

Economics and the Backlash against AIDS-Specific Funding

Nicoli Natrass

(University of Cape Town)

Gregg Gonsalves

(Yale)

Paper for the WHO/World Bank/UNAIDS Economics Reference Group

Washington, 21 April 2009

Introduction

This paper discusses the backlash against AIDS-specific funding in favour of general health systems support. We argue that this is not supported by the evidence and is flawed by a failure to recognise the cross-cutting nature of the AIDS response, the powerful role that civil society organisations can play in holding governments to account and the potential for building better health systems on the back of AIDS-specific interventions. We also contend that economists William Easterly (2006) and Mead Over (2008) have contributed to the backlash through their flawed analysis of the rollout of antiretroviral treatment (ART) in developing countries. The paper concludes that economists can contribute most constructively when they inform rather than pre-empt social choice, cast their analytical nets broadly rather than narrowly, and adopt a more political-economic perspective.¹

¹ We would like to thank Alan Whiteside, Sean Archer, Jeremy Seekings, Nathan Geffen, Rebecca Hodes, Jim Levinsohn, Mike Morris, Stephen Lewis and Paula Donovan for their comments on earlier drafts. The errors, omissions and arguments are, of course, our responsibility alone.

The Backlash

The world economy is in a crisis. International credit markets are moribund, global output is shrinking for the first time since the war and an estimated 53 million people will sink into poverty in 2009 (World Bank, 2009).² The need for a global response is widely accepted and the World Bank is requesting that rich countries devote 0.7% of their stimulus packages to a Vulnerability Fund to support hard-hit countries. Most of these countries are in Africa and include all the HIV hyper-epidemic countries.³ Yet in the World Bank's assessment of what needs to be done, the words HIV and AIDS do not appear and no differentiation is made between countries with major health crises and the rest (World Bank, 2009). Whereas the Obama Administration is planning new massive domestic investments (US\$634 million) in health as part of the US stimulus package, the international aid agenda seems rather different.

The indications are that the era of sharply increasing funding for HIV/AIDS is over. There are worrying signals from some donors that foreign aid will contract (World Bank 2009) and it already appears that the US is falling short on its President's Emergency Fund for AIDS Relief (PEPFAR) commitments.⁴ Michel Sidibé, the Executive Director of UNAIDS, is likely to find it an uphill struggle to get the \$17 billion needed from donors, and the \$8 billion needed from affected country governments to meet HIV prevention and ART targets over the next two years.

Sidibé's task has been made harder by the widely-held view that AIDS-specific funding has had more than its fair share of development resources already. Global funding for

² See

<http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:22102337~pagePK:64257043~piPK:437376~theSitePK:4607,00.html> and <http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:22102327~pagePK:64257043~piPK:437376~theSitePK:4607,00.html>

³ The Global Economic Crisis: Assessing Vulnerability with a Poverty Lens. Available on: <http://siteresources.worldbank.org/NEWS/Resources/WBGVulnerableCountriesBrief.pdf>

⁴ According to the Global AIDS Alliance, the Obama budget request for funding for the 150 account (which funds foreign operations including PEPFAR and the Global Fund) in 2009 sets the administration on a path to miss its commitments to PEPFAR and its fair share contribution to the Global Fund (GAA, 2009).

AIDS rose from \$1.6 billion in 2001 to \$10 billion in 2007 and to \$13.7 billion in 2009 (UNAIDS, 2008: 188; Sidibé, 2009: 4). The WHO's Commission on Macroeconomics and Health (CMH, 2001) set the stage for this global response by highlighting the beneficial impact of enhanced funding for health (including AIDS) on economic growth and human development. The initial growth in funding, impetus, boosted significantly in 2003 by the World Health Organisation's '3 by 5' campaign and the creation of the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria, reflected a growing concern about the exceptional impact of AIDS and the socio-economic dangers it posed for the world (UNAIDS 2006: 5). Bilateral efforts, notably the US government's PEPFAR, together with unprecedented contributions from private foundations (notably Gates) and the mobilising efforts of the Clinton Foundation, contributed further to the global response. An estimated four million people in developing countries now owe their lives to this international effort to scale up ART (Sidibé, 2009).

However, even before the global economic crisis, and at the height of the long boom which underpinned the increase in global funding for AIDS, a backlash was evident. The common theme was that the 'AIDS lobby' had garnered an 'unfair' amount of resources, was wasting them on socially dubious expenditure and that the money should rather be allocated to other objectives (see e.g. Garrett, 2007). Some claimed that UNAIDS had deliberately inflated HIV estimates (Chin, 2006; Pisani, 2007). This resulted in high-level calls for a 'major over-haul of the international AIDS response' (Lewis and Donovan, 2007: 532) and defensive responses from UNAIDS and the WHO (De Lay and De Kock, 2007). Others argued that UNAIDS had misdirected its program efforts, although they differed over whether the resources should rather have gone into addressing poverty and

development (Stillwaggon, 2006)⁵ or more aggressively into sexual behaviour change (Epstein 2007, 2008; Pisani 2007; Chin, 2006).⁶

The core of the backlash, however, came from those asserting that AIDS-related funding had undermined health systems in developing countries. This argument, articulated most aggressively (and polemically) by Roger England, holds that the amount of money poured into AIDS was not only unwarranted, but actually harmed health systems. In a series of opinion pieces in the influential *British Medical Journal* England (2007a, 2007b, 2008) he argued that AIDS is not the ‘global catastrophe’ claimed by ‘AIDS exceptionalists’, that donor aid for AIDS is out of proportion to the contribution of AIDS to overall disease burden and that it would have been more cost-effective to put the money into bed nets, immunisations and childhood diseases. He accuses UNAIDS of creating and imposing ‘the biggest vertical programme in history’ which has eroded the public health sector (by diverting human resources), undermined government efficiency (with additional reporting requirements and poorly co-ordinated donor activities) and effectively removed national control over spending priorities. He proposes that UNAIDS be shut down and that money be withheld from the Global Fund until it joins sector-wide basket fund arrangements to combine donor and domestic funding (2008: 1072). In his view, funding for health systems and funding for HIV amounts to a zero-sum game: ‘until we do put HIV in its place, countries will not get the delivery systems they need.’ (2007b: 1073).

⁵ Stillwaggon believes that AIDS is fundamentally a disease of poverty and that the best way of combating AIDS would have been simply to promote economic development and poverty reduction. This argument, however, does not stand up to scrutiny: while poor people certainly find it difficult to cope with HIV (Barnet and Whiteside, 2002; Poku, 2005), it is not the case that HIV specifically targets the poor or poor countries (e.g. Gillespie *et al.* 2007; Mishra *et al.* 2007). There is no evidence to support the claim that channelling AIDS-related international assistance away from AIDS interventions and towards poverty alleviation is an appropriate way of fighting HIV. Nor is there any reason to believe that raising incomes of poor people will necessarily reduce HIV incidence.

