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Economics and the Backlash against AIDS-Specific Funding

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Economics and the Backlash against AIDS-Specific Funding

Introduction

There is a growing backlash against AIDS-related funding on the grounds that too many resources have been allocated to the AIDS response, especially to antiretroviral treatment (ART). Proponents claim that health systems have been undermined, money wasted and misdirected, and that Africans themselves believe AIDS resources should be allocated elsewhere. We argue that such sweeping generalisations are not supported by the evidence and that the backlash fails 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.[1] The paper also discusses the contributions of economists William Easterly (2006) and Mead Over (2008) to the backlash, arguing 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.

The Backlash

The age of rapidly expanding financial resources to combat AIDS is over. The global economic crisis has cut into the resources available for foreign aid at precisely the moment when more resources are needed to support millions of newly poor people (World Bank, 2009). The US is already falling short on its President's Emergency Fund for AIDS Relief (PEPFAR) commitments (GAA, 2009) and Michel Sidibé, the Executive Director of UNAIDS, will struggle to mobilise the $25 billion needed from donors and 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 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

[1] This part of the paper draws on and expands the argument in Nattrass and Gonsalves (2009).

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, 2007; Pisani, 2008). 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)[2] or more aggressively into sexual behaviour change (Epstein 2007, 2008; Pisani 2008; Chin, 2007).[3]

[2] 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 (Barnett 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.

[3] 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).

The core of the backlash, however, came from those asserting that AIDS-related funding had undermined health systems in developing countries. In a series of opinion pieces in the *British Medical Journal*, Roger England (2007a, 2007b, 2008) 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).

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 has been shown to be in line with the burden of disease caused by AIDS (De Lay *et al*, 2007; Stuckler *et al*, 2008: 1565) – a finding that is supported by more recent analysis of the cross-country relationship between the share of spending on AIDS and the contribution of AIDS to the disease burden (Nattrass and Gonsalves, 2009). As shown in Figure 1, AIDS spending from all sources (domestic and foreign) in 2006/7 as a percentage of total health spending was on average lower than the share of disability adjusted life years (DALYs) lost to AIDS. The simple regression line indicates that a one percentage point increase in the share of AIDS DALYs was accompanied, on average, by an increase of only half a percentage point in the share of AIDS in total health spending. All the hyper epidemic countries of Southern Africa are below the 45˚ line – indicating that the share of AIDS spending is lower than the burden of disease caused by AIDS.

Note also that 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). Thus, although there are cases of AIDS spending crowding out other spending (World Bank Independent Evaluation Report, 2009; WHO MPSCG, 2009), AIDS spending in aggregate did not 'crowd out' other health-related spending.

