



Will escalating spending on HIV treatment displace funding for treatment of other diseases?

In 2009 news media regularly reported examples of adverse events in a public health system that, many would argue, is in crisis, with widespread work stoppages by overworked doctors, shut-down of critical units in hospitals, shortages of vitally needed supplies and equipment – all of which result in denial of treatment to patients or, at best, inadequate treatment. Newly appointed health minister Dr Aaron Motsoaledi honestly conceded that the public health system faces ‘very serious challenges’.¹

Many of these failures can be attributed to a combination of limited resources and management incompetence, but the burden of HIV/AIDS presents another serious, long-term problem that has contributed to a crumbling public health system. During the recent era of denialism and obfuscation, the government refused to provide life-saving antiretrovirals (ARVs) to hundreds of thousands of people living with HIV/AIDS. In 2003, under intense political pressure, the government began to increase spending on HIV treatment, and in 2009/2010 will spend R11.4 billion² or approximately 13% of the R87 billion allocated to health in the 2009/10 budget.³ In its 2007 HIV Plan, the Department of Health set a goal of treating 80% of those who need ARVs by 2011.⁴

The associated cost estimates are staggering, with one projection putting HIV expenditure over 5 years at US\$6.4 billion (about R52 billion). Overall annual spending on HIV may eventually exceed 20% of the entire national health budget.⁴ Yet even these scaled-up budgets have fallen short: the Deputy Chair of the National AIDS Council reported that the health budget would need an extra R1 billion for ARVs as the number of infected patients needing treatment grows.⁵ The former Minister of Health estimated that 1.5 million people would need ARVs by 2011, and confirmed that South Africa would need sustainable donor help to meet these needs.⁶

While it is encouraging that the government has finally recognised the scope of the problem of treating the nation’s growing HIV population, it is important to note that the drastic growth in HIV treatment spending has taken place in the context of a largely static national health budget.⁷ As the budget for providing treatment to the enormous number of people living with AIDS continues to increase, policy makers must face a troubling question: what is the impact of this massively scaled-up spending on HIV treatment on the public health system? Is it possible that increased funding to meet the government’s 80% goal will displace (or ‘crowd out’) resources critically needed to meet other pressing health priorities? Although this is a disturbing question, commentators elsewhere in the world have raised the issue⁸ and South Africa’s policy makers cannot afford a head-in-the-sand

approach to what is not only a major public health but also a moral and political issue.

Given that many patients needing treatment are in the prime of life, and that compliant treatment with ARVs can result in prolonging good-quality life for many years, we believe that the government’s scaled-up spending on HIV treatment is necessary. In addition, a number of recent studies have shown that providing reduced-price antiretroviral treatment may produce other positive impacts, such as reducing the clinical burden (and associated costs) of patients on ARVs on specific elements of the South African health system,^{9,10} but these positive impacts must be seen in the context of an overall health budget that has failed to meet other critical health needs. Between 1998 and 2006, annual per capita health expenditure has remained virtually constant in real terms, and small increases have not kept pace with the annual inflation rate, population growth, or the greatly increased burden of disease.⁶

As spending for HIV treatment has consumed an ever-larger proportion of the health budget, budgets for other services – including those that support treatment of many other chronic diseases – appear to have remained static. Underfunding of these services has contributed to the public sector’s diminished capacity to treat these diseases, as has occurred elsewhere.¹¹ For example, the burden of delivering HIV services to children has limited the scope of other critical paediatric services such as immunisations and treatment of other chronic conditions.¹² Similarly, because funding for HIV treatment constitutes a substantial portion of international health aid to developing countries, this may have limited the funding available for general and population health needs.¹³

A contentious international debate is raging over whether increased donor and government funding directed specifically to HIV treatment has displaced or ‘crowded out’ funding for other diseases.¹⁴⁻¹⁶ Although it is of concern that, as funding for HIV increases, funding for other diseases appears not to have kept pace with growing needs, we believe that it would be premature to conclude that the government has diverted funding to HIV treatment that would otherwise have been directed to treatment of other diseases. However, if the current budgeting trend continues, and spending targeted at HIV increases substantially in future years while the overall budget grows at less than the rate of medical inflation, this would increase the possibility that HIV treatment spending would eventually produce adverse health outcomes for those who also need, and can benefit from, treatment for other diseases. Policy makers must be alert to this possible outcome, which is one that could be exacerbated as the cost of treating an expanding population of HIV patients over coming years rises drastically,



at the same time as demands for prevention and treatment of other major sources of illness and death continue to increase. It would be medically, politically and morally – and probably legally – unacceptable for expanded treatment of the HIV population to come at an unacceptable cost to patients who bear the burden of other chronic diseases and health conditions and could also benefit significantly from appropriate treatment, especially when more cost-effective HIV prevention options are readily available.¹⁷

