



# ECONOMICS REFERENCE GROUP

Technical Working Group for  
Sustainable Financing



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Sustainable Financing

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# INTRODUCTION



Over the past two decades, the fight against HIV & AIDS has achieved significant success. New infections are on the decline and increasing access to effective anti-retroviral therapy (ART) in low- and middle-income countries (LMICs) has transformed AIDS from a fatal to a long-term manageable condition. Yet the long-term costs of treatment, the prospect of increasing numbers of patients needing more expensive second- and third-line drugs, and the need for continued prevention measures necessitate a high level of sustained funding for decades to come.

UNAIDS estimates that by 2015, approximately US\$24 billion will be needed for HIV interventions annually (WHO, UNICEF, & UNAIDS, 2013). However, donor funding has plateaued in recent years: after rising from US\$1.2 billion in 2002 to US\$8.7 billion in 2008, donor commitments have

remained largely constant (UNAIDS and Kaiser Family Foundation, 2012). At the same time, many LMICs have experienced a period of economic growth, and are increasingly able and willing to take ownership of their HIV & AIDS response (UNAIDS, 2013). In 2011, domestic sources accounted for the first time for more than half of the funding for HIV programs in LMICs (UNAIDS, 2013). This represents a significant shift away from a donor-driven funding structure to a country-led model on average, a trend that is likely to continue in the near future, but there is still large variation across countries and some remain heavily dependent.

UNAIDS and the World Bank have co-convened an Economics Reference Group (ERG), bringing together senior HIV experts, health economists and practitioners to provide guidance on key issues regarding

financing the AIDS response. The goal of the ERG is to improve the efficiency, effectiveness, and sustainability of HIV programs in LMICs by generating knowledge and insights that

improve decision-making at the national and global levels. The ERG will operate primarily through three Technical Working Groups to produce technical inputs in specific areas:



## 3 AREAS

**1 COSTING, TECHNICAL EFFICIENCY AND EXPENDITURE TRACKING**

**2 HIV ALLOCATIVE EFFICIENCY AND EFFECTIVENESS**

**3 SUSTAINABLE FINANCING**



This background summary serves as a launching point for the first meeting of the Technical Working Group for Sustainable Financing (TWGSF). The TWGSF will review existing evidence related to the

sustainability of HIV funding and responses, suggest new research in areas where knowledge gaps have been identified, and develop specific policy guidance based on research findings.



FOR THE INITIAL MEETING,  
FOUR KEY DIMENSIONS  
OF SUSTAINABLE FINANCING  
HAVE BEEN IDENTIFIED  
FOR DISCUSSION:

- 1 ISSUES OF 'FAIR SHARE' AND 'GLOBAL SOLIDARITY'
- 2 EXPANDING INTERNATIONAL AND DOMESTIC REVENUE MOBILIZATION
- 3 INTEGRATING AIDS FINANCING INTO NATIONAL HEALTH FINANCING SYSTEMS
- 4 PLANNING THE TRANSITION TO DOMESTIC FUNDING AND PROGRAMMING

## 1 ISSUES OF 'FAIR SHARE' AND 'GLOBAL SOLIDARITY':

How much can LMICs reasonably be expected to contribute to their HIV programs, given their fiscal constraints, the size of their AIDS epidemics and the scale of other health and social sector priorities ('fair share'); and what type of responsibility and capacity do external donors have to honor their international financing commitments given the scale of the AIDS response both at the global and national levels (global solidarity)?



## 2

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### EXPANDING INTERNATIONAL AND DOMESTIC REVENUE MOBILIZATION:

What are potential sources of additional domestic revenue to support long-term HIV & AIDS resource needs? What kind of innovative revenue mobilizing efforts have been undertaken in different countries and what is their feasibility for replication? What is the best strategy to maximize the impact of existing AIDS resources and to mobilize additional sources of revenue at the global level?

## 3

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### INTEGRATING AIDS FINANCING INTO NATIONAL HEALTH FINANCING SYSTEMS:

Which HIV services should be integrated into national/horizontal health financing systems and how can sustainability be ensured? What kind of institutional reforms are needed for integration to be successful? How would the process of integration differ between low/middle income and low/high burden countries?

## 4

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### PLANNING THE TRANSITION TO DOMESTIC FUNDING AND PROGRAMMING:

Especially in middle income countries, how should transitions toward increased domestic programmatic and financial ownership of programs be made? What existing experiences can be shared with the TWGSF and what lessons can be drawn from these cases? What tools are available or could be developed to increase financial transparency, enhance accountability, and create a better framework for integrated financial planning, budgeting, and monitoring between national governments and donor organizations?

This background brief is intended to facilitate the first discussions of the TWGSF on November 25-26, 2013. It defines and presents some of the recent evidence and commentary on each of these four dimensions and identifies several salient research and policy priorities the TWGSF

could consider pursuing in 2014 for each dimension. The brief concludes with brief case studies of AIDS financing transitions in South Africa and India that help illustrate all four dimensions. The brief will be edited following presentations and discussions of the first TWGSF meeting.



# FAIR SHARE AND GLOBAL SOLIDARITY



## 1. Introduction

A significant gap currently exists between estimated resource needs and combined donor and domestic funding for the global AIDS response. UNAIDS estimates that an extra \$US 7 billion will be needed annually by 2015 to meet the needs of AIDS efforts in middle- and low-income countries (UNAIDS, 2013). In this context, it has become necessary to understand which countries are in a position to increase funding for their HIV response, and which will continue to have the greatest need for donor support (Greener, 2011). The concept of 'fair share' has emerged from this debate, defined as the amount a country can reasonably be expected to contribute to its HIV response. Multiple metrics have been proposed to measure 'fair share,' each with distinct advantages and disadvantages. During its first meeting, the TWGSF will be asked to engage in a substantive discussion about the feasibility and reasonableness of the currently proposed metrics, and if possible to provide guidance on an agreed set of standards.

Conversely, the concept of 'global solidarity' has been used to define the amount a donor country can or should be expected to provide for the AIDS response. With most developing countries unable to fully finance their HIV programs, continued donor support and involvement will be essential. As with the concept of fair share, multiple metrics and normative standards have been proposed, with each approaching measurement in a slightly different way.

The TWGSF may also suggest areas for further analysis and development of useful tools and additional metrics relevant to the issue of fair and sustainable financial burden sharing.

This section will highlight some of the current literature and metrics for both 'fair share' and 'global solidarity.' After discussing advantages and disadvantages of each metric, it will conclude with a discussion that highlights issues needing further clarification and research for the TWGSF to consider pursuing.

## 2. Overview of Current Metrics and Targets for 'Fair Share'

Current metrics for 'fair share' fall into three categories: 1) Targets that would increase the resources available for HIV & AIDS by increasing overall health spending; 2) Targets that aim to increase HIV spending as a proportion of overall health budgets; and 3) Metrics that compare countries to each other in their investment commitment to AIDS. This section provides a brief definition of and discusses advantages and disadvantages of each proposed metric for 'fair share.'

### Health Spending Targets

**The Abuja Target.** In Abuja, Nigeria in 2001, African Union Heads of State committed to allocate 15% of government expenditure to health (Veloshnee Govender, 2008). This increased commitment to health would also create more fiscal space for HIV & AIDS, assuming the percentage of the government's health budget going to HIV remains constant.

Yet critics argue that this target is too broad to be used in actual planning exercises, as it fails to account for country-specific political, economic and epidemiological situations. For example, low-income countries may have less fiscal space to increase their health budgets from domestic resources than do middle-income countries. The Abuja target may also be unrealistic for countries currently spending far below 15% of their total expenditures on health. Moreover, no clear guidelines have been published as to how this target should be measured (Witter, 2013) (Borowitz & Korah, 2013). Questions such as whether to measure country budgets, which are often theoretical, or actual expenditures on HIV & AIDS, and whether to include earmarked

aid and overall development assistance – which are included in some, but not all, country budgets - into these calculations have not been clearly answered. As a result, sources differ in their definitions of country success (UNAIDS, 2013) (Africa Public Health Alliance, 2010) (WHO, 2011).

**Government expenditure on health as a share of GDP.** Experts studying sector-specific funding have proposed that countries should spend a minimum of 3% of GDP on health to achieve optimal health results; however, many developing countries currently spend far less. (PEPFAR and Results for Development Institute, 2013). Again, meeting this target would increase funding available for HIV & AIDS by increasing overall health spending, assuming the percentage of government budgets allocated to HIV & AIDS remains constant. Still, 3% of GDP may not be equally realistic for both low- and middle-income countries; and it does not take into account country-specific economic and health needs. Drawbacks to this measure are similar to those associated with the Abuja Target.

