Responding to Health Challenges:

the role of domestic resource mobilisation

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EXECUTIVE SUMMARY

Responding to Health Challenges: the role of domestic resource mobilisation

In 1990, the United Nations Development Programmes Human Development Index gave renewed recognition of the importance of health in development. Initially the UNDP, then the World Bank and the WHO, recognised that health was more than a human right, it was also critical for economic development. At the same time, HIV was spreading rapidly across the world. Initial fear that this would be a devastating global epidemic proved unfounded but in parts of eastern and southern Africa, prevalence rose and it was clear that AIDS would be ***the*** development challenge of the new century. The African Development Forum of the Economic Commission for Africa (UNECA), held in December 2000, was a watershed. The Commission on HIV/AIDS and Governance in Africa, established as a result concluded, "the epidemic poses a great threat to governance in Africa. In many parts of the continent the impact of AIDS already has significant consequences for all forms of social, economic and political activity and thus for governance for years to come". There was recognition by most ministers of health and some ministers of finance of scale and scope of the problem.

Internationally, donors stepped up to the plate. In 2001, at the African Summit in Nigeria, United Nations Secretary-General Kofi Annan called for spending on AIDS to be increased, and suggested "a war chest" of $7-10 billion. At the 2001 G8 summit, a new Global AIDS and Health Fund was announced to target AIDS, tuberculosis and malaria. In this year, the African Heads of State made the Abuja Declaration, a commitment to allocate at least 15% of annual budgets to the health sector by 2015. “Perhaps most importantly, the assembled African leaders made a promise that they would assume full responsibility for – and ownership of – the AIDS response.” In 2001, the UN hosted a General Assembly Special Session (UNGASS) on HIV/AIDS in New York, the first UN meeting devoted to a public health issue. In January 2003, President Bush announced the President's Emergency Plan for AIDS Relief (PEPFAR), with funding of $15 billion. Between 2003 and 2010 international funding for HIV/AIDS rocketed. The largest share came from the US government, through the PEPFAR, followed by the Global Fund (GF). As Laurie Garrett wrote:

> *By 2008 [AIDS funding] could be characterized as anecdotally enormously successful, but statistically, concretely, unable to account for precisely how donor funds saved lives, prevented ailments, or averted epidemics. Nobody was clearly in charge, and many NGOS and multilaterals openly battled one another over reputations and cash. Hooked on growth, global health had become a political movement, expert at lobbying the G8 and OECD for cash, and determined to reap larger financial harvests every single year. (Garrett 2013)*

The steady increase in international funding faltered from 2011, three years after the

financial crisis. There has been a growing examination, led unfortunately for the most part by donors and international agencies, to assess how to share the response to health issues. (This is driven by AIDS but applies to TB and malaria, and we need to remain aware of the importance of non-communicable diseases in the years ahead).

The paper is designed for ministers of finance and health of African countries, officials in these ministries, donors, implementers and civil society. It asks a series of important questions against a back drop of increasing demand and declining international funding:

- Where will resources for health in general, and AIDS, TB and malaria specifically, come from?
- Is there a need to increase domestic financing and why?
- How can this be done?
- What are the roles of governments, the GF and donors?

An important paper from Results for Development, notes:

> *While there may be scope for … 12 countries to increase its domestic financial contribution to the national AIDS effort, the political and fiscal challenges of doing so should not be underestimated. There are many obstacles to be overcome — including rigid budgeting practices that make it hard to reallocate revenues toward AIDS; the limited analytical and advocacy capacity of AIDS and health officials to make the case to their counterparts in finance ministries for more funds; and deeply ingrained perceptions by finance and other senior government officials that "donors will take care of the AIDS program," as indeed donors have done over the past decade.*

Current status of domestic financing

The biggest challenge the health sector now faces, is funding. Many of the current countries with the heaviest disease burdens are unable to fund their responses to AIDS, TB and malaria without international support. Significant progress has been made within Domestic Financing – between 2006 and 2011 global domestic investment has doubled spending on AIDS, TB and malaria. African countries are closer to reaching the agreed Abuja target, allocating 15% of their total government expenditure to health. In the table below, the percentage of government expenditure on health, as a proportion of total expenditure, is illustrated. (This is for expenditure on health, and not specifically allocated towards the three diseases AIDS, TB and malaria.)

Domestic Investment 2011: % of total government expenditure[1]

Country	%
Rwanda	23.7%
Togo	15.4%
Botswana	8.7%
Malawi	18.5%
Zambia	16.0%
Nigeria	7.5%
Kenya	5.9%
Tanzania	11.1%

Source: WHO: Global Health Observatory Data Repository

There are however, large inequities between country's contributions and ability to pay in the

low and middle-income countries, where the three diseases are concentrated.

Challenges in measuring health spending and options to address this

Tracking health expenditure, both donor and domestic, is problematic. Donors operate (understandably) in accordance with their national imperatives; domestic health spending is reported by governments as total spend on health. This amount is not necessarily disaggregated between general health expenditure and expenditure on the three diseases. The budgets allocated to the health ministry may not be further disaggregated to a level of disease or health system (similarly to prevention or treatment). Domestic funds for individual diseases flow through a cascade of hierarchical pools of funds that begin with country income. Quantifying the final domestic spend on health, especially at disease level, becomes challenging.

The definition of health expenditure differs between countries, with some including a proportion of welfare or disability in their health expenditure. Health expenditure may also go towards the development of infrastructure, such as building public hospitals; other countries may define this as public works or infrastructure expenditure. This is a challenge, as in countries with poor historical allocations of health expenditure, in the past substantial funding has been directed to infrastructure (building of hospitals). This definition problem accounts for some of the inequalities when measuring domestic health spending.

Another issue is that domestic health expenditure often includes international sources of funds, which is difficult to segregate out for countries without strong accounting systems in place. International donor funding is pooled with domestic funds, and then only afterwards is allocated to ministry budgets (i.e. health). This does not provide a reliable means of differentiating between donor and domestic funds.

All these issues can be addressed by implementing strong accounting frameworks. Greater international support can be given to countries by means of assistance in designing systems or accounting frameworks to manage funds. Helping countries track funds will improve accountability for domestic finances raised and spent. It will also provide a stronger assessment of domestic health spending, and a disaggregation of where funds are allocated.

Placing greater country ownership of spending, is crucial for the response. In an era of high international funding, donors are concerned about maximising value for money and achieving efficacy. An increase of domestic investment from countries will have the effect of shifting the responsibility of ensuring maximum value for money, accountability and measurement to recipient governments. This will ensure that international funding continues to flow. The burden needs to be shared and there must be evidence of this co-ownership. Ways to ensure better reporting (and accountability) of finances is by forming trust funds for specific diseases, and encouraging civil society to play a role.

Opportunities to increase domestic funding

Many African countries are now analysing options for sustainable financing of HIV, and

possible mechanisms for implementation. Some are aimed at shifting existing budgets toward HIV/AIDS spending, while others are considered new revenue collection. Options have been identified that, if implemented correctly, could generate approximately $15.5 billion annually including:

Summary of three diseases	US $ Billions
75% of an alcohol levy	3.9
Contributions from high revenue enterprises	2.4
Airline levy by all African countries	1.7
2% of public sector budgets earmarked for AIDS	2.4
Mobile phone levy	2.0
1% income tax levy earmarked for AIDS	3.1

Domestic financing could be enhanced by the establishment of a fund to generate and collect cash through levies on bank transactions and interest, air tickets, alcohol, soft drinks and cigarettes, as well as taxes on goods and services traded. Other small additions of taxes could be added to telephone calls and to each kilowatt of electricity consumed. Other initiatives to diversify funding sources include:

- An AIDS bond, attracting private-sector purchasers wishing to raise their corporate social responsibility (CSR) profile.
- A 'dormant' fund, using unclaimed property commercial accounts.
- An AIDS lottery.
- Remittances from the diaspora.
- Boosting private sector contributions.

Innovative financing methods have the potential to raise significant amounts. However, there are a number of caveats. First, up to now AIDS has dominated the global health architecture. The importance of TB, malaria and other diseases (including NCDs) is often overlooked. The challenge is to move forward with health issues; to use metrics such the Burden of Disease data to allocate funds; ensure economic tools are applied for value for money; and advocate for political leadership. Second, prevention is always a goal in health. African governments can save huge amounts by preventing all diseases, but especially AIDS. Bed nets are better than treating cases and dealing with the consequences of malaria. Third, health and especially AIDS, requires governments to look a long way into the future. A new HIV infection in a 20 year old today will mean that person will require treatment in five to 10 years, but will then need it for life. Finally, there are competing funding needs (climate change is the current favourite) and so sectors need to demonstrate their importance. There are two arguments from UNAIDS, specifically in favour of increased support of HIV treatment and prevention, and the disease's ongoing financing. First, investment into care and treatment today will lower costs in the long run by keeping people healthy. This will contribute to national productivity and less hospitalisation. Second, UNAIDS argues extensive ART treatment will act as a form of prevention: pay now so that you will not have to pay later. Epidemiologic data supports both arguments.

Partnership of the Global Fund, International Donors, and Domestic Governments

There exists a complementary nature of a partnership between the domestic players and international funders. It is well recognised that in order to respond to the three diseases, a co-ordinated approach must be taken. The international community has led this response in Africa and great strides have been made. Without continued support for the prevention, care and treatment for these diseases, Africa is at risk of losing ground in this fight. Therefore, it is important that the global community work together to prevent these epidemics from reversing the gains the world has made over the past 10 years, as a resurgence of these epidemics would result in costs that would likely grow beyond an affordable range.

A critical part of the Global Fund (GF) resource mobilization strategy is to advocate with implementing countries to increase their domestic resources. There still exists a gap in funding to reach all those affected, with international assistance reaching a plateau since 2008. Domestic financing has steadily been increasing since 2006. This is a strong indication of the commitment of governments to financing the response to the three diseases. In part, this is due to economic growth and perhaps greater availability of funds (in Africa), but there still exists a shortfall to fully respond to the disease needs and eradicate AIDS, TB and malaria. The financing architecture for the three diseases is dominated by a small number of countries, either donor countries from the OECD, or those middle-income countries with large epidemics.

There are four principal criteria that would be related to the level of investment that a government would be able to make for the three diseases:

- The level of national income, measured by gross domestic product (GDP) or gross national income (GNI). This is a proxy of the total level of resources available within a country.
- The degree to which the government is able to raise revenue from the economy through taxes, levies, domestic borrowing, or other means.
- The proportion of the government budget devoted towards debt servicing – where this is large, it can significantly reduce the available recurrent budget.
- The pre-existing pattern of disbursement to the different sectors. For example, if historical allocations to health have been low, then health infrastructure is likely to be poor and this will reduce the short-run capacity to absorb rapid increases and convert them into service delivery.

The core question is whether it is possible to define the ‘right’ mix of domestic and international investment in any particular country. Is there an acceptable ‘benchmark’ for the amount that countries might be able to invest from their own resources, and could that be used as a basis for defining the responsibility of the international community to provide additional assistance?

Drawing a clear picture of the current status in domestic spending and accurately measuring current and future allocations in expenditure will enable the international community to support

African countries. A shift of responsibility from donor countries needs to be made toward providing mechanisms of support in policy to raise and manage funding – this includes establishing policy to capture additional revenue, developing strong accounting frameworks to track funds, and mechanisms for accountability.

One should never neglect the major concerns of efficiencies and value for money, however providing support in these new areas will not only strengthen partnerships, it will increase available finance, improve relationships and effectively give control to countries that bear the burden of disease. This will draw the global community closer to winning the fight against AIDS, TB and malaria.

Recommendations

There is a need for better data. We are not clear on who is spending what. This is true of both domestic and international funding. However the data needs to be improved and accessible.

At the Ministerial Meeting on Domestic Financing for Health in Addis Ababa, participants stressed the need to have the latest reliable data on health expenditure. It was also recognised that a distinction between domestic and donor funds should be made to monitor the contributions of governments.

Development agencies need to support the work of collecting data, overseeing the process where necessary to ensure that sound data is gathered. Separate initiative funding should be allocated to support the work of national statistics bodies. The collection of quality data will ensure that funding is allocated correctly and used effectively within the context of health.

The Global Fund should work with other key donors as a 'thought leader'. It should provide support above and beyond funding.

This has been recognised and the GF is in partnership with programmes, such as the Pledge Guarantee for Health (PGH) and the Micro Health Insurance (MHI) programme.

The GF has begun providing support in various programmes. Programmes need to be implemented that are fit for purpose and meet set objectives. Common objectives are raising finances, sustainability, monitoring and evaluation. This will empower countries to do more on their own. The GF can use its experience to transfer best practices to other countries and use 'what works'.

The World Bank's research programme in technical efficiency should help shape health systems in years to come. This will assist countries in maximising the quality of domestic investments in terms of results and value for money.

Development partners should pay attention to guiding countries in allocative efficiency. Some countries may be neglecting prevention or treatment. In order to reach a tipping point, resources must be directed toward prevention **and** treatment. The combination will differ across countries.

Public private partnerships (PPPs) are key to domestic funding. These should be strengthened, expanded and new areas for PPPs should be explored.