⁶ Note that Chin and Epstein’s criticism of UNAIDS, an organization with an uncertain mandate and a constituency of many different UN agencies which pull it in different directions, invests it with a power to affect the epidemic that the organization simply does not have. Failure to reach at-risk populations is less a fault of UNAIDS than it is of member states of the UN itself, particularly in Africa (see e.g. De Waal 2006).

However, contrary to England's assertions, the balance of evidence suggests that AIDS funding has not been excessive nor at the cost of other health programs. WHO funding for HIV is in line with the burden of disease caused by AIDS (De Lay *et al*, 2007; Stuckler *et al*, 2008: 1565) and even though AIDS-specific funding rose from less than 10% of health-related aid in the early 1990s to over a third in 2003, stabilising back down to about a quarter in 2005, the fact that the total health budget quadrupled in real terms over the period meant that *all* categories of health expenditure were able to rise (Shiffman, 2007: 97; Yu *et al*, 2008). AIDS spending thus did not 'crowd out' other health-related spending in any absolute sense.

In addition, if one takes into account the way in which the fight against AIDS has broadened beyond health interventions targeted at HIV, the AIDS response looks less like "the biggest vertical programme in history", and more like the biggest horizontal programme in history.⁷ To begin with, the relationship between AIDS and TB, which in most parts of the world can be considered a co-epidemic, means that AIDS and TB programming should be (and increasingly are) inextricably linked. In fact, the resurgence in interest in TB in the last decade or so has largely arisen because of the AIDS response. The linkage between AIDS and hepatitis C infection in drug users, the link between human papilloma virus and cervical cancer in HIV-positive women and sexually transmitted diseases in general, means that when talking about AIDS, one is talking about a far larger network of infectious diseases, which has required a coordinated response. Moving beyond health, AIDS has involved a multi-sectoral response which has cut across disciplines, ministries and people's lives to involve issues around education, human rights, and industrial practices. AIDS has driven money and resources into a wide set of health and development areas and that this phenomenon has driven a need to manage AIDS and related efforts horizontally in most places, across ministries and programmes.

There is, nevertheless, a basis for some of the backlash concerns, notably: that in some cases AIDS programs may have attracted human resources away from the primary health sector (e.g. in Malawi); that AIDS spending may have crowded out government spending

⁷ Thanks to Stephen Lewis and Paula Donovan for this insight.

in other areas (though this appears to be the case only in countries like Zambia, Mozambique and Uganda facing IMF-imposed fiscal ceilings); that the detailed reporting requirements of foreign donors have increased administrative burdens on already-overburdened service providers; that the cultural values of donors have inappropriately shaped AIDS programs in developing countries; and that greater synergies could have been achieved if HIV interventions had been better co-ordinated between donors and with the public health system (see Yu *et al*, 2008; Shakow, 2006; Epstein, 2007). Even so, the balance of evidence suggests that AIDS programs probably *strengthened* the overall health response in places such as Haiti, Mexico, Lesotho, Ethiopia, Botswana, Rwanda and South Africa (e.g. Walton *et al*, 2004; Koenig *et al*, 2004; Kifle *et al*, 2008; Yu *et al*, 2008; Steinberg, 2007, Piot *et al*, 2009).⁸

It is now widely accepted that more research is needed into the relationship between AIDS programming and overall health systems capacity, and that more effort is required to build better synergies between disease-specific interventions and health systems support⁹ (Ooms *et al*, 2007; Yu *et al*, 2008). But this is hardly news for UNAIDS/WHO which has long stressed the need to address systemic constraints on disease-specific interventions (e.g. WHO 2006; UNAIDS 2007).¹⁰ This is why over a third of Global Fund grants have effectively been allocated for health systems strengthening (Piot *et al*, 2009: 3). *The import of the backlash has not been to put new insights on the table, but rather to fuel a political struggle between donors, development agencies and non-governmental organisations over foreign aid and to empower those wishing to extract resources for general health systems support and to channel that money through country-governments, sidelining civil society organisations in the process.*

This is a serious problem for the innovative AIDS programming which made the roll-out of ART possible in developing countries. The lessons learned from the fight against

⁸ Health Ministers in Lesotho, Mexico and Ethiopia spoke out at the 2008 Mexico International AIDS conference about the benefits of AIDS funding for the strengthening of their health systems.

⁹ There is a 'positive synergies' research effort underway under the auspices of the International Health Partnership which should be reporting by mid 2009.

¹⁰ See also UN General Assembly, Sixtieth session, Agenda item 45: Follow-up to the outcome of the twenty-sixth special session: Implementation of the Declaration of Commitment on HIV/AIDS (available on: http://data.unaids.org/pub/InformationNote/2006/20060324_HLM_GA_A60737_en.pdf)

AIDS, notably the importance of community mobilisation and involving health-care consumers in decision-making, have been drowned by a new discourse of ‘country ownership’ (read ‘government control’) and ‘sector wide approaches’. This has already had a major impact via the International Health Partnership (IHP) of 16 countries (launched in September 2007) which channels donor funding primarily from Europe to developing country governments. Although the founding ‘compact’ is not explicitly hostile to AIDS funding (indeed, AIDS is mentioned and the document is signed by UNAIDS),¹¹ it set the stage for what has become a revisionist agenda where Millennium Development Goals (MDGs) 4 and 5 (to promote maternal and child health) have been pitted against AIDS (MDG 6) and where broader health systems support has been pitted against, rather than built on the success of, AIDS-related interventions.

In September 2008, Gordon Brown (the Prime Minister of the UK and leading member and proponent of the IHP) announced a new initiative with the World Bank: the Task Force for Innovative International Financing for Health Systems. Echoing backlash claims as if they were stylized facts, the document states that MDGs 4 and 5 have been ‘neglected’ relative to AIDS¹² and that priority should be given to sector-wide approaches and general health systems support (TIIFHS, 2009). In a concrete manifestation of the mood of the times, the Global Fund was not included in the Task Force – despite it having developed various innovative funding mechanisms, and despite committing AIDS-related funding to general health systems support as part of country grants.¹³

¹¹ Available on: http://www.internationalhealthpartnership.net/pdf/IHP_compact.pdf

¹² The report claims that in 2006, ‘more than 50% of external funding for health provided directly to countries supported MDG6, leaving only \$2.25 per capita for everything else’ (TIIFHS, 2009: 1). The report goes on to assume that MDGs 4 and 5 have been ‘neglected’. Firstly, the basis for this calculation is unclear and almost certainly fails to account for the fact that a lot of AIDS funding is directly supportive of maternal and child health (notably prevention of mother to child transmission). Secondly, simply contrasting the money for AIDS and the money for other MDGs is insufficient grounds for concluding that the other MDGs have therefore been ‘neglected’ (ibid: 2) because of AIDS.

