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#4

MANAGING THE TRANSITION TO DOMESTIC FINANCING

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POLICY BRIEF #4: MANAGING THE TRANSITION TO DOMESTIC FINANCING – MEETING THE CHALLENGE OF FRONT-LOADED INVESTMENTS

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Introduction

As change sweeps through the funding environment for HIV, its vital investments will increasingly need to be sustained and managed within national budgets, without compromising other social sectors. The change comes in two main forms. First there is the ambitious plan to end AIDS as a public health concern by 2030, which calls for immediate action, and therefore funding. Success will mean zero new HIV infections, zero discrimination and zero AIDS-related deaths. The plan includes an accelerated 'Fast Track' programme to cover the first five years to 2020. 'Fast Track' aims to bring down the rate of new infections in the short-term in order to reduce the need for future resources. It plans to do this by relying on 'front-loaded' investments in HIV prevention and AIDS treatment.

Meanwhile, the nature of HIV financing is changing too, with more funding coming from the national governments of countries affected by AIDS, particularly middle-income countries.

In the decade before the financial crisis of 2008, global funding had been increasing steadily - thanks largely to bilateral and multilateral contributions from OECD countries, particularly the USA. As we work towards an AIDS free world, external donor-driven investments are unlikely to grow dramatically, while domestic resources will be increasingly important.

Here we highlight two possible strategies that could help meet the Fast Track program's short-term goals, while presenting the main pros and cons of each:

- **Establishing trust funds** - earmarked for HIV and possibly other health priorities
- **Borrowing funds** - from either external or domestic sources to increase resources in the short-term

Establishing trust funds

Trust funds are one of the instruments already used in global HIV funding. For example, the Global Fund, the most significant multilateral funding agency, is a trust fund[1]. In domestic HIV financing,

however, trust funds have played a marginal role. But now, as domestic funding increases and donor commitments drop off in some countries, they're beginning to attract more interest.

It is still, of course, early days. There is one long-standing example of an HIV trust fund in low-income countries. The AIDS levy in Zimbabwe is paid into a trust fund which has been the main channel for domestic financing of the country's HIV response since 2000. In three other countries - Kenya, Tanzania and Uganda - trust funds are in the process of clearing government and parliamentary approval, as described below.

The Zimbabwe model

Zimbabwe's National AIDS Trust Fund is a 3-percent mark-up on corporate and personal income tax. It is the principal source of domestic funding of the National AIDS Council (NAC). In 2012, it accounted for 87 percent of NAC's revenues (US$ 32.5 million out of US$ 37.6 million). Spending administered through NAC, however, accounts for only a small proportion of the total costs of Zimbabwe's national HIV response (US$ 315 million in 2012), and domestic financing (largely the AIDS levy) amounts to only 11 percent of the financing of the national HIV response.

Emerging models

Tanzania – the AIDS Trust Fund was set up in March 2015, to fund the national HIV response. It will be governed by a Board of Trustees, including two members of the Tanzania Commission for AIDS, three representatives of major donors, and one ministerial appointee. Funds will be held separate from government accounts, and may come from Parliament, loans, donations, grants, and investment income.

Uganda - an AIDS trust fund was established in the HIV and AIDS Prevention and Control Act passed in 2014. The law assigns some tax revenues to the Trust Fund, but the revenues are small compared to the costs of the HIV response or to current domestic financing. Further tax revenues will be identified by the Ministry of Finance, supplemented by grants from the domestic government or any foreign government. The trust fund will be administered by the Ministry of Health in consultation with the Ministry of Finance.

Kenya - in some ways the proposed HIV Trust Fund in Kenya is the most far-reaching proposal on the table, in terms of the scale of financing, and because it is seen as supporting the pathway to universal health coverage. It is thought 2 percent of government revenues will be assigned to the HIV Trust Fund - a rate considerably higher than in Zimbabwe or Uganda – and in line with the total recent spending through normal budget channels. The fund will also be open to contributions from other sources, and looking further ahead, the HIV Trust Fund could ease the transition to universal health coverage, contributing to the financing of HIV treatment costs under a national health insurance.

Lessons learned

While trust funds in domestic funding are largely uncharted territory, we can still draw lessons from the experience so far.

So far, trust funds have not provided a means of sustainable financing. With the exception of Kenya, where the proposed funding would cover the full amount of recent HIV spending, the amount of funding often accounts for only a small proportion of the overall costs of the HIV response (11 percent in Zimbabwe, less than one percent in Uganda). They're generally funded by conventional taxes – income taxes, excise taxes, or a cut of tax revenues overall.

Most AIDS trust funds have two key features. First, they are administered as extra-budgetary funds – spending allocations from the fund are made outside the regular budget process, with some governance and accounting structure specific to the fund. These are often designated for a specific purpose, where it is recognised the normal budget process may not yield an efficient outcome - ideal for HIV where health and financial returns are spread over decades.

Second, funding often involves some earmarked taxes, which have the advantage of providing some protection from the fluctuations of the year-to-year budget process. On both of these counts, there is considerable experience outside the sphere of HIV financing.

Establishing a trust fund can be a lengthy process. Government has to be convinced that it is a good idea, governance and accountability mechanisms

[1] A trust fund in this sense is a fund of money intended to be used for public purposes and administered separately from government

need to be set up to protect it from fraud or corruption, and other potential funders such as donors or philanthropic foundations need to be persuaded that the fund is a suitable vehicle for their resources.

Pros and cons

Trust funds offer a way of separating the HIV response from the fluctuations of the annual domestic or donor budget processes - and establishing an inviting environment for external or philanthropic contributions where government finance is insufficient. On the other hand, trust funds also reduce government's fiscal flexibility if they entail a commitment for a fixed sum or proportion of budget, as has been suggested in Kenya.

In most cases, proposals for trust funds come loaded with firm suggestions on how they should be financed, including some earmarked tax. These taxes do provide managers of the national HIV response with a fairly predictable domestic revenue stream, but if this revenue doesn't match spending needs, the funding may lead to insufficient spending allocations.

Borrowing for financing hiv responses

Borrowing - mainly from the World Bank – has always played a role in the external financing of HIV responses in some countries. But now it has been superseded by grant-based funding and borrowing now only accounts for around one percent of external HIV funding globally. However, with new lenders such as China entering the market, it would seem to be a good time to revisit whether it is feasible or advisable to borrow either internally or externally in order to finance HIV responses.

