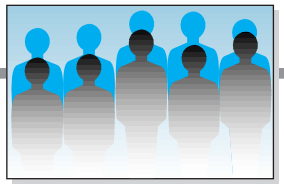

Coping with the Impact of AIDS

MEAD OVER

The AIDS epidemic is straining the limited resources available to many developing country governments. How can governments provide support to those affected by AIDS without neglecting others in need or abandoning important development goals?

WHILE SOME countries still have the opportunity to avert a full-blown AIDS epidemic, others are already confronting widespread HIV infection. What can be done to help people with AIDS in developing countries? What will be the impact of AIDS morbidity and mortality on health systems, on poverty, and on developing economies generally? And what should governments do to mitigate that impact?

Many societies consider it a priority to help those who are disadvantaged from birth—the poor and the handicapped—or those who suffer some calamity during their lifetime. While people with HIV/AIDS clearly fall into the second category, equity considerations and budgetary constraints suggest that any given society should treat HIV/AIDS the same way it treats the problems of sickness, poverty, and vulnerability more generally. Governments should be guided by two propositions in their efforts to alleviate the suffering caused by the AIDS epidemic.

First, all patients suffering from illnesses for which treatment does not affect transmission, regardless of cause, should be equally eligible for public assistance. Thus, a patient suffering from terminal cancer should have the same right to public support as an HIV-infected patient. This leaves open the question of how much of the cost of treatment should be covered by public funding. The standard arguments (externalities, public goods) for public subsidies do not apply here: the benefits of treatment accrue almost entirely to the individuals being treated. Nevertheless, other arguments—compassion, society's moral responsibility to its less fortunate members, the belief that health or health care is a basic need—typically support substantial public subsidies for the sick. This has significant implications for an overall approach to the HIV/AIDS epidemic.

Second, governments should focus on helping equally poor people equally, regardless of the cause of their poverty. Research in Kagera, Tanzania, finds that the death of an adult from AIDS depresses per capita food consumption in the poorest households by 15 percent—but this is not much different from the effect of adult deaths from other causes. Children in AIDS-stricken households are malnourished and drop out of school, resulting in serious long-term harm—but children in other poor households suffer the same fate. Thus, an adult death (from whatever cause) may be useful as an additional indicator that a household needs help, but, in the interests of equity, a death should not by itself trigger government antipoverty assistance.

Impact on the HIV-infected

The first and most basic impact of HIV/AIDS is on those who contract the disease. Medication to relieve symptoms and treat opportunistic illnesses (illnesses that affect people with weak immune systems) can, sometimes at low cost, ease suffering and prolong the productive lives of people infected with HIV. But as the immune system collapses, leaving the AIDS patient susceptible to the opportunistic illnesses that are ultimately fatal, available treatments become increasingly expensive and their efficacy less certain.

The table presents the costs of treating an AIDS patient under three different assumptions regarding the aggressiveness of the treatment strategy. Palliative care, which alleviates the symptoms of some of the more common opportunistic illnesses that appear in the early stages of AIDS, and treatment of the less complex opportunistic illnesses extend many patients' lives by several years and would be affordable in most countries (the cost per patient is approximately $300 in sub-Saharan

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Africa and $1,000 in Thailand). Tragically, however, the trained personnel and basic drugs needed for this level of care are often unavailable in the poorest countries. As AIDS cases begin to appear, governments should take prompt action to ensure that health personnel and AIDS patients know how to obtain and use the necessary drugs. Such an improvement in the availability and use of basic drugs against opportunistic illnesses is the primary aim of the UNAIDS (Joint United Nations Programme on HIV/AIDS) HIV Drug Access Initiative.

Annual cost per patient of AIDS treatments
(dollars)

	Sub-Saharan Africa	Thailand	United Kingdom
Palliative care plus treatment of inexpensive opportunistic illnesses	300	1,014	—
Palliative care plus treatment of all opportunistic illnesses	490	1,657	—
Antiretroviral, triple-drug therapy			
AZT, [1] ddI, [2] and IDV [3]	—	9,595	19,803
AZT, ddI, and RTV [4]	—	13,285	23,493

Source: World Bank Policy Research Report, 1997, *Confronting AIDS: Public Priorities in a Global Epidemic* (New York: Oxford University Press for the World Bank).
Note: — means not available.
[1] Zidovudine.
[2] Didanosine.
[3] Indinavir.
[4] Ritonavir.

The drugs used to treat some of the rarer opportunistic illnesses are substantially more expensive. Including them increases the cost of treating the average AIDS patient by two-thirds, in Africa as well as in Thailand. This extra expense buys relatively little additional healthy life for the average person with AIDS. For example, an AIDS patient stricken with cryptococcal meningitis in the Democratic Republic of the Congo (formerly Zaïre) is estimated to live an average of only 150 additional days under the most advanced, expensive treatment for that disease. Since the cost of treatment is $870, more than seven times the country's per capita income, many patients and their families would be likely to refuse treatment, even if it were available at cost. Governments of middle-income countries with serious AIDS epidemics can subsidize this care to the same degree that they subsidize other curative health care, but this does little to reduce transmission.