### HIV & AIDS Spending Targets

**Government expenditure on HIV & AIDS as a share of GDP.** Several recent studies have determined that low-income countries with high HIV prevalence can afford to spend up to 2% of their national GDP on an HIV & AIDS response without compromising other sectors (Haacker & Lule, 2012) (Williams & Gouws, 2012). This provides a clear-cut and easy-to-measure metric to help donors determine if a country's HIV resource needs exceed their reasonable ability to pay. However, it may not be equally realistic for all countries, and it fails to account for the relative disease burden of

HIV & AIDS. This measure also conflicts with the 3% target described above. If a country were to spend 3% of its GDP on health with 2% of its GDP dedicated to HIV & AIDS, it would then be spending 2/3 of its health budget on the AIDS response. This could jeopardize other important health priorities.

**The DALY Share target.** The proportion of government health budgets allocated to HIV & AIDS constitutes another measure of commitment. Countries are considered to have met their DALY Share if the proportion of government funding for health allocated to HIV & AIDS meets or exceeds the proportion of DALYs lost due to HIV & AIDS in the population. This has the advantage of accounting for relative disease burden, although it does not account for relative costs of treating diseases. As ART is scaled up, the relative disease burden of HIV & AIDS may decrease while the cost of treatment remains. To date, no metric has been published that incorporates both disease burden and relative cost of treatment.

### Cross-Country Comparison Metrics

**The Domestic Investment Priority Index (DIPI).** In 2010, UNAIDS introduced the Domestic Investment Priority Index as a metric for the priority placed by countries on their national AIDS response. The DIPI is calculated by dividing the percentage of government revenue directed to the HIV & AIDS response by the population HIV prevalence. A high value usually indicates a high level of priority. This metric is based on the idea that two countries with equal wealth and equal population prevalence of HIV & AIDS would be expected to spend equal amounts of money on an AIDS response if they placed equal priority on the disease.

$$DIPI = \frac{\text{PUBLIC EXPENDITURE ON HIV / AIDS}}{\text{GOVERNMENT REVENUE}} \times \frac{\text{NATIONAL POPULATION}}{\text{PEOPLE LIVING WITH HIV / AIDS}}$$

This provides a standardized measure with which to compare country commitment to HIV, but at present it lacks an obvious normative target value. As a result, a country's DIPI is more meaningful when compared to others than as a stand-alone metric.

Expected Domestic Contribution (EDC). Omar Galarraga et al (2013) recently proposed a model that measures Expected Domestic Contribution to the HIV & AIDS response as a function of gross national income (GNI) per capita, health spending per capita as a proportion of GNI per capita, and debt service per capita.<sup>1</sup> Countries were then categorized according to actual versus expected domestic contribution and resource needs. The study found that seventeen countries had domestic funding below that expected by the model, and that total funding (donor + domestic) would exceed the estimated need if domestic contribution were increased to the EDC. Conversely, twenty-seven countries had domestic funding above the expected level, but total domestic and donor funding did not meet estimated need (Galarraga O, 2013). This is useful in that it clearly identifies countries that are either under- or over-funded by donors based on their ability to pay. However, the metric does not consider the size of a country's HIV epidemic.

<sup>1</sup> In the model, GNI per capita represents country income, which is expected to increase the capacity for domestic HIV funding. Health spending per capita as a proportion of GNI per capita is used as a proxy for the size of the health sector in the national economy, assuming that greater total spending on health would be associated with a greater capacity for domestic HIV funding. Debt service per capita represents countries' access to credit markets, which the authors assert may predict greater capacity to borrow and invest in HIV programming.

### 3. Potential focus issues and questions for TWGSF

#### Potential to Increase Funding for HIV & AIDS by meeting targets

Potential to increase funding for HIV & AIDS by meeting metrics for 'fair share' varies based on a country's current spending and economic capacity. Countries such as Ethiopia, which currently has very low general government expenditure, could increase funding by increasing GGE. Other

countries such as Kenya, which is currently far below the Abuja Target, could increase HIV spending by increasing government spending for health (PEPFAR and Results for Development Institute, 2013). Figure 1 below illustrates the increases in funding that could result from varying combinations of meeting these targets in countries with different contexts.

F.1

#### DOMESTIC AIDS EXPENDITURES UNDER BENCHMARK SCENARIOS (\$US MILLIONS ANNUALLY)



In the coming decade, countries will likely move in increasingly divergent directions. Middle-income countries with medium to small HIV burdens may soon be able to fully finance their own response by meeting ‘fair share’ targets; whereas most low-income countries—and in particular those with high burdens of disease—will be unable to meet their resource needs for HIV & AIDS even if they were to meet all or most of the targets described above (PEPFAR and Results for Development Institute, 2013). As a result, they will be reliant on donor aid for many years to come.

### ***Tension between aspirational goals and country-specific solutions***

In the discussion of appropriate metrics and targets for ‘fair share,’ there is a tension between international aspirational goals and country-specific solutions. Targets such as the Abuja Target and percent GDP dedicated to health or HIV & AIDS can be useful in motivating countries to increase HIV & AIDS spending, but they may not be realistic (economically or politically) for

all countries to meet. A need remains to develop country specific plans for growth that take into account economic projections, size of the epidemic, and relative size of other social and economic priorities for growth.

Research questions surrounding ‘fair share’ that the TWGSF may wish to consider include:

- ***What are the most appropriate indicators for assessing “fair share” for domestic financing?***
- ***Are there ways these indicators can be improved and refined to fit country contexts?***
- ***How can we bridge the gap between theoretical targets and benchmarks and actual financing commitments made in countries?***
- ***How can countries that appear to be economically capable of financing their own response be motivated to do so?***

## **4. Current Metrics and Targets for ‘Global Solidarity’**

Donor contributions to the global AIDS response can be measured in many ways, and no one metric paints a complete picture of donor contributions. Current metrics and targets used to measure ‘global solidarity’ include, but are not limited to the following.

***Total dollar amount contributed to Overall Development Assistance (ODA) or the HIV response.*** This is the most straightforward measurement of country contributions, but it does not take into account relative donor wealth and economic capacity for increasing external aid.

***Percent GDP contributed to ODA.*** UNGASS has suggested a target of 0.7% GDP dedicated to Overall Development Assistance. This takes into account donor wealth, but is not specific to HIV & AIDS. Unfortunately, countries have consistently fallen short of this target over the past few years.

***Disbursements for HIV per US \$1 Million GDP.*** This metric most directly measures contributions to HIV & AIDS, while taking into account relative donor wealth. However, it does not account for assistance to other health or development priorities that may affect the HIV & AIDS response.

**Percent of ODA dedicated to HIV.** This measures the level of priority donor countries place on HIV & AIDS compared to other

