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CTL-for-Health/FTT-with-Health: Resource-Needs Estimates and an Assessment of Funding Modalities

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Executive Summary

Global health activists have recently taken up the challenge of identifying new sources of revenue in rich countries to help fund desperately needed health investments in developing countries. Health activists in Europe and elsewhere have joined their Southern partners in demanding that developing countries meet the Abuja Declaration-style commitments of spending 15% of government budgets on health. Activists are also insistent that donor governments not be excused from meeting their pre-existing commitments to expand donor/development assistance for health, for example by fulfilling their promises to commit 0.7% of gross national income to official development assistance (15% of which, equivalent to 0.1% of GNI, would be for health). However, even if these domestic and donor goals are met, there is still likely to be a shortfall in needed resources. Accordingly, activists have rallied around new innovative funding proposals including a Currency Transaction Levy-for-health (CTL-for-health) or a broader Financial Transaction Tax-with-health (FTT-with-health). Either measure could serve the dual purpose of dampening excess speculative activity in designated financial markets and of raising funds, certainly for health, but possibly – in the case of an FTT-with-health – for broader purposes including recouping bail-out costs, achieving fiscal balances, creating jobs, and funding climate control and other development activities.

Although calculating the financial resources needed to reach Millennium Development and other health goals in developing countries is difficult, costing was undertaken in 2009 by the Taskforce on Innovative International Financing for Health Systems. Unfortunately, this costing was limited to low-income countries, and its outcome-goals were often under-ambitious with respect to previous international health goals such as Universal Access to HIV/AIDS prevention, treatment, and care. Accordingly, the author used subsidiary estimates on targeted global health needs to calculate a more global resource needs estimate 2009-2016. A comparison between the Taskforce's estimate and the author's estimate is found in the chart below.

Health Need	Additional Resources Needed 2009-2015	Additional Resources Needed in 2015
Taskforce Working Group 1 Totals:		
WHO-Normative	\$251 billion	\$45 billion
MBB maximum-impact	\$227 billion	\$58 billion
Author's Calculations		
Malaria	\$27 billion	\$3.5 billion
Tuberculosis	\$28 billion	\$6.2 billion*
HIV/AIDS	\$125 billion	\$35 billion
Newborn, Maternal and Child Health, and Reproductive Health	\$127 billion**	\$18.2 billion
Chronic and Neglected Diseases	\$131 billion***	\$18.7 billion***
Human Resources for Health****	\$68 billion	\$13.5 billion
Totals (excluding/including \$50 billion for HRH)	\$456 billion	\$95.1 billion

* Assumes steady-state rather than scale-up investment; ** Focuses on aid dependent countries; *** Somewhat speculative given the absence of baseline expenditure figures.

Within the range of \$227-\$456 billion needed over seven years, developing countries will obviously be expected to significantly increase their health investments as their economies recover from the global recession. Likewise, donor/development assistance for health can be expected to expand, though not at the needed pace. Nonetheless, significant additional

resources will be needed, even under optimistic assumptions about governments' ability to meet earlier promises and about projected growth. It is expected that a CTL-for-health or an FTT-with-health could go a long way in closing any remaining resource gap.

Assuming that a CTL-for-health or an FTT-with-health is adopted and that its revenues will be deployed to help fill the expected gap in funding for global health needs, there are critical questions remaining about how resources might be channeled through existing health financing mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the World Bank, the GAVI Alliance, UNITAID, European Commission MDG contracts (EC MDG Contracts), the International Health Partnership and related initiatives (IHP+), and bilateral funding including the US President's Emergency Plan for AIDS Relief (PEPFAR) and Global Health Initiative (GHI). Alternatively, emerging or new mechanisms could be used such as the Global Fund, GAVI, World Bank and WHO Joint Health System Strengthening Platform (Joint HSS Platform) or a recently proposed Global Fund for the Health MDGs. These mechanisms have different strengths and weaknesses as summarized in the charts below.

Mechanism	Past Performance	Priority Focus	Country Ownership/Coordination/Harmonization
Global Fund	Strong: results-based funding, long-term commitments, reduced volatility, equity	HIV, TB, malaria, Health System Strengthening (HSS)	Country-led but behind on harmonization
GAVI	Strong: long-term commitment, low volatility, equity	Immunization and HSS	Country-led but behind on harmonization
World Bank	Weak: poor performance-based funding, conditionalities and debt-based financing, not focused on the poor	Health Finance, multi-sectoralism, health systems	Engages with Ministries of Finance but behind on harmonization
UNITAID	Strong: Market impact, secure sources of revenue, value for money, medium-term commitments	Medicines and diagnostics for HIV, TB and malaria	N.A. in general but patent pool will make it easy to procure affordable medicines
EC MDG Contracts	Mixed: Has underemphasized health	HSS, general budget support (in theory)	Strong in theory, but mixed
IHP+	Weak: Only 4 compacts to date, has not been able to raise money	National health planning and financial accountability	Strong
Bilateral Aid	Mixed: Varies by donor in terms of volatility, duration, disbursement/commitment ratio, and conditionality	Varies by country, US historically focused on priority diseases; European donors focus more on child and maternal health, and HSS	Varies by country, generally very weak
Joint HSS Platform	Just being piloted now	HSS for priority diseases and positive synergies in regard to health systems more broadly	Expected to be strong
Proposed Global Fund for Health	NA, but plans to use Global Fund model	Comprehensive primary health care, human resources for health, and HSS	Undeveloped at present; potential for reduced transaction costs

Mechanism	Civil Society Engagement	Political Reputation	Overall
Global Fund	Very strong, funding for CSS, but persistent weaknesses in CCMs	Mixed: dwindling support	
GAVI	Strong: growing role in governance, funding for CSS	Strong: Private sector support	
World Bank	Weak and contentious at global level; lack of knowledge at country level, history has funded CS capacity building	Some European donors like it	
UNITAID	Strong at global level	Strong but not well known	
EC MDG Contracts	Weak		
IHP+	Mixed at first, still hard at country level but now funding local CS strengthening	Best in UK; failure to deliver funding is very problematic	
Bilateral Aid	Generally weak but mixed, PEPFAR allows informal consultation, funds local NGOs	Governments like to control the purse-strings, but developing countries are deeply ambivalent	
Joint HSS Platform	Weak at beginning, will be important at country level	Boosted by High Level Taskforce on Innovative Financing	
Proposed Global Fund for Health	Strong role proposed, but may be difficult to coordinate so many diverse health advocates	Just starting to be debated	

1. Brief Overview of Proposals and Options for a Currency Transaction Levy-for-Health or Financial Transaction Tax-with-Health

Led initially by health, climate change, and other development activists and subsequently taken up by politicians in the UK, France, and other European countries, there has been growing (but more recently waning) political support for a small tax on foreign exchange or currency transactions, a CTL, and/or on a broader set of financial transactions, e.g., stocks, bonds, foreign exchange, commodities, derivatives, and other financial instruments, an FTT. Nobel laureate James Tobin first proposed the idea of a CTL almost 40 years ago. Although the original Tobin tax was designed to throw sand in wheels of rampant financial speculation, more recent proposals have propounded a more pluralistic set of objectives mostly in response to the crushing financial crisis. That crisis has wrecked the fiscal balance sheet of governments worldwide, thrown tens of millions out of jobs and into poverty, and reduced needed funding for global public goods including Millennium Development Goals (MDGs), universal access, climate change, education-for-all, and human development more broadly. Global health activists initially rallied behind a CTL-for-health that might have little or no impact on the volume of trades but could still raise \$33 billion a year, if levied on all major currencies, and urged the High Level Taskforce on Innovative International Financing for Health Systems to include such an alternative in its deliberations. Thereafter, a pluralistic coalition of activists began promoting a larger and broader FTT, partially in response to

Gordon Brown's championing of such a measure, which could raise \$200-\$900 billion annually depending on the particular formula adopted.

As calls for a broader FTT emerged, the targeted uses of its potential revenues broadened and narrowed simultaneously. Potential uses of revenues broadened in the sense that proponents began to champion speculation-dampening as an express policy goal of an FTT.¹ As acknowledgement of the harmful effects of short-term speculation and assets bubbles grew with respect to currency, commodity, real estate, credit default swap, and other exotic over-the-counter derivatives and spot markets, analysts argued that an FTT could slow down socially useless casino trading and better align capital flows with economic fundamentals² and with the needs of the real economy.³ Simultaneously, potential uses of the FTT broadened as labor groups in rich countries clamored for job-creation; state, provincial, and local governments petitioned for safety-net and basic public-service supports; and major financial institutions demanded continued efforts to underwrite financial market liquidity⁴. On the international arena, climate change and development advocates also made strong claims to shares of the FTT.

Paradoxically, the proposed uses of FTT revenues also narrowed geographically – many politicians and domestic advocates began to focus on internal needs of rich countries that had paid for financial sector bailouts, spent money hand-over-fist on fiscal stimulus to counteract plunges in private spending, and seen their tax revenues plunge. Thereafter, proposed uses narrowed even further, as some analysts began to focus less on dampening speculation and more on insuring against loss that might arise in the next financial meltdown. In a sense, these analysts are working on behalf of the “progressive” wing of the financial industry that believes that prudential reserves, paid in advance, would dampen some of the worst excesses that had battered their investors' bottom-lines; pay for future, hopefully more modest financial meltdowns; and simultaneously dilute demand for more robust re-regulation of the financial industry. In this broadened/narrowed context, health advocates have been fighting to include global health as a “destination” for FTT revenues, and thus essentially championed an FTT-with-health.⁵

It is beyond the remit of this paper to analyze the variables of proposed CTLs and FTTs in depth, but it is appropriate to summarize some of the tensions that exist, especially tensions that must be navigated if revenues are to be targeted towards global health needs.

First, the tension in fundamental goals, between rebalancing rich countries' fiscal imbalances and addressing global needs, is huge. The Trade Union Advisory Committee to the OECD

¹ The volume of financial transactions in the global economy is 73.5 times higher than nominal world GDP, nearly a five-fold increase from 1990. Financial trading has been growing exponentially in relation to world trade and investment in productive activity in the real economy. Not only has the volume of speculative trading increase, so has its speed, which predictably leads to trend-dependent assets bubble and bursts or bull and bear markets. Stephan Schulmeister, *A General Financial Transaction Tax: A Short Cut of the Pros, the Cons and a Proposal*. WIFO Working Papers 334/2009.

² “Economics fundamentals” in this context means the “real value of an asset,” which in a business example would be based on the company's revenue, earnings, assets, liabilities and growth.

³ The “real economy” is the part of the economy that is concerned with actually producing goods and services, as opposed to the part of the economy that is concerned with buying and selling on the financial markets

⁴ “Liquidity” in this context refers both to the ease of buying and selling assets at minimal cost and financial institution's ability to meet financial obligations to its lenders and borrowers.

⁵ This term is shorthand for an FTT that would among other things provide substantial and long-term funding for global health.

estimates that fiscal consolidation (reduced net deficit spending) will require \$300-370bn per year in increased revenue and reduced expenditures over the coming years.⁶ Simultaneously, to meet Official Development Assistance (ODA) goals of 0.7% of gross national income and the costs of climate-change adaptation and mitigations in developing countries will require an additional \$324-\$336bn per year between 2012 and 2017 (\$156bn for climate change, \$168-180bn for ODA). Although analysts agree that the fiscal consolidation component is necessary because of unprecedented post-war budget deficits and government debt/GDP ratios, that consolidation will undermine spending on public services and welfare and resulting reduced budgets will fall far short of catalyzing a prompt return to full employment. In essence, there is a zero-sum tension between meeting the internally focused political and financial needs of powerful domestic constituents and political decision-makers in rich countries, where financial transactions and institutions are centered, and the global needs of other governments and of poor people in developing countries. Non-financial-center⁷ and climate-change-impacted countries that have also suffered fiscal strains from the economic crisis want some portion of FTT revenue, and global justice advocates are pressing the unmet health, education, and human development needs of the poor. Unfortunately, when push gets to shove and without sustained and successful advocacy by CTL-for-health/FTT-with-health advocates, politically powerful constituencies in rich countries are likely to win the lion's share of the resources.

