US leadership, millions of people living with HIV are receiving treatment, and perinatal transmission has been reduced. Research breakthroughs in the use of antiretroviral therapy mean that the tools to reduce new HIV infections in the United States and abroad are available. Reducing resources now could jeopardize these gains. Although global HIV incidence declined by 38% from 2001 to 2013, approximately 2.1 million people are newly infected each year. If funding for HIV prevention and care are reduced, more people could become infected, drug-resistant HIV could develop, and tuberculosis and other HIV-associated infections could spread. Costs related to HIV, tuberculosis, and all other causes of morbidity and mortality should be evaluated on their own merits. The point Emanuel missed is that with an infectious disease pandemic that is not curable and for which there is no preventive vaccine, stopping needed resources can result in a more expensive resurgence. For example, in the late 1980s in the United States, tuberculosis control programs were defunded and tuberculosis, including multidrug-resistant tuberculosis, resurfaced. Robbing Peter to pay Paul is not an effective strategy.

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In Reply There is always a scarcity of resources for public health initiatives. Inevitably, choices need to be made. Choosing to spend money on one option means the benefits that might have been accrued from the alternatives must be foregone. Those lost benefits are the opportunity cost of going with one option. Because the world will always have a scarcity of resources, including for public health measures, there are always opportunity costs. Spending money for HIV/AIDS prevention and treatment necessarily comes at the cost of not funding other potential public health efforts. Dr Cahill and colleagues seem to be unwilling to grapple with the scarcity of public health resources and what benefits might be foregone by not funding other programs. They only tout the benefits of spending money on HIV/AIDS interventions, never mentioning the opportunity costs. Simply mentioning that HIV/AIDS interventions might be cost-effective does not address the opportunity costs of those interventions—only relative cost-effectiveness does that.

Cahill and colleagues also suggest that this logic is “[r]obbing Peter to pay Paul.” Rather, it is more important to confront the very real scarcity of public health resources and their opportunity costs. Their position is socially, ethically, and financially irresponsible as it seems to imply that resource limits do not exist.

I do not doubt the many benefits of HIV/AIDS public health measures. Whether measured in terms of mortality, years of life lost, or cost, however, HIV/AIDS now has a relatively low health impact in the United States. This is largely because of the success of past investments. But the benefits of past investments do not create an entitlement to current and future public health resources. Otherwise, huge sums might still be spent combating polio or intestinal parasites in the United States.

Public health spending should be determined by the benefits of that spending. The big problem facing the United States today is not combating HIV/AIDS but the epidemic of chronic conditions, suicide, mental health, and lifestyle problems. Thus, as I argued in the Editorial, there is a good case to be made that public health spending should be directed not at HIV/AIDS but at health problems that are more prevalent and have greater social and health costs.

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CORRECTION

Incorrect Value in Figure: In the US Preventive Services Task Force Evidence Report entitled “Screening for Obstructive Sleep Apnea in Adults: Evidence Report and Systematic Review for the US Preventive Services Task Force” published in the January 24/31, 2017, issue of JAMA, a value was incorrectly reported in a figure. In Figure 2, the top left box should have reported 1206 citations identified, rather than 1205. This article has been corrected online.