¹³ The head of the Global Fund and the Global AIDS Vaccine Initiative were reduced to writing a letter to the leaders of the Task Team, (Brown and Zoellick) saying that they were, and continued to be supportive of health systems development and have developed various innovative financing mechanisms. See: <http://www.internationalhealthpartnership.net/pdf/IHP%20Update%2013/Taskforce/london%20meeting/new/GAVI%20and%20GFATM%20letter.pdf>

In some respects we are witnessing a revival of the primary health care agenda articulated most famously in 1978 at Alma Ata.¹⁴ But this appears to be happening without taking on board the key lessons of the intervening decades. The first is that pitting ‘vertical’ against ‘horizontal’ approaches is unhelpful because some health interventions were better suited to vertical programs (e.g. the eradication of small pox) whereas others (such as malaria control) work better when integrated within broader public health initiatives (Mills, 2005). The experience of the AIDS response has also taught us the value of ‘diagonal’ health interventions which integrate disease-specific protocols with broader supply chain management, human resource development and preventative screening.

The second lesson of the failed primary health agenda is that adopting an old-style public administration approach to health planning without being alert to the ‘underlying patterns of accountability and incentives’ which affect implementation (World Bank, 2004: 316) is doomed to failure. The key weakness of the Alma Ata agenda was that insufficient attention was paid to the political-economy of decision-making within government, and to the ways in which institutional and political constraints at country-level undermine the intentions of donors and planners (see e.g. Easterly, 2006). In the absence of easily measurable outputs and clear, politically feasible and sustainable mechanisms to hold government to account, funds for general budget support can all too easily vanish out of the health system, killing priority interventions entirely. As the Zambian experience shows, when donors in the late 1990s switched from supporting the vertical TB programme in favour of an ‘integrated’ approach, the TB program effectively ground to a halt (Bosman, 2000). An ill-considered shift from AIDS-specific to general funding could have the same result.

In sum, we argue that the growing disenchantment with AIDS-related funding does not have a sound evidential basis and the shift towards sector-wide approaches pays insufficient attention to political-economic constraints. It is also our contention that economists have contributed to the backlash through their rhetoric and flawed analysis.

¹⁴ The Alma-Ata Declaration from the 1978 International Conference on Primary Health Care is available on: http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

While a similar critique could be made of other social scientists, we focus in the second part of this paper on economics because it comprises a powerful set of tools for analysing trade-offs and influencing public policy. Indeed, one of us (Nicoli Nattrass) has used these tools to demonstrate the cost-effectiveness of mother to child transmission prevention in South Africa, thereby assisting the Treatment Action Campaign in its successful campaign to change government policy (Nattrass, 2004). But economic modelling, whilst appearing to be ‘technical’ and ‘scientific’, is often built on assumptions which are far from self-evident, or even justified by the facts or social values. The other author of this paper (Gregg Gonsalves) is an international AIDS activist and as such faces the challenge of being typecast as an advocate promoting ‘sectional’ interests. Yet economists rarely consider the ways in which they too may be partisans. Unlike Gregg, whose activist role and identity is clear, the economists we focus on below are also advocates – but sneakily so because they do so under the cloak and authority of economics.

We highlight three types of flawed reasoning:

- 1) Assuming that ‘optimal’ economic estimates/conclusions are necessarily best for society – irrespective of what people may want or think. We call this the ‘omniscient economist fallacy’.
- 2) Assuming that the narrow application of economic techniques is necessarily appropriate to policy questions which may be better (or at least differently) addressed taking into account a broader range of inputs and factors. We call this the ‘myopic economist fallacy’.
- 3) Concluding that because Policy A has faults, Policy B is necessarily better *even though Policy B has not been interrogated to the same level of rigour*. This is a version of the fallacious ‘argument from ignorance’ so we call it the ‘ignorant economist fallacy’.

The rest of the paper discusses two important contributions by economists to the backlash against AIDS-specific funding for ART. The first, by William Easterly (2006) in many

ways shaped the backlash and gave it legitimacy. The second, more recent, intervention by Mead Over (2008), is explicitly political in that it is framed as advice for the new US President, but employs much of the technical and discursive armoury of economics.

Easterly's 'Searchers' and the Political-Economy of ART

Easterly argues in his influential book, *The White Man's Burden*, that 'it is the job of economists to point out trade-offs' and not to make 'utopian' claims about spending 'whatever it takes' (2006: 256). He accuses the WHO 2001 Commission on Macroeconomics and Health (CMH) of such utopianism for recommending an increase in developing country health budgets of 2% of GNP, and in donor country health assistance by 0.1% of their GNP, to improve primary health care, maternal and childhood health and to combat AIDS, malaria and TB (CMH, 2001: 6-12). Easterly complains that the CMH report was 'influential in gaining adherents for AIDS treatment in poor countries' – a bad thing in his opinion because, he believes, more deaths could be prevented if the expanded budget had been allocated to other priorities (*ibid*: 258).

He specifically takes the CMH to task for not confronting trade-offs:

"In an obscure footnote to the report, the commission notes that people often asked it what its priorities would be if only a lower sum were forthcoming, but it says it was "ethically and politically" unable to choose. The most charitable view is that this statement is the commission's strategy to get the money it wants. Otherwise, this refusal to make choices is inexcusable. Public policy is the science of doing the best you can with limited resources – it is a dereliction of duty for professional economists to shrink from confronting trade-offs. Even when you get new resources, you still have to decide where they would be best used" (2006: 256-7).

But consider what the Commission actually said (footnote 24):

"Many have asked the Commission what to do if the donor money is not made available – in essence, how to triage with less money. We are asked to prioritize

millions of readily preventable deaths per year, since we have already narrowed our focus to a small number of conditions that have an enormous social burden and that have low-cost interventions that are at least partially effective. Not only is this kind of triaging ethically and politically beyond our capacity, but it is also exceedingly hard to do in a sensible way. Those who hope for a simple answer, for example to focus on the cheap interventions (immunizations) while putting off the expensive interventions (higher cost prevention programs and antiretroviral therapy needed to fight AIDS) to a later date, misjudge the practical choices we face. The AIDS pandemic will destroy African economic development unless controlled; to fight measles, but not AIDS, will not begin to meet Africa's human and economic needs. It would be wrong to go to the other extreme as well, and let the legitimate need to fight AIDS end up starving the cheaper interventions, so we advocate *both*. Moreover, the infrastructure developed to fight AIDS will support the infrastructure needed to fight measles, especially if strengthening such complementarities is explicitly built into the AIDS control effort. It is vastly more fruitful to design and finance a comprehensive program that addresses many critical health needs than to pick and choose the apparently inexpensive items" (CMH, 2001: 113-4).