The GF seeks to develop PPP. The MHI programme is working at both a country and regional level to formulate business models for

quality primary health care that are affordable, sustainable, scalable, and replicable. There are a number of other initiatives underway, which seek to deliver health care at a low cost. In Addis Ababa examples successful of PPPs were shared. Specifically, Mozambique was cited as good practice with clear separation of responsibilities where government provided policy and monitoring support as appropriate. There is scope for other countries to implement more PPP opportunities.

Health officials must be empowered to make the case to their counterparts in finance ministries for more funds.

There is a need to revisit the discussion of health and development and the costs of disease.

Political leadership is critical, and we need to develop advocacy messages to ensure that health continues to be a priority.

A few countries have already committed finance and health ministers to being champions for increased domestic spending on the continent. Access to health care and services have improved because of leadership from African leaders. Within African countries the responsibilities lie on leaders to make that change happen.

Development partners can work together with African leaders to develop advocacy messages, which are country specific. Development partners have experience working within complex international political scenarios, but African leaders will know what would work best within their context. Strong advocacy messages will ensure that health is a priority within government.

The role of civil society needs to be recognized and improved.

Civil society has had a strong influence on ensuring that health is a priority. Some countries still lag behind, not placing enough emphasis on health nor the importance of funding domestically. Nigeria is in the process of passing their National Health Bill, which promotes domestic funding. Civil society has shaped the health bills of many countries, such as South Africa.

We need to address the perception that "donors will take care of the AIDS programme".

The reality is that international development assistance (IDA) is decreasing at a time when the need for money is increasing. The international health funding landscape is changing, with funds redistributed to other development agenda items. IDA cannot be relied on as a source of funds, and the time has come for countries to step up to the mark and take responsibility of their own needs.

Development partners need to drive home the message that countries need to support their own programmes, and work with countries to enable them to do so. The ministerial meeting on domestic financing for health has shown that African countries are ready to do so. Now is the time for donors to help countries help themselves.

A question exists if it is possible to define the 'right' mix of domestic and international investment in any particular country? Initial thoughts are that this will vary country by country.

We should establish on a country by country basis an acceptable 'benchmark' for countries to invest from their own resources.

Development partners should play a role in assisting countries to define a mix of domestic and international investment. This will vary depending on countries ability to pay, a country's wealth, and the amount of international funding given to other key development areas. International funding directed to other priority areas should free up domestic funding for health. This will vary country by country but a norm, or a benchmark, should be developed so that countries can aim to reach set targets.

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2. Background

"Who controls the past controls the future. Who controls the present controls the past".
George Orwell

The 1990 United Nations Development Programme's Human Development Report stated: "The real wealth of a nation is its people. And the purpose of development is to create an enabling environment for people to enjoy long, healthy and creative lives". The Human Development Index (HDI) was constructed from three indices: life expectancy, educational attainment, and standard of living. AIDS had a dramatic impact on life expectancy, and hence the HDI, in some countries.

Health is crucial for human development.

The role of health in development was further recognised in 1993 by the World Bank in their sixteenth World Development Report (WDR), subtitled *Investing in Health*.[1] It also introduced the concept of burden of disease, work lead by Murray and Lopez. Under the subheading *Why Health Matters,* the report stated:

> *Good health, as people know from their own experience, is a crucial part of well-being, but spending on health can also be justified on purely economic grounds. Improved health contributes to economic growth in four ways: it reduces production losses caused by worker illness; it permits the use of natural resources that had been totally or nearly inaccessible because of disease; it increases the enrolment of children in school and makes them better able to learn; and it frees for alternative uses resources that would otherwise have to be spent on treating illness.* (World Bank 1993)

Coming plagues rear their heads.

In the early 1990s, indicators show there was an improvement in the quantity (length) and quality (Disability Adjusted Life Years - DALYs) of life. There were warnings not all was well. In Garrett's (1994) book, *The Coming Plague*, argued although scientists believed vaccines and antibiotics meant the end of global infectious disease threats, there were new and remerging illnesses.[2] Indeed, Garrett subsequently argued a functioning and efficient public health system was crucial to respond to disease threats.[3]

AIDS appears in 1981 - global panic.

There was, however, an invisible worm quietly growing in scope and scale: the HIV epidemic that has transformed public health. AIDS cases were first identified in 1981; the disease named in 1983; and by 1990, it was recognised by a few farsighted academics and public health specialists as a global threat. The 1993 WDR warned, "The AIDS epidemic through its effects on savings and productivity, poses a threat to economic growth in many countries that are already in distress."[4]

The Joint United Nations Programme on AIDS (UNAIDS), was established in 1996. In the same year, treatments that promised to extend patients' lives significantly were announced. However, this "triple therapy" was hugely expensive.

The AIDS epidemic caught global attention in 2000 when The US National Security Council stated that AIDS was, "a threat to U.S. national security that could topple foreign governments, touch off ethnic wars and undo decades of work in building free-market democracies abroad."[5]

The Durban AIDS Conference in July 2000 saw pressure for worldwide treatment; drug companies offering to lower prices; and Botswana announcing that they were to provide medicine to all. In New York the Millennium Summit at the United Nations set eight measurable millennium development goals for 2015. Health goals are reducing child mortality rates; improving maternal health; and combating HIV/AIDS, malaria and other diseases.

Africa wakes to the AIDS threat.

Concern about the impact of the disease was being expressed in Africa. The African Development Forum of the Economic Commission for Africa (UNECA), held in December 2000, was a watershed. The Commission on HIV/AIDS and Governance in Africa, established as a result, concluded "the epidemic poses a great threat to governance in Africa. In many parts of the continent the impact of AIDS already has significant consequences for all forms of social, economic and political activity and thus for governance for years to come."[6]

Arguments for investment in health were expanded in the WHO's Commission on Macro-Economics and Health (WHO 2001). The Commission stated:

> *Health is an intrinsic human right as well as a central input to poverty reduction and socioeconomic development. Cost-effective interventions for controlling major diseases exist, but a serious lack of money for health and a range of system constraints hamper global and national efforts to expand health services to the poor. The high burden of preventable diseases … calls for strategic planning of investments across health and health-related sectors to improve the lives of poor people and promote development.*[7]

African leaders commit to Abuja Declaration.

In 2001, at the African Summit in Nigeria, United Nations Secretary-General Kofi Annan called for spending on AIDS to be increased and suggested "a war chest" of $7-10 billion[8] (at the time only $1 billion per year was being spent). At the G8 summit it was announced a new Global AIDS and Health Fund would be established to target AIDS, tuberculosis and malaria. In this year, the African heads of state made the Abuja Declaration, a commitment to allocate at least 15% of annual budgets to the health sector by 2015. “Perhaps most importantly, the assembled African leaders made a promise that they would assume full responsibility for – and ownership of – the AIDS response.”[9]

The Global Fund is conceived.

In 2001, the UN hosted a General Assembly Special Session (UNGASS) on HIV/AIDS in New York, the first UN meeting devoted to a public health issue. In January 2003, President Bush announced the President's Emergency Plan for AIDS Relief (PEPFAR), with funding of $15 billion. International support to the AIDS response began to grow.

International funding grows.

Between 2003 and 2010 international funding for HIV and AIDS rocketed. The largest share came from the US government, through the PEPFAR, followed by the Global Fund (GF). It is worth noting that both were vertical funding mechanisms. In the case of PEPFAR, the US government, or more commonly their implementing agents, were to work in consultation with the recipient

countries and governments. For the GF, countries applied for funding. The question is, who wrote the national policies, strategic plans, and applications and what was the role of the donors in determining how the applications are framed? “In many cases, foreign consultants are hired to do the majority of the writing and funding partners are called in to review parts or all of the policy.”[10] This is of significance in the analysis of domestic funding.

Global governance changes.

“The spectacular growth of global health was propelled by urgency and activism, chiefly directed to the AIDS pandemic.”[11] This led to two fundamental changes in global health architecture, with the WHO’s importance and funding being diminished, and numerous entrants in the field: “spawning confusion, complexity, even anarchy in the governance of global health"[12].

> *By 2008 [AIDS funding] could be characterized as anecdotally enormously successful, but statistically, concretely, unable to account for precisely [how] donor funds saved lives, prevented ailments, or averted epidemics. Nobody was clearly in charge, and many NGOS and multilaterals openly battled one another over reputations and cash. Hooked on growth, global health had become a political movement, expert at lobbying the G8 and OECD for cash, and determined to reap larger financial harvests every single year.*[13]

AIDS, TB and malaria linked.

The AIDS epidemic was and remains a major global health threat and, for some African countries, it is a key development challenge. For the first part of the century the AIDS epidemic was treated as an exceptional disease. The close links with TB lead to that disease being included. The inclusion of malaria in the GF portfolio was because of the disease burden it accounted for; according to the Disease Control Priorities Project bed nets for malaria prevention were the most cost effective medical public health intervention (terms of dollars per year of life saved).[2] As AIDS was not the crisis once feared in Asia, the Caribbean and Latin America, but as malaria is an issue here, including this disease ensured the GF was global.

The need to increase domestic funding for AIDS, TB and malaria.

As a result of the AIDS epidemic, massive amounts of international funding were raised, however, these are now plateauing and will probably decline. At the same time domestic founding is growing. The paper looks at the trends and the rationale and ability of governments to finance the three diseases and linked health systems strengthening.

The role of government.

The paper is designed for ministers of finance and health of African countries, officials in these ministries, donors, implementers and civil society. It asks a series of important questions against a back drop of increasing demand and declining international funding:

- Where are the resources for health in general, and AIDS, TB and malaria specifically, coming from?
- Is there a need to increase domestic financing and why?
- How can this be done?
- What are the roles of governments, the GF and donors?

[2] Next cost-effective interventions were aspirin/beta-blockers for myocardial infarction, household malaria spraying, tobacco tax and BCG vaccine for tuberculosis (TB). ARVs are not high on the list.

3. 2013 Health Challenges: Disease burden and financing

The concept of universal health coverage.

In 2005, all WHO Member States made the commitment to achieve universal health coverage (UHC). This ties in with the belief that everyone should have access to the health services they need without risking financial ruin or impoverishment. The concept of universal health coverage was presented in *The World Health Report 2010* as having three dimensions: the health services that are needed, the number of people that need them, and the costs to whoever must pay – users and third-party funders. Under universal coverage, out-of-pocket payments would not exceed a threshold of affordability – usually set at zero for the poorest most disadvantaged people.

Governments to decide on the appropriate mix.

Governments should decide what health services are needed and how to make sure they are universally available, affordable, efficient and of good quality.[14] [15] They will differ from country to country as resources and causes of ill-health vary. In deciding which services to provide, institutes such as the National Institute for Health and Clinical Excellence (NICE) in England and Wales and the Health Intervention and Technology Assessment Programme (HITAP) in Thailand evaluate whether interventions are effective and affordable.

UHC is a challenge in the HIV, TB and malaria context.

While African countries have yet to achieve universal health coverage, this is a topic of relevance specifically in the context of HIV/AIDS, TB, and malaria. There need to be affordable intervention options. The establishment of research coordination committees, who can coordinate the efforts of research institutions, and hence, assess cost the effectiveness and value for money of options, is needed. These could maximise the proportion of the population covered by existing services and open up the door to more health services by offering additional types of interventions. While there are no national bodies in Africa which assess effectiveness of health interventions across diseases, there are a few that focus on specific research. For example, HIV research in Kenya is overseen by the Kenya HIV and AIDS Research Coordination Committee (KARSCOM), coordinating the efforts of research institutions, development partners, and medical centres.[16]

It is a challenge to decide how best to support health within budgetary limits - low-income countries cannot usually raise sufficient funds to eliminate excess out-of-pocket expenditures for all the health services that people need. Three options exist for spending: maximise the proportion of the population covered by existing services, diversify health services by offering more types of interventions, or use the money for financial compensation, thereby reducing cash payments for health care.[17]

Governments to decide on the appropriate mix.

Before moving towards UHC, the services and supporting policies required in any setting need to be defined, as well as the cost. Governments must establish how to move closer to universal coverage with limited financial resources. It is almost certain that the replacement for the Millennium Development Goals will not include specific health goals but instead will push for a form of UHC for all.[18] UHC will be the crucial post millennium health target and must be factored into thinking over the next two years.

Health (and climate) slip down the agenda.

An analysis of the post 2015 MDG High Level Panel Report by means of a 'word cloud' (number of times a word is mentioned in a report/document) places health below a number of other development goals such as Poverty, Growth and Access. This gives an indication of how the topic of health has fallen in terms of the post MDG priorities. Interestingly, in this diagram there are no specific diseases mentioned, and climate is a surprisingly low priority.

Slide 1: Post-2015 MDG High Level Panel Report Word Cloud

Source: Wagstaff, 2013[3]

3.1. The 2013 Disease burden

It is evident now in 2013 that the global population is better off and healthier than in 2000 (and all periods previously). However, there are new challenges including the rise in non-communicable diseases, environmental change and global governance.

AIDS and TB major killers outside developed nations.