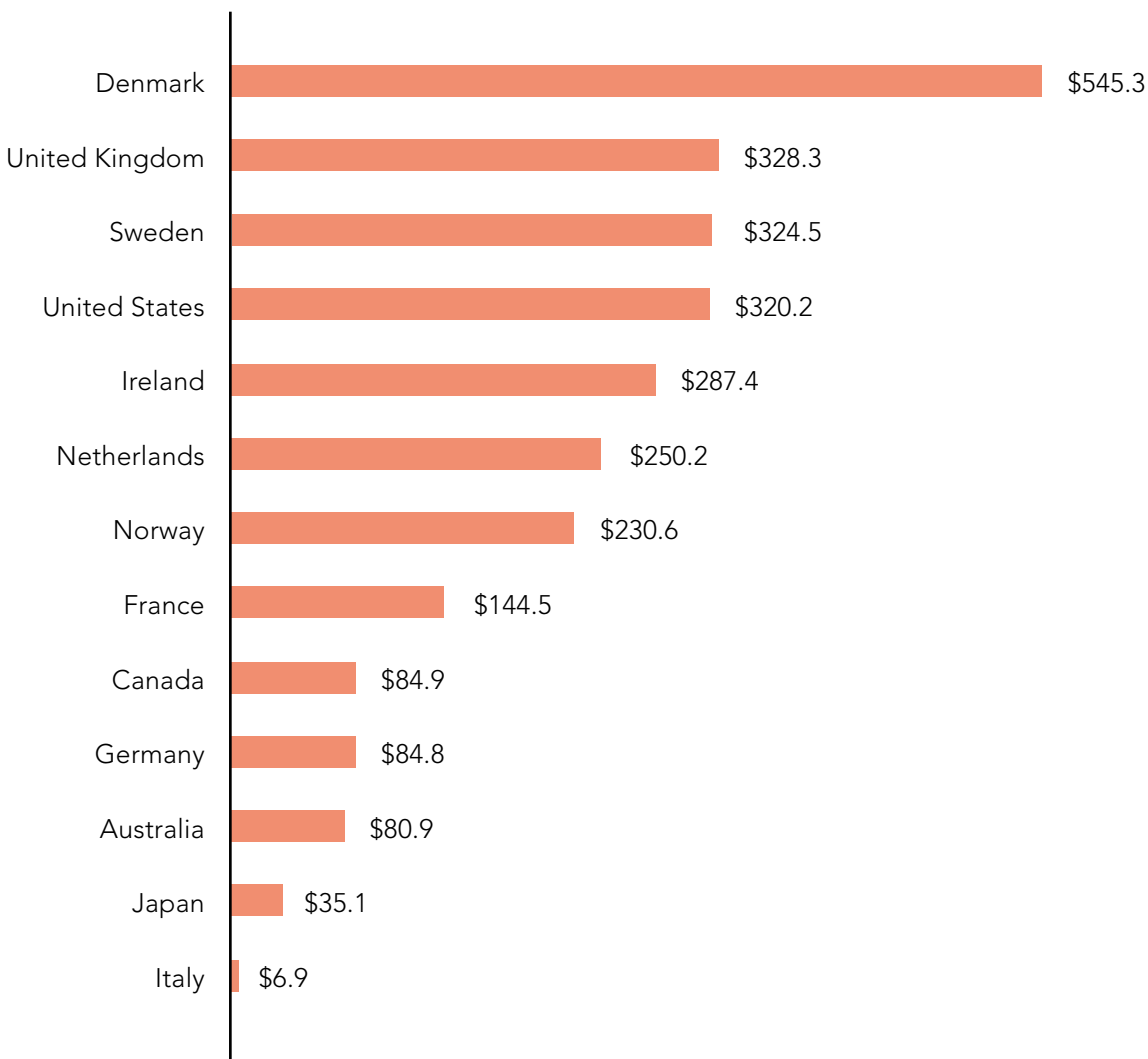
development assistance. However, it does not measure 'generosity,' as it does not take into account total amount of aid.

## 5. Potential focus issues and questions for TWGSF

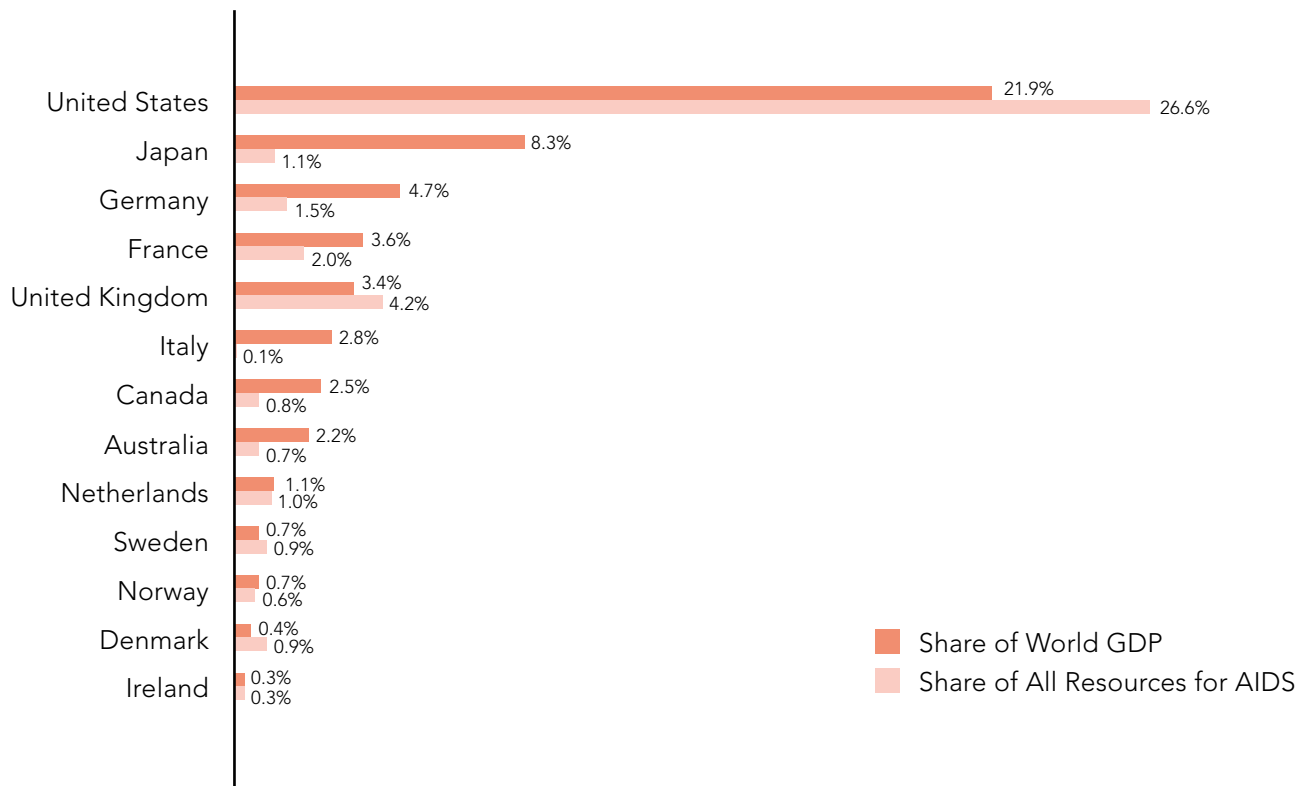
Different metrics paint vastly different pictures of country generosity and 'global solidarity' (e.g., Figures 2 and 3). The United States, for example, commits less than half of

the target 0.7% GNP to ODA—well behind several other countries—but it ranks second only to Denmark in disbursement for HIV per US\$1 million GDP (see Figure 2).

**F.2 DONOR RANK BY DISBURSEMENTS FOR HIV PER US\$1 MILLION GDP\*, 2012**



## DONOR SHARE OF WORLD GDP\* COMPARED TO DONOR SHARE OF ALL RESOURCES AVAILABLE FOR HIV, 2012



To properly evaluate the usefulness of different 'global solidarity' measures, several questions need to be answered:

- Which contributions should be measured?** Most current measures do not account for country contributions to the World Bank, UNICEF, and other bilateral organizations that directly affect HIV programs. Should these contributions be taken into account, and if so how? In addition, should tax breaks for foundations and individual donors that contribute to the global HIV response also be included in government aid calculations? Why or why not?
- How can contributions to HIV be balanced with contributions to other health priorities?** At what level of aid (overall, health-related or HIV-specific) should contributions be measured, and how can a balance be taken into account?
- Which countries should be included in 'global solidarity' rankings?** Only G8 countries? All developed countries?
- How can countries be motivated to donate more?** Donors have consistently fallen short in meeting both the UNGASS target and others. Over recent years, some bilateral donors have also delayed or failed to meet the disbursement of



*their pledges to multilateral agencies such as the Global Fund (Galárraga O, 2013). With simply setting targets apparently insufficient to motivate donor participation, how can country commitments be monitored and how*

*can countries be motivated to meet them? Could matching schemes, results-based financing, or releases of funds to countries and providers based on performance enhance trust and catalyze donations?*



# EXPANDING INTERNATIONAL AND DOMESTIC RESOURCE MOBILIZATION



## 1. Introduction

As the global resources available for HIV & AIDS have plateaued and more pressure is put on countries to mobilize their own resources, countries have turned to 'innovative' mechanisms of financing to generate additional revenues. These include levies on airline tickets and mobile phone minutes, tobacco and alcohol taxes, HIV & AIDS trust funds, and public and

private sector mainstreaming. This section provides a brief description of select mechanisms and their application in various countries. It is followed by a discussion about the potential for innovative financing measures to begin filling the funding gap, and suggestions of issues and questions about revenue mobilization that the TWGSF may want to explore.

## 2. Overview of Innovative Financing Mechanisms

A number of financing mechanisms have been proposed and piloted in recent years.

**Airline Levy.** A levy on domestic and international flights has been used by both

lower- and higher-income countries to finance HIV & AIDS contributions. Revenues from airline levies by Cameroon, Chile, Congo, France, Madagascar, Mali, Mauritius, Niger and the Republic of Korea currently

comprise over 60% of contributions to UNITAID, an international organization that works to increase access to treatment and diagnostics for HIV & AIDS, TB and malaria (UNITAID, 2012). Other countries currently implement an airline levy to finance their domestic HIV response.

