ANTIRETROVIRAL TREATMENT AND THE PROBLEM OF POLITICAL WILL IN SOUTH AFRICA

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South African AIDS policy has long been characterised by suspicion on the part of President Mbeki and his Health Ministers towards antiretroviral therapy.[1,2] The Minister of Health, Manto Tshabalala-Msimang, resisted the introduction of antiretrovirals for mother-to-child transmission prevention (MTCTP) until forced to do by a Constitutional Court ruling – and she resisted the introduction of highly active antiretroviral therapy (HAART) for AIDS-sick people until a cabinet revolt in late 2003 forced her to back down on this too. Since then, the public sector rollout of HAART has gained momentum, but it has been uneven across the provinces and continues to be constrained by a marked absence of political will at high levels.

South Africa's premier demographic model (the ASSA2003 model) predicts that only in 2008 will HAART coverage reach 50% (see Fig. 1). This does not reflect well on South Africa. Recent comparative analysis shows that South Africa's HAART coverage is below par given its economic, institutional and epidemiological characterists.[3] As illustrated in Fig. 2, South Africa is among those countries whose HAART coverage is less than expected given international norms. Although South Africa comprises a large share (25%) of the total number of sub-Saharan Africans on HAART (whether in the public, private or not-for-profit sectors), this comparative analysis indicates that South Africa should be doing a lot better. Furthermore, South Africa has performed poorly with regard to its own domestic targets set by the 2003 Operational Plan. As can be seen in Fig. 3, by the end of 2005, the numbers of people on HAART in the public sector was still less than 30% of the original planned total.

Part of the problem has to do with procrastination by the Health Minister with regard to drug procurement. On 2 March 2004, she unveiled her drug procurement timetable to the parliamentary portfolio committee on health showing that the earliest that drugs would be available for a public sector rollout was July 2004 (and in the end, the tender was only finalised in March 2005). It was only after the Treatment Action Campaign (TAC) threatened legal action that the provinces were allowed to obtain drug supplies through an interim tender process.

South Africa's public sector HAART rollout is strongly underpinned by external funding and support – especially in the Western Cape and KwaZulu-Natal. Of the total number of public sector HAART patients (111 786), 54% were part funded by external donors (the largest being PEPFAR) working in partnership with the public sector. The contribution that

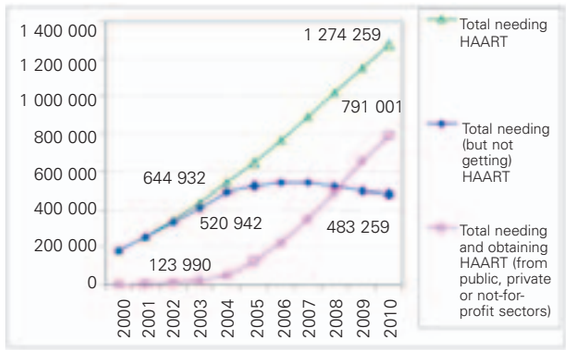

Fig. 1. Numbers of people needing and obtaining HAART (mid-points for each year) whether from the public or the private sectors (source: ASSA2003 demographic model).

donors make to public sector patients varies between donors, across projects (with some treatment sites being fully funded by donors, and others simply obtaining targeted support) and over time. For example, the first public sector donor project, which was between Médecins Sans Frontières (MSF) and the Western Cape government, was initially almost entirely funded and managed by MSF, but over the past few years, the province has assumed a greater role, with the plan being that as of 2007 the sites will be run entirely by the public sector.[6] The Western Cape government also received funding from the Global Fund (which was disbursed in October 2004) for six HAART sites including the sites it was operating in partnership with MSF. This makes it impossible to disentangle precisely the relative contribution of government and donor agencies to the HAART rollout.