There are some exceptions, as the Global Disease Burden data shows, specifically AIDS and TB and malaria. The WHO finds the major killers in low-income countries are lower respiratory infections: 98 per 100 000; this is followed by AIDS, 70 per 100 000; malaria is 7th on the list at 38 deaths followed by TB at 32. In lower middle income countries heart disease and stroke top the list, with AIDS coming in 7th at 24 deaths per 100 000 and TB 8th

[3] Note almost two-thirds of the global domestic financing is in upper-middle income countries. Low-income countries account for only 10% of the global total and lower-middle income countries about 25%.

at 22. Malaria does not feature on this list. In upper middle and high income countries none of these diseases appear in the top ten.[19]

3.2. International financing

The role of development assistance is questioned.

There is a general debate about international development assistance (IDA) which has intensified since the financial crisis of 2008. IDA declined between 1990 and 2000, from $80.3 billion to $76.4 billion (in 2009 dollars) but then began to rise. By 2010 the amount had increased to $123.5 billion largely driven by health spending. IDA fell by 2.7% in real terms from 2010 to 2011, the first drop since 1997 (OECD, 2012).[20] This trend is expected to continue. The 2011 IDA level represented 0.31% of the combined gross national income (GNI) of Development Assistance Committee (DAC) countries, (the international target is 0.7% of GNI). The largest donors in 2011 were (in decreasing order): the United States, Germany, the United Kingdom, France, the EU institutions, and Japan. The donors by proportion of GNI were, in decreasing order: Norway, Luxembourg, Sweden, Denmark, and the Netherlands. The principal recipients by total amount in 2010 were, in decreasing order: Afghanistan, Indonesia, India, China, and Iraq.[21]

The intellectual debate on IDA.

Four key books spelt out some dilemmas on IDA and its role, efficacy, and importance. Moyo's book, *Dead Aid*, argued IDA promotes corruption in government and dependence in citizens.[22] Sachs, in the *The End of Poverty: Economic Possibilities for Our Time,* suggests IDA should help the world's poorest people to get a foothold on the development ladder. His hypothesis is that IDA as an investment in global economic growth will strengthen the security of all nations. [23] Easterly, in *The White Man's Burden,* says successful poverty reduction programs are usually achieved through indigenous, ground-level planning, not through well-intentioned but policy-distorting official development assistance (ODA) that can worsen the plight of economies.[24] Finally, Collier, in *The Bottom Billion,* says the effect of aid in failing states is minimal and for it to be effective there is greater need for monitoring by donors.[25]

These lenses were not applied to health. It was seen as exceptional, with a moral imperative. This was driven by the AIDS epidemic.[4] Development assistance for health (DAH) was about 6% of IDA in 1990, 12% in 2001 and 19% by 2010).[26].

Development health financing increases.

DAH greatly increased, almost doubling from $5.7 billion in 1990 to $10.8 billion in 2001, and nearly tripling to $28.1 billion (2010 dollars) by 2012, according to estimates by the Institute for Health Metrics and Evaluation.[27] Most, (about 70%) of DAH, comes from governments. It should also be noted almost all money going through the World Bank, UN system, and GF comes from governments. In 2010, the United States was the largest governmental DAH donor; others (in decreasing order) were the United Kingdom, France, Germany, Canada, Japan, Norway, Spain, the Netherlands, and Australia.

[4] Sachs suggested if every American donated the price of a movie ticket and bag of popcorn the AIDS response would be funded.

Table 1 – Top Five Development Assistance Donors and Recipients

IDA Donors	DAH Donors	GF Donors	DAH Recipients
United States	United States	United States	Afghanistan
Germany	United Kingdom	France	Indonesia
United Kingdom	France	United Kingdom	India
France	Germany	Germany	China
EU Institutions	Canada	Japan	Iraq

Source: IMHE Database 2012[28]

DAH falls in UN, rises in GAVI and Global Fund.

There have been changes in the way DAH is disbursed, with a shift away from the traditional multilateral institutions and towards public private partnership (PPPs). The share of DAH channeled through UN agencies decreased from 35% in 1990 to 26% in 2000 and 17% in 2010, while the share of the World Bank and regional banks fell from 23% in 2000 to 8% by 2010. The shares via GFATM and GAVI grew from less than 1% of DAH each in 2002 (the first year for which data is available) to 12% and 4%, respectively, in 2010. The share of DAH going through bilateral agencies fluctuated but remained significant: 49% in 1990, 32% in 2000 and 43% in 2010.[29] This is illustrated on Figures 1 and 2.

Figure 1: International HIV/AIDS Disbursements in 2012, by Donor Governments[30]

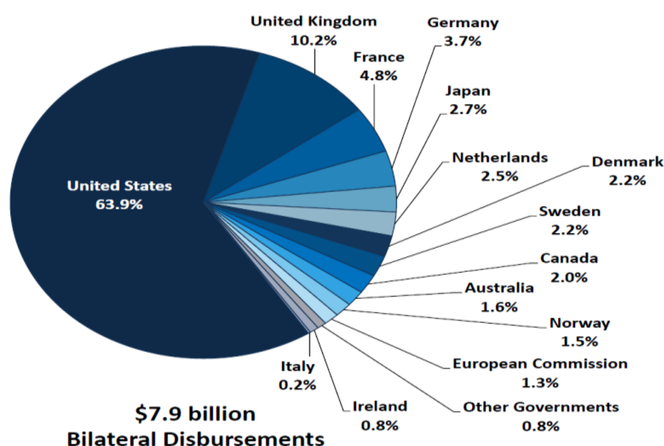
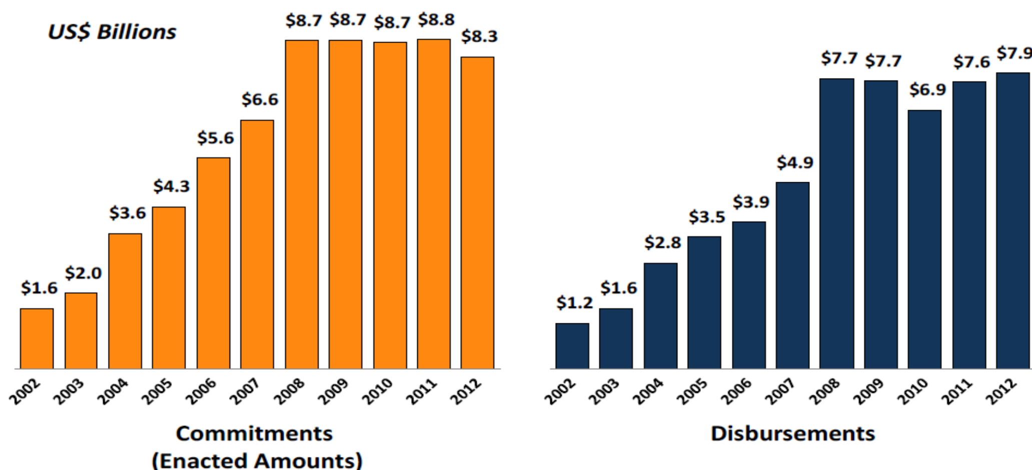


Figure 2: Total International AIDS Disbursements 2002-2012[31]



Control of AIDS slips from developing country governments.

A major consequence of the international attention to AIDS was that the issue and responsibility was taken away from developing country governments. There were two key aspects that made this somewhat inevitable: the involvement of advocates particularly from the developing world and the influx of resources, especially the GF and PEPFAR. This concern was noted in a recent review of 12 PEPFAR countries. The authors remark on, “deeply ingrained perceptions by finance and other senior government officials that ‘donors will take care of the AIDS program,’ as indeed donors have done over the past decade”.[32] This is significant for the discussion on domestic financing.

$87 Billion needed for the ATM response 2014-2016.

Before moving on to the sources of funding, it is worth asking how much is needed to finance HIV, TB and malaria programs in GF recipients. The GF collaborated with partners (UNAIDS, WHO, Stop TB partnership and the Roll Back Malaria Partnership) to estimate the total resources required over the 2014-2016 period. The Fund estimates US $87 billion will be required to reach all vulnerable populations in eligible low and middle income countries with essential services, to bring the three diseases under control.[33] It is expected that $24 billion will come from international funding; $23 billion from existing domestic funding with a further $14 billion raised domestically, giving a total of $37 billion. Finally the GF is raising an additional $15 billion, amounting to $76 billion. This will cover 87% of the resources needed.

The response is long term and expensive. Changes in global attention mean the place of AIDS TB and malaria is no longer clear. There needs to be (re) thinking on global rights and responsibilities. We argue the GF must be truly global: all nations must be involved as recipients, contributors or in governance.

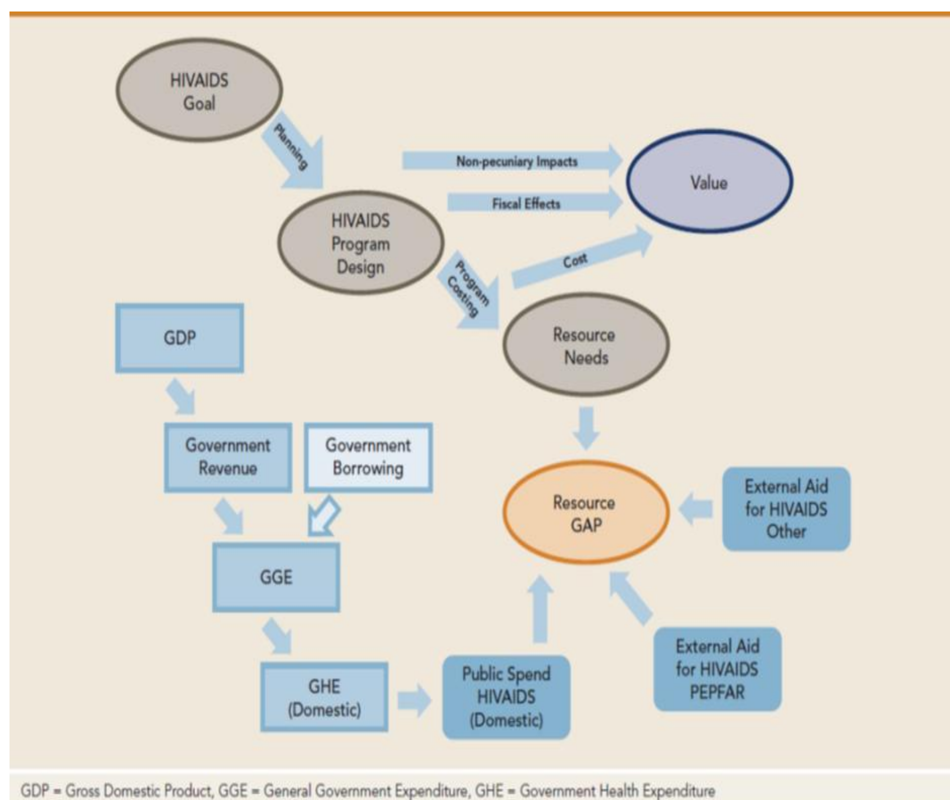
4. The resource mobilisation processes

Expenditure on health in a country can come from domestic or international sources. International development assistance for health has been discussed above. Domestic funding can come from the public sector, private health care and out of pocket expenditure. The mix varies from country to country, in this paper the focus is on domestic public funds.

No good deed goes unpunished.

There is a concern, particularly among bilateral donors, about the cost of AIDS and the long term nature of its treatment. This was well described for the US in a Foreign Affairs article, *No Good Deed Goes Unpunished* (one of the authors was a former American Ambassador to South Africa).[34] This concern over the 'treatment mortgage' does not apply to TB and malaria. As the US is the largest donor to health and HIV/AIDS (and the GF) these concerns should be taken seriously. The Results for Development analysis is particularly important, although it is for only 12 countries.[35]The logic model diagrammed in the figure below is for AIDS but can be applied to any disease, as well as non health spending. Resource needs for AIDS control goals are matched against financing.

Figure 3: AIDS financing model



Source: Results for Development

4.1. Government Budgeting

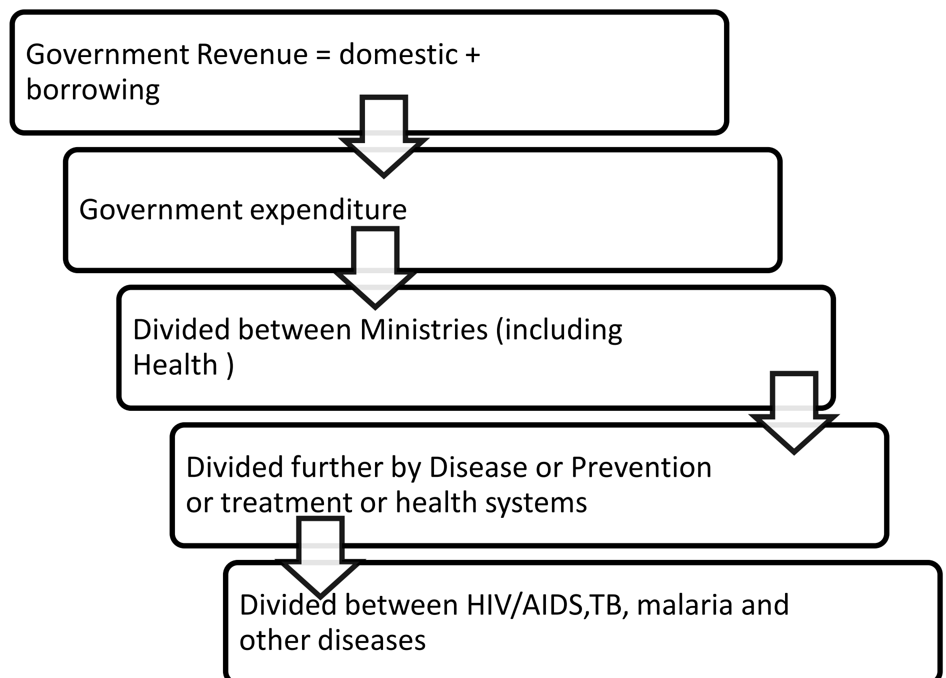
Determinants of funding.