Contrary to Easterly's caricature of its argument, the CMH was not shirking its duty to do economic analysis – it was simply taking more factors into account than is the case with standard cost-effectiveness comparisons of isolated interventions. It was also making a serious point about complementarities between building infrastructure for health and combating AIDS, and between health and development outcomes. Easterly ignores, rather than responds to, this broader analysis (thereby committing the 'myopic economist fallacy').

This narrow focus on ranking isolated interventions (money for ART vs. money for health systems) is at the intellectual heart of the backlash against AIDS-specific interventions. By shifting the analysis away from macroeconomic impact/benefits and systemic complementarities, the exceptional impact of AIDS on human development – and the exceptional potential for the AIDS response to address it – is essentially

disregarded. This is a major flaw because the impact of ART extends far beyond the impact on the individual receiving it.

Consider the case of South Africa, where one fifth of the adult population is HIV-positive. In the absence of an ART rollout, life expectancy would have dropped from 61 years in 1996 to 46 by 2010. However, as shown in Figure 1, rolling out Mother to Child Transmission Prevention (MTCTP) and ART from the early 2000s reduced the fall to 56. This was because ART extended lives *and* helped prevent new HIV infections. The preventative impact of ART on HIV incidence is, of course, a product of the design of the demographic model (ASSA2003) – but the assumptions are consistent with (indeed, are based on) a substantial literature demonstrating that ART reduces infectivity and that concerns about large-scale behavioural disinhibition (i.e. people engaging in riskier sex because of ART) are unwarranted (see review of evidence in Nattrass, 2007 and Granich *et al*, 2009). ART has preventative effects, and the combination of prolonging life and preventing new infections has a profound impact on key development indicators like life expectancy. This is what makes AIDS and the AIDS response exceptional in ways that simply do not apply to other diseases.

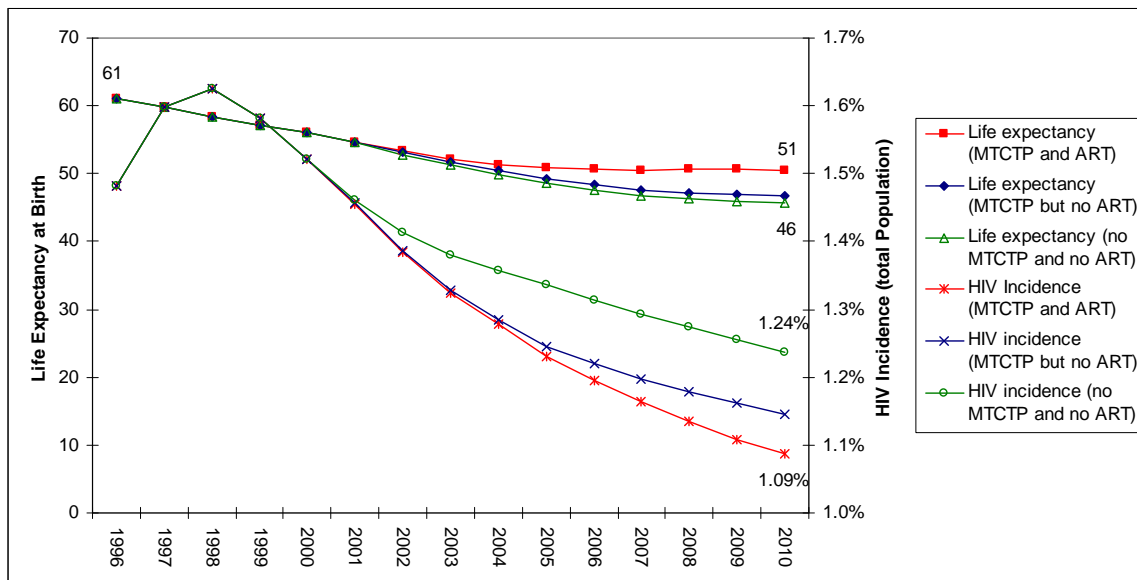


Figure 1: The Impact of the AIDS Response on Life Expectancy and HIV Incidence in South Africa (projections using the ASSA2003 model)

Figure 2 shows the impact of rolling out ART on infant mortality. The top three lines are modelled outcomes (again, using ASSA2003). It shows that rolling out MTCTP substantially reduces infant mortality, but that an ART rollout magnifies the effect (by reducing new adult HIV infections and reducing the risk of transmission from mother to child). The figure also shows the sharp decline in infant mortality which took place in Khayelitsha – an outcome which has been attributed by the City of Cape Town to the AIDS response (Azevedo, 2007). Contrasting funding for AIDS (MDG 6) with money going to MDG 4 (child health) makes no sense in this context. The complementarities are simply too strong to ignore.

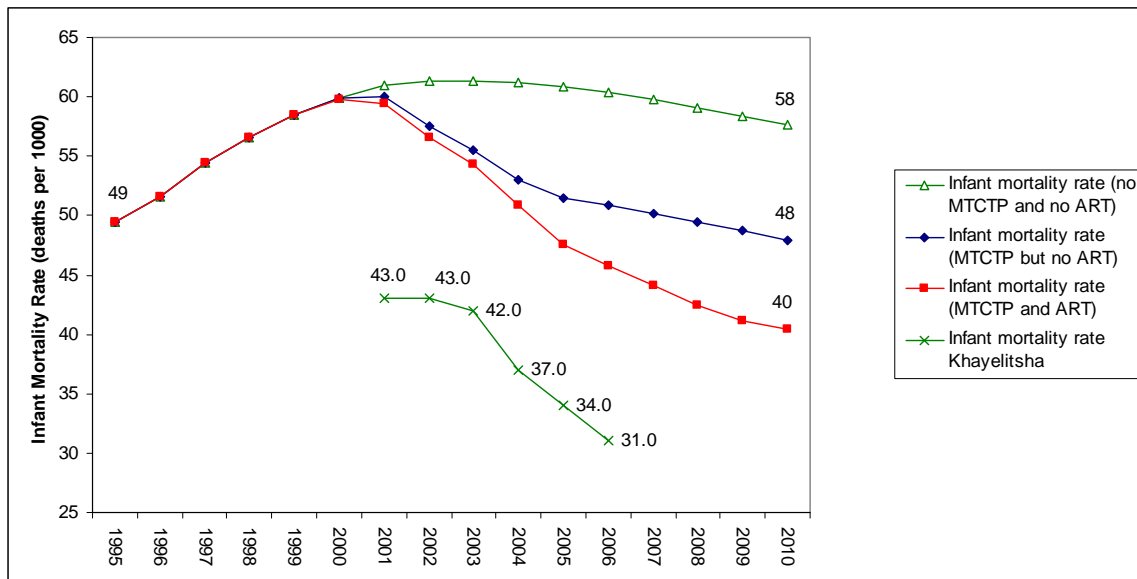


Figure 2: Infant Mortality in South Africa

Equally importantly, one needs to consider the practical challenges of implementing policies and to build that explicitly into the analysis. Easterly's important contribution is to highlight the need to take political and institutional constraints seriously. Our difficulty with his analysis, however, is that he does not take the necessary step of applying his own insights to the issue of AIDS policy.