Second, there is a political tension between a demand "to make the banks pay (for themselves)" and one "to make banks pay (for the Great Recession)". The International Monetary Fund (IMF), the US and Canada, and now Germany seem to be more narrowly focused on: (1) recouping the direct costs of the financial sector bailout and simultaneously taxing either excess bank profits and bonuses or excess liabilities as a means of dampening speculation, and (2) collecting a bank resolution fee that will pay for the future euthanasia of failing, too-large-to-fail financial institutions. Despite wanting to pre-fund a resolution mechanism, proponents want to do so without creating "moral hazard" (the counter-productive policy of immunizing all the downside risks of speculative activity⁸) and without prompting backlash by a public that is furious at bank bailouts. We could call this a financial insurance proposal (banks prepay for their own risks of failure). The financial goals of this kind of tax are relatively modest – in the US raising \$90-\$117 billion total over ten years to pay for TARP losses and another \$50 billion total for a resolution trust fund. Proponents of a broader FTT, on the other hand, want much more money – hundreds of billions of dollars a year – and want that money to redress fiscal imbalances, reduce debt, promote job creation, and help both developed and developing countries dig their way out of the recessionary trough that they were thrown into. For countries already struggling to meet MDGs, the food, fuel, and financial/recessionary crises from 2007-2010 have been a triple-calamity, and additional resources are desperately needed to make up for lost ground.

Third, the FTT must decide what level of ambition and caution it has in terms of: (1) tax rates, the scope of covered transactions, and the total amount of money raised after adjusting

⁶ TUAC. 2010. The Parameters of a Financial Transaction Tax and the OECD Global Public Good Resource Gap, 2010-2020. http://www.tuac.org/en/public/e-docs/00/00/06/7C/document_doc.phtml.

⁷ The world's major financial centers are New York City, London, Hong Kong, Singapore, Tokyo, Chicago, Zurich, Geneva, Shenzhen, Sydney, and Shanghai, meaning that countries that do not house major financial centers would collect relatively little from taxing financial market transactions. Z/Yen Group. 2010. Global Financial Centers 7. http://217.154.230.218/NR/rdonlyres/661216D8-AD60-486B-A96F-EE75BB61B28A/0/BC_RS_GFC7full.pdf.

⁸ To guard against perverse incentives, President Obama is also proposing a tax on bank liabilities, an increase in reserve requirements, and break up or dissolution of too-big-to-fail financial conglomerates.

for the impact of the tax on trading volume, and (2) the desire to avoid negatively impacting socially useful commercial transactions and saving/lending liquidity more broadly. Architects of the FTT must decide whether they want to safeguard certain market participants, for example central banks and/or small-scale households, and whether they want to impose differential rates on different transaction classes, for example more inhibitory rates on hot speculative transactions and lower rates on savings-, trade-, and consumption-oriented transactions.

Fourth, there is tension between large-scale FTTs which must be levied through coordinated global action and more narrowly drawn FTTs and CTLs that can be adopted by individual governments or groups of countries and still generate significant revenues. The centers of global finance, particularly the US and the UK, express great concern about the risk of tax avoidance and trading-activity arbitrage – that financial traders will move to other, non-taxed jurisdictions or to unregulated and untaxed over-the-counter trading systems. These risks will be reduced if more countries collaborate in enacting an FTT, if countries utilize existing, easy-to-use computer systems to collect the tax, and if countries cooperate to increase scrutiny and regulatory control of over-the-counter transactions so that they too can be taxed. Moreover, the risk of financial market relocation is greatly exaggerated, as there are already significant differences in trading costs between countries and yet the UK and the US remain dominant financial centers. Because prospects for global cooperation are relatively dim, proponents of a CTL-for-health are emphasizing the benefits of a CTL that can be adopted unilaterally, even by smaller currencies, and thereafter extended gradually and more broadly, hopefully to major currencies like the dollar, the euro, the pound, and the yen.

Fifth, there is a tension in designing taxes where the burdens are primarily borne by rich investors and large financial institutions versus where the real incidence is passed through to smaller institutional and individual customers. Although many taxpayers are in favor of soaking the rich, most of them want to avoid paying higher taxes on their savings and retirement accounts and retail currency transactions. CTL/FTT advocates should acknowledge and respond to the risk that the actual tax incidence might be passed on to borrowers. Rich people, rich financial institutions, and rich exchanges specialize in trying to keep their costs down and keeping money in their own pockets. It is naïve to think that they would let hundreds of billions of dollars leak from their personal and institutional bottom lines without trying to add the tax into the costs of financial services offered to others, some of whom would not otherwise be affected by an FTT.

Health activists are at a strategic crossroads with respect to a CTL/FTT. They initially preferred a ring-fenced CTL-for-health, but had trouble garnering publicity or broader political support. The ripple of support for a CTL-for-health was swamped by a much larger FTT-for-all wave that had unions, climate-change activists, development activists, financial systems reformers, and even publicity-seeking politicians behind it. Health activists changed strategies and moved their surfboard to the FTT wave as they realized that the casino economy was itself bad for health, especially for the health of poor people. Although they persistently advocated that global needs, particularly health needs, should be targeted by FTT revenues, they avoided political battles on apportionment that might splinter the emerging FTT coalition. They also explored using a quicker unilateral or core-country CTL-for-health as proof of concept for more comprehensive and coordinated FTT. Thereafter, they watched with some dismay as domestic needs got prioritized and with even greater dismay as

US/UK/IMF opposition⁹ created a cross current that undermined their collective momentum and turned politicians' fancy toward more modest financial insurance solutions.

The challenge now is for health activists to consolidate wide-spread political support for the idea that an FTT can help fight bloat in the financial industry, reduce short-termism and speculative churning in favor of investing in the real economy, and at the same time generate resources for global health commitments, including MDGs 4, 5, and 6 and universal access to HIV treatment, prevention, care and support. Alternatively, they must force a launch of a more modest CTL-for-health wherever they can, for example in a Nordic country, so that proof-of-concept can be established.

2. Additional Health Resource Needs, Projected Funding, and Funding Gaps

Estimating additional resources needed, above current funding levels, to expand health spending in developing countries in order to achieve MDG health goals is difficult. Although information on current health expenditures is flawed, particularly because so much is off-budget and out-of-pocket, estimates of future needs are even more imprecise. Nonetheless, in addition to major 2001 and 2009 macro-studies purporting to detail overall health spending needs, there have been disease- and need-specific estimates focusing on scaling-up particular responses, e.g., HIV or human resources for health. However, overlaps, gaps, and inconsistencies in these reports, including countries covered, level of ambition, and activities costed, make it hard to know exactly how much money is needed over what period of time to reach the health-related MDGs and other more ambitious global health goals. The task is further complicated because there are complementarities, positive synergies, and economies of scale and scope when acting boldly to meet multiple health needs while strengthening underlying health systems. Moreover, robust responses can change epidemiological trajectories, whereby early investments can reap significant savings in the future. When complementarities, synergistic efficiencies, and prevention benefits occur, health-spending needs may decrease over time. Despite residual degrees of imprecision, it is important to estimate approximate global health resource needs both to assess the possible impact of a health-related CTL/FTT and for informing advocacy at the global and national level.

*Commission on Macroeconomics and Health (2001)*¹⁰

In 2001, the Commission on Macroeconomics and Health (CMH) estimated that an additional \$57 billion would be needed annually by 2007¹¹ – on top of the 2002 spending level of \$106 billion – in order to reach mid-term benchmarks on 2015 Millennium Development Goals 4 (child health), 5 (maternal health), and 6 (HIV, TB, malaria, and other diseases) in 83 poor countries.¹² By 2015, annual additional resource needs would reach \$94 billion. Translated to per person costs, CMH recommended that health expenditures should, on average, reach

⁹ The IMF has adopted a relatively critical perspective on an FTT and has instead proposed a Financial Activities Tax that would tax profits and excess remuneration packages in the financial sector. IMF. 2010. A Fair and Substantial Contribution by the Financial Sector: Interim Report for the G-20.

http://news.bbc.co.uk/2/shared/bsp/hi/pdfs/2010_04_20_imf_g20_interim_report.pdf.

¹⁰ Commission on Macroeconomics and Health. 2001. Investing in Health for Economic Development.

<http://www.cid.harvard.edu/archive/cmh/cmhrefport.pdf>.

¹¹ CMH used 2002 constant US dollars.

¹² Ibid. The countries are shown in Table A2.B and include 48 least developed countries, 23 other low-income countries, 19 lower-middle-income countries, and only 3 upper-middle-income countries, Botswana, Gabon, and South Africa (CMH, 2001, p. 175.)

\$34 per person by 2007 and \$38 per person by 2015. Needless to say, these early estimates of resource needs were not met, with the predictable consequence that resource needs have escalated.

Of the \$94 billion additional needed by 2015, CMH estimated that developing countries should and could invest the most toward their health needs. CMH anticipated increased domestic health expenditures totaling \$35 billion by 2007 and \$63 billion by 2015 (61% and 67% of total need respectively) with middle-income countries being able to spend more than least-developed and low-income countries. To achieve this level of health financing, African countries would need to abide by their Abuja Declaration, which required them to allocate at least 15% of their national budgets to improving their health sector performance.¹³ Alternatively, the CMH anticipated that countries would raise their health expenditure first by 1% and then by 2% of the gross domestic product. Based on these estimates of increased domestic resources, the CMH estimated that total donor assistance for health should reach \$27 billion by 2007 and \$38 billion by 2015. Although CMH figures were the best-to-date estimates for calculating resource needs for health in 83 poor countries, they were far from precise. For example, early efforts to use CMH costing methodologies in five developing countries showed the need for significantly increased resources in countries heavily impacted by HIV/AIDS.¹⁴

Taskforce on Innovative International Financing for Health Systems (2009)

The most recent and comprehensive effort to estimate resource needs for reaching the health-related MDGs was undertaken by Working Group 1 of the Taskforce on Innovative Financing for Health Systems (Taskforce).¹⁵ Its estimates do not match up directly with the CMH's because they are limited to 49 low-income countries and because they took 2008 as the base year for spending instead of 2002. Complicating the comparison of Working Group 1's estimate even further, two scale-up sub-working groups used two significantly different costing methodologies to come up with separate global resource need estimates. Despite these caveats, Working Group 1's estimates have a great deal of credibility given the array of technical resources and updated data that were amassed for their development.

The first sub-working-group used the WHO normative method for assessing resource needs, known as global price tags (WHO-normative), which focused on resources required to scale up country health systems to a level that was considered "best practice" by experts and practitioners. It reflects a more facility-based approach and prioritized building up the service and physical infrastructure of health centers and district hospitals and training and recruiting a health workforce top-heavy with doctors, nurses and midwives. The second sub-working-group used the World Bank/UNICEF method, known as marginal budgeting for bottlenecks (MBB), which identified critical constraints in existing health systems blocking intervention scale-up and then specified cost-effective strategies to overcome them. In

¹³ Africa Union. 2001. Abuja Declaration on HIV, AIDS, TB and other related infectious diseases http://www.un.org/ga/aids/pdf/abuja_declaration.pdf. See also, Africa Union. 2006. Abuja Call for Accelerated Action Toward Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa. <http://www.chr.up.ac.za/undp/regional/docs/audeclaration1.pdf>.

¹⁴ Millennium Project. 2004. Millennium Development Goals Needs Assessments: Country Case Studies of Bangladesh, Cambodia, Ghana, Tanzania and Uganda. http://www.unmillenniumproject.org/documents/mp_ccspaper_jan1704.pdf.

¹⁵ Constraints to Scaling Up and Costs – Working Group 1 Report. 2009. http://www.internationalhealthpartnership.net//CMS_files/documents/working_group_1_report_EN.pdf.

making these estimates, the MBB sub-group calculated three different impact scenarios – maximum, medium, and minimum. It assumed a more community-based approach that would greatly expand the number of community health workers but delay significant infrastructure and clinical service investments until later. Under both scale-up scenarios, spending on health in the 49 low-income countries was estimated at \$31 billion in 2008, an average of \$25 per capita, \$9 of which came from government, \$10 private/out-of-pocket, and \$6 from donor assistance for health.¹⁶

A comparison of overall resource needs 2009-2015 for the two scale-up models shows some interesting differences. Total additional resource needs under the WHO-normative model were \$251 billion versus \$227 billion for the maximum-impact MBB model and only \$112 billion for the medium-impact MBB model, largely because initial investments are less under MBB costing.¹⁷ However, incremental annual cost by 2015 (above the \$31 billion being spent in 2008), was \$45 billion for WHO-normative, \$58 billion for maximum-impact MBB, and \$36 billion for medium-impact MBB. Additional per capita costs by 2015 were \$29, \$38, and \$24 respectively (see edited charts from Working Group 1 Report below).