What are the determinants of funding to a disease? The Research for Development paper notes:

> *"Domestic funds for AIDS flow through a cascade of hierarchical pools of funds that start with country income. Within this overall country income constraint, the size of these pools for government revenue, total government expenditure, health expenditure, and AIDS expenditure are largely a function of policy choices. But, at each lower level the resource allocation decisions are constrained by the decision at the level above. So, AIDS spending levels depend heavily on health spending and overall government size".*[36]

It is worth noting that governments can borrow if they choose to, thus another diagram might be:

Figure 4 Raising, Spending Money and Decision Points



Decisions need to be based on politics and economics.

One of the basic rules of public economics is that the resources (money) can be used only once. At each point in the diagram above there are choices that have to be made, thus the issues become more than economic decisions. Consideration must be given to politics, human rights, morality and policy. It is also worth noting that there may be different levels of spending, responsibility and control in a country: national, provincial and local governments.[37] There will be spending in ministries, other than health, that will impact the health of the population – for example school campaigns. These need to be considered but are beyond the scope of this paper.

Health needs change.

All budgets require constant attention from governments and policy makers, as the needs of a population do not remain static. For health, specific issues include changes in population numbers and distribution patterns, as well as changing disease burdens. Because health needs change, collecting accurate data and incorporating it into the budgeting process is required, so that sufficient resources can be allocated to managing needs.[38]

Budgeting depends on finance not health.

Government budgets are often based on previous year's expenditure plus 'x'. The actual drawing up of the budget is done almost entirely by civil servants, including the financial directorates in ministries or departments. These budgets go to the national level (Minister of Finance), which then negotiates with departments. Departments will defend their estimates and agree to budget cuts, so that estimates match the amount of money the minister of finance allocates. This is then presented and (hopefully) approved by parliament. Choices are made. The roles of civil society and watchdog groups are important in this. There are special interests, such as gender or child budget monitoring, and these can be valuable.

Information is critical for resource allocation.

Resources may be poorly allocated. This can happen for a number of reasons. One possible explanation is that countries do not have access to full information required to make good decisions regarding funds. However, in this paper it is important to note AIDS is a privileged disease. We already know what works in terms of treatment, and modern advancement constantly reduces the cost of treatment. The cost means economic tools become especially important and "most countries do not have access to information about the cost effectiveness of different interventions".[39]

There are issues of applicability: the studies on different cost-effective interventions can be inadequate as policy makers might view studies conducted in one region as inapplicable to others.[40] Countries may not allocate public resources correctly because of the contradictory results, which occur in the scientific world.[41] This lack of consistency leaves policy makers unable to determine how to effectively budget for different health initiatives.

There is a critical need for political leadership.

Moving away from technical reasons as to why governments fail to budget and allocate resources optimally, a third explanation for poor resource allocation on healthcare is a lack of political will, leadership and/or transparency. The key to successfully strengthening the health system in Africa will "ultimately reside in national leadership"[42]. Leadership needs to have a political vision that gives health a priority over other national challenges. National strategies should be based on demand rather than supply or donor driven agendas. Countries should work towards setting their own management systems or trusts to oversee collection and spending of funds.

Money can attract like 'ants to a sugar bowl'.

Poor resource allocation can result from a country's lack of control over their resources. This is due to the fact that some international donors have their own agendas to fulfil. In many of these cases, recipient countries are "likely to be hesitant to turn down resources, even if those resources will skew the national response towards intervention which planners do not believe will be successful".[43] As a result, countries (or aid organisations) adjust their plans, or spending based on the goals of the donor. This may not be the best use of funds, but rather a means for the "ants to get into the sugar bowl".[44]

4.2. IDA and increasing national roles

Development health financing to fill resource gaps.

IDA was based on the assumption that low-income countries had difficulty with raising domestic resources. Scholars suggested that increasing domestic resource mobilization in Africa would be a 'hard option'. Thus, discussions on how to fill Africa's 'resource gaps' focused heavily on the increase of external flows, such as IDA and FDI, as well as debt reduction

Dangers of 'fungibility'.

In general, "although total foreign aid into a developing country does not reduce public spending, aid to a specific sector often results in diverting public resources to other sectors of the economy".[45] The health and agricultural related projects exhibited the most substitution, compared to sectors, such as education, energy, transportation and communication.[46] A study by Shiffman (2007) examined the effect of increased donor funding for HIV/AIDS on other health-sector development and found that "governments probably substituted funds, but increases in overall health aid may have masked some of the effects".[47] Lordan (2011) found that donor funding for HIV/AIDS was significantly displacing effects for malaria and health sector funding, but not for TB.[48]

It is important to consider the long term consequences of health aid fungibility as this, coupled with volatility in donor funding, will have negative effects on the allocation of resources.[49] As donors reduce or stop funding for their priority activities, it becomes difficult for governments to shift resources back to this activity, especially if funds are committed.

IDA can play a catalytic role but governments have to commit.

It is important that governments recognize negative long term consequences associated with under-spending and reallocating health funds into other sectors. While IDA and DAH play an important "catalytic function for countries to finance their push towards universal coverage and better health policies", domestic resources for health must increase in order to ensure sustainable health financing in the long run.[50]

Efficiency, effectiveness and value for money.

One area that has been seen as particularly important in the area of AIDS support, is increasing efficiency and effectiveness. The argument is: a great deal of money has been spent on this disease; because there was so much it may not have been spent in the most efficient and effective manner; by spending better we can get 'more health for our money'; once this is done we can request 'more money for our health'. This fits in with some of the current buzz words like 'value for money' and is an argument for better economic analysis.

Donor will take care of the AIDS problem, they always have.

The R4D 12 country study noted:

> *While there may be scope for each of the 12 countries to increase its domestic financial contribution to the national AIDS effort, the political and fiscal challenges of doing so should not be underestimated. There are many obstacles to be overcome — including rigid budgeting practices that make it hard to reallocate revenues toward AIDS; the limited analytical and advocacy capacity of AIDS and health officials to make the case to their counterparts in finance ministries for more funds; and deeply ingrained perceptions by finance and other senior government officials that "donors will take care of*

the AIDS program," as indeed donors have done over the past decade.[51]

The next part of the paper looks at domestic resource mobilization. Critical, is that the decision is taken to allocate any increased funding to health, and specifically to the three diseases and associated health system strengthening.

4.3. Benefits of domestic resource mobilization

What is domestic resource mobilisation?

Domestic resource mobilization (DRM) can be defined as "the generation of savings from domestic resources and their allocation to socially productive investments".[52] DRM involves the mobilizing of human and financial resources for investment, and both the public and the private sector have important roles to play in DRM. The public sector mobilizes domestic resources through "taxation and public revenue for investment in social services and infrastructure", while the private sector "mobilizes the savings of households and firms through financial intermediaries, which allocate resources to investment in productive activities". [53]

Domestic mobilization reduces dependency on external flows.

Strengthening domestic resource mobilization reduces governments' dependency on external flows of financing and vulnerability to external shocks.[54] DRM can play a critical role in the long-term sustainability of development efforts, especially in health where aid is extremely fungible. Increasing domestic resource mobilization increases policy space, gives ownership over development processes and strengthens state capacity.[55]

Increased spending on medical care translates into economic benefits.

Turning to health, a working paper from the African Development Bank demonstrates that if governments increased spending on medical care interventions, such as ART, the expenditure would slow down HIV/AIDS, translating into economic benefits. [56] More adults would be alive, healthy and working, increasing overall employment productivity.[57] The report also notes that if public finances are used to achieve socially optimal reduction targets in the HIV prevalence rates, the debt burden of these countries will be alleviated. Specifically, if Botswana, Lesotho and Swaziland invested optimally in health, debt burdens could be reduced by 5%, 1% and 13% of GDP, respectively.[58]

Health spending improves development indicators.

Domestic spending and investments in health results in lower infant and child mortality rates.[59] Countries with higher levels of 'good governance' were more effective at reducing the infant and child morality.[60] This is important because it demonstrates the role of good governance, accountability and transparency in effective health spending. It is also an indicator of the value of having a vibrant civil society.

The role of the private sector.

Almost 50% of total health expenditures in the African region are from private spending, of which "approximately 71% of expenditures are from direct household out-of-pocket payments to various health service providers."[61] The private sector can contribute via health insurance or national social health insurance schemes. This is critical in producing and supplying health technologies, drugs, and other health related commodities, such as bed nets.

The 12 Country PEPFAR study says countries can contribute more.

The headlines of the 12 country PEPFAR study were that domestic AIDS spending falls short of benchmarks for 'fair share' in most, and all had fiscal space to contribute more from domestic resources. (Botswana and South Africa should soon be able to finance their AIDS programs entirely from domestic resources. It should be noted that although the study predicts no

gap, Wilson of the World Bank warns Treatment as Prevention means the entire domestic South African health budget would be spent on this intervention[5]).

Research For Development concluded that even if countries paid the maximum 'fair share' domestic financing of their AIDS programs, many, especially low-income, high burden countries, will need substantial external support for 'some time'. This also holds true for TB and malaria. Worryingly, they state it would be difficult politically to achieve the maximum domestic financing targets, although, achieving them even partially would represent progress.

The necessary but not sufficient prerequisites.

In order to achieve the goal of more ambitious domestic funding levels and robust financing for national programs, countries should generate and publish better data on each disease (AIDS, TB, or malaria) and expenditures; have more accurate and up to date national baseline expenditures; have better quality and consistency of estimated disease resource needs; and agree financing scenarios with 'fair and sustainable' benchmarks. Donors need to provide countries with more predictable, medium term estimates of future financing.

[5] This was presented at the Treatment as Prevention Conference in London in September 2013

5. Domestic investment in health

More domestic funding will help mobilize international resources.

A critical part of the GF resource mobilization strategy is advocating for implementing countries to increase domestic resources. There needs to be a commitment to raise at least $37 billion. This local funding is important in terms of ownership, accountability and sustainability. It is also to support the replenishment, as it will enable the GF to leverage additional resources from traditional and new donors, including the private sector.

During the first decade of the century the constraint was capacity. Today the biggest challenge in terms of health is funding (although capacity remains an issue). Many of the countries with the heaviest disease burdens have limited means of self-financing their responses to AIDS, TB and malaria.[62] They have national strategies but face challenges of operationalizing them and securing the resources. As a result, plans are often left unimplemented and/or under-resourced. [63]

5.1. Financing background

Whose responsibility and what is fair share.

Health is a responsibility of government, and therefore, one of the criteria for development assistance is that there be a commitment by governments to spend domestic resources, as well as allocated development assistance on health. International support should be additional to government expenditure and not displace domestic funding. There are three big questions.

- How can domestic funding be mobilized?
- How does domestic funding influence donor decisions, and vice versa?
- What is fair share? [6]

The 'Abuja Declaration' says African Governments should spend 15% of government expenditure on health. The 'Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa' proposed by the African Union[7], expresses expectations about binding commitments from the international community. How important are these? There have been a significant number of declarations with respect to health. These are listed in the Appendix. The question remains: how binding they in fact are and how seriously governments take them? This is certainly an opportunity for civil society.

Funding architecture changing but is dominated by a few donor and recipient countries.

The composition of the international response to HIV, TB and malaria has changed significantly since 2007. International funding has levelled. Funding for all three diseases from domestic public sources in low and middle-income countries began to grow steadily after 2001 in line with economic growth (see Figure 5). Although increased domestic allocations were off a very low base they have continued to grow despite the global economic downturn.

There are, however, large inequities between the contributions and ability to pay in the low and middle-income countries where the diseases are concentrated. The financing architecture for the three diseases is dominated

[6] The general government expenditure on health as a % of total government expenditure is 7.5% in Cambodia, 7.5% in Congo DRC and 22.39 per cent in Uganda.
[7] This draws upon the 2001 ', the 2006 'Abuja Call' and 2010 'Kampala Declaration'

by a small number of countries, either donor countries from the OECD, or those middle-income countries with large epidemics.

