
DFID HEALTH RESOURCE CENTRE

GHP Study Paper 2:

ECONOMIC AND FINANCIAL ASPECTS OF THE GLOBAL HEALTH PARTNERSHIPS

This paper forms part of the 2004 DFID Study: *Global Health Partnerships:
Assessing the Impact.*

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Title: Economic and Financial Aspects of the Global Health Partnerships

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ABBREVIATIONS

ART	Anti Retroviral Therapy
CCM	Country Coordinating Mechanism
CMH	Commission for Macroeconomics and Health
CRS	Creditor Reporting Systems
DAC	Development Assistance Committee
EPI	Expanded Programme of Immunisation
GAVI	Global Alliance for Vaccines and Immunisation
GDF	Global Drugs Facility
GDP	Gross Domestic Product
GHP	Global Health Programme
GFATM	Global Fund To Fight AIDS, TB and Malaria
GPEI	Global Polio Eradication Initiative
GPG	Global Public Good
HIPC	Heavily Indebted Poor Countries Initiative
IAVI	International AIDS Vaccine Initiative
IDA	International Development Association
IFF	International Financing Facility
IMF	International Monetary Fund
MAP	Multi Country HIV/AIDS Program
MDG	Millennium Development Goals
MoF/(F)MoH	(Federal) Ministry of Finance/Health
MTEF	Medium Term Expenditure Framework
NGO	Non Government Organisation
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
PEPFAR	President's Emergency Plan for AIDS Relief
PSA	Public Service Agreement
PPP	Public Private Partnership
PRSP	Poverty Reduction Strategy Paper
R&D	Research and Development
RBM	Roll Back Malaria
STD	Sexually Transmitted Diseases
SWAp	Sector Wide Approach
WHO	World Health Organisation

EXECUTIVE SUMMARY

I. Global Health Partnerships (GHPs) have brought, and will continue to bring, welcome additional resources to support country efforts to combat communicable diseases. However, in themselves they will be insufficient to provide countries with the financial means required to deliver a reasonable package of basic health services. Paradoxically, at the same time the very size of the financing GHPs poses major challenges in terms of:

- managing public finances to ensure that the increased aid flows can be absorbed without compromising macroeconomic stability and
- financial sustainability in terms of sustaining the activities supported by the GHPs and the increased aid dependence implied

ii. Although not particularly large in terms of overall funding for health in developing countries, the financing GHPs do play a major funding role in some countries - particularly low income countries. Together with other health initiatives such as PEPFAR and MAP and assuming funds are disbursed as planned, these GHPs are likely to double the level of resources for health in around 10 countries and significantly increase it in many others. It is fairly obvious that these countries will be unable to sustain the activities and services promoted by the GHPs through their own resources in the medium term. The fact that the GHP model often envisages further expansion to develop and introduce new products and/or expand existing ones means there is a major risk that countries future spending patterns will be dictated by the GHPs rather than by the countries' own priorities (if the two differ, as they are likely to) for some time to come. These pressures will vary by disease – according to GFATM the funding needs for HIV/AIDS are likely to rise steadily for at least a decade, a pattern likely to be repeated for TB, whilst funding requirements for malaria, though subject to much uncertainty, may begin to decline after 2010. The cost savings from GHPs which aim to eliminate or eradicate diseases are likely to be minor – with the exception of polio – and do little to offset these increasing funding needs. An important question for DFID is whether it should focus its efforts on GHP expansion or whether it should seek to assist countries consolidate earlier efforts through budget or sector support where appropriate. Such decisions would need to consider, amongst other things, the overall performance of the GHP in question, the specific programmes or directions being promoted by the GHP, and also the fallout from not supporting a particular GHP. There is a risk there that DFID may become locked into a cycle of support for GHPs either directly or by helping meet their recurrent implications. Similar questions will also apply to the use of the International Financing Facility (IFF). Though the mechanism is due to be piloted as a means of promoting market development of new vaccines, it will presumably also be used to meet the recurrent implications of the GHPs.

iii. In terms of macroeconomic stability, the evidence suggests that it is volatility in aid flows rather than the magnitude of support which is the key factor. The demand based approach to proposals adopted by GFATM (by far the largest financial GHP), and the fact that it only guarantees funding for two years, has its strengths but is not necessarily conducive to greater predictability in funding.

iv. The GHPs are beginning to deliver significant additional funding for communicable diseases and other GPGs. For malaria and TB, proposed GFATM funding far exceeds recent levels of donor funding for the diseases so even if funding through other channels were to decline, or even stop, overall spending should still increase. For HIV/AIDS GFATM funding is less significant though here there is some evidence,

at least up to 2002, that funding through alternative bilateral and multilateral sources has been increasing anyway and has supplemented rather than undermined by GFATM flows. These trends need to be seen against a backdrop of strong growth in development assistance for health which has been sustained over the last three decades and has seen significant increases in real donor spending on health and population (of the order of 3% per annum since 1975). Donor support for health has increased rapidly as a share of overall development assistance as the latter stagnated in the 1990s and is only now beginning to increase again. There is little evidence of displacement (or fungibility) at country level – either by donors or by Governments. However, it is perhaps too soon for such changes to be reflected in strategic plans and expenditure frameworks yet and it may be worth revisiting this issue in two or three years time. There are some concerns though that increased support for the GHPs has been at the expense of support for key interventions such as water and sanitation and family planning. Whilst the Foundations – especially the Bill and Melinda Gates Foundation - have provided considerable financial support and been instrumental in the establishment of a number of GHPs there is little evidence that donors have been able to leverage additional funds from a *wide range* of new sources and significantly diversify the funding base. Other financial contributions from the non Government sector have been modest though there have been additional, but often unquantified, in-kind contributions. Such funding has, however, in some cases provided important seed money to establish GHPs (e.g. MSF and DNDi and Until There's a Cure for IAVI) which have subsequently attracted additional resources from traditional donors.

v. The earmarked nature of GHPs undermines country level control of expenditure management processes. This is compounded by additionality conditions attached to some of the GHPs. Together these factors raise a series of fundamental questions. Who should determine priorities - Governments or donors? Should Governments be allowed to set their own priorities and make their own mistakes or do donors know best? The key question, therefore, is less about whether the GHPs are distortionary but more about whether the distortions introduced improve the global allocation of resources, and more specifically whether such distortions are a price worth paying. The evidence tends to suggest that the financing GHPs do improve the overall allocation of resources but cannot resolve the more important second issue. They appear to be relatively well targeted towards diseases which present the largest burden of ill health and to countries in greatest need in terms of socio economic status and especially so when viewed in relation to recent trends in development assistance for health and population. Typically over 60% of the financing GHP resources are channelled to Africa, where communicable diseases account for over 70% of the burden of disease and infectious and parasitic diseases alone account for more than half. The share of GHP funding going to low income countries is extremely high – over 98% for GAVI and GPEI and almost 78% for GFATM. This compares to around 64% for OECD donors as a whole. Lower income countries tend to get higher per capita allocations than better off ones. The GHPs are largely self targeting in that they focus on diseases which have the largest impact on the poor. However, they often operate within systems which are far from pro poor. It will be important therefore to ensure that investment in GHPs is not at the expense of investments in system strengthening.

vi. Most interventions funded by GHPs are potentially highly cost effective. This applies also to the newer vaccines being promoted by GAVI which, although costly, are also likely to be cost effective in many settings. ART is an exception – though perhaps justified on social justice grounds, it cannot be justified on the basis of its cost effectiveness. GHPs also offer the potential to develop new products which, in time, will hopefully offer cost effective alternatives to current methods.

vii. If DFID is interested in assessing the cost effectiveness of the GHPs, it will be important to get better data on expenditure by type of intervention. In terms of resource allocation DFID will need to consider whether the global allocation of GHP resources is good enough to warrant further investment or, if gaps are identified, whether DFID should channel more resource bilaterally. Key questions will include the balance *between* diseases, the balance *within* diseases (e.g. between prevention and cure) and also whether important conditions (e.g. reproductive health) which are not the subject of GHPs but are important for achieving the MDGs and broader systems strengthening are being adequately covered.

viii. There is little clarity on funding needs or the timing of these needs. Approaches to financial management and strategic planning differ significantly between GHPs, making assessments of where, and when, to invest extra resources problematic. In addition, important issues such as sustainability are often viewed from the perspective of individual GHPs rather than from a broader perspective. Whilst such efforts at the individual GHP level are to be welcome – and GAVI provides a good example here - it would be helpful to develop a series of resource scenarios mapping out possible future needs, taking into account the timing, cost and likely uptake of new products for GHPs as a whole and also encourage measures to increase consistency in the way that GHPs present their financial plans.

ix. Pressure to achieve the MDGs may create a range of short-term incentives which may compromise long term development objectives. For instance, in the run-up to 2015, there is a risk that donors may become less willing to fund R&D GHPs whose products are unlikely to be widely adopted before 2015 but which have enormous potential in the longer term. Again, it will be important for DFID to take a balanced approach and, if necessary, be willing to cover neglected areas.

1 MAIN REPORT: KEY FINDINGS

1.1 Introduction

This report considers some of the key financial and economic issues related to the Global Health Partnerships. The key findings are reported here with more detail provided in the annexes.

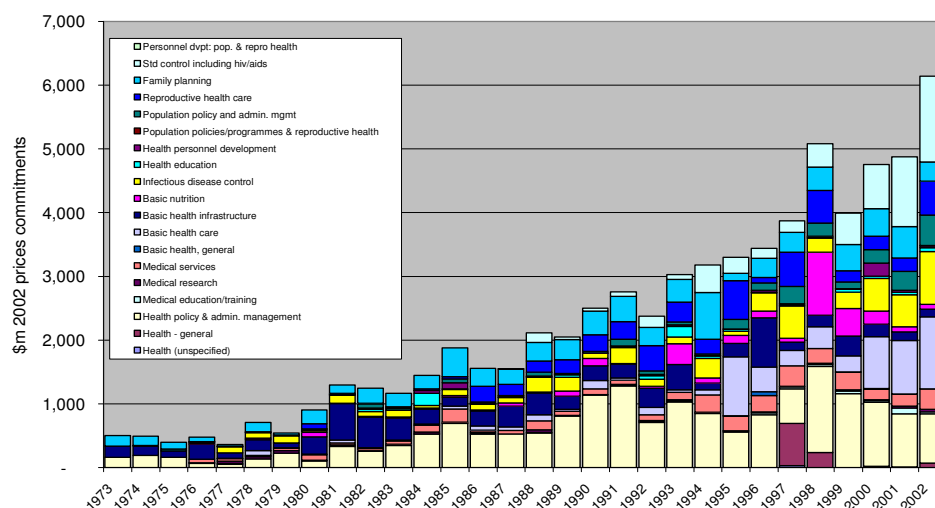
1.2 Tracking Expenditure

There is currently no accurate way of tracking expenditure on Global Public Goods (GPGs) or communicable diseases. DAC data are the best means of tracking development assistance flows but suffer from a number of significant weaknesses. At the country level national health accounts data is often weak and insufficiently disaggregated to answer questions in relation to spending on individual diseases. Investment in improving surveillance of financial flows (a global public good in itself) through global efforts under DAC or through national health accounts (NHA) is a clear priority if donors such as DFID are serious about tracking financing trends. Strengthening national health accounts should be the priority – given that domestic funding often predominates – whilst recognising that accounting for donor inputs poses significant challenges. This would involve a change in current approaches and poses difficult, if not intractable, methodological questions. It would also place significant additional burdens on capacity at the country level. However, disease specific NHA can influence policy and encourage action – in Rwanda donors and Government increased expenditure on HIV/AIDS rapidly when NHA revealed how little was being spent.

1.3 Additionality

Donor support for health spending has been *increasing* continuously over the past decade despite declines in overall ODA during the 1990s (chart below). As a result, the share of health in total ODA has been increasing. The fact that overall ODA flows are also now beginning to increase again – by 7% between 2001 and 2002 and a further 3.9% between 2002 and 2003 – bodes well for the future funding of communicable diseases and GPGs.

Total Development Assistance for Health and Population by Type since 1973



The major financing GHPs are too new, and the data are too weak, to make definitive assessments as to whether they supplement, or are at the expense of, existing spending. The indications, though, are that there is significant additionality. For malaria, GFATM commitments alone (of around \$350m per annum) are around three times greater than recent levels of donor support for malaria. Thus, even if bilateral flows were reduced (of which there is little evidence) or even stopped, overall flows would still be expected to increase overall if resources are spent as planned. There is a similar picture for TB with GFATM accounting for an estimated two-thirds of total donor support. In the case of HIV/AIDS, although GFATM is important in absolute terms (with average annual commitments of around \$1bn), it is less significant overall (accounting for only around 20% of total support for HIV/AIDS between 2000 and 2002 though this will no doubt have increased by now). However, donor spending through traditional sources – for both infectious disease control and STD control - appears to have been increasing rapidly since 1996 and there is no evidence of any slowdown at least up to 2002.

Due to the positive impact of GHPs on global allocation of resources (see later) whilst it may not be possible to say whether the GHPs are actually at the expense of other type of development assistance, it is possible to say that:

- *if* the GHPs are at the expense of non-health development assistance, they appear to promote a more pro poor global allocation of resources
- *if* the GHPs are at the expense of overall health and population assistance, they appear to promote a more pro poor global allocation of resources
- *if* the GHPs are just substituting for bilateral efforts to combat the communicable diseases, there seems little prospect that it will significantly worsen the overall allocation of resources

There is some evidence that investment through the GHPs is crowding out donor support for interventions such as water and sanitation which, whilst essential for improving health as well as the other MDGs, have seen significant declines in donor funding in recent years. Within health, there is some evidence that donor support for reproductive health including family planning may have suffered as a result of increased spending on communicable diseases since the mid 1990s.

More reassuringly, much of the increase in development assistance for health and population seems to have been at the expense of investment in productive activities - particularly agriculture, economic infrastructure such as energy, transport and mining and commodity support and programme assistance - which is likely to have had relatively little negative impact on health or on equity.

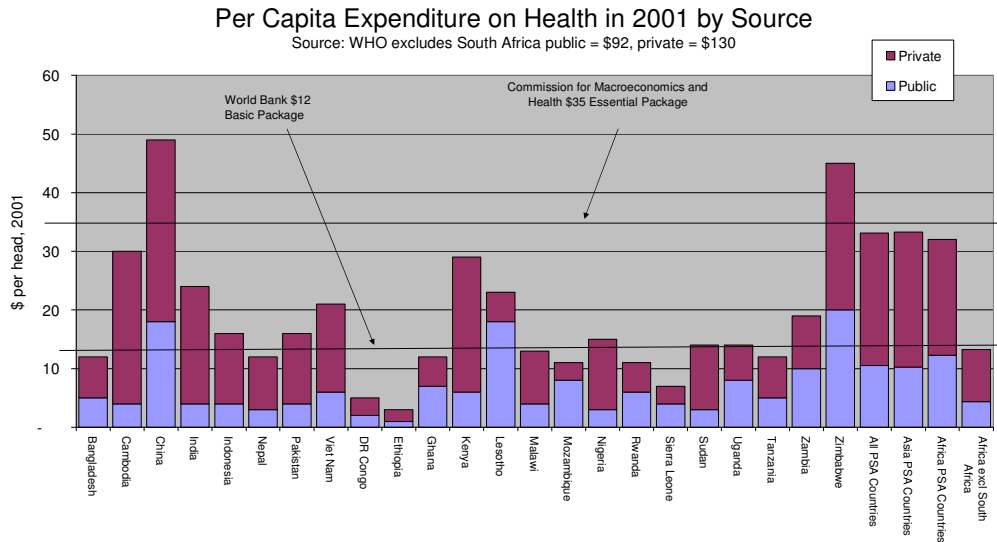
Any additionality may prove to be short lived. Given the magnitude of funds committed through the GHPs, and the fact that they have in many cases been bolted on to existing spending programmes and within extremely rigid and unresponsive expenditure management systems, it would be surprising if such funding were not mainly, if not fully, additional in the short term. Indeed, there are few concrete examples of Government or donors changing their spending plans to reflect the GHPs. Ultimately, the majority of funding in most countries for communicable diseases comes from domestic sources and the picture will only become clear when future strategic plans and MTEFs are developed which fully take account of GHPs. It may make sense to revisit this issue in two or three years time.

The added value of GHPs is typically seen as one of raising the profile of particular issues and adopting innovative financing approaches which raise funds which could not be accessed through traditional means. There is little evidence that donor funding has been able to leverage additional financial support (with the exception of the foundations, notably the Gates Foundation). Even here, it is the foundations which have often provided seed money which has been used to leverage additional funding from donors. Financial contributions from the private sector have often been rather disappointing though there have been significant, but often unquantified, in kind contributions and support at the country level. Thus, it would appear that the GHPs have largely been an effective way of raising resources from existing sources rather than a means of diversifying the funding base.

There may be opportunities to leverage additional resources related to the conditions applied by other donors as has been done recently with DFID's commitment to GFATM to unlock USAID funding. Here there is clear additionality and DFID should look out for similar opportunities elsewhere.

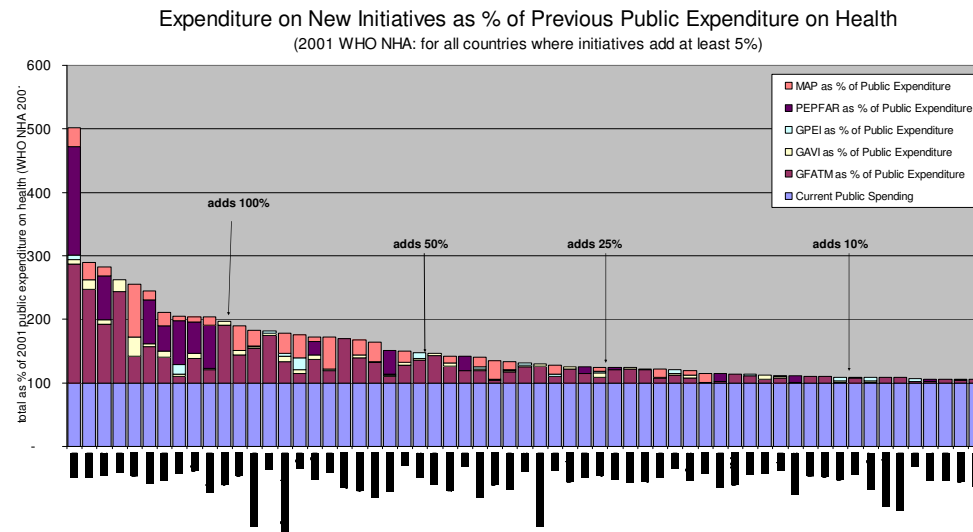
1.4 Adequacy

The GHPs are certainly bringing welcome additional funding. However, despite their size and the major implications for sustainability and aid dependence, the financing GHPs currently do little to address the chronic under funding of the services in low income countries. Increasing public expenditure to a minimum of \$12 per head – far below the \$35 to \$40 that the Commission for Macroeconomics and Health thinks is necessary - in the 25 DFID PSA countries in Africa and Asia alone would require an estimated \$17bn per annum – some four or five times that proposed through the financing GHPs.



1.5 Sustainability and Aid Dependency

Although the financing GHPs are relatively minor in terms of overall public funding for health they do significantly add to existing resource flows in a number of countries. In 13 countries, the GHPs are likely to account for at least a 50% increase in health spend, and in 3 of these it exceeds 100% (Ethiopia, Liberia and Malawi). The issue also has to be viewed in context of other health initiatives such as MAP and PEPFAR which will intensify sustainability and dependency concerns. It is clear that there is little, if any, chance that many low income countries will be able to meet ongoing costs themselves if GHPs funding for current activities ends as planned after a 5 year period and the GHPs embark on programmes to expand coverage. The chart below compares existing spending with that proposed under the various global initiatives.



The absolute size of the GHPs will also pose major challenges in terms of macroeconomic management. It is estimated that in at least 14 countries the average annual GHP commitment exceeds 1% of GDP and in at least 16 countries it exceeds 5% of Government consumption expenditure. This overall impact of these flows will be mitigated to the extent that:

- GHPs provide commodity support which is likely to have less inflationary impact
- funding is provided in a stable and predictable manner
- countries are able to manage public finances more effectively than has been the case in the past and
- that fungibility negates the impact of the GHPs on overall levels of public spending.

This issue is likely to grow in importance as the GHPs are likely to significantly increase aid dependence. It will be important therefore to build up the evidence base in this area.

The GHP model, which often focuses on introducing and improving access to new products and leaving the running costs of existing programmes to Government and bilateral/multilateral channels, is likely to perpetuate existing distortions and sustainability issues. In effect, there is a risk that country spending patterns will be dictated by the GHPs, and the need to sustain the activities and services provided by them, rather than by national priorities.

It is reassuring to see that GAVI specifically, and other donors more implicitly, no longer equate sustainability with self sufficiency and are considering alternative approaches such as spreading support over a longer period, bridge financing and considering alternative funding sources. Nonetheless, it is important that sustainability is considered *before* the introduction of new products rather than *after* as is the case at present.

Timing may be a key element in relation to sustainability. The period 2008 to 2010 is likely to be a crunch period with initial GAVI and GFATM commitments coming to an end. At this point Governments will be expected to take on a much larger share of the burden, whilst the GHPs embark on further expansion programmes which serve to build up further recurrent implications and calls on limited Government resources in the future. GAVI is currently considering bridging finance to extend funding beyond this period and allow countries to spread their support over a longer period which may ease the transition. The needs of some GHPs will hopefully decline (e.g. GPEI) and free up some donor resources. However, if the ongoing product development GHPs are to bear fruit this is likely to place greater strain on Governments and donor budgets at around this time. Whilst, it could be argued that this knowledge does give donors and Government's time to prepare past experience suggests that such rational long term planning is unlikely and that donors and Governments will have to make sharp unplanned adjustments when the time comes. Whilst the IFF is currently being thought of in terms of addressing specific needs (e.g. speeding market maturity for vaccines) consideration might be given to using the additional funds as a way of making existing services sustainable rather than promoting new ones.

Given that the majority of the financial benefits from polio eradication are likely to be enjoyed by developed countries, it could be argued that non-ODA sources (OECD health budgets in this case) should contribute to filling this financing gap.

GHPs tend to be looked at in isolation and not in terms of other developments at the global level. With the possible exception of GFATM, the impact on overall financing is probably not so great so this is perhaps understandable. However, taken together – and allowing for other new initiatives such as MAP and PEPFAR - the implications are potentially huge. It would be useful to develop a number of resource scenarios bringing together the needs of all the GHPs, incorporating assumptions about the

timing, cost and likely coverage of the outputs of the R&D Public Private Partnerships (PPPs) into some form of global MTEF. Though individual GHPs have attempted this, overall needs remain unclear. Such planning would also usefully be linked with ongoing discussion about the International Financing Facility to ensure that funds are available when needed. To this extent, the IFF may prove to be a useful insurance mechanism as well as financing specific interventions.

1.6 Cost Effectiveness and Efficiency

The GHPs are generally investing in *potentially* highly cost effective interventions. However, the extent to which this potential is translated into reality will depend on a number of factors, including health system capacity and disease prevalence. Support for ART is an exception - it might be justified for humanitarian/social justice reasons but currently not on economic/cost effectiveness grounds (though there are suggestions that current approaches do not fully capture the effects of HIV/AIDS on society as a whole – an area which might warrant further investigation). The evidence also strongly supports the efficiency case for expanding access to the expensive, but still highly cost effective, newer vaccines being promoted by GAVI. Overall, it is highly probable that, of the financing GHPs, GAVI is likely, on average, to offer the best value for money in terms of health improvements per pound spent. Accelerating progress towards the MDGs will require actions in other key areas notably female education and water and sanitation – and will also require higher levels of efficiency in translating resources for health into health outputs and outcomes than has been the case in the past. It is not possible to assess the likely cost effectiveness of the outputs of the R&D GHPs as it will be dependant on a number of factors especially the cost of the final product.

Cost Effectiveness of Health Interventions Aimed at Priority Diseases

Condition	Cost per DALY	Source
TB		
DOTS for smear positive patients	<\$40	CMH Working Group 5: Paper 8
BCG	<\$50	
DOTS for smear negative patients	\$10 to \$20	
Immunisation		
EPI plus	\$12 to \$17	CMH Working Group 5: Paper 10
Measles	\$2.5 to \$5	
HIV/AIDS		Creese 2002
Condom distribution	\$1-\$100	
Improved Blood Safety	\$1-\$43	
Prevention of MTCT (nevirapine)	\$1-12	
Peer Education for CSWs	\$4-7	
HAART	\$1,100 to \$1,800	
Malaria		Goodman, Coleman and Mills (2000)
Insect treated bednets	\$19 to 85	
Residual spraying	\$16 to \$29	
Chaemoprophylaxis for children	\$8 to \$41	

One of the key problems in identifying very ambitious basic health care packages such as that identified by the CMH is that they give little specific guidance on how countries might prioritise. For a country spending \$4 per head on health, the relevant question would be “how do we spend the fifth dollar?” not necessarily “what would we do with the thirty fifth dollar?” Using cost effectiveness as a criteria there would be

little case for using early increases in the amount of available resources to expand access to ART.

Monitoring cost effectiveness would involve more detailed analysis of GHP spending by intervention rather than the current approach which looks more at functional use e.g. expenditure on commodities, salaries etc.