Table 2: Additional costs by year for the 49 countries (total and per capita)								
Total (in US\$ billions)								
	2009	2010	2011	2012	2013	2014	2015	Total
WHO Normative Approach	\$19.34	\$27.47	\$36.01	\$41.79	\$39.56	\$42.11	\$45.16	\$251.44
Capital	\$12.80	\$17.58	\$22.88	\$23.34	\$13.60	\$8.28	\$2.25	\$100.73
Recurrent	\$6.54	\$9.88	\$13.12	\$18.45	\$25.96	\$33.84	\$42.91	\$150.70
MBB Maximum Scenario	\$12.73	\$16.7	\$23.57	\$24.43	\$27.66	\$64.17	\$57.99	\$227.24
Capital	\$9.73	\$10.63	\$13.47	\$11.35	\$10.79	\$43.2	\$33.28	\$132.45
Recurrent	\$3	\$6.06	\$10.09	\$13.08	\$16.87	\$20.97	\$24.71	\$94.79
MBB Medium Scenario	\$4.3	\$5.65	\$7.31	\$12.64	\$18.61	\$26.62	\$36.48	\$111.62
Capital	\$2.49	\$2.45	\$2.69	\$5.61	\$8.29	\$13.06	\$19.36	\$53.94
Recurrent	\$1.81	\$3.21	\$4.62	\$7.03	\$10.32	\$13.56	\$17.13	\$57.68
Per capita (in US\$)								
	2009	2010	2011	2012	2013	2014	2015	
WHO Normative Approach	\$14.20	\$19.75	\$25.35	\$28.82	\$26.72	\$27.87	\$29.30	
Capital	\$9.40	\$12.64	\$16.11	\$16.10	\$9.18	\$5.48	\$1.46	
Recurrent	\$4.80	\$7.11	\$9.24	\$12.72	\$17.54	\$22.40	\$27.84	
MBB Maximum Scenario	\$8.9	\$11.67	\$16.47	\$16.41	\$18.58	\$41.61	\$37.6	
Capital	\$6.8	\$7.43	\$9.42	\$7.62	\$7.25	\$28.01	\$21.58	
Recurrent	\$2.1	\$4.24	\$7.06	\$8.79	\$11.33	\$13.6	\$16.02	
MBB Medium Scenario	\$3	\$3.95	\$5.11	\$8.49	\$12.51	\$17.26	\$23.66	
Capital	\$1.74	\$1.71	\$1.88	\$3.77	\$5.57	\$8.47	\$12.55	
Recurrent	\$1.26	\$2.24	\$3.23	\$4.73	\$6.94	\$8.79	\$11.11	

¹⁶ This 2008 estimate is considerably less than CMH's 2002 health spending estimate (\$106 billion) because CMH estimates covered many more countries (83 vs. 49).

¹⁷ Ibid. The Scale-up Two group actually projected three different impact scenarios, MBB maximum, medium, and minimum.

Depending on assumptions about whether private investments would continue to increase and whether countries and donors would live up to existing global health commitments, there were optimistic, no-change, and pessimistic assumptions about the size of the funding gap 2009-2015. Under the optimistic, all-commitments-met scenario, the seven-year gap would be \$100 billion under WHO-normative and \$76 billion under maximum-impact MBB. Under “no change” assumptions, the gap would be \$225 billion under WHO-normative and \$200 billion under maximum-impact MBB. Because the Taskforce apparently considered the medium-impact MBB scenario more “realistic” in the current fiscal climate than the maximum-impact scenario, it is the one that it highlighted in Working Group 1’s and Taskforce Reports.

Table 11: Funding requirements and funding gap for 2009-2015 for each group of countries and under the three financing scenarios (billion constant 2005 US\$)

All countries	Sources of additional funding				WHO scenario		MBB Maximum Scenario		MBB Medium Scenario		MBB Minimum Scenario	
	Gov't	DAH	Private	Total	Cost	Gap	Cost	Gap	Cost	Gap	Cost	Gap
Optimistic	87	39	25	151	251	100	227	76	112	-40	67	-84
No change	12	0.7	14	27	251	225	227	200	112	85	67	41
Pessimistic	0.03	-0.6	14	13	251	238	227	214	112	99	67	54

Despite the strengths of the Taskforce’s attempt to estimate health resource needs for low-income countries, there are several flaws in its methodology, which might require an upward revision of their estimates.

- First, the Taskforce focused on low-income countries only, which excludes many low- and upper-middle-income countries with high burdens of disease. Although these middle-income countries might be presumed to be better able to finance medical needs domestically, some of the low-income countries are still quite poor and other middle-income countries have a very high density of extremely poor residents.
- Second, neither costing model used by Working Group 1 actually assumes total achievement of health MDGs¹⁸ and the MBB-medium-impact scenario is particularly unambitious.¹⁹ Setting the bar too low is particularly apparent with respect to HIV, where the WHO-normative sub-group assumed that only 5.2 million people would be on ARVs in 2015 (Working Group 1 Report, p. 17), a far cry from universal access goals. There also appears to have been a failure to include updated TB costing estimates (ibid. fn 32).
- Third, Working Group 1 assumed that private health expenditures as a percentage of GDP would remain the same and thus, presumably, that poor patients could continue to pay very high sums out of pocket or otherwise contribute proportionate amounts to risk pooling. Health activists on the other hand assume that the proportion of health funding that should be financed out-of-pocket by poor people needs to be significantly reduced and thus that there will be an even greater challenge to raising sufficient government and donor resources for health.

¹⁸ For example, assumptions about access to essential medicines only increased to 50% by 2015 (ibid. p. 9), health workforce density ratios adapted to country norms (ibid. p. 11), not necessarily international standards, and costs of building medical education infrastructure were excluded (ibid. p.12).

¹⁹ World Bank/ UNICEF/UNFPA/Partnership for Maternal, Newborn and Child Health. 2009. Background Document for the Taskforce on Innovative International Financing for Health Systems Working Group 1: Constraints to Scaling Up and Costs. http://www.internationalhealthpartnership.net//CMS/files/documents/wb_unicef_unfpa_pmnch_background_to_constraints_to_scaling_up_and_costs_EN.pdf.

- Fourth, there are good reasons to believe that scale-up costs might escalate per capita as health systems expand to serve hard-to-reach, sicker, and less health literate rural populations.

Disease- and Health-Need-Specific Targets

In addition to the “macro” resource needs estimates above, health researchers have also been costing disease- and health-need specific programming. Because of some degree of overlap and synergy, these bottom-up estimates cannot simply be added together to create a fully credible alternative resource need estimate. However, these calculations can help advocates working on particular health issues and can also serve as a counter-check to less granular, all-health-needs estimates. Starting in 2006 and 2007, WHO and other partners undertook major costing exercises on key global health needs, including HIV/AIDS, tuberculosis, malaria, maternal and child health, and human resources for health. Rather than focus on the countries identified by the CMH or later by the Taskforce, however, these studies focused on countries with the greatest health need in the selected area. The value of these studies is that they are more detailed about what they do and do not cover and they incorporated more recent and ambitious goals for a comprehensive response to priority health needs. But here again, there is some confusion about what costs were included and some variations in estimates even from the same agencies. Nonetheless, to help establish an aggregate ballpark figure, it will be useful to catalogue disease-specific, resource-need estimates in a broader number of health-impacted developing countries.

Malaria

A 2007 study of resource needs for comprehensive malaria control estimated that \$38-\$45 billion total would be required between 2006 and 2015 in 108 malaria endemic countries depending on optimistic or pessimistic assumptions about malaria control.²⁰ (See Chart below left, *ibid.*). Average costs during this period ranged from \$3.8 to \$4.5 billion per year. These estimates grew according to a more recent study from \$5.3 billion in 2009 to a peak of \$6.2 billion in 2010, and then to an average of \$5.1 billion per year between 2011 and 2020.²¹ (See Chart below right, *ibid.*) The updated costs 2009-2015 total roughly \$38 billion (author’s calculations).

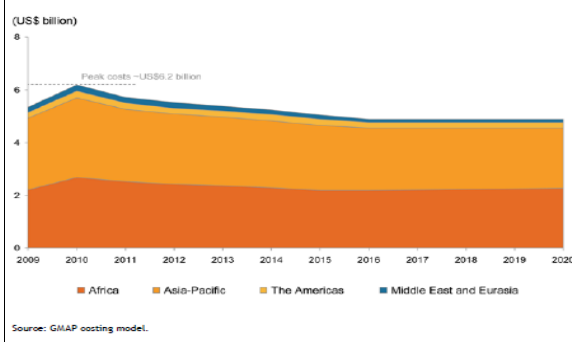
²⁰ Kiszewski A. et al. 2007. Estimated global resources needed to attain international malaria control goals. WHO Bulletin; 85(8): 623-630. <http://www.who.int/bulletin/volumes/85/8/06-039529.pdf>.

²¹ Roll Back Malaria Partnership. 2008. The Global Malaria Action Plan for a Malaria Free World. <http://www.rbm.who.int/gmap/gmap.pdf>.

Table 1. Estimated costs for scaling up malaria control interventions, 2006-2015

Year	Estimated cost (US\$ billion)					
	Pessimistic scenario			Optimistic scenario		
	Africa	Asia, Oceania, Americas	Total	Africa	Asia, Oceania, Americas	Total
2006	1,689	1,842	3,531	1,671	1,835	3,506
2007	1,774	2,045	3,819	1,686	1,972	3,658
2008	1,854	2,018	3,872	1,657	1,857	3,514
2009	2,076	2,440	4,516	1,724	2,159	3,883
2010	1,991	2,763	4,254	1,576	1,932	3,508
2011	2,151	2,338	4,489	1,687	1,973	3,661
2012	2,575	2,760	5,335	1,990	2,389	4,380
2013	2,445	2,497	4,942	1,797	2,092	3,889
2014	2,362	2,430	4,792	1,662	2,000	3,662
2015	2,700	2,960	5,660	1,957	2,511	4,468
Total	21,617	23,593	45,210	17,407	20,720	38,129
Average/year	2,162	2,359	4,521	1,741	2,072	3,813
Percent	47.8	52.2	100	45.7	54.3	100

Figure II.19: Annual costs by region



Since global funding commitments for malaria reached only \$1.6 billion in 2009, there is still a substantial gap going forward.²² If one assumes steady-state funding at \$1.6 billion from 2009 to 2015, then the seven-year gap between resource need (\$38 billion) and current level of funding (\$11 billion) is \$27 billion.²³

Tuberculosis

The total cost of the Global Plan to Stop TB 2006-2015, \$56.1 billion over ten years²⁴, has escalated considerably since 2006 because of revised epidemiological estimates and higher costs for MDR- and XDR-TB control,²⁵ for joint HIV/TB control,²⁶ and for research and development. The revised 2009-2015 resource need estimate now totals \$57 billion over seven years²⁷ (see Charts below, *ibid.*). The additional costs of diagnosing and treating MDR- and XDR-TB in high burden countries are especially significant, amounting to \$16.2 billion over six years, rising from \$1.3 billion to 2010 to \$4.4 billion in 2015 – nearly half of total need.²⁸ By 2015, total resource needs will be approximately \$10.3 billion (\$9 billion for implementation and \$1.2-\$1.4 billion for R&D).

²² Roll Back Malaria. 2010. Progress and Impact Series – Malaria Funding & Resource Utilization: The First Decade of Roll Back Malaria.

<http://www.rollbackmalaria.org/ProgressImpactSeries/docs/RBMMalariaFinancingReport-en.pdf>.

²³ It is important to note that the Global Fund provides approximately 70% of funding toward malaria control, though the U.S. is poised to play an even greater role (currently 15%) under the President's Malaria Initiative and U.S. authorizing legislation that could increase US malaria funding to \$ 5 \$1 billion/year for five years.

²⁴ Stop TB Partnership. 2006. The Global Plan to Stop TB: 2006-2015 – Actions for Life: Towards a World Free of Tuberculosis. <http://www.stoptb.org/globalplan/assets/documents/GlobalPlanFinal.pdf>

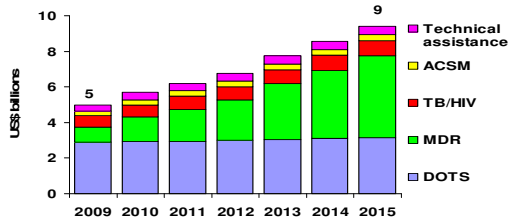
²⁵ WHO & Stop TB Partnership. 2007. The Global MDR-TB & XDR-TB Response Plan 2007-2008. http://whqlibdoc.who.int/hq/2007/WHO_HTM_TB_2007.387_eng.pdf.

²⁶ ACTION. 2009. Living with HIV, Dying of TB: A Critique of the Response of Global AIDS Donors to the Co-Epidemic. http://ado.3cdn.net/a631eddb43e73e407e_vcm6bf5ai.pdf.

