**The Role of Financing in Ensuring Access to Essential Drugs**

**External assistance and pharmaceutical financing**

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

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

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

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

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

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

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

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

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

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

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

**I- Identification of the needs**

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

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

**II- Economic environment**

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

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

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

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

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

**III- Financing mechanisms**

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