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**Notes from the IAEN and IAS Conferences, Bangkok, 2004**

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## **1. SCOPE OF THIS NOTE**

This note provides some immediate feedback from the IAEN (International AIDS Economic Network) pre-conference titled "AIDS in the 21<sup>st</sup> Century: Who Will Pay?" as well as the first 3 days of the main IAS conference, titled "Access for All".

The feedback is focused around 4 key areas:

- Funding the HIV/AIDS response
- Costs and consequences of scaling up prevention, treatment and care
- Private sector role
- HIV/AIDS and health systems development,

Plus:

- Who should get access to ART?
- Economic impact of AIDS

## 2. FUNDING THE HIV/AIDS RESPONSE

Several presentations highlighted HIV/AIDS funding requirements, funding that has been pledged/received, and the actual and projected resource gap.

### i) Funding requirements

UNAIDS estimate \$6 billion as the 2003 requirement and \$20 billion is projected to be needed in 2007 - to be spent on 28 interventions, of which 19 preventive, and 6 on treatment and care plus orphan care...)

Funding breakdown:

- 52% on prevention
- 33% on treatment and care
- 8% orphan
- 7% policy and programme

**Resource needs for WHO 3 by 5 initiative** (Published in Lancet 364 63-64 (2004))

\$5.7 - \$5.9 billion is needed to meet WHO 3 by 5 target (which represents 50% of those currently in need of treatment). ART represents 43% of this total cost. David Evans of WHO reminded the audience that these are recurrent costs, and as such will need to be continually met. In addition, further resources will be needed to provide treatment to the additional 50% of those currently in need, but not receiving treatment, as well as for new cases as they arise. WHO estimates have been made assuming provision at three main entry points: TB clinic, health facility and antenatal clinics.

### ii) Response to date

Speakers from the Global Fund and PEPFAR presented on their respective contributions.

#### **Global Fund (GF)**

Richard Feachem reported:

\$5.4 billion has been pledged to the Fund to date, of which \$3 billion has already been contributed.

Current status (including recent round 4): 296 programmes in 128 countries  
Commitment is \$3 billion over 2 years, and \$8 billion over 5 years

Distribution by:

**Disease:** 60% HIV, 20% TB, 20% Malaria (fund is now the major funder of TB and malaria, (not so with HIV/AIDS!))

**Channels (Govt/non-govt):** 50% Govt: 50% Non Govt/Private

**By type of support:** 50% drugs and commodities, 50% infrastructure, training, M and E, etc.

Feachem opined that the Ideal funding share of GF should be 1/3 USA, 1/3 EU, 1/3 Others (private, other bilaterals).

He emphasized the need for a fine balance between demand, resource availability and absorptive capacity. He claimed GF had proved absorptive sceptics wrong, "absorptive capacity exists in even poorest African country". However, a later presentation by R. Brugha of the London School showed that actual disbursements from rounds 1 and 2 of GF have been quite low:

Round 1: disbursements - Tanzania (13%), Zambia (19%) and Uganda (37%)  
Round 2: disbursements - Mozambique (0%), Uganda (18%), Sub Saharan Africa (26 countries) (22%)

Brugha did however note that this disbursement profile is probably still faster than that of many other donors. He made the point that GF stands out from other funders (eg PEPFAR, World Bank MAP, Clinton Foundation) as being more transparent and open to lesson learning.

Feachem provided feedback from an assessment of 25 countries with one year old grants from GF. He said 12 were on track or overachieving targets, 8 grants have achieved substantial progress and 5 are substantially underachieving against agreed targets.

### **PEPFAR (The President's Emergency Plan for AIDS Relief)**

The conditionality of PEPFAR was criticised by many, including the activist lobby and Princess Mabel Wisse Smit of the Netherlands in her Plenary address. She pointed out that abstinence and being faithful are not options for many women, especially those at risk in a primary relationship and for young girls whose first sexual contact may not be by choice. Connie Carrino, Director of the Office of HIV/AIDS, USAID during her keynote address at IAEN was challenged on PEPFAR policy towards support of generic drugs. Her response was that safety is the first criteria, thus, drugs have to be approved by the US regulatory organisation. PEPFAR funds in principle can be used for generics and non-generics.

Princess Mabel concluded it was best to "put money in the GF" – as it represents the most flexible funding instrument. The activist lobby was backing the "FUND the FUND" campaign throughout the conference.