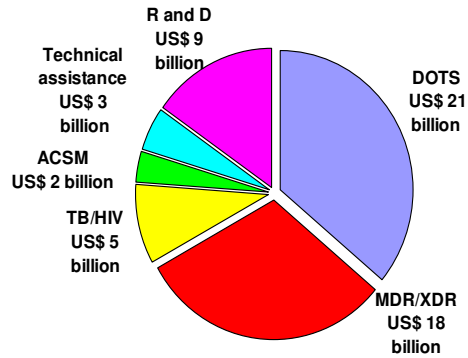
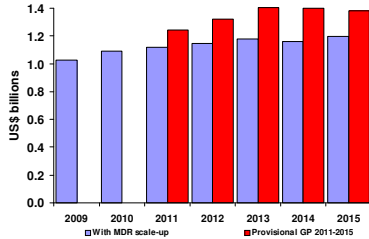
²⁷ Global Plan to Stop TB. 2009. Progress and Financial Requirements.

²⁸ WHO. 2010. Multidrug and extensively drug-resistant TB (M/XDR-TB): 2010 Global Report on Surveillance and Response. http://whqlibdoc.who.int/publications/2010/9789241599191_eng.pdf.

Implementation Needs



R&D Needs



According to the WHO, funding for non-R&D TB control has grown from \$2.7 billion in 2006 to \$4.1 billion in 2010 in 22 high burden countries and another 96 countries that collectively account for 94% of the global TB burden.²⁹ The gap between funding reported by countries and their Global Plan funding requirement is projected to be \$2.1 billion in 2010.³⁰ A rough estimate of the funding gap for TB control 2009-2015, assuming a constant \$4.1 billion annual investment, is \$28 billion (\$57 billion total additional need minus seven years of current-level funding, \$29 billion, author's calculations). The gap in year 2015 funding will be nearly \$6.2 billion (\$10.3 billion minus \$4.1 billion).

HIV/AIDS

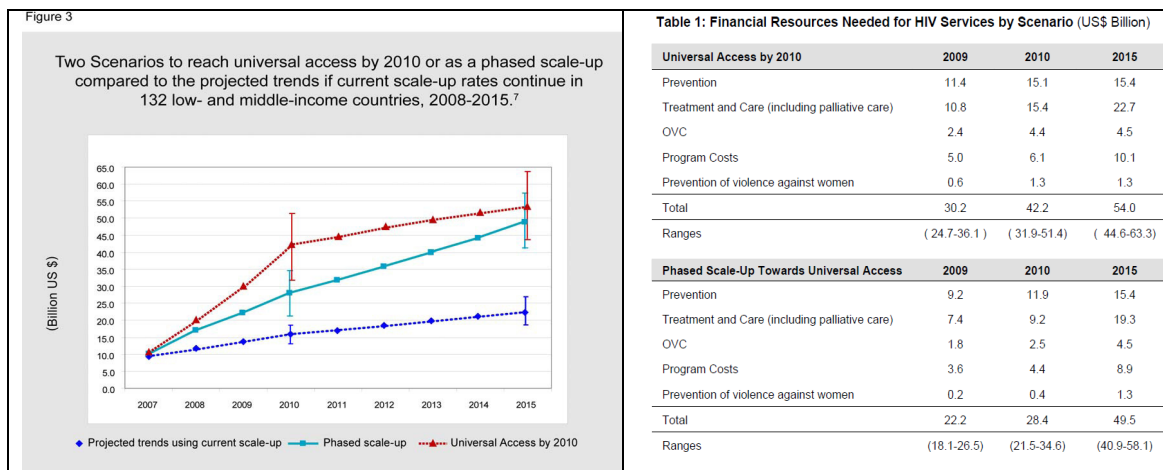
Funding for HIV/AIDS has experienced the most dramatic scale-up over the last decade, increasing from approximately \$300 million in 1997 to \$13.8-\$15.6 billion in 2008. In 2007, UNAIDS prepared a comprehensive estimate of resource needs for HIV/AIDS between 2007 and 2015.³¹ This Report featured three different funding scenarios, one based on the current pace of scale-up, a second called Phased Scale-Up (Universal Access by 2015), and a third based on the 2005 global commitment to Universal Access by 2010 (see chart left below, *ibid.*).³² A detailed breakdown for 2009-2010 showed annual funding needs rising from \$22.2-30.2 billion in 2009 for Phased Scale-Up and Universal Access respectively to \$49.5-\$54 billion in 2015. (See chart below right, *ibid.*)

²⁹ Most of the funding made available for TB control (87%) is provided by national governments, with 9% provided by the Global Fund and 4% by other donors. The prospects for continuing growth in TB funding seem strong both because TB was allotted \$4 billion over five years in the U.S. PEPFAR reauthorization and because Global Fund approvals for TB increased in Rounds 8 and 9. On the other hand, the Obama administration has essentially flat-funded TB in its last two fiscal year budgets and the Global Fund is running out of money.

³⁰ WHO. 2009. Global Tuberculosis Control: A short update to the 2009 report. http://www.who.int/tb/publications/global_report/2009/update/tbu_9.pdf.

³¹ UNAIDS. 2007. Financial Resources Required to Achieve Universal Access to HIV Prevention, Treatment, Care and Support. http://data.unaids.org/pub/Report/2007/20070925_advocacy_grne2_en.pdf.

³² This estimate has some overlap with TB because of HIV/TB co-infection. ACTION. 2009. Living with HIV, Dying of TB: A Critique of the Response of Global AIDS Donors to the Co-Epidemic. http://ado.3cdn.net/a631eddb43e73e407e_vcm6bf5ai.pdf.

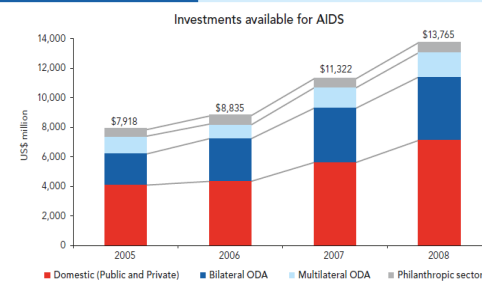


This estimate of resource needs produced sticker shock in the global health community, and in February 2009 UNAIDS issued another report lowering the estimates.³³ In this report, UNAIDS introduced a new concept of Universal Access based on slower, and more variable country-defined targets. Pursuant to this revised, bottom-up methodology, resource needs for 2009 and 2010 dropped significantly to \$19.8 and \$25.1 billion respectively.

The 2009 Report announced that a new spending threshold of \$13.8 billion had been reached in 2008 (see Chart left below, *ibid.*). Hecht et al. calculated an even higher figure of \$15.6 billion in 2008 (see Chart right below).³⁴

UNAIDS 2009

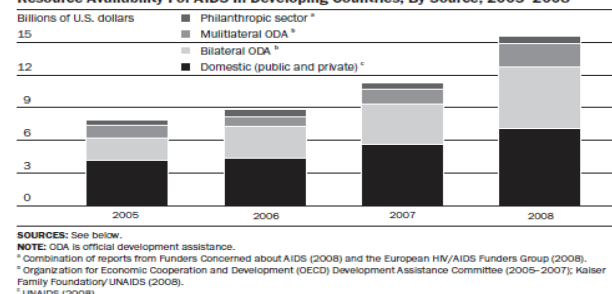
FIGURE 4



Hecht et al. 2009

EXHIBIT 3

Resource Availability For AIDS In Developing Countries, By Source, 2005-2008

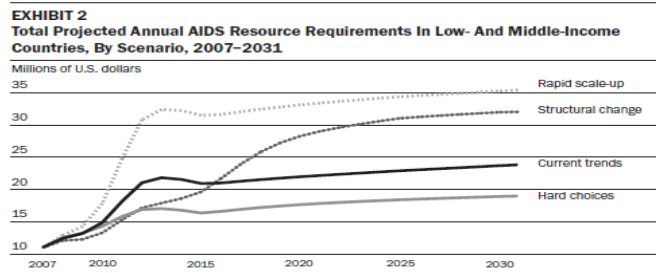


Hecht et al. also projected future resource needs pursuant to multiple scenarios for 2007 through 2031. For purposes of cross comparison, their estimates of funding needs for 2015 ranged from approximately \$17 billion to \$32 billion depending on the ambition of the scale-up (see Chart below, *ibid.*). The \$32 billion by 2015 figure is the most relevant since it addresses the universal access scenario and is roughly consistent with UNAIDS estimates.

³³ UNAIDS. 2009. What Countries Need: Investments needed for 2010 targets.

http://data.unaids.org/pub/Report/2009/20090210_investments_needed_2010_en.pdf

³⁴ Hecht R, Bollinger L, Stover J, et al. 2009. Critical Choices in Financing the Response to the Global HIV/AIDS Pandemic. *Health Affairs*; 28(6):1591-1605. According to Hecht et al. nearly 52% of AIDS funding came from domestic public and private resources, 31% from bilateral sources, 12% percent from multilaterals including the Global Fund, and 5% from charities.



The differences between the 2007 and 2009 UNAIDS estimates and the arrival of Scenario 2031 estimates make it a little difficult to calculate total HIV/AIDS needs 2009-2015. However, it seems most appropriate to use the 2007 UNAIDS Phased Scale-Up calculations (reduced by 10% to compensate for the downward revisions in the number of people estimated be living with HIV) to estimate resource needs for HIV/AIDS 2009-2015. This produces a total of approximately \$228 billion. Assuming baseline HIV resources of \$13.8-\$15.6 billion in 2008,³⁵ approximately \$103 billion will be available 2009-2015, leaving a net funding gap of \$125 billion. Although these HIV/AIDS resource needs estimates are quite high, they will undoubtedly be adjusted upward under new WHO treatment guidelines.³⁶

Newborn, Maternal, and Child Health, and Family Planning Needs

In 2007, researchers prepared an estimate of additional resources needed to scale up maternal and newborn health services in 75 countries.³⁷ The model estimated costs for care during pregnancy, childbirth, the neonatal and postpartum time period. Using a Rapid Scale-Up Model that would reach 95% coverage for key interventions would cost an average \$5.6 billion per year or \$55.7 billion over ten years. After subtracting estimates for 2006-2008 (\$6 billion) to obtain 2009-2015 estimates, the revised, seven-year, additional resource need estimate totals \$49.7 billion.

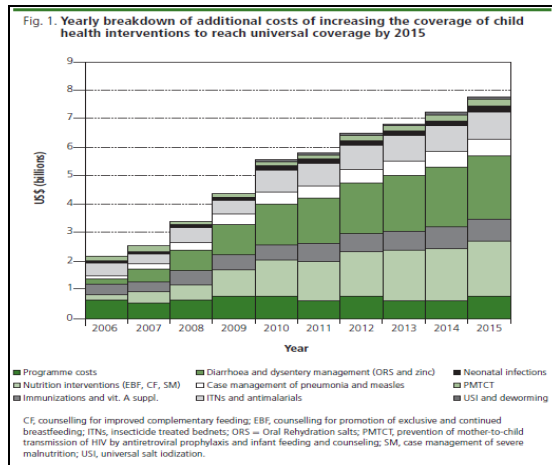
Maternal and Neonatal Resource Needs Estimates

³⁵ Calculating potential increases in donor and domestic funding for HIV/AIDS is difficult, especially given the recent financial crisis. On the other hand, the U.S. essentially doubled the amount of money available for HIV in its PEPFAR reauthorization to \$39 billion from FY2010-2015, potentially adding at least another \$3 billion a year to current spending levels. In addition, HIV proposals to the Global Fund have increased and in Round 8 were three times larger than earlier rounds.

³⁶ WHO. 2009. Rapid Advice: Antiretroviral therapy for HIV infected adults and adolescents. http://www.who.int/hiv/pub/arv/rapid_advice_art.pdf. According to these new WHO ARV treatment guidelines, patients in developing countries should be starting treatment much earlier, when their cell counts reach 350 CD4/ml rather than the current standard of 200. This revision could add four to five million to the six million who need treatment under previous guidelines but who are not yet receiving it. In addition to expanding the number of patients eligible for treatment, the WHO guidelines also recommend an improved but more costly first-line treatment regimen that substitutes zivodine or tenofovir for stavudine and possibly lamivudine for emtricitabine. The improved regimens cost two to three times as much as the current best price for a stavudine-based regimen (\$140, \$200, \$229 vs. \$79 per patient per year). Clinton Health Access Initiative. 2010. ARV Price List. http://www.clintonfoundation.org/files/chai_arv_priceList_april2010_english.pdf. However, even these expanded costs might be underestimates if further research validates WHO's new Test and Treat strategy, which would offer routine opt out testing and immediate initiation of antiretroviral therapy with both positive treatment and prevention effects. Although it is difficult to estimate exactly how much higher treatment costs would be 2009-2015, the revised start-point and more costly first-line regimen could add \$4-6 billion per year by 2015.

