient selection, which is likely to be inequitable and most open to abuse and corruption.

5.6 Promote national policy and regulation that balances minimum standards of care and treatment with increasing access

Within the confined field of HIV/AIDS treatment programmes, the relatively high cost of treatment accompanied by the huge demand and desperate need for treatment will see clinical and financial short-cuts being taken by clinicians and patients alike. Monotherapy, dual-therapy regimes or intermittent and interrupted regimes may end up being common, especially amongst the poor. Such regimes may still impose a large financial burden and hardship upon the patient, and worst still, leave him/her no better off clinically. Evidence of the uncontrolled use of ARVs in the formal and informal private sector in Zimbabwe has already been described, with prescribers and dispensers using 'any ARV that they could lay their hands on', and monotherapy being commonplace.¹⁰⁸

This situation, which is in large part a consequence of a functional and under-resourced healthcare system, is almost certain to lead to the development of ARV resistance. The cheaper generic versions of ARVs that currently exist may become redundant, leaving the people of the poor world susceptible once again to the high price of new and patented medicines. In the rush to quickly expand care and treatment it is important that proper consideration is given to such potential problems further down the line so as not to store up an even worse set of problems to the ones that exist now.

National minimum standards that are enforceable and monitored are therefore essential elements of an equitable care and treatment plan. However, standards that are set too high can act as a barrier to increasing access. In the under-resourced setting there is a need to balance the highest standards of clinical excellence against cost and feasibility. National policies therefore need to take account of the coverage achieved by different types of providers and the quality of care they provide. Donors need to be more active in helping countries to fulfil their regulatory responsibilities of setting prescribing and dispensing rules and ensuring compliance.

6. Conclusions

This report identifies a range of equity-related concerns related to the planned expansion of ART in southern Africa. Central to the discussion is the fact that the human and developmental needs of southern Africans outstrip the resources available to meet these needs. In a context where debt outflows exceed health spending, of widening global inequality and significantly unequal power relations in global trade and finance, the challenge of equitably expanding care and treatment cannot be divorced from the challenge of creating a fairer and more just political economy at the global, regional and country level.

The question of who does and doesn't benefit from these scarce resources is one that inevitably involves the competing demands and interests from different sections of society. An equitable response will therefore require those in charge of resource allocation decisions to find ways of pro-actively representing the interests of the poor and disempowered, and of structuring these within public policy. Furthermore, health systems must increasingly look to the manner in which they mitigate the health effects of social and economic disparities, and represent values that reinforce social solidarity and equity.

The report also raises questions about the design and implementation of treatment programmes. It is argued that unless treatment programmes are carefully and appropriately planned and organised, they may worsen inequities and produce unwanted outcomes. The expansion of treatment requires corresponding investments in health systems, particularly in the health personnel and primary healthcare dimensions of health systems. It would appear that much more could be done to carefully develop context-specific plans for the expansion of treatment to reduce inequities and not aggravate them, to avoid the inappropriate withdrawal of resources from other health interventions or from other parts of the health system. Doing things in a way that will promote integration, sustainability and long-term *local* capacity development will require coordinated strategic planning and strong public health leadership. Donors also have an obligation to ensure that their plans are sustainable and are part of an appropriate long-term strategy to improve healthcare for all.

The danger that quick-fix, vertical and multiple top-down approaches will fragment the already fragile health systems of southern Africa and lead to a worse outcomes in the long-run should not be discounted lightly. It is vital that treatment access is expanded in southern Africa. It is equally critical that appropriate and realistic targets are set, and that this is done in a way that strengthens the health system's capacity to provide ART and comprehensive PHC in a sustainable and equitable manner.



Acknowledgements

Rene Loewenson has been an invaluable support to the finalisation of this paper, both conceptually and editorially. Joe Decosas, Robin Gorna, Catherine Sozi and Mike Rowson also made valuable comments on early drafts. Patricia Morton assisted with some of the graphs and in collecting data on the economic background of certain countries, much of which has not been included in the report. Finally, this paper has benefited from a series of case studies that were commissioned by Equinet and Oxfam and authored by: Jean-Marion Aitken, Lee Berthiaume, Mickey Chopra, Julia Kemp, Adeline Kimambo, Tendayi Kureya, Petrida Ijumba, Antoinette Ntuli, Ashnie Padarath, Sunanda Ray and Innocent Semali.