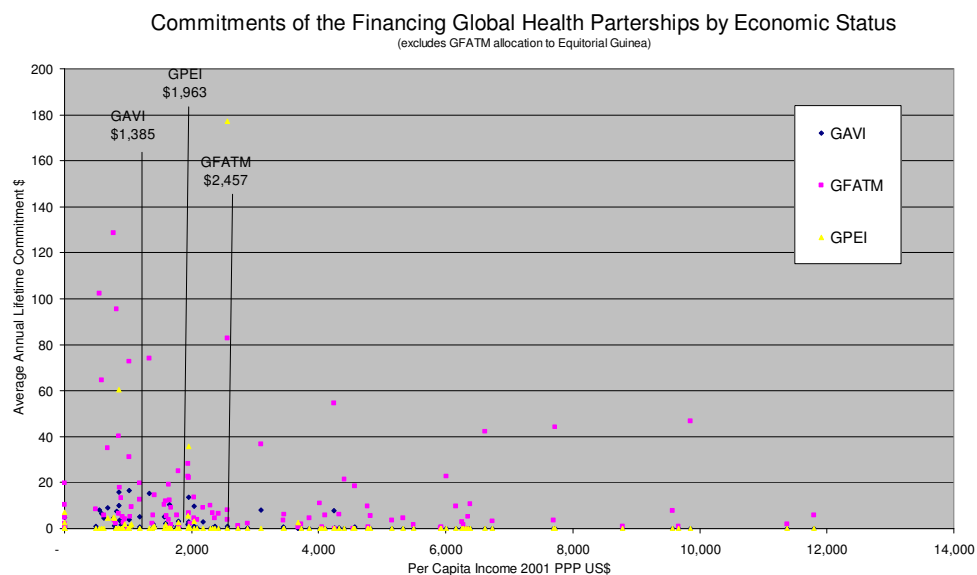
Reviews have been unable to make definitive judgements on the efficiency of GHPs or to make comparisons, given the differing core functions. Most reviews suggest that administrative costs appear reasonable and in some cases it can be argued that efficiency savings made through the GHP operations can in part offset the cost of the partnership itself. Donors often have unrealistic expectations as to just how “lean and mean” GHPs can be.

1.7 Needs Based Allocation

The review considered whether the financing GHPs were allocating resources according to need (in terms of burden of disease), by region (with a particular focus on sub Saharan Africa) and according to income status (in terms of average per capita incomes), comparing results against recent trends in donor support for health and population.

Concerns have been raised about the allocation criteria and allocation of funds to higher income countries. Approaches vary from very hands off demand led approaches (GFATM) to ones based on estimates of needs at the country level (GPEI, GAVI). GAVI has a strict income related criteria for eligibility (per capita income < \$1000) whilst GFATM provides a sliding scale of support by income status.

All the key GHPs appear to take a needs based approach *within their own area of operation*. Allocation by GHPs appear to be more focussed on poorer countries than recent trends in overall donor assistance for health and population in the past, and at least as pro poor and probably more pro poor than development assistance for infectious disease and STD control (using allocations to Africa and income status as a proxy and acknowledging the shortcomings in the data). Though GFATM does provide support to higher income countries, its allocation pattern is no less pro poor than existing allocations of development assistance for health and for malaria and TB is more pro poor than recent allocations for infectious diseases.



GAVI has a heavy focus on low income countries, especially in Africa, and provides additional support for countries with the greatest outstanding needs. There are some outliers e.g. the low share of GFATM resources for HIV/AIDS going to Africa in view of its share of the burden of disease, raising the question of whether steps should be taken to increase this share.

Comparison of Share of Burden of Disease faced by Africa with Allocation from relevant GHP by Disease

	% Burden of Disease in Africa	% Allocation by Relevant GHP
Infectious and parasitic diseases	54.6	n/a
Tuberculosis	26.2	31.6% (GFATM)
HIV/AIDS	82.9	61.0% (GFATM) and 91% of HIV-TB
Childhood diseases	47.1	65.0% (GAVI)
Malaria	81.9	78.4% (GFATM)
Poliomyelitis	16.2	29.3% (GPEI)
Meningitis	36.8	See GAVI
Hepatitis	42.0	See GAVI
Tropical diseases	54.9	n/a

Whilst funding for communicable diseases is undoubtedly insufficient to meet outstanding needs, the issue of whether it is under funded in the context of other priorities, the chronic under funding of health sectors as a whole and the modest prospects for future growth in funding is more open to debate. Recent analysis of spending on HIV/AIDS control suggests that spending in this area may represent around half of total aid flows for health. Yet HIV/AIDS only accounts for around 5% of the global burden of disease and only in Africa does it exceed 10% (it is up to 27% in high adult high child mortality countries and just under 20% overall). Malaria accounts for around half of the HIV/AIDS burden of ill health yet development

assistance for malaria is only around one-twenty fifth of that provided for HIV/AIDS control and this despite the fact that investments in malaria are arguably likelier, on average, to be more cost effective and more pro poor than HIV/AIDS interventions. The same arguments could be used for TB and immunisation. Such a view would not hold if Governments were already providing significant support for malaria and little donor support was required, but there seems to be little evidence of this. It will therefore be important to consider how appropriate the allocation between diseases is – a point also picked up at the GFATM Partner's Forum. In addition, there are also questions about the balance between prevention and treatment, especially for HIV/AIDS. These findings raise the question as to whether additional steps – such as a more proscriptive, less demand based approach - might be taken to further improve the global allocation of resources.

Polio is another extreme case. Though it accounts for only around 0.1% of the global burden of ill health and most of the benefits from eradication will go to developed countries, it accounts for a significant share – between 5 and 10% - of development assistance flows for health and population. Whilst this may be justified through the benefits of eradication, it does raise the question as to whether support should be funded out of development assistance budget and, within this, out of country programmes. In Pakistan, for example, it is estimated that more than a quarter of donor support in recent years has been for polio although, in recent years at least, this has not been at the expense of the DFID country programme.

To some extent, the GHPs are self targeting in that they focus on diseases which are mainly faced by the poor or on services which the poor stand to benefit most from (TB, immunisation, malaria prevention). Whilst GHPs often operate within the context of health systems which do not tend to be pro poor, they tend to provide services in areas which are amongst the more pro poor.

It will be important to monitor the implementation of performance based approaches to assess whether it results in inequity as poorer countries with weaker institutional capacity find it difficult to achieve the targets necessary to unlock available funds.

A key question for DFID here is whether it should advocate for changes in the resource allocation approaches by working directly with the GHPs themselves or whether it should seek to promote a more equitable global allocation of resources through providing bilateral support to fill some of the perceived gaps.

1.8 MDG Perspective

As 2015 draws closer, obsession with achieving the target could potentially introduce a number of perverse incentives. Whilst the symbolic importance of achieving the 2015 targets is, of course, huge, it is essential that efforts to achieve them does not undermine longer term development prospects. Some of the incentives relate to possible deficiencies in the MDG targets so it will be important to ensure that the development community operates in the spirit of the MDGs rather than follows the targets to the letter (or does the 2005 MDG review present a real opportunity to revisit the MDGs?). It is important DFID recognise these pressures and seek wherever possible to counteract them. Examples include the following:

- the risk that the GHPs will focus on easy to reach groups as the MDGs are, in theory, achievable without meeting the needs of the poor, as they have no specific equity dimension.
- the risk that too much emphasis will be placed on the financing GHPs at the expense of the product development GHPs (many of which are unlikely to

deliver before 2010 and, as a result, are will probably make little impact before 2015).

- the risk that too little attention will be placed on diseases targeted for eradication or elimination which, although GPGs, will have little impact on the MDGs (e.g. polio, other neglected diseases). Equally, there is a risk that donors will invest too much in these areas – perhaps securing quick wins but doing little to progress towards the MDGs
- the risk that accelerating funding to achieve the 2015 targets will be at the expense of longer term funding flows and may undermine progress post 2015
- the risk that some important interventions may actually impede progress towards some MDGs. For example, whilst ART will play a key role in terms of reducing the number of AIDS orphans, it may actually *increase* the prevalence of HIV in the population.

1.9 Financing Model

As already noted, the GHP model often sees Governments taking over the responsibility for traditional products while the GHP moves upstream to develop and increase access to new ones. It is immediately clear that in many, if not most countries, Government will be unable to meet the recurrent costs associated with the GHPs. The question facing DFID is whether it should be willing to meet such costs and plan accordingly now as the GHPs move onto newer and more innovative approaches. Otherwise DFID risks locking itself into a never ending cycle of support for the GHPs. DFID will need to consider whether, and at what point, it should be looking to shift resources into consolidating existing programmes rather than promoting further increases in coverage by the GHPs. Considerations will include:

- the overall performance of the GHP in question,
- the specific direction its proposed expansion takes,
- the minimum contribution DFID can realistically make,
- the overall financing situation and sustainability challenges faced in recipient countries and the viability of alternative financing instruments

1.10 Financial Management

It is important for GHPs to adopt prudent (business like) approaches to expenditure management. Practices vary widely between GHPs, from what might be characterised as *extremely conservative* approach (GFATM - with some concerns that it is sitting on a cash mountain) to a *high risk approach* (the Global Drug Facility of the Stop TB Partnership where commitments have been made in the absence of confirmed funding). There is little to say one has been more effective than the other as the GDF has always been able to fulfil its commitments. In fact, there has been some degree of convergence already in the approach to financial management within these GHPs. However, the different practices make it very difficult for donors and other key stakeholders to make informed decisions about the magnitude and timing of future resource needs. In principle, DFID should seek to ensure greater transparency and consistency in approaches to financial planning. There may be a case for the development of resource based budgets in addition to needs based budgets as has been attempted both by GHPs (e.g. GDF) and at country level (e.g. Ghana).

Estimates of GHP funding requirements tend to be made on an individual basis. There is often a great deal of uncertainty and little consistency in how the estimates are arrived at. In some cases, funding requirements may be more of an advocacy

tool (GDF) whereas in other cases (GFATM) there is more acknowledgment that plans need to be resource based. Again it is difficult to see how donors can make informed decisions about funding. In many cases the funding requirements are so unachievable that they give little guidance as to how marginal resources should be used – in such cases intermediate targets would be helpful.

Many of the GHPs stress the importance of diversifying their funding sources. Whilst this may make sense at the level of the individual GHP, it may not for GHPs as a whole. It could just mean that the same amount of money gets spread more thinly with increased transactions costs, as differing GHPs chase the same resources. There may be a case for DFID operating in a more flexible manner, not necessarily investing in the most effective GHPs but the most relatively under funded ones.

1.11 Other Constraints

Finance is not necessarily the major constraint at country level. The lack of human resources is arguably the binding constraint and the GHPs place major demands on limited capacity and could introduce massive distortions in the use of human resources.

The issue of capacity constraints is also relevant in terms of the light touch lender of last resort approach being promoted by the GHPs, especially GFATM. This applies equally to the relatively affluent countries such as Swaziland and Namibia which have been awarded very large amounts of funding but still have weak systems and need considerable support to ensure the funds are used effectively. In these countries, DFID is unable to provide significant support due to the country's income status and other donors are often unwilling to do so believing that their needs are being met through the GHPs. It is not clear how this issue can be addressed.

1.12 Country Level Issues

A range of issues are relevant from the country perspective, some of which reinforce the findings set out above:

Additionality

The additionality conditions included in some GHPs are inappropriate in the sense that they undermine national ownership. There are also serious questions as to whether additionality is measurable and, even if it is, whether it is enforceable. There are questions as to whether the most effective and most sustainable way of increasing spending on communicable disease should be through negotiation with Government – and convincing Ministries of Health and Finance and the population as a whole that increased spending on communicable diseases is warranted – rather than through the earmarked funding approach adopted by the GHPs.

In most cases GHPs appear to have resulted in additional public expenditure. In most cases it has been used to cover financing gaps under existing programmes, suggesting at least that this is consistent with the rational and planned allocation of resources *within the communicable diseases sub-sector*. In some cases GHP funding has been used to fund new programmes which are likely to have been driven more by the availability of funds than any rational assessment of priorities. The general assumption seems to be that, if GHPs cover existing funding gaps, they are not distortionary. This is almost certainly untrue. The relevant question to ask is “if money had been made available without strings would Government have spent

money on this?" The answer would invariably be no. There is little evidence that donor and Government funding decisions have been influenced so far by allocations though the real test will come when Governments update health plans and MTEFs.

Irrespective of what they fund, the earmarked nature of GHP support and any additionality conditions attached undermine the strategic planning role of the Finance Ministry as it attempts to allocate resources in line with national priorities. Whilst this may be less damaging in some settings, it can seriously undermine the credibility of efforts to develop credible medium term expenditure frameworks. The Ministry of Finance in Tanzania expressed such concerns as follows: "We are concerned that the mechanism of aid delivery proposed by the Global Fund against AIDS, Tuberculosis and Malaria, has the potential of undermining government accountability and negate all efforts made so far to improve development partnership and aid effectiveness." In some cases Governments have tried to stick to expenditure ceilings implying that GHP funding would have to be at the expense of other public expenditure (Uganda) or expenditure on HIV/AIDS (India). In both cases the matter has not yet been fully resolved. Even if Governments do retain control over public expenditure *totals* and it is still possible that GHP spending could crowd out alternative programmes which might have been more pro poor.

The question seems to be less "are the GHPs are distortionary or not?". They are. The more important question is whether the distortions introduced are a good or a bad thing. Here, it may be important to distinguish between countries with a mature, well respected and highly participatory approach to the establishment of national priorities such as Uganda, and countries where this is not the case. The impact of additionality and earmarking are likely to be more destructive in the former.

Uncertainty

The uncertainty of GHP funding has caused problems. In some cases (e.g. Ghana), where Government has identified programmes for GHPs as part of its national strategies, distortions have been created by *non approval* of GFATM proposals. In some cases proposals rejected by donors have been approved by GHPs – though it is not clear whether they were poor proposals or were marginal ones which were justified when more resources became available. Given the size of GHP commitments, any measures which improve predictability of funding will assist overall expenditure management. This may happen automatically as the track record of GFATM develops – an alternative approach might be to move towards indicative (needs based) allocations.

Coordination

GHPs have generally not been well coordinated either with Government planning processes or even between themselves. There has been some movement towards greater utilisation of local systems but there has often been destabilisation of SWAP approaches and concerns about impact on macroeconomic stability. There have been some promising moves – for example GFATM is willing to channel resources through the common fund in Mozambique and monitor performance against outputs not inputs. Some countries have adapted their approaches e.g. by developing needs based budgets as well as resource based budgets in Ghana – though this has had capacity implications.

Concerns have been expressed in many settings about the lack of absorptive capacity. These are alleviated somewhat when funding is for NGOs or the private sector though here long term sustainability issues come to the fore.

Allocation

Concerns have been expressed about the balance between disease specific programmes and system backbone investments such as strengthening of district management capacity, quality assurance, training and supervision reinforced by an approval system which creates incentives for a vertical approach. This suggests a key role for traditional funding sources in covering health systems needs (but also in responding to any inequities in the disease wise allocation by the GHPs).

Poverty Impact

Proposals tend to give little indication as to how the investments will focus on the poor. There are few explicit policies (Ghana is one example) regarding the criteria for rationing access and costs of using ARVs. This is largely relevant only because GHPs are not properly integrated into country planning and budgeting approaches. Where they are fully integrated, this would be less of a concern as country efforts would be best judged on the basis of PRSPs and performance against its targets and there would be no need to hold the GHPs to higher standards than other areas of expenditure

Capacity Implications

There are concerns about the shortcomings of the light touch approach adopted by some of the GHPs. In middle income countries with severe capacity constraints are receiving large awards from GHPs (Swaziland, Namibia). At the opposite end of the spectrum, countries in, or emerging from, crisis e.g. Sierra Leone. Should/could DFID or other donors provide top sliced funding to support such countries to ensure GHP funding is put to effective use?

Chasing GHPs funding has often diverted the attention of staff away from ongoing country level processes. There are concerns that transactions costs are increased by new reporting requirements and the requirement for GHPs budgets to use standard and not country level budget classifications, and that CCMs add little in situations where participatory arrangements are already fairly well developed. Despite claims that GFATM is radically policy free, in some settings there has been a feeling that it is becoming an agency in itself with its own rules and procedures. At the same time, some have voiced concern about the lack of guidance in other areas e.g. on how much countries should be bidding for.

Finally, there are concerns that the approaches perpetuate vertical programmes and that opportunities to strengthen systems have not been fully utilised.

1.13 DFID Policy Options

Possible approaches in relation to the financing GHPs include:

- placing less emphasis on additionality
- advocating a shift towards longer term, equity based allocation approaches (especially GFATM) which are more consistent with ongoing country level processes and could promote greater predictability in funding flows
- increasing focus on sustainability and ensure it is fully considered *before* major decisions are made.

In relation to funding, the GHPs are clearly here to stay but there is no reason why DFID cannot channel support for communicable diseases through the bilateral programmes as well as through the GHPs. To some extent, the choice depends upon the performance of the GHPs and any gaps it leaves, and whether DFID's role should change after the initial start up phase or completion of the first phase of funding.

Options might include:

- ensuring sufficient resources are allocated to systems-strengthening approaches in all settings – countries under stress as well as middle income countries
- targeted bilateral support for communicable diseases where it is felt the GHPs are leaving gaps – to be provided for through a global pot, not from the country programme, especially for diseases where cross border externalities are great
- provision of budget support or sector support where appropriate to support Governments in ensuring the sustainability of GHPs especially after 2008 (or when necessary)
- to consider how to respond to the polio dividend once eradication is achieved. This will include money freed up from the aid programme but also the Government's health budget.

ANNEX 1: RELATIONSHIP BETWEEN INPUTS, OUTPUTS AND OUTCOMES

Assessment of Impact

Questions considered here include:

- is it possible to assess impact?
- what evidence is available so far?
- what approaches might be taken to assessing impact?
- how do the GHPs make the economic case for their existence?

As illustrated in box 1 below, there are several key drawbacks preventing a proper assessment of impact:

- it is too early to assess impact, given that many GHPs are still in their early stages
- it is difficult to attribute any impacts to the partnerships
- it is all but impossible to identify the counterfactual (see box 1).

Box 1: IAVI Evaluation

“it is impossible to examine IAVI’s performance against any “counterfactual.” Nonetheless, in the end, the panel believes that it is useful, even if largely conjectural, to create a “counterfactual for the future,” by asking: “What would happen in key areas of IAVI’s activities if IAVI were to “cease operations?” The panel believes that, in that case, global efforts on advocacy, communications, and the policy and access agendas would decrease quickly and significantly. Some funding for AIDS vaccines would also erode. In addition, the panel believes that no other organization could fill the gaps in these areas in any reasonable period of time. In this case, the enabling environment for the uptake of an eventual vaccine would be undermined in a number of countries now and more countries later”

Few attempts have been made to carry out a full cost benefit analysis (box 2 below)

Box 2: Economic evaluation of Mectizan distribution

“Economic evaluations of the Onchocerciasis Control Program (OPC) in West Africa have calculated a net present value – equivalent discounted benefits minus discounted costs – of \$485 million for the programme over a 39-year period, using a conservative 10% rate to discount future health and productivity gains. The net present value for the African Program for Onchocerciasis Control (APOC) is calculated at \$88 million over a 21-year time period, also using a 10% discount rate. Cost-effectiveness analyses of ivermectin distribution have found a cost of \$14–\$30 per disability-adjusted life-year prevented – estimates comparable with other priority disease control programmes. However, the economic success of ivermectin distribution is sensitive to the fact that the drug itself has been donated free of charge. The market value of Merck’s donations to the APOC for just 1 year considerably outweighs the benefits calculated for both the OPC and the APOC over the life of

these projects. Pending the development of an effective macrofilaricide, the distribution of ivermectin will remain a public health priority into the foreseeable future".
Waters, Rehwinkel Burnham

How Do The GHPs Make Their Own Economic Case?

The main financing GHPs make the economic case for accelerated actions based on:

- impact on economic growth at the macro level (by affecting the most economically productive sections of the population)
- impact on income at the individual level
- poverty focus (especially for malaria and TB)
- low cost of interventions
- the proposed strategies being the most cost effective way of addressing the disease in question

However, only GAVI makes the key case that the interventions are a cost effective way of improving health outcomes – probably because immunisation is amongst the most cost effective of available interventions. This reinforces the fact that the GHPs tend to view their role in isolation from other efforts. This makes it difficult for potential funders as well as potential beneficiaries to gauge the relative merits of different approaches.

The Financial Case for the GHPs?

Benefits of Eradication

Estimating the costs and benefits of eradication is extremely problematic. However, in the case of polio, the net benefits appear large. Bart et al found that based on eradication in 2005, the cost savings from not having to treat those with polio amounted to some \$13.6bn to 2040 – not including annual savings of around \$1.7bn through not having to immunise. Break even would be achieved within 2 years of eradication being achieved. Of the \$1.7bn savings a high proportion – around 60% - would accrue to developed countries who could discontinue their expensive immunisation programmes.

Net Costs of the GHP: Stop TB

Another way of assessing the viability of GHPs is to compare any cost savings which can be attributed to the GHPs to the costs of maintaining the partnership. If the savings outweigh the costs, one can argue the partnership is, in effect, cost free. This approach was taken in a review of the Stop TB Partnership (box 3)

Box 3: Net Costs of the Stop TB Partnership

The direct costs of the Partnership are relatively modest - US\$ 18.05m for the Secretariat in 2002, of which US\$13.0m was for the GDF. The Secretariat claim that GDF procurement results in savings of the order of 30% and the available evidence

tends to support this. Such savings¹ (which are not considered to be the most important benefit of GDF) have in part offset the actual costs incurred by the Partnership². Though a rather artificial comparison, this is nonetheless illustrative. On the same basis, if the GDF grant facility had been expanded in line with its Strategic Plan, or even its approved 2002 budget, all non- GDF Secretariat costs would have been offset.

Stop TB Evaluation IHSD 2003

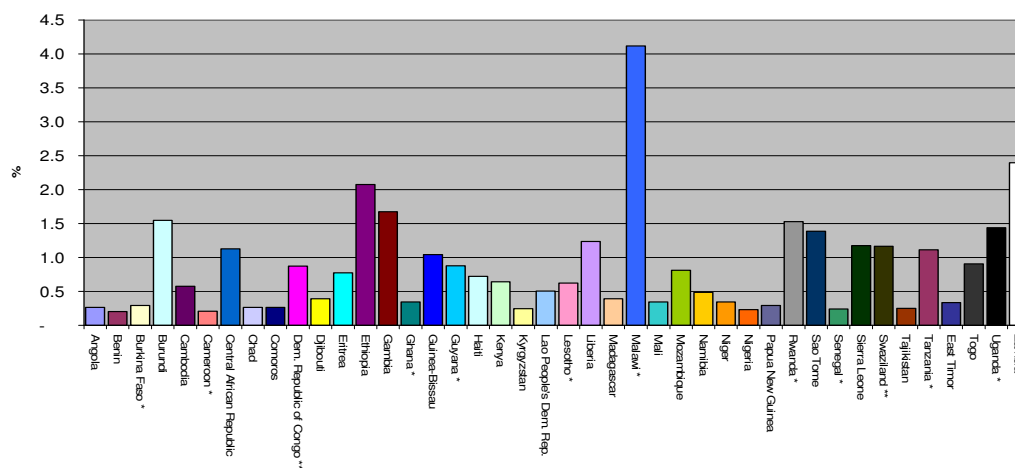
Impact of the GHPs on Macroeconomic Stability

It is also important to flag up the potential impact of the global programmes on macroeconomic stability. The GHPs imply large increases in aid flows and possibly substantial increases in aid dependence. The issue is partly one of the *magnitude* of aid flows and related concerns about the Dutch Disease effect through which increased aid renders a country uncompetitive through its effects on inflation and exchange rates and through the crowding out of private sector activity.

As charts 1 and 2 show, the GHPs' commitments often exceed 1% of GDP and 5% of Government consumption expenditure³.

Chart 1

Countries Where Average Annual GHP Commitment Exceeds 0.2% of GDP



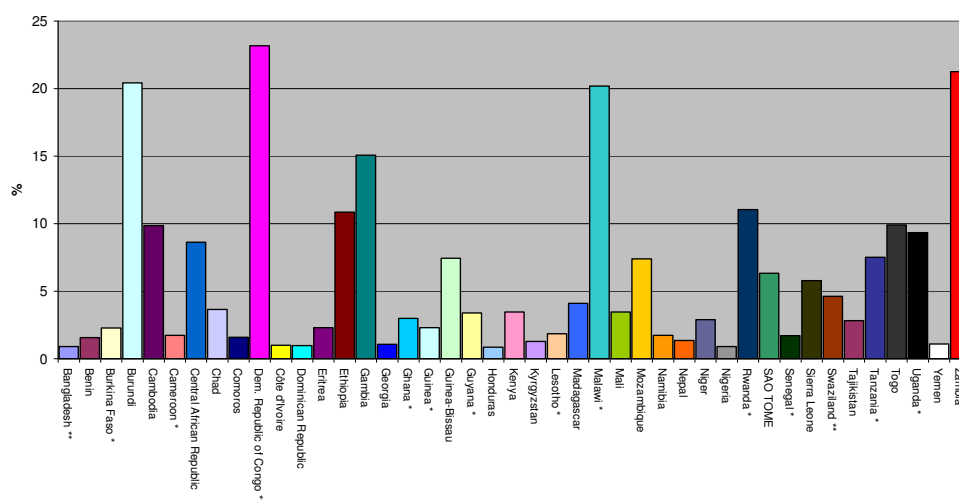
¹ The benefits (the savings) accrue to countries and result in greater provision than would otherwise be the case and hence directly benefit those suffering from TB. Figures presented here are based on a 30% reduction in drug prices as a result of GDF procurement.

