

POINT OF VIEW

HIV/AIDS and health care. What are the issues?

Anita Alban



This Point of View is based on work carried out for Danida on the role of sector health programmes in a HIV epidemic. The views expressed are solely the views of the author.

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Background

Approximately 40 million people are currently living with HIV/AIDS globally (UNAIDS, 2001); a development that few could foresee just five years ago when predictions and prognosis varied from 20-40 million HIV infected by 2000. Over the past ten years the course of the epidemic has continued to surprise developing countries as well as researchers, forecasters, international organisations and the global society at large.

Ill health and poverty are closely linked with the cause-and-effect running in both directions. That is, sick people are more likely to become poor, while those who are poor are more vulnerable to disease and disability. The reverse is also true; people in good health are better able to learn, earn a living and be more productive than those who are sick. (UNAIDS and The World Bank, 2001).

Compounding to the problem of ill health in developing countries is HIV/AIDS, which disables and kills mostly adults in the prime of their lives as workers and parents. Given that annual per capita growth in Africa for the past three years has averaged 1.2%, decreases in growth caused by AIDS have a significant effect on the welfare of the population. Much of the explanation is the increased cost of health care programmes when the prevalence increases. Experiences from Africa shows that when the epidemic is below 5%, HIV/AIDS programmes cost about \$ 3 per capita. However, when the HIV prevalence rate exceeds 15%, the cost of HIV/AIDS programmes rise rapidly to about \$ 10-12 per capita (R. Bonnel, 2000). A significant amount of money is thus being spent on health care in society that will not increase health status per se.

Response to the crisis

Depending to some degree on the HIV epidemic and the health care infrastructure the impact of HIV/AIDS can be measured in the cost it incurs on the system. A number of studies have been carried out mainly in Africa. They show that HIV-related bed occupancy vary from 5%-80% (Guinness and Alban).

The demand for health care is thus increasing dramatically in countries with even relatively low prevalence. For example in Ghana with a relatively low epidemic of 3.5% of the adult population infected at the end of 1999, approximately 25% of the public health budget is spent on patients with HIV/AIDS. Part of the expenditure is related to interventions such as safe blood procedures and to the utilisation of hospital beds.

For most, if not all, health services in developing countries the increased demand for services is not matched by extra resources and the opportunity cost can very well imply a lower level of health service for all patients (Kumaranayake et al, 2000). The deterioration of health services caused by the increased demand is not appropriately addressed by governments in the National Strategic Plans and by donors supporting local government in the fight of HIV/AIDS.

On the supply side, health personnel are falling ill and dying. In health care, as in many other sectors, the human resource aspect of the epidemic has so far been dealt with inappropriately. The rate at which health staff fall ill and die from HIV/AIDS is estimated at a level comparable to other segments of the population in the country and yet this deficit has not been countered by the

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development of appropriate policies to alleviate the impact. In very few places extra staff is being trained based on attrition rates incorporating the impact of HIV/AIDS and effective workplace programmes within health care facilities are in short supply. Paradoxically, with the increased need and demand for the services of nurses and doctors, health staff is decimated and replacements unavailable; ever decreasing numbers of health professionals are obliged to cope with increasing health service demands. Those left to cope are increasingly frustrated by the overwhelming work load and a depressive work environment largely comprised of the suffering and pain of young people and children.

With the exception of Thailand, no country, even those with the most widespread epidemics, has carried out an effective and systematic up-scaling of HIV prevention and care activities. Even though effective prevention strategies exist, and appropriate care responses are well documented (treatment of STIs, introduction of VCT, blood screening, targeting of vulnerable populations, MTCT, treatment of OIs including TB, and prophylaxis such as co-trimoxazol), few of these interventions have been scaled up sufficiently to make a difference at national or even health district level. This paradox may be explained by a number of factors: the importance of coverage has not been fully recognised by health authorities or donors and has therefore not figured as a priority on the health care agenda; the resources necessary for high coverage have not been found; the existing health care infrastructure is insufficient to provide increased coverage, adequate human resources are lacking, inappropriate technology (e.g. laboratories) and inappropriate drug distribution systems etc.

Scaling-up is an expansion of the coverage of existing HIV/AIDS activities, e.g. provision of VCT services increased from 5% to 20% among 15-49 years old or provision of STI services increased from 30% to 50%. Scaling-up does not necessarily mean achieving 100% coverage; it can mean going to scale within the existing capacity and infrastructure in a planned, coordinated and systematic manner, including monitoring the coverage reached and sustained (The World Bank, 2000).