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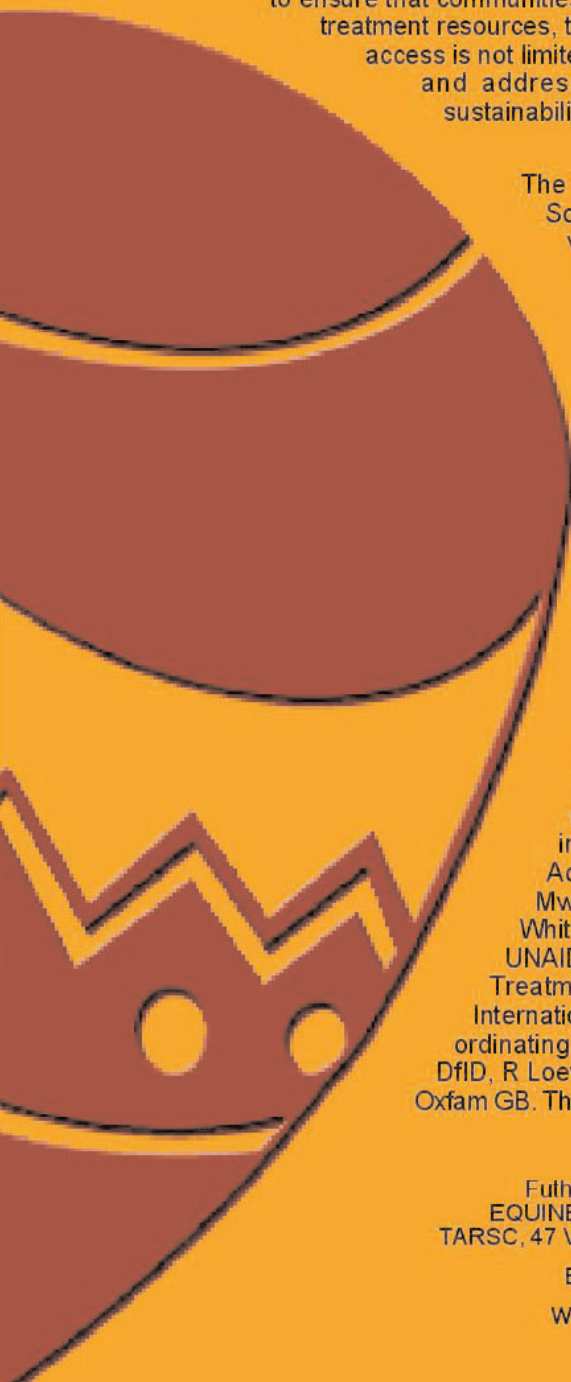
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HIV/AIDS has had a deep impact on health and health equity issues in Southern Africa. Health services in southern Africa have faced a significant challenge to ensure that communities access prevention and care. With new treatment resources, this now includes ensuring that treatment access is not limited to the wealthiest globally or nationally, and addresses wider health system needs for sustainability and equity.

The Regional Network for Equity in Health in Southern Africa (EQUINET) and Oxfam GB with government and civil society partners have initiated a programme of research, policy analysis and intervention on equity in health sector responses to HIV/AIDS. The programme has reviewed policy issues relevant to equitable health care responses to HIV/AIDS in Malawi, South Africa, Tanzania and Zimbabwe and in relation to health personnel and nutrition. The discussion papers in this series arise out of this work. They are also available on the EQUINET and Oxfam Websites.

The work has been co-ordinated at the EQUINET secretariat at Training and Research Support Centre (TARSC). Important analytic and review inputs were made by an international review panel including W Zulu PanAfrican Treatment Activist Movement, D McCoy HST, G Mwaluko TANESA, S Ray SAFAIDS, A Whiteside HEARD University of Natal, C Sozi UNAIDS, R Laing Boston University, N Khumalo, Treatment Action Campaign; J Decosas Plan International, T Balfour SADC Health Sector Co-ordinating Unit, W Bannenberg HERA, R Gorna, DfID, R Loewenson EQUINET and D Mullins/Z Bam Oxfam GB. Their contribution is gratefully acknowledged.

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