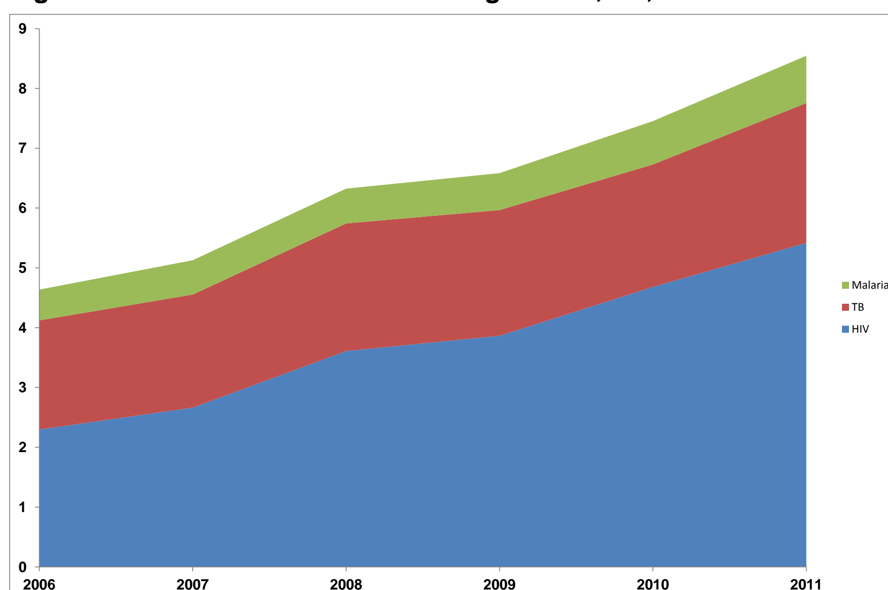
5.2. Past levels of domestic investment

Domestic public investment. Table 2 shows estimates of total domestic public investment in the three diseases within GFATM-eligible countries for 2006-11, as prepared in March 2013 for the GFATM replenishment request. The estimated global total of domestic investment was about $8.5 billion, which is approximately 47% of the estimated global total from all sources (including external).

Table 2: Summary of Domestic Investment 2006-2011 ($US billion)

Summary of three diseases	2006	2007	2008	2009	2010	2011
Domestic Investment Total	**4.64**	**5.13**	**6.32**	**6.58**	**7.45**	**8.55**
HIV	2.30	2.66	3.61	3.86	4.68	5.42
TB	1.82	1.89	2.13	2.10	2.05	2.34
Malaria	0.51	0.57	0.58	0.62	0.73	0.79

Figure 5: Trends in domestic financing for HIV, TB, Malaria 2006-11



Source: Data submitted for GFATM replenishment request, March 2013[8]

[8] Note almost two-thirds of the global domestic financing is in upper-middle income countries. Low-income countries account for only 10% of the global total and lower-middle income countries about 25%.

5.3. What constitutes ‘fair share’ for HIV, TB and malaria? Is health a public or merit good?

Domestic funding will still account for less than half the resources.

It is estimated, US $87 billion will be required to reach all vulnerable populations in eligible low and middle income countries between 2014 and 2016. The hope is that $24 billion will come from international funding, excluding the $15 billion the GF aims to raise on 3rd December at the pledging conference in Washington. At present it is believed $23 billion will come from existing domestic funding. The target is to raise a further $14 billion domestically, giving a total of $37 billion. The total funding for HIV/AIDS, TB and malaria at that point would be $76 billion; 87% of the resources needed. However, this means more than half resources will come from international sources. This is unsustainable given the global economic climate, and the competition for funds. One question to pose is the role of China and India in this area.

What is a fair share?

These imbalances raise the question of what kind of funding distribution could be regarded as constituting ‘fair share’. What contributions can or should be expected from low and middle-income countries given their economic and fiscal situations, and their disease burden – and what contributions can or should be forthcoming from high-income countries?

While it is important to maximise the potential of domestic sources to finance the three diseases, it is equally imperative to understand their limitations. A productive debate requires acknowledgement that both domestic and international sources will need to be sustained and increased if global targets are to be met. In this sense, it is vital to discuss this issue in the context of a shared responsibility.

The concepts of public and private goods.

Much of the debate about shared responsibility for the provision of health services in general, refers ultimately to whether or not health service provision might be regarded as a ‘public good’, or alternatively a ‘merit good’ – terms that are understood in different ways, and often not distinguished from each other.

Treatment more a ‘private good’ than prevention.

From a purely economic standpoint, many of the services or commodities that are part of the response to the three diseases are private, rather than public goods. They are both ‘rival’ (meaning that they cannot be consumed by more than one individual at a time) and ‘excludable’ (meaning that it is possible to prevent their consumption by everybody). The response to all three diseases involves a diverse set of activities that are delivered in varied circumstances, some of which are public, and some private, while others may be classified as somewhere in-between. However, it is also clear that even the components that satisfy the attributes of private goods are universally regarded as ‘merit goods’ – in that they generate significant externalities in the form of economic benefits to individuals and society as a whole, and would be under-consumed in a purely private market due to the relatively low-income levels in the countries or communities with highest burden.

5.4. Rationale for domestic engagement

The world is at a tipping point…

… and national governments must shoulder more responsibility

Despite significant progress in the battle against HIV/AIDS, TB and malaria, these epidemics continue to impose a devastating human and economic toll. Without sufficient resources to support the prevention, care and treatment for these diseases, the world is at risk of losing ground in this fight.[64] Therefore, it

is important that the global community work together to prevent these epidemics from reversing the gains made over the past 10 years, as a resurgence of these epidemics would result in costs that would grow beyond an affordable range.[65] In the past, the international community took responsibility, today if national governments do not take a lead then it is probable that international resources will diminish further.

A critical part of the GF resource mobilization strategy is to advocate with implementing countries to increase their domestic resources – at least $37 billion is needed from national governments, and there will still be a shortfall.

There is a need for public intervention.

The key implication from economic arguments is a clear justification for public-sector intervention in response to the three diseases. This implies the responsibility for the response is a public one – in other words it is shared across the whole of society within affected countries, and between countries given the global nature of all three diseases and their economic consequences.

Country ownership is crucial for the response and international mobilization.

These considerations justify a closer examination of the pattern of current financing, whether there would be a better or fairer way to share it, and whether there are alternative sources of funding that would work better. Increasing their own level of investment is an effective way for low and middle-income countries to gain a greater degree of ownership of their own programmes, control over how resources are deployed, and leverage in global debates over the size and distribution of aid budgets from high-income countries.

The right mix of public and private funding.

The core question is whether it is possible to define the 'right' mix of domestic and international investment in any particular country. Is there an acceptable 'benchmark' for the amount that countries might be able to invest from their own resources, and that could be used as a basis for defining the responsibility of the international community to provide additional assistance?

5.5. How much is enough? What can countries afford?

IDA is falling and the gap is growing.

The reality is that IDA is decreasing at a time when the need for money is increasing in a number of African countries. This is primarily because of the rise in AIDS and consequently TB. The international community is concerned by this and looking at ways to fill the gap. This paper is just one of a number of recently commissioned or published works. Before moving on to review these, some background is necessary.

The principal criteria for the level of investment.

There are four principal criteria that would be related to the level of investment that a government would be able to make for the three diseases:

- The level of national income, measured by gross domestic product (GDP) or GNI. This is a first approximation of total level of resources available within a country.
- The degree to which the government is able to raise revenue from the economy through taxes, levies, domestic borrowing, or other means. This might be measured by the total government revenue, or more usually by the government recurrent expenditure budget (which is usually larger as a result of deficit borrowing).

- The proportion of the government budget devoted towards debt servicing – where this is large, it can significantly reduce the available recurrent budget.
- The pre-existing pattern of disbursement to the different sectors. For example, if historical allocations to health have been low, then health infrastructure is likely to be poor and this will reduce the short-run capacity to absorb rapid increases and convert them into service delivery.

5.5.1. Recent studies

Increasing to the 'fair' level.

A 2013 publication by Galárraga et al.[66] modelled per-capita domestic HIV contributions as a function of per-capita income, relative size of the health sector, and per-capita foreign debt service, and used the predicted values to represent a benchmark against which to identify imbalances between countries. The authors concluded that global domestic financing could increase substantially if countries that were below their expected level increased in order to match it.

The PEPFAR 12 country study.

The study of HIV financing in 12 PEPFAR countries [67] described three possible benchmarks for measuring 'fair share' for domestic financing: 1) domestic spending would be expected to rise in line with economic growth; 2) domestic spending would be expected to rise in line with health budgets (particularly relevant to the 'Abuja Target' to spend 15% of overall government expenditure on health); and 3) the share of the health budget allocated to HIV could increase to match its share in the total national disease burden (as measured by the DALY).

The 'DIPI' Index of Domestic Priority. A new idea.

The approach taken here is related to all of those described above, and is based on the index of domestic priority (the 'DIPI') developed by UNAIDS for the purpose of benchmarking HIV domestic investment, but also applicable by extension to both TB and malaria.[9] This is based on two main assumptions:

1. A country's <u>ability</u> to pay from domestic public sources is dependent on the overall size of the government expenditure budget, which is a proxy for the available resources.
2. A country's <u>need</u> to pay for HIV from domestic public sources is related to a unit of disease burden, chosen as follows:
    - For HIV, the number of people living with HIV.
    - For TB, the number of people living with TB.
    - For malaria, the size of the population at risk.

The DIPI index expresses the ratio:

$$DIPI = \frac{Domestic\ expenditure\ per\ unit\ of\ disease\ burden}{Government\ budget\ per\ capita}$$

Both the numerator and denominator of this expression are larger in a country with higher available income, but the ratio between them may not be any larger than it is in a low-income country. The value of the DIPI index should not vary simply because of differences in income levels or disease burden levels. The differences in DIPI values could therefore have a normative interpretation – expressing the 'level of effort' or priority accorded to each of the three diseases in a country.

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[9] Regrettably nothing is published and citable (yet) – this was an internal GFATM paper written by Robert Greener for the GF.

TB has highest ranking followed by HIV and lowest is malaria.

There are very different values of the DIPI index for all three diseases. The median value for HIV in 2011 was 0.27 – this means that the investment per person living with HIV averages about 27% of the per-capita government budget across countries. The median for TB was 0.51, meaning that the investment per TB case is about 51% of the per-capita government budget, somewhat higher than for HIV. For malaria, the median value was only 0.00056. This means that the average investment per person at risk of malaria is only about 0.06% of the per-capita government budget. Even allowing for the fact that the denominator is larger (the population at risk rather than the number of cases), it is clear that domestic investment priority for malaria[10] is somewhat lower than for the other two diseases.

In the case of HIV, many of the highest spending countries are below the median. For TB, most of the highest spending countries are on or just above the median, and for malaria, the picture is balanced – there are high spending countries both above and below the median. The enormous variation between countries in the values of the DIPI index suggest that there is significant potential for increased domestic investment in some of them but not others, and that the index values might be used as a first-level indicator or benchmark for assessing this potential.

A sample of countries show varying levels of DIPI, some have yet to reach the median value of 0.27. The table below indicates a sample of countries, with a few other key indicators to illustrate the % of total government expenditure, HIV prevalence and treatment or coverage of ARTs."

Table 3: Summary of Domestic Investment 2006-2011 ($US billion)

	DIPI	% of total govt expenditure[11]	HIV Prevalence	Treatment/ Coverage: ART
Rwanda	0.62	23.7%	2.9%	81.7%
Togo	0.66	15.4%	3.2%	42.0%
Botswana	0.24	8.7%	23.4%	95.0%
Malawi	0.01	18.5%	10.0%	67.0%
Zambia	0.13	16.0%	12.5%	77.0%
Nigeria	0.10	7.5%	4.1%	26.5%
Kenya	0.40	5.9%	6.2%	72.3%
Tanzania	1.00	11.1%	5.8%	39.7%
Median	0.27			
75th Percentile	0.68			

Source: UNAIDS, Oxford Policy Management and Authors own calculations

[10] It should be noted that investment in malaria is concentrated on prevention activities, with very little spending taking place on treatment.

6. Potential for domestic growth

6.1. Economic growth and reprioritisation of health

Economies will grow.

The DIPI index suggests a method for projecting the potential for future growth. As a starting point, we would expect domestic expenditure to increase in line with economic growth, which would translate into growth of available resources and government budgets, all else being equal.

But will governments prioritise health and the three diseases?

A first estimate of the expected future domestic expenditure was therefore made by applying the IMF forecasts of the growth of total government expenditure to the 2011 estimates. This assumes all countries will continue to allocate the same proportion of available budgets to the three diseases as they do at present. The resulting projections are shown in the first row of Table 3. This might be thought of as a "business as usual" forecast, countries will continue to invest according to the pattern found in 2011, and there will be no prioritisation in favour of the three diseases before 2016. It can, therefore, be regarded as a pessimistic forecast, or lower bound.

As a second step, we establish a normative criterion based upon the DIPI index, which assumes that countries below the median DIPI level for each disease are able to reallocate in order to increase toward that level by a target year (in this case 2020), while countries above that level remain as they are (i.e. increase only according to economic growth). The resulting projections for both scenarios are shown in the following table.

Table 4: Summary of Domestic Investment 2006-2011 ($US billion)

Summary of three diseases	2011	2012	2013	2014	2015	2016
Economic growth only	8.55	8.81	9.01	9.36	9.74	10.18
Moving to the median DIPI value	8.55	8.81	9.69	10.79	11.92	12.96

Probably not enough.

Under these assumptions, the total domestic spending on the three diseases might be expected to grow from $8.55 billion in 2011 to $10.18 billion in 2016, as a result of economic growth alone. If countries with below-average priority for the three diseases reallocate accordingly as well, the global total could rise to almost $13 billion. The total for the three years 2014-16 might therefore rise to somewhere between the two – from $30-35 billion, implying a growth rate of between 4-8% per annum. Importantly, this is well short of the global need for those three years, which is in the vicinity of $87 billion. A shortfall of some $52-57 still remains. This analysis therefore suggests that it is unrealistic to meet the current global targets for the three diseases purely through increases in domestic investment. There is a continuing need for further increases from the international community.