² For example, in 2002 savings of 30% on the \$10.75m expenditure on drugs amounts to some \$3.22m, almost 2/3 of non-GDF Secretariat spending

³ The GHP commitments cannot always be directly compared to Government spending levels as some is to be disbursed through the private or NGO sector.

Chart 2

Countries Where Annual GHP Commitments Exceed 0.75% of Government Consumption Expenditure



Sources: GHP commitment data; World Development Indicators 2003

The overall impact of these flows will depend heavily on the quality of public expenditure management. The role of the World Bank and IMF, as well as bilaterals such as DFID who are also active in this area, will be vital. There are perhaps some grounds for optimism that practices have improved in this area in recent years. It will also be affected by the quality and the content of the programmes funded to the extent that high quality investments are likely to promote growth, and commodity based programmes are likely to have less serious macroeconomic implications.

The issue of *volatility* in aid flows is arguably a far greater problem. Slower than anticipated disbursements and rejected applications have contributed to uncertainty about resource flows in a number of countries though such factors are not specific to GHPs. Perhaps it is not unexpected that there would be teething problems as both the GHP and the countries become familiar with using a new mechanism. The lack of clarity has resulted in a situation for GFATM where there are pressures from some quarters to increase the size of applications (often by donors) with counterbalancing pressures to reduce the size of any application to maximise the chances of approval (often Governments who tend to adopt a more risk averse approach). A key question here is whether such problems might be expected to decline over time as predictability improves, or whether there is a case for providing greater predictability through, for example, the development of indicative allocations by country. Related to this is the concern that by insisting on additionality, the GHPs undermine the very processes (MTEFs) which are designed to increase predictability. A further concern is that the GHPs may adopt project based approaches to avoid macroeconomic ceilings as appears to be the case in Uganda. Whilst increasing overall public spending which still has the same macroeconomic effects it also introduces additional inefficiencies such as greater transactions costs associated with project based approaches.

Why does macroeconomic stability matter? Health outcomes are far more closely linked with overall economic progress than investment in the health sector. The positive effects of increased health investment are likely to be more than offset if

economic prospects are compromised. It is important therefore that such concerns are not glossed over.

The performance focus inherent in the financing GHPs may also cause problems associated with uncertainty about funding flows – and these are more likely to be pressing in the lower income/capacity constrained countries which are perhaps less likely to meet agreed targets. This raises the question as to whether it would be helpful to establish “early warning systems” or some alternative means of ensuring that Finance Departments are aware of the possibility of future shocks related to shortfalls in disbursement of GHP funds.

Caveats: GHPs as a Lender (or Supporter) of Last Resort

In a way it is not appropriate to compare what the GHPs are financing against what is being funded through country programmes. If the GHPs are funding existing gaps and effectively acting as a “supporter of last resort”, you would expect them to be funding more marginal, and therefore, less cost effective activities. It would only be possible to question the use of funds where less cost effective interventions are being financed whilst proven cost effective interventions remain under funded. Along these lines the Global Fund “seeks to promote the importance of balance between interventions, but does not require that each proposal be so balanced, as long as it contains sufficient information to demonstrate that this balance is achieved through the combined efforts of all partners”.

Assessment of Allocative Efficiency

Questions considered here include:

- are GHPs shifting resources away from conditions which are best treated at country level (e.g. non communicable diseases/injuries)?
- are GHPs allocating resources to the diseases which present the greatest disease burden (or, more specifically, diseases for which additional spending can reduce the disease burden)?
- are GHPs allocating resources to the countries most in need?

Allocation compared to Burden of Disease

Charts 3 to 7 indicate clearly that the overall burden of disease in sub Saharan Africa is around 5 to 6 times that in developed countries and that overall 70% of this burden is due to communicable diseases with around 50% due to infectious and parasitic diseases alone. HIV/AIDS accounts for almost half of the burden of disease caused by infectious diseases in high adult, very high child mortality countries in Africa and just under a quarter in high adult, high child mortality countries. On these grounds one might expect a considerable share of GHP funding to go to sub Saharan Africa.

Chart 3

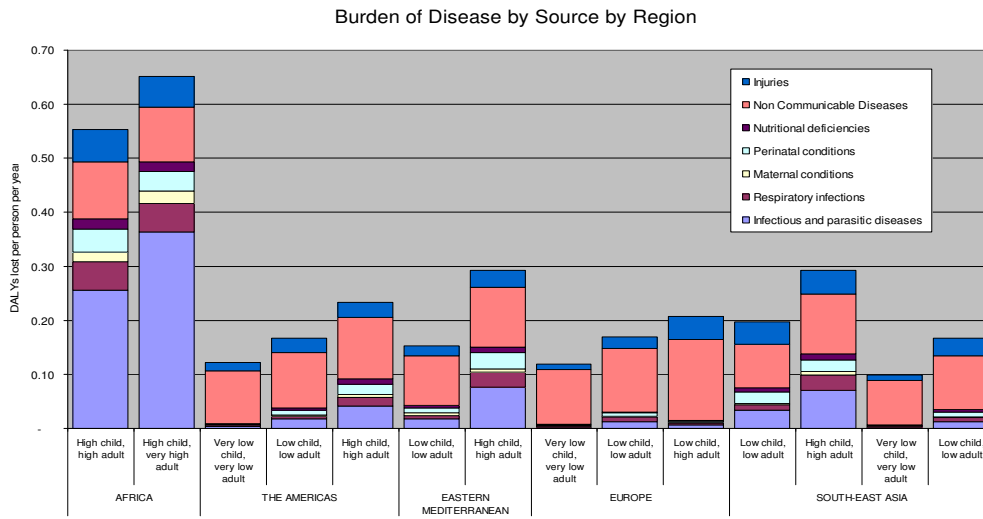


Chart 4

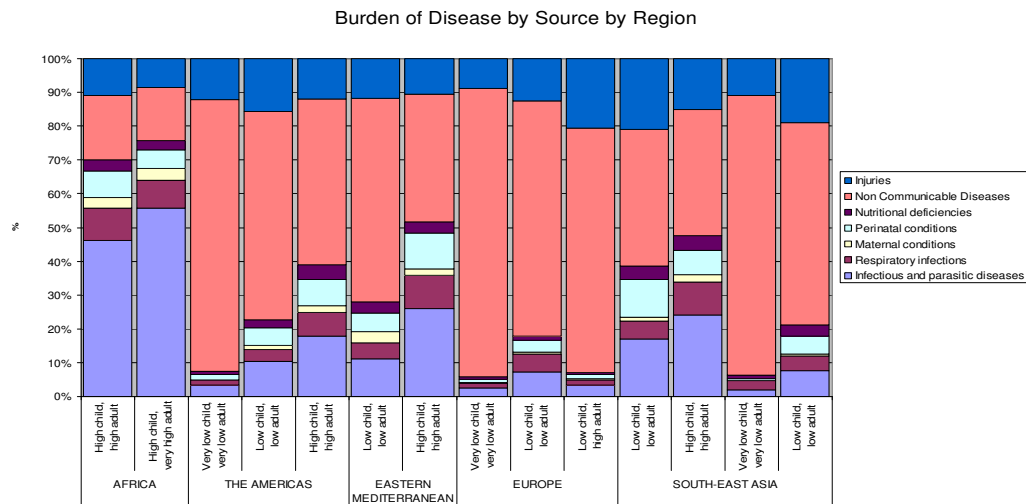


Chart 5

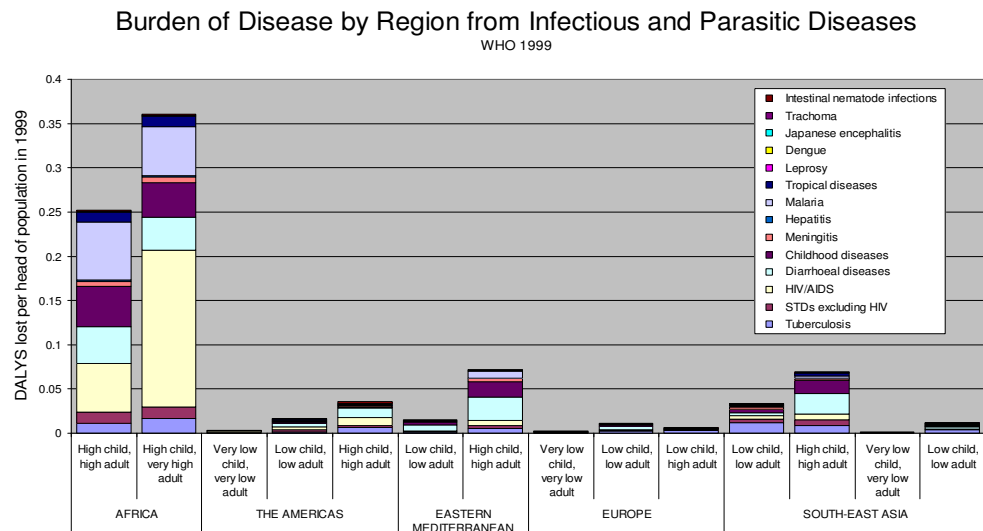


Chart 6

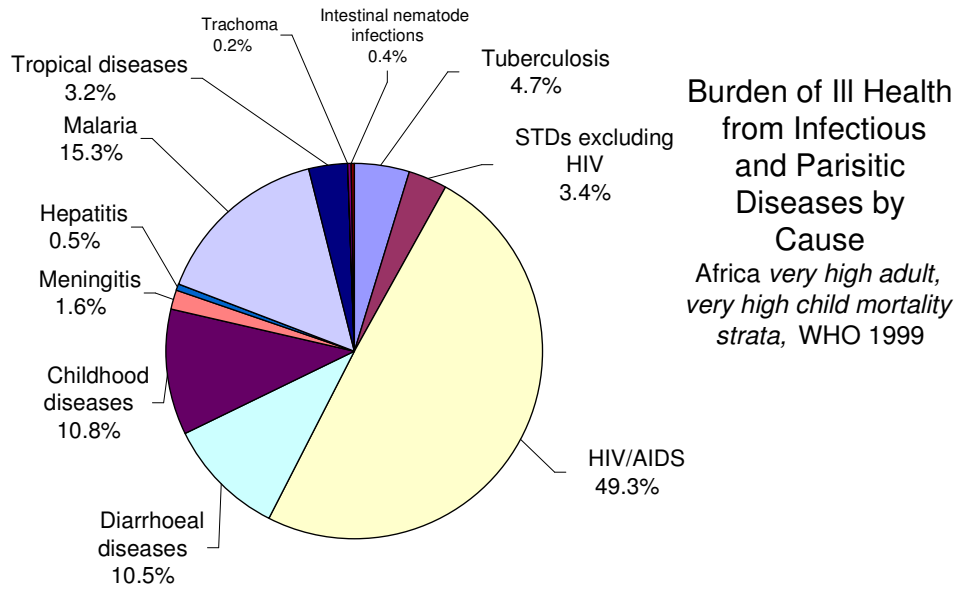
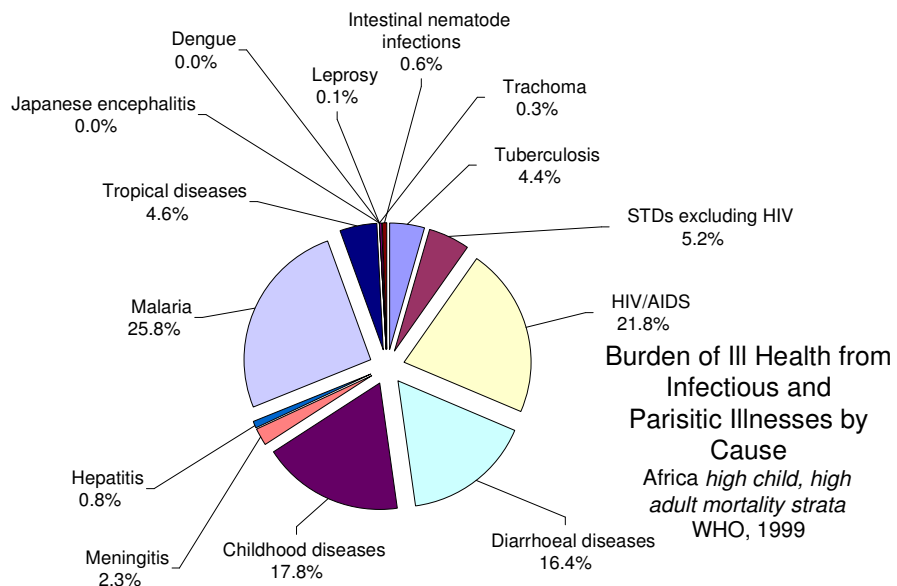


Chart 7



What is the Basis for Allocating GHP Resources?

Basis for Allocation

The basis for allocation of resources varies widely from a more demand led approach with very broad eligibility criteria with a sliding scale to ensure more intensive support for low income countries (GFATM) to more mechanistic approaches based on bottom up costing of needs (GAVI/GPEI).

Countries are eligible for GAVI funding if they have a GNP of less than \$1000. In addition, they must have a functioning interagency coordination committee (ICC) or equivalent means of collaborating with government and international aid organizations working within the communities, provide a recent immunisation assessment and have an existing multi-year immunisation plan in place.

For GFATM, eligibility is on a sliding scale. IDA eligible low income countries are fully eligible. Lower middle income countries are required to secure co-financing, focus on poor or vulnerable populations and move towards greater domestic financing. Upper middle income countries are only eligible if they face a very high current disease burden. High income countries are not eligible.

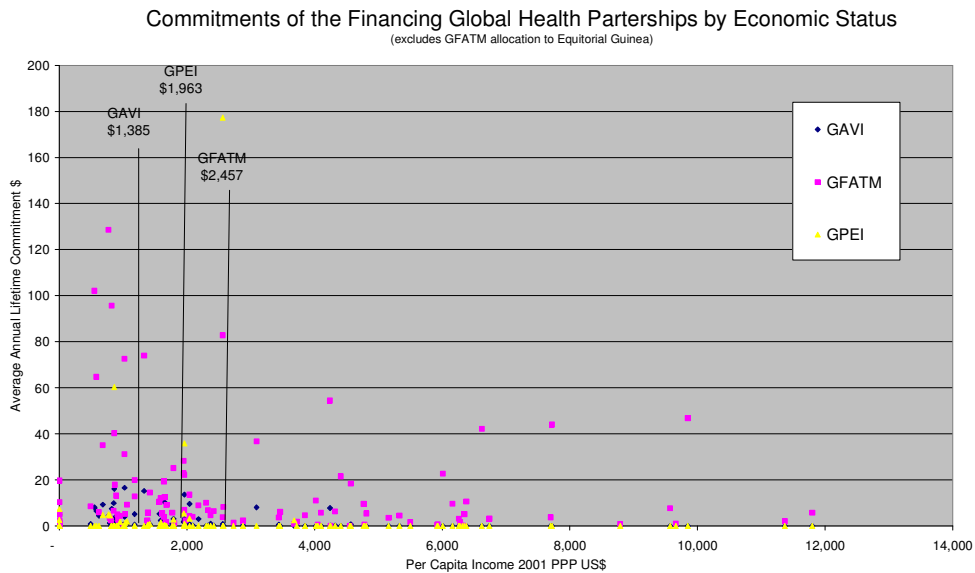
There is increased emphasis on the development of performance based systems. The Vaccine Fund has established a system of performance-based grants. For those countries receiving financial support to strengthen their immunisation systems, as opposed to those countries receiving only vaccines and safe injection equipment, the Vaccine Fund will provide a “share” worth \$20 toward immunising each child. This share will be delivered in two stages in order to reward progress: the first half up-front as an investment in improving immunisation services and the second half retrospectively as a reward for having immunised additional children. Independent Data Quality Audits are used to verify performance. Countries must report annually on the progress they have made and those that do not meet their targets will not receive the second set of shares. Follow on funding for GFATM (after the initial 2 year approval) is dependent upon performance against agreed targets which in some cases relate to financial inputs from Government.

Given past experience with the application of conditionalities and concerns that a performance focus may compromise equity objectives (as poorer countries are less able to meet the requirements), it will be important to track where objectives are not being met and why and what impact this has on overall allocation patterns.

What are the results – who gets what?

Chart 8 shows allocations by county by socio economic status. There is a clear tendency for resources to be channelled to poorer countries though there are also significant differences between the average economic status of the recipients of the financing GHPs. The average recipient of GAVI funds has an average per capita income of just under \$1,400 per head (2001 at Purchasing Power Parity) around the level of Uganda, for GPEI it is over 40% higher at just over \$1950, similar to Pakistan and Ghana, whilst for GFATM it is around 77% at just over \$2450 around the level of India or Bolivia.

Chart 8



Regional Allocations

GFATM: According to the GFATM website, 60% of commitments are for Africa; 60% is for AIDS. Half of the money will be used by governments; half by non-governmental partners. Nearly half is for the purchase of medicines and commodities, and half is for infrastructure, training and other support costs.

GAVI: According to the GAVI website, 66% of funding is for Africa.

GPEI: According to GPEI’s estimates of resource requirements, 9.9% of needs for 2004 and 2005 are for Africa, reflecting the fact that resources are highly concentrated in the 6 remaining polio-endemic countries.

Although GFATM guidelines indicate a preference for lower income countries, actual commitments are only loosely associated with a country’s socio economic status (Chart 9). For GAVI there is a much more pronounced gradient.

Chart 9

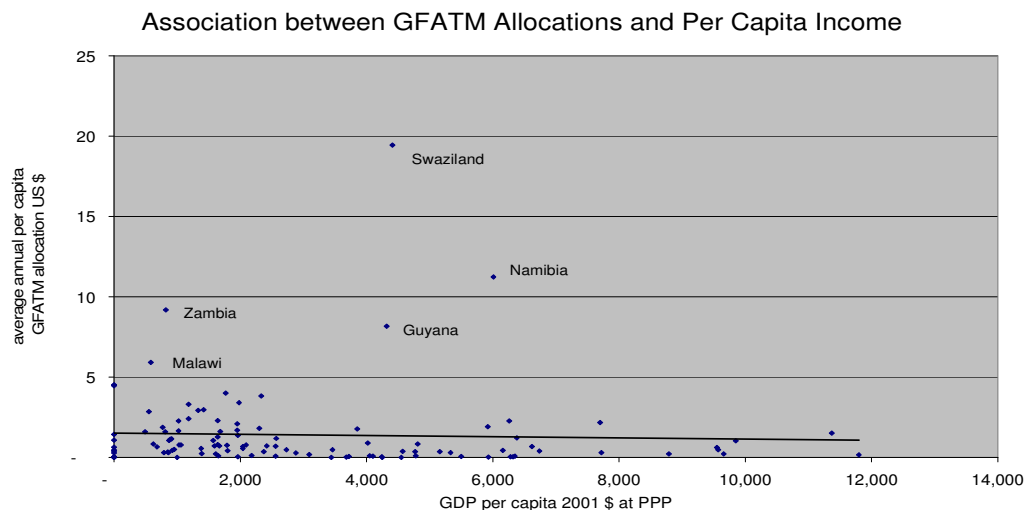
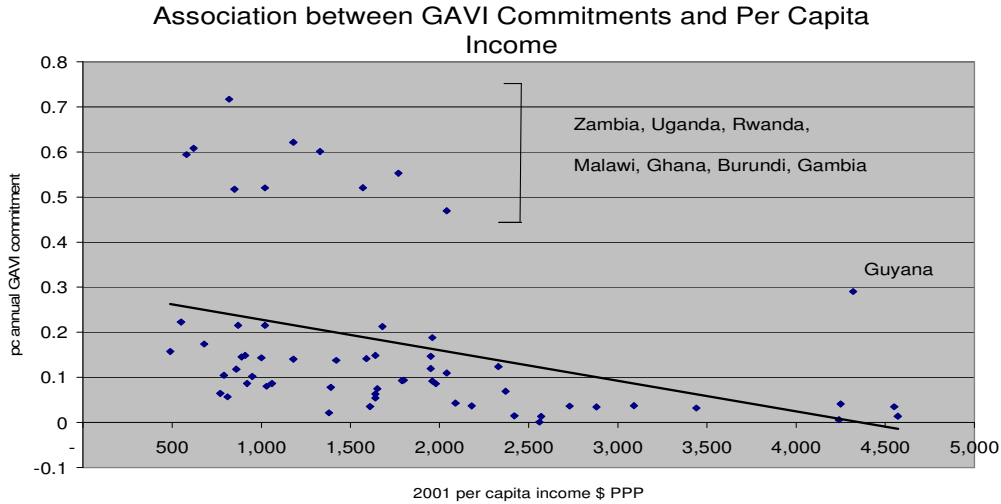


Chart 10

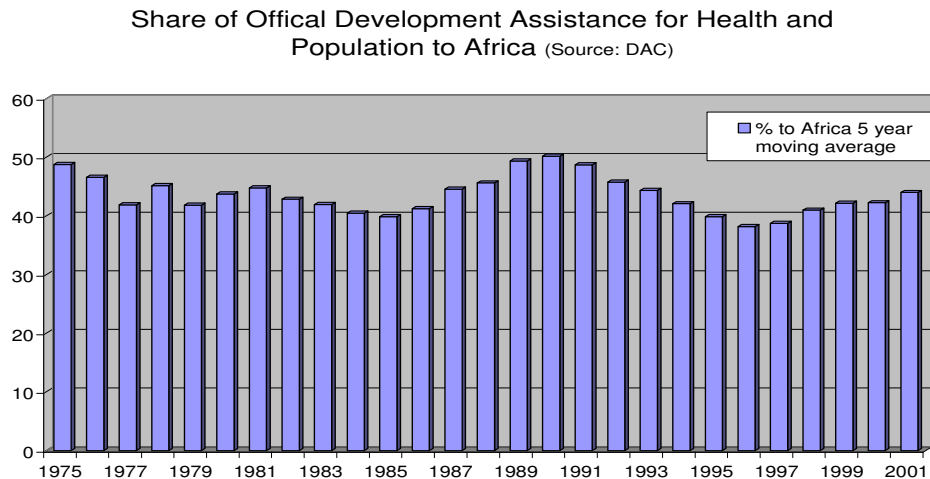


Comparison with Existing Flows

Africa Focus

The following charts compare the regional allocation of resources with those under existing approaches using Africa as a proxy for income status. DAC data also shows that the share of development assistance for health and population to Africa has declined significantly since the 1970s and, though it has begun to increase since the mid 1990s (chart 11). However, it remains far below the share allocated by GAVI and GFATM (see chart 13 overleaf). In short, donor support for the GHPs appears to have more of an Africa focus than development assistance for health as a whole. Thus, if donor support for GHPs is at the expense of other health programmes, the distributional impact appears to be positive.

Chart 11



As a follow on, past trends in allocation for infectious diseases and STD control were compared to commitments made by the financing GHPs. In both cases, although the share of donor support going to Africa has been increasing, it has still been below the share allocated through GAVI and GFATM (chart 12), This suggests that if funding for GHPs has been at the expense of traditional support for communicable diseases, the distributional effect is likely to have been positive (again using allocation to Africa as a proxy).

Chart 12

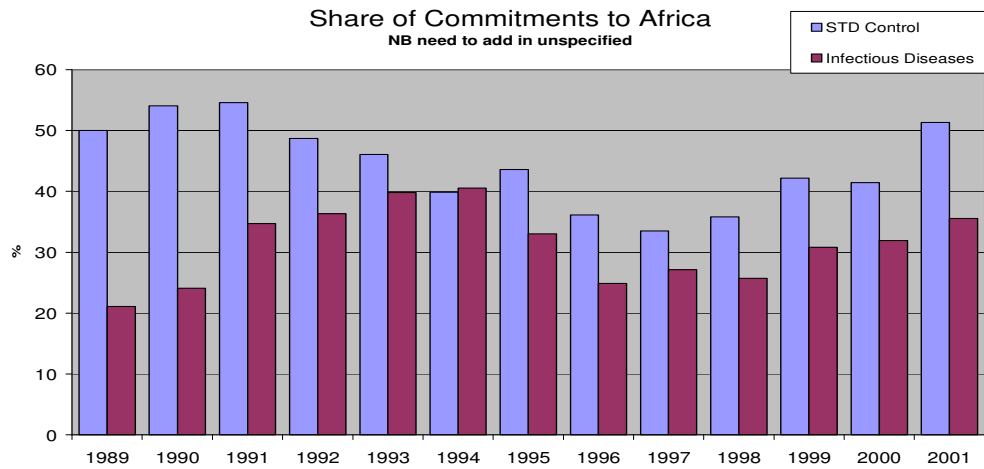
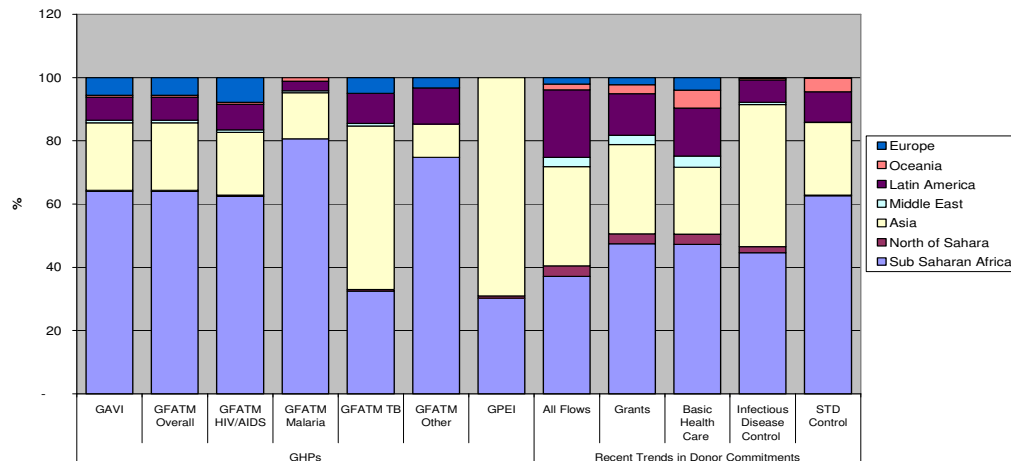


Chart 13 compares the GHPs allocation by region with DAC data on recent trends⁴ in development assistance for health and population. The data support the view that the GHPs are more Africa focused than overall health and population flows over recent years, GPEI being an exception here.