Airline levies generally collect a \$1-20 tax from each air traveler. This is viewed as a progressive tax that can generate a reliable stream of income without affecting demand for flights. Implementation costs are also low when it can be implemented using pre-existing airport tax systems (World Health Organization, 2010). However, revenue from these levies must compete for earmarked status with other priorities such as carbon dioxide emissions, which have also lobbied for these funds.

**Mobile Phone Levy.** Multiple countries now place levies on mobile phone usage with proceeds supporting HIV programs. These levies provide a consistent source of funding, however they can also be seen as regressive, as they increase the cost of minutes for the poor as well as the rich.

**HIV & AIDS Levy.** Since 1999, Zimbabwe has levied an extra 3% tax on all taxable incomes for individuals and institutions (World Health Organization, 2010) (Southern African Development Community, 2008). Unfortunately, due to hyper-inflation, the levy has not made a significant contribution to the HIV & AIDS resource pool. Instead, multiple studies found that this levy has become a burden to taxpayers (including poor taxpayers) while failing to contribute significantly to the AIDS resource pool. This type of levy also depends on government ability to collect revenue, which is often limited in LMICs.

**Tobacco and Alcohol Tax.** Cape Verde, Comoros, and other countries impose alcohol excise taxes with funds earmarked for HIV programs (UNAIDS, 2012). These earmarked 'sin' taxes provide a steady source of revenue while also discouraging use of unhealthy products that cause other chronic disease. However, these taxes can also be regressive, disproportionately affecting poor people.

**HIV & AIDS Trust Funds.** HIV & AIDS trust funds are currently in use or under consideration in Malawi, Kenya, Zimbabwe, Botswana, South Africa, Tanzania, and Zambia, among other countries (Lievens, 2011). Trust Funds can be 'funded' or 'unfunded,' with 'funded' trust funds capitalizing off of interest from a large endowment and eventually becoming self-sustaining, and 'unfunded' trust funds receiving an annual contribution from public or private sources that can include many of the levies and taxes described above.

**Public and Private Sector Mainstreaming.** Multiple countries currently require all public or private bodies to devote 2% of their budget to HIV-related activities and workplace policies for their staff (UNAIDS, 2012). Internal mainstreaming involves addressing the spread of HIV within an organization, with a focus on workplace programs. External mainstreaming involves a sector using its own comparative advantage to address the spread of HIV & AIDS in the population (e.g., the education sector offering safe sex education in schools) (Republic of Namibia, 2008). This has the advantage of creating a multi-sectoral response to HIV & AIDS in addition to increasing funding; however, a focus on quality of programming—and particularly workplace programs—is essential if this approach is to be effective (Lievens, 2011).



### 3. Potential focus issues and questions for TWGSF

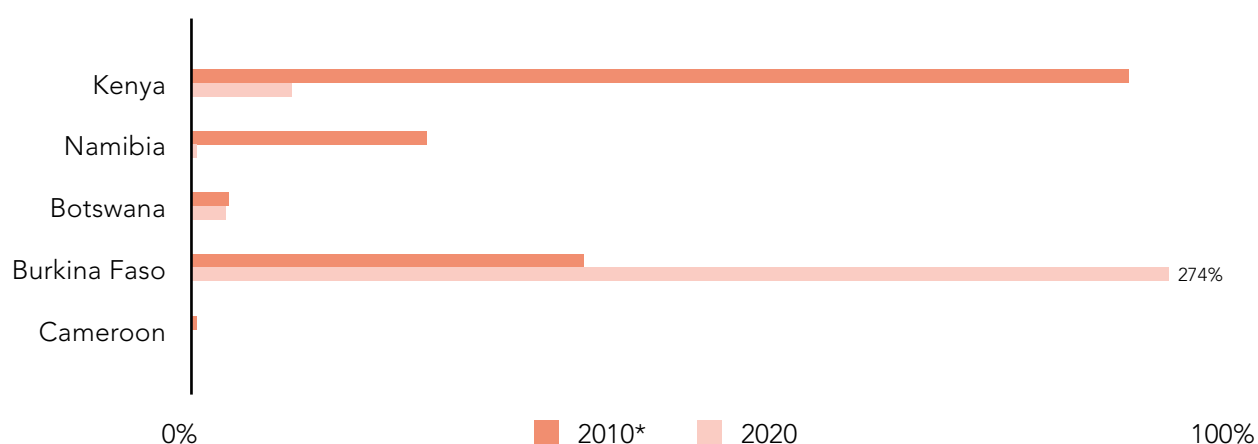
#### **What is the revenue generation potential of innovative financing mechanisms?**

Potential for innovative financing mechanisms to generate sufficient income varies widely by country. As illustrated in Figure 4, revenue from a country-specific

airline levy would cover 274% of the projected financing gap for HIV & AIDS in Burkina Faso by 2020, but less than 10% in Botswana (Lievens, 2011). Similar discrepancies exist for other mechanisms of funding.

F.4

#### **REVENUE FROM AIRLINE LEVY AS A % OF THE FINANCING GAP (LIEVENS, 2011)**



This variation underscores the need for country-specific research to determine the feasibility and revenue generation potential of these mechanisms. It is not immediately clear that these innovative financing mechanisms will be sufficient to make a significant difference in funding levels for all countries. If the TWGSF were to pursue this issue, potential tasks could include the following:

- Country-specific feasibility and revenue projection studies;
- Proposal and testing of new innovative financing mechanisms; or

- A 'toolkit' that can inform country decisions by providing up-to-date research on individual mechanisms, as well as guidance on how to evaluate and quantify these mechanisms in country contexts (Ombam, 2013).

Other conceptual questions in this debate include:

**What are the pros and cons of relying on general vs. earmarked taxes for HIV & AIDS?** As a greater share of domestic resources are deployed for financing HIV & AIDS programs, there is a growing debate on whether to ' earmark' a share of tax revenues

or finance it out of general tax collection by the government. In the first case, ministries of finance will seek a strong justification for earmarking resources for HIV and not for other priorities such as education or infrastructure. Earmarked resources, especially through natural resource levies such as mineral taxes, can also be volatile depending on external factors such as global price movements. Conversely, strong political commitment to HIV & AIDS is needed to secure resources from the general tax pool amid multiple important demands on scarce resources in LMICs.

***Should and how can countries expand use of broad-based revenue 'levers'/'handles'?***

Several countries graduating from low to middle income status are simultaneously developing modern taxation and budgetary systems, leading to greater tractability in using revenue levers, like social funds with earmarked taxes, for public policy priorities. For instance, since 2005, the Government of India has been collecting an education deduction on taxable income for primary and tertiary education and committing the resources to a non-lapsable fund which can be used to pay for targeted education schemes or general programs like providing a midday meal to children (KPMG Asia Pacific Tax Center, 2012). Similarly, Mongolia, enjoying a boom in non-tax revenues from its mineral exports, has earmarked a portion of these revenues for a Human Development Fund which supports projects meant to counter inequality by funding payments related to cash hand-outs to all citizens, pensions, healthcare, education, and housing (Isakova, Plekhanov, & Zettelmeyer, 2012). Borrowing for financing of HIV response is also becoming more commonplace, but has not been adequately evaluated. There is a significant knowledge gap regarding the concept and application of these revenue levers individually and collectively, and their impact on ensuring sustainability of financing in the future.

***What are the linkages policymakers must know between allocative efficiency and sustainable financing?*** Future resource

needs are closely tied to current policy decisions, and could potentially be significantly reduced through effective prevention investments. It has been estimated that each dollar that Thailand invested in its HIV prevention program saved \$43 dollars in avoided future treatment costs (Over et al. 2007; Revenga et al. 2006). Likewise, ongoing research in South Africa has preliminarily found that circumcision of males is highly cost saving: saving almost \$1000 in future treatment costs for every male circumcised (Haacker, 2013). The executive director of UNAIDS recently stated, "We could wait for economies to grow, as they appear to be doing, and hope for increased investments. Or we can re-examine our models of investments and methods of program delivery . . . We have to do more with less" (Sidibé, 2011). Yet prevention currently makes up a small proportion of the HIV/AIDS response in many countries.

***New fund mobilization or reallocation?***

Since sustainable financing of HIV & AIDS must be considered in the context of various health commitments competing for newly mobilized funds or reallocation from other sectors, can the TWG consider researching general principles for deciding which of the two means of enhancing funding (newly-mobilized or reallocated) should be prioritized given different capacities and potential for each?

