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June 5, 2009

Balancing HIV with other Public Health Priorities

Montego Bay, Jamaica*

Over the past two days there have been several excellent presentations which dealt extensively with the status of the epidemic and provided a most useful exchange of information on the best practices our Region has to offer. These are of critical importance, as given the heterogeneity of the epidemic globally, it makes eminent sense to seek and point out those experiences which may have relevance for countries at similar stages of the epidemic. It is also gratifying to note that this session of ECOSOC to which this meeting will contribute will have a major focus on health as I am sure that this is in recognition of the fact that there can be no substantive discussion about social development without taking account of health. Unfortunately this acceptance of health as an equal development partner is more often observed in the breach.

I wish to frame my remarks more within the context of the third objective of the meeting which is to:

“Take account of the response of Governments to current global and regional economic trends and the likely implications for the fight against HIV in the broader context of regional health and development goals”.

My perspective will be that of the countries and I will not address any balancing that must also concern the multiple agencies and Funds which help to support programs at the country level. Obviously these agencies are also affected by the crisis and must make choices in terms of allocation of their, but partly because I am not privy to the process of decision making, discussion here would not be profitable.

There is the reasonable assumption that the current economic crisis will affect the achievement of the regional health goals and stymie our development agenda, thus we should first examine the impact of this crisis on the health sector and more specifically on the HIV programs. As has been pointed out, poverty levels are likely to increase across the board in the developing world as a result of the crisis, but the impact will likely be more severe in the poorest countries. The World Bank estimates an increase in six million poor people in Latin America and the Caribbean as a result of the regional

* Presented at the ECOSOC's Regional Consultation on HIV, Montego Bay, Jamaica, 5 June 2009

reduction of economic activity. There is not only a decrease in national economic activity, but there is ample evidence of a decrease in Official Development Assistance (ODA) during times of crisis and a marked reduction of remittances.

The need to balance HIV with other Public Health priorities is a constant challenge for governments and their program managers even in good times, but it becomes even more acute in times of crisis. Thus it is relevant to reflect briefly on our experience with economic crises in this region as a backdrop to analysis of the challenge. It is probably a general rule that there is a decline in the social achievement indicators as a result of any economic crisis and the resulting poverty. The crisis of the nineties and the adjustments that accompanied it produced graphic descriptions of the impact especially on the health of children.

The result was extremely variable in the Americas and at the macro level it was difficult to find at least in the short and medium term, the catastrophic changes in child health for example that were seen in other places. We know that child health is a function of private expenditure on health promoting goods, private allocation of time to health promoting activities and public expenditure on health care. Economic shocks will affect child health to the extent that these three components are affected differentially (Ferreira and Schady 2008.) In addition, it is possible that the structures established during periods of prosperity, such as community services and effective systems of primary health care were robust enough to withstand or minimize the effect of the shocks on child health. One of the lessons learned from the crisis of the 1990's was the absolute necessity for the kinds of social insurance to offer some modicum of protection to the most vulnerable groups of the population.

The impact of the current crisis on HIV has been the focus of a major study by the World Bank involving 69 countries in which 3.4 million people are under treatment. In 12 % of the countries there is already an impact on treatment programs. It is anticipated that the crisis will lead to increased mortality and morbidity, greater transmission risks and higher financial costs resulting from interruptions leading to treatment failures. In addition there is likely to be increased burden on the health systems, as there are more HIV related illnesses with possibly a reversal of economic and social gains. The impact will vary according to the severity of the epidemic and is therefore likely to be more acutely felt in Sub-Saharan Africa and the Caribbean. The report stressed that the majority of the countries expected prevention activities to be jeopardized, as there may be the tendency in cases of resource shortage to give preference to established treatment programs at the expense of prevention.

One aspect of prioritizing HIV is not only in relation to other programs, but by paying particular attention to how the current programs are operated. The Report suggested that some of the priority interventions needed within the HIV programs included perhaps the most obvious one of ensuring that the existing funding was optimally effective. This might involve better collaboration among the national and external funders to avoid duplication and careful scrutiny of the budget to re-allocate resources across the prevention and treatment programs. It may be necessary to have

external funding bridge critical funding gaps and pay even greater attention to monitoring the risks of program interruption.

There is one critical point to be made in relation to the impact of crisis on societal allocation of resources. This is not the first and will not be the last crisis to stress the health and other social sectors and a key variable to explain declines in key social achievement indicators in every crisis is the pro-cyclical behavior of social expenditure. It should be stressed with ECOSOC that if we accept the essential public good nature of health then expenditure in this sector should not be procyclical, but rather be countercyclical. Indeed there is a plausible argument that all the social expenditure should be countercyclical. There is no indication that this occurred during the economic crisis of the nineties and none that it is occurring now. In the nineties all sectors were affected similarly and there was no evidence of a differential protection of health or any of the social sectors in this region. Thus our concern is not only for balancing HIV in relation to other health priorities but for arguing that all public health programs, especially those with the highest externalities should be prioritized in moments of economic crisis.

It should not be necessary to have to explain the relation of health to national development goals. It should only be necessary to point out the essential nature of development as not being co terminous with economic growth and health being related to other components of development or other capabilities such as education. The relation between health and the environment, for example, has been known since the time of Hippocrates, but it is becoming clearer that attention to health is critical in the context of one of the great drivers of international action-climate change. The potential impact of climate change on the infectious disease through multiplication of vectors has been described repeatedly, but the effect of climate change is likely to extend to the NCDs as well and I prefer to allude to the co benefits in this area that derive from the efforts to mitigate climate change by reducing carbon emissions. The decrease in consumption of meat for example that will result in a reduction of carbon emission will have a positive effect on cardiovascular disease. There is another co benefit to be derived from the reduction of black carbon emanating from diesel fuel and wood stoves which contributes to chronic pulmonary disease. The impact of climate change on HIV may occur through the increased possibility of transmission as there increased migration of people when their environment deteriorates.