Chart 13

Allocation By Region: GHPs Compared to Recent Trends



⁴ taking an average for 1998 to 2002. As noted elsewhere, there are significant shortcomings in the DAC data and these are compounded by the fact that up to 20% of recorded assistance is not specified by country. Figures shown here refer only to data where specified.

Allocation by Income Group

Chart 14 illustrates the fact that GHP resources are also more heavily focused on low income countries than recent donor commitments. On the whole, a comparison of allocations by disease (as far as is possible) suggests that GHP allocations seem to be at least as pro poor as past allocations in these areas – perhaps more pro poor for malaria, slightly less so for HIV/AIDS. Finally, chart 15 shows that GHPs allocations are also considerably more pro poor than the overall aid programmes of the major contributors to the GHPs, especially USAID, Spain, Germany and France. The GHPs are also on average more pro poor than other donors which are amongst the more pro poor bilaterals such as DFID, Netherlands, Japan and Italy.

Chart 14

Allocation by Income Group: GHPs Compared to Recent Trends

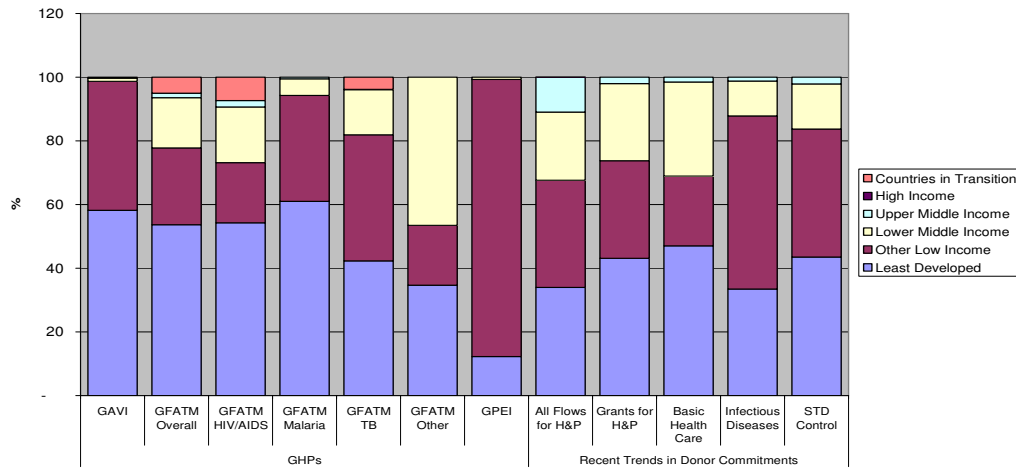
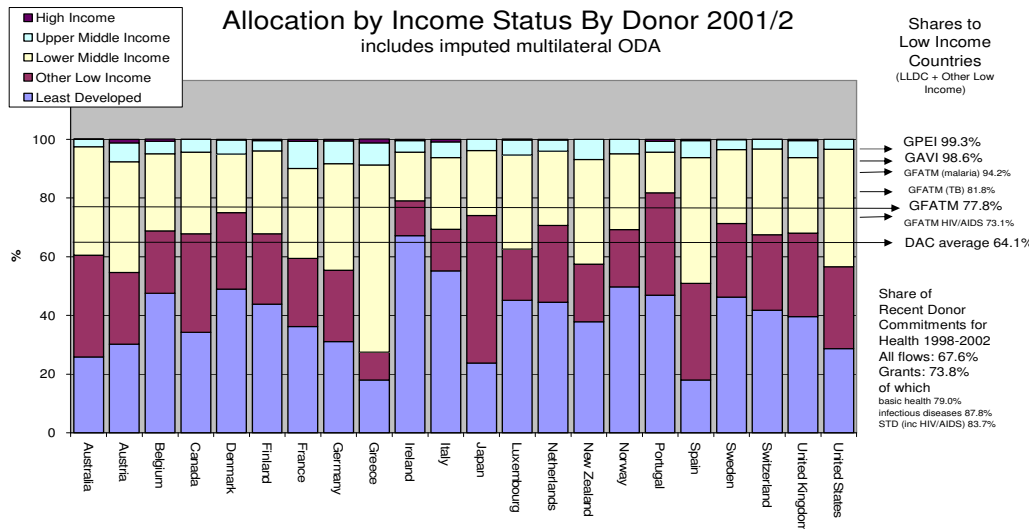


Chart 15



Thus, whilst it may not be possible to say whether the GHPs are actually at the expense of other type of development assistance, it is possible to say that:

- *if* the GHPs are at the expense of non-health development assistance, they appear to promote a more pro poor global allocation of resources
- *if* the GHPs are at the expense of overall health and population assistance, they appear to promote a more pro poor global allocation of resources
- *if* the GHPs are just substituting for bilateral efforts to combat the communicable diseases, there seems little prospect that they will significantly worsen the overall allocation of resource.

At the same time some donors are providing relatively little development assistance in relation to GDP (chart 16), relatively little support for health and population in relation to their overall programmes (chart 17) and not focusing their resources on countries in need (chart 15). Measures to increase overall bilateral spending and focus it on the social sectors in low income countries could clearly change this comparison with the GHPs.

Chart 16

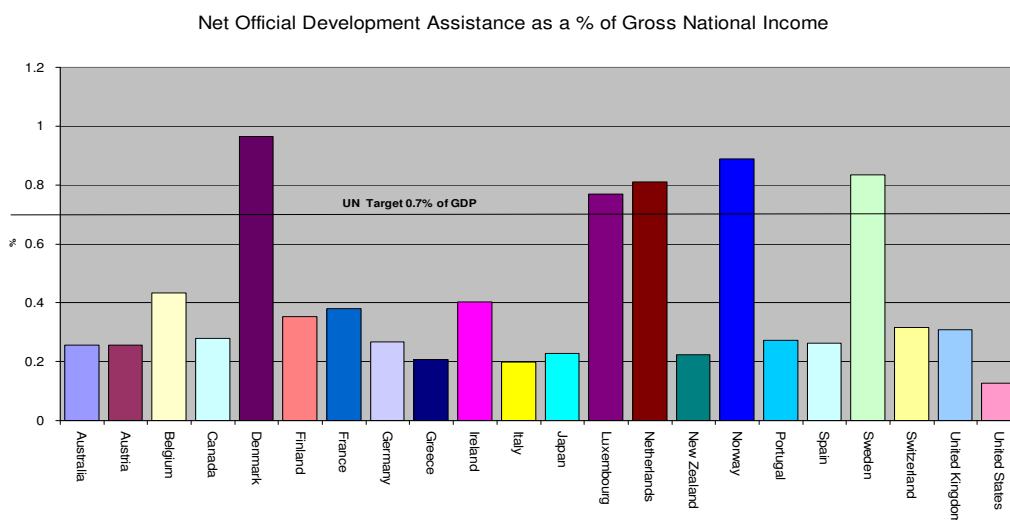
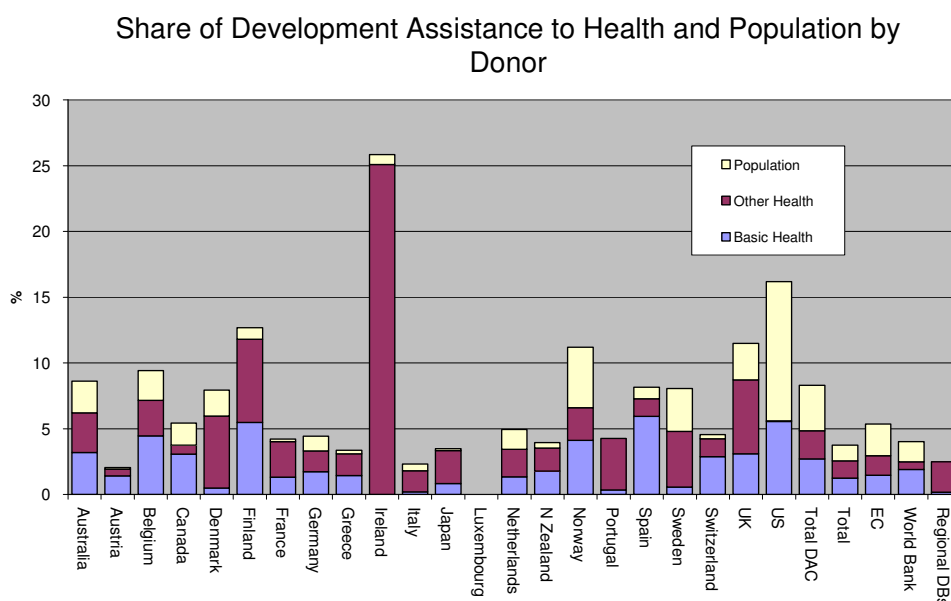


Chart 17



How Cost Effective are the Key Strategies?

Most interventions aimed at communicable diseases are highly cost effective (table 1) although, as Mills points out, it is not clear whether it is better to address specific diseases as opposed to an overall package of essential health services. Moreover, it is clear that cost effectiveness results are highly dependant upon the quality of health systems and in the provision of other complementary inputs such as education, water and sanitation etc.

Table 1: Cost Effectiveness of Health Interventions Aimed at Priority Diseases

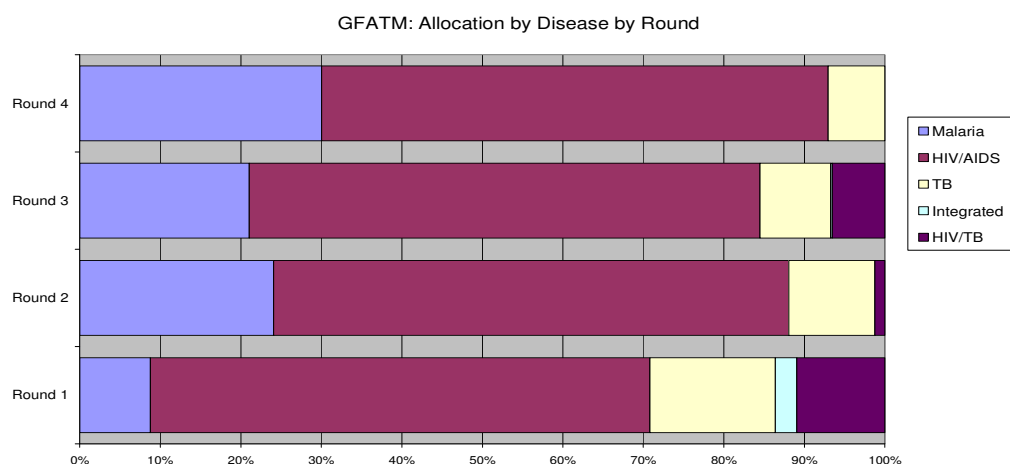
Condition	Cost per DALY	Source
TB DOTS for smear positive patients BCG DOTS for smear negative patients	<\$40 <\$50 \$10 to \$20	CMH Working Group 5: Paper 8
Immunisation EPI plus Measles	\$12 to \$17 \$2.5 to \$5	CMH Working Group 5: Paper 10
HIV/AIDS Condom distribution Improved Blood Safety Prevention of MTCT (nevirapine) Peer Education for CSWs HAART	\$1-\$100 \$1-\$43 \$1-12 \$4-7 \$1,100 to \$1,800	Creese 2002
Malaria Insect treated bednets Residual spraying Chaemoprophylaxis for children	\$19 to 85 \$16 to \$29 \$8 to \$41	Goodman, Coleman and Mills (2000)

Table 1 shows that there is significant variance in the cost effectiveness of the key interventions supported through the GHPs. Although actual cost effectiveness will depend upon local circumstances – cost factors, the strengthen of health systems, epidemiological factors- most of the interventions outlined above would be considered extremely cost effective uses of limited resources. The exception is ART. Based on existing evidence, ART is not a cost effective use of resources⁵ – its use can be justified on humanitarian but not economic grounds. Though declining prices of ARVs would improve its cost effectiveness even if drugs were free, it would still be a less cost effective intervention than most funded under the GHPs. Indeed, Mills finds that ART is the only intervention, amongst a range of key interventions, for which costs actually exceed benefits. This is of relevance as the majority of GFATM commitments are for HIV/AIDS, of which a large, though unclear, proportion of funding is for ART.

There is also a pronounced shift over time towards support for malaria at the expense of TB (chart 18) though it is less clear what implications this has for overall cost effectiveness.

⁵ unless, as some argue, provision of ARTs is an essential component of the overall care package that incentivises people to come for testing and therefore can help people know their status, and therefore can aid in prevention

Chart 18



There are no clear trends in terms of allocation by region (table 2). East Asia and the Pacific did well out of the first round but not the second, whereas Sub Saharan Africa did relatively poorly in the third round but did well in the fourth.

Table 2: Trends in GFATM Allocations by Region and Round

	EAST ASIA & THE PACIFIC		EASTERN EUROPE & CENTRAL ASIA		LATIN AMERICA & THE CARIBBEAN		NORTH AFRICA & THE MIDDLE EAST		SOUTH ASIA		SUB-SAHARAN AFRICA	
	\$m	% of Round	\$m	% of Round	\$m	% of Round	\$m	% of Round	\$m	% of Round	\$m	% of Round
Round 1	132.3	23.7	27.2	4.9	71.4	12.8	4.7	0.9	13.7	2.5	308.0	55.3
Round 2	65.2	7.6	72.7	8.5	98.7	11.5	53.4	6.2	65.5	7.7	500.1	58.4
Round 3	88.9	13.9	58.9	9.2	89.4	14.0	45.8	7.1	31.6	4.9	326.4	50.9
Round 4	114.9	11.9	53.1	5.5	26.5	2.7	28.7	3.0	82.1	8.5	662.6	68.5
Total	401.2	13.3	211.9	7.0	286.0	9.5	132.6	4.4	192.9	6.4	1,797.1	59.5

Serious doubts have been expressed about the value for money offered by the newer vaccines currently being promoted by GAVI. Although such vaccines are undoubtedly more expensive and generally less cost effective than existing vaccines, they are still highly cost effective (in most circumstances) and should still be a priority use of limited resources (table 3). Expansion of newer vaccines should not take place at the expense of traditional ones but at the expense of other less cost effective interventions.

Table 3: Cost Effectiveness of New Vaccines in Low Income Settings

	Deaths		Deaths Prevented		Life Years Saved		Cost \$m	Cost per Life Year Saved \$	
	High	Low	Low	High	Low	High		Low	High
Hep B	607	850	391	547	6.8	9.5	103	11	15
Hib	143	163	87	96			103	21	22
Rotavirus	312	324	104	192	6.0	11.6	187	16	31
SP Conjugate	745	993	363	727	21.1	42.2	825	20	39

Source: Miller, McCann 2000

If DFID were serious in wanting to emphasise cost effectiveness, it would be useful to track expenditure by GHP by intervention over time – looking at what the GHPs are actually delivering rather than what they are spending on. At present, only superficial analyses of spend are carried out. For example, GFATM provides data on spending by functional use e.g. commodities, salaries and by disease but not by intervention.

At the GFATM Partners Forum, it was argued by some that “efficiency and cost-effectiveness should be included in the rationale for allocating Global Fund monies” and that Global Fund country experiences should be promptly publicised.

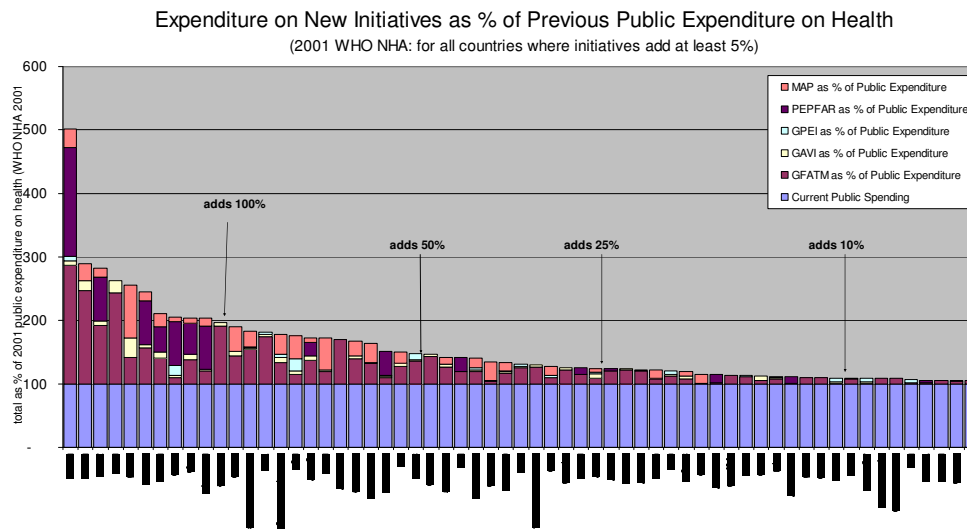
Do the Global Partnerships Affect Financing Patterns at the Country Level?

The commitments of the global programmes remain relatively modest in the context of overall health spending in developing countries. Current GFATM commitments – amounting to around \$1.6bn over the next 5 years - compare to estimated annual public spending on health of some \$110.2bn in GFATM recipient countries (heavily skewed by the inclusion of Argentina, Russia, Turkey and Iran). For GAVI, the annual commitment of \$200m compares to average annual expenditure of some \$38.8bn in GAVI recipient countries. Even for the top 25 GFATM and GAVI recipients, annual commitments totalling \$1.25bn only accounted for 2-3% of total public spending on health of \$50.9bn. For GPEI the impact is greater, with average expenditure of \$320m set against total public spending of some \$8.8bn in recipient countries.

These averages conceal more than they reveal. Chart 19 shows that at the country level the situation is rather different. 5 countries have GHP commitments in excess of \$5 per capita per year (and over \$18 in Swaziland). In 11 countries, the commitments from the financing GHPs exceed 50% of WHO's estimates of total 2001 public expenditure on health. For Ethiopia, Liberia and Malawi it exceeds 100%, largely due to low public spend in the first two and a combination of low public spending and high allocations from global funds in the last⁶. The GHPs also need to be seen in the context of significant additional flows through MAP and PEPFAR as shown in the chart below.

⁶ Note – these figures are crude. Current spending figures are from WHO WHR 2003 and refer to 2001 and may therefore also include spending on polio eradication. They may not agree with countries' own estimates. PEPFAR figures are illustrative and assume funding is allocated in proportion to the estimated number of people living with HIV and does not account for the fact that a significant share of the funds may not be spent in country.

Chart 19



Less information is available in terms of the balance of effort between different diseases at country level though there are some concerns (see box 4 on Tanzania). The GFATM Partners forum also reflected concerns that “resources are currently concentrated on AIDS, and should be allocated more equitably to TB and malaria efforts”.

Box 4: Too Little HIV/AIDS Spending on Prevention?

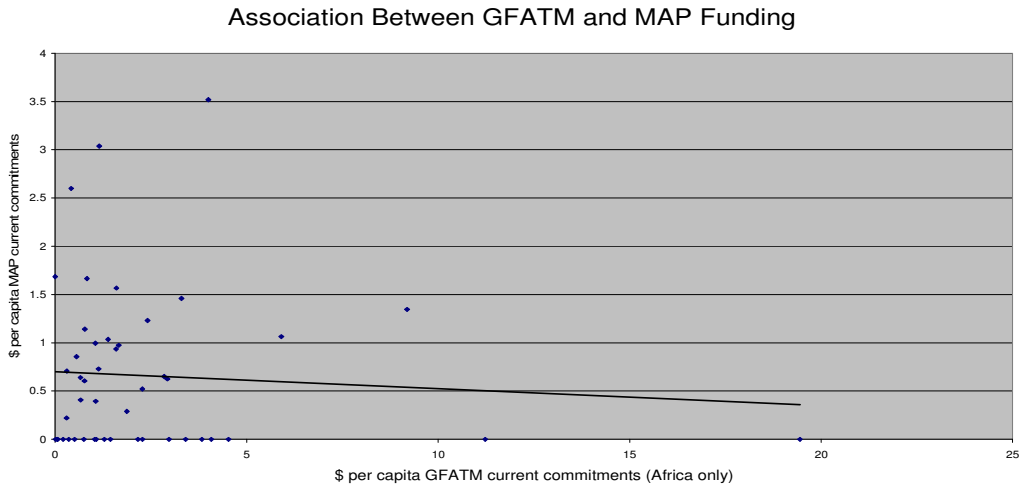
There is already some evidence that the pattern of spending is becoming unbalanced, with a big increase in commitments to care and treatment, while prevention interventions remain too small scale and localised, and mitigation continues to lack policy direction or significant funding.

Foster and Mwinyimvua PUBLIC EXPENDITURE REVIEW HIV/AIDS MULTI-SECTORAL UPDATE FOR 2004

Complementarity with other new initiatives

It is interesting to note that commitments under MAP appear to complement those of the Global Fund (chart 20), whilst those for PEPFAR may reinforce GFATM spending patterns as the initiative is focused on countries due to receive significant funding from GFATM.

Chart 20



Allocation of Resources According to Burden of Disease

As already noted, the GHPs seem to have targeted resources more effectively to low income countries than existing mechanisms. Some GHPs have done this better than others. Charts 21 and 22 examine whether there is any correspondence between the allocation of resources by the GHPs and measures of need. In general they show that, within disease categories, resources tend to be allocated in relation to needs although the relationship is often relatively weak.

Chart 21

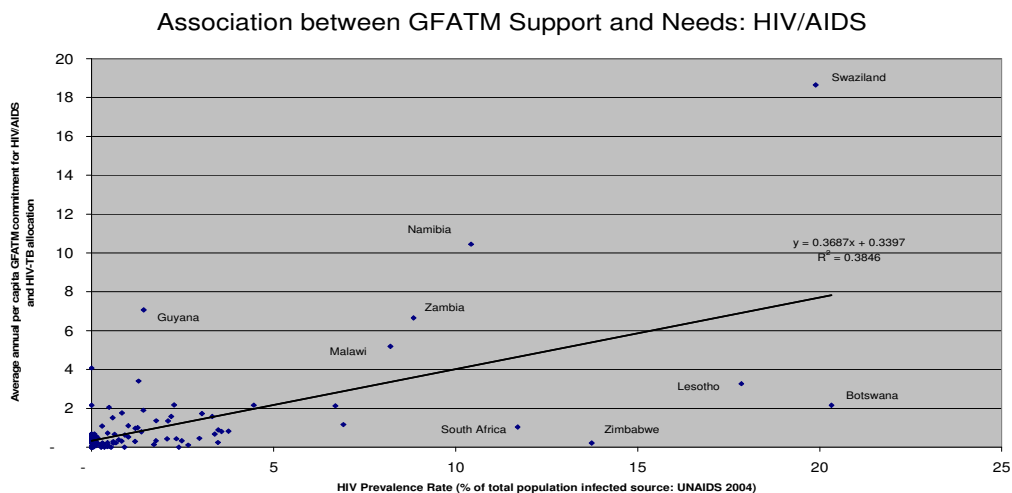
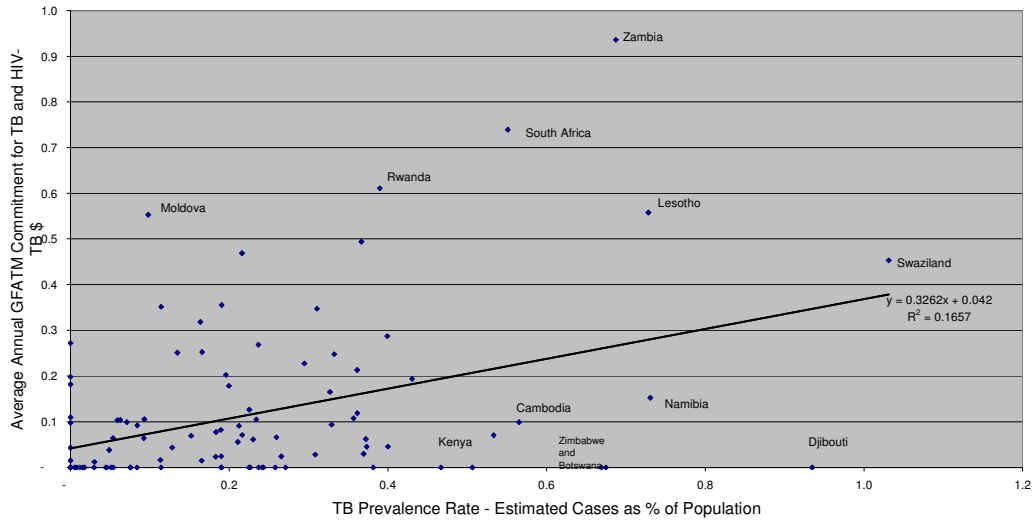


Chart 22

Association between TB Prevalence Rate and GFATM Commitment for TB



Analysis of the GAVI pattern of commitments in charts 23 and 24 shows that allocations do appear to be based on outstanding need in terms of their potential targets (at least when outliers – India and China – are excluded) but also are equitable in the sense that additional support is provided to countries with lower coverage rates at the outset.