If the overall health budget is not increased to take into account the needs of all patient populations, the government will face a seemingly irreconcilable resource allocation problem: how to respond to a moral and political imperative to ramp up HIV spending after years of non-intervention, while at the same time addressing rising demands to fund other equally compelling health priorities. Sadly, the history of the government's resource allocation policy has been one of *ad hoc*, unplanned knee-jerk reaction to each crisis as it arises. Typically, peremptory budget cuts for other health services have been announced at short notice, without prior consultation with key stakeholders, and with the inevitable social, political and legal ramifications.¹⁸

In an attempt to shift private resources to a deteriorating public health sector, the government has proposed the development of a form of National Health Insurance (NHI) administered by a new entity that would raise funds from the taxpayers and users of the private health sector to purchase health care benefits for the population. The Minister of Health has claimed that the NHI would deliver 'universal coverage and better healthcare in one united healthcare system'.¹⁹ Critics have argued that before implementing a policy that could cost up to 20% of South Africa's GDP, the government must first fix the severe problems crippling its public health system, including its failure to use health resources efficiently and distribute them fairly.²⁰ Yet the public health sector currently has no mechanism for fairly, rationally and efficiently allocating health resources among the many diverse patient populations who need and can benefit from treatment.

The perceived *ad hoc*, non-participatory and arbitrary distribution of resources has both undermined the morale of health professionals and challenged the credibility of health administrators. The question is, therefore, not whether we should stop increasing funding for HIV treatment until we can 'make up' funding for other health services. Rather, we must ask: how can the government rationally, efficiently, and in a non-discriminatory fashion allocate its limited health resources among patients who have a bewilderingly wide variety of health needs?

Notwithstanding the proven downstream primary health care benefits of certain HIV programmes,¹⁵ most would agree that limited resources should be fairly and rationally allocated, and that it would not be equitable to aim to treat

100% of patients with one disease while limiting treatment to only 10 - 20% of patients with other diseases that could also be effectively ameliorated. However, it is often impossible to obtain consensus on what is rational and fair when health services must compete for scarce resources. A process for allocating limited medical resources, called 'Accountability for Reasonableness' (A4R), can be of value here.²¹ Four conditions must be satisfied: (i) relevant reasons must be given for priorities being set; (ii) transparency must be ensured by involving representatives of all relevant stakeholders in the decision-making process and publicising the details of the process; (iii) there should be opportunities to appeal any decision; and (iv) leadership should be provided to drive the process and ensure accountability.

Using an adaptation of this process, some South African academic institutions have been increasingly involved with public sector administrators and clinicians to develop ethically acceptable province-wide resource allocation policies for a range of critical health services (e.g. access to intensive care, renal dialysis and transplantation, etc.).²² The initial results are showing promise, and we recommend that this process be extended and adapted for use more centrally within provincial health administrations and at the national level.

While use of A4R would not solve all of the problems that arise when there are insufficient resources to provide the best possible care to all who need it, it would, we believe, help to allocate resources accountably and ethically in the face of mounting health care needs and an inability to do everything that could be done for all. The government has recognised the practical impossibility, given limited resources, of providing ARVs to 100% of those who need them. This is already the case for many life-saving treatments that are withheld when a disease is too advanced for effective and sustained responses to be achieved. Given the need to treat disease populations in a non-discriminatory fashion, disease-specific programmes, such as those for HIV, should be designed with the additional goal of strengthening the public health infrastructure to increase the capacity to provide a decent package of care and treatment to all who need it.²³ As the growing health needs of the nation's HIV population are met, policy makers must ensure that other diseases are not neglected.