### iii) Resource Gap

Estimates of current funding gap for HIV/TB/Malaria combined (source UNAIDS) are:

For 2005: total required \$17 billion – projected shortfall \$8 billion  
For 2006: total required \$26 billion – projected shortfall \$14 billion

Feachem recommended ideal share of future funding should be 1/3 domestic and 2/3 international sources. Domestic share should include contributions from the corporate sector. However, he stressed that for the foreseeable future many countries will rely on international financial support.

### **3. OTHER ISSUES RELATED TO FUNDING**

#### Donor coordination

A re-occurring theme was the need for better donor coordination and harmonisation of funding and procedures (particularly in those 15 countries who will be heavily funded by GFTAM, PEPFAR, MAP and bilaterals). The so-called 'three one's' provide the best mechanism for doing this - one national framework, one national coordinating body and one monitoring and evaluation framework. Feachem suggested one of two ways of doing this – either let national AIDS coordinating bodies themselves take control of donor funding mechanisms or expand the mandate of CCMs.

A few presentations focussed on the CCM mechanism itself – how representative? how participative? how well it was functioning? R. Brugha's study noted some tension between CCMs and national AIDS bodies. Aidspan has recently completed a study on CCMs (which was to be presented at a later session of the conference). There was some discussion on the ideal way of supporting and integrating the civil society response. There was a view that civil society should be involved in CCMs, however, the importance of having an autonomous civil society mechanism was recognised as well. Kieran Daly of the International HIV/AIDS Alliance pointed out that rates of disbursement to NGOs through government are very slow, therefore funding should go through other NGOs (ideally existing intermediary NGOs). Currently in Zambia, MAP funds for NGOs are being managed by government, while GFTAM funding for NGOs are going through CCM. He said this provided an ideal case study for determining which channel works best.

#### ART and user fees

As expected there were conflicting views on the issue of charging for ART. Alan Whiteside has issued a declaration on the IAEN website that ART be provided free of charge in the public sector. Mead Over challenged this, saying that the existence of significant externalities (i.e. impact of ART on prevention (both behaviours and viral load) means that a zero price is not ideal. Uganda's proposal to introduce cost sharing in its national ART scale up effort came under severe criticism.

#### Impact of large funding flows

Robert Greener, economist at UNAIDS, pointed out possible negative effects to the sector of substantial AIDS resource flows. These included:

- Inflationary effect of large HIV/AIDS expenditures (Dutch disease)
- Volatility of funding flows
- Damage of off budget expenditure
- Can undermine fiscal discipline
- Absorptive capacity

### **4. COSTS AND CONSEQUENCES OF SCALING UP TREATMENT AND CARE**

Country level treatment and care scale up efforts have largely been informed by a variety of models (egg. GOAL, ABC, AIDSTREATCOST (Abt Associates), Over, M et al (India)). Most models incorporate both costs and impact dimensions of different

interventions (except AIDSTREATCOST which focused only on costs). They also help in estimating likely HIV/AIDS spend as a proportion of total health budgets.

i) The AIDSTREATCOST model was used in Zambia and Uganda to estimate the cost to implement ART programmes, including HR requirements. To reach 4% VCT uptake in Zambia would require 50 full time equivalent lab technicians (or 15% of the entire public lab work force). Estimated annual per patient cost of providing ART (first line regimen) is \$488 in Zambia and \$483 in Uganda. ART represents 50% of this cost, and monitoring tests are the second largest cost component. This study also raises the issue that, given financial and human resource constraints, hard choices will need to be made as to who to treat: e.g. equity criteria (treat poor first), epidemiological criteria (treat those most likely to spread disease), occupation criteria (teachers and nurses first).

ii) Over, M et al have used a model to estimate costs and consequences of 3 strategies for scaling up ART in India: i) provision of free ART to those below the poverty line (BPL), ii) provision of MTCT, and iii) Adhere, which uses public funds for IEC, training and lab strengthening but relies on provision by private sector doctors. Total annual costs of BPL, MTCT and Adhere are estimated to be \$7 billion, \$1,173 million, and \$2 billion respectively. MTCT would represent 59% of the present health budget. BPL, the most expensive, would account for 62% of health and social welfare budgets combined. Sensitivity analysis was conducted to assess impact of interventions under various scenarios (including % condom use, impact of ART on behaviours and viral load.). At 90% condom use, ART would cost \$35 per healthy life year gained. Adhere was found to be the most cost effective of the three interventions. Their model incorporated the synergistic effect of ART and prevention.