Chart 23

GAVI: Association between Funding and "Demand"
excluding India and China

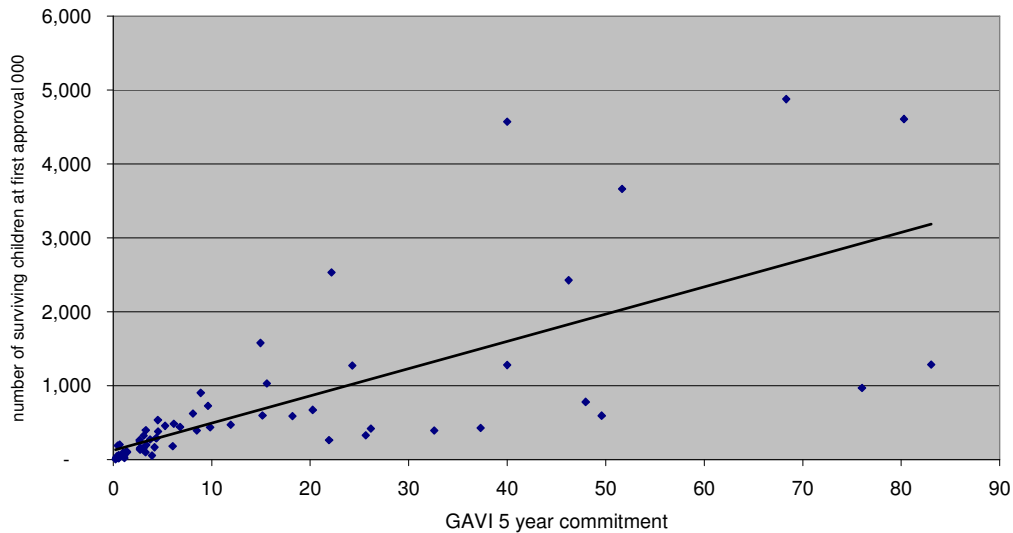
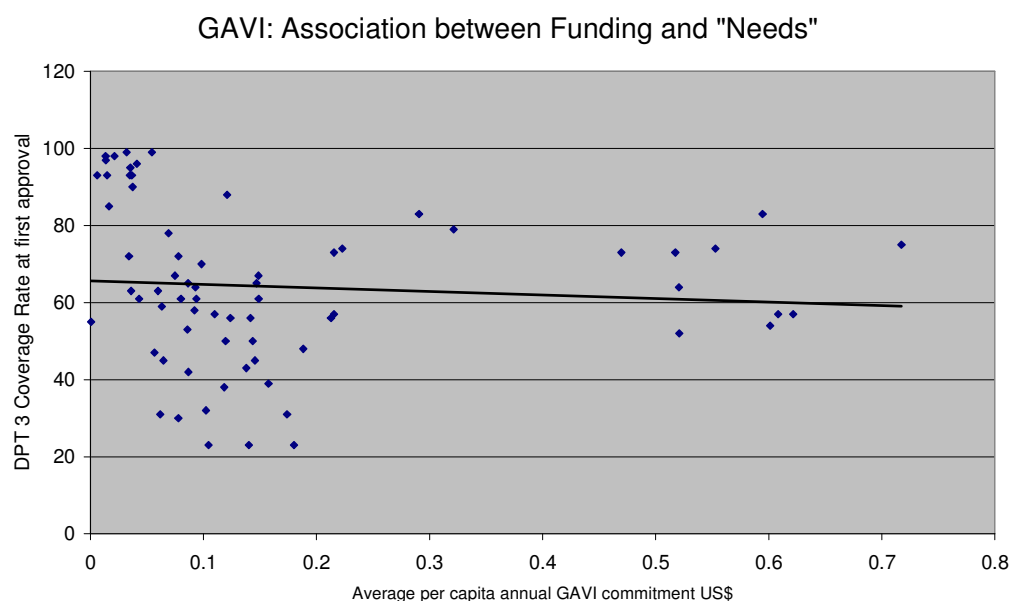


Chart 24



Assessment of Technical and Administrative Efficiency

Questions considered here include:

- are the partnerships lean and mean?
- what are the net costs?

There are no specific benchmarks for what constitutes an appropriate level of spending by GHPs on their core functions – especially where the core functions of the organisation differ significantly. The few evaluations have been unable to make specific value for money judgements. According to the IAVI evaluation, “the panel cannot make a detailed judgment about the “value for money” of this expenditure. However, it believes that IAVI has prudently managed the funds entrusted to it and that its accomplishments for this level of expenditure have to be seen as very substantial. In addition, as also noted earlier, about 85% of IAVI’s expenditure has gone for program efforts, which appears to be very reasonable, especially for an organization only 7 years old”.

The Stop TB evaluation found that the direct costs of the Partnership to be modest (US\$ 18.05m for the Secretariat in 2002, of which US\$13.0m was for the GDF) but also that the cost savings from reduced procurement costs associated with bulk buying by the GDF partially offset the costs of the Partnership⁷. The review also found that the costs paid by the Partnership to WHO (to meet the costing of hosting the partnership) more or less equalled the costs actually incurred by the host organisation, deflecting concerns that the arrangement was seen as a way for WHO to raise money. In short, “the general conclusions (were) that the partnership does add value, that any value it does add will have large health benefits compared to the

⁷ It is difficult to attribute the changes in price to GDF but expert opinion suggests it was at least, in part, responsible. It could also be argued that countries derived additional benefits from the overall reductions in price in the market and that had GDF operated in line with its Strategic Plan targets the costs of the Partnership would have been more than offset.

costs involved and also in comparison with other uses of funds and that in any case the “net” costs of the Partnership are low⁸”.

Overheads tend to be low in comparison to levels of commitments:

- The Vaccine Fund uses 98 percent of its contributions for programmes
- less than 3% of annual commitments are used for central administration and management of the Global Fund each year. An additional 2% is used for local oversight of grants by Local Fund Agents.

The expectations of donors are often unrealistic - DFID initially envisaged that the GFATM would have a core staff of some 15 professionals (“A Secretariat staff of 12-15 professionals with associated support staff is envisaged (it is suggested 8-10 would be sufficient)” – original working paper). Clearly this has not been achieved but this does not mean that GFATM does not need these additional staff to function effectively. Most reviews have suggested that it is often not pure numbers of staff but the structure, skill mix and problems such as turnover or recruitment difficulties which represent greater problems. Table 4 provides some key information on the size of the secretariat for a number of GHPs

Table 4: Key Characteristics of the Major GHPs

Feature	Stop TB	GAVI	RBM	GFATM
Administration - nos. - prof/general - budget	Secretariat 26 staff in post (19 professional, 7 support staff. Secretariat expenditure (excluding GDF) of 2.5m in 2001 5.05m in 2002. Country level commitments of \$53.8m (included projected TRC 7)	Secretariat 16, (8 professional and 4 general staff 4 short term staff). Secretariat budget of \$3.9m for 2003. Country level commitments of \$1.03bn over 5 years	Secretariat 16 professionals + 3 support staff)	Secretariat 74 staff (58 permanent 16 interim) .Secretariat staff \$38.7m budget for 2003, \$16 m of which is for in-country Local Fund Agents to oversee those entities in charge of grant implementation (PRs). Actual expenditure was \$31.8m of which \$10.1m on LFA fees \$922m committed over 5 years during R1 and R2; \$130m disbursed to date. Budget for 2004 is \$52.7m of which \$22.2m is LFA fees

Assessment of Equity

Key questions include:

- do the GHPs focus resources on poor countries?
- do the GHPs focus resources on the countries with the greatest disease burdens?
- are the GHPs self targeting in that they focus on diseases of the poor?
- do the GHPs take any steps to ensure most benefits go to the poor?

⁸ Whilst the Secretariat attempts to capture the full formal costs of the Partnership including specific in-kind costs, it does not purport to capture the full costs (e.g. cost of donor Board attendance). The working assumption here would be that the partner considers that the benefits outweigh the costs involved.

Do resources go to countries in need?

Charts 25 to 27 build on the results shown in chart 8 earlier to demonstrate that the average recipient country has a low income per head and the level of support tends to decline with increasing economic status

Chart 25

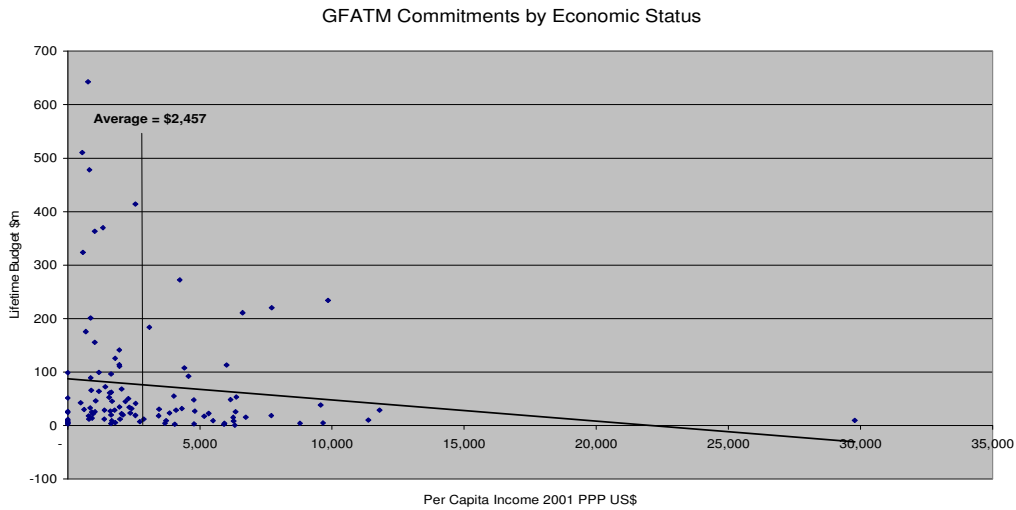


Chart 26

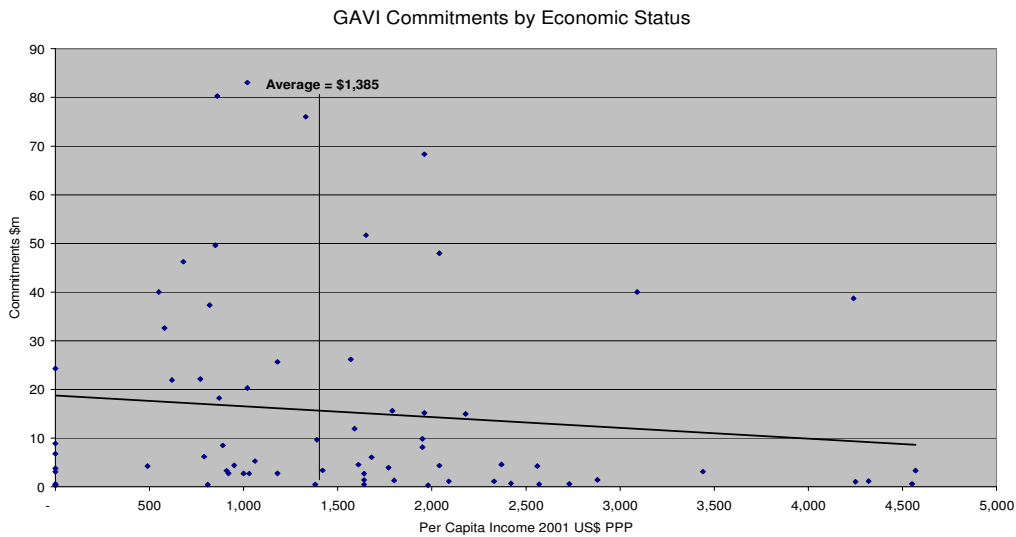
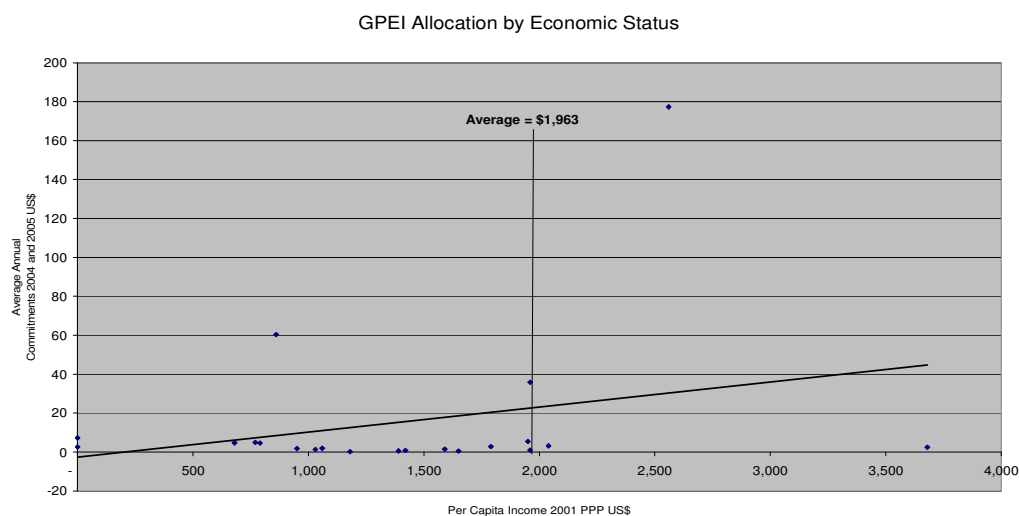


Chart 27



Balance of Expenditure between Diseases

Table 5 below compares the current approaches to resource allocation with the size of the disease burden. This should be treated with caution as resources should be allocated with a number of factors in mind – cost effectiveness of interventions, Government preferences, and availability of funding from alternative sources. The results suggest that GAVI allocates a disproportionate share of resources to Africa in view of the disease burden and GPEI allocates a larger than expected share of resources to Africa. GFATM, by contrast allocates a rather lower than expected share of resources for HIV/AIDS to Africa than might be expected.

Table 5: Comparison of Share of Burden of Disease faced by Africa with Allocation from relevant GHP by Disease

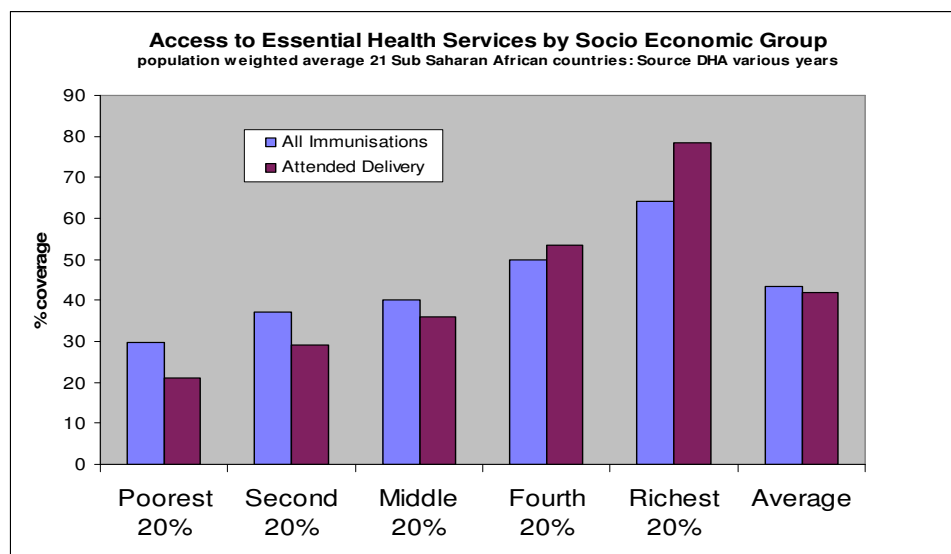
	% Burden of Disease in Africa	% Allocation by Relevant GHP
Infectious and parasitic diseases	54.6	n/a
Tuberculosis	26.2	31.6% (GFATM)
HIV/AIDS	82.9	61.0% (GFATM) and 91% of HIV-TB
Childhood diseases	47.1	65.0% (GAVI)
Malaria	81.9	78.4% (GFATM)
Poliomyelitis	16.2	29.3% (GPEI)
Meningitis	36.8	See GAVI
Hepatitis	42.0	See GAVI
Tropical diseases	54.9	n/a

Are the GHPs self targeting?

Most GHPs focus on diseases which disproportionately affect the poorest and are therefore to some degree self targeting, HIV/AIDS being a possible exception:

- **HIV/AIDS** – there is little unambiguous evidence to show whether HIV/AIDS is a disease of the poor. Cogneau and Grimm⁹ 2003 maintain that “only partial evidence is available suggesting that urban, more educated people, teachers, and truck-drivers are more exposed to the risk of HIV/AIDS”. In South Africa, the HSRC Study of HIV/AIDS 2002 found a negative correlation between HIV and socio-economic status which disappeared when only Africans were considered. Similarly, it found negative correlation between level of schooling and prevalence of HIV/AIDS which reverses when white South Africans are excluded.
- **Malaria** – though there is little consistent evidence of socio economic differentials in incidence, the poor are more vulnerable to the consequences of infection due to inequality in access to prevention and treatment. Expenditure on prevention is more strongly correlated with income than treatment – suggesting investment in prevention is likely to be more pro poor – whilst recognising that the poor often seek care from traditional sources than through modern medicine¹⁰.
- **TB** – usually considered to be a disease of the poor and whilst prevalence does indeed tend to be greater amongst the poor, there is growing evidence that the better off also suffer¹¹.
- **Immunisation** – Demographic and Health Surveys clearly show that better off groups have higher coverage rates than the poor, suggesting that increased efforts are likely to have a disproportionate effect on the poor (for the traditional vaccines at least). As shown in the chart the socio economic gradient is perhaps less pronounced than for some other services.

Chart 28



It may not be enough to say that funds are targeting on conditions primarily faced by the poor in situations where funding is being channelled through health systems

⁹ Socio-economic status, sexual behaviour, and differential AIDS mortality Evidence from Cote d'Ivoire Cogneau and Grimm 2003

¹⁰ Eve Worralla, Suprotik Basub, and Kara Hanson “Ensuring that malaria control interventions reach the poor” 2002.

¹¹ The economic impacts of tuberculosis: Stop TB Partnership Ahlburg 2000

which themselves are not pro poor (chart 28). The GHPs have few specific measures to ensure resources focus on the needs of the poor. Nonetheless, there is some evidence that investment in primary care, where much of the GHP funding is allocated, is more pro poor than for secondary or tertiary care (Gwatkin 2003).

ANNEX 2: FINANCING IMPACT

This section considers:

- what are the recent trends in the financing of health services and what implications do they have?
- have the GHPs provided additional funds and developed new funding sources?
- are the GHPs distortionary and, if so, was this a good thing?
- were additional funds the major constraint?
- what are the implications for sustainability and aid dependency?
- who should fund what?

Approaches To Health Financing

Data on recent trends in health spending in DFID PSA countries show:

- private expenditure dominates the financing of health services in both regions (but especially so in Asia).
- the vast majority of private expenditure (especially in Africa) is accounted for by out of pocket expenditure which has long been recognised as an inefficient and inequitable way of financing health care.
- risk pooling is generally minimal and confined to the better off - with some notable exceptions
- some evidence that health spending is increasing as a share of GDP in both regions and that the public share of health spending is increasing in Africa - probably reflecting greater aid flows and resulting in increasing levels of aid dependence.

Financing patterns vary widely *within* regions and averages are highly skewed by China and South Africa.

Table 6: Key Health Financing Indicators: DFID PSA Countries

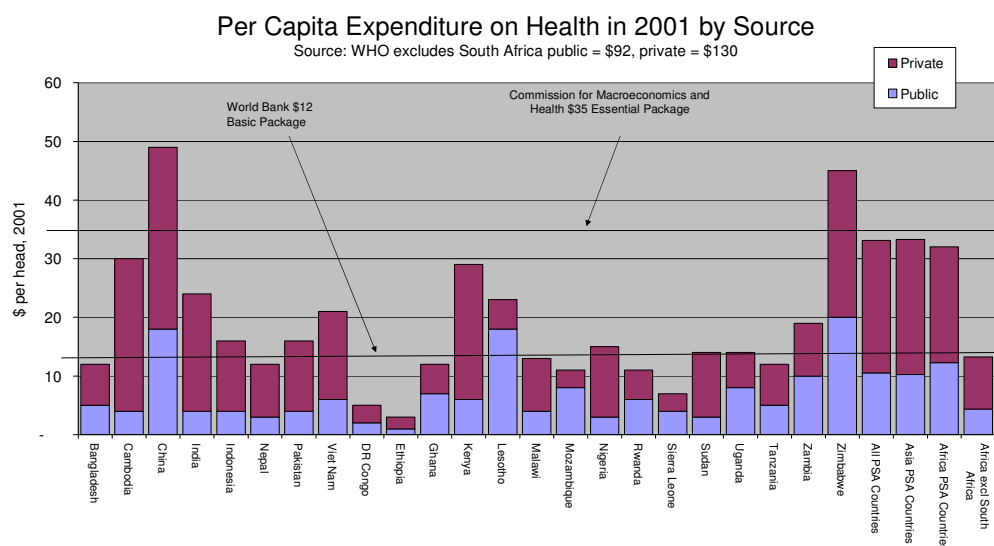
Indicator	Average by Region	1997	1998	1999	2000	2001	Ranges and Comments
Health as % of GDP	Asia PSA Countries	4.60	4.61	4.83	4.93	4.98	<2.5% in Indonesia to >11.5% in Cambodia
	Africa PSA Countries	4.53	4.70	4.57	4.68	4.78	
Public Share of Total Health Expenditure	Asia PSA Countries	28.84	29.86	29.14	28.35	28.77	<15% in Cambodia to >75% in Lesotho
	Africa PSA Countries	33.12	34.63	34.08	35.29	37.69	
Health as % of Total Public Expenditure	Asia PSA Countries	8.28	8.10	7.38	6.93	6.66	<5% in India, Nigeria, Sudan to >15% in Mozambique, Uganda and Cambodia
	Africa PSA Countries	7.91	7.86	7.22	7.68	7.60	
External Resources as % of Total Health Expenditure	Asia PSA Countries	2.05	2.30	2.47	2.51	1.64	<0.2% in China to >45% in Zambia
	Africa PSA Countries	9.43	12.82	13.72	15.70	16.92	
Out of Pocket Expenditure as % of Private Expenditure	Asia PSA Countries	96.60	96.20	96.25	96.54	96.62	<25% in South Africa to 100% in many countries
	Africa PSA Countries	80.62	81.03	79.71	79.66	79.76	

Per Capita Public Expenditure on Health (current exchange rate)	Asia PSA Countries	8.11	8.46	8.98	9.91	10.22	<\$5 in Ethiopia to >\$220 in South Africa
	Africa PSA Countries	17.53	15.43	13.95	13.75	12.27	

Source: WHO World Health Report 2003 – note figures do not necessarily correspond to country figures

Lack of Government funding for health is a major constraint (chart 29). Within the African context, only Uganda and Mozambique were reported to exceed the Abuja Declaration target of allocating at least 15% of Government spending to health. Public spending in the 25 PSA countries averaged only \$10.5 per head in 2001 (and only \$4.3 per head in the African PSA countries once South Africa is excluded). This is well below that required to deliver any decent package of basic health care. Spending in Uganda and Tanzania, for example, is around a third and a half, respectively, of that required to deliver the locally defined minimum essential package of care. There are only 4 countries in which estimated public spending in 2001 exceeded the \$12 to fund the World Bank essential health package (China, Lesotho, South Africa and Zimbabwe) and only in South Africa did it exceed the \$35 package identified in 2001 by the Commission for Macroeconomics and Health. Ethiopia spends around \$1 per person per year on health through the public sector.

Chart 29



Ultimately most spending on communicable diseases is in the form of out of pocket payments, which account for around three quarters of total health spending in low income countries (box 5)

Box 5: Spending on Malaria in Tanzania

Tanzania spends approximately \$US 2.14 per person per annum on malaria services. This is approximately 15% of spending on health in the average developing country. In Tanzania it represents approximately 39% of all health expenditures. Malaria accounts for 30% of the total burden of disease. Approximately three-quarters of malaria expenditures are household expenditures in the formal and informal private sector. Government contributes 20%; donors 9%. Of total malaria expenditure, one-third is spent on anti-malarial drugs, and almost half on bednets, insecticides and coils. Anecdotal evidence suggests that the use of traditional healers for malaria treatment is small.

Source: Jowett et al, 2000

Recent Trends

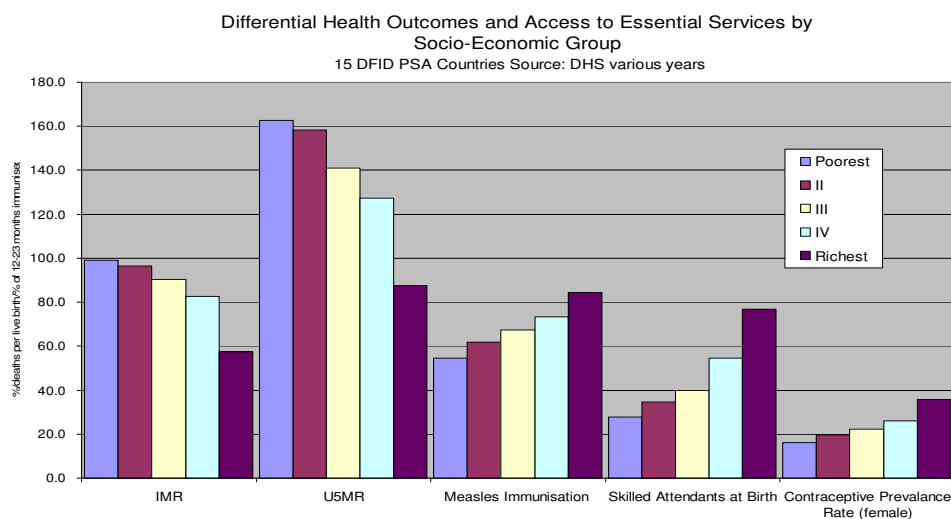
The HIPC initiative has resulted in an increased share of resource going to the health sector and in some cases HIPC funds are specifically tied to spending on health (Ghana, Ethiopia). However, many of the gains appear to have been made in the run up to the HIPC completion point and a review of PRSPs carried out by WHO indicates that, although spending on health is expected to increase in absolute terms, it is only likely to increase marginally as a share of public or social sector spending.