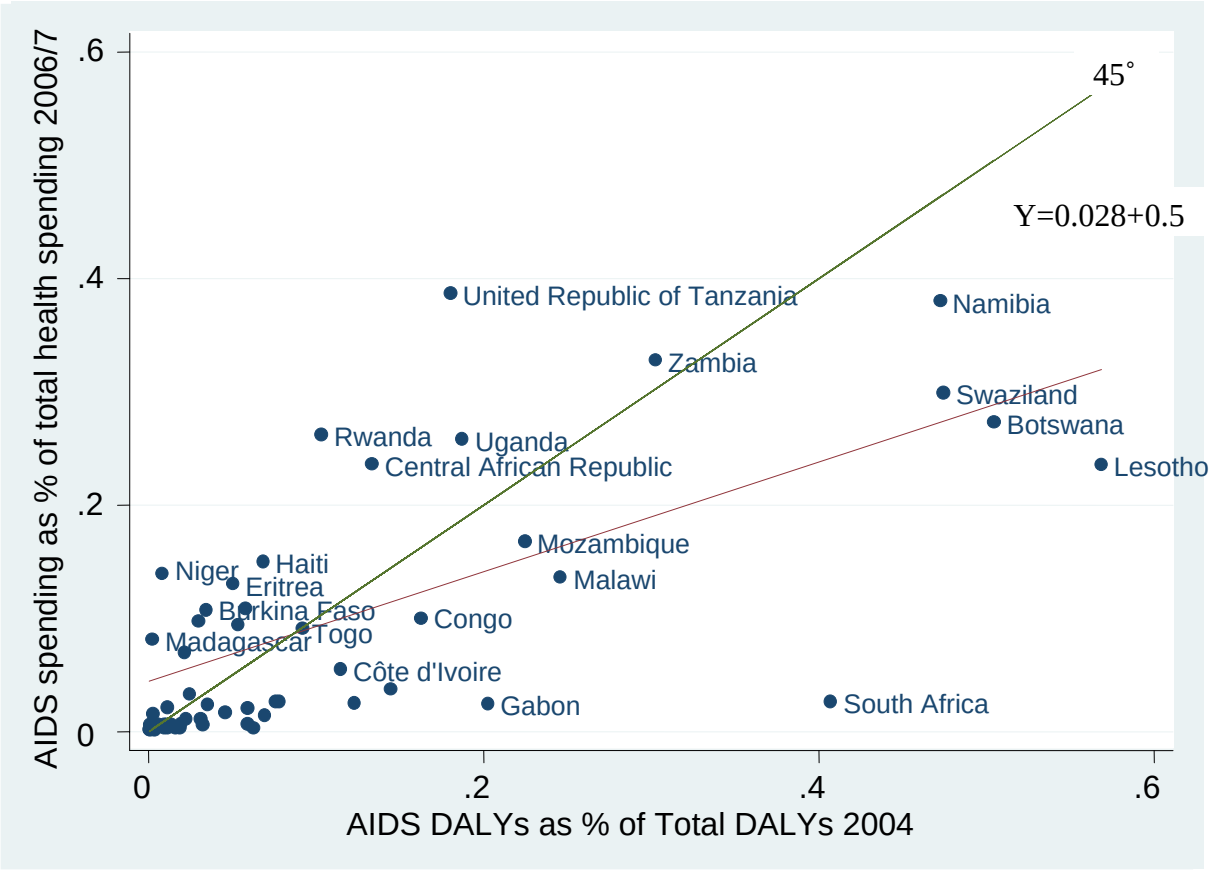

Figure 1: AIDS spending as % of total health spending vs the share of AIDS in the total burden of disease (in Nattrass and Gonsalves, 2009).

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.[4] 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 of 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

[4] Thanks to Stephen Lewis and Paula Donovan for this insight.

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; that AIDS spending may have crowded out government spending 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-over burdened 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; World Bank Independent Evaluation Group, 2009; WHO MPSCG, 2009). Even so, there is substantial evidence indicating that AIDS programs probably *strengthened* the overall health response, especially in places such as Cambodia, 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; Global Fund, 2009; El-Sadr and Abrams, 2007; WHO MPSCG, 2009).[5] And, while 82% of World Bank funded AIDS projects, many of which were conducted as emergency responses in difficult situations, have been deemed unsatisfactory (World Bank Independent Evaluation Group, 2009), 94% of AIDS projects funded by the Global Fund were evaluated as successful (Global Fund, 2009).

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 support[6] (Ooms *et al*, 2007; Yu *et al*, 2008; MPSCG, 2009). 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).[7] This is why over a third of Global Fund grants have effectively been allocated for health systems strengthening (Piot et al, 2009: 3;

[5] 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.

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

[7] 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

Global Fund, 2009). 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 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),[8] 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 stylised facts, the document states that MDGs 4 and 5 have been 'neglected' relative to AIDS[9] 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

[8] Available on: http://www.internationalhealthpartnership.net/pdf/IHP_compact.pdf

[9] 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.

innovative funding mechanisms, and despite committing AIDS-related funding to general health systems support as part of country grants.[10]

In some respects we are witnessing a revival of the primary health care agenda articulated most famously in 1978 at Alma Ata.[11] 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 (Ooms *et al*, 2008).