Economists are taught that tools such as cost-effectiveness and macroeconomic modelling can assist in finding optimal outcomes. But the lessons of public choice theory and political-economy are that such plans can be contested, subverted and misdirected. This can lead to a form of ‘cognitive dissonance’ in which economists veer from the idealistic promotion of optimal outcomes to cynical assessments of why these optimal strategies are unlikely to be implemented effectively, if at all. Easterly’s *The White Man’s Burden*, is a clear example: whilst exhorting economists to do good work, most of the volume rests on his distinction between ‘searchers’, i.e. innovative agents who respond to local conditions, and ‘planners’ in governments and aid agencies who impose their priorities on others, fail to motivate people to carry out their plans and never check to see if the poor actually benefitted from them (2006: 5-6). His frustration with planners is so great that he actually concludes that ‘the right plan is to have no plan’ (2006: 5). But in the next breath he suggests that a *different* plan (to ARVs) should have been drawn up – i.e. involving interventions like bed nets and vaccinations which are ‘simpler for searchers to find ways to administer’ than ART (*ibid*: 260).

Easterly assumes that the interventions he favours are what the poor would prefer (thereby committing the ‘omniscient economist fallacy’). Asking the poor what they want is, of course, not easy. Yet public opinion is important and should not be disregarded simply because it is difficult to measure. There are a range of indicators which suggest that significant numbers of poor people support greater spending on health care and on AIDS specifically. For example, there is substantial support for civil society organizations like the Treatment Action Campaign from poor people¹⁵ and the ‘Afrobarometer’ surveys in Southern Africa routinely show strong preferences for prioritising health spending, including on AIDS (Nattrass, 2004: 63-5). Although Easterly frames ART as an invention of Northern NGOs and ‘planners’, it was the poor in places

¹⁵ The Treatment Action Campaign has branches throughout the country, even in deep rural areas, and can mobilize thousands of people for large marches. Indeed, the constraint on the numbers attending marches is the cost of bussing people to the march.

like Brazil, Thailand and South Africa that underpinned the activism that made the expansion of ART in the developing world possible.¹⁶

More problematically, Easterly provides no analysis of how and why his alternative agenda to ART will be successful. He appears to be committing the ‘ignorant economist fallacy’ by assuming that moving away from a supposedly externally driven and planner oriented ART intervention, will automatically result in a better, ‘searcher driven’ alternative.

Easterly, of course, is correct to highlight the problems of self-interested inefficient bureaucrats. Everyone, including the IHP, would like to see bold and energetic innovators/‘searchers’ taking on the crumbling health systems in developing countries, holding government officials to account and demanding access to basic health care for all. So, the question then becomes: how do we nurture and support such champions? Our answer is that the history of AIDS treatment activism suggests that community organisations and activists can provide the necessary fertile ground and support structures for the change agents we need. Ironically, then, it is precisely because AIDS is an issue that produces cadres of committed and motivated activists in AIDS affected countries (and which are increasingly networked globally) that we have seen – for the first time – concerted community action in support of AIDS treatment *and* better health care. As Yu *et al* noted in a recent assessment of the evidence on the relationship between AIDS spending and health systems:

‘AIDS activists increasingly advocate for the right of access to universal primary health care. They have also changed the dynamics between health care providers and clients, thus helping prepare health systems for the delivery of chronic care, which requires much more give-and-take between care providers and their clients than does the delivery of acute care. Indeed it is the activism for AIDS that has

¹⁶ National leaders of AIDS civil society organisation (like Treatment Action Campaign in South Africa and the AIDS Support Organisation in Uganda) are more likely to be educated and middle class than the typical member. But their effectiveness depends on their ability to mobilise people at grass roots level, and the support they are increasingly getting from new leaders drawn from poorer and more working class backgrounds.

created solidarity about health as a concern for humanity, and as part of the evolving paradigm on globalization' (2008: 6).

In other words, not only does it make sense technically to develop health infrastructure that supports AIDS interventions and other primary health care objectives (as suggested by the CMH), but the political dynamics are such that one is more likely to see developing country governments held to account by activists who are, by the very nature of their illness, seeking both AIDS treatment *and* better health care services. As it is impossible to manage HIV disease effectively without medical personnel, laboratory services, diagnostic tools, a safe and reliable supply of drugs, primary health care facilities and referral hospitals etc, a successful ART rollout is necessarily a 'diagonal' program requiring health care strengthening. As AIDS become a chronic manageable illness with the advent of ART, it becomes more and more a disease of primary care rather than specialist concern, requiring health systems in developing countries to move from an emphasis on acute care to a chronic disease model, and one in which activists for better overall primary healthcare and AIDS treatment have a common stake.

To reiterate the point we made earlier: the need to strengthen health systems as part of the AIDS response has long been recognised by UNAIDS and the Global Fund. Civil society organisations have also been endorsing and carrying through this agenda for some time (for example, the Treatment Action Campaign's mobilization to integrate MTCTP and reproductive health services, and to integrate TB and ART services).¹⁷ It is a myth that AIDS interventions are necessarily stand-alone, interventions that undermine the public health system and that AIDS activists are unconcerned about broader public health. There is clearly a need to strengthen health systems, but we should be doing this in partnership with effective community-lead AIDS organisations and by finding new ways of harnessing the energies of civil society to demand better public health systems and to hold governments to account.

¹⁷ Details of these campaigns can be found on www.tac.org.za

Given the current push from within the IHP for general budgetary support to country governments, the need to ensure accountability and efficiency is now *the* key issue. Yet the IHP has not moved beyond vague calls for ‘good governance’, for the development ‘technically sound’ health strategies and for ‘efficient and effective service delivery arrangements’. The Task Team (on innovative finance) acknowledges that this entails changing the ways in which governments currently deliver health care – but at the same time insists that any transformation and capacity creation must respond to ‘domestically driven reform agendas’ (TIIFHS, 2009: 4). While this could imply broader domestic constituencies than governments, the Task Team effectively endorses national government control (a very UN stance). The fundamental problem with this – as articulated most cogently by Easterly himself – is that the political-economic obstacles to meaningful institutional reform are entirely side-stepped. The Task Team acknowledges the usefulness of holding officials to account, but is silent on how this is best achieved. Working constructively with the ‘AIDS sector’, rather than pitting the general health agenda against the AIDS agenda, is an obvious way forward.

We now turn to a discussion of a more recent contribution by an economist to the backlash: that by Mead Over (2008).