Accurate projections of funding needs based on varying combinations of treatment and prevention programs will be essential for improved decision-making at the country level. The ERG has commissioned a separate working group that will provide technical inputs on allocative efficiency in the HIV & AIDS response, and their work will be directly relevant to questions of sustainable financing. The TWGSF may wish to consider a formal dialogue or collaboration on research tasks with the allocative efficiency working group.



# INTEGRATING HIV & AIDS FINANCING INTO NATIONAL HEALTH FINANCING SYSTEMS



## 1. Introduction

The HIV & AIDS response has been largely driven from its inception by donors, especially in LMICs in sub-Saharan Africa, Asia, and the Caribbean. With few exceptions, funds were allocated and expenditure incurred through parallel budgeting and service delivery mechanisms. That reality is changing for several reasons. First, HIV & AIDS has evolved from a health emergency to a long-term disease management issue. Second, available donor resources for HIV & AIDS response are currently stagnating and may decline in the near future. Third, strategic reorganization within major donors (Global Fund, World Bank, and PEPFAR) and the focus on other health challenges such as immunization and non-communicable diseases will potentially reduce the visibility of HIV & AIDS financing in the future, both

domestically and internationally. Finally, with countries promoting universal health coverage, there is a movement to marry vertical HIV & AIDS efforts with health system strengthening. As domestic resources become the dominant source of financing of the AIDS response, both the donor community and the countries themselves are focusing more holistically on financial and programmatic sustainability.

Following the discussion on 'fair share' and resource mobilization, integration of HIV & AIDS into health financing systems is now an important area of policy debate in the context of financial sustainability of the AIDS response. Several salient issues and evidence are surveyed below, followed by suggestions on potential focus topics for the TWGSF.

## 2. Salient issues and recent work

“Integration of HIV & AIDS financing” refers here to the process of moving toward national health financing systems where funds for HIV & AIDS are collected, pooled, and used to pay for/purchase health services together with funds for other health services rather than through separate financing/payment structures. (A follow-on but separate concept is that such integrated funding can imply integrated delivery of HIV & AIDS services alongside other health services.)

Much of the debate on integrating HIV & AIDS financing with national health financing systems has focused largely on health insurance mechanisms at the country level. Mexico, Brazil, and Thailand are cited as examples of countries that moved towards early integration of HIV & AIDS services with largely publicly funded health insurance mechanisms with nearly universal coverage. These countries leveraged the opportunity afforded by health sector reform and introduction of comprehensive health insurance in the late 1990s to expand coverage of ART at a time when treatment costs were high [(Nunn, da Fonseca, Bastos, & Gruskin, 2009); (Bautista et al., 2008); (Patcharanarumol, et al., 2013)].

As low prevalence countries which experienced significant economic growth in the last decade or more, the individual contexts of the relationship between HIV & AIDS policy design, available funding envelope, and the pathway to integration are important to consider. For instance, Brazil decided in 1996 to provide ART to all, challenging conventional wisdom that LMICs should focus on prevention and that adherence would be hard to ensure. Within a decade, Brazil was paying \$400 million for ARV drugs to support therapy for 180,000 individuals, with about 20,000 new patients joining treatment every year (Greco &

Simao, 2007). But long term sustainability is threatened by increases in both the number of individuals who need to initiate ART each year and the complexity of the regimens for infected individuals who are surviving for longer periods of time. In Thailand, the government paid for about 71% of the total HIV & AIDS expenditure during 2008-11 in just treatment and care after first introducing a policy of tax-financed universal ART in only 2003 (Patcharanarumol, et al., 2013). However, the impending departure of Global Fund funding may mean that gaps in reaching migrants and other key affected populations will open up. In Mexico, the nature of the challenges differs in that while Seguro Popular has reduced out-of-pocket health expenditures and produced a shift to public providers among poorer population groups, there is evidence that poor quality of care may be interfering with improved health outcomes (Barros, 2009).

The evidence from high-prevalence and high burden countries is mixed. As examples, Rwanda has a relatively well-functioning national health insurance system, while South Africa remains highly fragmented between public and private sectors as the country’s national health insurance vision is being designed and piloted. In both cases, ART continues to be delivered separately, although treatments of opportunistic infections are included in benefits packages of Rwanda’s ‘mutuelles’ (Doetinchem, Lamontagne & Greener, 2010). Before endorsing integration of HIV & AIDS services with domestic health insurance mechanisms to enhance sustainability, there is a need to better evaluate cross-country variation in existing coverage and services and capacity for integration.

A recent UNAIDS review of the experiences with integration of HIV & AIDS into domestic health insurance schemes (Doetinchem,



Lamontagne, & Greener, Aug 2010) begins such comparisons. The report gives an overview of HIV & AIDS coverage and subsidies for 65 countries split by their vulnerability profile (generally correlated positively with prevalence and inversely with per-capita health spending and achievement in delivering ART and PMTCT services). Importantly, it made some critical observations challenging conventional thinking about the wisdom and mechanics of integration at the national level:

- a. There is a great variety of coverage mechanisms and funding sources in the country sample, and formal health insurance programs do not appear to be inherently better or worse than other health financing modalities (e.g., general revenue-financed public health services) in covering HIV & AIDS services.
- b. Health insurance is a mechanism of choice either for countries with operational health insurance systems already in place or for countries in the process of implementing a policy preference for health insurance as a universal coverage mechanism.
- c. While financial concerns like resource share, cost effectiveness, and efficiency are important, political commitment is indispensable to achieving this financing transition.

The report concludes by suggesting that while studying insurance mechanisms at the country level is important to understanding how the HIV & AIDS-related cost, population, and/or service coverage can be extended, there is little reason to believe that these mechanisms are the best or only means of doing so. This raises important questions regarding the 'transition' of HIV & AIDS services, especially in high-burden and low-income countries, towards greater

integration with domestic health financing mechanisms for long term financial sustainability.

UNAIDS has recently commissioned additional work on a policy brief to provide further guidance on integration, including conditions which make financing integration more or less feasible or desirable and potential best practices in designing and implementing such integration. The brief is to be followed by two more in-depth country cases that will investigate the historical and political processes that led to integration and help identify constraints, successes, pitfalls, and overall lessons relevant for integration attempts elsewhere.

### **Other issues related to financing integration**

***Differences across low and middle-income countries.*** Even with substantial increase in domestic resources, the HIV & AIDS response in low and lower middle income countries is going to remain overwhelmingly externally funded. In 12 PEPFAR countries, the funding gap would range from nearly 90 per cent of resource needs for Ethiopia and Rwanda to nearly one-third in the case of Nigeria (Results for Development Institute, 2013). For upper middle income countries in the sample (Botswana, Namibia, and South Africa), the funding gap would disappear if public expenditure increases to meet both the Abuja Target and the DALY Share (as explained in Section 1). From a public finance point of view, it is important to note that the scope for integrating HIV & AIDS financing into horizontal systems seems more feasible in upper middle income countries with larger domestic shares of HIV & AIDS spending.

***Fiscal Space, HIV & AIDS Policy Design, and Integration of Financing.*** Fiscal space



refers to a country's capacity "to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position" (Heller, 2005). Since the financial sustainability of HIV & AIDS response is directly linked to current and future policy choices on benefits, purchasing, and provision of AIDS services which define funding needs, policy design and fiscal space are interrelated. Policy choices affecting fiscal space in turn affect the nature and scale of the challenge of integrating HIV & AIDS financing, particularly when new

HIV & AIDS infections are declining and survival rates are increasing due to ART. For instance, focusing on prevention in concentrated epidemics such as India can mean that nearly 70 per cent of allocations go towards programs targeted at high-risk groups, thereby limiting the scale of the integration challenge (Government of India, 2006). In generalized epidemics, the integration challenge is likely to be far greater. Hence, analyses of policy design, fiscal space, and country context should help determine the feasibility of integrating HIV & AIDS funding.

## 4. Potential focus issues and questions for TWGSF

The debate on integration of sustainable HIV & AIDS financing into national health systems is still evolving. There is, however, some urgency in having a clearer understanding of the issues especially in the context of stagnation or decline in donor resources for HIV & AIDS in future. At the same time, a significant number of low and lower middle income countries are moving towards universal health coverage, which implies a holistic approach to determining investment priorities in health. A few critical issues listed below could benefit from further attention from the TWGSF.