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

[10] 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

[11] 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

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. 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'.

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 prioritise 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 (immunisations) 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 2, 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)[12] – 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 preventive 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

[12] The ASSA2003 model is the latest available demographic model from the Actuarial Society of South Africa. It is available from: *http://www.actuarialsociety.org.za/Aids_Model-269.aspx*

AIDS and the AIDS response exceptional in ways that simply do not apply to other diseases.

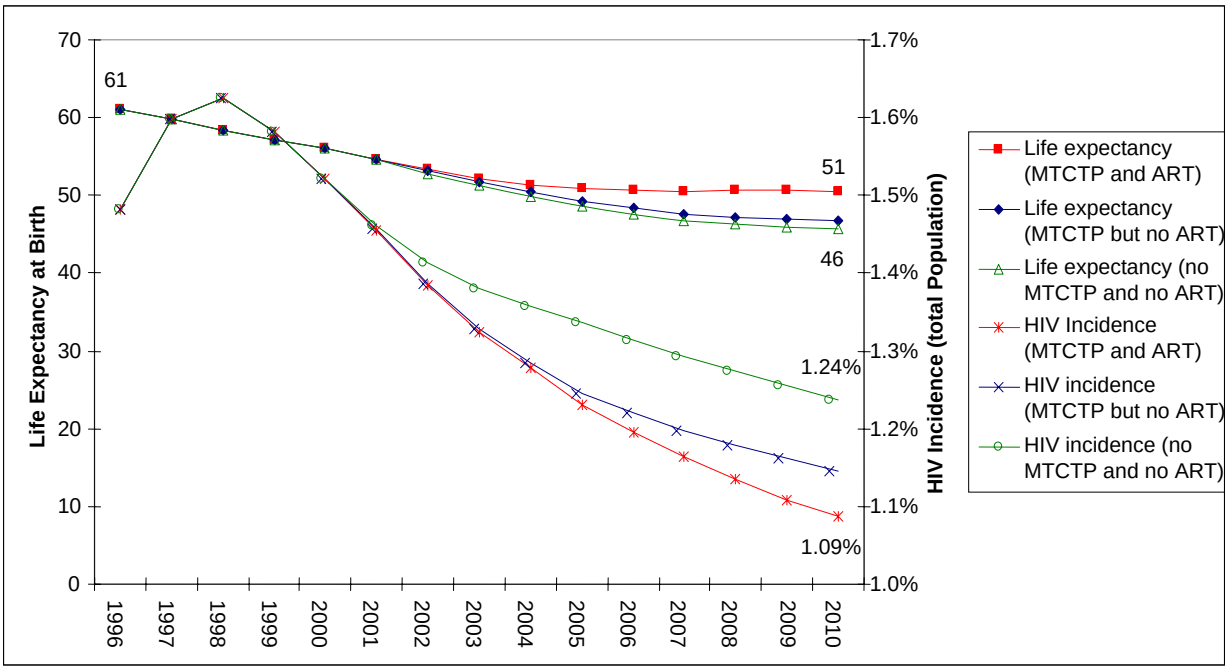

Figure 2: The Impact of the AIDS Response on Life Expectancy and HIV Incidence in South Africa (projections using the ASSA2003 model)

Figure 3 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.

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.