HIV programs require long-term spending stretched over decades, so there is little point in spreading the costs over a long period. But there are still three key circumstances when borrowing can be a good solution:

- to manage a **spike** in costs of an HIV response – such as the need for front-loaded investments or to ride the storm during national conflict, natural disasters and health shocks
- when a **high rate of return** covers the initial costs of intervention
- when there is justification for securing contributions from the **next generation**

Managing spikes

Borrowing can spread costs over a longer period, helping manage spikes in the cost of an HIV response, or major disruption caused by conflict, natural disasters or major health shocks, like Ebola.

Spikes in expenditure are common in more ambitious HIV programs. For example, scaling-up of male circumcision requires significant investment, but costs go down as soon as you reach the targeted coverage rate because after that you only need to circumcise new cohorts. On top of that, the intervention means there will be fewer cases of HIV to treat, while also bringing down the cost of treatment and services.

When projects with a high rate of return easily cover the initial costs

It can make sense to borrow money for some interventions because the benefit of reducing cases of HIV outweighs the initial costs over a relatively short period. Even though the costs of treating HIV have fallen steeply over the last years, this point is likely to remain relevant.

This approach, however, does bring challenges. While interventions like condom provision, can reduce costs, governments or donors might only be willing to underwrite particular, sometimes less effective interventions, for a whole host of reasons. On top of this, it is notoriously hard to predict epidemiological outcomes and financial returns - which in turn makes it hard to predict just how much an intervention will bring costs down in the long term.

The political process might also result in a situation where cost effective, and cost-saving HIV prevention interventions simply don't get enough funding. This might happen when there is a cap on overall spending,

and much of the budget is spent on treatment. In this situation, it is worth making a compelling case that additional investments in HIV prevention – possibly but not necessarily financed by higher deficits – would release fiscal space in the relatively near future. Highlighting this possibility could start a policy dialogue that unlocks additional funding.

Securing funds from the next generation

If HIV incidence is substantially reduced in line with the Fast Track strategy, young people entering adulthood in 2030 or beyond are far less likely to contract HIV than at present - and if they do get infected, they're far more likely to survive due to high treatment coverage. Debt financing introduces the logic of sharing the cost with future generations, who will benefit from the money spent now to end AIDS. Borrowing effectively passes on some of the costs to the next generation, who will need to service the debt in future years.

It 'could' doesn't mean it 'should'

The challenges of HIV financing have been linked with the issue of sustainability of public debt. The net present value of future HIV-related costs may be thought of as an 'HIV debt'. If, as in some cases, the IMF thinks a level of public debt of 70 percent of GDP is problematic, and the HIV 'debt' is a similar amount, fiscal adjustment could prove a significant fiscal and political challenge. The international practice of donors recognizes this point, prioritizing not only countries with high HIV prevalence, but also countries with low GDP per capita, where the HIV 'debt' relative to GDP tends to be high. This could also be allied with concessional lending at low interest rates, or by the use of donor funding to buy down debt in the future. New lenders, such as the Government of China, may also be willing to lend at lower interest rates than have been experienced by low-income countries in the past.

The analogy to debt has also been used to assess whether a country with a low level of public debt could finance the HIV response by borrowing. Technically this method is logical, but from a fiscal perspective it is problematic. First, if the proponents of the HIV response can't convince the government to fund the HIV response from current revenues, the Ministry of Finance will be just as reluctant to commit future revenues (which is what borrowing does). Second, when it is wise to finance the HIV response through debt (because of spikes, high return programs or involving the next generation), the level of public debt is largely irrelevant.

Conclusion

There are considerable challenges facing low- and middle-income countries to scale up their coverage for health and HIV, while also meeting the short-term needs to front-load investments in HIV prevention in order to minimise the long-term costs. This brief has looked at two of the options that might be considered.

Trust funds can provide a useful vehicle for channeling government budget contributions and combining them with contributions from internal and external sources, including donors. In this way, they might offer a way to ensure that funding is able to respond to the challenge of front-loading without distorting other budget allocations. However, the process of establishing well-governed trust funds and clearing all of the political and administrative approval can be lengthy and complex.

With regard to borrowing, there are plausible arguments for passing on some of the costs of HIV programmes to future programmes through borrowing, but there are also sound fiscal and policy reasons why governments would be reluctant to do so. Ultimately the balance between these is a matter for governments to decide, and is more likely to be feasible in middle-income rather than low-income countries. The issue cannot however be divorced from the need to persuade governments and either domestic or external lenders that allocating either current or future resources to HIV programmes is a sound investment.

GUIDANCE NOTE: BORROWING FOR FINANCING HIV RESPONSES

This note[1] provides an overview of the role of borrowing in financing HIV responses, discusses the case for (and against) borrowing, and gives some recommendations on the use of borrowing in financing HIV responses.