Progress in improving health outcomes and access to essential services

Health indicators and coverage of MDG relevant health services vary widely both between countries and between socio economic groups within countries (chart 30):

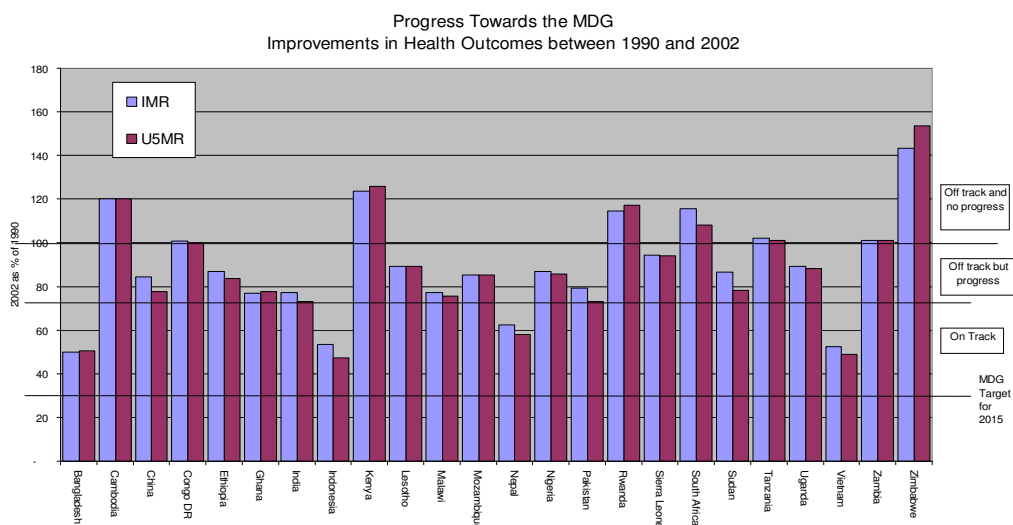
overall infant mortality rates vary from 20 per 100,000 live births in Vietnam to 165 in Sierra Leone and Afghanistan whilst the share of attended deliveries varies from around 12% in Afghanistan to around 85% in Vietnam and South Africa. infant and child mortality rates for the poorest quintile are considerably higher than for the richest quintile whilst the poorest quintile are much less likely to use modern contraceptive methods, immunise their children against measles and have an attended delivery.

Chart 30



Outcomes and access have generally improved though not for some countries and rarely at rates necessary to achieve the MDGs. Of the 24 PSA countries for which data are available, infant mortality has actually *increased* in 8 and only in 4 is the IMR MDG likely to be achieved if present trends are maintained (chart 31).

Chart 31



Has development assistance for health declined?

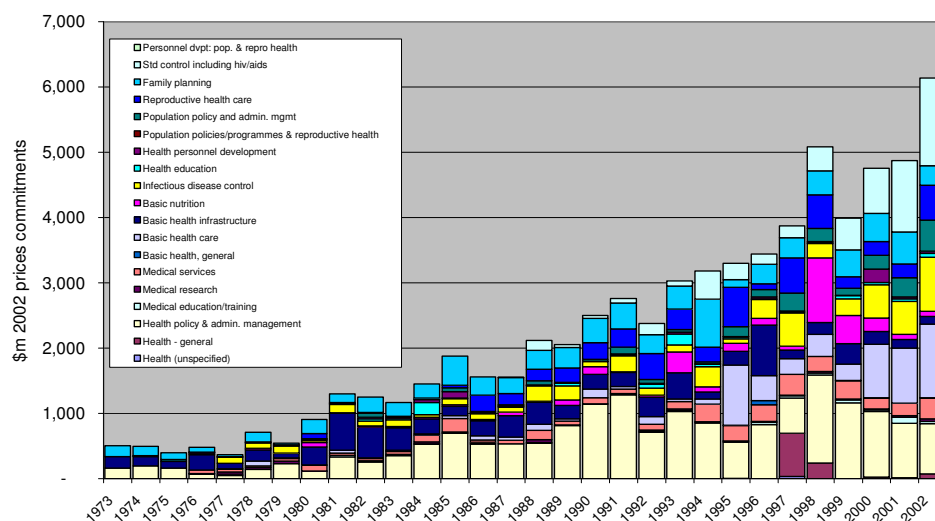
The ToRs ask whether funding through the GHPs has offset the decline in development assistance for health. In practice it would appear that assistance for health has increased rapidly over the last few decades. Although development assistance as a whole declined over the 1990s and has only just exceeded its 1990 levels in real terms, support for health seems to have increased throughout. According to DAC analysis, development assistance for health increased by 3% per annum between 1975 and 1998¹² to around \$3.5bn per annum by 1998. Updating this analysis suggests the figure has now increased to just under \$5bn per annum in 2003. Support for health and population activities accounts for roughly 7% of official development assistance from bilateral and multilateral sources. In broad terms, around a third has supported basic health (including infectious disease control and immunisation), just over a third for reproductive health and population activities (including STDs and HIV/AIDS control), with the balance going on general and non basic services.

Chart 32 (below) illustrates both the increases as well as the change in distribution.

¹² Recent Trends in Official Development Assistance to Health September 2000 OECD

Chart 32

Total Development Assistance for Health and Population by Type since 1973



At the same time there is evidence that spending on other sectors –such as water and sanitation which is an important determinants of health outcomes - have declined significantly in recent years¹³.

Analysis of Donor Support for Communicable Diseases at the Global Level

Evidence on actual spending by disease is very weak. As Attaram points out, “we note with alarm that nobody knows – or can know, if they want to – how much of the \$750 million that RBM counted as promises from various donors after the *Abuja Summit* has actually been delivered”. Assessing spending levels is extremely problematic because much disease specific spending takes place as part of integrated programmes. Disaggregation might be possible but it would be time consuming.

Routine Reporting

Although the DAC and CRS aid reporting systems have significant shortcomings, they are the best routine data source available¹⁴. Commitments are reported according to CRS codes of which the most relevant ones for this exercise are 12250: Infectious diseases control - which includes immunisation, prevention and control of malaria and TB, diarrhoeal diseases and vector borne diseases such as river blindness and guinea worm and 13040 STD Control including HIV/AIDS. Analysis of CRS data shows that commitments for health and population have grown significantly during the 1990s as overall development assistance has declined, with

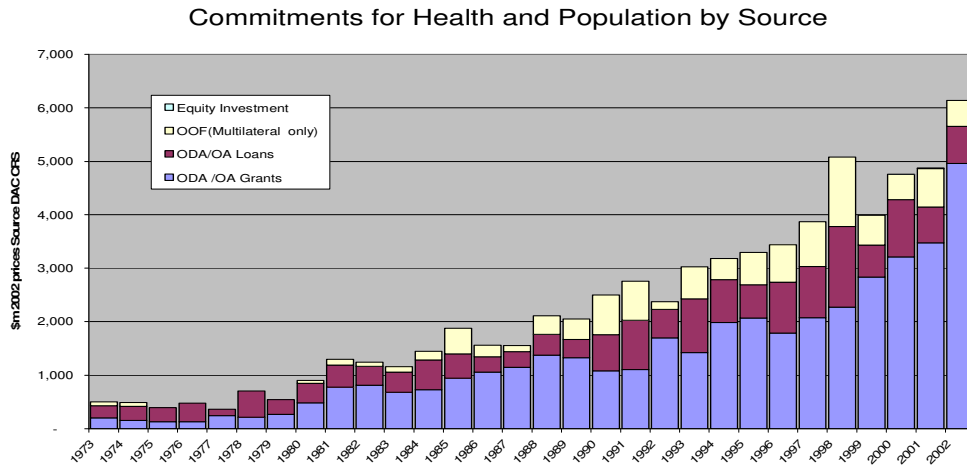
¹³ Supporting the Development of Water and Sanitation Services in Developing Countries OECD 2002. Commitments declined from an average of \$3.5bn (1996-98) to \$3.1bn (1999-2001)

¹⁴ They primarily include data on commitments and coverage is not complete especially in relation to multilateral donors particularly the UN and the EC. In 2000 they were thought to underestimate true flows by around 20-25%.

the share of health and population increasing from 5% in 1991 to 8.2% in 2000 (based on 3 year moving averages).

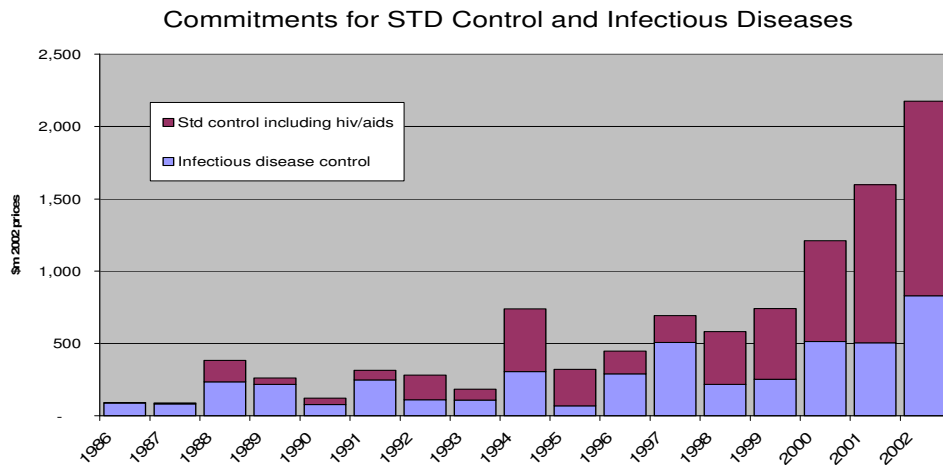
As chart 33 shows, most support for the health sector is highly concessionary with limited flows through loans and other flows through the multilaterals (primarily lending by the World Bank and regional development banks at near market rates).

Chart 33



Commitments for infectious diseases and STD control – which contain the majority of spending on communicable diseases - have grown rapidly in real terms (chart 34).

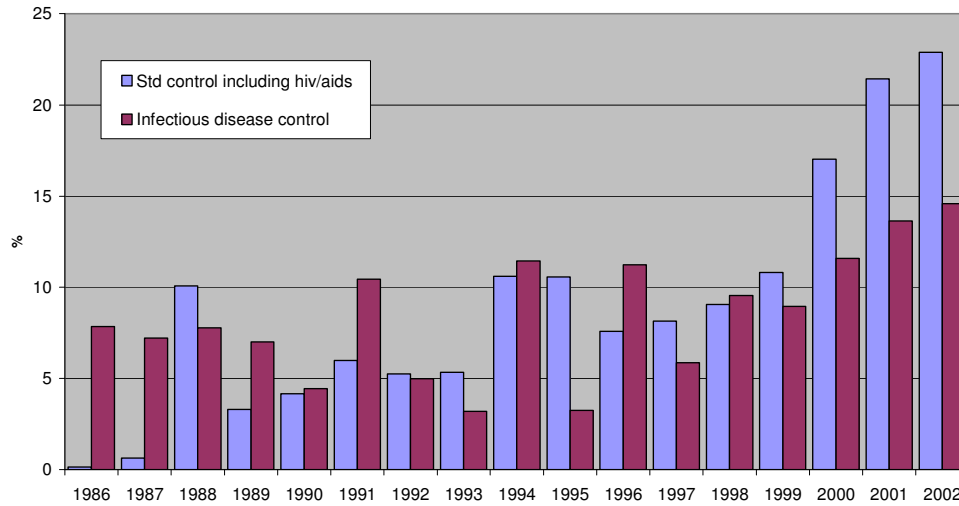
Chart 34



For STD control in particular and also, but to a lesser degree, infectious disease control, commitments have increased as a share of total commitments for health and population (chart 35).

Chart 35

Commitments for STD Control and Infectious Diseases as % of Total Commitments for Health and Population

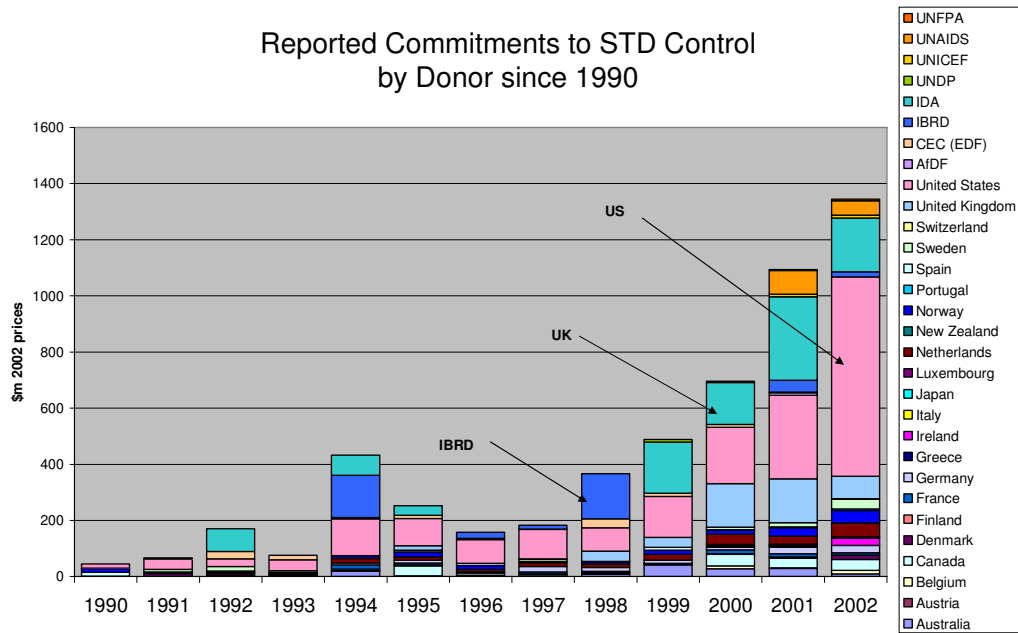


Funding Sources

A few key donors have been responsible for the majority of support in these areas over the last decade or so with the US, World Bank and UK, for example, accounting for 36.7%, 18.7% and 9.1% of spending on STD control respectively (chart 36).

Chart 36

Reported Commitments to STD Control by Donor since 1990



Specific Studies

Global Expenditure on HIV/AIDS

An analysis of aid spending on HIV/AIDS control has just been completed (June 2004) by DAC in collaboration with UNAIDS. It is more reliable than routine analysis of DAC statistics as it carried out a more in depth analysis of multilateral spending and also incorporates the multisectoral aspects of spending on HIV/AIDS (so is not necessarily comparable with other figures quoted in this paper). The average annual *commitment* between 2000 and 2002 was estimated at between \$2.18bn and \$2.43bn. Of this, some \$1.04bn was accounted for by bilateral support (of which the US and the UK alone accounted for over 70% with \$567m and \$147m respectively)¹⁵. The Global Fund accounted for a further \$474m and imputed expenditure by the multilaterals at \$575m (of which IDA accounted for \$338m, the EC \$123m and UNICEF \$81m). UNAIDS accounted for a further \$88m per annum. In absolute terms, Nigeria, Kenya and Uganda were the largest beneficiaries (with \$91m, \$61m and \$53m respectively). Grenada, Barbados and Sao Tome all received over \$10 per head of population, whilst in Barbados, Botswana and Zambia over 15% of all aid flows were for HIV/AIDS control.

Global Expenditures on TB

WHO prepares an annual report on financing for TB in the high burden countries "Global tuberculosis control - surveillance, planning, financing". The key table in relation to funding is reproduced below.

¹⁵ An additional \$254m was estimated as possible bilateral support for HIV/AIDS control

Table 7: Overview of TB Spending

TABLE 17

Total TB control costs and government contributions: high-burden countries, 2002 and 2003

	TOTAL NTP COSTS (US\$ MILLIONS)		TOTAL TB CONTROL COST (US\$ MILLIONS)		TOTAL COST PER PATIENT TREATED (US\$)		GOVERNMENT CONTRIBUTION TO TOTAL TB CONTROL COST			
	2002 (EXPENDITURES)	2003 (BUDGET)	2002 (ACTUAL)	2003 (PLANNED)	2002 (ACTUAL)	2003 (PLANNED)	AS % OF TOTAL TB CONTROL COST		AS % GOVERNMENT HEALTH EXPENDITURES	
							2002 (ACTUAL)	2003 (PLANNED)	2002 (ACTUAL)	2003 (PLANNED)
1 India	25	42	75	96	72	73	93	88	1	2
2 China	61	95	61	95	153	199	95	77	0.3	0.3
3 Indonesia	18	32	22	38	148	172	92	67	2	2
4 Nigeria	NA	13	NA	19	NA	380	NA	55	NA	8
5 Bangladesh	7 ^d	17	12	28	155	171	NA	62	2	2
6 Pakistan	NA	6	7 ^{e,g}	8	NA	146	NA	59	NA	1
7 Ethiopia	5	11	8	14	76	129	53	41	4	5
8 Philippines	6	7	34	36	296	298	99	93	3	3
9 South Africa ^a	NA	NA	300	300	1491	1491	100	100	6	6
10 DR Congo	7	10	17	23	251	288	63	58	3	4
11 Russian Federation ^b	124	124	175–225	175–225	1419–1824	1419–1824	99	99	2	2
12 Kenya	4	11	5	14	71	125	79	46	2	4
13 Vietnam	4	7	14	17	158	172	96	91	3	4
14 UR Tanzania	NA	5	14 ^{c,h}	16	NA	231	NA	75	NA	6
15 Brazil	13	16	39	41	669	704	100	100	0.2	0.2
16 Uganda	2	5	2	6	70	115	65	31	2	2
17 Zimbabwe	NA	NA	22 ^{e,i}	22 ^{e,i}	NA	NA	NA	NA	NA	NA
18 Mozambique	NA	8	10 ^{e,j}	10 ^{e,j}	NA	NA	NA	NA	NA	NA
19 Thailand	7	7 ^{e,f}	9	9 ^{e,f}	198	NA	100	100	0.3	NA
20 Afghanistan ^c	2	3	2	3	174	280	0	0	0	0
21 Cambodia	3	6	5	9	217	300	78	46	5	6
22 Myanmar ^c	1	5	1	5	21	65	25	6	NA	NA
High-burden countries	289	430	834–884	984–1031	158^k	199^k	95^k	75^k	2^k	2^k

NA Indicates not available.

^a No data were provided by the NTP; the cost per patient was estimated using recently published costing studies, and multiplied by the number of patients notified in 2002 to give the estimated total cost.^b Data were not provided for 2002; numbers for 2002 were assumed to be the same as those provided for 2003.^c Reflects NTP budgets and expenditures only, insufficient data available to estimate costs not included in the NTP budget.^d Estimate based on data provided in GFATM proposal.^e Data not provided on WHO surveillance form.^f Costs for 2003 assumed to be equal to those for 2002.^g Cost per patient estimated using data submitted in previous years, and multiplied by the number of cases that were notified in 2002 to give estimate of total cost.^h Total cost estimated by multiplying cost per patient for 2003 by number of cases notified in 2002.ⁱ Estimate based on previous costing analyses, with cost per patient multiplied by the number of cases notified in 2002.^j Cost per patient estimated using budget data and by assuming that care is provided on an outpatient basis (as stated in GFATM proposal).^k Total cost estimated by multiplying the cost per patient by number of cases notified in 2002.^l Median value.**Global Expenditures on Malaria**

On the basis of analysing DAC data, Attaram reports that “the total amount of international aid dedicated to malaria control, from the 23 richest donor countries plus the World Bank, remains in the range of \$100 million annually – a figure that is virtually unchanged since the start of RBM. This lack of progress toward increasing funding very seriously threatens RBM and demands that WHO regularly audit and report on malaria control funding, with the certainty that RBM will fail to meet its deadline of 2010 if this is not done”. To the extent that GFATM is committed to disbursing some \$350m for malaria per annum (current commitment overall of around \$1.8bn) this will result in additional funding for malaria even if there is some (or even total) displacement of existing flows provided, of course, that these funds are actually disbursed.

IHSD is just in the process of completing a survey of international funding for TB and malaria control on behalf of the Stop TB Partnership and Roll Back Malaria which should shed further light on the subject. Results are expected in November 2004.

National Health Accounts Exercises: Country Spending

Data on current health spending at the country level is weak and highly aggregated. Although national health accounts exercises are becoming more widespread, they do not generally provide data on expenditure by programme. There are certain cases where this has been done e.g. HIV/AIDS accounts in Rwanda, reproductive health

accounts in Rajasthan. Thought is also being given to piloting malaria accounts by RBM. In practice, such exercises have not been well integrated into overall health accounts. If the donor community is serious about tracking flows for the major communicable diseases, major investments will be required in support of NHA which go beyond the current methodologies agreed in international fora.

Whilst donor support is important, most funding for HIV/AIDS control comes from Government or from out of pocket spending by individuals. The Rwanda HIV NHA found that around 93% of spending on HIV was out of pocket spending. The focus on donor support is also becoming more unreliable as some countries such as Uganda move rapidly toward budget rather than project support. The ultimate solution to tracking expenditures for health should be down to comprehensive coverage of national health accounts.

In Rwanda, the first NHA HIV/AIDS sub analysis in 1998 showed that only 10 percent of all health expenditures in the country went toward prevention and treatment of the disease. Moreover, while donors financed more than half the health sector, only 1 percent of their funds went toward HIV/AIDS services and programs. Households were the primary financiers of HIV/AIDS services, providing 93.5 percent of total HIV/AIDS funding; donors provided 6 percent while the government contributed less than 1 percent. Revelation of the financial burden on households and the paucity of donor funds led the donor community to increase its contribution to the fight against HIV/AIDS in Rwanda by tripling its assistance from \$0.5 million in 1998 to \$1.5 million in 2000. Additionally, NHA enabled the Ministry of Health to design and implement policy interventions targeted at improving the financing of prevention activities and increasing access to basic health care services for people living with HIV/AIDS.

Are the GHPs distortionary and have they provided additional funding?

The presumption is that the GHPs have delivered additional funding. For GFATM, it is a requirement with the guidelines requiring that any proposal “demonstrate that Global Fund financing will be additional to existing efforts to combat HIV/AIDS, tuberculosis, and malaria, rather than replacing them”. This requirement, if fulfilled, is by definition distortionary. This is true even if the funding is used to cover the financing gaps under existing plans. Where countries have defined essential service packages (such as Uganda, Tanzania, Malawi and Zambia) available funding currently falls well short in many areas not just those covered by the GHPs. The true test of whether global flows are distortionary would be to ask “if the funds were available to the Ministry of Finance (or Ministry of Health), would they be spent on the activities set out in the GFATM proposal”. Though it will never be possible to answer that question, reality suggests that the answer will invariably be no. As such the more relevant question is “is the inevitable distortionary effect of the GHPs on funding a good or a bad thing?”

In terms of additionality, DAC data suggests that support for infectious disease control and particularly STD control increased before the establishment of GFATM (though it did coincide with rapid increased in spending on GPEI from 1996 and may also reflect better reporting). Most of this seems to be down to the fact that the share of donor assistance for the health and population sector going to STD control and infectious diseases began to increase sharply from the mid 1990s. In short, the increase appears to predate the establishment of the key financing GHPs and thus suggests that there has certainly been additional spending in these areas over the last decade, even if it not yet possible to say if the GHPs have displaced some, all or none of the existing spending.

HIV/AIDS commitments from bilateral donors doubled from some \$692m in 2000 to \$964m in 2001 and \$1,253bn in 2002 suggesting that GFATM support has been additional at least during this period or at least that it has not been associated with a decline in spending from other sources.

For malaria, GFATM will be the main financier and funding will still increase even if other donors immediately stopped funding malaria as proposed commitments under GFATM exceed past spending on malaria. GFATM proposals to date imply commitments of the order of \$350m per annum on malaria control with a further \$13m per annum on integrated activities – though this would decline if disbursement is slow and funding is not continued after year 2. Nonetheless GFATM still appears to significantly increase funding for malaria activities. There are concerns in some countries that GFATM funding is displacing other donor spending e.g. Ghana reducing their support for malaria in view of proposed GFATM funding.

The situation for TB is similar, with GFATM as a dominant financier. Grants account for around 10% of overall spending and GFATM accounts for two thirds of this. This picture is skewed by the fact that many of the high burden countries are relatively wealthy and fund all TB costs domestically (South Africa, Brazil, Thailand) whilst a number of countries finance more than 90% of costs domestically (India, China, Indonesia, Vietnam, Philippines, Russia and Vietnam). An outstanding funding gap of some \$80m was reported for 2003, of which around \$49m was accounted for by the 22 TB High Burden Countries. Bhutan, China, Latvia and Mozambique all reported financing gaps exceeding \$5m.

At the same time it is also worth pointing out that donor support for other interventions essential for improving health have declined. Average commitments for water and sanitation declined from an average of \$3.48bn over the period 1996-8 to \$3.10bn in 1999-2001. The US and UK bucked this trend but Japan and Germany (the two biggest bilateral donors in the sector) significantly reduced their support. As such, the question may not be whether the GHPs are being financed at the expense of investment in the health sector – rather that they are being financed at the expense of other essential health interventions. Either way, the implications are the same – that the overall impact on health outcomes may be negated.