6.2. Fiscal space and innovative sources

New and innovative financing options.

African countries have depended heavily on external funding sources for health for many years. Donor funds are declining as a result of the global financial crisis and new donor priorities. There is a shortfall in funding required to meet the gap which would need to be met at a domestic level. It is important to look at innovative ways of raising the additional funding. Many African countries are analysing options for sustainable financing of HIV, and possible mechanisms for implementation.

New and innovative financing options.

Oxford Policy Management (OPM) has been working in countries, examining the projected financing gap, based on projected resource needs in strategic plans, and on expectations of both domestic and external financing. Options have been identified that, if implemented correctly, could generate approximately $15.5 billion annually[68]. Some are aimed at shifting existing budgets toward HIV/AIDS; others are considered new revenue collection.

Table 5: Options for domestic-HIV financing in Africa

Summary of three diseases	US $ billions
75% of an alcohol levy	3.9
Contributions from high-revenue enterprises	2.4
Airline levy by all African countries	1.7
2% of public sector budgets earmarked for AIDS	2.4
Mobile phone levy	2.0
1% income tax levy earmarked for AIDS	3.1

Source: Estimates for UNAIDS by Oxford Policy Management, 2012

Domestic financing could be enhanced by the establishment of funds to generate and collect cash through levies on bank transactions and interest, air tickets, alcohol, soft drinks and cigarettes, as well as taxes on goods and services traded. Small additions of taxes could be added to telephone calls and to each kilowatt of electricity consumed. Other initiatives to diversify funding sources include:

- An AIDS bond, attracting private-sector purchasers wishing to raise their corporate social responsibility (CSR) profile.
- A ‘dormant’ fund, using unclaimed property commercial accounts.
- An AIDS lottery.
- Remittances from the diaspora.
- Boosting private sector contributions.

Air ticket levy.

The air ticket levy initiative, already in operation, was set up by President Jacques Chirac and the French government in 2006 and has raised over one billion Euros in France alone. The majority of the funds have gone to fight HIV/AIDS, TB malaria. Within Africa, six countries have implemented this levy: Cameroon, Congo, Madagascar, Mali, Mauritius and Niger. Mozambique are planning to implement the air ticket levy.

Gabon, Rwanda and Uganda charge levies on mobile phone usage, and Nigeria and Kenya are considering the same. With Internet and mobile phone technology proliferating throughout Africa, there is an opportunity to mobilise government resources from these technologies.

UNITAID and Trust Funds.

UNITAID makes use of innovative financing to increase funding for greater access to treatments and diagnostics for HIV/AIDS, TB and malaria in low-income countries. Based in Geneva, and hosted by the World Health Organization, approximately half of UNITAID's finances come from a (global) levy on air tickets. Trust funds can be set up and managed within a country. Kenya and Tanzania already have initiatives in place and have set up trust funds or steering committee's to manage this resource. Malawi is evaluating options to increase its domestic funding.

Mining taxation.

The mining and minerals sector is a large economic player in Africa. In some cases the HIV/AIDS and TB epidemics have part of their roots in mining and how labour operates and is treated. The diseases have an impact on the productivity of the mining workforce and this industry could be called to contribute. Although more research needs to be done on how to capitalise on potential mining sector levies, one source could be a tax on salaries or wages directed to a health fund. The links make for a strong motivation for a levy here.

Holding governments to account with additional taxes.

Resistance to increased taxes may occur from citizens, not as a result of the purpose of the funds, but rather the absence of faith in government not to pocket the funds. IDA places greater pressure on countries to be accountable for the funds received. Where funds are raised domestically there may be less pressure by countries to spend the money as effectively. This is where civil society watchdogs have an important role.

Many demands for financing requires informed advocacy.

Innovative financing methods from a global level have the potential to raise significant amounts: estimates range from $165billion to $232billion[12]. But all of these schemes have been suggested as sources of income for competing programs to address a range of pressing issues, including climate change programs, core funding for the United Nations system, and peacekeeping operations. Even if political will could be mobilized to support implementation of these international tax systems, global health would be in the queue. This makes informed advocacy critical.

6.3. Current initiatives

Current initiatives in Kenya, Malawi, Zimbabwe and Zambia.

Some options have been implemented by a handful of countries with varying success. Lessons can be learnt from a few key countries.

Zimbabwe was the first to introduce an AIDS levy, known as the National Aids Trust Fund (NATF) in 1999. This is to provide financial support for HIV interventions; to establish and fund the secretariat functions of the National AIDS Council (NAC); and reduce reliance on external funding. The funds are raised through a 3% levy collected from taxable income from all sectors. In 2011 it was reported that $26.5 million was collected. [69]

[12] World Bank, United Nations, International Monetary Fund, African Development Bank, World Health Organisation, International Food Policy Research Institute, Bill and Melinda Gates Foundation. Estimates for UNAIDS by Oxford Policy Management, 2012

Kenya established a High Level Steering Committee for Sustainable HIV Financing to pool additional public and private resources. The current proposal is for the allocation of 0.5% to 1% of government ordinary revenues to the Trust Fund. This will also be enhanced by additional strategies, such as an airline levy. The revenue in the Trust Fund has been calculated to fill 70% of the HIV funding gap between 2010 and 2020, and 159% of the gap between 2020 and 2030[70] [71]. Kenya is also considering the levy on mobile phone usage to further increase revenues.

Malawi is currently evaluating alternative options in order to increase domestic funding. Three potential approaches have been identified: airline levy, telecommunications levy, and expanding public sector mainstreaming. The potential amount that each of these activities could bring in Table 6.

Table 6: Options for domestic-HIV financing in Africa

Options for domestic-HIV financing in Malawi	US$ millions 2012/2013	US$ millions 2020/2021
Airline levy	5	6.1
Telecommunications levy	2.4	3.1
Expanding public sector mainstreaming	12.2	20.4

Source: UNAIDS, 2013

Tanzania is in the process of establishing a trust fund specifically for HIV/AIDS – Tanzania Aids Trust Fund (ATF). This will work under the government of Tanzania and will draw funds from a government ring fenced budget. The government is expected to initially contribute about EUR150 million per year to the fund, which aims to reduce donor dependency by 40%. Currently, donor dependency stands at 97%. The government of **Uganda** is planning to follow the lead of the other countries with intentions to establish a US$1 billion-dollar HIV Trust Fund to finance local HIV programmes.

Mobile phone tax in practice Gabon.

Gabon's tax on mobile phone companies is used to cover populations that are not economically capable of contributing to the national health insurance system. In 2009, Gabon collected $25 million with the levy of mobile phone companies. Large telecommunication companies are already engaging in philanthropic behaviour for development projects– such as Orange's Data for Development Project. If more governments framed these taxes as a way to directly benefit health and development, this could be another way for corporations to contribute by means of corporate social responsibility.

Economic arguments: pay now, save later and for AIDS, treatment is prevention.

These funds and initiatives have been developed with the objective of raising money to meet the health needs. Within Africa there are competing funding needs and so sectors need to demonstrate their importance. Two arguments pushed by UNAIDS are specifically in favour of increased support of HIV treatment and prevention, and the ongoing financing. First, investment into care and treatment today will lower costs in the long run by keeping people healthy. This will contribute to national productivity and less hospitalisation.

Second, UNAIDS argues extensive ART treatment will act as a form of prevention: Pay now so that you will not have to pay later. Epidemiologic data supports both arguments.

6.4. The pharmaceutical manufacturing plan

Cost of drugs is huge.

Although pharmaceutical manufacturing is not a method to raise revenue, this is a way to reduce the costs of prevention and treatment of diseases. It could also contribute to economic growth in countries where plants are located.[13] Unit costs of commodities make up a huge proportion of the total cost of treatment and prevention of HIV/AIDS and TB. The biggest cost in financing the three diseases is the unit costs of medicines. Investment into research and development of the pharmaceutical market will ease the financing burden on countries.

It can be brought down.

UNITAID – which raises most of its funds through a tax on airline tickets – has intervened in the market by pushing for price reductions for commodities. Since its inception in 2006, by leveraging market dynamics, UNITAID and CHAI have resulted in a 50% reduction in the price of AIDS drugs following negotiations with pharmaceutical companies.[72]

The pharmaceutical industry has a major impact on the African health system. The goal of increasing the proportion of the population with access to affordable essential drugs on a sustainable basis led to the development of the Pharmaceutical Manufacturing Plan for Africa (PMPA), to strengthen Africa's ability to produce high quality, affordable pharmaceuticals.

There is a problem with quality of drugs.

Africa imports more than 95% of active pharmaceutical ingredients (API), and roughly 75% of finished formulations.[73] Up to half of malaria medicines in some markets are counterfeit, and as many as 84% in countries sampled in Africa were substandard.[74] These problems can be avoided with an increase of investment in skills and technology in pharmaceuticals and proper legislation and control. Developing products locally (within Africa) will also reduce costs.

Manufacture need leadership and control.

Growing the Africa based industry of pharmaceuticals will require political commitment, policy coherence and sound sector strategy. Financial investment would be needed to enhance skills and technology. Domestic investment would strengthen the health system, and reduce the cost for drugs. The overall value for money would increase for treatment and prevention of HIV/AIDS, TB and malaria. An additional benefit of local manufacture would be employment creation, especially in supply chains.

There is a role for the private sector.

ART is the biggest proportion from HIV/AIDS programme financing, shifting production (or a portion of the production) domestically within Africa will increase the continent's capacity to bear the costs. PPPs should be explored – production would be best in the hands of the private sector but it would require government to establish regulatory mechanisms for the success of this intervention.

[13] A consideration is that since the market is small, there can be one plant for east Africa, not one each in Tanzania, Kenya, Uganda and Rwanda

7. Economic Tools

7.1. Rethink HIV

Applying cost benefit analysis.

In 2011, a new organisation, the Rush Foundation, noted that 30 years after the identification of AIDS, the support for fight against HIV/AIDS has slowed, with funding shortfalls and donor fatigue. Despite this, HIV is still the biggest killer of women of reproductive age in the world, and of men aged 15-59 in sub-Saharan Africa. The Foundation asked the Copenhagen Consensus Centre to commission a group of leading health academics to analyse policy choices and identify the most effective ways to tackle the pandemic across sub-Saharan Africa.

How best to spend an extra $10 billion.

On the basis of these papers, which were presented to an Expert Panel, the panel was tasked with answering the question:

If we successfully raised an additional US$10 billion over the next 5 years to combat HIV/AIDS in sub-Saharan Africa, how could it best be spent?

There were eighteen research papers by teams of top health economists, epidemiologists, and demographers who examine the cost-effectiveness of a range of responses to HIV/AIDS in sub-Saharan Africa. The topics were:

- Efforts to Prevent Sexual Transmission.
- Efforts to Prevent Non-Sexual Transmission.
- Treatment and Initiatives to Reduce the Impact of the HIV/AIDS Epidemic.
- Vaccine Research and Development.
- Social Policy Levers.
- Initiatives to Strengthen Health Systems.

Six key analyses, or ‘Assessment Papers’, were supplemented by twelve ‘Perspective Papers’. The body of research was released online and later published.[75] The Expert Panel expressed alarm about the lack of high-quality, existing, reliable research into the evidence of the effectiveness of currently funded AIDS interventions[76].

Vaccines come out top.

The top ten suggestions were to: 1) scale-up vaccine funding by $100 million per year; 2) introduce medical infant male circumcision; 3) prevent mother-to-child transmission; 4) make blood transfusions safe; 5) scale-up ART enrolment; 6) make medical injections safe; 7) scale-up male circumcision; 8) mass media info campaigns; 9) large-scale testing and counselling; and 10) cash transfer to keep girls in schooling.

The significance of this project was the common parameters used by all authors. The alternative estimates for DALY depending on the economy were $1,000 and $5,000; the discount rates were 3% and 5%; and prevalence was 11% (medium) and 25% (high). Cost for intervention could be low or high.

7.2. The UNAIDS investment framework

Lancet and UNAIDS thinking.

The investment framework is based on a policy paper published in The Lancet[77], which sets out a new framework for investment for the global HIV response. The framework is based on existing evidence of what works in HIV prevention, treatment, care and support. It was intended to facilitate more focused and strategic use of scarce resources, and promotes the idea of investment thinking – that substantive investment today can and will translate into future benefits. It was developed by international experts from UNAIDS, the GF, PEPFAR, the Bill and Melinda Gates Foundation, the World Bank, the WHO, and academic and policy institutions. Modelling of the frameworks impact shows implementation would avert 12.2 million new infections and 7.4 million AIDS-related deaths between 2011 and 2020.

Investing now is cost effective.

This modelling demonstrates that the investment is highly cost-effective, with additional investment largely offset by future savings in treatment costs. A critical point is enabling the HIV response to reach an inflection point in both investments and rates of HIV infection. The investment framework aims to:

- Maximise the benefits of the HIV response.
- Support more rational resource allocation based on country epidemiology and context.
- Encourage countries to prioritise and implement the most effective programmatic activities.
- Increase efficiency in HIV prevention, treatment, care and support programming, and
- Help countries, governments and their partners to guide HIV responses, and make the most of their programmes.

7.3. Efficiency and value for money

Efficiency measures help management and resource mobilisation.