The Role of Borrowing for Financing the HIV Response So Far

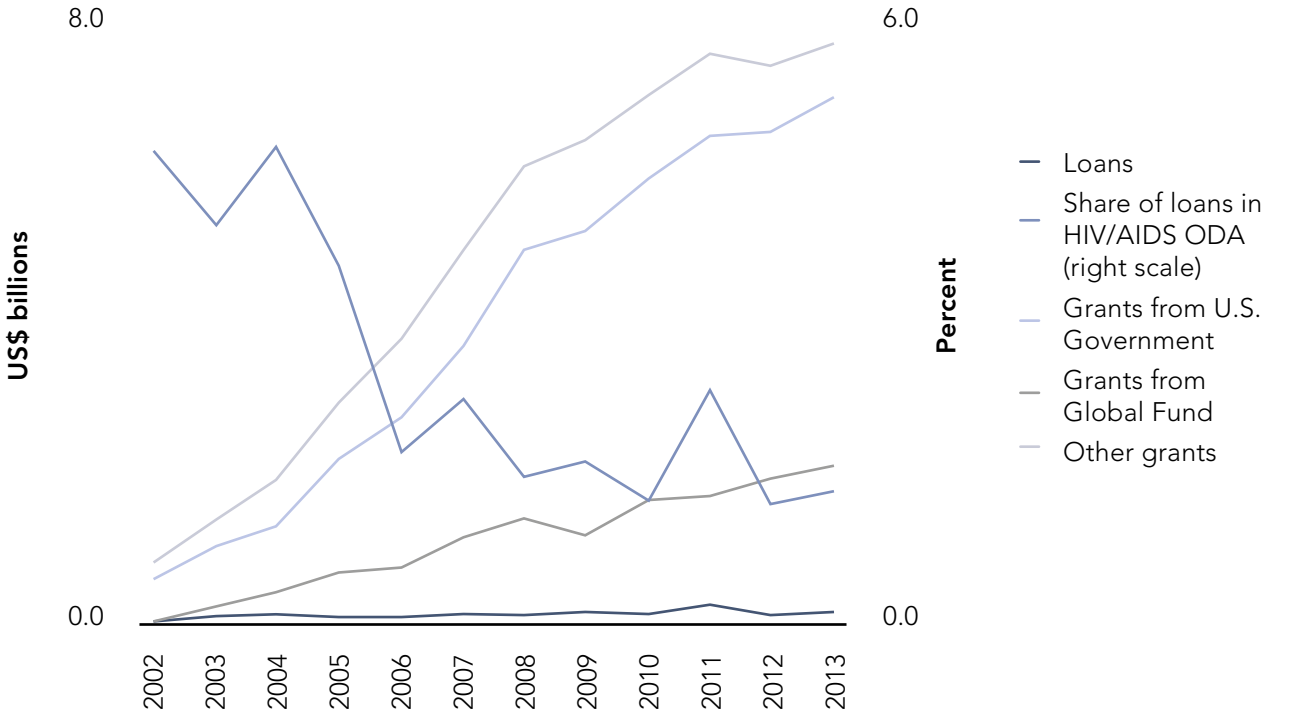
Borrowing has played a role in the external financing of HIV/AIDS responses from the dawn of time. Especially the World Bank has played a major part in financing HIV/AIDS programs in the early stages of the HIV response, but its role has receded as grant financing became the dominant source of external funding. Figure 1 summarizes data on official development assistance for HIV/AIDS programs, distinguishing between grants and loans. As of 2002, loans – almost entirely from the World Bank – accounted for 5 percent of external financing of HIV responses.[2] The 10-fold increase in HIV/AIDS funding between 2002 and 2013 was almost entirely accounted for by steep increases in grants from the U.S. Government and the Global Fund. The share of loans in external HIV financing consequently declined to one percent. Overall, the World Bank board

[1] Prepared by Markus Haacker, mhaacker@hsph.harvard.edu, under contract to UNAIDS (contact: Nertila Tavanxi, tavanxhin@unaids.org).
[2] Over the period 2002 to 2013, the World Bank (US$ 1.06 billion) accounted for over 90 percent of loan financing of HIV responses (US$ 1.17 billion). Almost all of the balance reflected one project between Germany and China.

has approved US$ 3.1 billion in HIV/AIDS-related loans between 1988 and early 2012 (World Bank (2015, 2015b).[3] Of this, US$ 2.5 billion were disbursed, and US$ 1.7 billion of the latter had not been repaid to the World Bank as of February 2015.[4]

F.1

OFFICIAL DEVELOPMENT ASSISTANCE IN SUPPORT OF HIV/AIDS RESPONSE ($US MILLIONS, UNLESS OTHERWISE)



Source: OECD, 2015

The role of domestic (or non-ODA external) borrowing to finance HIV/AIDS programs is more difficult to establish. Domestically financed public HIV/AIDS spending could be financed by reducing expenditures in other areas, raising additional taxes, and borrowing. However, as the budgets do not show how specific expenditures are being financed, data on domestic borrowing in support of HIV/AIDS programs is essentially unavailable.

[3] Calculated based on occurrence of the terms HIV, AIDS, VIH, or SIDA in the project name.
[4] These numbers understate the World Bank's role in HIV/AIDS financing, as they do not include projects which do not headline HIV/AIDS but do include an HIV/AIDS component. World Bank (2008) identifies stand-alone HIV/AIDS projects with commitments totaling US$ 1.7 billion, and projects including HIV/AIDS components with commitments over US$ 460 million until 2007.
[5] A similar argument applies to donors' financing of grants – these grants could be financed by borrowing, increasing tax revenues, or expenditure cuts in other areas. However, because there is no direct connection between HIV/AIDS spending and its financing, and as HIV/AIDS financing and contributions to international organizations like the Global Fund account for a small proportion of government spending in donor countries, it is not possible to assign spending on the HIV response to specific sources of financing.

Three Cases for Debt Financing of Government Expenditures

Borrowing does not create additional fiscal space per se, but provides the government with additional resources early on, while constraining its resources later on through interest payments and as a loan is repaid. For this reason, high rates of borrowing to finance the government's regular operations are normally ill-advised. An increasing level of debt service would progressively erode the government's financial resources, and the high levels of government spending would eventually become unsustainable.

There are, however, a number of circumstances when borrowing is a sensible policy, by addressing specific needs or in consideration of the outcomes of the expenditures financed in this way. Three such circumstances are discussed below, although it should be noted that they are not mutually exclusive and all three aspects might apply at the same time.

- **Accommodating a shock to government revenues, a spike in expenditures, or both.** The most common examples are armed conflicts, natural disasters, and health shocks. This point is illustrated below by reference to the fiscal response to Ebola. Additionally, certain projects (e.g., construction of large power plants) require high expenditures over a short period, and borrowing is a means of spreading the costs and avoiding temporary squeezes in other expenditures.

- **Inter-generational equity aspects.** If the benefits of public spending are spread over long time periods, debt-financing is a means of collecting contributions from the beneficiaries later on.