Mead Over: ART as the New Dependency

The rhetoric in the title of Mead Over’s recent article, ‘Prevention Failure: The Ballooning Entitlement Burden of US Global AIDS Treatment Spending and What to Do’ speaks volumes. In contrast to the CMH which regarded ART as an investment in human capital and development, Over depicts PEPFAR as an ‘international transfer program, comparable perhaps to US food assistance’ (2008: 6). In the paper he argues further that the issue is complicated because:

‘these beneficiaries are vitally dependent on continued receipt of AIDS treatment and linked to an international network of articulate AIDS treatment advocates, any withdrawal of treatment funding which threatens their lives will expose the

governments of the US and other donor countries to reputational risk at home and abroad and may threaten US politicians at the ballot box' (*ibid*: 14).

Over is, of course, correct in that transfers from rich countries are keeping poor people alive on ART in developing countries. Our concern here is with his discourse, and the way in which his argument has been constructed to undermine this new (but fragile) form of global solidarity. In the context of US political debate, and in which his piece is an explicit intervention, welfare is a highly charged subject: from Ronald Reagan to Bill Clinton and beyond, 'welfare' has been a dirty word, which conjures up the image of lazy, poor people, usually of African-American descent (e.g. Ronald Reagan's 'welfare queens'), who do not deserve social or economic support and welfare programs have been targeted for 'reform' or elimination (e.g. Clinton's welfare reform initiative). Over's framing of PEPFAR as an example of a 'new welfare program' resonates with this political stance. More problematically, it gives an illusion of coherence to an argument which in many fundamental ways ignores the evidence about ART.

Over worries (understandably) about the fact that the US is responsible for about $\frac{3}{4}$ of the total external AIDS funding burden and hence bares most of the burden of entitlements (*ibid*: 14-5). He reports that depending on the scale up assumptions, the number of people on ART funded by the USA will rise to 5.4 million by 2016 (costing \$4.5 billion – i.e. about a fifth of the USA entire overseas aid budget) or, if one assumes a scale up to 95% coverage, to 15 million (costing \$11.6 billion) in 2016 (*ibid*: 16). This would take up half the overseas aid budget (*ibid*: 17). This, for Over, is highly problematic because:

'Those people whose lives currently are sustained by donor funding of their AIDS treatment may feel that they are entitled to continuation of that treatment, that their donor has entered into an implicit contract to provide life-sustaining drugs in exchange for their conscientious adherence. Furthermore, international and domestic opinion will hold donors responsible for maintaining treatment subsidies to individuals who have already started treatment' (*ibid*: 18).

Note that Over acknowledges that ‘international and domestic opinion’ will probably put pressure on donors to continue treatment. But rather than seeing this as a social preference to be taken seriously, the clear implication of his argument is that some other agenda would be better (another example of the ‘omniscient economist fallacy’).

Over makes a compelling case that commitments to ART funding will reduce the space for other, ‘discretionary’ development funding – but then goes on to make the far less compelling (we would say, bizarre) case that the situation is bad for people on ART as well: ‘From the recipient’s side, the downside of entitlements is dependency. Those who receive entitlements typically become dependent on them, and never more starkly than in the case of expensive life-giving drugs (*ibid*: 18). Of course people are necessarily ‘dependent’ on medication that is keeping them alive but how could this possibly be worse than not being dependent – i.e. being dead? He tries to argue that dependency is bad for developing country governments too (in that it ties them to the US in a ‘post-modern colonial relationship’ (*ibid*: 21)) – but ultimately his argument is one about US political interests.

Over’s solution is two-fold: that the US should back away from bilateral funding of ART and should instead channel support for treatment through multilateral institutions like the Global Fund; and that more funding should be earmarked for HIV prevention rather than treatment. Although he also proposes a set of uncontroversial policies, such as supporting projects to promote adherence, creating a volunteer service to provide human resources for health to developing countries and promoting access to generic drugs, his juxtaposition of treatment versus prevention harks back to the pre-ART rollout days when no research was available to inform the debate. He assumes that ART will probably worsen the epidemic – a stance which ignores the evidence showing that ART has benefits for HIV prevention (see earlier discussion).

Over’s undue pessimism about the impact of ART on HIV prevention is matched by his gloomy take on the impact of the ART rollout on the health systems – an analysis which also fails to take into account any cost-savings and released pressure on the system

resulting from fewer AIDS-related opportunistic infections (*ibid*: 24-5). As studies from Brazil (Levi and Vitória, 2002) and South Africa (Badri *et al*, 2006) have shown, rolling out ART can actually be cost-savings in this respect (ignoring it is an example of the ‘myopic economist fallacy’).

Like Easterly, Over believes that more money should be allocated to HIV prevention (*ibid*: 30). But neither of them mobilise any evidence to support why prevention will be more successful at combating the HIV epidemic than ART. They both commit the ‘ignorant economist fallacy’ by basing their support for prevention on wishful thinking. The HIV prevention they champion in opposition to ART is an ideal theoretical construct, which seems to assume that a powerful, evidence-based armamentarium of interventions with population-level efficacy exists and all we need are the resources and political will to make them available more widely. In fact, except for male circumcision, needle exchange for drug users and a few other interventions among certain risk groups such as sex workers, clear evidence of population level impact of HIV prevention programs is scarce (Potts *et al*, 2009). A case can be made that large shifts in incidence have been due more to spontaneous community mobilization than to public health programming.¹⁸ Indeed, the record for prevention interventions is so disappointing that it is one of the reasons for continued interest in ART as a lynch-pin for HIV prevention (e.g. Granich *et al*, 2009).

Over acknowledges the problem by calling for more research into HIV prevention (*ibid*: 14, 32). However, prevention research is currently largely focused on biomedical interventions, such as vaccines and microbicides, which due to scientific obstacles, may take decades to arrive. The failure of HIV prevention programming is not because of the lack of resources alone but a weak scientific basis for the interventions currently in use; a narrow conception of prevention which emphasizes biomedical approaches; the collapsing of non-biomedical approaches into behavior change models which emphasize individual psychology rather than the structural factors which drive risk; and a failure of HIV prevention proponents to evaluate their own work critically. Framing a case for HIV

¹⁸ See Epstein, 2007 for a discussion of Uganda.

prevention simply as one about resources alone paves the way for continued ‘prevention failure’ which is in no one’s interest and could set back the quest for effective HIV prevention strategies for decades to come.

Conclusion

We have argued that the backlash against AIDS-related funding, especially ART, runs the risk of abandoning the very mechanisms – i.e. a mobilised civil society – which made positive changes to health systems possible in the first place. Roger England’s critique of AIDS is based on an idealized notion of health systems development largely based on theory without confronting the historical or political realities which have hampered the quest for the lofty notions of health for all enshrined in the Alma Ata Declaration.