Additional investment in health infrastructure is needed to compensate for the deterioration caused by the HIV/AIDS epidemic of existing health coverage and human capital and to ensure the up-scaling of cost-effective interventions. There is an urgent need for the increased awareness and understanding of health care decision makers of the current levels of coverage and of the cost and benefits of expanding the response.

The priorities

The painful debate on whether activities should be focused on halting the epidemic or on assisting PLWHA in developing countries cannot be avoided; a feasible and effective balance must be found—in every country, among all stakeholders, including the donor community. As the global consensus to include anti retroviral drugs (ARV) as part of the standard HIV/AIDS intervention package is gathering momentum (via the UNGASS Declaration of Commitment on HIV/AIDS: Global Crisis – Global Action, July 2001), and following the implementation of the Global Fund to fight AIDS, Tuberculosis and Malaria, GFATM (effective in 2002), some outstanding issues emerge; these include:

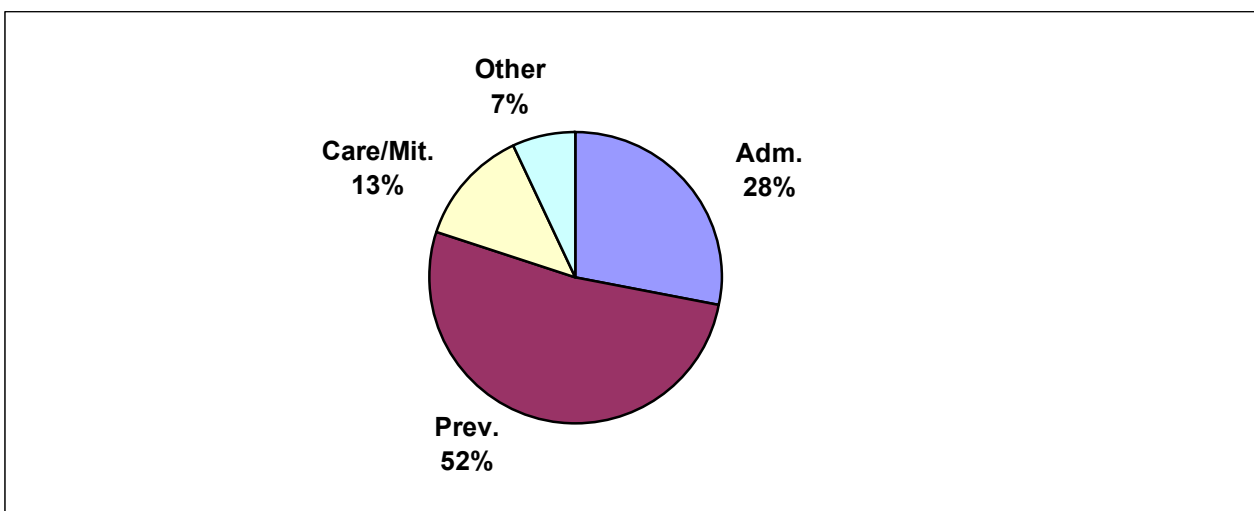
- How to ensure a balance between resource allocation for prevention versus care activities

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- How to administer ARV drugs in developing countries (including the problem of providing the infrastructure and human resources to handle high tech drugs in a low tech environment);
- How to determine the recipients of such advanced drugs in the short run and in the long run;
- How to finance the drugs, the infrastructure improvements and the education of staff to monitor the drugs

The priorities as stated in the National Strategic Plans often deviate significantly from the realities as they unfold in resource allocation. Malawi provides an interesting example of plan versus reality – see figure 1. According to the national HIV/AIDS plan 52% of the resources should be spent on prevention, 13% on care and mitigation, and 28% on management and administration; almost two years into the plan the majority of resources have been allocated to the management component. This happened because it was considered necessary by the government and the donors to establish an administrative system to manage more substantial investments. However, resources for care and prevention interventions have not emerged in any significantly amount to make a difference. If funds for the activity priorities are not soon identified, then very little will have been achieved to control the epidemic.

Figure 1. Malawi HIV/AIDS priorities, Strategic Framework



Source: Malawi National HIV/AIDS Strategic Framework 2000-2004, 1999

A Review of cost-effectiveness of HIV/AIDS interventions shows that the most cost-effective strategies are targeted interventions such as commercial sex workers interventions (US\$ 1-10 per DALY, Disability Aadjusted life Years). Blood screening, STI interventions, some MTCT regimes and VCT are all interventions in medium and high prevalence countries with a cost-effectiveness below US\$ 50 per DALY and thus recommendable for developing countries. Most care interventions including drugs have a low cost-effectiveness although TB care interventions are reasonably cost-effective within a developing country context (US\$ 200 per DALY). ARV drugs, even at very low prices, do not compare to the cost-effectiveness of HIV prevention interventions and TB care and prophylaxis are more cost-effective than the use of ARVs (Creese, Floyd, Alban and Guinness). Thus, the opportunity cost of introducing ARVs in an environment with an incomplete HIV prevention agenda is high.