In S. Africa, economic modelling and evaluation played a key role in supporting the cabinet decision to scale up treatment. It indicated ART roll out was affordable, targeting 50,000 in first year, and increasing to one million persons in next 5 to 6 years. However, it was reported actual allocations, under the health budget, have been substantially lower than those requested.

### Cost effectiveness

Jean Paul Moatti, of University of Mediterranean, felt that too much emphasis has been given to cost effectiveness analysis of ART (i.e. whether cost effective relative to prevention). What is needed is benefit cost analysis he said (has the cost of doing nothing been included?) Lilani Kumaranayake of the London School challenged this, "priority setting and cost effectiveness remain valid". We especially need to know the optimal mix of prevention and treatment for different prevalence settings. Much better knowledge of the synergistic effect of treatment and prevention is urgently required to inform resource allocation decisions.

### Drug prices and WTO

IAEN included a presentation from the Federal Reserve Bank of New York on relationship between ART drug prices and per capita income, especially how competition from generics has affected drug prices in low income countries (post 2003 and the Doha declaration). Not surprisingly, the study concluded a positive variation between drug prices and per capita income after 2003 compared to 2001.

The main conference included a presentation on "Improving WTO Rules on HIV Pharmaceutical Patents for Developing Countries" by M Wang from University of Philadelphia. She concluded major problems exist with the DOHA agreement (on



compulsory licensing and parallel import concessions). Applications are reviewed on a case by case basis, plus the range of generics currently available are limited (for example, China has only 4 generics). Currently there are no generics for second line regimen drugs. Having pointed out weaknesses of current system she then went on to propose a new approach – what is required is a new global treaty that includes better patent negotiation, as well as better monitoring.

## 5. PRIVATE SECTOR ROLE

The focus here was largely around corporate responsibility of treatment and care for employees. IAEN (and also main conference – at least the first three days) did not give much attention to other private sector delivery channels (social marketing/franchising), delivery through private doctors, issues of leakage of ARTs into private pharmacies...) – a large gap.

At the IAEN conference, two presentations concentrated on corporate sector responsibilities. The first was by Debbie Muirhead of Aurum Health Research in S. Africa who presented on the costs of initiating and delivering an employer based ART programme. The study aimed to “quantify direct financial and economic costs of ART roll out across a large workforce from the perspective of the employer – provider”. A variety of influences have lead to a number of large employers in S Africa to undertake and finance ART programmes for their employees. The study aimed to provide costs data to guide and inform other employers wishing to initiate ART. She estimated average cost per patient month on treatment across sites is \$205 (of which 63% is spent on drugs and lab monitoring). She also concluded that significant economies of scale can be achieved if the ART roll-out is centrally developed and supported. Adjusting for government salaries, she estimates that a similar programme would cost \$124 per patient/month in the public sector.

The second IAEN presentation was by Kate Taylor of the World Economic Forum on findings of a survey of WEF members (i.e. the large global corporations) on their response to AIDS and their employees. The survey elicited whether companies had AIDS policies in place, including:

- Awareness raising
- Determining HIV status
- Provision of treatment and care
- Regular monitoring and evaluation

She flashed results from a number of countries (e.g.. only 8% of Indian companies understood the likely impact of HIV/AIDS on their business).

There seems to be a general lack of information on productivity losses for companies arising as a result of HIV/AIDS. This would appear to be critical information for advocating to companies to provide treatment and care to their employees. A study by Debbie Muirhead “Firm level economic impact of HIV/AIDS: absenteeism, medical costs and turnover for a mining workplace in S. Africa” (not presented at either conference) suggests projected low losses to companies from absenteeism. The major cost would be medical costs (at 82%), and productivity losses only accounting for 6% of total cost. She explains this could be a result of existing excess capacity in production process. Also the findings do not include lost productivity while at work.

## 6. HIV/AIDS AND HEALTH SYSTEMS DEVELOPMENT

Overall, this topic did not receive adequate attention in either conference. Most discussion in this area focussed on lack of human resources for treatment and care roll out in Africa. Many spoke of the “haemorrhaging of nurses to the developed world”. Feachem mentioned the opportunity of Global Fund resources to strengthen the health sector broadly (and benefit other health problems). Over 50% of GF resources support general infrastructure development, including establishment of procurement and logistics systems, monitoring and evaluation. However, it is not yet clear if, in the latter two areas, GF resources support strengthening of government systems or creation of parallel systems.

