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Économie publique/Public economics

12 | 2003/1
Varia

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Édition électronique
URL : http://journals.openedition.org/economiepublique/326
ISSN : 1778-7440

Éditeur
IDEP - Institut d'économie publique

Édition imprimée
Date de publication : 15 janvier 2004
ISBN : 2-8041-3945-X
ISSN : 1373-8496

Référence électronique
Kenneth J. Arrow, « The Locus of Decisions about AIDS/HIV, Malaria Treatment : what does Welfare Economics say ? A Question », *Économie publique/Public economics* [En ligne], 12 | 2003/1, mis en ligne le 03 janvier 2006, consulté le 02 mai 2019. URL : http://journals.openedition.org/economiepublique/326

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public economics

économiepublique

Revue de **l'Institut d'Économie Publique**

Deux numéros par an

nº 12 – 2003/1

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Imprimé en Belgique

ISSN 1373-8496
ISBN 2-8041-3945-X

D 2003/0074/278

économiepublique sur internet : www.economie-publique.fr

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Centre de la Vieille-Charité

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La revue économiepublique bénéficie du soutien du Conseil régional Provence-Alpes-Côte d’Azur

ISSN 1373-8496

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The Locus of Decisions about AIDS/HIV, Malaria Treatment : what does Welfare Economics say ? A Question

I have some questions about our attitudes to health care in the context of resource allocation as a whole. Traditional welfare economics, from Smith on, says that trade-offs between resource uses should be made by those who benefit and lose. In the context of health, then, should we subsidize anti-malarial or anti-retroviral drugs, or should we simply provide more resources to the individuals or nations ? Our standard theories and the usual advice of economists, for example with regard to housing subsidies, certainly tends to the cash transfer, to giving the greatest freedom of choice to the consumer.

Don't think I am unaware of the objections and reservations, many of which are in my earlier papers. They certainly modify the stark statement above, but they do not eliminate the problem. I'll list some. (1) Asymmetric information : this seems to be used sometimes as a general critique of all of welfare economics. (2) Uncertainty : in view of the uncertainty of medical care, there is a high economic value to insurance ; but markets for health insurance will not emerge in sufficient quantities because of moral hazards (see (1)). (3) Increasing returns, especially in pharmaceuticals, with high costs of development and testing. (4) Externalities : these are infectious diseases, so the social value of treatment exceeds the private.

Implications of (1). General remark : Classical and neo-classical economics is, in fact, based on asymmetric information. Each individual is assumed to know his or her utility function or production function. That was why the market was considered to be not merely as good as any other system but superior (in a Pareto sense, of course). Information, values, and endowments determine actions ; the ideal situation is when they are collocated. How then can transfers earmarked for health be justified (as for as asymmetric information is concerned) ? I am immediately concerned about this issue. I currently chair a study group for the United States

* Workshop on "Economic Issues related to access to HIV/AIDS care in developing countries", organized by IDEP and ANRS, Université de la Méditerranée, Marseilles 27 May 2003

Institute of Medicine whose subject is analyzing whether international expenditures to support more expensive anti-malarial drugs are justified.fh. Example : The Global Fund made a grant of $50,000,000 to Uganda for some anti-malarial project. The Ministry of Finance promptly reduced the Ministry of Health budget by an equal amount. It was probably carrying out the mandates it had learned from the current policies of the World Bank and the I.M.F. Of course, this was caught and reversed. But clearly a clever Minister of Finance will have learned a lesson and made the substitution another way. (This points to another implication of asymmetric information ; it is clearly impossible to avoid making funds fungible, even if you think they should not be.)

One argument based on asymmetric information is paternalism ; the international authorities know better than the countries or individuals involved. I think we do not want to go down that path.

What does asymmetric information make of individual responsibility ? It certainly can be maintained that AIDS/HIV can be avoided with very high probability by appropriate individual behavior, e.g., safe sex and avoidance of contaminated drug needles. Since the behavior cannot be monitored at all well, there would appear to be a strong case for imposing costs, either the risks of the illness or the costs of treatment, on the victims. It has been reported that the incidence of unsafe sex in San Francisco has risen sharply in recent years (possibly due to the presence of anti-retroviral drugs). It has also been claimed that Uganda's relatively good performance in containing AIDS/HIV has been due to greater reliance on individual responsibility.

I realize that this question flies in the face of conventional pieties. If I am wrong, I would like to understand why. Incidentally, there is no parallel question with regard to malaria.

Implications of (2) : Since insurance markets fail, government or publicly financed medical care can be regarded as a substitute. But that still leaves open the actual functioning of the system. If we had a fully functioning competitive insurance market, poorer individuals and countries would have poorer coverage.

Implications of (3) : This is not an issue with regard to current or immediately prospective anti-malarial drugs, for which intellectual property rights are non-existent and which have not been tested in ways which would meet FDA standards. But it is an issue in prospect and would certainly be important if we moved to possible (but currently non-existent) vaccines.

Obviously, when set-up costs are high, there is room to discuss their allocation in accordance to ability to pay. I have no problems with that. One does have to keep in mind the need to create incentives for the development of future drugs. At the moment, the system comes down to having the United States users bear the bulk of the development costs, with much less being covered by the monopsonistic systems of the other OECD countries and, we hope, very little by the rest of the world. So far,

the system has been working reasonably well. It provides, however, no incentive to develop drugs whose market is exclusively in poor countries. Thus AIDS/HIV drugs can be available because of the American market, but anti-malarials are not. Even within the United States, we have had the need to encourage orphan drugs through special privileges and subsidies. Again that system seems to be working well so far.

Implications of (4) : There are at least two kinds of relevant externalities here. One is the obvious question of contagion. The more AIDS/HIV victims there are, the more likely an uninfected individual will encounter one and become infected. A similar consideration holds for malaria, though the mosquito is an intermediary. Hence, there is a social return to reducing infection. My understanding, though, is that if the prevalence is sufficiently high, a reduction has low marginal value, because there are so many alternative sources of infection. This has certainly been claimed for malaria. Hence, the case for intervention is not automatic.

There is one more remedy for externality of contagion, not usually thought as economic, namely, quarantine. In the past, that remedy has been used more frequently than it is today. The current sense is that it is an infringement on freedom. If AIDS victims are a source of contagion, why are they not quarantined ? I have asked knowledgeable friends this question. The answer I get loops back to the first point (locus of information) ; it is that any potential infectee can protect himself or herself by suitable measures, and therefore the infected one need not be quarantined. But in that case we want to create strong incentives for potential infectees to take precautionary measure.

The other externality to treatment is negative, not positive. It is the increased possibility of mutation to drug-resistant strains of the infectious agent. This is already a serious issue for currently-used anti-malarial drugs and is the basis for the interest into shifting to newer (and more expensive) drugs.

The world seems to be moving to greater compassion for AIDS/HIV victims and, to a lesser extent, to the victims of other illnesses (malaria, tuberculosis). The economic costs are apt to be pretty small on any relevant world scale. But to the extent that economics is relevant, it seems to me that it raises questions that are important to address.