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The emerging issues

The health care sector has an important role to play in HIV prevention. The sector establishes the infrastructure for STI treatment with its clinics and drug provision (including condoms). The care sector assists in implementing MTCT services, which decrease transmission rate among newborns; MTCT services include the implementation of VCT services (often in collaboration with NGOs). The youth friendly reproductive health facilities—agreed on in the ICPD+5 (International Conference on Population Development, 1999)—will emerge within the health care sector. The infrastructure includes care facilities, laboratory facilities, reproductive health facilities, STI facilities, transport and drugs. Up-scaling of HIV preventive measures in health care is urgently needed.

The up-scaling process must consider cost-effectiveness, affordability/feasibility and equity issues and take account of local circumstances. However, with the exception of blood safety interventions, few, if any, developing countries with a HIV epidemic consider these factors. STI treatment, a recognized cost-effective form of HIV prevention (Gilson et al, 1996), is not scaled up to a degree sufficient to impact on the epidemic. The VCT services have so far been driven by NGOs rather than by government programmes; whilst there is only an estimated 5% VCT coverage in Sub-Saharan Africa at present, it is now one of the fastest growing HIV interventions, the agenda being directed by donors and NGOs. The need to develop youth friendly services to ensure affordable access to reproductive health care for young people seems to be a priority for international organisations rather than for governments; very few colleges, vocational training centres, youth centres and schools are able to make recommendations for reproductive health care to their young clients. The World Bank report of 2000 on up-scaling of HIV interventions offers rough estimates regarding coverage of the most important HIV interventions per region and per country in Africa. It is vital that such educated guesses be re-calculated for individual countries when resources are being allocated for going to scale; there can be no impact made on the epidemic unless accurate coverage figures are known so that provision of appropriate service needs can be ensured.

The HIV/AIDS care issue is an enormous obligation for the health services; since even societies' most impoverished members demand health services when they fall ill, the health care systems currently in place are overburdened. The increased demand from PLWHA cannot be met without extra resources and re-organisation of activities. Current practices of delivering health care services must be analysed to ensure efficient delivery. Today the issue of technical efficiency is seldom addressed. A study from Zimbabwe (Hansen et al, 1999) demonstrates that not all patients are treated at the most cost-effective level of service. Many patients were noted as occupying beds in high-level institutions when they could have been treated at a lower and less costly level of provision. The example from Zimbabwe demonstrates that the cost per discharge in a district hospital is almost one third of the cost of a discharge from a central/university hospital, with no significant difference in service delivery (drugs, laboratory tests).

When the number of HIV/AIDS patients in the health services increases and demand for services (visits, bed-days) reaches the supply, re-allocation of resources and re-organisation of the service provision must be carefully considered to ensure efficient use of whatever resources are available. This includes the consideration of the utilisation of costly resources versus less costly resources: hospital care versus community care/home based care (HBC). However, it should be recalled that

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not all HBC is delivered in an efficient and equitable manner. The health care sector has a very important role to play in encouraging, educating and supporting local NGOs; this support must be consistent, supplementary to the local community services, and based on the resources available in the local community. Communities with few resources should receive greater assistance from the health services than more advantaged communities.

The communities need to be strengthened to cope with caring for PLWHA and orphans; capacity building of communities to care for their members is an important concern. The role of the health care system is to build support capacity in the communities and to ensure an appropriate coverage of services. Not all communities can recruit a sufficient number of carers and not all families and communities have sufficient resources to respond to the epidemic. In many countries sick people must pay a high proportion of the cost of treatment and care themselves and not all can afford drugs. A study from Rwanda concluded that approximately 10% of the 400 000 PLWHA could afford treatment for symptoms and opportunistic infections, while 75% could afford drugs from the essential drug list. The poorest sector of the population could only afford the services of traditional healers when seeking pain and symptom relief (Schneider et al, 2001). HIV/AIDS highlights the problem of access by the poor to appropriate health care. In most developing countries access to care (*if* care services are available) is determined by ability to pay the user fees. The increased attention by decision makers to seriously introduce HAART (Highly Active Anti-Retroviral Treatment) in developing countries will no doubt renew the discussion on access to care in poor countries. Hopefully it will find new sustainable solutions too.

Important links and key references:

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Websites:

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