The most aggressive—and expensive—therapies attempt to attack directly the retrovirus that causes AIDS. These therapies, collectively referred to as antiretroviral therapy, have achieved dramatic improvements, at least temporarily, in the health of some individuals in high-income countries. Unfortunately, others do not benefit or are even made sicker by the treatments available. Furthermore, these experimental treatments can be properly administered only in extremely advanced clinical settings, and, as shown in the table, they raise the cost of treatment to at least $9,000 a patient a year. The level of funding that would be needed to make such treatments available in developing countries is extremely high. And if donor countries were to provide the necessary funds at the expense of other health care interventions, the cost in lives lost to measles, malaria, and tuberculosis would greatly outweigh the benefits.

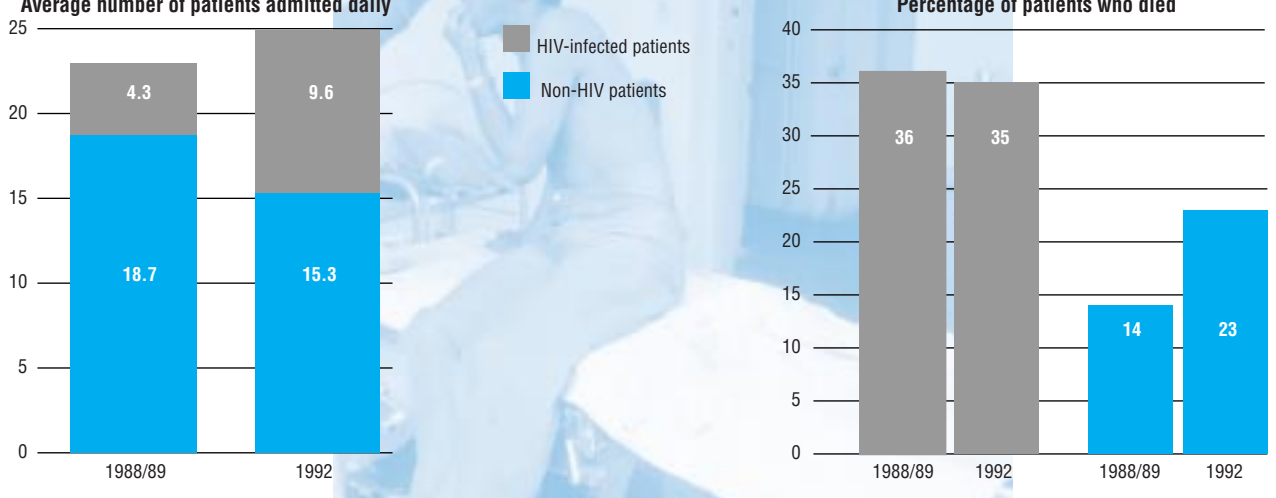
In countries with severe AIDS epidemics, health policymakers have sought low-cost ways to provide compassionate care to AIDS patients. An analysis of alternative treatment and care options shows that community-initiated care provided at home, while often shifting costs from the national taxpayer to the local community, greatly reduces the cost of care and therefore offers hope that affordable measures exist for improving the quality of the last years of life for AIDS patients.

Impact on health care

A generalized AIDS epidemic is a severe shock to the health sector. It increases the demand for medical care and reduces the supply of care at a given quality and price. As the number of people with HIV/AIDS mounts, access to medical care becomes more difficult and more expensive for everyone, including people not infected with HIV, and total health expenditures rise.

The impact of AIDS on an entire curative health care sector is demonstrated by what happened at the Kenyatta National Hospital in Nairobi, Kenya (Chart 1) between 1988/89 and 1992, when the number of HIV-infected patients admitted daily more than doubled. The mortality rate of

Chart 1
Impact of AIDS on hospital admissions and mortality at Kenyatta National Hospital, Nairobi, Kenya



Source: Katherine Floyd and Charles F. Gilks, 1996, "Impact of, and Response to, the HIV Epidemic at Kenyatta National Hospital, Nairobi," Report 1 (April) (Liverpool, England: Liverpool School of Medicine).

HIV-negative inpatients rose by more than two-thirds, indicating that those with less serious conditions could not even get admitted to the hospital.

The impact of a serious AIDS epidemic on government health spending will be amplified in countries that provide larger subsidies for health care. For example, suppose that the infection rate in India, now quite low nationally, were to rise to 5 percent of the adult population over the next 10 years. Even if India's subsidy of health care remained at its current low level of 21 percent, the government's health expenditures would increase by about one-third (Chart 2). If India were to subsidize half the cost of health care—a share closer to the average for poor developing countries—the AIDS epidemic would increase government spending by about 41 percent.