The pendulum swing back to supporting health systems rather than disease-specific interventions is evident within the IHP (as noted earlier), in recent DfiD statements and actions and in Oxfam UK’s call for a ‘moratorium’ on new vertical health initiatives. AIDS activists in the South, most of whom are strong supporters of primary health care and of building more efficient, accountable and redistributive developmental states, now find themselves in conflict with their erstwhile allies and donors. They recognise that better health systems are key to a sustainable and effective AIDS response – but they are correctly suspicious of calls to divert resources from dedicated programmes to general ‘capacity building’. As Easterly would himself remind us, non-targeted donor support is too easily wasted, diverted or – in the case of countries undergoing IMF adjustment programs – simply used to shore up foreign reserves.

We have come a long way since the idea of development was first mooted by colonial bureaucrats in the 1940s. We have learned that approaching development policy through the lens of public administration rather than political-economy is doomed to failure. Unless development policies can be aligned with the political incentives facing public officials, they will not be implemented successfully – no matter how rationally or

efficiently they are designed by donors and development planners. This is why developmental discourse, unless firmly located within a broader strategy to ensure concrete, desired action on the part of national governments, is in danger of becoming little more than rhetoric. Worse still, it may be a cynical rhetoric because experience has shown us, time and time again, that money for ‘capacity building’ and ‘general budget support’ is all too easily captured and redirected to other ends. Civil society representatives involved in IHP processes are already complaining about how difficult it is to hold governments to account for the way they intend to disburse funds for general health systems support.

The IHP’s commitment to strengthening health systems is commendable but we need a more nuanced approach to combating epidemics like AIDS and TB, indeed other priority areas which cause high morbidity and mortality in the developing world such as childhood diarrhoeal and other infectious diseases. We need to strengthen health systems in ways that acknowledge the need for some verticality for these epidemics and other health issues. A shift which weakens the Global Fund, or broadens its mandate to make it too general (i.e. transform it into a Global Health Fund) could undermine both AIDS interventions and the civil society mobilisation which generated and supported the push for better AIDS interventions and better health care.

AIDS has been remarkably successful in overturning assumptions about international aid and public health interventions in the developing world. Ooms (2008) goes so far as arguing that there has been a ‘paradigm shift’ in the mind of donors away from short-term, emergency-related, aid for health towards greater acceptance of long-term dependence of developing countries on foreign aid flows. But even if this paradigm shift exists for some donors, it is neither universal, nor stable – as the backlash demonstrates clearly. The fact that AIDS funding has grown so fast, to the point where the share of funding for AIDS is broadly in line with the share of AIDS in the global burden of diseases (Stuckler *et al*, 2008: 1565) means that AIDS funding is now particularly vulnerable to the trade-off questions posed by Easterly back in 2006. Unless these are posed squarely and addressed systematically and reasonably, the ‘paradigm shift’ in

favour of AIDS and health will disappear like the morning mist. And for the trade-off questions to be posed in this manner, we need to cut below the moralised discourse about aid flows at aggregate, global, level, to more country-specific analyses of what is actually needed. And in this respect, a critical, political-economy perspective is essential.

So how can economists help? We argue that key research needs include:

1. Country-specific explorations of health and development priorities and whether other economic policies, notably IMF-imposed fiscal ceilings, are acting as impediments to the efficient use of donor funds. Such analysis should take social preferences seriously and acknowledge political-economic constraints.
2. Designing health interventions which will not get hijacked by rent-seekers, subverted by unaccountable bureaucracies or implemented in ways that cannot be monitored by civil society organisations. Put differently, this means designing interventions which can be championed, monitored and implemented by Easterly's innovators/searchers. This entails cost-effectiveness analysis, but in a way that incorporates explicit institutional and political analysis of whether and how 'effective' interventions can be introduced and sustained.
3. Exploring how to harness the power of civil society organisations to assist with the AIDS response and to monitor and hold governments to account. Not all civil society initiatives are as successful as others and there is a clear need for innovative forms of assessment.
4. Exploring how to maximise synergies in health and development spending. The backlash against AIDS funding has created an unhelpful discourse in which disease is pitted against disease, and health against development and 'horizontal' against 'vertical' interventions. This detracts energy and attention away from the crucial – but infinitely more difficult – task of ensuring synergies between AIDS interventions, primary health and development programs. This means pushing economic analysis into new territories and to encourage economists to engage not only with narrow economic variables, but also with institutional design, political process and broader social/economic objectives.

To return to our opening observations about the impact of the global crisis; today's world is one of shrinking budgets and difficult trade-offs. The political and economic environment is becoming harsher by the day for AIDS-related funding. But this does not mean that it will be impossible to keep up the fight against HIV, and it does not mean that the AIDS funding agenda should necessarily cede ground to other financial or developmental priorities. Cost-effectiveness analysis can help shape the public debate about how to prioritize development interventions. But such calculations should inform such debate, not pre-empt it. Real political and institutional dynamics shape what is possible, and social contestation over values and priorities profoundly affects the rank-ordering and design of policies.

References

- Azevedo, V. 2007. City Health: Khayelitsha. Presentation of the City of Cape Town, July.
- Badri, M. *et al.* (2006) Cost-effectiveness of highly active antiretroviral therapy in South Africa. *PLOS Medicine* 3, 1, pp. 1–9.
- Barnett, T. and A. Whiteside. 2002. *AIDS in the 21st Century: Disease and Globalization*, New York: Palgrave, Macmillan.
- Bosman, M. 2000. 'Health sector reform and tuberculosis control: the case of Zambia', in *International Journal of Tuberculosis and Lung Disease*, 4 (7): 606-614.
- Chin, J. 2007. *The AIDS Pandemic: The Collision of Epidemiology with Political Correctness*, Oxford: Radcliffe Publishing.
- Commission on Macroeconomics and Health (CMH). 2001. Macroeconomics and Health: Investing in Health for Economic Development. Report of the Commission on Macroeconomics and Health. Available on <http://www.cid.harvard.edu/archive/cmh/cmhreport.pdf>
- De Lay, P. and K. De Cock. 2007. 'UNAIDS Rejects Claims of Exaggeration and Bias', *Nature*, 448: 251, 19 July.
- De Lay, P, Greener, R. and J Izazola, 2007. Are we spending too much on HIV?, in *British Medical Journal*, 334 (345).
- England, R. 2007a. 'Are we spending too much on HIV?', in *British Medical Journal*, 334 (7589) 344.
- England, R. 2007b. 'The Dangers of Disease-Specific Programs for Developing Countries', in *British Medical Journal*, 335: 565
- England, R. 2008. 'Writing is on the wall for UNAIDS', *The British Medical Journal*, 336: 1072.
- Epstein, H. 2007. *The Invisible Cure: Africa, the West and the Fight against AIDS*, New York: Farrar, Straus and Giroux.
- Epstein, H. (2008). AIDS and the Irrational, *British Medical Journal*, 337: a2638. Available on http://www.bmj.com/cgi/content/full/337/nov25_2/a2638
- Garrett, L. The Challenge of Global Health. *Foreign Affairs*. 2007 ;(January/February):