Given the heavy reliance on domestic funding for communicable disease control, additionality is if anything more likely to be undermined by Government action rather than that of donors.

However, with the partial exception of TB, the amounts that countries spend by programme is largely unknown. This is largely inevitable – in practice such figures are unknowable to any degree of precision where programmes are integrated. (Vertical programmes at least have the advantage of greater clarity on costs). Expenditure reviews – including programme specific expenditure reviews such as that on HIV/AIDS in Tanzania - and more detailed health accounts exercises incorporating programme wise analysis would cast greater light on this but also come at a high cost in terms of funding and use of scarce capacity.

Additionality in the longer term?

The fact that the GHPs were established and became operational so quickly is likely to have increased the element of additionality in the short term as GHP programmes were simply added to existing strategic plans or programmes of work and added to existing Government expenditure plans. The real question will be whether donors withdraw their assistance from areas currently covered by the GHPs (and whether Government can fill these gaps) or whether Governments amend their own spending

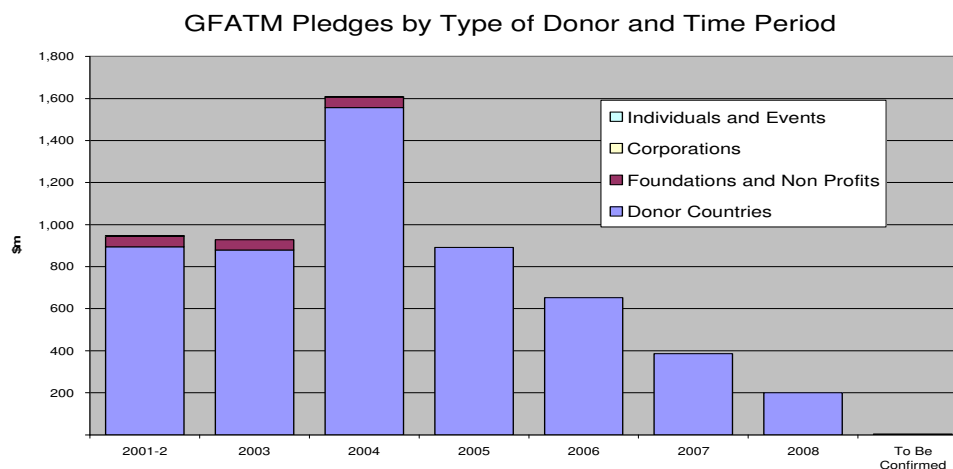
plans to reflect likely inputs from the GHPs which, once they have developed a track record, should deliver more predictable amounts of funding. Bearing this in mind it may be worthwhile to revisit this issue in two or three years time.

Have the GHPs developed additional funding sources?

Most GHPs have been heavily reliant on a small number of funding sources. In many cases this has been traditional donor sources. With the exception of the foundations, especially Gates¹⁶, the GHPs do not seem to have brought significant additional financial resources to the table. Private financial contributions have been very modest. GFATM has secured only modest cash contributions from the private sector (Winterthur, Eni, Statoil and the Gates Foundation) and is committed to increasing this. The Fund is also investigating innovative approaches to securing additional contributions from companies and individuals. The Board is also considering options for accessing in kind contributions given that the recent private sector study estimated that “between 15 and 30 percent of funds awarded in Round 2 could be substituted with in-kind contributions” though this would require the use of a third party to manage the support on GFATM’s behalf (notably the Global Drug Facility under the Stop TB Partnership and the AIDS Drug and Diagnostic Facility currently being developed by WHO). However, support has been provided in other ways. Other types of support include pro bono technical advice. This would ideally be quantified and included in financial statements (Stop TB provides a possible model for this). Equally, there are in country contributions, for example workplace treatment and preventions services developed by the private sector

Most funds continue to be provided by the traditional donors. 97.3% of pledges for GFATM are from donor countries (chart 37) although for GAVI, the Gates Foundation has played a key role.

Chart 37



In other cases new players such as the foundations provide significant funding for seed money (e.g. Gates for GAVI, MSF for DNDi and Until There’s a Cure for IAVI) and more traditional donors provide more significant support later. Thus, rather than

¹⁶ The Bill and Melinda Gates Foundation has an endowment of some \$27bn and has made grants of some \$7.2bn since its inception¹⁶. The Foundation made grants of \$576m and \$507m for global health in 2003 and 2002 – just under half of total grants. Major grants include The Vaccine Fund (\$750 million) and International AIDS Vaccine Initiative (\$126.5 million). Though relatively small in terms of overall aid flows, the GF has invested strategically in a number of areas.

donor funding leveraging new sources of funding, it can be argued that the opposite is taking place.

OECD estimates suggest that foundations contribute of the order of \$3bn per annum for development activities. Most of this comes from US Foundations and relatively little goes to sub Saharan Africa. Of the \$2.5bn provided by US Foundations in 2000, it is estimated that just under \$950m or 38.5% was for health care, with almost a third going to reproductive health care.

Implications for Sustainability and Aid Dependency?

The flip side of the additional donor financing is increasing aid dependency. Given the amounts of development assistance involved, aid dependency could increase significantly in many countries.

Sustainability concerns are compounded as the World Bank and USAID have also been significantly increasing their support for HIV/AIDS through the MAP and PEPFAR initiatives.

Under PEPFAR, the US plan to provide \$15bn over 5 years (\$10bn of this is new money of which \$1bn is expected to go to the GFATM and \$9bn to be disbursed bilaterally). It aims to “treat... at least two million HIV-infected persons with anti-retroviral therapy, preventing seven million new infections, and providing care and support for 10 million persons infected with or affected by HIV, including orphans and vulnerable children in 15 focus countries¹⁷.”

Under the Multi-Country HIV/AIDS Program (MAP) for Africa, the World Bank is assisting countries in scaling up national HIV/AIDS efforts through the provision of IDA resources “as well as leveraging co-financing on a country-by-country basis through the International Partnership Against AIDS in Africa (IPAA)”. As of July 2004, 28 African countries and three regional programs have received US\$1,088.2 million within the MAP approach and MAP projects are being prepared in another ten countries and for regional programmes.

Both provide significant additional resources concentrated in a relatively small number of countries. Under PEPFAR, the US plans to provide an additional \$2.85 per capita per year to the 15 target countries (or \$78.5 per person infected with HIV/AIDS). This exceeds current Government spending in Ethiopia and is more than 50% of existing public health spending in Tanzania, Nigeria, Mozambique, Zambia and Kenya¹⁸. Resources under MAP are smaller but are also significant averaging \$0.61 per head of population (over \$3 per head in Eritrea and Gambia) and \$21.5 per person infected with HIV/AIDS¹⁹. It represents an additional 80% over total Government expenditures on health in Burundi and between 30 and 50% extra in Gambia, Eritrea, Democratic Republic of Congo and Niger.

¹⁷ Botswana, Cote d'Ivoire, Ethiopia, Guyana, Haiti, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, Vietnam, and Zambia.

¹⁸ Indicative only – assumes all funds are allocated to countries according to the number of HIV-infected. Actual figures will depend on how funds are actually allocated. A high proportion of funds is currently going to US base organisations to run programmes.

¹⁹ An underestimate as it excludes number of HIV infected in Sierra Leone and Guinea Bissau and also ignores inputs from regional MAP programmes.

Possible inputs from the Global Fund, GAVI and GPEI and PPFAR and MAP alone could double overall health spending (which is already highly dependant on aid) in 10 countries (8 of which are DFID PSA countries). They could quadruple funding in Ethiopia as well as increasing it by a half in a further 25 countries (5 of which are DFID PSA countries). Perhaps not surprisingly, the impact on South Africa, India and Vietnam is small. This does raise the question of

- sustainability - once the initial funding from these initiatives is exhausted will they be continued?
- aid allocation – is the rapid shift towards development assistance for health warranted in the light of other priorities if these initiatives are funded from existing programmes?
- macroeconomic impact – the impact of the additional aid flows on macroeconomic variables.

It is inconceivable that the most aid dependent countries will be able to assume much more than a minor share of the recurrent financing burden incurred by the GHPs even in the medium term. This means that support for the GHPs will need to be extended and/or bilateral or other forms of support will be required to cover the funding gaps if the benefits achieved through the GHPs are to be sustained.

The issue is acknowledged by GAVI with the Board accepting the following definition of financial sustainability in June 2001: *"Although self-sufficiency is the ultimate goal, in the nearer term sustainable financing is the ability of a country to mobilize and efficiently use domestic and supplementary external resources on a reliable basis to achieve current and future target levels of immunization performance in terms of access, utilization, quality, safety and equity"*. The development of Financial Sustainability Plans is an important step forward in helping to identify the future financial implications. However, whilst a positive step it could also be argued that sustainability should have been considered *before* funding decisions were made. The issue has not been considered explicitly by GFATM, which is likely to have much larger recurrent implications. However, it has refined its eligibility criteria replacing the previous criteria of "co-financing" and "moving over time to an increasing reliance on domestic resources" with a single criterion termed "counterpart financing." which incorporates funding from all sources.

In the light of this the implications of not sustaining GHP activities need to be considered. In the case of some activities (e.g. ART, treatment of bednets) it will affect *existing* beneficiaries and reduce the cost effectiveness of the interventions supported. In the case of others (e.g. immunisation) it will not affect those who have already benefited from GHPs but will reduce the number of potential future beneficiaries.

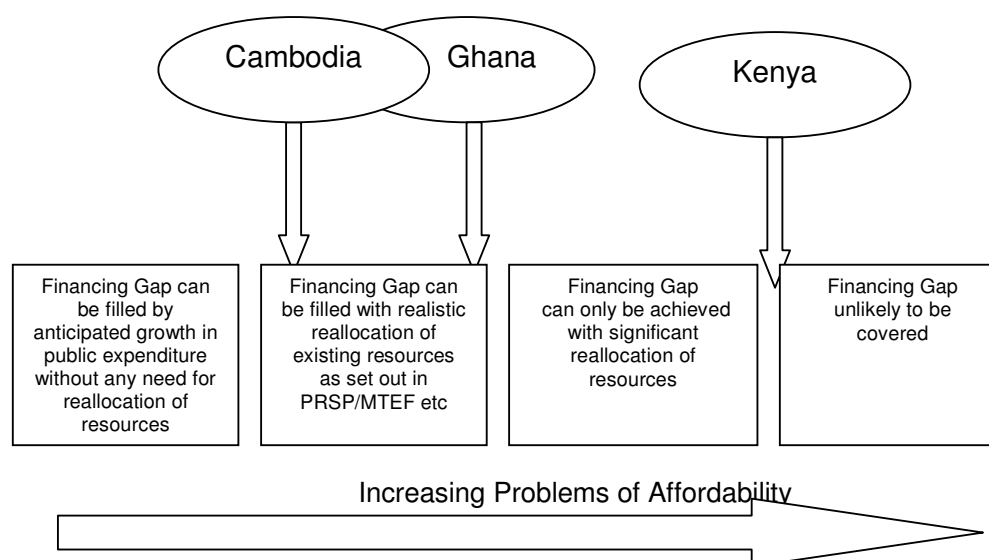
The Need for a Global Perspective

One of the key problems is that sustainability, perhaps quite understandably, tends to be viewed only from the perspective of the individual GHPs. For example, meeting the increased recurrent costs associated with GAVI may require only minor shifts in the allocation of resources to the health or within the health but the implications can be quite considerable when all GFATM is also considered. This is best analysed when looking at the implications in a range of countries – Kenya with poor domestic revenue prospects and large GHP commitments, Cambodia with relatively good expenditure prospects and modest GHP commitments and Ghana which falls somewhere in between (see schematic below).

Key Factors Affecting Sustainability

	Kenya	Cambodia	Ghana
Size of GAVI Financing Gap	large	small	modest
Prospects for Domestic Expenditure on Health	poor	good	modest
Degree of Competition from Other Sources (GFATM)	very high	modest	modest

Implications for Affordability



Source: IHSD, 2003

Table 8 shows projections on how much Government funding for immunisation would have to rise both in dollar terms and as a share of domestic spending on health to cover the financing gap, depending on whether the gap is funded by Government, donors or a combination of the two.

Table 8: Annual Budget Required for Immunisation under Different Scenarios for Covering the Financing Gap

	Method of Covering Financing Gap	Amount (Share) of Domestic Funding to Immunisation 2001 (\$m)/(%)	Amount (Share) of Domestic Financing to Immunisation to Cover Financing Gap Average 2003/6	Amount (Share) of Domestic Financing to Immunisation to Cover Financing Gap Average 2007/2009
Kenya	100% Government funded	\$7.7m (6.9%)	\$17.8m (15.7%)	\$43.1 (31.9%)
	50% donor/50% Government	\$7.7m (6.9%)	\$15.0m (13.3%)	\$29.2m (21.6%)
	100% Donor Funded	\$7.7m (6.9%)	\$12.2m (10.9%)	\$15.4m (11.4%)
Ghana	100% Government funded		\$3.7m (4.5%)	\$15.1m (10.0%)
	50% donor/50% Government	N/a	\$2.7m (3.3%)	\$7.6m (5.0%)

	100% Donor Funded		\$1.7m (2.1%)	- (0.0%)
Cambodia	100% Government funded	\$1.2m (3.4%)	\$4.9m (8.5%)	\$6.6m (9.2%)
	50% donor/50% Government	\$1.2m (3.4%)	\$2.5m (4.3%)	\$3.3m (4.6%)
	100% Donor Funded	\$1.2m (3.4%)	\$0.1m (0.2%)	\$0.03m (0.1%)

Notes: Base case scenarios are used; other scenarios are considered in the background paper. Kenya case relates to scenario A, which plans for 90% coverage. Ghana - figures relate to 2002-2006 and 2007-2011

In Kenya, it was estimated that the share of health spending going to immunisation will have to almost double over the next 5 years even if the financing gap estimated in the Financial Sustainability Plan (FSP) is fully funded by donors – at the same time it will be faced with finding more than \$40m per annum to sustain GFATM funded activities.

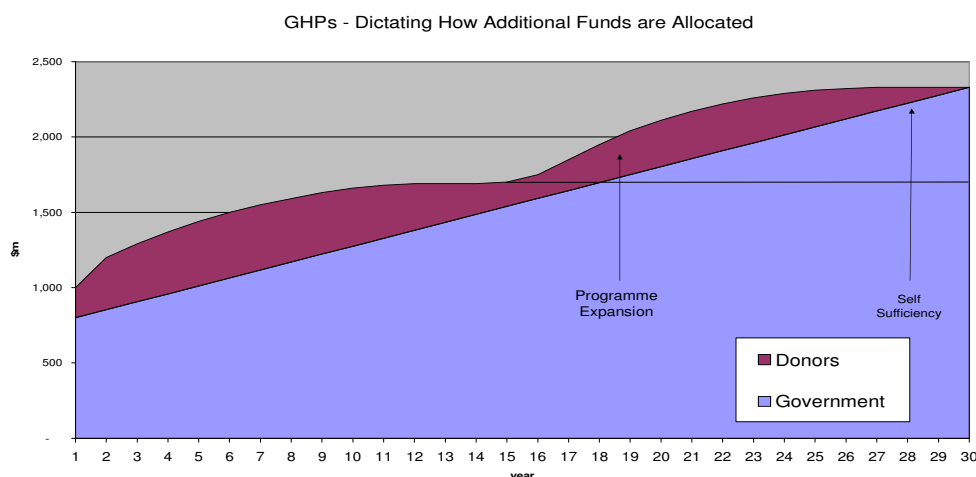
Another key dimension to this is that the additional recurrent implications are unlikely to hit countries in a gradual manner but may be concentrated in the period 2008 to 2010. It also raises the question as to whether DFID's role might be a) to continue to support expansion of global funds after the first wave of commitments has been completed or b) revert to providing support at the country level to enable existing gains to be consolidated.

Another effect of the financing model adopted by some of the GHPs is that, over time, the pattern of health spending is dictated by the direction of the GHPs rather than the priorities of Governments. As the GHPs develop and establish new programmes, countries are expected to take over the running costs. However, having achieved that, the model suggests that the GHPs will then move on to the establishment of new programmes e.g. introduction of new vaccines expansion, from 3 by 5 to 5 by 7 etc. as illustrated in the schematic below (chart 38)

DFID will need to consider whether, and at what point, it should be looking to shift resources into consolidating existing programmes rather than promoting further increases in coverage by the GHPs. Considerations will include:

- the overall performance of the GHP in question,
- the specific direction its proposed expansion takes,
- the minimum contribution DFID can realistically make,
- the overall financing situation and sustainability challenges faced in recipient countries and the viability of alternative financing instruments

Chart 38



Clearly there are also other dimensions to the sustainability debate which relate to issues beyond financing (box 6) but these are not dealt with here.

Box 6: APOC Evaluation

“A large amount of energy and initiative has been unleashed by the joint action of CSA, APOC Headquarters staff, the NGDO Co-ordination Group, JAF and TCC, and the cascade of nationals who have in turn been empowered and enthused by them. This activity has been made possible by the availability large sums of donor money. *The evaluation team is deeply concerned about the sustainability of this activity and enthusiasm, once APOC funding comes to an end.* There appears in many instances to be a lack of understanding that CDTI may have to continue to 2020 and beyond, with little definitive planning to mobilise the resources and set in place the routines which will ensure the continuation of the programme”.

Funding Requirements - What Is Required?

Global Estimates

Estimating what is required to achieve the MDGs is fraught with difficulty. One approach is to estimate how much support is needed to generate the levels of economic growth required to achieve the poverty target. However, the evidence shows that income growth and other complementary investments play a far more important role in improving health outcomes than investment in health itself (Filmer and Pritchett). Income growth would not only improve health outcomes, it would also strengthen Government finances and their ability to fund health programmes.

An alternative way is to estimate the direct cost of achieving the individual MDGs. The cost of achieving the health MDGs has been estimated by the World Bank at \$20-25bn per annum as part of the US\$35-76 billion²⁰ required to achieve all of the non income MDGs. The CMH puts the figure rather higher (table 9). Investments in education (the additional costs of achieving universal primary education are estimated to be \$9-\$15bn) and water and sanitation (\$5-21bn p.a) will also contribute to improved health outcomes.

²⁰ Devarajan, Miller and Swanson, 2002.

Table 9: Expenditure Required to Achieve the MDGs: Commission for Macroeconomics and Health

		Incremental Costs 2007 (\$bn 2002)	Incremental Costs 2015 (\$bn 2002)
TB	Treatment	0.08	0.44
Malaria	Prevention	1.03	2.33
	Treatment	0.85	1.95
HIV/AIDS	Prevention	4.25	8.7
	Care	9.45	26.45
	HAART	3.95	5.7
Total		19.3	45.8

Source: CMH; midpoint of ranges taken

However, little progress has been made over the last decade in increasing health expenditure. In addition, there is little evidence that health spending is related at all to health outcomes. This raises the issue of whether it is additional resources or the better use of existing resources which is more important, and furthermore whether access to finance is the binding constraint or whether implementation capacity is more important. What is clear is that additional spending on health can only be justified if it is more effective than has been the case in the past.

It is also clear that existing spending is well below that required to make sustained progress towards the MDGs. To bring public spending on health in all DFID priority countries in Africa up to at least \$12 per head would cost an additional \$17bn per annum (more than half of which would be for India alone) – four to five times the proposed annual commitments of the financing GHPs. In short, at the current levels, the GHPs do relatively little to close the overall financing gaps.

What Do the Individual GHPs Require?

In some cases, the GHPs estimate a country wise breakdown of the costs of achieving global objectives (GPEI). In others (GFATM), funding is essentially supply led. Although revenue mobilisation targets are still based on global needs, in practice allocations are determined by available funds and the partnership's rules in relation to financial prudence (GAVI, GDF/Stop TB). Whilst GFATM has quite strict rules about the level of commitments it can enter into, GDF financial management has been more relaxed, adopting a more high risk strategy based on building up commitments rapidly without necessarily having officially pledged funding.

Although greater emphasis on Product Development PPPs may be warranted given the long lead times, it seems relatively unlikely that they will make a major contribution to the MDGs. Without wanting to downplay the importance of achieving the 2015 targets, it probably makes sense for DFID to consider the longer term view and focus on longer term/high impact interventions than short term/low impact ones.

Requirements of the key financing GHPs:

- **GFATM:** The Fund acknowledges that its size is the outcome of a subtle interplay between demand, availability of finance, and its role in the broader development finance landscape. Based on its current funding policies, it estimates that it needs \$1.3bn to fund renewals and a further \$2bn for new proposals during 2005 (and

possibly up to \$700m more when appeals are considered). Current pledges for 2005 amount to some \$886m. Board members have been circulated projections outlining how the Fund might reach a steady state of \$3bn per annum per annum by 2008. This is double current levels but half of what is considered to be an ideal amount and much less than the \$8bn referred to in the CMH report and the \$10bn per annum figure highlighted by the UN Secretary General. The Fund estimate that “the demand for international development finance in HIV/AIDS will continue to rise steadily for at least a decade and probably much longer”, implying that significant additional resources will be needed for anti retroviral therapy. Needs for TB are expected to increase along similar lines, whilst for malaria the situation is less clear. GFATM is already the major global funder of malaria and needs for external assistance may decline after 2010.

- **Stop TB:** The Stop TB Partnership estimate that \$950m is required in 2004 and \$1.1bn in 2005 to allow targets to be met in 21 of the 22 High Burden Countries. Given current estimated expenditure, the shortfall is some \$300m for both 2004 and 2005. In addition, the Russian Federation’s 5-year plan (2003–7) indicates resource requirements of more than US\$ 400 million per year, with a funding gap of around US\$ 200 million in each year. Around 70% of the total resources requirements are typically met by governments, with 10% from grants, of which GFATM accounts for two-thirds. The funding gap is around 20% of total requirements in 2004 and 2005 and is greatest in countries with relatively poor case detection. GFATM funding has reduced, but not eliminated, the gaps in Nigeria, Pakistan, Ethiopia, and China, whilst some countries such as Afghanistan, Kenya, Tanzania and Cambodia have funding gaps which although small in absolute terms are large in relation to their total resource requirements. The Stop TB Partnership plan to prepare a second global plan covering the period 2006 to 2015 to be inaugurated in September 2005. One of the aims of this will be to identify resource needs and gaps and present the latest evidence on cost effectiveness.
- **Polio:** For 2004–2005, funds are required primarily to interrupt polio transmission globally. The currently estimated funding gap of \$ 130 million is some 17% of projected costs of \$765 m. For 2006–2008, funding is required to achieve global certification, develop products for the cessation of Oral Polio Vaccine use and mainstream the polio eradication infrastructure. It is estimated that \$380m will be required during this period – around \$200m in 2006, falling to below \$100m in 2007 and 2008.
- **GAVI:** Plans to develop a long term strategic plan to (2015) by the end of December 2004 and a work plan for 2006-7 by December 2005. It has already taken steps to integrate its plans into country processes. Financial sustainability plans (which have been carried out in 30 countries by 2004) are signed by finance ministers, and the Financing Task Force is investigating further measures to integrate FSPs into national planning and budgeting processes (including PRSPs and MTEFs). The Vaccine Fund plans a resource mobilisation consistent with the strategic plan objective which are yet to be defined but milestones for 2005 and 2006 and \$325 and \$400m respectively. GAVI is also planning to pilot innovative financing mechanisms such as advance purchase contracts. Initial expectations have not been met – additional financing for immunisation has not been forthcoming and prices of vaccines have not dropped as expected. Countries have therefore not been able to extend coverage as expected and are considering dropping expensive vaccines such as Hib. GAVI is considering

options for bridge financing and possibilities of providing initial subsidies to support the introduction of new vaccines until such time as prices drop.

Table 10: GAVI Estimated Requirements

(in millions of dollars)	2006-2010	2011-2015	2006-2015
Strengthen immunization systems to reach higher levels of coverage	\$2,205 M	\$2,210 M	\$4,415 M
Procure and introduce new and underused vaccines into national immunization programmes	\$221	\$2,017	\$2,238
Launch supplemental immunization activities to reduce mortality due to measles and maternal and neonatal tetanus.	\$715	\$458	\$1,173
Create the polio vaccine stockpile	\$235		\$235
Immunization IFF funds needed	\$3,376	\$4,685	\$8,061

Product Development: Recent work by Towse suggests that there is at least a \$2 billion funding gap and there are concerns that the activities of many PPPs are being distorted (e.g. undertaking relatively cheaper research) and that such suboptimal approaches may not lead to the ideal results. The need for multiyear commitments is also stressed.

Table 11: Estimated Costs of Selected Public Private Partnerships

	Objective	Current Commitments to 2007	Required Funding to 2007	Shortfall
IAVI	8 to 12 novel vaccine candidates into clinical trials and advance the best 2 or 3 to final stage testing phase III by 2007	174	1036	862
IPM	To accelerate the discovery, development and accessibility of safe and effective microbicides	94.5	775	680
TB Alliance	1 new drug for registration by 2010	35.75	249	213
DNDi	6-7 new registered drugs by 2015	0	255	255
MMV	1 new drug every 5 years starting in 2010	97	152	83
Total		401	2467	2066

Source: Towse (2004)

Costs depend on the nature of the output, failure/attrition rates and estimated costs at different stages of development minus any in kind support from industry at below market cost. There is great uncertainty with estimated costs ranging from \$400m to \$4bn.