³⁷ Johns B. et al. 2007. Estimated global resources needed to attain universal coverage of maternal and newborn health services. *WHO bulletin*, 85(4): 256-263. <http://www.who.int/bulletin/volumes/85/4/06-032037.pdf>.

Child Health Resource Needs Estimates



Researchers have also estimated additional resource needs for under-5, non-neonatal child health.³⁸ Focusing on additional resource needs for 2009-2015 in 75 priority countries, the adjusted seven-year resource need estimate for child health is approximately \$38 billion or \$5.4 billion per year, after subtracting out projected costs for malaria and PMTCT, which are covered in earlier, disease specific estimates. Adding the maternal and neonatal 2009-2015 total of \$49.7 billion to the 2009-2015 child health total of \$38 billion produced a total additional maternal, neonatal and child health resource need of \$87.7 billion from 2009-2015.

Updating newborn, maternal and child health resource needs estimates from 2007 while adding family planning costs and eliminating overlaps for HIV and malaria has been challenging.³⁹ The Global Campaign for the Health Millennium Development Goals' First Year Report 2008 provides a preliminary updated estimate.⁴⁰ Focusing on 51 aid dependent countries and excluding costs related to vaccines, malaria services, and PMTCT produced a seven year additional cost, 2009-2015, of \$79.4 billion (see chart below left, *ibid.*). (Focusing on all developing countries, the resource needs would be \$137 billion.) Even more recent figures from the Guttmacher Institute suggest that annual resource needs for expanded family planning and maternal and newborn care, when their synergies are combined, would have an average annual cost of \$24.6 billion, \$12.8 billion more than was being spent in 2008.⁴¹ (See chart below right, *ibid.*). Adding the additional \$5.4 billion needed per year for child health to the revised \$12.8 billion needed for neonatal, maternal, and reproductive health, there is a total of \$18.2 billion needed each year over current baseline expenditures, producing a seven-year total of \$127.4 billion 2009-2015.⁴²

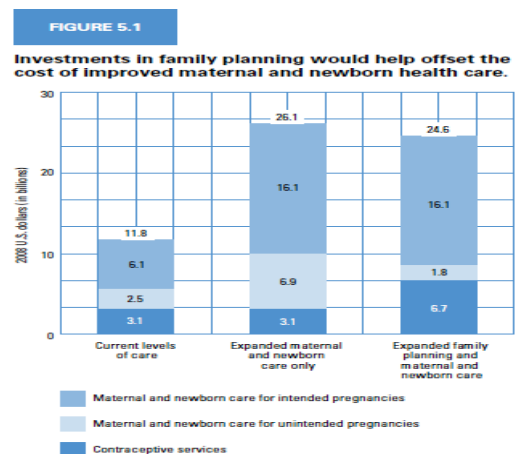
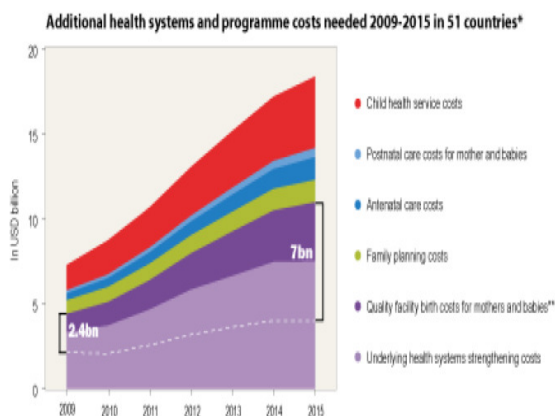
³⁸ Stenberg K, Johns B, Scherpbier R, Edejer T. 2007. A financial road map to scaling up essential child health interventions in 75 countries. *WHO Bulletin* 85(4): 305-314. <http://www.who.int/bulletin/volumes/85/4/06-032052.pdf>.

³⁹ Bernstein S, Vlassoff M. 2006. Summary of an Analysis of Resource Requirements for Reproductive Health. http://www.unmillenniumproject.org/documents/Resource_requirements-for-RH-1.pdf; Dennis S, Zuckerman E. 2007. Mapping Multilateral Development Banks' Reproductive Health and HIV/AIDS Spending. http://sarpn.org.za/documents/d0002828/MDBs_GenderAction_AIDS_Sept2007.pdf; Ethelston S, Leahy E. 2006. Research Commentary - Reproductive Health: How much? Who pays?. http://www.popact.org/Publications/Research_Commentaries/Reproductive_Health_-_How_much_Who_pays/Reproductive_health.pdf.

⁴⁰ The Global Campaign for the Health Millennium Development Goals. 2008. First Year Report 2008. www.norad.no/default.asp?FILE=items/9244/108/GlobalCampaignHealthMDGs.pdf.

⁴¹ Singh S et al. 2009. Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health. <http://www.guttmacher.org/pubs/AddingItUp2009.pdf>

⁴² Norway, Canada, the Netherlands, and the UK have all promised additional resources for maternal, newborn and childhood health and GAVI is hoping to raise more money as well for childhood immunizations and related health system strengthening. Likewise, the U.S. has promised more money for child, maternal, and reproductive health in its Global Health Initiative.



Chronic Diseases, Mental Health, and Neglected Diseases

Chronic diseases, such as heart disease, stroke, cancer, respiratory diseases and diabetes, are by far the leading cause of mortality in the world, representing 60% of all deaths. Moreover, the burden of chronic disease in the developing world has increased dramatically such that 80% of chronic disease deaths now occur in developing countries, and the risks of chronic disease are increasing as a result of the ageing of populations, urbanization, and the globalization of risk factors. To date there do not appear to be any robust resource needs estimates for preventing and treating chronic diseases as a class, but there is little doubt that providing equitable care for chronic diseases in developing countries will cost billions of dollars a year based on partial costing done to date. For example, the cost of preventing cardiovascular disease in high-risk individuals in just 23 low- and middle-income developing countries was estimated at \$47 billion, 2006-2015, or \$4.7 billion per year.⁴³ Controlling tobacco sale/consumption would cost \$1 billion per year⁴⁴ and addressing a core mental health package would cost approximately \$10 billion/year.⁴⁵ The annual cost of controlling neglected tropical diseases is estimated at approximately \$2-3 billion per year over the next five to seven years.⁴⁶ Unfortunately there are no estimates of current funding in developing countries for chronic and neglected diseases. However, assuming a ballpark aggregate cost of \$18.7 billion over 7 years, total need 2009-2015 for chronic disease, mental health, and neglected diseases would reach \$131 billion.

Human Resources for Health and Health System Strengthening

⁴³ Lim S et al. Prevention of cardiovascular disease in high-risk individuals in low-income and middle-income countries: health effects and costs. *Lancet* 370: 2054-62. 2007.

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61699-7/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61699-7/fulltext).

⁴⁴ Asaria P et al. Chronic disease prevention: health effects and financial costs of strategies to reduce salt intake and control tobacco use. *Lancet* 370: 2044-53. 2007.

[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(07\)61698-5/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(07)61698-5/fulltext).

⁴⁵ Chisholm D., Lund C & Laxena S. Cost of scaling up mental healthcare in low- and middle-income countries. *Brit. J. Of Psychiatry* 191: 528-35. 2007.

⁴⁶ Hoetz P J et al. Rescuing the Bottom Billion Through Control of Neglected Tropical Diseases. *Scientific America*. *Lancet* 373: 1570-75. 2009.

http://globalnetwork.org/files/press_releases/Rescuing_the_bottom_billion_through_control_of_neglected_tropical_diseases.pdf.

There is a drastic shortage of human resources for health. The WHO World Health Report 2006 documented this shortage and calculated the cost required to train, hire, and retain additional health workers in the 57 most adversely impacted countries.⁴⁷ These calculations are set forth in the first chart below. They show education and training costs totaling \$54 billion over seven years,⁴⁸ incremental operating costs of hiring the new professional health workers of \$124 billion over seven years, and additional incremental costs of \$371 billion over seven years for doubling the salaries of all health workers to aid retention and slow the brain drain. There are multiple additional health system strengthening costs that are not included in the WHO estimates.

HRH Funding Needs	Average Annual Costs	Total Cost 2009-15
Education & training costs (doctors, nurses, & midwives)	\$7.7 billion	\$54 billion
Incremental operating costs for hiring new professional HCWs	\$17.7 billion	\$124 billion
Incremental costs for doubling HCW salaries	\$53 billion	\$371 billion
Additional, un-estimated costs:	???	
<ul style="list-style-type: none"> • Building health education facilities • Building health infrastructure • Hiring, training, and paying auxiliary HCWs, including CHWs • Health system strengthening – procurement & supply systems, health management, information 		
TOTALS	\$78.4 billion	\$549 billion

In 2007, WHO began a preliminary study of year-by-year costs of educating the needed number of health workers and doubling their salaries. The unpublished and unofficial figures for 2009-2015 are shown in the chart below. The 2006 estimate suggests seven-year additional costs of \$549 billion versus the \$497 billion 2007 estimate.

Costs for Educating Health Workers and Doubling Salaries (billions) WHO 2007

Year	Africa	Dev. Countries
2009	\$6.7	\$58
2010	\$7.5	\$64
2011	\$8.0	\$66
2012	\$9.2	\$69
2013	\$10.9	\$74
2014	\$12.7	\$80
2015	\$14.6	\$86
Totals	\$69.6	\$497

Other researchers, using more conservative costing assumptions (steady state wages, no training costs, and a failure to cost all HCW cadres) and a greater degree of task-shifting estimated that the cost of addressing the critical shortage of doctors, nurses and midwives in

⁴⁷ World Health Organization. 2006. World Health Report: Working Together for Health. http://www.who.int/whr/2006/whr06_en.pdf.

⁴⁸ A Taskforce of the Global Health Workforce Alliance estimated Africa alone needed to spend \$2.64 billion a year to educate and train the 1.5 million extra health workers. The costs of employment were additional. Global Health Workforce Alliance. 2008. Scaling Up, Saving Lives Taskforce for Scaling Up Education and Training for Health Workers. http://www.who.int/workforcealliance/documents/Global_Health%20FINAL%20REPORT.pdf.

39 sub-Saharan African countries would be \$20 billion.⁴⁹ WHO-normative costing for the High Level Taskforce calculated the costs of training and hiring 3.48 million health workers in low-income countries at \$76 billion from 2009-2015, a sixth of the estimate above.⁵⁰ Pursuant to the WHO's methodology, the actual cost of health worker salaries for discrete areas of service delivery was built into the Taskforce's overall resource needs estimates. However, because education/training costs (\$54 billion from WHO 2006) and health management costs (\$14 billion) are clearly additional in the WHO-normative costing exercise, it is estimated that \$68 billion will be for non-duplicative HRH costs 2009-2015.

Totals

Adding up all the updated disease-specific and non-duplicative HRH estimates, there is a total resource gap 2009-2015 of \$456 billion, assuming no additional resources from countries or donors. (See chart below). (If ODA-for-health immediately reached the 0.1% target, the resource gap would be \$292 billion⁵¹). This grand total figure is approximately twice as much as the Working Group 1's estimates. Much of the disparity between the disease/need specific gap analysis and the Taskforce gap analysis can be attributed to the inclusion of middle-income countries where per intervention costs are often higher.

Health Need	Additional Resources Needed 2009-2015	Addition Resources Needed 2015
Malaria	\$27 billion	\$3.5 billion
Tuberculosis	\$28 billion	\$6.2 billion*
HIV/AIDS	\$125 billion	\$35 billion
Newborn, Maternal and Child Health, and Reproductive Health	\$127 billion**	\$18.2 billion
Chronic and Neglected Diseases	\$131 billion***	\$18.7 billion***
Human Resources for Health****	\$68 billion	\$13.5 billion
Totals (excluding/including \$50 billion for HRH)	\$456 billion	\$95.1 billion
Working Group 1 Totals:		
WHO-Normative	\$251 billion	\$45 billion
MBB maximum-impact	\$227 billion	\$58 billion

* Assumes steady-state rather than scale-up investment; ** Focuses on aid dependent countries; *** Somewhat speculative given the absence of baseline expenditure figures.

⁴⁹ Scheffler R. et al. Estimates of Health Care Professional Shortages in Sub-Saharan Africa by 2015. *Health Affairs* 28(5): w849-62. 2009. <http://content.healthaffairs.org/cgi/reprint/28/5/w849>.