Mead Over made the important point that it's not just a question of sufficient resources (both human and financial) – even when doctors are available in the system they are often not present at health facilities. He quoted the World Bank study in S. Asia that found 70% of doctors absent from their place of duty. Referring to WDR 2004, he said it was important to empower people, as well as strengthen incentives for service providers and accountability mechanisms e.g. through contracting (such as in Cambodia).

G Owen from Abt Associates presented their on-going study examining the impact of the Global Fund on health systems in 5 countries (SWEF). They are assessing impact in terms of:

- Policy environment
- Human resources
- Pharmaceuticals and commodities
- Public private mix

It was too early to feed back results from the study, however emerging issues for Benin and Ethiopia were:

- GF was resulting in some displacement of health care workers from non-focal health activities
- In Benin, a separate procurement and logistics system has been established for treatment and care
- Decentralisation is a major policy shift in Benin, however it is unclear the degree to which GF resources support/undermine this
- Harmonisation of cost recovery policy

There was a session on the need to better integrate HIV/AIDS into broader MCH and FP programmes. The rationale for such integration includes: similar target groups (i.e. the sexually active), both concerned with issues of gender, rights and choice, as well as violence against women.

One speaker stressed on the synergism between reproductive health and MTCT. ANC is an important entry point for HIV prevention and care. MTCT requires primary RH services, including FP. There is an urgent need for integrated packages.

Currently two models for MTCT provision exist – MTCT located in the RH division within the Ministry of Health or within the National AIDS Coordinating Body (as in India). The former provides for better integration of MTCT and RH.

Several models exist for strengthening integration of HIV/AIDS into RH programmes, for example the WHO IMPAC model.

Dr Viroj Tangcharoensathien from the Ministry of Health, Thailand drawing on the Thai experience of ART roll out, concluded that well developed health systems are key to success. He presented a useful 2 by 2 matrix on health systems and public financing.

Health System	Public Financing	
	Resources Inadequate	Resources adequate
Weak	Do not initiate ART Focus on prevention	Rehabilitate health system (esp. VCT) Focus on prevention Ensure effective small scale ART
Adequate	Limited ART Focus prevention Develop long term financial sustainability plan	Large scale up of ART Focus on prevention Ensure financial sustainability

A presentation from Nigeria of ART scale up using PEPFAR funds reported drug stock out for a period of 2 weeks.

## 7. OTHER

### i) Economic impact of HIV/AIDS

The IAEN conference, surprisingly, did not have any papers on macro-economic impact of AIDS. Some sessions, however, focussed on household level impact, including orphans. Robert Greener (economist with UNAIDS) said there are indications that household impact is more severe than considered in past, especially when inter-generational effects are considered. Changes in household consumption patterns are being picked up in DHS national household surveys.

However, another presentation by Cynthia Donovan from Michigan University challenged the assumption that AIDS related mortality results in severe labour constraints, increased poverty rates, and land scarcity among affected households. Her findings suggest lower rates of economic impact, since the prime victims tend to be younger female dependents. The greatest difference between AIDS affected and non-affected households (in terms ex post land cultivation, total land area and cultivation rates and total income) were when a male household head was lost to AIDS (which occurred in less than one third of cases sampled). They conclude this finding has important implications for mitigation efforts, such as food aid targeting or support to labour saving technologies. This implies the need for a more nuanced mitigation approach – poorer households headed by HIV/AIDS widow are most vulnerable and in need.

### ii) Prioritising who receives treatment and care

D Simion of University of Boston presented a paper on “Rationing ART in Africa, Efficiency, Equity and Reality” Scarcity of funds, HR and infrastructure mean that universal treatment and access for all (as for other health care) will take years to achieve and so some form of rationing will have to operate. Even the 3 by 5 programme aims to cover 50% of those currently in need of treatment. He pointed out that there are two main types of rationing (implicit and explicit). Explicit are those that target specific sub populations, while implicit are un-stated conditions that either favour or limit access by certain groups. Examples of explicit rationing are policies that favour the poor (e.g. MSF programmes), health workers (policy in Kenya), government staff (policy in Uganda), medical criteria (e.g. CD4 count less than 200). Other explicit approaches are based on ability to pay, and demonstration of adherence. Implicit approaches include waiting and queuing. Rationing based on queuing will allow elites to queue jump, and for a black market to emerge. He concluded his presentation by stating there is a definite trade off between efficiency and equity of ART provision.