Who must live and who must die?

Following consistent pressure government finally announced the roll-out of its antiretroviral (ARV) treatment plan in October 2003. University of Cape Town economist ***Nicoli Nattrass*** *has been engaged in research around various aspects of the provision of ARVs. In a recent book titled 'The Moral Economy of AIDS' she highlights some of the challenges in the provision of ARVs and argues that prevention and treatment need to be linked to measures to reduce poverty such as the provision of a basic income grant. Health-e News Service journalist Sue Valentine interviewed Nattrass about the book and her views around HIV/AIDS.*

Valentine: *What are some of the points that we need to debate in society and what are some of the trade-offs that they imply?*
Nattrass: I think the first thing we need to do is get a clear understanding of what the costs and benefits are in addressing this pandemic. It certainly is going to cost a lot of money to have a full-scale AIDS intervention. That would require we all pay more taxation. I estimate this will be the equivalent of raising Value Added Tax (VAT) by 5% points for the next 20 years, so we would have to pay for it. But the question is, is it worth it?

When you go down that route it's really raising questions about what it means to be a society. To pay more taxation, to reach everybody who needs treatment, makes us a more egalitarian place to live in. If we as the elite, rather choose not to treat everybody and have a much smaller response, effectively what we're saying is that those people who are too poor to access medicines on their own, or are stuck out in rural areas, are going to be condemned to die. So what we would be doing under that scenario would be taking the big gap between rich and poor and turning it into a divide between those who are going to live and those who are going to die and that really does have implications for social solidarity.

Valentine: *Finance minister Trevor Manuel has said, and cited evidence to prove, that the impact of HIV is not going to be that huge on the economy – so to be very blunt and crude; it is cheaper to let those people die and not treat them. What is your response?*
Nattrass: Well this is a very interesting question. Certainly because there is a close connection between HIV infection and poverty it is the case that most

people with HIV are poor and unemployed. So when they die, they have no direct impact on the economy other than to pull what meagre household savings and resources there might have been into their care in the last years that they live. So there is an impact there, but it's quite small. Where the economic modelling shows a big impact is when AIDS starts to get into the highly skilled occupations which it is beginning to at the moment, so the problem is getting worse.

But given that most people with HIV infection tend not to be economically active, most economic models do in fact show that AIDS will shrink the population and it's going to shrink the size of the economic pie. But because there are fewer people, each remaining person will have a larger slice. Put differently, per capita incomes may well rise as a result of the AIDS pandemic. If that happens, it is in the interests of the economic elite to stand back, protect themselves from the pandemic as best they can, and wait for it to burn out, because they could be in a better position afterwards.

Valentine: *But that has serious implications for a society and its coherence.*
Nattrass: It absolutely does which is why we need to have a very serious discussion about what we all need to contribute through extra revenues and through maybe sacrificing other spending priorities to address that. And what worries me about the current debate is that we as a society are sitting in the thrall of the finance minister. He almost appears to us like some high priest of finance. He comes across and he sermonises about what we can and cannot afford and what is feasible and this is really deflecting attention from a much-needed social debate about how we actually as a society ought to respond. Because you cannot just tax people without having a discussion and getting people on board so they understand that this is what is really necessary. And this government has not actually confronted that social implication at all. They have been burying in a discourse of what's technically affordable and what is not.

In this respect I think we have a lot to learn from the Irish case in the last ten years or so. The Irish societies had a long series of social discussions and debates about what they should be doing about welfare spending and education policies and wages and employment going all the way down to local level, see SALB 27 (5). And this accord process has really helped the Irish system to develop far more into a social democracy than it was before. I think that's the path we should be going down.