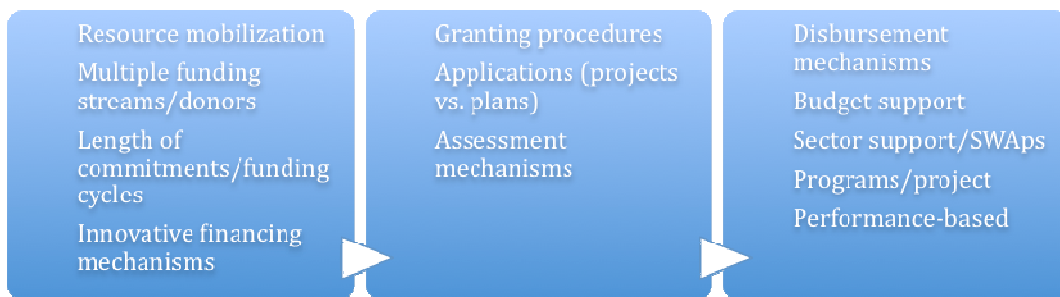
⁵⁰ This total includes service delivery HRH (\$62 billion) plus myriad management-related HRH costs (\$14 billion). World Health Organization. 2009. *WHO Report submitted to Working Group I of the High Level Taskforce on Innovative International Financing for Health Systems*, at 21-22, 32. Available at: http://www.who.int/choice/publications/d_ScalingUp_MDGs_WHO_report.pdf.

⁵¹ If OECD were to meet its .1% GNI commitment to global health each year over the next seven years, \$241 billion would be donated for health based on 2008 gross income figures (\$33 trillion x 7 years x .001). Since DAC ODA for health totaled \$15.6 billion in 2007 (\$10.9 billion bilateral and \$4.7 billion multilateral) steady-state funding would raise \$109 billion (\$15.6 billion x 7 years), OECD. 2010. *Development Aid at a Glance: Statistics by Region – The Developing World*. Accordingly, additional (over baseline) ODA-for-health would total \$132 billion over the seven years (\$241 billion - \$109 billion), assuming the .1% target was met and assuming no growth in OECD income. The resulting resource gap for global health would be \$292 billion (\$456 billion - \$132 billion).

3. Allocation of FTT Resources Via Existing and New Health Financing Mechanisms

Assuming that a CTL-for-health or an FTT-with-health is adopted and that it will attempt to help fill the huge gap in funding for global health needs, there are critical questions remaining about how resources might be channeled through existing health financing mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the World Bank, the GAVI Alliance, UNITAID, European Commission MDG contracts (EC MDG Contracts), the International Health Partnership and related initiatives (IHP+), and bilateral funding including the US President's Emergency Plan for AIDS Relief (PEPFAR) and Global Health Initiative (GHI). Alternatively, emerging/new mechanisms could be used such as the Global Fund/GAVI/World Bank/WHO Joint Health System Strengthening Platform (Joint HSS Platform) or a recently proposed Global Fund for Health MDGs.

With all of these financing mechanisms it is important to distinguish the ways they collect resources from their granting procedures and from their mechanisms of in-country disbursement.



With respect to each of these health-financing mechanisms there are questions to be answered about their comparative strengths and weaknesses.

- Are particular mechanisms adaptable, do they have sound administrative and control mechanisms, do they adhere to Paris Declaration and Aid Effectiveness standards,⁵² and do they have capacity to channel money efficiently and accountably into effective and equitable health programming by both public and non-public health sectors?
- Will particular mechanisms be more or less country-driven and partnership-oriented?
- Will particular mechanisms be more or less inclusive of civil society in policy-setting, implementation, and oversight activities?
- Will particular mechanisms build sustainable capacity and resilient health systems?

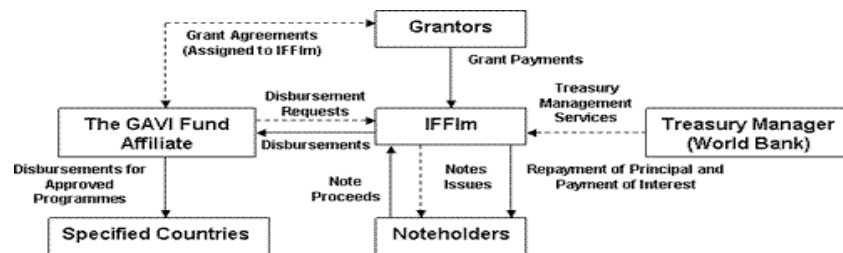
Collecting and Disbursing CTL/FTT Revenues

Before discussing the merits of particular funding destinations, it is necessary to categorize choices concerning tax collection and political control of disbursement decisions. The UK and US can be expected to argue, as the main hubs of financial transactions, that they should collect and retain all taxes collected on in-country transactions. A proposal of this sort would certainly raise the ire of more peripheral OECD countries and of developing countries more broadly. More coherent proposals suggest either that the major portion of gross tax collected

⁵² OECD. Paris Declaration on Aid Effectiveness 2005 and the Accra Agenda for Action 2008. <http://www.oecd.org/dataoecd/11/41/34428351.pdf>.

be distributed to all countries that participate via their proportional participation in the taxed transactions or alternatively based on their share of the gross global product. Taxes collected and dispersed in this manner might result in some of the CTL/FTT eventually being dispersed for ODA, including donor/development assistance for health (DAH), but presumably according to sovereign decisions and via mechanisms involving parliamentary and executive processes. Health advocates have been insistent, however, that CTL/FTT revenues for health be additional to existing donor commitments (0.7% for ODA overall, including 0.1% for health as recommended by the Commission on Macroeconomics and Health).

If health, development and climate change advocates win out, not all of the money will go directly to country treasuries – a portion might be directly disbursed to particular funding mechanisms. There are precedents for this form of direct funding, including the International Finance Facility for Immunizations (IFFIm). The IFFIm sells sovereign-backed bonds on global markets to front-load resources for the GAVI Alliance’s immunization programmes and then will use long-term government pledges to repay the bonds. Thus, far United Kingdom, France, Italy, Spain, Sweden, Norway and South Africa have pledged to contribute US\$ 5.3 billion to IFFIm over 20 years.⁵³



Another example is the UNITAID airline tax, which represented 72% of UNITAID’s financial base by the end of 2008. This mandatory tax applies to all flights departing from countries that impose it and is paid by passengers when purchasing their tickets. The cost of the airline tax for passengers is very low ranging from US\$ 1 for economy-class tickets to US\$10 and US\$ 40 for business- and first-class travel.⁵⁴ Other direct-funding examples, but ones targeting the private sector, include the Advance Market Commitment for pneumococcal vaccines, a pilot-project partnership contract between donors and pharmaceutical companies. It ensures that research on pneumococcal vaccines moves forward and that, once the research is completed, the vaccines will be sold at prices that the target population can afford. Nearly US\$1.5 billion has been raised for this effort so far.⁵⁵

Resources for UNITAID are being expanded further by the Millennium Foundation for Innovative Finance for Health, which has launched MASSIVEGOOD as its flagship “innovative financing” project in the USA, UK, Germany, Austria, Switzerland and Spain. With MASSIVEGOOD, travelers can make a \$2, £2 or €2 voluntary “micro-contribution” towards major global health causes every time they buy a plane ticket, reserve a hotel room or rent a car. Funds from these voluntary payments will go to UNITAID to purchase drugs to reduce child mortality, improve maternal health and to stop the millions of needless deaths from

⁵³ <http://www.iff-immunisation.org/index.html>.

⁵⁴ As of November 2008, seven of UNITAID’s 29 member countries were implementing the airline tax: Chile, Côte d’Ivoire, France, Republic of Korea, Madagascar, Mauritius and Niger. Norway allocates part of its tax on CO₂ emissions from aviation fuel to UNITAID. <http://www.unitaid.eu/en/How-innovative-financing-works.html>.

⁵⁵ <http://www.vaccineamc.org/>.

HIV/AIDS, malaria and tuberculosis in the developing world. A related, consumption-based initiative is Project RED whereby companies like Nike, Apple, the Gap, and Starbucks donate up to 50% of their profits on selected consumer RED™ products to the Global Fund's fight against AIDS. Project RED claims to have raised over US\$140 million by late-2009.⁵⁶

These direct-funding mechanisms are a subset of a larger group of proposals that have been developed as supplements to existing ODA commitments.⁵⁷ Accordingly CTL/FTT resources managed and transferred to particular institutions, say GAVI or the Global Fund, should not free donors from their obligation to invest 0.7% of GDP for ODA, including 0.1% for DAH.⁵⁸ However, the presence of innovative financing mechanisms and of direct payments to global health institutions might eventually impact donors' decisions about whether to allocate their bilateral ODA to other multilateral institutions, e.g., UNICEF or WHO, to general budget or sector support, or to the social determinants of health and/or community mobilization. In an era recently characterized by "health exceptionalism" and in response to dedicated funding sources for health, donors might also change their percentage targets for health from the current level of 17% to historically lower levels.

Budget Support: Pros and Cons

Questions about the intermediate "destination" of funding must be addressed. Proponents of sector budget support, general budget support, and other pooled financing mechanisms at the country level argue that such pooled funding increases government ownership and control, aligns with government budget cycles, and eases public finance management.⁵⁹ With pooling, the government knows its total resource envelope and can plan and spend accordingly. If existing government capacity to handle pooled funding is less than desirable, then proponents argue that governments should receive technical assistance to build durable public sector management capacity. Proponents argue further that the alleged incapacity of governments to manage pooled funding must be weighed against its less-than-perfect alternative: the inefficient, convoluted, duplicative, and uncoordinated mechanisms of finance administration orchestrated by donors.

Critics of pooled financing directly to governments admit these potential benefits, but focus as well on historical analysis of some governments' poor planning, inefficiency, corruption, and incapacity to even spend as planned or to monitor and account for the actual flow of resources. Critics worry that most governments neglect important health needs and/or vulnerable populations and that some governments persistently refuse to grant resources to NGO/CBO/FBO organizations for community level health-related activities. A related concern about pooled funding mechanisms from a civil society perspective is that of governance – civil society feels that government-controlled pooled financing modalities have often been

⁵⁶ <http://blog.joinred.com/2009/11/thank-you-140-million-to-africa-so-far.html>.

⁵⁷ The Leading Group on Innovative Financing for Development expressly states that these mechanisms should be supplemental to ODA, which by itself will be insufficient to close the development gap. <http://www.leadinggroup.org/rubrique176.html>.

⁵⁸ This has been specific campaign recommendation of Action for Global Health. AfGH. 2008. Health Aid: Why Europe must deliver more aid, better spent to save the health Millennium Development Goals; AfGH. 2009. Health in Crisis: Why in a time of economic crisis, Europe must do more than ever to achieve the health Millennium Development Goals.

⁵⁹ Vidal C, Pillay R. *An Issues Paper for UNDP: Official Development Assistance as Direct Budget Support*. New York City. 2004. www.unssc.org/web1/programmes/rccs/cca_undaf_training_material/teamrccs/file2.asp?ID=1815. Oxfam. Fast Forward: How the European Commission can Take the Lead in Providing Budget Support. 2008. http://www.oxfam.org/sites/www.oxfam.org/files/bp111_ec_aid_fast_forward_0805.pdf.

planned and implemented without the participation and oversight of civil society. In sum, critics fear that donor funds get put inside a black box and then disappear both in terms of tracking and performance outcomes. They have evidence that government-controlled resources do not reach the local level (as little as 20%), where health programming is most needed, and thus that direct funding to CBOs might have a larger payment.⁶⁰

Finally, some critics have noted that there is a silver-lining to donor-controlled project- or program-financing, namely that it stays off the books (in terms of the country's public budget) and thus is not subject to IMF-mediated macroeconomic constraints.⁶¹ These IMF prescriptions limit overall government spending on health and may contribute to so-called substitution or subadditionality effects whereby governments decrease their health spending in proportion to donor aid for health.⁶²

The Global Fund to Fight AIDS, Tuberculosis and Malaria

As its name suggests, the Global Fund focuses on three priority diseases: HIV/AIDS, tuberculosis, and malaria. At present, it provides a quarter of all international financing for HIV/AIDS, two-thirds for tuberculosis, and three quarters for malaria. As a funding mechanism, the Global Fund responds to country-driven applications for funding, which are assessed based on technical merit only, after which funds are dispersed according to performance-based criteria negotiated with recipients. The Global Fund has committed \$19.3 billion and disbursed over \$9.3 billion to 144 countries, mainly through a rounds-based granting system with two-years of initial funding, up to three years of renewal, and thereafter rolling-continuation grants for good performers. Of the three major AIDS donors (the Global Fund, PEPFAR, and World Bank MAP), the Global Fund's performance-based funding model is the strongest since, even though hampered by poor information, it systematically bases funding decisions on past performance.⁶³

The Global Fund is at the beginning of a replenishment process for 2011-13, whereby it needs significantly more money than the \$10 billion it received 2008-10. The Global Fund has submitted three resource scenarios, each which would produce dramatically different impact outcomes:

- Scenario 1 would allow for the continuation of funding of existing programs but new programs could only be funded at a significantly lower level than the past. This scenario does not represent an estimation of the expected volume of high-quality

⁶⁰ See The World Bank. *Healthy Development: The World Bank Strategy for Health, Nutrition, and Population Results*. Washington D.C. 2007.