- **What are best practices for sequencing of HIV & AIDS financing integration?** For example, is integration of individual-centric ARVs the starting point? Do costing tools and means of analyzing impacts on overall benefits policies need to be developed and tailored?
- **For both the integration and resource mobilization dimension,** is there evidence of crowding out of financing for other targeted or general health interventions because of HIV & AIDS

in countries that have integrated, particularly those with high prevalence? How would integration of HIV & AIDS funding impact resource tracking and financial monitoring?

- **While focusing on integration of core financing functions (collection, pooling, purchasing), should the TWGSF undertake analyses that explore the (economic) follow-on implications for integration of service delivery?** For example, what effect on average wage bills might integrating formerly-separated (and potentially higher paid) HIV & AIDS health workers?
- **Can the TWGSF help to quantify and potentially advocate for funding synergies across health (HIV & AIDS) and non-health budget sectors?** Holistic integration will require that HIV & AIDS not be treated as a discrete epidemic. For instance, how can the TWGSF assess/build evidence that might make the case for decreased overall health costs from greater integration?



- The global health community is engaged in debates about post-MDG priorities and strategies, with universal health coverage one possible post-MDG goal. ***As evidence and guidelines on integration of HIV & AIDS financing develop from UNAIDS and others' work, should the TWGSF engage somehow on post-MDG***

***plans on universal health coverage to ensure adequate attention to HIV & AIDS in such plans?*** “Engagement” could be at the global or country level—such as helping inform the inclusion of HIV & AIDS funding and services in South African’s burgeoning national health insurance system.



# TRANSITIONS FROM DONOR TO DOMESTIC FINANCING: COUNTRY 'COMPACT' CASE STUDIES



## 1 Introduction

As countries increase domestic funding for their HIV & AIDS programs and reduce their dependence on donor assistance, it is necessary to establish systems and processes so that transitions are smooth and sustainable, including means of monitoring transitions and ensuring transparency and accountability for commitments made by donors and countries. This is especially critical in middle-income countries where donor funding decreases and thus necessary increases in domestic funding will probably be more substantial and happen more quickly. The establishment of country 'compacts' could provide a workable mechanism for effective coordination between the donor community and governments.

The financing transition is a process of increasingly transferring the ownership of the AIDS response from donors to countries. This requires the adaptation and harmonization of donor implementation frameworks to country systems, aligning with annual budget cycles, medium and long term planning processes and expenditure tracking systems, and country-led strategies. The new funding model of the Global Fund recognizes this explicitly and provides the flexibility to apply over a three-year grant window to harmonize with the country's strategic plan. World Bank's funding for HIV & AIDS programs have largely been designed to support country level national strategic plans, as have PEPFAR Partnership Framework Implementation Plans (PFIPs).

The following section provides a working definition of donor/country compacts and shows how compact-like agreements have

been used to facilitate the donor-to-national transition in HIV program implementation in South Africa and India.

## 2. Using Country Compacts for Donor-to-National Transition: Cases of South Africa and India

The notion of country compacts is still in an evolutionary stage. Initial work has focused on the characteristics of existing financing agreements between countries and donors and guiding principles that can be drawn from these experiences (Results for Development, 2013).

A country compact is an explicit agreement between a country's government and one or more donors that outlines programmatic and financial commitments made by one or both parties to the country's AIDS program, and specifies mechanisms to hold parties accountable to the provisions contained therein (Results for Development, 2013). Currently, such agreements are donor-specific and are often negotiated separately to conform to the financial management norms and regulations of each donor. Moreover, the funding instruments and associated agreements often vary across donors—for example, the World Bank negotiates loan or credit agreements with counterpart Ministries (usually the Ministry of Finance), PEPFAR's frameworks are with National AIDS Councils or Ministries of Health, while the signers of Global Fund agreements include civil society representatives. Systematic review of country compacts with the World Bank, Global Fund and PEPFAR reveal a plethora of such arrangements instruments (Results for Development, 2013).

Going forward, improvements in the design and implementation of compacts

may help manage the transition process from donor to domestic financing, especially in middle income countries. We present two case studies for the TWGSF to consider: a) The transition outlined in PEPFAR and South Africa's Partnership Framework Implementation Plan (PFIP) and b) Handover of AVAHAN interventions to the National AIDS Control Program in India. These two cases highlight the importance of coordination, harmonization, transparency, and monitoring in achieving the desired objective of the transition and ensure sustainability.

### **Case 1: South Africa – Establishment of PFIP with PEPFAR**

***[Case adapted from UNAIDS, 2013, Box 3]***

South Africa has the largest HIV epidemic in the world with approximately 5.7 million people living with HIV. After several years of low domestic prioritization and underinvestment, the Government's allocations for HIV & AIDS increased significantly from 2008 onwards. Over US\$1.5 billion was spent in 2009/10 – more than in any other low- and middle-income country. Between a quarter and one-third of the total resources came from donors, with domestic resources making up the majority of total expenditure on HIV & AIDS in South Africa (Results for Development, 2013).

In terms of establishment of a formal PFIP, South Africa is an important case to analyse. The government is already financing the majority of the AIDS response, but there is a large PEPFAR program spending about \$500 million annually (see below) and contributions from the Global Fund—the third largest AIDS financier in South Africa—were estimated at \$US 82 million in 2012. As the largest economy in sub-Saharan Africa with the highest burden of HIV globally, a successful PFIP would set the stage for replication of similar agreements in other countries.

PEPFAR efforts began in South Africa in 2004 and scaled up rapidly, going from an allocation of \$89.3 million to US\$483.7 million in 2012 with a peak of US\$590.9 million in 2008. In its first five years of operation, there was a six-fold increase in allocations through PEPFAR. In the re-authorization of PEPFAR in 2008, the focus and scope of the program shifted from an expansion of treatment to that of building and sustaining health outcomes and systems, aligning them more closely with national priorities (Government of South Africa, 2012). It is in this context that a Partnership Framework (PF) was negotiated and signed in 2010 and a Partnership Framework Implementation Plan (PFIP) drawn up for 2012/13 – 2016/17 to provide the operational guidelines for the broad strategy outlined in the PF.

In the PFIP, the two governments agreed that PEPFAR assistance would decline gradually from \$US 484 million in 2012 to \$US 250 million by 2017, while the government of South Africa would increase its financial commitment from \$US 1.2 billion to \$US 1.9 billion over the five year period. Programmatically, PEPFAR's role would transition from one of direct service delivery to technical assistance. Broad

targets were also established for specific program areas such as treatment, male circumcision, and orphan care.

There have been significant challenges, but South Africa and PEPFAR's experience with the PFIP has been largely positive so far. Despite national budget constraints, South Africa's National Treasury was able to prepare for the PEPFAR transition by allocating additional funds to the national HIV budget. As ART service delivery was a main transition area in 2012/13, the South African Department of Health and PEPFAR agreed on which PEPFAR backed ART services would be absorbed by the government to minimize disruptions in treatment services.

PEPFAR and the government are also working towards joint planning and budgeting—a main objective outlined in the PFIP. In early 2013, the four joint PEPFAR and government work streams under the PFIP (Prevention, Care and Treatment, Orphans and Vulnerable Children, and Health Systems Strengthening) met to go over and, in some cases, adjust budgetary allocations in PEPFAR's Country Operating Plan (COP) for 2013/14. Further government involvement is expected in PEPFAR's 2014/15 COP planning.

Challenges throughout the PFIP implementation process have included: less than ideal capacity on both sides to find the time to engage in joint planning; concerns by both parties about sharing full financial information; lack of tools, templates, and processes to share information even when concerns about sharing can be alleviated; finding ways to engage provincial level leadership; and difficulties in securing additional government funding for AIDS in the context of a constrained national budget.

## Case 2: India - Transition from AVAHAN to National AIDS Control Program

**[Abridged and adapted from Sgaier, Ramakrishnan, Dhingra et al (2013), How the Avahan Prevention Program Transitioned from Gates Foundation to the Government of India, Health Affairs 32 (7): 1265-1273]**

The Government of India responded to the threat of an expanding HIV & AIDS epidemic by launching the first phase of the National AIDS Control Program (NACP-1) in 1992 with a budget of US\$84 million almost wholly funded by the World Bank. This was followed by NACP-II in 1999 with an increased budget of US\$ 236 million, of which 80 percent was provided by the World Bank and other donors such as DFID, European Union, and SIDA.

In 2003, the Bill & Melinda Gates Foundation launched its AIDS initiative in India, the Avahan program, to expand the reach of prevention efforts aimed at the most-at-risk populations and other at risk groups—specifically, the male clients of sex workers and long-distance truck drivers. The Avahan program focused on six 'high-prevalence' states of India which had 83 percent of the national HIV burden, complementing the Government of India's efforts and distributing the focus areas among Avahan and NACP to avoid duplication.