Measurement of spending against achievements is an important aspect of financing. Relating outputs to money spent and inputs purchased, in order to assess the cost-effectiveness of interventions should be integral to funding. A basic level of data use would be by Fund Portfolio Manager's (FPMs) and the GF's Technical Review Panel (TRP) to assess whether budgets are reasonable, given output targets.

From the countries perspectives and health systems, it enables a comparison of options, and an ability to assess unit costs of key commodity inputs, as well as costing of human capital (labour costs). Where costs are higher than average, funds could be directed to more efficient programmes and higher prices could be challenged and reduced.

In the wake of declining IDA, improving the efficiency and effectiveness of spending is critical to the success of health programmes. Greater reliance on domestic funds, shifts the onus onto local governments to ensure their money is used efficiently. Scaling up prevention and treatment programmes will bring about greater efficiency gains and value for money from economies of scale.

An allocative efficiency question lies in determining the balance between prevention and treatment. Allocative efficiency speaks to the marginal cost of producing health care and its marginal benefit or price. The benefits sought are those that increase health. In order to increase health, attention needs to be given both to treatment and prevention. In the case of AIDS, it has been

shown that treatment is an effective form of prevention – the risk of transmission can decrease significantly for an individual on treatment. At the same time an 'ounce of prevention is worth a pound of cure'. Prevention ensures that healthy individuals remain healthy, and do not require more costly treatment in later years.

AIDS transition occurs when the number of new infections falls below deaths with people living with HIV.

A combination of the correct prevention and treatment programs will ultimately lead us closer to a 'tipping point'. Donor policy should aim to sustain current treatment levels, while reducing the number of new infections below the number of AIDS deaths, so the total number of people with HIV declines. There is a need to pay attention to the allocation of spending between prevention and treatment to maximise investment in terms of results.

Centralised expenditure has advantages.

Countries can achieve these efficiency gains by dedicating centralised departments responsible for the co-ordination of goods and services within health care, specifically responding to the needs of HIV/AIDS, TB and malaria. Centralised departments can ensure that the best value for money is achieved, specifically when it comes down to the procurement of goods. Kenya's establishment of its steering committee for sustainable financing for HIV and Tanzania's Aids Trust Fund demonstrate this. The establishment of a steering committee for financing should assist the Kenyan National AIDS Control Council (NACC) to make better decisions with financing and help bargain for better prices for international goods and locally supplied services.

Kenya faces specific challenges with decentralised government.

Kenya has recognised the importance of effectiveness and value for money. The KNASP[78] III stresses cost-effectiveness as one criterion for the allocation of resources. Analysis has been commissioned by NACC on the cost effectiveness of interventions. A baseline of the value for money of various interventions will increase the voice of beneficiaries for more and better quality services and more responsive systems. However, we note the move to decentralised government in Kenya with 47 districts, may bring challenges.

An example of cost effectiveness: the kindest cut.

According to a cost-effectiveness analysis, voluntary, medically assisted adult male circumcision for men in rural Nyanza, Kenya, ages 25–49 represents the most economically favourable of all HIV prevention interventions, costing an estimated US $225 per HIV infection averted. Other strategies with strong evidence of cost-effectiveness, include geographically targeted prevention programmes for Sex Workers and clients, harm reduction interventions for people who inject drugs, focused programmes for men who have sex with men (MSM), risk reduction interventions for truck drivers, and targeted prevention initiatives in fishing communities and prisons.

The GF has attempted to track unit costs for key commodity inputs[14] via a price and quality and reporting tool (PQR). This reporting tool serves as a valuable resource for procurement negotiation and costing, however, it is still limited to a select number of commodity inputs and does not include other components of procurement or service delivery.[79]

The World Bank has a major research programme in technical efficiency, which is now finally starting to report. This programme conducts research on the production functions of various health systems with the aim of minimizing cost and maximizing quality. For example, what the most efficient combination of doctors, nurses and health services need in order to produce

[14] Commodity inputs include antiretrovirals (ARVs), bed nets etc.

outpatient visits or inpatient stays. The focus is to reach a cost of inputs that is minimized for a given level of output, or quality, or both. The programme outputs of this research programme will start to have an impact on the design of health systems and hence, have an impact on costs (savings).

The need for support in middle-income countries.

Most people requiring treatment and services for HIV/AIDS, TB, and malaria live in low to middle income countries. However, the pattern is changing with 70% of the poor living in middle-income countries.[80] It is no longer a case of funding lower-income countries, but now rather a question of accessing those spread among middle-income countries. Increasing value for money motivates spending on health, and pushes for greater international attention.

Prevention is crucial.

An agenda needs to be set to prioritise strategies for reducing new infections (including treatment options as it is shown to be a form of prevention). Maximum results can be gained by shifting focus on to intensifying what is known to work, and delivering services to where they are needed most. The efficacy of nets in the prevention of malaria is a case in point - there are huge returns that are made from scaling up programmes of this kind. The costs of prevention and treatment of HIV and TB are complex, as there is huge variability between countries, even within countries themselves. The organisation of national aids committees and funding steering committees provides oversight into these costs – commissioning studies to assess value for money, as well as bargaining for cheaper supply of goods and services.

8. Conclusion and recommendations

The last 30 years have seen significant changes in the way the world works. In general, there has been an improvement in the length and quality of life of most people. However, huge challenges still face mankind: environmental change; inequality; employment and simply learning to live together. In the area of development, economic growth means that in 20 years there will be fewer 'low-income' countries by today's definitions. Global inequality will remain an issue, not just between nations but also within them.[15]

The paper argues health is a basic human right and that, in terms of infectious diseases, AIDS, TB and malaria pose a unique threat and should be treated as exceptional, demanding a place at the forefront of the global agenda. It recognizes that it was the AIDS epidemic which led to an unprecedented international mobilization that has brought life and hope to millions.

There is an implicit international consensus that the response to the three diseases constitutes a global merit good requiring a collective international response. There is an acceptance of shared responsibility to sustain both domestic and international investments. It is possible to devise acceptable benchmarks that will help to define the most appropriate mix within countries of domestic and international financing, and will help to ensure that international financing is distributed to best effect. The tools for action are in place, the political rhetoric is in place, now only the political will and economic analysis is needed on the part of all of the partners.

Domestic expenditure on HIV can continue to increase as economies grow and countries reallocate in line with ability to pay and disease burden, but it is important to stress that domestic financing is limited by economic capacity, especially in low-income countries. The analysis described here indicates that domestic expenditure on the three diseases can be expected to grow by about 4% per annum in line with economic growth alone, and more than twice as fast if low-spending countries reallocate in line with ability to pay and disease burden.

Nevertheless, there are substantial unfunded needs beyond the domestic ability to pay in low and middle-income countries. Business as usual will not bring an end to the impacts of the three diseases; it will merely prolong them for another generation. If the 2015 coverage targets are to be met, it follows that there will need to be short-term but substantial increases in the level of international funding. Beyond the need for continued and sustained commitment by traditional donors, there is also a need to further investigate other financing options – for example, new donors, innovative sources, bridging loans and continued efficiency gains.

At the heart of this paper is the need for domestic financing. Ultimately this is about the message countries convey. If they fail to treat their citizens to the

[15] Not the subject of this paper but worth looking at.

best of their ability, the moral argument for the international community to step into the breach is lost. If they do step up to the plate, then the fact that particularly AIDS and TB are expensive diseases, will mean there can be an argument for continued international support. In this case, the GF is the organization that has the best fit for purpose.

The discussion with GF staff on the prospect of increased domestic funding was sobering. One response was: "The overall financing for health picture is unclear – budget amounts go up and down with no meaningful trend. However, a larger problem is that budgets are very rarely matched by disbursements – what is budgeted for at the beginning of the year seems to have very little bearing on the amount of funding actually received by a ministry or disease program".

The recommendations below reflect what we heard and learnt in the process of writing this paper. They need to be refined but are a beginning.

- There is a need for better data. We are not clear on who is spending what. This is true of both domestic and international funding. However, the data needs to be improved and accessible.
- Political leadership is critical, and we need to develop advocacy messages to ensure that health continues to be a priority.
- We should revisit the economic arguments for health, including the macro-economic ones.
- Governments must address rigid budgeting practices that make it hard to reallocate revenues toward health.
- Health officials must be empowered to make the case to their counterparts in finance ministries for more funds.
- We need to address the perception that "donors will take care of the AIDS program".
- The role of civil society needs to be recognized and improved.
- The core question of whether it is possible to define the 'right' mix of domestic and international investment in any particular country needs to be addressed. Initial thoughts are this will vary country by country.
- We should establish on a country by country basis an acceptable 'benchmark' for countries to invest from their own resources.
- The GF should work with other key donors as a 'thought leader'. In particular it should look to providing data and information.

Appendix 1

Health Declarations

Declaration of Alma-Ata, 6-12 September 1978, Alma-Ata, USSR. Governments and all health partners were urged to promote health for all. It is expressed that governments should formulate policies and strategies for primary health care. Moreover, governments should ensure coordination with other sectors, mobilise resources for health and show commitment to providing primary health care for all.

Lome Declaration on HIV/AIDS in Africa, 10 to 12 July 2000, Lome, Togo. The Declaration called for a plan of action to accelerate health sector reform with a focus on HIV. Governments were urged to further recommit to previous declarations on HIV/AIDS. Furthermore, an appeal was made to enhance the capacity of governments and ministries of health to deal with HIV/AIDS. Governments were encouraged to keep the issue of AIDS high on the agenda.

United Nations Millennium Declaration, 6-8 September 2000, New York. The Declaration aimed at promoting peace, equality, development, observance of human rights, among other values. The Millennium Declaration saw the birth of the Millennium Development Goals.

Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, 27 April 2001, Abuja, Nigeria. This was a commitment by African Heads of State to spend at least 15% of budgets on health. The Declaration considers AIDS an emergency on the continent and calls for a comprehensive strategy to mobilize all sectors of society. Governments are urged to increase the priority given to health.

Maputo Declaration on malaria, HIV/AIDS, Tuberculosis and other related infectious diseases, 10-12 July 2003, Maputo, Mozambique. The Declaration commits to the creation of partnerships between the UN, pharmaceutical companies and others to increase local and regional production of affordable medicines for TB, HIV and malaria. There is also a commitment to scale up HIV treatment.

Addis Ababa, Solemn Declaration on gender equality in Africa, 6-8 July 2004, Addis Ababa, Ethiopia. This was a commitment to address HIV/AIDS related gender issues through the enactment of legislation to end discrimination against women living with HIV. Calls were made to increase budgetary allocations to health so as to lessen the burden of care on women. It was further agreed that an African Trust Fund be established to build the capacity of African women.

Gaborone Declaration on a roadmap towards universal access to prevention, treatment and care, 10-14 October 2005, Gaborone, Botswana. This was a commitment to provide universal access to treatment and care of HIV, TB and malaria by 2015. Focus should be on strengthening health systems to ensure for efficient and effective delivery of universal health services. In addition, countries are urged to make use of Trade Related Aspects of Intellectual Property Rights (TRIPS) flexibilities and to work with World Trade Organisation (WTO) to remove all constraints affecting the importing and exporting of generic medicines.

The Abuja Call for accelerated action towards universal access to HIV/AIDS, TB and malaria services in Africa, 2–4 May 2006, Abuja, Nigeria. This was a call for African

governments to intensify efforts in fighting the three diseases. Governments rededicated to providing national leadership, to mobilise resources, to strengthen health systems, to provide treatment, prevention and care, to foster partnerships and to engage in research and development, among other efforts.

The Addis Ababa Declaration on community health in the African Region, 20-22 November 2006, Addis Ababa, Ethiopia. A commitment was made to empower communities and community management structures to ensure adequate health delivery for all. There was also a call to strengthen interactions between health services and the community. Governments are called upon to devise policies and strategies of enhancing community health and information sharing on best practices. In addition, governments are urged to increase funding for community health.

Ouagadougou Declaration on primary health care and health systems in Africa, 28-30 April 2008, Ouagadougou, Burkina Faso. This was a commitment for governments to update their national health policies and plans according to the Primary Health Care approach. The Declaration called for intersectoral collaborations, improvements in health information generation, and health systems strengthening for the general improvement in health and the realization of health targets.

The Algiers Declaration, ministerial conference on research for health in the African Region, 23-26 June 2008, Algiers, Algeria. This was a commitment to allocate at least 2% of national health expenditure and at least 5% of external aid for health projects and programmes to research and research capacity building, and invest more in research aimed at improving health systems. The call was to improve the health evidence base and to translate knowledge into policy.

Libreville Declaration on health and environment in Africa, 29 August 2008, Libreville, Gabon. Called for the updating of regional and sub-regional frameworks to effectively address impacts of health on environment. There were also calls for achieving a balance on health and environmental budget. The Declaration further advocates for the setting up of national monitoring and evaluation mechanisms to assess performance in implementing priority programmes and peer review mechanisms to learn from each other's experience.

Kampala Declaration, actions on maternal, newborn and child health and development in Africa by 2015, 27 July 2010, Kampala, Uganda. Commitments were made to strengthen health systems with regard to maternal and child health. Governments committed to providing sustainable financing and also to explore best practices.