BUDGETING FOR THE PUBLIC SECTOR ROLLOUT

National financial data on the HAART rollout are similarly opaque, with the available information being limited to the

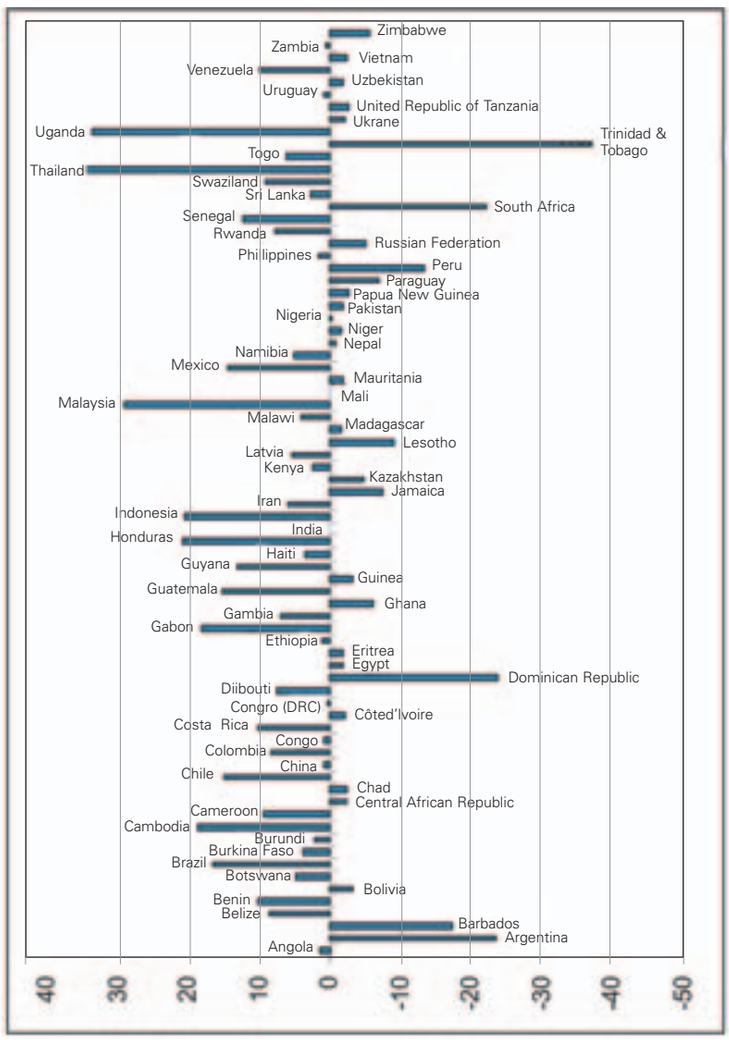

Fig. 2. The difference between actual HAART coverage and predicted HAART coverage in December 2004 (using regression model 4.5 reported in reference 3).

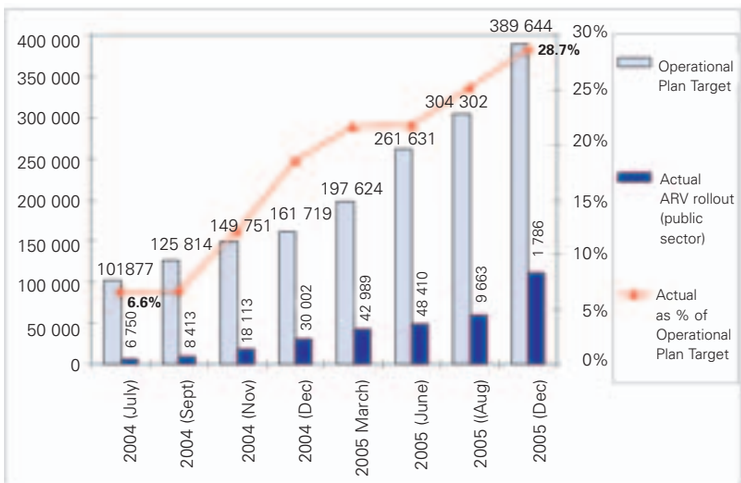

Fig. 3. Planned and actual growth in the provision of antiretroviral treatment (sources: ASSA2003 demographic model and references 4 and 5).