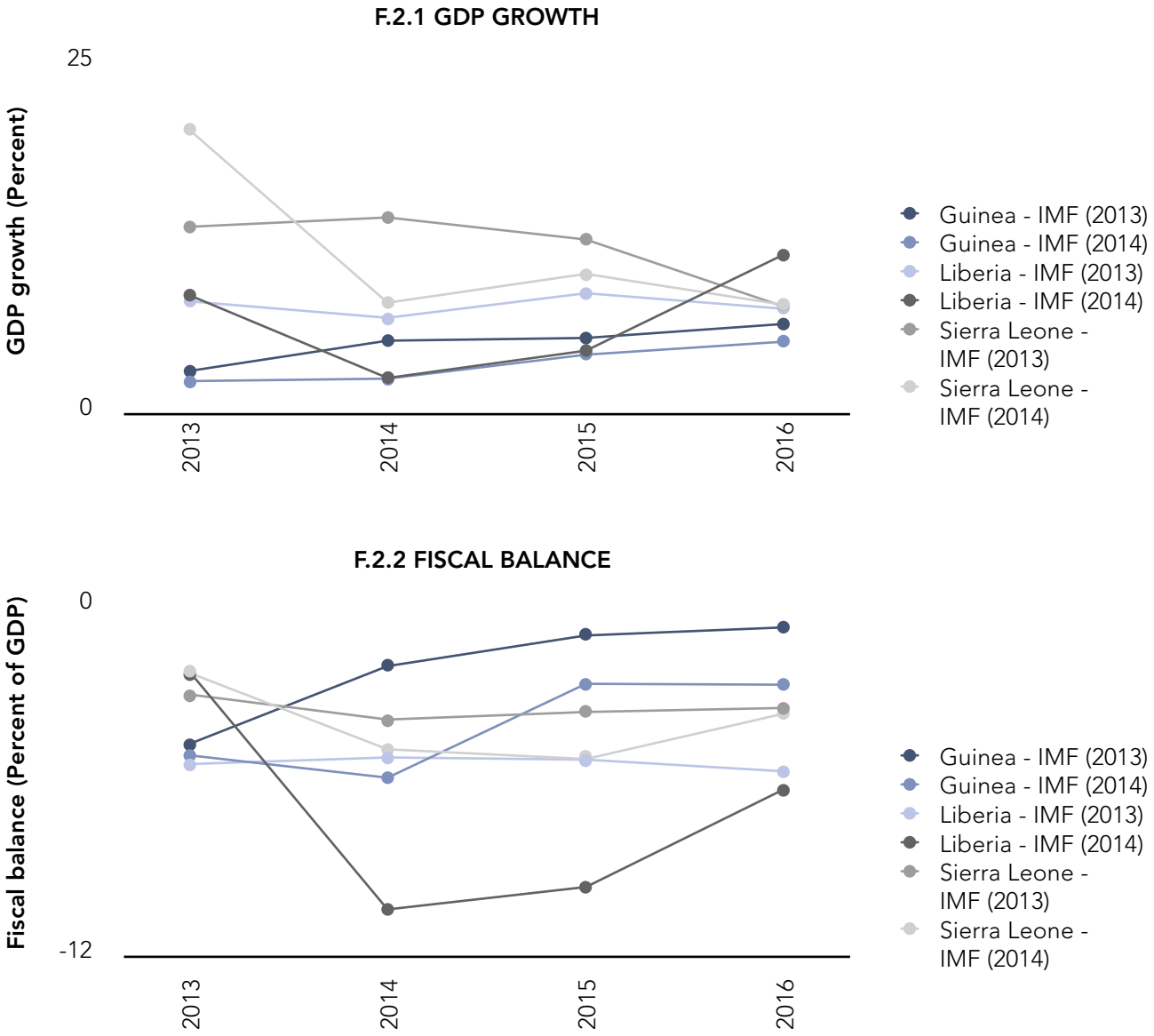
- **Financing projects with a high rate of return.** Some public investment projects generate fiscal revenues (directly or through increased tax revenues) so that they increase fiscal space, i.e., the financial returns are more than enough to re-finance the initial costs.

HIV/AIDS is Unlike Ebola…

Some shocks – natural disasters, armed conflicts, or health emergencies – impose a steep fiscal cost and may at the same time disrupt the economy and therefore government revenues. The most significant recent example is the Ebola epidemic, the economic and fiscal consequences of which are illustrated in Figure 2, which compares projections of key macroeconomic indicators (GDP growth and the fiscal balance) published by the IMF in October 2013 (preceding the Ebola epidemic) and October 2014 (near its peak). In each country, GDP growth was reduced by several percentage points in 2014 and 2015, but is expected to recover by 2016. More relevant here, the Ebola epidemic has resulted in a steep deterioration in the fiscal balance in 2014 and 2015, amounting to up to 5 percentage points (Liberia, 2014), but by 2016 is expected to return to a value close to what was projected before the onset of the Ebola epidemic.[6]

[6] The difference between the WEO estimates and projections from October 2013 and October 2014, respectively, also reflect updates not related to Ebola. Also for this reason, the 2013 estimates (preceding the arrival of Ebola) have changed, most visibly for GDP growth in Sierra Leone. To establish that the deterioration in the macroeconomic indicators principally reflects the impact of Ebola, a number of IMF staff reports which discuss the impact of Ebola have been reviewed (see IMF (2014b, 2014c, 2014d)).

F.2 KEY ECONOMIC INDICATORS FOR GUINEA, LIBERIA, SIERRA LEONE, 2013-2016



Source: IMF (2013, 2014)

This means that the governments have accommodated the revenue losses and increased expenditure needs associated with the impact of and response to Ebola at least in part by borrowing rather than compressing expenditures in other areas, and are thus spreading the costs over a longer period. The response to Ebola, though, does not offer a template for HIV/AIDS financing, because HIV/AIDS programs represent long-term spending needs extending over decades, whereas Ebola represents a spike in financing needs concentrated over one or two years. This means that, unlike in the case of Ebola, there is not much of a point in spreading the costs of the HIV/AIDS response over a longer period.

… But Some HIV Programs Envisage Spikes in Expenditure Early On

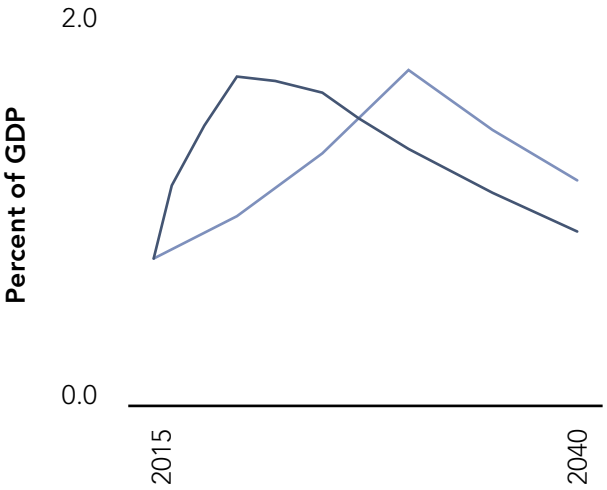
However, ambitious HIV programs tend to envisage a steep increase in expenditures early on, but this expenditure may decline in subsequent years, in percent of GDP if not in absolute terms. This partly reflects that the programmed expenditure increase includes items like the scaling-up of male circumcision requiring lower expenditures once the targeted coverage rate is reached, and – more significantly – that reduced HIV incidence eventually results in lower costs of treatment and other services.

This point is illustrated in Figure 3, showing an example in which domestic financing needs are projected to increase steeply over the next 5 years, and the government wishes to slow down the absorption of current government revenues by the HIV response.[7] For this reason, it financed some of the initial build-up in costs by borrowing, which peaks at 0.8 percent of GDP in 2020 and contributes to an increase in public debt of 4.9 percent of GDP by 2026. The evolution of debt service (interest and repayments) is illustrated in Figure 3.2, the amount is assumed to be fully repaid by 2040.