Box 7: Estimated Requirements for PPPs: Commission for Macroeconomics and Health

To help channel the increased R&D outlays, we endorse the establishment of a new Global Health Research Fund (GHRF), with disbursements of around \$1.5 billion per year. This fund would support basic and applied biomedical and health sciences research on the health problems affecting the world's poor and on the health systems and policies needed to address them. Another \$1.5 billion per year of R&D support should be funded through existing channels. These include the Special Programme for Research and Training in Tropical Diseases (TDR), the Initiative for Vaccine Research (IVR), the Special Programme of Research, Development and Research Training in Human Reproduction (HRP) (all housed at WHO) and the public-private partnerships for AIDS, TB, malaria, and other disease control programs that have recently been established.

Estimates are often based on well meaning, but very flimsy, premises²¹. It therefore makes relatively little sense to aggregate requirements. What would be useful would be an exercise to estimate requirements through independent means in a consistent manner.

There is a case for developing a number of resource scenarios bringing together the needs of all the GHPs – a sort of global MTEF. Though, individual GHPs have attempted this overall needs remain unclear. Such planning would also usefully be linked with ongoing discussion about the International Financing Facility to ensure that funds are available when needed. To this extent the IFF may prove to be a useful insurance mechanism as well as financing specific interventions.

A more detailed breakdown of funding needs by GHP is an annex 3.

When is Funding Needed?

There is a distinction between how much is needed on the ground, and when and how much the partnerships need and when. Concerns have been expressed that some partnerships may be seen as overcapitalised and sitting on money or run the risk of being seen that way – either due to their prudent financial guidelines (GFATM) or failure to develop a vaccine (IAVI).

Funding Policies

GFATM: As at end May 2004, contributions received amounted to some \$2.32bn against disbursements of just \$347m., \$1.36bn committed and \$74.5m operating expenses (income on investment more than 10% of total disbursements). Overall, \$1.07bn was available for commitment; with \$796m waiting signed grant agreement, \$211m was available for new commitments. GFATM can only make commitments up to the cumulative uncommitted amount pledged through the calendar year of the

²¹ "The annual direct economic cost of malaria across Africa... will exceed \$3.5bn (in 2000), twice what it was in 1995". A possible benchmark might be to consider what should be spent on malaria research in Africa is the ratio of resources that the pharmaceutical industry allocates for its R&D. In the drug industry, research ranges from 8-18% of the total budget. Setting a conservative goal of investing 10% of the cost of African malaria in research suggests that at least \$350 million should be funding work to understand malaria and its control. Ideally, at least 10% of this \$350 million, \$35 million, should be directed through MIM to support activities in research capacity building. The Panel recognizes that such a dramatic increase in funding is not realistic. For the time being, however, a more realistic goal would be to double the current total funds spent on MIM, from approximately \$8million to \$16 million. Every effort should be made to achieve, at the very least, this level of growth". MIM evaluation

Board decision. Assets to meet the full cost of approved grants must be deposited with Trustee or readily available.

The Global Drugs Facility has taken a higher risk approach to managing its finances – making commitments well in excess of proven commitments. In practice this has been effective as a key donor – CIDA – has been willing to fund the gap.

Which is best? Strategically GHPs should manage a financial portfolio prudently. However, donors do not always respond to this. Tactically, it is often a more effective approach to spend money hand over fist, create periodic crises and hope donors will bail you out. Although more high risk, this is often more effective.

In practice there has been some degree of convergence. The Fund is currently considering whether these funding principles can be amended (relaxed) in view of experience to date. At the same time, the GDF has been developing a resource based as well as a needs based budget.

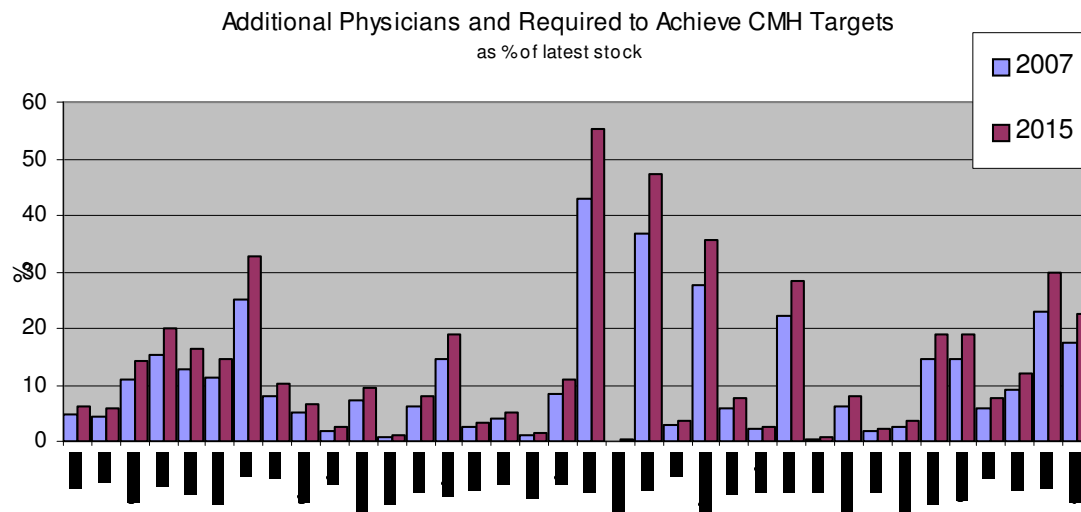
Overall, the different practices related to fund management make it very difficult for donors and other key stakeholders to make informed decisions about the magnitude and timing of future resource needs. In principle, DFID should seek to ensure greater transparency and consistency in approaches to financial planning.

Is Financing the Main Constraint?

An extremely important constraint facing programme expansion is a lack of human resources.

Zambia is an extreme example. Estimates show that providing HAART to everyone who is clinically eligible would, after five years, require twice the number of laboratory technicians and half the doctors currently available in the public health system. Even at more modest levels of population coverage, the human resource constraint may be more binding on HAART expansion than the financial constraint. Thus, the success of Zambia's HAART programme over the medium term could depend more on its human resource capacity than on its budget capacity. Applying similar staffing levels across Africa shows that the additional requirement for physicians is up to 50% of the existing stock (chart 39). The situation in Tanzania, where the human resource stock has been declining is particularly pressing (table 12).

Chart 39

**Table 12: Human Resource Implications of HAART in Tanzania**

	Additional Staffing Requirements according to target Coverage of PLWA end 2005		Current Stock		Annual Output**	Requirement as % of current stock****	Annual Production as % of Additional Requirement****
	65,000	260000	Strict*	Loose* *			
Doctors	81.9	335.4	510	1571	105	21.3	31.3
Nurses	81.9	335.4	3290	10729	553	3.1	164.9
Lab Technicians	199.08	815.28	458	1327	101	61.4	12.4
Pharmacists	94.5	387	111	365	66	106.0	17.1

1.13.1.1 Notes

* medical officers, nursing officers, lab technicians, pharmacists

** also includes medical specialists, assistance medical officers, nurse, nurse/midwives, pharmaceutical technicians and assistants and laboratory assistants

*** loose definition

**** high target, loose definition

Selected Country Experiences

Key findings from discussions with DFID advisers and review of key documents suggest:

- that GHPs have generally not been well coordinated either with Government planning processes or between themselves. GHPs resulted in destabilisation of SWAp approaches and raise concerns about impact on macroeconomic stability. There are some promising moves e.g. GFATM is willing to channel resources through the common fund in Mozambique and monitor performance against outputs not inputs. Some countries have adapted their approaches e.g. Ghana. has developed needs based budgets as well as resource based budgets – though this has had capacity implications

- limited evidence that donor and Government funding decisions have been influenced by GHP allocations
- some movement towards greater utilisation of local systems, if not completely integrating with SWAp processes.
- that chasing GHPs funding has diverted the attention of staff away from ongoing country level processes.
- concerns that transactions costs are increased by new reporting requirements, and that CCMs add little in situations where participatory arrangements are already fairly well developed. Despite claims that GFATM is radically policy free, in some settings there is a feeling that it is becoming an agency in itself with its own rules and procedures. On the other hand, there is too little guidance in other areas e.g. on how many countries should be bidding for.
- money is welcome but has undermined existing budgeting and planning processes especially any MTEF processes. Lack of transparency has made budgeting harder – where Governments have tried to plan for GFATM inputs, they have been left in trouble when no award has been made.
- concerns that the approaches perpetuate vertical programmes and that opportunities to strengthen systems which whilst to some extent available are not utilised
- concerns about longer term sustainability and balance between interventions

The extent to which GHP funding has been incorporated into overall planning and budgeting processes has depended very much on the stage of the budget cycle. In many ways GFATM has been a victim of its own success – it was established so quickly that it was not possible to consider it as part of ongoing processes. However, lack of clarity on likely resource flows has also hampered the integration process. The real question is whether GHPs are being integrated into currently ongoing processes. Of the recent case studies, Uganda seems the only case in which spending may be at the expense of existing public programmes though the outcome is still unclear.

The GFATM has, for perfectly valid reasons, decided to adopt a demand based approach. This has posed countries a dilemma – should they put forward a reasonable proposal with some expectation of success or an ambitious one with more limited chances of success. There is evidence that donors have been active in encouraging Governments to inflate their proposals. There have been complaints about a lack of transparency in the application process. There have been particular problems where countries have assumed the GFATM will cover certain gaps and have struggled when support has not been forthcoming. It is understood that GFATM is considering a shift towards a line of credit type approach rather than closed applications – going to the Board in November

Country Experiences²²

Southern Africa

GFATM funding in South Africa is additional and is provided in parallel to Government systems mainly to 2 large NGOs (even though there are procedures at district, provincial and central levels for providing such support and a well developed MTEF). RSA has made a number of applications but has a poor record. The CCM approach is to package the proposals it receives rather uncritically and forward them

²² utilises examples from a SWAp Mapping Study carried out by IHSD in 2003

to the Fund resulting in proposals which are somewhat of a hotchpotch. The jury is out on the proposals themselves. There are some questions as to whether one, Love Life, focusing on a social marketing approach to changing lifestyles, is working though another providing more traditional support for youth centres and youth groups seems to be sound.

There is some concern about the effects of the GHPs in middle income countries such as Swaziland and Namibia. GFATM is intentionally “light touch” but is also the dominant and often the only donor in such countries such as Swaziland. Yet such Governments are in great need of support (technical assistance rather than financial support) to strengthen their health systems and put the GFATM money to good use. Though GFATM has not actually displaced existing donors others are standing back and no donor is willing to lead. This might suggest additionality needs to be considered in a rather different way in terms of additional support to make sure the GHPs work effectively. Should some DFID support for the GHPs be top sliced to provide direct support to countries or should the GHPs be encouraged to provide a more operational role?

Mozambique

There were initial concerns that possible access to GFATM funding was undermining the nascent SWAp process. However, the situation now seems rather more positive. The MoH has completed a TA-assisted study for rolling out ART and this has resulted in a single plan with all funds to be channelled through the Common Fund. Although GFATM still has “some hoops to jump through”, in principle they are happy to channel their resources through the Common Fund though they will require evidence of progress against targets. Some of the other initiatives have created more problems – PEPFAR in particular is off budget and it is providing extremely difficult for donors to find out what is going on.

Ethiopia

There are a large number of global initiatives active in the health sector. The resources implied vastly exceed those available through Government. Though necessary and very welcome they place huge burden on implementation and absorptive capacity. There are concerns that vertical tendencies are reinforced and that there is little attention to system strengthening. Only GFATM is seen as providing the option to strengthen systems (and this option was not taken up). The GHPs are seen as undermining the emerging SWAp and creating an additional burden on Government. All planning has been done at federal level and the Woredas, who will be responsible for implementation, have little ownership. There is a major confusion about reporting formats. The centre has no powers to ensure lower levels comply. Human resources are a major constraint significantly enhanced planning skills, significantly increased numbers of qualified health personnel to implement the programmes, and much better partnership with NGOs to help achieve the targets. Within the federal Ministry of Health 24% of posts are vacant and there is no proactive recruitment to fill these posts. The global initiatives also encourage a parallel career path for promising recruits.

There are significant shortcomings in financial management. Late releases of GFATM funds have delayed procurement and there are concerns about supply interruptions. Disbursement is slow and one region reported receiving less than \$ 3,000, which may have cost more in administration costs than the value of the disbursement. Global initiatives are not harmonised either among themselves or with the Ethiopian planning, allocation and reporting cycles.

Ghana

Activities which were not envisaged in the SWAp were the new global initiatives such as GAVI and GFATM. These proposals have the potential to disrupt financial plans by distorting the resource envelope and MTEF framework, especially in terms of long term sustainability of funds for continuing activities. Earmarked project funds from some partners (USAID, JICA) are often still negotiated separately and, whilst attempts are made to integrate these into the strategic framework, it is very difficult to determine, project and plan for the funding levels.

GFATM funding has been incorporated into current planning processes by asking programmes to develop both resource based and needs based budgets which adds to the burden especially at district level. This has diverted the attention of health staff but the funding is welcome as helping Ghana to where it should be financially. The process skewed priorities and has also led to uncertainty. A rejected proposal left a major funding gap for treatment. There is no real evidence of diversion though some suspect donors will make different decisions about malaria. Systems are fairly parallel – MoH is principal recipient and, though money is not pooled, it is channelled through existing systems. There are some questions about what value the CCM adds. given that there is already a relatively strong civil society voice. There are some concerns about mission creep – that the Fund is developing its own rules and procedures.

For GAVI, support for systems strengthening has been extremely important and has been incorporated within existing sector plans and budgets. Expenditure has gone up from \$3m to \$14m, raising massive concerns about sustainability. This has been alleviated slightly to the extent that GAVI is allowing Ghana to spread its support over a longer period to ease the transition.

Tanzania

GFATM funding has been approved for HIV/AIDS (\$5.4m for one year) and malaria (\$19m over 3 years). The malaria funding is intended to cover one element of the National Malaria Medium Term Strategic Plan, and has been programmed into the Malaria Control Programme MTEF. Initial injections of funding can probably be absorbed, but the issue of longer term subsidy and the relative balance of funding between priority diseases remain of concern

In terms of HIV/AIDS, all funds are outside the framework of the existing strategy, including large sums of money expected from the Clinton Foundation and Bush Initiative. These, along with the resubmitted TB/HIV GFATM proposal, and the longer term sustainability concerns arising from the GAVI funding for new vaccines, are compounding concerns around the financing of the sector programme.

Indeed, concern was expressed by the MoF in December 2002 regarding the possible use of parallel systems by GFATM: "We are concerned that the mechanism of aid delivery proposed by the Global Fund against AIDS, Tuberculosis and Malaria, has the potential of undermining government accountability and negate all efforts made so far to improve development partnership and aid effectiveness." (MOH Dec 2002)

Senegal

Funding mechanisms such as GAVI and GFATM were not included in the PDIS (sector programme), and Senegal has already benefited from both (GAVI extension

of EPI to include hepatitis B and GFATM money towards malaria, TB and AIDS treatment (ARVs)). These sums are large both in relation to previous funding for the activities and also in relation to donor contributions to the PDIS. They are already affecting the pattern of health financing, although the longer term impacts are yet to be seen. One example quoted is that of an NGO in Senegal that USAID has decided to stop funding but are now receiving more funding than they had previously due to the huge influx of funds from GFATM.

ANNEX 3: KEY FUNDING SOURCE AND NEEDS OF THE MAJOR GHPS

	Spending to date	Key funders	Future Requirements
GFATM	Commitments of \$8.05bn over 5 year period under first 4 rounds. \$540m spent to date	Key Donors – USAID, France, EC, Germany, Italy, UK, Netherlands, Denmark Between 2002 and 2004, pledges total US\$ 3.1 billion, with an additional US\$ 1.9 billion pledged for 2005 to 2008 or for an unspecified period Key donors Rotary International, US (CDC), World Bank, UK, USAID, Japan	Ideally \$7-8bn rather less than the \$10bn per annum requested by Kofi Annan. \$3bn per annum seen as realistic cruising altitude
GPEI	~ \$2.5bn between 1988 and 2003		\$765m for 2004-5 (of which funding gap of \$130m) and \$380m for 2006-8. OPV and NID/SNIDs account for bulk of spending – expected to be complete by end 2006
GAVI	Commitments of \$1.05bn over 5 year period. Secretariat biennial budgets ~ \$7.2bn. By June 2004 \$429m disbursed (of which \$282m for vaccines) and \$341m received in country Projected ~ \$20m by end 2004	Gates, USAID, Norway, Netherlands, UK, Merck (in kind)	Latest GAVI estimates suggest \$8.06bn required between 2006 and 2015
DNDI		Seed money up to \$7.5m from MSF, some EU funding for artesonate projects	\$258m from 2003 to 2014 of which ~\$40 fixed costs and \$218m project related costs
IAVI	\$84.1m to end 2002	IAVI has been supported by a number of NGOs, including Until There's a Cure and Crusaid. Foundations such as Rockefeller, Sloan, and Starr were early donors to IAVI. Yahoo! and BD (Becton Dickinson) have provided IAVI with important in-kind contributions and BD is also providing direct financial support. In addition, eight governments are now helping to finance IAVI's work, including the US, Canada, and six European governments. Denmark, Ireland, the Netherlands, Norway, Sweden, and the United Kingdom	Towse estimates \$255m required by 2007 Have called for R&D spending on vaccines to increase from \$650m to \$1.3bn Desired operating budget \$30m per annum Current commitment of \$310m to 2008 against estimated needs of \$655m. Towse estimates needs of \$1.04bn by 2007 – of which shortfall is \$862m
IPM	\$94.5m committed up to 2007	Launched with funding from Rockefeller Gates Foundation accounts for just under 2/3 of commitments. Other large donors include Rockefeller, Ireland and Netherlands	IPM estimate \$500m is required globally to develop a first generation product
MIM	\$2.7m committed in 2003 –	largest donors include US NIH, Sida and National Library of Medicine US	Towse estimates \$775m required by 2007 of which shortfall is \$680m
MMV	\$55m committed	Bill and Melinda Gates Foundation, Exxon Mobil Corporation, Global Forum for Health Research, International Federation of Pharmaceutical Manufacturers Associations (IFPMA), WHO, the Rockefeller Foundation, the World Bank, Roll Back Malaria Global partnership, TDR, the United Kingdom Department for International Development (DFID), Swiss Agency for Development and Cooperation, the Netherlands Minister for Development	Desired operating budget \$30m per annum Towse estimates \$152m required by 2007

MDP	<p>"The OPC and APOC programme expenditures, while significant, are dwarfed by the value of Merck's contributions through the MDP. In the year 2001, the value of the ivermectin contributed by Merck – calculated at \$1.50 per tablet – was \$28.1 million for the OCP, \$143.6 million for APOC and \$3.0 million for the OEPA. The additional costs of the MDP paid by Merck – shipping the ivermectin from France where it is produced to the destination countries, customs clearance, and programme management and administration – amount to just 1.1% of total programme costs.</p>	Cooperation and the Wellcome Trust	<p>MDP's work on onchocerciasis is fully supported by Merck & Co., Inc. while its work on LF is jointly supported by Merck and GlaxoSmithKline</p>	<p>A plan of action and corresponding 5-year budget has been prepared for the 2003–2007 time period – anticipating \$14.2 million in expenditures during this time period, 32.9% of which is for aerial operations (JPC 2002; Kale et al. 2002). After this period, any other special efforts will be the responsibility of national authorities.</p>
MVI	<p>started with seed funding of \$50 million from the Bill & Melinda Gates Foundation in June 1999</p>	<p>Launched with \$50m seed money from the Gates Foundation in 1999. Additional \$100m provided in 2003Partners include malaria experts around the world, government agencies, academia, public and private research institutions, and vaccine producers</p>	<p>New funding will allow more of what has been discovered over the past 10-15 years to finally be evaluated in people-currently the only way to know if potential malaria vaccines might work.</p>	
APOC	<p>Total budget 196-2007 of \$131m</p>	<p>Key donors World Bank \$3m 1996-2002 – also US (\$13m), Gates (\$10m) and CIDA (\$5m)</p>	<p>OCF was launched in 1974 and closed its operations on 31 December 2002 having met its objective to eliminate onchocerciasis as a problem of public health importance and an impediment to socioeconomic development in West Africa. There are still 5 Special Intervention Zones including Sierra Leone, BUT APOC covers different countries and is ongoing with a plan for phasing out 2008-2010. This seems a bit misleading.</p>	
SCI				
GAE/ELF	<p>In 1998 GlaxoSmithKline and WHO signed a contribution MOU, covering amongst other things the donation of the albendazole required for the LF Elimination Programme. (In support of World Health Assembly Resolution WHA50.29 1997 calling for the elimination of LF(In 1999 Merck & Co. expanded its donation of Mectizan for onchocerciasis to include the treatment of LF in African countries where onchocerciasis and LF disease</p>	<p>Gates Foundation, World Bank GlaxoSmithKline and Merck (in kind)</p>	<p>In 1998, SmithKline Beecham, now GlaxoSmithKline (GSK), agreed to donate its drug albendazole free-of-charge until the disease is eliminated. This is likely to be a donation of between 4-6 billion tablets over a 20-year period. Merck & Co., Inc. also pledged to expand its Mectizan Donation Program for Onchocerciasis in all areas of Africa where the two diseases co-exist. In February 2001 the Bill & Melinda Gates Foundation gave \$20 million to accelerate the elimination of Lymphatic Filariasis (LF) during the first five years of the 20-year global program</p>	
ITI	<p>\$58m committed to date</p>	<p>Major donors are Gates Foundation \$25m and Pfizer \$22m</p>	<p>To 2020 or until LF is eliminated as a public health problem worldwide</p>	
GAE/L	<p>Commenced in 1995 using donation from the Nippon Foundation</p>	<p>Nippon Foundation, DANIDA, Novartis, Sasakawa Memorial Health Foundation, World Health Organization (WHO) and the World Bank</p>	<p>Under the terms of the MoU with Novartis and the Novartis Foundation for Sustainable Development, MDT to the value of around US\$ 30 million will be donated free of cost to all countries in need up to the end of 2005 now being extended to 2010</p>	

GWEP	The campaign brings together WHO, UNICEF, the CDC, the World Bank, other organizations, industry and countries in a programme of eradication efforts, training, and research. Dupont has donated more than 2 million square meters of nylon cloth to filter drinking water – a key step in interrupting transmission. Additionally, a larvicide is donated by American Cyanamid (now part of BASF)	Major funders include: BASF, Bill & Melinda Gates Foundation, DuPont, Johnson & Johnson, and Precision Fabrics	The Nippon Foundation and the Sasakawa Memorial Health Foundation have pledged to contribute USD 24m 2000-2005
RBM	\$35m spent through RBM in 2002 with an additional \$95m of donor funding outside RBM	Key funders WHO, DFID and USAID with smaller inputs from Italy and Japan, World Bank and others.	African Heads of State requested \$1 billion for RBM in the <i>Abuja Declaration</i> CMH estimates that by 2007, a scaled-up effort of malaria control would cost from \$1.5 – \$2.5 billion per annum of which \$0.5 – \$1.1 billion would be for sub-Saharan Africa
Stop TB	\$11.8m in 2001 and \$18.1m in 2002 of which some 80% is for the GDF.	Key funders of STBP CIDA and Netherlands (GDF) and USAID, UK, Netherlands others for Secretariat – significant in kind contributions	\$9.1bn under current Global Plan to Stop TB. New plan currently under development.
WPSS	Aventis has donated \$25m over the next 5 years	Aventis, Bristol-Myers Squibb providing materials and funding - \$400k - over 2 year period. MSF providing in kind support Major funders include: BASF, Bill & Melinda Gates Foundation, DuPont, Johnson & Johnson, and Precision Fabrics	Aventis donated \$25 million for the next five years and will work in close collaboration with WHO on a three-point strategy including drug donations (eflornithine, pentamidine, melarsoprol), disease management, and research and development. Bristol-Myers Squibb has committed to fund the cost of supplying the bulk material for eflornithine (one year and 400 000 USD for a two years period) and Bayer has agreed to restart production and donate two other drugs used to treat sleeping sickness: suramin and nifurtimox. Médecins sans Frontières, which acted with WHO to bring these drugs back into production, will provide storage, packaging, distribution, and administration of the drugs, in accordance with WHO's directions, to national control programmes and nongovernmental organizations. Duration: A five-year period, until June 2006.

ANNEX 4: KEY DOCUMENTS

Saving Lives, Buying Time: Economics of Malaria Drugs In an Age of Resistance (2004)

Board on Global Health (BGH)

PUBLIC EXPENDITURE REVIEW HIV/AIDS MULTI-SECTORAL UPDATE FOR 2004 Foster and Mwinyimvua November 2003

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APPRAISING A HEALTH PROJECT: Economic Benefits of the Onchocerciasis Control Programme in West Africa HCO DISSEMINATION NOTES Human Capital Development and Operations Policy January 8, 1996

GLOBAL FUND COUNTRY CASE STUDIES REPORT Cheri Grace January 2003

Emerging Lessons in Preparing For Uptake of New Vaccines Gargle Ghosh Centre for Global Development, USA

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The Economic Impacts of Tuberculosis Dennis A. Ahlburg, 2001

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Using The National Health Accounts Sub analysis To Track Resource Flows for HIV/AIDS PHR Plus 2004

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Demonstrating Value: Performance Metrics for Health Product Development Public-Private Partnerships Marc Pfitzer Foundation Strategy Group, Switzerland 2004

REVIEW OF THE MULTILATERAL INITIATIVE ON MALARIA (MIM) 2002
Bockarie et al

Copenhagen Consensus: Challenge Paper On Communicable Diseases Mills and Shillcutt*
February 2004

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