occasional cryptic remark in various general budget documents. However, judging from an August 2004 Treasury document reviewing government finances,[7] sufficient finances were allocated by the national Treasury to provincial governments to fund the Operational Plan. The report states that a sum of R300 million had been allocated to the 'comprehensive HIV and AIDS programme, ARV rollout in particular' for 2004/5. At this stage, the Treasury would have been working in terms of the budget provided by the Operational Plan which proposed to have 54 000 people on treatment by March 2004 at a total cost of R296 million.[4] This included budgeting for additional staff, laboratory testing, antiretroviral drugs, nutritional supplements, health systems up-grading, programme management, capital investment and research. Of course by late 2004 (when Treasury finalised its medium-term expenditure framework) it would have been clear that the rollout was proceeding far more slowly and at best was only going to achieve its March 2004 target a year later (as had indeed been announced by President Mbeki in his 2004 State of the Nation address[8]). This, together with the fact that HAART prices had fallen further since the operational plan was budgeted, meant that the allocation of R300 million for the 2004/5 financial year was more than sufficient to fund the (delayed-by-one-year) planned comprehensive rollout.

Yet, by the time March 2005 came along, the rollout was still only at about 80% of the original first year's treatment target (i.e. at about 43 000 people). In other words, more money had been allocated by the national Treasury for the comprehensive rollout in 2004/5 than had been used by the national and provincial health departments for that purpose. Despite this poor showing, the Treasury continued to be optimistic and supportive, and allocated enough in 2005/6 to have 150 000 people on HAART by March 2006,[9] while making the commitment to allocate further budget to the rollout as it progressed.

The Treasury's target of 150 000 HAART patients in the public sector by March 2006 appears to be spot-on with the achieved level of 111 786 by the end of December 2005. The national Treasury had, in other words, allocated sufficient resources to fund all of these patients. Yet as it turned out, the Global Fund, PEPFAR and various other NGO

partnerships took the pressure off the South African state to such an extent that only 51 494 HAART patients needed to be fully covered by the government budget. If we assume that the average contribution of donors to public sector projects is 50% of the total costs (which is probably an underestimate given that the Global Fund contributes substantially more to the Western Cape by paying for drugs, personnel, diagnostic testing and infrastructure[6]), then at least a quarter of the budget allocated by the national treasury for the HAART rollout was not used for that purpose.

THE PROBLEM OF POLITICAL WILL

According to a recent assessment by the International Treatment Preparedness Coalition (ITPC) of South Africa's HAART rollout,[10] the major constraint is political leadership. The economic analysis presented here supports the ITPC's contention. It suggests very strongly that the overall public sector rollout in South Africa is not constrained by budgetary allocations but is instead constrained by ineffective leadership in the national Department of Health. While it is true that a rapid and sustained HAART rollout requires additional investment in, and upgrading of, the public health sector, it is important to note that this was all budgeted for in the Operational Plan, and as argued above, existing subsequent allocations for the rollout by the national Treasury are consistent with that Operational Plan (although revised downwards to account for the slow initial pace of the rollout).

Put bluntly, if the national Health Minister had prioritised upgrading the health system and rolling out treatment, the Minister of Finance would have provided her with the funds and a further 30 000 people (at least) would be on HAART in the public sector. If the Ministry of Health had managed to roll out treatment in line with the original planned targets (which were initially budgeted for by the National Treasury) then an additional 278 000 people would be on HAART. Instead, the Health Minister has yet to chart a way forward to address the human resources crisis in the health sector,[11] and has undermined the HAART rollout yet further by sending out confusing messages about the relative benefits of HAART, nutrition and unproven alternative remedies.[2,12] She has also undermined attempts by provinces to access Global Fund grants[6] and has yet to use her powers under the Patents Act to issue compulsory licences to enable the local production or importation of generic versions of the patented drugs which compromise over half of the value of the March 2005 tender.[13]

There are strong grounds for concluding that South Africa could have achieved a much higher HAART coverage than it has, and that the major constraint on the rollout is political will. The national Treasury has made resources available to the Health Minister to facilitate a HAART rollout, yet a significant proportion of these have not been used for this purpose. The Health Minister appears to be undermining rather than energising the rollout. A large part of South Africa's failure to achieve a higher HAART coverage must be placed at her door – and that of President Mbeki, who at the very least is complicit in so far as keeping her in her post is concerned.

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