The Avahan program (and agreement donor and recipient government) was different from the funding arrangements used in the World Bank and a majority of Global Fund agreements, where government ministries are the counterparties. AVAHAN did not transfer funds to the Government's National AIDS Control Organization (NACO) in the first phase, but rather negotiated

an implementation arrangement to execute the program directly through contracts to NGOs and community-based organizations on the ground. The major institutional innovation for NACP-II had been the establishment of State AIDS Control Societies (SACS). These were responsible for implementation of the national strategic plan as per the needs of the respective states and funds were allocated on the basis of annual implementation plans. Avahan utilized this devolved structure to formulate state-level Memoranda of Understanding with SACS to coordinate implementation of targeted interventions for high risk groups. In the transition phase, however, it funded institutional structures at the national and sub-national levels to ensure better planning and coordination.

The total budget of the first five year phase of Avahan (2003-08) was US\$268 million with the proviso that the program would be phased out and handed over to the government after reaching its objectives of scale-up. By the end of 2007, the Avahan program had achieved its main target of reaching 80 percent of most-at-risk population with HIV prevention services. It had also established Technical Support Units to provide national and state level program guidance, and supported the government to draw up the strategic plan for NACP-III (2007-12) drawing on the lessons learnt from Avahan's implementation experience.

The transition plan had three major components: policy planning and development, financing the plan, and managing and implementing the program during transition. For the first component, the government recognized the importance of strong political commitment, evidence-

based strategic planning, focusing on prevention of HIV among high-risk groups, and technical capacity building within NACO to achieve significant scale up in a short period of time. There was no conflict of interest between the two sides as far as the overall objectives of the program were concerned.

Regarding financing of the transition plan, it was important to harmonize the cost of service provision between Avahan and NACO, the former being significantly higher. This is true of many donor supported programs across the world, which need to be re-aligned with domestic program cost structures (especially health worker salaries) that are usually lower. An attempt to transition health workers from donor-funded clinics with higher salaries towards public health centers with lower pay can lead to attrition and loss of institutional knowledge and capacity which works to the detriment of the program in the long run. To avoid this, BMGF allocated an additional US\$ 90 million for the transition period between 2008-12. This gave time to the Government of India to formulate its post-transition human resource strategy and harmonize salary and other delivery related costs to sustainable levels.

Finally, it required considerably enhanced technical and managerial capacity for NACO to scale up its own program as well as absorb Avahan's share of the program interventions at the same time. This required considerable coordination and collaboration between NACO and Avahan among both partners to upgrade skills in data driven management, field supervision, guideline development, training tools, financial management

and monitoring. The process was highly successful – by 2010, NACO was implementing over 1600 high risk group interventions, nearly doubling the number of interventions from 2006 (at the start of the transition phase). Monitoring of individual interventions showed that there were no adverse impacts of the transition on key indicators, implying that the 'compact' was implemented successfully on all sides (Sgaier et.al.2013).

The key lesson from Avahan's 'compact' with Government of India is that it is critical to harmonize objectives, processes and systems on both sides, giving a greater stake for countries to lead a successful transition. Moreover, the transition takes time—it has to be planned in well in advance with ample margin for mid-course corrections if needed.

[Abridged and adapted from Sgaier, Ramakrishnan, Dhingra and others (2013), How the Avahan Prevention Program Transitioned from Gates Foundation to the Government of India, Health Affairs 32 (7): 1265-1273]

### **3. Cases' linkages to other dimensions of sustainable financing**

There are certainly overlaps and connections among the four dimensions introduced by this brief and proposed for discussion in TWGSF's first meeting. The following table concludes the brief by highlighting some linkages between the previous two country compact cases and the previously-discussed dimensions, including fair share and global solidarity, resource mobilization, and integration into health financing systems.



INDICATOR	SOUTH AFRICA	INDIA
<b>Fair Share</b>	South Africa is an upper middle income country and an economic power in the region. Its domestic share of HIV spending would increase from 64 to nearly 80 per cent as PEPFAR funding decreases over the next five years.	Share of domestic resources went up from 10 per cent in NACP-II (1999-06) to 25 per cent in NACP-III (2007-12) while the overall resource envelope increased 5 times from \$458 million to \$2.5 billion. Govt's contribution increased by over 13 times in absolute terms implying strong commitment for HIV financing.
<b>Global Solidarity</b>	PEPFAR ensured rapid scale up of treatment at a time when the government's commitment was low, with significant increases in funding between 2004-8. PEPFAR allocations have been stable thereafter, funding nearly 25 percent of the total program.	The number of stakeholders for NACP-II increased significantly and laid the groundwork for a comprehensive response. Avahan managed to leverage the institutional structures at the sub-national level and demonstrated the feasibility of a nationwide scaled up response.
<b>Resource Mobilization</b>	No earmarking or use of innovative tax instruments for HIV resource mobilization. Period of economic growth and rising mineral prices aided domestic fiscal health, but line ministries still face budget cuts in 2013-2015. But health has been protected from cuts and AIDS budget is increasing, in part due to PEPFAR transition.	Civil society activism and high political commitment ensured increasing allocation for HIV in Five Year Plan as well as annual budget of the Ministry of Health to support the scale up after Avahan transition. Department of AIDS Control was established within the Ministry of Health, thereby ensuring sustainability of HIV policy and financing in the future.
<b>Integration of AIDS financing into national health financing systems</b>	PFIP shifts the strategic focus of PEPFAR from service delivery to health systems strengthening and technical support, and its objective would enhance integration of HIV services to improve efficiency of the national response. However, little focus to date on potential challenges of integrating HIV financing and delivery into future National Health Insurance. May signal need for HIV-focused analysis and piloting in NHI design phase.	NACP-III disaggregated and costed the HIV services in the targeted prevention package as part of the transition compact, with the objective of integration of some of the services into health system. Still a work in progress.



## 5. Potential focus issues and questions for TWGSF

These two cases illustrate just some of the issues arising in ensuring smooth HIV financing transitions between donors and countries. As more countries embark on their own HIV financing transitions, it could be useful for the WGSF to provide technical guidance on the economically-informed principles, best practices, and tools/mechanisms that would enable strong compacts for smooth, sustainable transitions.

UNAIDS is currently supporting a research effort that is creating an inventory of compacts/agreements used by the largest HIV donors and analyzing those for best practices (preliminary results to be presented in the TWGSF first meeting). That work will begin to shed light on question such as:

- **What is the optimal length/duration of compacts?**
- **How many and which actors should be included in compacts?**
- **What kind of financing targets should be included, and what principles, processes, and tools are used to determine these?**
- **What monitoring and evaluation mechanisms are necessary and feasible?**
- **What are the consequences of either countries or donors not meeting the conditions of the agreement?**

Following the initial study, the TWGSF could consider fine-tuning guidance on these questions based on greater access to various donors' and countries' experiences, processes, and constraints. More generally,

however, the TWGSF may wish to consider the following for this dimension:

- **What is the overall record to date for HIV-financing transitions where they have occurred?** What have been the final outcomes and what are the lessons to be learned from these experiences?
- **What is (or should be) the role of country compacts in ensuring a sustainable financing policy for HIV programs?** How can elements of these compacts be differentiated according to investment priorities, domestic funding needs and capacities, epidemiology (epidemic type), and donor agencies?
- **Who are the key stakeholders for country-donor transition agreements?** What is an efficient balance between streamlining the process with fewer actors or maximizing inclusion/participation of stakeholders?
- **What role do coordination mechanisms to harmonize program delivery standards and unit costs play in country compacts?**
- **How can the parties be made accountable for their financial performance?** What instruments (annual scorecards and reports, independent verification of performance, annual review meetings, etc) have been shown to be most effective in using the results of financial monitoring to improve performance?
- **What are the key factors for minimizing risks during the financing transition process and to ensure sustainability?**



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# ANNEX 1

## Key findings from pre-meeting interviews of TWGSF participants



DIMENSION OF SUSTAINABLE FINDING	KEY COMMENTS
<b>Fair Share and Global Solidarity</b>	<p>There is a need to map fiscal flows by understanding country models of growth and revenue projection in the short term (up to 5 years), and clarify definitions on what constitutes public and private spending on HIV. More technical work is needed on the integration of System of Health Accounts (SHA) with Public Expenditure Reviews (PER) and moving towards separate disease subaccounts within SHA.</p>
	<p>Donor funding should have a role to play in stimulating domestic government contributions instead of displacing it. It is important to establish whether donor funding models disincentivize domestic government funding.</p>
	<p>It is important to begin to standardize how HIV contributions or resources are measured, e.g. as percentage of health or government budgets, or as share of GDP. Currently, different databases measure this differently.</p>
	<p>Need for political mobilization at the country level should not be underestimated. Allocation to health and HIV is a political decision, and high level engagement has worked better for donors in negotiating higher counterpart resource mobilization.</p>
	<p>A reasonable pathway to increasing spending is needed instead of an arbitrary spending target like the Abuja Target. The latter may be fine as an aspirational goal, but context must be taken into account to determine funding growth pathways for planning sustainable funding levels.</p>
	<p>Defining and standardizing how recipient fair share is to be understood and calculated is really important.</p>
	<p>It is important not to look only at disease by disease funding which works better from a procurement perspective and not from a health system financing perspective.</p>

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Country context, revenue sources, and political situation are very important to consider for calculating fair share, although generic aspirational benchmarks may still be useful. It is important to monitor donor commitments as well.