- Gillespie, S., Kadiyala, S., and R. Greener. 2007. 'Is poverty or wealth driving HIV transmission?', *AIDS*, 21, Supplement 7: s5-s16.
- Global AIDS Alliance (GAA). 2009. Obama budget reverses progress on Global AIDS and Health, March 6. 2009. Available on:
http://aidsalliance.3cdn.net/7a04d58500f1f150e3_7ym6b9eds.pdf
- Granich R., Gilks, C., Dye, C., De Cock, K. and B. Williams. 2009. "Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: a mathematical model", in *The Lancet*, vol. 373, January 3, 2009.
- Kifle, M., Bushen, O. and Lemma, W. 2008. 'Telemedicine and its potential use to strengthen health systems including HIV/AIDS service in Ethiopia: A national assessment', paper presented at the *XVII International AIDS Conference*, Mexico City, August. <http://www.aids2008.org/abstract.aspx?elementId=200720281>
- Koenig, S., Fernet, L., Farmer, P. 2004. Scaling-up HIV Treatment Programmes in Resource-limited Settings: The Rural Haiti Experience, in *AIDS*, vol.18, Supp 3, June: s21-s25.
- Levi, C. and Vitória, M. (2002) Fighting against AIDS: The Brazilian Experience. *AIDS*, 16, pp.2373-2383.
- Lewis, S. and P. Donovan. 2007. 'Time for a Change?', *Nature*, 447: 531-2, May.
- Mills, A. 2005. Mass campaigns versus general health services: what have we learned in 40 years about vertical versus horizontal approaches? In *Bulletin of the World Health Organisation*, April, 2005: 83 (4): 315-6.
- Mishra, V., Bignami-Van Assche, S., Greener, R., Vaessen, M., Hony, R., Ghys, P, Ties Boerma, J., Van Assche, A., Khan, S., and Rutstein, S. (2007). HIV Infection does not disproportionately affect the poorer in Sub-Saharan Africa. *AIDS*, 21 (supplement 7), s17-s28.
- Natrass, N. 2004. *The Moral Economy of AIDS in South Africa*, Cambridge University Press, Cambridge and Cape Town.
- Natrass, N. 2007. "Modelling the relationship between antiretroviral treatment and HIV prevention: Limitations of the Spectrum AIDS Impact Model in a changing policy environment", in *African Journal of AIDS Research*, vol.6, no.2: 129-137.
- Ooms, G., Van Damme, W. And M. Temmerman. 2007. "Medicines without Doctors: Why the Global Fund Must Fund Salaries of Health Workers to Expand AIDS Treatment" in *PLOS Medicine*, April, vol.4 Issue 4.

- Ooms G. 2008. Shifting paradigms: how the fight for 'universal access to AIDS treatment and prevention' supports achieving 'comprehensive primary health care for all'. *Global Health*. 2008 ;411.
- Ooms G, Van Damme W, Baker B, Zeitz P, Schrecker T. 2008. The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems? *Globalization and Health*. 2008 ;4(1):6.
- Over, M. 2008. 'Prevention Failure: The Ballooning Entitlement Burden of US Global AIDS Treatment Spending and What to Do About It', *Centre for Global Development*, Working Paper no.144, April 2008.
- Piot, P., Kazatchkine, M., Dybul, M. and J. Lob-Levyt. 2009. 'AIDS: lessons learnt and myths dispelled', *The Lancet*, published online March 20, 2009. DOI:10.1016/S0140-6736(09)60321-4.
- Potts, M., Halperin, D., Kirby, D., Swidler, A., Marseille, E., Klausner, J., Hearst, N., Wamai, R., Kahn, J. and J. Walsh. 2009. 'Reassessing HIV Prevention;', in *Science*, vol. 320, 9 May: 749-50.
- Shakow, A. 2006. 'Global Fund and World Bank HIV/AIDS Programs: A Comparative Advantage Study", Prepared for the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank HIV/AIDS Program, available at: <http://siteresources.worldbank.org/INTHIVAIDS/Resources/375798-1103037153392/GFWBReportFinalVersion.pdf>
- Shiffman, J. 2007. Has Donor Prioritization of HIV/AIDS Displaced AIDS for other Health Issues?", in *Health Policy and Planning*, 2008: 23: 95-100.
- Sidibé, M. 2009. UNAIDS: Letter to Partners, 10 February, UNAIDS, Geneva
- Steinberg, J. 2007. *The Three Letter Plague*, Jonathan Ball, New York.
- Stillwaggon, E. 2006. *AIDS and the Ecology of Poverty*, Oxford: Oxford University Press.
- Stuckler D, King L, Robinson H, McKee M. 2008. WHO's budgetary allocations and burden of disease: a comparative analysis. *Lancet*. 2008 Nov 1;372(9649):1563-9.
- Taskforce for Innovative International Financing for Health Systems (TIIFHS). 2009. Working Group 1: Constraints and Costs. First Report for the Taskforce, 13 March 2009. Available on: <http://www.internationalhealthpartnership.net/pdf/IHP%20Update%2013/Taskforce/london%20meeting/new/Working%20Group%201%20First%20Report%20090311.pdf>

- UNAIDS. 2006. *2006 UNAIDS Annual Report: Making the Money Work*, Geneva: UNAIDS. Available on:
http://data.unaids.org/pub/Report/2007/2006_unaids_annual_report_en.pdf
- UNAIDS, 2007. *2007 AIDS Epidemic Update*, 19 November, 2007. Available on:
<http://www.unaids.org/en/KnowledgeCentre/HIVData/EpiUpdate/EpiUpdArchive/2007/default.asp>
- UNAIDS, 2008. *Report on the Global AIDS Epidemic*, UNAIDS, Geneva. Available on
www.unaids.org
- Walton, D., Farmer, P., Lambert, W., Leandre, F., Koenig, S. and J. Mukherjee. 2004. 'Integrated HIV Prevention and Care Strengthens Primary Health Care: Lessons from Rural Haiti', in *Journal of Public Health Policy*, vol.25, no.2: 137-158.
<http://www.pih.org/inforesources/Articles/JPHP-LessonsRuralHaiti.pdf>
- World Bank. 2004. *Making services work for poor people: world development report for 2004*, World Bank, Washington.
- World Bank, 2009. *Swimming Against the Tide: How Developing Countries are Coping with the Global Crisis*, March. Available on:
<http://siteresources.worldbank.org/NEWS/Resources/swimmingagainstthetide-march2009.pdf>
- World Health Organisation (WHO). 2006. *Towards Universal Access to 2010: How WHO is strengthening health services to fight HIV/AIDS*, Geneva: WHO.
- Yu D, Souteyrand Y, Banda MA, Kaufman J, Perriens JH. Investment in HIV/AIDS programs: Does it help strengthen health systems in developing countries? *Global Health*. 2008 ;48.