Having framed briefly how the health and other social achievement indicators should be prioritized in time of crisis, it is now relevant to examine how HIV should fare in relation to other problems within public health. The rationale for highlighting HIV, the special nature of the epidemic and the calls for devoting priority attention and funding to the epidemic have gone through several phases. In the initial stages of the epidemic when the data sources were not as robust and the modeling of the epidemic not as accurate, it was fashionable to demand attention because of the potential destruction of our economies and the possibility of breaching our national securities. We know now that the apocalyptic scenario did not occur and the macro economic data do not show at least for our region, the kinds of catastrophic results that we feared. This is not to

minimize however the significant microeconomic effects that can be demonstrated especially at the household level and the attendant social correlates which make it a difficult problem. The destruction or destabilization of families and households bring with them significant economic changes. But there is another aspect of the epidemic which warrants our attention.

The Caribbean Heads of Government have recognized HIV and NCDs as major problems. The Caribbean Commission on Health and Development showed clearly that the three most important health issues with which this region would have to deal were the NCDs, HIV and the health sequelae of injuries and violence. There is a similar picture for Latin America and the Caribbean as a whole where the NCDs now account for 65% of the burden of disease. But the new phenomenon which is engaging us is the possibility of HIV now becoming a chronic disease, thus in some ways changing the priority focus in relation to other diseases. As treatment regimens become more effective and efficient, patients who survive the first few years are experiencing life expectancies similar to those with other noncommunicable diseases and need chronic care.

A major multi center review in several developed countries showed that life expectancy of persons under treatment with HAART increased to about two-thirds of persons who were HIV-negative. A significant and as yet undetermined fraction of the mortality in the HIV positives is due to the same modifiable risk factors that are responsible for NCDs. There is general agreement that the important characteristic is the chronicity of care irrespective of whether the disease is communicable or non communicable, and it is becoming clear that the systems for chronic care will be stretched by having to deal with both the communicable disease of AIDS as well as the noncommunicable diseases such as diabetes. It will be the properly focused primary health care system with its emphasis not only on facility based care but also on community involvement of care which must be the paradigm for addressing adequately the whole range of the chronic diseases irrespective of their origin. Thus in terms of priorities for chronic disease care and the systems that have to be established to provide it, there may be little difference between HIV/AIDS and other chronic diseases.

The Western Asia Ministerial Meeting in Doha, Qatar as a contribution to the debate at ECOSOC in a series of key messages and a formal declaration put the case very forcibly for the developmental consequences of the NCDs. Failure to address what is the major burden of disease in the developing countries as a whole can jeopardize the achievement of most of the MDGs. To the extent that the long term management of patients with HIV becomes similar in a general sense to that for the classical chronic non communicable diseases, I can see considerable identity of focus and argument.

But because of the increasingly chronic nature of HIV/AIDS and the genesis of the disease and its drivers, there is a case for priority attention within public health to the kind of prevention that does not apply with the same cogency in other diseases. We know how to prevent HIV/AIDS. Simply put, it is by prevention of the infection. It is this aspect which merits a higher degree of priority than is being currently assigned. This is critical if for no other reason than that more persons are becoming infected that are

currently being enrolled in ARV therapy and the prospect of an ever increasing pool of persons to be treated is not a pleasant one. We know the effectiveness and cost effectiveness of some of the interventions being promoted for prevention, especially the biomedical ones such as condom use and male circumcision. Priority has to be given to addressing the social drivers of the disease such as stigma and discrimination and more rigorous analysis of the structural and behavioral interventions that form part of what is being called “highly effective prevention therapy”.

Not infrequently questions have been raised about the validity of treating HIV exceptionally and whether indeed there should be priority funding for this disease. There has been debate as to whether the additional funding has served to distort or strengthen the health system, especially of the most severely affected countries. This is a new version of an age-old debate which has gained more notice because of the magnitude of the funding involved. It turns around whether priority attention should be paid to a focused program that deals with one disease or a set of diseases or whether more attention should be paid to strengthening the health systems. Of course the logical and rational answer is that both are necessary and must receive attention. There is no doubt that HIV and the need for universal access have stressed and continue to stress the health systems. But at the same time it is equally patent that health systems in the absence of program represent an abstraction. The most careful analyses of the impact of the large additional funding that has come to countries for HIV programs show that the optimal approach is to enhance program delivery through strengthening of the health systems. Special attention must be paid to improving the health information systems, improving the supply chain system and strengthening the human resources for health.

I have deliberately not discussed the complex process of priority setting in health generally. I have come to appreciate that it involves economic theory as well as considerations of ethics and social justice. There are priority decisions to be made within HIV that turn around cost effectiveness of therapeutic as well as prevention interventions. There is the technical approach which may be based on specific rules that are related to efficiency or equity concerns and there is also the approach which seeks through consultation and debate especially involving multiple stakeholders to arrive at a position deemed to be reasonable. All of this is interesting, but it is not for today!

In sum, I have related the necessity for balancing HIV and public health needs to the economic crisis, emphasizing that since this has not been the first and will not be the last, we should take advantage of the lessons to be learned. I have argued that it is not only necessary to balance HIV against other public health priorities, but the case should be made for countercyclical financing of the social sector including health and obviously HIV. I have pointed out the evolving similarity between HIV/AIDS and the chronic diseases because of the extended and extending life span of patients who are properly treated. There is no need to address health systems concerns and treatment of HIV as being antagonistic and thus needing any balancing. They must be viewed in a complementary fashion and not as either-or considerations.

I trust these observations will be useful in preparing the regional contribution to the ECOSOC deliberations.