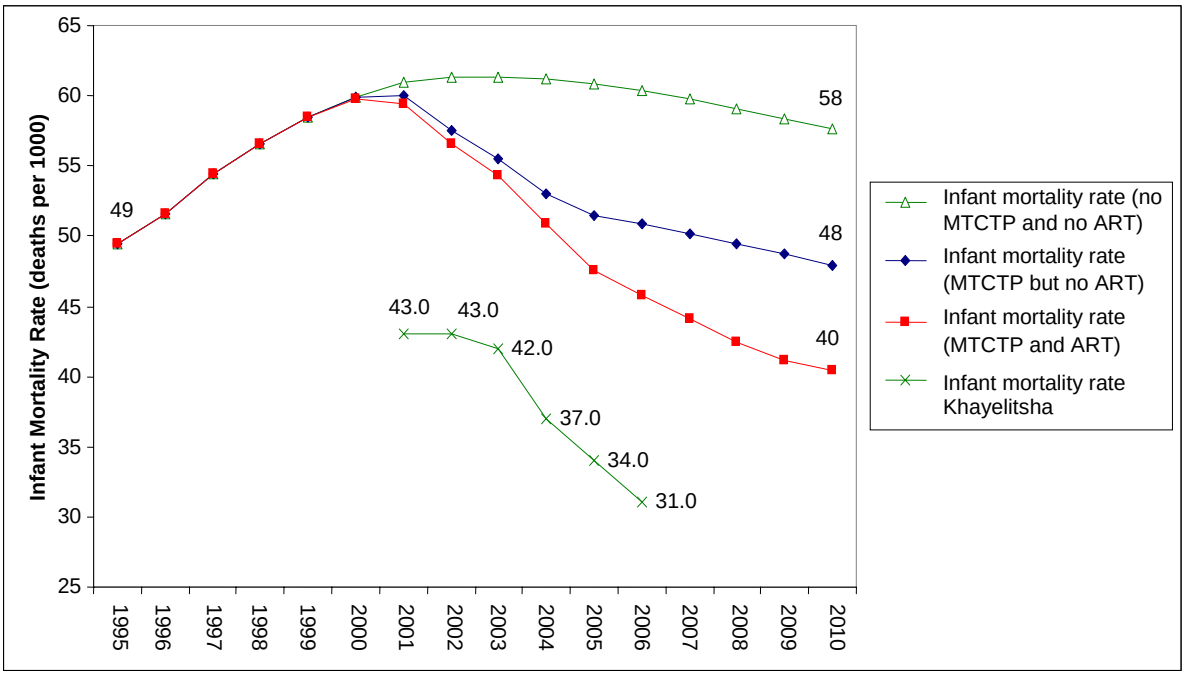

Figure 3: Infant Mortality in South Africa (source: Nattrass and Gonsalves, 2009)

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: whist 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 organisations like the Treatment Action Campaign from poor people[13] and the '*Afrobarometer*' surveys in Southern Africa routinely show strong preferences for prioritising health spending, including on AIDS (Nattrass, 2004: 63-5; Nattrass, 2009). In the 2005 *Afrobarometer* survey of 18 countries, Health/AIDS was one of the top three concerns of respondents (typically coming in third after unemployment/income and food/famine) and the majority of respondents in most countries reported that they would prefer more money to go on AIDS even if it meant less money for other priorities like education (see fuller discussion in Nattrass, 2009). Although Easterly frames ART as an invention of Northern NGOs and 'planners', it is also worth emphasising that it was organisations with strong support from the poor in places like Brazil, Thailand and South Africa which underpinned the activism that made the expansion of ART in the developing world possible.[14]

More problematically, Easterly provides no analysis of how and why his alternative agenda to ART will be successful. He seems to assume that simply 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

[13] 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.

[14] 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.

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 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 becomes 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 mobilisation to integrate MTCTP and reproductive health services, and to integrate TB and ART services).[15] 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.

[15] 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 of '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 – and one which the WHO MPSCG has recently endorsed (2009).

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 ¾ 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. By ignoring it, Over commits 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. 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 mobilisation than to public health programming.[16] 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).

[16] See Epstein, 2007 for a discussion of Uganda.

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 emphasises biomedical approaches; the collapsing of non-biomedical approaches into behavior change models which emphasise 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 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 idealised 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 diarrhoea 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 prioritise 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.

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