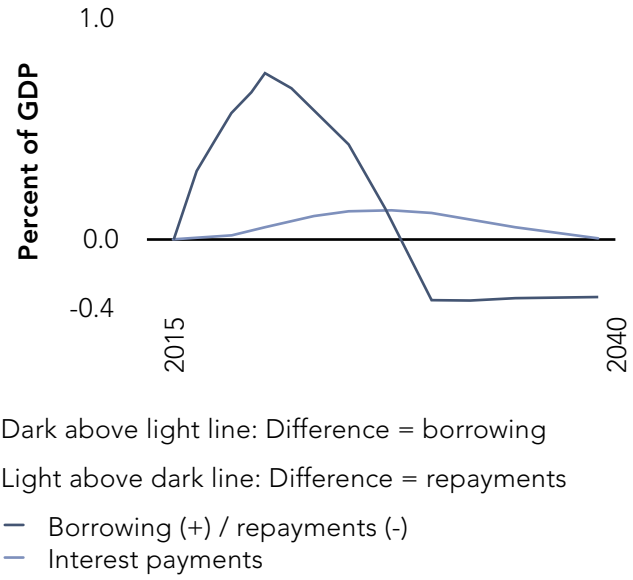
F.2

KEY ECONOMIC INDICATORS FOR GUINEA, LIBERIA, SIERRA LEONE, 2013-2016

F.3.1 CURRENT COSTS VS. ABSORPTION OF CURRENT REVENUES,2015-2040



F.3.2 BORROWING,REPAYMENTS, AND INTEREST BURDEN, 2015-2040



Source: IMF (2013, 2014)

[7] The example is generic and not based on a specific country case. The interest rate is set at 3 percent, and it is assumed that GDP grows at a rate of 5 percent annually. Because GDP in later years is larger, the area in Figure 3.2 representing repayments is smaller than the area representing borrowing.

Some HIV Spending Creates Fiscal Space

In the literature on the cost-effectiveness of HIV prevention interventions it is frequently pointed out that some interventions are cost-saving, i.e., the financial savings resulting from reduced HIV incidence outweighing the costs of achieving it. Even though the costs of HIV treatment have fallen steeply over the last years, this point is likely to remain relevant. In a "90-90-90" scenario,[8] an individual who contracts HIV can expect to obtain treatment early, and remain on treatment for several decades – even at annual costs of treatment around US$ 300, each HIV infection would result in a cost of several US$ 1,000, higher than many of the estimates reported for the costs per HIV infection averted for across HIV prevention interventions (see, e.g., Galárraga and others (2009), Bertozzi and others (2006), Canning (2006)).

Testing the current HIV/AIDS strategy in terms of the contributions of various interventions to reducing the number of HIV infections, and – considering the strategy's objectives in terms of treatment access and other services to people living with HIV – the financial savings which can be attributed to the various HIV prevention interventions, can therefore provide pointers to (i) scope for improving the cost-effectiveness of the HIV response overall (not the focus of this guidance note), and (ii) scope for additional HIV investments which can be refinanced from the resulting savings (Haacker, 2015). Where there is no more scope for soliciting additional funding from current revenues, the projected savings would provide an inducement for financing the expenditures through an increased fiscal deficit – and because the additional debt could be repaid from the resulting financial savings, the operation would overall release fiscal space – for financing other aspects of the HIV/AIDS response or other government policy priorities.

There are a number of challenges in following this path. While the HIV response usually contains a number of interventions which are cost-saving, like condom provision, these might be the most accepted parts of the program, whereas the interventions affected by decisions about the scale of HIV/AIDS spending that the government or donors might be willing to underwrite could be the less effective ones. Moreover, both the cost projections and the epidemiological projections are subject to a high degree of uncertainty, and so are the estimates of the financial returns to additional investments in the HIV response.

On the other hand, the political process might also result in a situation in which highly cost-effective, and cost-saving, HIV prevention interventions do not receive sufficient funding. This could be an outcome if there is an upper limit to the resources the government is willing to commit, and much of this is absorbed by treatment costs. In this situation, making a compelling case that additional investments in HIV prevention – possibly but not necessarily financed by higher deficits – would release fiscal space could contribute to a policy dialogue towards unlocking additional fiscal resources.

The point whether an HIV intervention is cost-saving is related to, sometimes conflated with, but distinct from the question on whether the

[8] Under the "90-90-90" targets, by 2020 90 percent of people living with HIV will know their status, 90 percent of those knowing their status will receive treatment, and 90 percent of those receiving treatment will achieve viral suppression. Under these objectives, people living with HIV will generally obtain treatment a few years after they become infected.

economic returns (Resch and others, 2011) exceed the costs. The question of economic returns plays a role in welfare economics because a government intervention which results in economic returns exceeding the costs could theoretically be financed by additional taxes in a way that leaves everyone better off. This reasoning, however, does not translate to the context of HIV/AIDS, because most of the "economic returns" reflect increased survival of people living with HIV rather than improved productivity (as in a typical macroeconomic context) – because most of the "economic returns" is absorbed by cost of living of the people surviving, they cannot be used – by taxing the gains – for refinancing the costs of the underlying HIV interventions. Positive economic returns exceeding the costs of the underlying HIV interventions therefore do not provide a motive for additional HIV/AIDS financing by borrowing along the lines discussed in this section.

Passing On The Buck

Large investment projects are typically financed by loans, because they are bulky (so that it does make sense to spread the costs and minimize temporary shifts in expenditures on other government priorities, discussed earlier), and because the benefits are spread over time, possibly over decades. Debt financing in this context is an instrument for passing some of the costs to the beneficiaries, who will need to service the debt in future years. On the other hand, there are certain types of government expenditure such as education which primarily benefit a future generation but which are not normally financed by debt, but are part of a social contract whereby one generation funds the education of the respective next generation.

Aspects of the response to HIV have the character of investments for the benefit of a future generation. This link is explicit in the goal of an "AIDS-free generation". More generally, under the objective of ending AIDS and the 90-90-90 agenda, young people entering adulthood in 2030 or beyond would face a much reduced prospect of contracting AIDS (and if they do get infected, an increased survival prospect). Financing part of the HIV response by loan is a vehicle for extracting a contribution from this generation of beneficiaries. In contrast, the model of a social contract between generations, as it applies in the case of education spending, does not fit because "ending AIDS" is a one-off project.