The Brazzaville Declaration on non-communicable diseases (NCDs) prevention and control in the WHO African Region, 6 April 2011, Brazzaville, Republic of Congo. This was a commitment by governments to tackling NCDs. The declaration urged Heads of State to improve health systems in order to fight NCDs. A call is made for the creation and development of control strategies, guidelines, policies, legislations, regulatory frameworks and partnerships to fight NCDs.

Addis Ababa, African Union roadmap on shared responsibility and global solidarity for AIDS, TB and malaria response in Africa, 16 July 2012, Addis Ababa, Ethiopia. The

summit endorsed the Roadmap on Shared Responsibility and Global Solidarity for HIV, TB and malaria and the Pharmaceutical Manufacturing Plan for Africa Business Plan. The Roadmap focuses on three main pillars: health governance, diversified financing and access to medicines.

Tunis Declaration on value for money, sustainability and accountability in the health sector, 5 July, 2012, Tunis, Tunisia. This was a commitment to enhance value for money, increase accountability and improve sustainability of health resources. Governments are urged to fight corruption and prioritise high impact interventions.

African Union road map for scaling up human resources for health (HRH) for improved health service delivery in the African region 2012-2025, 19-23 November 2012, Luanda, Angola. This calls for the improvement of HRH in the African region. This is a commitment to improve the deployment, retention and performance of HRH.

Declaration of the Special Summit of African Union on HIV/AIDS, TB and malaria, 12-16 July 2013, Abuja, Nigeria. The Declaration advocates for countries to honour the 2001 Abuja Declaration and other declarations. It further calls for the mobilization of domestic resources and identification of sustainable ways of health financing. Governments are urged to explore diversified ways of health financing in order to increase domestic resources for health.

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[1] World Bank (1993) *World Development Report,* Oxford University Press, Oxford

[2] Garrett, L (1994) *The Coming Plague: Newly Emerging Diseases in a World out of Balance.* Macmillan
[3] Garrett, L (2011) *Betrayal of Trust: The collapse of Global Public Health.* Hyperion
[4] Ibid page 20

[5] Sheehan, C. C (2008) *Securitizing the HIV/AIDS Pandemic in U.S. Foreign Policy.* ProQuest
[6] Economic Commission for Africa (2008) *Securing Our Future: Report of the Commission on HIV/AIDS and Governance in Africa.* Available online: http://www.uneca.org/sites/default/files/publications/securingourfuturereport_en_0.pdf
[7] WHO (2013) *Macroeconomics and Health.* Available online: http://www.who.int/macrohealth/en/
[8] UN News Centre (2001) *At Abuja African Summit, Annan calls for major mobilization to fight HIV/AID.* Available online http://www.un.org/apps/news/story.asp/h%3Cspan%20class='pullme'%3EIn%20short,%20when%20you%20empower%20a%20woman,%20you%20change%20the%20world%3C/span%3Ettp://www.unfpa.org/www.fao.org/www.unicef.org/html/newsmakers.asp?NewsID=46#.UnpDwnBHLj4
[9] UNAIDS (2013) *Abuja +12: Shaping the future of health in Africa.* Available online: http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2013/JC2524_Abuja_report_en.pdf
[10] Oberth, G (2013) *Who governs public health.* PhD thesis. University of Cape Town

[11] Garrett, L (2013) *Existential Challenges to Global Health.* Centre on International Cooperation

[12] ibid
[13] Ibid

[14] Chisholm, D. & Evans, D. B. (2010) *Improving health system efficiency as a means of moving towards universal coverage.* Geneva, World Health Organization
[15] OECD (2010) *Improving value in health care: measuring quality.* Paris, Organisation for Economic Co-operation and Development

[16] NACC (2010)
[17] WHO (2013) *The World Health Report*
[18] Wilkinson, R. and Hulme, D. (eds) (2012) *The Millennium Development Goals and Beyond Global Development after 2015,* London: Routledge
[19] Available online: http://www.who.int/mediacentre/factsheets/fs310/en/index1.html accessed 08/09/2013

|

[21] Moon, S. & Omole, O. (2013) *Development Assistance for Health: Critiques and Proposals for Change.* Centre on Global Health Security Working Group Papers. Working Group on Financing | Paper 1. April 2013. www.chathamhouse.org.
[22] Moyo, D. (2009) *Dead Aid: Why Aid Is Not Working and How There Is a Better Way for Africa*. New York: Farrar, Straus and Giroux
[23] Sachs, J. (2006) *The End of Poverty: Economic Possibilities for Our Time.* New York: Penguin
[24] Easterly, W. (2007) *The White Man's Burden: Why the West's Efforts to Aid the Rest Have Done So Much Ill and So Little Good.* Oxford: Oxford University Press
[25] Collier, P. (2008) The bottom billion: Why the poorest countries are failing and what can be done about it. Oxford University Press
[26] IHME (2012) *Financing Global Health 2012: The End of the Golden Age?* Seattle: Institute for Health Metrics and Evaluation. Available on: http://www.healthmetricsandevaluation.org/publications/policyreport/ financing-global-health-2012-end-golden-age
[27] ibid

[28] Available online: http://www.healthmetricsandevaluation.org/publications/policy-report/financing-global-health-2012-end-golden-age

[29] IHME (2012). *Financing Global Health 2012: The End of the Golden Age?* Seattle: Institute for Health Metrics and Evaluation. Available online: http://www.healthmetricsandevaluation.org/publications/policyreport/ financing-global-health-2012-end-golden-age.
[30] Kates, J., Wexler, A., Lief, E., Avila, C. & Gobet, B. (2011) *Financing the Response to AIDS in Low- and Middle- Income Countries: International Assistance from Donor Governments in 2010.* Joint Report from UNAIDS and the Kaiser Family Foundation. Retrieved from http://www.kff.org/hivaids/7347.cfm
[31] ibid
[32] Results for Development Institute (2013) *Financing National AIDS Responses for Impact, Fairness, and Sustainability A Review of 12 PEPFAR Countries in Africa,* Washington October 2013
[33] The Global Fund (2013) *The Global Fund to Fight AIDS, Tuberculosis and malaria. Fourth Replenishment (2013-2016) Needs Assessment.* The Global Fund.
[34] Lyman, P. & Wittels, S. (2010) *No Good Deed Goes Unpunished.* Foreign Affairs. 1 July 2010. Web. 5 Nov. 2013.
[35] Results for Development op cit page 14
[36] Ibid page 14
[37] Hassim, A., Haywood, M., & Berger, J. (2007) *Budgeting for Health.* In Health and Democracy Siber Ink: South Africa.
[38] ibid
[39] Forsythe, S., Stover, J., & Bollinger, L. (2009). *The past, present and future of HIV, AIDS and resource allocation.* BMC Public Health, 9(Suppl 1): S4.
[40] ibid
[41] ibid

[42] Cooke, J (2009) Public Health in Africa: *A Report of the CSIS Global Health Policy Centre.* Centre for Strategic & International Studies. Retrieved from: http://csis.org/files/media/csis/pubs/090420_cooke_pubhealthafrica_web.pdf

[43] Forsythe, S., Stover, J., & Bollinger, L. (2009) *The past, present and future of HIV, AIDS and resource allocation.* BMC Public Health, 9(Suppl 1): S4.

[44] Pisani, E. (2008) *The Wisdom of Whores: Bureaucrats, Brothels and the Business of AIDS.* London: Granta and New York: Norton

[45] Devarajan, S., Rajkumar, A.S., & Swaroop, V. (1999) *What does Aid to Africa Finance?* The World Bank, Development Research group. Retrieved from: http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/1999/08/15/000094946_9904020601437/additional/280868028_20050283051934.pdf

[46] ibid

[47] Shiffman, J (2007) *Has donor prioritization of HIV/AIDS displaced aid for other health issues?* Health Policy Plan, 23 (2) pp. 95-100

[48] Lordan, G., Tang, K. K., & Carmignani, F. (2011) *Has HIV/AIDS displaced other health funding priorities? Evidence from a new dataset of development aid for health.* Social Science & Medicine, 73 (1) pp. 351-355

[49] Gottret, P., & Schieber, G. (2006) *Health Financing Revisited: A practitioners Guide*. The World Bank. Retrieved from: http://siteresources.worldbank.org/INTHSD/Resources/topics/Health-Financing/HFRFull.pdf

[50] Stenberg, K., Elovainio, R., Chisholm, D., Fuhr, D., Perucic, A., Rekve, D., & Yurekli, A. (2010) *Responding to the Challenge of Resource Mobilization Mechanisms for Raising Additional Domestic Resources for Health*: World Health Report, Background Paper 13. *World Health Organization.* Retrieved from: http://www.who.int/healthsystems/topics/financing/healthreport/13Innovativedomfinancing.pdf

[51] Results for Development Institute (2013) *Financing National AIDS Responses for Impact, Fairness, and Sustainability: A Review of 12 PEPFAR Countries in Africa,* Washington October 2013. pp 5

[52] Osoro, N. (2009) *Domestic Resource Mobilization.* In Parliaments, Poverty Reduction and the Budget Process in Africa. Parliamentary Centre. Retrieved from: http://www.parlcent.org/en/wp-content/uploads/2011/04/handbooks_and_guides/Parliaments_Poverty_Reduction_and_the_Budget_Process_in_Africa_EN.pdf

[53] ibid

[54] ibid

[55] ibid

[56] Anyanwu, J. C., Siliadn, Y.G., & Okonkwo, E. (2012) *Role of Fiscal Policy in Tackling the HIV/AIDS Epidemic in Southern Africa.* African Development Bank Group. Retrieved from: http://www.afdb.org/fileadmin/uploads/afdb/Documents/Publications/WPS%20Nos%20148%20Role%20of%20Fiscal%20Policy%20in%20Tackling%20the%20HIV%20AIDS%20Epidemic%20in%20Southern%20Africa%20BD.pdf

[57] ibid

[58] ibid

[59] Farag, M., Nandakumar, A.K., Wallack, S.S., Gaumer, G., & Erbil, C (2013) *Health Expenditures, health outcomes and the role of good governance.* International Journal of Health Care Finance Economy, 13(1) pp. 33-52

[60] ibid

[61] Sambo, L. G., & Kirigia, J. M. (2011) *Africa's Health: Could the Private Sector Accelerate the Progress Towards Health MDGs?* International Archives of Medicine, 4(39) pp. 1-9

[62] African Union (2013) *Delivering results toward ending AIDS, Tuberculosis and malaria in Africa.* African Union Accountability Report on Africa-G8 Partnership Commitments. Retrieved from:

http://www.unaids.org/en/media/unaids/contentassets/documents/document/2013/05/20130525_AccountabilityReport_EN.pdf

[63] Commission on HIV/AIDS and Government in Africa (2008) *Securing Our Future: Report of the Commission on HIV/AIDS and Government in Africa.* United Nations Economic Commission for Africa. Retrieved from: http://www.uneca.org/sites/default/files/publications/securingourfuturereport_en_0.pdf

[64] The Global Fund (2013) *The Global Fund to Fight AIDS, Tuberculosis and Malaria Fourth Replenishment (2013-2016) Needs Assessment.* The Global Fund.

[65] ibid

[66] Galárraga O, Wirtz VJ, Santa-Ana-Tellez Y, Korenromp EL (2013) *Financing HIV Programming: How Much Should Low- And Middle-Income Countries and their Donors Pay?* PLoS ONE 8(7): e67565. doi:10.1371/journal.pone.0067565

[67] Results for Development Institute (2013) *"Financing National AIDS Responses for Impact, Fairness, and Sustainability: A Review of 12 PEPFAR Countries in Africa"* [Final Draft], March 2013.

[68] Garrett, L. (2013) *Existential Challenges to Global Health,* Centre on International Cooperation.

[69] Draft Annual Report 2011, NAC

[70] UNAIDS (2013) *Efficient and Sustainable HIV Responses: Case studies on country progress*.

[71] Lievens, T. & Kioko, U. (2012) *Sustainable financing for HIV/AIDS in Kenya*: Oxford Policy Management, Oxford.

[72] Innovative financing for development (2009) Available online: http://www.un.org/esa/ffd/documents/InnovativeFinForDev.pdf (Accessed on 4 November 2013)

[73] Ngozwana, S. (2013) *Presentation of 'The Pharmaceutical Manufacturing Plan for Africa'.* Available online: http://www.thedti.gov.za/business_regulation/presentations/generic_medicines.pdf (Accessed on 4 November 2013)

[74] WHO (2011) Available online: http://www.who.int/medicines/publications/WHO_QAMSA_report.pdf

[75] Lomborg, B. (Ed.)(2012) *Rethink HIV: Smarter Ways to Invest in Ending HIV in Sub-Saharan Africa.* Cambridge University Press.

[76] Available online: http://www.rethinkhiv.com

[77] Schwartländer, B., *et al.* (2011) *Towards an improved investment approach for an effective response to HIV/AIDS.* The Lancet, 377(9782), 2031-2041.

[78] Kenya National AIDS Strategic Plan.

[79] Silverman, R & Glassman, A (2013) *Measurement obstacles to achieving value for money at the global fund: A problem statement.* Center for Global Development.

[80] Sumner, A. (2010) *Global poverty and the new bottom billion: What if three-quarters of the world's poor live in middle-income countries?* Brighton, Institute of Development Studies, September 2010.