<http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1154048816360/HNPStrategyFinalTextAnnexes.pdf>. Gauthier B. 2006. PETS-QSDS in Sub-Saharan Africa: A Stocktaking Study. HEC Montreal. <http://siteresources.worldbank.org/INTPUBSERV/Resources/477250-1165937779670/Gauthier.PETS.QSDS.Africa.STOCKTAKING.7Sept06.pdf>

⁶¹ Gorik Ooms G, Wim Van Damme W, Baker B, Zeitz P, Schrecker T. 2008. The 'diagonal' approach to Global Fund financing: a cure for the broader malaise of health systems?. *Globalization & Health* 4: 6. <http://www.globalizationandhealth.com/content/pdf/1744-8603-4-6.pdf>.

⁶² Lu C, Schneider MT, Gubbins P, Leach-Kemon K, Jamison D, Murray CJL. Public financing of health in developing countries: a cross-national systematic analysis. *Lancet* 2010;10.1016/S0140-6736(10)60233-4. published online April 9; Farag M., et al. Does Funding From Donors Displace Government Spending for Health in Developing Countries? *Health Affairs* 28(4): 1045-55, 2009; Atunes A F, Carrin G, Evans D. 2008. General budget support in developing countries: ensuring the health sector's interest. http://www.who.int/health_financing/documents/pb_e_08_2-budget_support.pdf.

⁶³ Nandini O, Rosenzweig S, Bernstein M. 2010. Are Funding Decisions Based on Performance? <http://www.cgdev.org/content/publications/detail/1424030/>.

proposals but rather the level of demand that could be met by the foreseen resources. Resources required in 2011-2013: US\$ 13bn.

- Scenario 2 would allow for the continuation of funding of existing programs and for funding of new proposals at a level that matches recent years. This would allow current trajectories of progress to be preserved. Resources required in 2011-2013: US\$ 17bn.
- Scenario 3 would allow for the continuation of funding of existing programs and well-performing programs could be scaled up significantly, allowing for more rapid progress towards achievement of the health-related Millennium Development Goals. Resources required in 2011-2013: US\$ 20bn.⁶⁴

Although full replenishment of the Global Fund will be challenging, its funding model has several advantages: pooling of donations from multiple donors thereby reducing volatility and a relatively long funding period (historically up to five years with the possibility of continuations thereafter).

Despite its initial success, the Global Fund has been undergoing significant review to modify and simplify its grant architecture, to better coordinate with recipients' processes, to increase the impact of its programming on health- and community-system strengthening, and to further integrate priority disease programming with child and maternal health and sexual and reproductive health.

A core feature of the new grant architecture is the "single stream of funding per Principal Recipient per disease."⁶⁵ Under this system the Global Fund will maintain one funding agreement for each Principal Recipient per disease, which will then be amended when a new proposal for funding the same disease is approved. Under the old grant system each newly approved proposal resulted in a separate grant agreement with its own budget, performance and reporting framework, renewal cycles, etc. The Global Fund's commitment to dual-track financing⁶⁶ will not change under the new grant architecture: where there are two or more Principal Recipients for a country disease program, a separate stream of funding will be maintained for each of them.

The Global Fund has also introduced another new way to apply for Global Fund resources known as "National Strategy Applications" (NSAs). This involves submitting a national strategy itself rather than a Global Fund-specific proposal form – as the primary basis of the application for Global Fund financing. NSAs are to be independently "validated" using broadly-agreed-upon, international standards, with some minimal additional information provided. It should create an incentive for country stakeholders to develop robust national strategies, eliminate parallel planning efforts and contribute to improving harmonization among donors. The national strategy application is initially a disease-specific strategy but may expand to cover broader health strategies. The First-Learning Wave for NSAs was instituted in 2009. At its 20th Board Meeting, the Global Fund approved four First-Wave NSAs out of twenty-two applications with approved funding totaling \$39 million over two years.

⁶⁴ Global Fund. 2010. Resource Scenarios 20011-2013.

http://www.theglobalfund.org/documents/replenishment/2010/Resource_Scenarios_en.pdf.

⁶⁵ Global Fund. 2010. Update on Implementing the New Grant Architecture.

<http://www.theglobalfund.org/documents/replenishment/2010/Update%20on%20Implementation%20of%20the%20New%20Grant%20Architecture.pdf>.

⁶⁶ Dual-track financing is the inclusion of both government and non-government Principal Recipients in proposals for Global Fund financing. Global Fund. 2008. Fact Sheet: Dual-Track Financing.

http://www.theglobalfund.org/documents/rounds/8/R8DTF_Factsheet_en.pdf.

In addition to prioritizing changes to its funding architecture, the Global Fund has also been intensifying its focus on health-system strengthening and positive synergies with child and maternal health. The Global Fund Framework Document states that it “will support programs that: address the three diseases in ways that strengthen health systems,” and will also “support the substantial scaling up and increased coverage of proven and effective interventions, which strengthen systems for working: within the health sector; across government departments; and with communities.”⁶⁷ The Global Fund’s mechanism for soliciting HSS applications from recipients has evolved over time so that a country partner may now apply either for disease-specific HSS elements as part of that disease’s proposal or for cross-cutting HSS elements that also affect other priority diseases via a special “cross-cutting HSS section” within a disease component. HSS proposals are judged primarily based on whether the proposal will address health systems constraints that affect outcomes for one or more of the three priority diseases, but the interventions are also permitted, indeed encouraged, to have a positive effect on other health outcomes as well.⁶⁸ According to a decision made at the Sixteenth Board Meeting, “The Global Fund shall allow broad flexibility regarding actions eligible for funding, such that they can contribute to system-wide effects and other programs can benefit.”⁶⁹ A particular target of the Global Fund’s synergistic efforts is child and maternal health where it seeks to encourage programmatic integration and positive spillover effects.⁷⁰

Besides funding HSS, the Global Fund has also agreed to fund and coordinate programming for community system strengthening (CSS) related to the three priority diseases. “Community systems strengthening” has been identified as a key means for strengthening the individual and network capacity of CSOs and includes the provision of financial, technical and other kinds of support to organizations and agencies that work directly with and in communities.⁷¹

Global Fund mechanisms for CS engagement are not perfect, but they represent a best practice at present. Civil society is engaged at all levels, ranging from having three seats of the Board (Northern NGO, Southern NGO, and Communities affected by the diseases), full engagement in Country Coordination Mechanisms⁷² at the country-level (with grant application and oversight responsibilities), and eligibility both as Principle Recipients (further encouraged by the Dual Track Financing Policy⁷³) and as sub-recipient implementers. Some CCMs do not involve civil society, affected communities, or vulnerable populations as deeply as desired, nor do they all operate efficiently, especially with respect to oversight responsibilities. In response to criticisms, the Global Fund has been providing

⁶⁷ Global Fund. *The Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria* § IV F.1. and § III H.3. http://www.theglobalfund.org/documents/TGF_Framework.pdf.

⁶⁸ Global Fund. 2008. Fact Sheet: The Global Fund’s Approach to Health System Strengthening. http://www.theglobalfund.org/documents/rounds/8/R8HSS_Factsheet_en.pdf.

⁶⁹ Global Fund, Sixteenth Board Meeting, Kunming, China, 12-13 November 2007. Decision Point GF/B16/DP10. http://www.theglobalfund.org/documents/board/16/GF-BM16-Decisions_en.pdf.

⁷⁰ Global Fund. 2010. Investments in the Health of Women and Children: Global Fund Support of Millennium Development Goals 4 and 5. http://www.theglobalfund.org/documents/replenishment/2010/Investment%20in%20Health%20of%20Women%20and%20Children_GF%20Support%20to%20MDG%204%20and%205.pdf.

⁷¹ Global Fund. 2008. *Fact Sheet: Community Systems Strengthening*. http://www.theglobalfund.org/documents/rounds/8/R8CSS_Factsheet_en.pdf.

⁷² Global Fund. 2008. *Country Coordination Mechanisms: Partnership and Leadership*. <http://www.theglobalfund.org/documents/ccm/CCMThematicReport01-PartnershipLeadership.pdf>.

⁷³ Global Fund. 2008. Fact Sheet: Dual Track Financing.

stronger support, financial and otherwise, to CCMs and has further been developing performance criteria for CCMs.

The Global Fund has entered an era of decreased political support, especially in Europe, as criticisms of disease-specific programs, verticalism, and global-health-initiative proliferation have grown. As a funding mechanism with no in-country presence, the Fund has also been criticized for failing to deliver technical assistance, capacity building, and programmatic oversight mechanisms and for tolerating weak performance despite its performance framework. Nonetheless, in many ways the Global Fund is seen by many as one of the strongest performers in global health.⁷⁴

GAVI

The GAVI Alliance's mission is to save children's lives and protect peoples' health by increasing access to immunizations in developing countries, both for widely, but under-utilized vaccines, and for innovative new vaccines as well. It aims to provide frontloaded and predictable funding that aligns grants to the duration of country health or immunization plans. To fulfill these funding goals, GAVI has benefited from two innovative financing mechanisms previously discussed, the IFFIm⁷⁵ and Advance Market Commitments, the second of which has received major funding support from the Gates Foundation. In its first 10 years, GAVI has committed US\$4 billion in funding to the world's poorest countries, accelerating 256 million children's access to new and underused vaccines and averted 5.4 million premature deaths.

To double its immunization coverage, GAVI has estimated that it requires US\$4.3 billion in donor funding over the next five years.⁷⁶ The Alliance is confident that existing donor support will provide US\$ 1.7 billion of its five-year funding requirement -- enough to cover current programs and their extensions. However, an additional US\$ 2.6 billion is needed to rollout pneumococcal and rotavirus diarrhea vaccines as well as advance new vaccines like HPV.⁷⁷ Fortunately, the recent announcement by the Gates foundation of US\$10 billion over ten years may alleviate some of GAVI's financial pressures.⁷⁸ A significant portion of the US\$1 billion promised to the International Finance Facility for Immunizations will be targeted to new investments in health systems.⁷⁹

GAVI has been judged effective in its "market shaping role": aggregating developing country markets and exerting downward pressure on prices through market forecasting, purchase guarantees, and bulk purchases. Like other global health initiatives, GAVI has also been criticized about its poor coordination with partner institutions, its inadequate technical

⁷⁴ Nandini O, Rosenzweig S, Bernstein M. 2010. Are Funding Decisions Based on Performance? <http://www.cgdev.org/content/publications/detail/1424030/>.

⁷⁵ http://www.gavialliance.org/resources/Ifim_booklet_EN.pdf.

⁷⁶ GAVI. 2010. Financing Country Demand for accelerated access to new and underused vaccines 2010-2015. http://www.gavialliance.org/resources/Financing_Country_Demand_March_2010.pdf.

⁷⁷ GAVI Alliance. 2010. Investing in immunization through the GAVI Alliance: The evidence base. http://www.gavialliance.org/resources/GAVI_Alliance_Evidence_Base_March_2010.pdf.

⁷⁸ Gulland A. 2010. Gates Foundation gives \$10 billion for research and delivery of vaccines. *BMJ*; 340:c65. http://www.bmj.com/cgi/content/full/340/feb02_3/c650.