"It Could" Does not Mean It Should

The semblance of the spending commitments under the HIV response to a debt has motivated linking the challenges of HIV financing with the issue of sustainability of public debt (see, e.g., Lule and Haacker, 2012).[9] If, for example, the IMF considers a level of public debt of 70 percent of GDP as problematic for fiscal and macroeconomic stability,iii and the HIV "debt" (the present discounted

[8] Under the "90-90-90" targets, by 2020 90 percent of people living with HIV will know their status, 90 percent of those knowing their status will receive treatment, and 90 percent of those receiving treatment will achieve viral suppression. Under these objectives, people living with HIV will generally obtain treatment a few years after they become infected.

value of the costs of the HIV program) is at this order of magnitude, this means that the magnitude of fiscal adjustment (e.g., expenditure cuts, or assigning the bulk of new revenues to HIV/AIDS) required to fund these costs is a very significant fiscal and political challenge. The international practice of donors recognizes this point, prioritizing not only countries with high HIV prevalence, but also countries with low GDP per capita where the HIV "debt" relative to GDP tends to be high.

The analogy to debt has also sometimes been used to assess whether a country with a level of public debt below the thresholds used in debt sustainability analyses could finance the HIV response by borrowing. Technically this point is correct, but from a fiscal perspective it is problematic. First, if the proponents of the HIV response are not successful in convincing the government to fund the HIV response from current revenues, the Ministry of Finance will be similarly reluctant to commit future revenues (which is what borrowing does). Second, the reasons discussed here on when borrowing is a sensible policy to finance the HIV response – managing the profile of spending, enabling investments which expand fiscal space, extracting contributions from future beneficiaries of current HIV policies – apply irrespective of the level of public debt. Conversely, if these conditions are not met, there is no valid reason for debt-financing of the HIV response.

Conclusions

Borrowing, notably from the World Bank, has played an important part in the emerging HIV response, but has been superseded by a grant-based funding model and now accounts for only about one percent of external HIV funding. There are no data available on domestic borrowing specifically in support of the HIV response, as the domestic financing is part of the overall government budget.

- Looking ahead, this note identifies three circumstances under which borrowing is a sensible policy of funding the HIV response by government of affected countries. These conditions overlap, and more than one can apply at the same time.

- Borrowing to manage spikes in the cost of the HIV response. E.g., high costs over a number of years could be spread over a longer period, or a steep increase in costs of the HIV response could be accommodated more gradually (Figure 3), to avoid sudden disruptions to expenditure programs in other areas.

- Borrowing to enable additional HIV investments which expand fiscal space. Whether or not this plays a role does not only depend on the financial savings (treatment costs etc.) resulting from investments in HIV prevention, but also on how the policy discourse on HIV financing plays out – the interventions for which additional financing is sought may not be the most cost-effective or "cost-saving" ones.

- Borrowing is a means of eliciting a contribution from some of the beneficiaries of current HIV policies, e.g., the next generation who – because of the "end of AIDS" – would face a much improved disease environment.

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GUIDANCE NOTE: TRUST FUNDS FOR FINANCING HIV RESPONSES

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This note[1] discusses the role of trust funds in the practice of and the policy discourse on the sustainable financing of HIV/AIDS responses, and also draws lessons from the non-HIV/AIDS-specific literature on earmarked taxes and extrabudgetary funds.

Introduction

Proposals for establishing trust funds have played a role in the recent policy dialogue on domestic HIV/AIDS financing.[2] However, there is only one long-standing example of a trust fund in this area – the AIDS levy which has been the main channel for domestic financing of the HIV/AIDS response in Zimbabwe since 2000. The note provides a stocktaking and discussion of this levy and of the situation in some countries (Kenya, Tanzania, Uganda) where efforts to introduce a trust fund are advanced, and discusses trust funds from a broader public finance perspective.

[1] Prepared by Markus Haacker, mhaacker@hsph.harvard.edu, under contract to UNAIDS (contact: Nertila Tavanxi, tavanxhin@unaids.org. The terms of reference HIV specified "a short paper of 5 pages or so outlining the pros and cons of HIV trust funds as a mean integrating HIV financing in countries of different socio-economic status, HIV domestic financing and epidemiology with quick references to cases where they have been used so far and recommendations for the future."

[2] See, for example, SADC (undated), UNAIDS (2013), or Wilson and others (2014).

Definition of Trust Funds

In the context of domestic HIV/AIDS financing, trust funds may be defined by two (or three) properties.

First, they are administered outside the government's regular budget process as *extrabudgetary funds*. While the fund might be predominantly funded from public sources, it is a separate entity (at least from an accounting perspective), and spending is determined outside of the government's annual budget process, according to the purpose of the fund, typically by an appointed board. Regarding the funding, it is useful to distinguish two types of trust funds. In an endowment-based fund, the fund administers some assets, and finances its operations from interest income, and additionally draws down from or adds to its endowment. The second and more common type in the context of HIV/AIDS type is a scheme in which operations are predominantly funded by current revenues, i.e., all or most of its revenues would come from the government transfer (in addition to external grants, private contributions, and own income, e.g., from interest).[3]

Second, of course, an HIV/AIDS trust fund is defined by its *purpose*. This purpose could be broadly defined as the financing of the HIV/AIDS response, but it could also underwrite specific activities or benefits certain populations living with or at high risk of contracting HIV.[4]

Third, although this is not necessarily part of a trust fund, in many cases proposals for establishing a trust fund assign specific revenues (e.g., a share of or mark-up on income tax) to the fund. Thus, *earmarked taxes* are an important aspect of the policy discourse on establishing trust funds.

Current Practice and Developments

Trust funds have been an important aspect of the global discourse on HIV/AIDS financing,[5] and one of the most important instruments for global HIV/AIDS financing, the Global Fund, is a trust fund. In contrast, trust funds have played a marginal role in domestic HIV financing in developing countries. This has changed over the last years, in the context of increasing domestic responsibility for the funding of the HIV/AIDS response, and trust funds have been discussed as one instrument to achieve sustainable domestic financing.[6]

The only long-standing example of a trust fund in support of the HIV/AIDS response is the AIDS levy, or National AIDS Trust

[3] Similarly, funds in the context of pensions and social security are classified in "funded" and "unfunded" schemes. In a funded scheme, the pension funds liabilities (its members' pension claims) are "funded" by its assets, accumulated from its members' contributions. In an "unfunded" scheme, pensions are financed from current contributions by members (see Lievens and others (2015) for a more detailed discussion). This note shies away from this terminology of "funded" vs. "unfunded" schemes because the terms "fund" and "funding" are also used with different meanings.
[4] This note is primarily concerned with trust funds in support of the HIV/AIDS response overall. An example for trust funds in support of specific populations are the funds set up in support of people living with HIV infected through unsafe blood, which were set up in a number of developed economies.
[5] E.g., the influential Harvard "consensus statement" (Members of the Faculty of Harvard University, 2001) called for the establishment of an HIV/AIDS trust fund.
[6] In addition to the cases discussed here, Lievens and others (2015) refer to efforts to establish a trust fund in Botswana, Namibia, and South Africa.