Valentine: *In your book you challenge the conventional wisdom that providing antiretrovirals is unaffordable for poor countries. What's your argument?*
Nattrass: Certainly the conventional wisdom among health economists looking at developing countries in Africa is that developing countries cannot afford to provide treatment and they should rather concentrate their resources purely on prevention. I argue in the book that this is not a good way to look at the economics of the

problem from a middle-income country like South Africa because we already have a fairly developed health sector and we're already treating people that have AIDS for their opportunistic infections. So in a middle income developing country context you need to look at the costs of what we are already spending and set them off against the costs of preventing those particular health sector costs, ie the costs of opportunistic infections. In other words, by giving somebody an antiretroviral drug you prevent new infections, therefore you prevent new people coming to the health sector to get treated. In so doing you lower the amount of illness that each person who is on antiretrovirals experiences and for that reason you also lower the cost to the health sector.

There is good evidence to show this is working in Brazil where a great deal of the costs put into the drugs is more than clawed back by the savings you get in the health sector from not having to treat the opportunistic infections of people with AIDS who do not have access to ART treatment. In fact, the studies from Brazil show cost savings. The Brazilians estimate that they have actually saved the health sector costs by providing antiretroviral drugs. My costing exercise suggests that you do not actually save money but that you claw back an awful lot of those costs.

Valentine: *You also challenge the research that warns that the provision of antiretroviral drugs may result in an increase in unsafe sexual behaviour as people see the drugs as a long-term treatment option and even a cure.*

Nattrass: The underlying demographic model that I use in my costing is the ASSA 2000 (Actuarial Society of SA model). They predict that if you give people antiretrovirals you will get fewer infections for two reasons: the first is that there is a lower viral load, so even if the person is going out and behaving badly as you are suggesting, they are less likely to pass on the virus because their viral loads are so low and viral loads are really important in driving down HIV infections. So that is the first thing, there is a medical benefit.

But there is also a behavioural benefit. The model I use in my book assumes that because each antiretroviral programme will be linked to voluntary counselling and testing intervention. People on antiretrovirals will be educated how to behave better. Now of course you can assume that maybe they will not in fact listen to the education and do the opposite and for this reason I have an entire chapter on this question – does providing antiretroviral drugs lead to increased risky sexual behaviour or not. I found that most of the literature on this refers to sexual behaviour amongst gay men in America, where the assumption has long been that antiretroviral drugs has resulted in an increase in sexual risk behaviour. However, if you actually look at the literature, most of the surveys are based on interviews at gay clubs and gay meeting places over time. So if they are staying away from such places they would not be included in the survey and what you get is what economists call 'adverse selection' and a selection bias that could be why we are seeing these surveys picking up an increase in risky sexual behaviour. Those surveys that try and avoid this selection bias actually show very low levels of risky sexual behaviour amongst gay men. In fact less than 5% have said they are increasing their risky sex behaviour because of the presence of antiretrovirals.

Most of them, the vast majority, say 'no'. Antiretrovirals are not very nice drugs to take; they are not cures, so in fact we should just behave more safely in our sexual behaviour. So I think there is no basis for assuming in South Africa that if we give out antiretrovirals we are going to see an increase in risky sexual behaviour and HIV infection. In fact I think, there is pretty good evidence showing that if we do not go out there and give people hope, we are probably more likely to see AIDS spreading much faster as young people say, 'well if there is no hope why should I not just spread it?' And there is some anthropological evidence showing that young people are in fact doing this.

Valentine: *Is there any evidence from middle-income countries that might show that the provision of ARV treatment does not result in risky sexual behaviour aside from the examples of gay sexual behaviour in the US?*

Nattrass: I have not seen a single study that is convincing about risky sexual behaviour. What I have seen is that levels of stigma have gone down and people are happier about disclosing their HIV status. Therefore, the assumption is that under those conditions you are more likely to get people disclosing to their partners and therefore protecting their partners. But I have not seen any study that asks people directly about their risky sexual behaviour. It is in fact a huge gap in the literature. As we roll out treatment that is one of the areas we need to learn a lot more about. How are people responding, how are people understanding the riskiness of antiretrovirals and the responsibilities involved?

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This is an edited version of an interview conducted by Sue Valentine on behalf of Health-E website – www.health-e.org.za. The book has been published by Cambridge University Press and can be found in bookstores countrywide at a subsidised price of R130.