

**AIDS**

**Trick or treatment?**

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**Two decades after the identification of HIV, the world has realised that poor people as well as rich ones should be treated for their illness**

PATENTS last for 20 years. On July 9th a famous one expired: the first antibody-based test for the human immunodeficiency virus. Yes, HIV has been around that long. And it is still getting worse. More than 40m people are now infected. At least 20m have died.

That is the background against which two meetings have just been held in Paris. The first, on HIV pathogenesis and treatment, organised by the International AIDS Society (IAS), was a scientific gathering. The second was about money, to discuss the Global Fund that was formed to fight AIDS, tuberculosis and malaria. But in dealing with AIDS, science and money are inextricably linked.

So, increasingly, are containment and treatment. And that is a big change. When HIV was first identified, no treatment was possible. When it became so, it was too expensive for most people. Health planners in poor countries therefore concentrated on prevention rather than cure. The reasons given for this were that cures were not cost-effective and that the poor could not be trusted to take their drugs properly, which would encourage the evolution of drug-resistant strains of the virus. What they forgot was that somebody who has no prospect of treatment has little incentive to be tested, and so identified as a potential link in the chain of transmission.

Both arguments have now been knocked down. If anything, African patients seem more sophisticated than their rich-country counterparts. Papa Salif Sow, of Dakar University in Senegal, told the IAS conference that the consensus of studies in Africa over the past few years was that 80-85% of people took their drugs exactly as prescribed. In the rich world, the figure is more like 60%.

## **Pay up, pay up and play the game**

The sneering assumption, then, that ignorant Africans will be less compliant with complex drug regimes than sophisticated westerners is false. One of the perils of non-compliance is the development of drug-resistant strains of HIV. This is already a problem in the rich world. A big new study, unveiled at the meeting, showed that about 10% of all newly infected patients in Europe now suffer from drug-resistant strains of the virus.

As for the economics of treatment, they have changed beyond recognition. Generic knock-offs of AIDS drugs, plus some hard bargaining by governments, can bring the price down to less than \$200 for a year's supply, says Jean-Paul Moatti, an economist at the University of the Mediterranean in Marseilles. As Dr Moatti told the conference, health authorities in rich countries consider a treatment to be economically desirable if it costs less than twice the GDP per head in that country. On this measure, treatment is now economically justifiable in a lot of poor countries. And new models that account for the loss of output from workers who will now never be born suggest that AIDS's economic impact will be worse than expected.

Unlike other sorts of scientific conference, AIDS conferences attract angry activists as well as sober scientists. This year's favourite slogan was "Treat the six million. Where's the ten billion?" Six million is the number of people who have severe enough symptoms to benefit from the anti-AIDS drug formulations known as HAART (highly active anti-retroviral therapy), the most expensive and effective sort. And \$10 billion is the amount of cash that, it is said, could usefully be spent each year on treating and preventing AIDS.

In an act of generosity that temporarily silenced America's critics, George Bush announced in February that he wanted his country to provide almost a third of that, by spending \$15 billion (\$10 billion of which would be new money) on AIDS over the next five years. The critics soon found their voice again when it became clear that much of this would be bilateral aid, rather than aid channelled through the Global Fund. But when the haggling stops, it looks as though the fund could see at least \$500m of American taxpayers' money heading its way next year.

A lot of that money, though, will be in the form of matching funds that are conditional on others stumping up two dollars for every American one. France has promised *euro*150m (\$168m) a year. Germany and Italy have each promised *euro*100m a year but don't say when the cash will start to flow. And there was no money from the European Union (as opposed to individual member states), despite the hopes raised at the recent G8 meeting in Evian.

As for corporate donors, few companies are in a position these days to sign big cheques for charity. But, as the fund has found, largesse comes in many forms. For

example, it has just signed a deal with a big, and as yet undisclosed, European bank whose clients, many of them in the developing world, will be able to use their credit cards to make donations. The fund is also having its profile raised by Publicis, an advertising firm that has taken on the fund as a *pro bono* client.

Even if the Global Fund does not get all it wants—eg, an annual budget of \$7 billion—the money will not be wasted. Tommy Thompson, America's health and human services secretary and also chairman of the Global Fund's board, says the bilateral part of Mr Bush's package is aimed at 14 African and Caribbean countries, which contain half the world's infected people. Following the new treatment paradigm, half the cash will be spent on HAART for 2m-3m people.

Anthony Fauci, the head of the National Institute of Allergy and Infectious Diseases in America, and one of Mr Bush's chief advisers on AIDS, also tried to allay some of the fears of activists by making it clear that the money would not have to be spent on the costly products of American drug companies. It can be used to buy generics instead.

As Ernest Darkoh of Botswana's health ministry pointed out, though, throwing money at the problem and then walking away is not enough. The money must be spent wisely on gathering information, building a suitable infrastructure, and training and paying medical staff. This needs political will to act—an often overlooked factor. But perhaps most important, the stigma of being infected has to be eliminated, and this takes time.

## **The devil and the detail**

In Botswana, some 300,000 adults are infected. Of these, 110,000 could benefit from HAART. What makes Botswana different from other countries is that HAART is already available to anybody who wants it, thanks to a collaboration between the government, the Gates Foundation and Merck, a drug company. But only 9,000 people have requested it, because of the shame they suffer if they admit that they are infected.

This, though, is a vast improvement on the 500 who were registered 12 months ago. And other African countries are also recruiting. Uganda has 10,000 people on HAART, Cameroon has 6,000 and even impoverished Mali has 700 recruits. Here, the lesson of Brazil is instructive. This country acted quickly to preach the anti-AIDS message, break the disease's stigma and wrestle cheap drugs from the pharmaceutical companies. Today only 0.6% of the adult population is infected.

When the money arrives—whether from the Americans, the fund, the World Bank, multinational companies (several of which now provide anti-AIDS drugs for employees) or from the resources of the infected countries themselves—the numbers in treatment should rise rapidly.