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**Expanding International and Domestic Resource Mobilization**

According to CHAI estimates, additional resource needs for a significant scale up in treatment from 15 to 26 million can be met within existing funding levels, provided the resources are allocated efficiently.

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Sustainability depends on predictable financing which implies governments (especially ministries of finance) are clear on which partner commits what and for how long, so that the remaining can come from domestic resources. Hence, greater transparency improves efficiency and sustainability.

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The discussion on financial sustainability must go beyond resource mobilization to include the effect of current policy decisions on future funding needs.

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The theory and practice of public finance offer tools for assessing the sustainability of public debt. Arguably, these tools are applicable to the analysis of the financial burden posed by HIV programs. Assessing the costs of HIV programs through a lens similar to Debt Sustainability Analyses by IMF and WB, for instance, would build on an internationally established precedent to offer a criterion for motivating a need for external assistance for high burden countries.

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There is a need for reliable short run projection models for greater efficiency and predictability (not necessarily standardized since ministries of finance work very differently across countries).

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Given competing health priorities, it will be interesting to understand how financing needs for other health and development priorities were affected where countries have developed resources for HIV from new revenue streams.

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It is important to consider new revenue sources along with the scope for reallocating existing tax revenues among sectors. Simple disease by disease revenue mobilization is not helpful as sustainable funding needs to be looked at in the context of competing health system commitments.

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It is useful to consider the social determinants of health and view the issue of health promotion in totality. HIV is a socioeconomic issue as well as a health issue and overall HIV financing would need to be multi sectorial for it to be properly addressed. Health authorities can use the health promotion objective to lobby for greater resource allocation in other (non)health sectors as well. There needs to be greater emphasis on funding synergies in the HIV response instead of continuing to view budgeting in discrete silos.

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Policymakers must not fall into the trap of pursuing “innovative financing” based on principal rather than practicality. To properly assess potential sources of new revenue, we must know how much revenue they can realistically raise through calculations at the country level or overall. If that potential is low, it may be better to focus on other options.

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**Integrating AIDS Financing into National Health Financing Systems**

Integrating components of HIV programmes (HIV testing, STI management, ART delivery) with general healthcare delivery mechanisms an easier question to address than the systemic integration between vertical and horizontal programs, which is essentially a political question.

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More technical work needs to be done especially in the context of payment systems both for general health insurance mechanisms as well as to demarcate service delivery costs. Fragmentation of payments for personal and institutional services creates inefficiencies and may ultimately be unsustainable.

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It is important to clearly understand whether a special or a generalized HIV & AIDS service delivery structure is needed before considering financing integration. If services are primarily personal as opposed to population based (like health education, etc.), Then integrating financing makes immediate sense through a combination of domestic or donor funding.

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It is important to think about financing services and interventions (like focusing on the target populations and delivery strategy) rather than entire programs for integration. A service oriented perspective is best as it keeps the focus on individuals and the service delivery interface (either at the level of the core PHC and delivery systems or specialized mechanisms to reach marginalized groups).

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As HIV is integrated into the overall health system, it becomes harder to monitor which diseases have received funding because there are so many shared resources. Funds are often doublecounted as having gone to multiple diseases. The new National Health Accounts approach looks for ways to allocate tracking of shared resources to prevent this issue from occurring. Problem: this is still too slow for monitoring of partnership agreements (where answers are needed easier and faster).

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**Transitions from Donor to Domestic Financing: Country 'Compact' Case Studies**

Even with a phased reduction in funding, donors should remain engaged at a policy level to ensure sustainability of the HIV response. Otherwise, the epidemic may bounce back as it did when reduced emphasis on malaria control led to re emergence in several regions.

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Funding transitions should be modeled such that (i) country income should be only one determinant of the minimum threshold for domestic financing as a percentage of donor funding, (ii) the overall trend of domestic financing should be increasing, and (iii) the development of a system for health and disease spending should be a prerequisite.

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Defining the term "transition" and laying it out in its entirety is important so as to resolve issues and challenges around its definition. Currently, it can mean different things to different participants (e.g. government vs. donors).

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It is key that using country compact as a tool to facilitate transitions is done in a way that is not just about handing over financing. Transitions are about more than just financing; the programmatic transition that a country will have to go through must also be considered.

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It is important to have a good sense of programmatic content to develop financing targets in compacts. Hence, transparency of information/data to accurately and realistically calculate financing and programmatic targets is essential. That has been a major deficit in HIV & AIDS partnership compacts as it has not been clear how financing targets are set and linked to program delivery.

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The disengagement dialogue needs to also look at how donors have distorted/affected delivery mechanisms and cost structures in health markets, particularly in wages of health workers. For instance, have AIDS donors distorted health labor markets in recipient countries by bidding up wages for dedicated AIDS workers? That is a major headache for countries as donors begin to pull out

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Most country compacts are done and signed at very high official levels. At the technical/implementation level, holding partners accountable would be easier if technical professionals were involved in the designing of the compact so that monitoring tools could be put in place right away. Monitoring can become really academic otherwise.

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It is useful to be very specific in discussing financing and programming for partnerships: to really identify the areas in which countries should lead and own the HIV & AIDS response, donors need to understand country budgeting and financing processes/budgetary cycles. This will be a means of identifying for everyone players who need to be involved and where. It will increase critical understanding of country programmes on part of donors, and better enable them to hold countries accountable. Hence, considering how donors can promote collaboration to produce material or conduct training to improve their mutual understanding of diverse in country processes will enable them to ask the right questions and properly finance the correct interventions.

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Publicly managed, owned, or run health systems are integral to sustainable funding of HIV. Parallel donor managed systems should therefore be integrated with local health systems.

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Moving to a good balance between domestic funding and donor contributions is essential instead of just targeting transitions. We need to track domestic contribution better even though it is smaller than donor funding, as that is essential to boosting domestic HIV funding.

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Policymakers should be wary of having only high level discussions of sustainable financing in the context of transitions. There is a dire need for more solid evidence of what happens on the ground as donors pull out. How often do systems and initiatives survive? There is space for considerable research on transition and measurement issues.

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Instead of looking at domestic vs. donor contributions in HIV & AIDS, we may want to look at how well countries are spending their own funds independent of donor money. Are they spending according to disease burden or by other priorities? Donors can incentivize good spending by offering additional funding for those programmes. [Note: this would be a theoretical exercise because donor and government funding are not often not separate]

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The history of AIDS financing is important to understanding and planning sustainability. Since partners initially rushed in with funds without planning for long run sustainability, developing programming and funding capabilities in recipients is important before donors wind down. Merely raising new domestic resources will not wean recipients off of donor support.

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<b>NAME OF KEY INFORMANT INTERVIEWED</b>	<b>AFFILIATION</b>
<b>Elya Tagar</b>	Clinton Health Access Initiative
<b>Joseph P. Kutzin</b>	World Health Organization (not a member of the TWGSF)
<b>Markus Haacker</b>	London School of Hygiene and Tropical Medicine
<b>Michael Borowitz</b>	Global Fund
<b>Nandini Oomman</b>	Independent analyst; ex CGD AIDS Monitor
<b>Regina Ombam</b>	Kenya National AIDS Control Council
<b>Stephen Resch</b>	Harvard School of Public Health
<b>Teresa Guthrie</b>	Independent analyst South Africa
<b>Mead Over</b>	Center for Global Development (not interviewed, but participated by sharing documents)

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# HIV ERG

HIV Economics Reference Group

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**BACKGROUND  
BRIEF FOR FIRST  
MEETING**

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ECONOMICS  
REFERENCE GROUP

Technical Working Group for  
Sustainable Financing