Fund, set up in Zimbabwe in 1999.[7] The AIDS levy is a 3-percent mark-up on the corporate and personal income tax. It is administered by and is the principal source of domestic funding of the National AIDS Council (NAC) – in 2012, it accounted for 87 percent of NAC's revenues (US$ 32.5 million out of total revenues of US$ 37.6 million).[8] Spending administered through NAC, however, accounts for only a small proportion of the total costs of Zimbabwe's national HIV response (US$ 315 million in 2012), and domestic financing (largely the AIDS levy) amounts to only 11 percent of the financing of the national HIV/AIDS response.

In Tanzania, the establishment of a trust fund has been on the table for several years,[9] and the AIDS Trust Fund was recently (March 25, 2015) established by Act of Parliament (Government of Tanzania, 2015). The purpose of the AIDS Trust Fund is the funding of the national response to HIV/AIDS. The trust fund will be governed by a Board of Trustees including two members of the Tanzania Commission for AIDS, three representatives of major donors, and one ministerial appointee. Funds will be held separate from government accounts. Details on the composition of anticipated funding are not available in the public domain, the Act – among other sources – refers to appropriations from Parliament, loans, donations, grants, and investment income.

In Uganda, an AIDS Trust Fund had also been under discussion for several years. An AIDS trust fund was established in the (otherwise controversial) HIV and AIDS Prevention and Control Act passed by Parliament in May and signed by the President in August 2014. The law assigns some tax revenues directly to the Trust Fund, these revenues however are very small compared to the costs of the HIV/AIDS response or current domestic financing.[10] In addition, it envisages further tax revenues identified by the Ministry of Finance, and grants from the domestic government or any foreign government. The trust fund will be administered by the Ministry of Health in consultation with the Ministry of Finance.

The proposed HIV Trust Fund in Kenya in some ways is the most far-reaching proposal on the table – in terms of the scale of financing, but also as it is seen as a contribution on the pathway to universal health coverage. According to the Kenya AIDS Strategic Framework (NACC, 2014), it is proposed that 2 percent of government revenues (about 0.4 percent of GDP) are assigned to the HIV trust fund, a rate considerably higher than in the Zimbabwe or Uganda,[11] as it is projected that the Government of Kenya will have to assume a much higher share of the costs of the HIV/AIDS response than at present.[12] Looking further ahead, the HIV Trust Fund could ease the transition to universal health coverage, contributing to the financing of HIV treatment costs under a national health insurance.

[7] For more details on the AIDS levy in Zimbabwe, see Madzingira (2008), Manenji (undated), National AIDS Council of Zimbabwe (2015, 2014, undated, undated (b)), UNAIDS (2012).
[8] Source: National AIDS Council of Zimbabwe, 2013.
[9] Vice President Bilal announced the government's intention to set up a trust fund as early as 2011 (Bilal, 2011).
[10] The act assigns "two percent of the total tax revenue collected from levies on beers, spirits or waragi, soft drinks and bottled water" to the AIDS Trust Fund. As these levies accounted for USh 267 billion in 2014 (Government of Uganda, 2015), equivalent to about US$ 103 million, 2 percent of these levies therefore account for about US$ 2 million, or 0.01 percent of GDP. In contrast, the funding projections for the HIV investment case contained in the latest "progress report" (Uganda AIDS Commission, 2014) envisage domestic funding going up from US$ 37 million in 2014 to US$ 73 million in 2018.
[11] This percentage is considerably higher than in Uganda (about 0.05 percent of government revenue assigned directly to the trust fund) and in Zimbabwe (about 0.9 percent of government revenue, and 0.25 percent of GDP)
[12] According to the latest NASA report, funding from the Government of Kenya accounted for about 20 percent of HIV/AIDS spending from public domestic or international sources in 2011/12.

Appraisal of Recent and Current Practice

The experience with trust funds as an instrument for financing HIV/AIDS responses is thin. In countries facing substantial HIV epidemics and financing challenges, only one long-standing example of a trust fund in support of the HIV/AIDS response is known, and in only a few more have trust funds cleared government and parliamentary approval and are heading towards implementation.

Nevertheless, a couple of lessons can be drawn from the experience. First, trust funds *per se* are not a means of sustainable financing, and the funding modalities are all but innovative. The amounts of funding committed to HIV trust funds (with the exception of the proposed fund in Kenya) account for a small proportion of the costs of the HIV/AIDS response (11 percent in Zimbabwe, less than one percent in Uganda). Whereas proposed trust funds are frequently cast under an "innovative financing" heading (UNAIDS (2013), Wilson and others (2014)), the current or proposed funding of trust funds is based on very conventional taxes – income taxes, excise taxes, or a cut of tax revenues overall.

There are two elements which are common to all or most current or proposed AIDS trust funds. First, they are extrabudgetary funds – spending allocations are made outside the regular budget process, and there is some governance and accounting structure specific to the fund. Second, in at least three or four cases, funding involves some earmarked taxes, which – together with the first aspect – provides some insulation or from the year-to-year budget process. On both of these counts, there is considerable experience outside the sphere of HIV/AIDS financing.

Trust Funds as Extrabudgetary Funds

HIV trust funds, by definition, are *extrabudgetary funds*, which occur frequently in government finance. For example, Ojiambo, Irungu, and Kitheka (2011) review 46 such entities in Kenya (one of the countries where a trust fund is under discussion). Allen and Radev (2010) find that transfers to extrabudgetary funds account for 9.4 percent of government expenditures across 23 transition/ developing countries. For these reasons, there is a body of literature on extrabudgetary funds (or "extrabudgetary units" as in IMF (2014)) in general, which may provide lessons on HIV trust funds.

Among the 13 objectives for which extrabudgetary funds are established listed by Allen and Radev (2010), 3 are particularly relevant in the context of HIV/AIDS – special funds (established for a specific purpose), development funds (established to support development programs usually involving donor contributions and sometimes internal sources), and revolving funds (which are not subject to budget rules that require budgetary appropriations to expire at the end of the year).

