

## Editorial: The AIDS crisis, cost-effectiveness and academic activism

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Recent articles by Marseille *et al.* (2002) and Creese *et al.* (2002), published shortly before the International AIDS Conference in Barcelona (7–12 July 2002), provoked an outcry in the AIDS community. Cost-effectiveness analysis (CEA) of HIV/AIDS interventions in sub-Saharan Africa led the authors to conclude that 'prevention is considerably more cost-effective than Highly Active Anti-Retroviral Therapy (HAART)'; and consequently, that 'the relatively meagre resources of the Global Fund, some US\$ 2 billion, should be used for HIV prevention rather than for HAART'. AIDS activists and field practitioners wondered how academics could coldly argue, solely on the basis of cost-effectiveness data, that the better option is not to treat the many people living with AIDS in low-income countries, while HAART so radically changed the lives of AIDS patients in more affluent nations – especially when concerted activism had brought down the price of first-line anti-retroviral drugs from some US\$ 10 000 to 350 per patient per year (Pérez-Casas *et al.* 2001).

Soon the heavyweights joined the chorus. Peter Piot (UNAIDS) stressed that we should invest simultaneously in prevention and care (Piot *et al.* 2002). At the Barcelona conference, Richard Feachem (Global Fund), Gro Harlem Brundtland (WHO) and Jeffrey Sachs voiced their disagreement with the conclusions of the CEA studies. All took unequivocal positions, stating, e.g. that 'The Global Fund will never hire such economists', 'prevention and treatment must go hand in hand', and 'it is wrong to accept that we have to choose between prevention or care, doing both is easily affordable'. All echoed the call of the activists: '10 billion dollars for the Global Fund, now!' and got the blessing of the international health establishment.

Nevertheless, while the arguments against the policy recommendations of Marseille and Creese are compelling, they are open to criticism as not all are equally strong:

(1) the economic data on which the CEA studies are based are weak or incomplete; (2) the authors used CEA to answer the wrong question; and (3) they took an unacceptable shortcut from CEA to policy making.

The empirical data used in the CEA studies are limited and some premises are indeed dubious. One could dismiss them as 'too flimsy economic data' (Goemaere *et al.* 2002), or stress that important externalities were ignored (Piot *et al.* 2002), or insist that HAART will have a positive effect on prevention. However, most arguments along these lines were quite systematically discussed in the original articles. Using sensitivity analysis, Marseille and Creese demonstrate – rather convincingly – the robustness of their conclusion: 'AIDS prevention is more cost-effective than HAART, for spending the US\$ 2 billion of the Global Fund'.

More fundamental criticism addresses the way CEA is being used by them. Their question 'How to maximize health benefit, as measured by DALYs gained per dollar, for the next incremental contribution of donor money to tackle AIDS in Africa?' misses some key points. First, prevention and care concern different people. To target all AIDS resources to those who are not yet affected by the problem would be rather lopsided. Also, why not include in the CEA comparison DALYs to be gained by interventions against other diseases? Results would be very different indeed. Secondly, CEA should not be limited to ranking different interventions, but should help decision-makers to understand the resources required to achieve desired outcomes (Kumaranayake & Walker 2002). Thirdly, Marseille and Creese implicitly accept that the currently inadequate resources for HIV/AIDS in sub-Saharan Africa ('a tiny lifeboat', according to Sachs) will remain so in the future. Their CEA calculation thus leads them to accept a different value for life in rich and poor countries. Gaining an African year of life for US\$ 350

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would be deemed too expensive, while in USA, interventions up to US\$ 50 000 per life year gained are widely considered worthwhile (Kahn & Marseille 2000; Freedberg *et al.* 2001).

Last but not the least, strong reservations are in order when Marseille and Creese jump from their technical conclusion 'HIV prevention is more cost-effective than HAART' to the policy recommendation 'HIV prevention before HAART in sub-Saharan Africa'. The link between CEA – concerned with efficient use of resources – and policy making, which is a far more complex process, is not so simple or straightforward. In OECD countries, HAART was not introduced on the grounds of being cost-effective, but because it prolongs the lives of people living with AIDS by several years, years with a relatively good quality of life. Effective health care for the sick is a basic human need. Ill people need to be treated because it is their right, not because it is cost-effective to do so. Health professionals have a duty to assist individuals and populations in distress. It is one of their strongest ethical imperatives, not a question of economics.

CEA is but one element in policy and priority-setting processes (Kumaranayake & Walker 2002). It can give useful information on efficiency, but utilitarian principles alone are insufficient. They have to be balanced with other values, such as human rights and community preferences (Roberts & Reich 2002), compassion and solidarity (Robertson *et al.* 2002). CEA alone ignores equity, focus on vulnerable groups, poverty reduction and quality of life (Kumaranayake & Walker 2002). Sound and democratic decision-making is not only grounded on technical evidence, but also on ethical principles, respect for and fair representation of the interests of patients, their families and communities.

The reactions of decision-makers on the international health scene in general and of the Global Fund in particular fortunately indicate that allocation of resources for HIV/AIDS control will not be based on narrow CEA alone. They seem to understand that their moral duty is to call for more resources, for more financial solidarity, so that AIDS care, including HAART, can be made globally affordable and accessible. How will history judge public health academics who in the twenty-first century ponder whether to treat millions of people living with AIDS with HAART, an intervention which is feasible and affordable? The AIDS crisis should force us all to take an unequivocal stand: health care for all is a fundamental human right (Conference on 'Health Care for All' 2001) – a right that cannot be undermined by dual North–South standards. CEA can help to shed light in a complex debate, but should not blur

moral argument, or divert from core values. Academics should expose, not accept, the unacceptable. The key question we must ask is not *whether* but *how*: How do we scale up HAART to reach those who need it? How can we organize HIV/AIDS care and prevention in such a way that it strengthens health care systems? How can we ensure that HAART, which indeed is not a magic bullet (Razum & Okoye 2001), enhances prevention? How do we convince the OECD countries to contribute US\$ 10 billion, <0.01% of their collective wealth, to tackle one of the worst epidemics in the history of mankind? How can we bring down even further the cost of HAART for people living with AIDS (Pérez-Casas *et al.* 2001)? How can we make the world a more humane place despite the AIDS crisis? And: How can we contribute to all this through academic activism based on sound research?

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