Although we believe that it is vitally important for the government to adopt a rational process to accomplish the above goals, a better and more effective resource allocation process will not substitute for adequate funding. Health administrators, clinicians and activists must advocate for increased spending on health care and aggressively seek donor assistance to deal with a humanitarian crisis of monumental proportions caused by our HIV/AIDS pandemic. This will become critically important as spending for HIV inevitably escalates, especially if this targeted funding of HIV treatment is seen as displacing funding that is also needed to build



the health system's capacity to provide decent medical care to all South Africans, many of whom are now inadequately served by a poorly managed, under-resourced health system. The tragedy of grossly inadequate health care for many draws attention to the shortcomings of a global political economy that encourages wastage, corruption and excessive greed that unfortunately also plague many nations.²⁴ Facing unprecedented challenges, our health administrators must adopt new paradigms of thinking and action to cope with rising health demands in context of severely limited resources. Failure to meet these challenges will ensure that the already unacceptably wide gap between rich and poor South Africans will only widen.

Theodore Fleischer

Bioethics Centre
University of Cape Town

Sebastian Kevany

University of California
San Francisco

Solomon R Benatar

Bioethics Centre
University of Cape Town

Corresponding author: T Fleischer (Theodore.Fleischer@uct.ac.za)

References

1. Philip R. Hospital hell. *Sunday Times* 2009; 24 May.
2. Mukotsanjeri V, Mwenge K, Giya G. *HIV and AIDS Analysis of the South African National Budget (2009/10)*. Cape Town: Institute for Democracy in South Africa, 2009.
3. PriceWaterHouse Coopers. Weathering the storm: Budget 2009. http://www.pwc.com/za/eng/pdf/pwc_Budget2009_summary.pdf (accessed 15 June 2009).
4. National Department of Health. HIV & AIDS and STI Strategic Plan for South Africa 2007-2011. National Department of health document. 2007. <http://www.info.gov.za/otherdocs/2007/aidsplan07.pdf> (accessed 27 February 2009).
5. Ndlovu N. Funds running out for ARVs. *Mail & Guardian* 2009; 3 April.
6. Cullinan K. Zim crisis 'A threat to SA AIDS success'. *Cape Times* 2009; 4 April.
7. Blecher M, Thomas S. Health care financing. In: *South African Health Review 2003/04*. Durban: Health Systems Trust, 2005. <http://www.hst.org.za/publications/423> (accessed 27 February 2009).
8. England R. Are we spending too much on HIV? *BMJ* 2007; 334: 344.
9. Badri M. Cost-effectiveness of highly active antiretroviral therapy in South Africa. *PLoS Med* 2006; 3(1): 0048-0056.
10. Nattrass N, Geffen N. The impact of reduced drug prices on the cost-effectiveness of HAART in South Africa. *African Journal of AIDS Research* 2005; 4(1): 65-67.
11. Houston S. Justice and HIV care in Africa – antiretrovirals in perspective. *Journal of the International Association of Physicians in AIDS Care* 2002; 1(2): 46-50.
12. Thom A, Cullinan K. Children 'forgotten' in antiretroviral roll-out. *Cape Times* 2005; 6 June. [See also, Reynolds L, Sanders D. Our children are dying in droves. *Cape Times* 2007; 22 August.]
13. Shiffman J. Has donor prioritization of HIV/AIDS displaced aid for other health issues? *Health Policy Plan* 2008; 23: 95-100.
14. De Lay P, Greener R, Izazola JA. Are we spending too much on HIV? *BMJ* 2007; 334: 345.
15. Yu D, Souteyrand Y, Banda MA, Kaufman J, Perriens JH. Investment in HIV/AIDS programs: Does it help strengthen health systems in developing countries? *Globalization and Health* 2008; doi: 10.1186/144-8603-4-8.
16. Smith A. Experts want African aid funds channelled away from HIV. *The Observer* 2009; 25 October.
17. Marseille E, Hoffman P, Kahn JG. HIV prevention before HAART in Sub-Saharan Africa. *Lancet* 2002; 359: 1851-1856.
18. Cairncross L. Hospitals forced to save money instead of lives. *Cape Times* 2007; 28 May.
19. The Times. State counts on private health facilities. *The Times* 2009; 6 June.
20. Broomberg J. Health reform must not destroy private sector. *Cape Times* 2009; 2 June.
21. Daniels N. Accountability for reasonableness: establishing fair process for priority setting is easier than agreeing on principles. *BMJ* 2000; 321: 1300-1301.
22. Benatar SR. Meeting infinite demands with finite means. *Cape Times* 2008; 24 June.
23. El-Sadr W, Abrams E. Scale-up of HIV care and treatment: Can it transform healthcare services in resource-limited settings? *AIDS* 2007; 21: suppl 5, S65-70.
24. Benatar SR, Gill S, Bakker I. Making progress in global health: the need for new paradigms. *International Affairs* 2009; 85(2): 347-371.