There are two common reasons for setting up a special fund. First, the fund may administer a levy collected for a specific purpose, e.g., a car or fuel tax that is earmarked for road maintenance. Second, and more relevant in the context of HIV, the government may set up fund in recognition that the budget process may not yield an efficient outcome.

In the case of HIV/AIDS, this may be the case because HIV prevention interventions are long-term investments, of which the health and financial returns are spread over decades (in this regard, resembling road funds). A perception that there is a political willingness to underwrite urgent care for people living with HIV, but not investments in HIV prevention with superior cost-effectiveness in terms of achieving health outcomes, could reflect such inefficiencies in the budget process. Also, stigma could result in insufficient budget allocations on interventions benefitting populations like female sex workers or men who have sex with men, and outsourcing the decisions on spending allocations within the HIV/AIDS budget to an agency with a public health mandate could result in a more efficient outcome.

Some AIDS trust funds exhibit features of a development fund, involving contributions from donors as well as the domestic government The intention to utilize the AIDS trust fund as a conduit for both domestic and external funding is apparent in the law on the AIDS trust fund in Tanzania, where one-half of the members of the Board of Trustees are drawn from major donors. The AIDS Trust Fund of Zimbabwe was also originally conceived to attract external grants and this dimension never took off because its establishment coincided with a breakdown in donor relations (Madzingira, 2008). Following this model could be sensible under two circumstances. First, donors may be unwilling to entrust the government with funds directly, because of a perceived lack of transparency in the public accounts. Setting up a fund separate from the government's accounts, with accounting standards that meet donors' demands, could help address this problem.[13] Second, establishing an HIV/AIDS trust fund could be a sensible financing arrangement in a transition to increased domestic ownership and financing of the HIV/AIDS response, with donors – in addition to the domestic government – contributing through the trust fund.

Finally, HIV trust fund could help address complication to the management of the HIV program associated with the annual budget cycle. Some of the expenditures of the HIV program (notably tenders for drug purchases) bulky and occur infrequently. If budget allocations expire at the end of the financial year, this could complicate the financial management of the HIV/AIDS response.[14] In contrast, if unspent funds remain in the trust fund, considerations on the annual budget cycle need not constrain procurement.

Earmarked Taxes

One of the properties of most AIDS trust funds – under preparation or at work – is funding, at least in part, by some earmarked tax. In Zimbabwe, the AIDS levy of 3 percent of corporate or personal income tax due covers most of the operating costs of the National AIDS Commission (which however accounts for only 11 percent of the costs of

[13] The administration of funds provided by the Global Fund could be interpreted in this way.
[14] The more substantial management problem with regard to the timing of revenues and expenditures, however, is the reconciliation of a cost-effective HIV/AIDS program and the associated profile of expenditures over time (which may involve a bump in spending early on) and the time profile of projected or targeted revenues. This problem is not necessarily addressed by a trust fund. See also discussion under earmarked taxes.

the national AIDS response); in Kenya, it is envisaged that an earmarked share of tax revenues overall would finance a substantial and increasing share of the costs of the national AIDS response; and in Uganda, the law establishing the AIDS trust fund earmarks a share of excise taxes on certain products (which however would cover only a very small share of the costs of the HIV/AIDS response).

Thus, contributions from earmarked taxes to the costs of the HIV/AIDS response range from a substantial share of the costs to an insignificant amount. Setting up a trust fund supported by earmarked taxes per se thus does not contribute to the financial sustainability of the HIV/AIDS response. The critical issue instead is how the costs of the envisaged HIV/AIDS response relate to projected funding, including a commitment from the national government (which does not need to come in form of an earmarked tax) and from donors.

Instead, advocacy for earmarked taxes for financing HIV/AIDS trust funds could rest on considerations in the area of political economy. First, if commitments on the domestic financing of the HIV/AIDS response are part of a grand bargain with donors on future funding, a high-level explicit commitment (in some cases set down in a law) on the part of the domestic government could motivate donors to commit to fund a share of the HIV/AIDS response in the future. Second, earmarked taxes isolate HIV/AIDS funding from the yearly budget process (but only if the earmarked funding accounts for all or most of domestic funding, as in Zimbabwe).

There are, however, a number of shortcomings in the use of earmarked taxes to finance an HIV trust fund. In general, earmarked taxes reduce the capabilities of policy makers to respond to changing circumstances and shifting priorities (Potter and Diamond, 1999). More concretely with regard to HIV/AIDS, none of the proposed earmarked taxes are closely linked to the demand for HIV/AIDS services. Earmarked taxes (unless they account for only a small proportion of domestic funding) therefore introduce rigidities to HIV/AIDS spending allocations. In the interest of attaining the best value for money, including by allocating spending most effectively over time, a scheme based on earmarked taxes would therefore need to be complemented by a mechanism to vary expenditures around the expected revenues, by borrowing (and repaying when the costs of the HIV/AIDS response come down) or accumulating some savings to accommodate anticipated expenditures or fluctuations in funding. One useful illustration of these issues is contained in the recent Kenya AIDS Strategic Framework – over the first years, the identified funding sources (including an earmarked share of tax revenues) are insufficient to meet the costs of the proposed HIV/AIDS response, but the funding exceeds the costs after several years, and these surpluses could be used to finance the earlier deficit. If borrowing, or convincing donors or the government to provide more funding over a number of years, is not feasible, the pace of the initial scaling-up of HIV/AIDS services would have to be slowed down.

Conclusions

Trust funds have been part of the policy discourse on the financing of the HIV/AIDS response for many years, but mainly on the global level, and the most significant multilateral funding agency, the Global Fund, is a trust fund. In terms of the

financing of national HIV/AIDS responses, trust funds have been discussed in recent years in the context of increased domestic responsibility and a slowdown in donor commitments. However, the experience to date is thin, and there is only one example of a trust fund in support of the domestic HIV/AIDS response from countries facing a severe HIV epidemic and steep financing challenges.

Trust funds are seen as an instrument of isolating the HIV/AIDS response from the annual domestic budget process, or establishing an inviting environment for external contributions where government finance is seen as intransparent. On the other hand, trust funds also add intransparencies and rigidities to the government's fiscal operations.

In most cases, proposals for establishing trust funds come with suggestions on how this is to be financed, including some earmarked tax. Earmarked taxes allow the managers of the national HIV response to draw on some fairly predictable domestic revenue stream. This revenue stream, however, may have little semblance to the profile of spending needs, and – in the absence of more flexible financing instruments – may result in inefficient spending allocations.

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