Governments will undoubtedly be pressured to increase their share of health care spending and to provide special subsidies for the treatment of HIV/AIDS. Unfortunately, because of the scarcity of resources and the inability or unwillingness of governments to increase public health spending enough to offset these pressures, either of these actions may exacerbate the impact of the epidemic on the health sector

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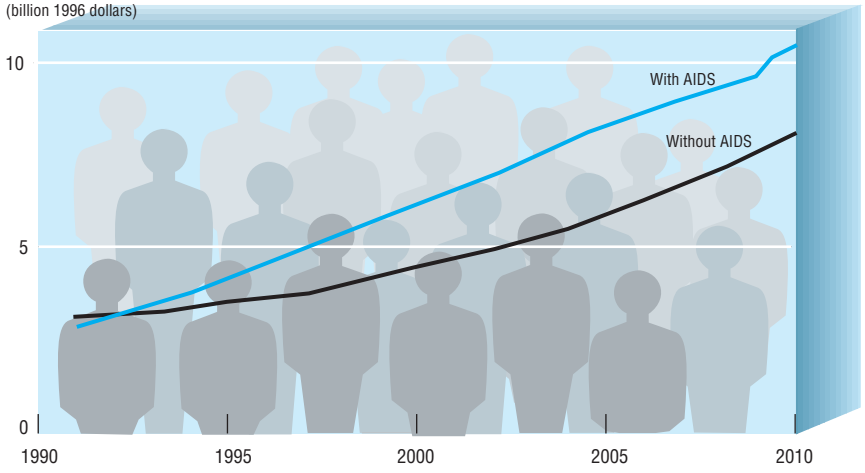
and make it harder for the majority who are not infected with HIV to obtain care.

However, there are things that governments can do. Governments should ensure that HIV-infected patients benefit from the same access to care as other patients with comparable illnesses and a similar ability to pay. Sometimes, because of discrimination, people with HIV are denied treatment or face barriers to care that others do not encounter. In other situations, people with HIV receive subsidized access to advanced therapies while people sick with other severe and difficult-to-treat diseases lack access to therapies with comparable costs. Although patients with HIV-related illnesses need and should receive a different mix of services than those with, say, cancer, diabetes, or kidney disease, they should pay the same percentage of their health care costs out of their own pockets as patients with other diseases. Other measures that governments can and should undertake include providing information about the efficacy of alternative treatments for opportunistic illnesses and AIDS; subsidizing the treatment of sexually transmitted diseases and infectious opportunistic illnesses as well as the start-up of blood-safety and AIDS care programs; and ensuring access to health care for the poorest, regardless of their HIV infection status.

Chart 2
Simulated impact of a severe AIDS epidemic on public health expenditures in India



Sources: Randall Ellis, Moneer Alam, and Indrani Gupta, 1997, "Health Insurance in India: Prognosis and Prospectus" (Boston University); and author's calculations.
Note: Calculations assume a public subsidy of health care expenditures of 21 percent.

Impact on poverty

The third major impact of the epidemic is on households and, in the aggregate, on the extent and depth of national poverty. To cope with the loss of adults in the prime of life to AIDS, households and extended families often reallocate their resources—for example, withdrawing children from school to help at home, working longer hours, adjusting household membership, or selling household assets—and turn to friends and relatives for cash and other kinds of assistance. Poorer households, having fewer assets, have more difficulty coping. Their children may be permanently disadvantaged by worsening malnutrition or withdrawal from school. However, governments and nongovernmental organizations should not forget that, in low-income countries, many households that have not experienced an AIDS death are nonetheless so poor that their children suffer similar disadvantages. And some households will have enough resources to cope with the death of an adult from AIDS without help from the government or a nongovernmental organization. Government assistance programs should thus target households based on both direct poverty indicators and the presence of AIDS, rather than on either indicator alone.

The role of government

We have seen that the epidemic's greatest impact is likely to be felt by individuals living with HIV/AIDS, the health sector, and the poorest households. Governments can play an important role in mitigating these impacts, especially by prohibiting discrimination against HIV-infected persons in health care settings and in the workforce and by strengthening anti-poverty policies. But the most important lesson for governments to learn is that it is imperative to prevent the impacts of AIDS in the first place, through vigorous, effective interventions aimed at changing the behavior of those most likely to contract and spread infection. Today's leaders can decide whether their children will grow up in a world where one out of four potential marriage partners is infected with a fatal sexually transmitted disease and AIDS patients occupy half of all hospital beds, leaving fewer beds for other patients. Prompt action today can prevent these impacts or, in countries already seriously affected, can reverse them. F&D

This article is based on a World Bank Policy Research Report, Confronting AIDS: Public Priorities in a Global Epidemic *(New York: Oxford University Press for the World Bank, 1997).*