⁷⁹ GAVI Alliance welcomes new funding to strengthen health systems. 2009. http://www.gavialliance.org/media_centre/statements/2009_09_23_IFFIm_HSS_funding.php.

support for GAVI applicants, and its incomplete engagement of recipients in priority setting.⁸⁰

The GAVI Alliance Board has committed US\$ 800 million over a five-year period 2006-2009 to investments that strengthen country capacity to deliver both immunization and other health services in a sustainable manner, including child and maternal health.⁸¹ That funding is intended to be flexible and sustained and to respond to variable needs at country level. It often addresses limited managerial and supervisory skills; infrastructure failures, including transportation, cold supply and equipment; and workforce numbers, training, and motivation. Major reviews of GAVI's health systems funding to date have found that it has been country-driven, but that proposal development and assessment and performance review need improvement.⁸² Another study found that it has largely been used for downstream, short-term fixes rather than for systemic reforms.⁸³

GAVI has had one civil society seat on its Board from its inception in 2000. Since 2007, GAVI has increased its support for CS representation and participation at the global, regional, and national level. It supported the development of a Civil Society Task Team and Civil Society Council. GAVI provides financial support to CSOs to strengthen coordination/representation mechanisms (\$7.2 million budgeted 2007-08), and it also funds CSOs directly for HSS activities (\$22 million budgeted for 10 pilot countries).⁸⁴ In consultation with CS, GAVI is currently expanding and reforming its mechanisms for CS engagement by: (1) hosting a website and moderated listserv, and (2) supporting an annual forum on policy making and implementation, 15-20 person Steering Committee, and a communications focal point.⁸⁵

World Bank

The World Bank's performance in health, nutrition, and population (HNP) has been mixed. Its mission is: "To assist countries in improving the health, nutrition, population outcomes of poor people via strengthening the health care systems and securing sustainable health financing. To protect the most vulnerable from the impoverishing effects of illness, malnutrition, and high fertility by developing health policies that enhance the knowledge, skills, and values leading to equitable economic and human development." The World Bank now funds a smaller share of global support for HNP in developing countries than a decade ago, shrinking from 18% of DAH to only 6% by 2008, but growing again in 2009. From 2002-2010 (projected) the World Bank provided US\$ 19.4 billion in country-level HNP support, all to governments, as well as policy advice and analytical work; US\$ 8.2 billion was for Health Systems Performance). (See Chart below *ibid.*) The World Bank provides approximately

⁸⁰ Lee K, Harmer A. 2010. Editorial: Ten years of the Global Alliance for Vaccines and Immunisation. *BMJ*; 340:c2004. http://www.bmj.com/cgi/content/full/340/apr20_2/c2004.

⁸¹ GAVI Alliance. 2008. Q&A: Health System Strengthening. http://www.gavialliance.org/resources/HSS_Q_A_ENsimple_page.pdf.

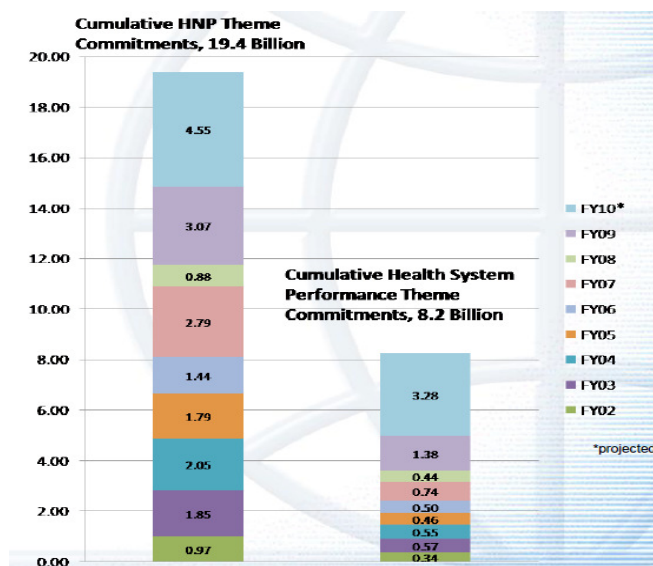
⁸² HLSP. 2009. GAVI health systems strengthening support evaluation 2009. Vol II. Full evaluation report. www.gavialliance.org/resources/Volume_1_Key_FindingsRecs_GAVI_HSS_Evaluation_FINAL_Report_8th_October_2009.pdf. Plowman B, Abramson W. 2009. Final Report: Health System Strengthening Tracking Study. http://www.gavialliance.org/resources/HSS_Tracking_Study_Final_Synthesis_November_09.pdf.

⁸³ Goeman L, Galichet B, Porignon DG, Hill PS, Hammami N, Essengue Elouma MS, et al. 2010. The response to flexibility: country intervention choices in the first four rounds of the GAVI Health Systems Strengthening applications. *Health Policy Plan*. <http://heapol.oxfordjournals.org/cgi/reprint/czq002>.

⁸⁴ GAVI. 2007. Enhancing civil society participation in GAVI Alliance governance and programme implementation 2007-2008: Background Paper.

⁸⁵ GAVI. 2009. GAVI Alliance Civil Society Meeting. http://www.gavialliance.org/resources/Report_on_GAVI_CSO_Day_21_Nov_Hanoi.pdf.

45% of its HNP to middle-income countries in the form of IBRD loans.⁸⁶ Its IDA arm provides the other 55% in the form of long-term, no-interest credits and occasional grants to 79 poorer countries.⁸⁷ Like the Global Fund and GAVI, the World Bank is entering its sixteenth IDA replenishment process for FY12-14 (IDA15 replenishment totaled US\$ 15.1 billion). The International Financial Corporation, the Bank's private sector arm, has committed US\$ 873 million in private health and pharmaceutical sector investments 1997-2008.



The World Bank has a negative history of involvement in health systems, initially in the 80's and 90's when it orchestrated structural adjustments that undermined public provision of health services, promoted privatization of health delivery, imposed user fees, and supported public sector wage constraints that have contributed significantly to the brain drain of health workers from low- and middle-income countries. More recent performance of the World Bank in health system strengthening has remained weak according to independent evaluations. When evaluating the World Bank's health-related performance over the last 10 years, the Independent Evaluation Group (IEG) reported:

- One third of health reform projects performed unsatisfactorily. In Africa results were particularly weak – 73% of projects failed to achieve satisfactory outcomes.
- Only half of the Bank's health support was focused on the poorest people, and much of the Bank's spending ended up helping the richest 20% of people.
- Only 29% of freestanding HIV projects had satisfactory outcomes; in Africa only 18%.

⁸⁶ IBRD works with middle-income and creditworthy poorer countries and provides loans, guarantees, risk management products, and (non-lending) analytical and advisory services. IBRD clients have access to capital on favorable terms in larger volumes, with longer maturities, and in a more sustainable manner than world financial markets typically provide. Compared to the average pre-crisis new commitment level of \$14 billion p.a. over FY05-08, new commitments in FY09 more than doubled to reach about \$33 billion. IBRD is projected to lend over \$40 billion in FY10, \$33 billion in FY11 and \$26 billion in FY12. World Bank. 2009. Review of IBRD and IFC Financial Capacities - Working with Partners to Support Global Development through the Crisis and Beyond. [http://siteresources.worldbank.org/DEVCOMMINT/Documentation/22331992/DC2009-0010\(E\)CapitalFinance.pdf](http://siteresources.worldbank.org/DEVCOMMINT/Documentation/22331992/DC2009-0010(E)CapitalFinance.pdf).

⁸⁷ IDA lends money (known as credits) on concessionary terms. This means that IDA credits have no interest charge and repayments are stretched over 25, 35 to 40 years, including a 10-year grace period. IDA also provides grants to countries at risk of debt distress. In fiscal year 2009, IDA commitments totaled US\$14 billion, of which 18 percent was provided on grant terms.

- Project monitoring was “weak” and evaluation “almost non-existent,” leading to inappropriate project designs, unrealistic targets, and the inability to measure the effectiveness of the Bank’s interventions. The IEG called this a “great concern.”
- Political risk and complexity were often missing in the risk analysis of health reform projects.⁸⁸

Although there has been some progress at the Bank since the IEG evaluation, including the launch of a new results-based financing framework, strengthened M&E, implementing plans to improve portfolio activities and to enhance its pro-poor focus, the most recent progress report on the Bank’s HNP performance continues to show poor performance: only 52% of HNP projects have achieved a satisfactory rating since the IEG review, compared to a baseline of 66% and a target to achieve a 75% satisfactory rating by July of 2008.⁸⁹ Other researchers have found that the Bank’s Multi-Country AIDS Program for Africa (MAP) funding decisions were not systematically linked to performance.⁹⁰

Historically, civil society’s engagement with the World Bank has been highly contentious. The spectrum of critique has ranged from shut-it-down to issue-related reforms. The Bank claims that it has been engaging civil society more broadly, that it facilitates dialogue between member governments and civil society on development issues ranging from policy to implementation, and that civil society engagement benefits operational performance by contributing local knowledge, technical expertise, and social legitimacy. Although the vast bulk of its funding is provided directly to governments, the Bank estimates that 10% of its annual funding portfolio, or US\$2 billion, is funded to CSOs through headquarters-based mechanisms, such as the Civil Society Fund, Development Marketplace and the Global Environment Facility, and indirectly through government-assisted social funds.⁹¹ The HNP program’s engagement with civil society has been characteristically fraught, especially given the adverse health impacts of structural adjustment. However, at a recent World Bank/Civil Society Roundtable, the Bank proposed the creation of a formal CS consultative group with HNP.

Some civil society advocates still think that there is a residual role for the World Bank based on its true comparative advantage in financing health infrastructure, in analysis, and in playing a convening and consultative role since it has an in-country presence unlike the Global Fund or GAVI. Nonetheless, health advocates are concerned about the policy advice that the World Bank might give partner countries based on its continuing espousal of private health insurance, expanded private sector health-service delivery, and performance-based pay incentives. There are additional concerns about the Bank’s reliance on concessional loans given the growing debt burden of developing countries in the aftermath of the global

⁸⁸ IEG. *Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population: An Evaluation of the World Bank Group since 1997*. 2009.

http://siteresources.worldbank.org/EXTWBASSHEANUTPOP/Resources/hnp_full_eval.pdf.

⁸⁹ The World Bank. *Implementation of the World Bank’s Strategy for Health, Nutrition and Population (HNP) Results: Achievements, Challenges, and the Way Forward: Progress Report*. 2009. http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2009/03/25/000334955_20090325043030/Rendered/PDF/478800BR0SecM2101Official0Use0Only1.pdf.

⁹⁰ Nandini O, Rosenzweig S, Bernstein M. 2010. Are Funding Decisions Based on Performance? <http://www.cgdev.org/content/publications/detail/1424030/>.

⁹¹ World Bank and Civil Society Webpage. <http://go.worldbank.org/PWRRFJ2QH0>. World Bank. 2009. World Bank-Civil Society Engagement: Review of Fiscal Years 2007 to 2009. <http://siteresources.worldbank.org/CSO/Resources/CivilSocietyBook2009final.pdf>.

financial crisis and global recession,⁹² though increased use of results-based buy-downs is promising. In sum, many CS health advocates are skeptical of the World Bank becoming a major recipient and conduit for health funding from the CTL/FTT or otherwise.

UNITAID Medicines Patent Pool Initiative

According to its constitution, “UNITAID’s mission is to contribute to scale up access to treatment for HIV/AIDS, malaria and tuberculosis for the people in developing countries by leveraging price reductions of quality drugs and diagnostics, which currently are unaffordable for most developing countries, and to accelerate the pace at which they are made available. To fulfill its mission, UNITAID will use sustainable, predictable and additional funding to help generate a steady demand for drugs and diagnostics, thereby significantly impacting market dynamics to reduce prices and increase availability and supply.”⁹³ UNITAID’s four main objectives are to: (1) increase access to efficacious, safe products of assured quality that address public health problems; (2) support adaptation of products targeting specific populations; (3) ensure affordable and sustainably priced products; and (4) assure availability in sufficient quantities and timely delivery to patients.⁹⁴ As one measure of its effectiveness, the UNITAID/Clinton Foundation partnership has reduced the cost of second-line ARV regimens by 43% and of pediatric regimens by 64% and has incentivized the development of new fixed-dose and pediatric formulations.

One of UNITAID’s major initiatives is to create a Patent Pool that seeks to collect licenses from patents and other proprietary rights from ARV right holders and then make those rights available on a non-discriminatory basis for generic sales in developing countries. The Pool expects to:

- Diversify supply sources to reduce prices: By making intellectual property (IP) available on clear, predictable terms the Pool will engender and/or enhance competition by facilitating market entry by multiple producers.
- Expand generic global market size to reduce prices & expand access: The Pool can help to expand the size of the global generic market by offering patent holders attractive terms on which to engage with developing countries.
- Facilitate the development of improved formulations: By improving access to IP, the Pool can help to spur the development of formulations, such as FDCs, pediatric and heat-stable products, that are well-adapted for use in resource-poor settings.
- Reduce transaction costs for FDCs: By serving as a “one stop shop” for patent-owners and generic producers, the Pool will reduce the number of licensing negotiations and other transaction costs required to develop or produce an FDC.
- Increase legal certainty to reduce prices: The Pool will provide generic producers with transparent information on the availability of licenses for patented products and the terms on which licenses will be granted, which can aid in investment decisions.⁹⁵

⁹² Li, Yuefen. *Collateral Damage from the Global Financial Crisis Could Land Developing Countries in another round Debt Crises*. United Nations Conference on Trade and Development, Geneva, 2009.

http://www.unctad.org/sections/gds_debt/docs/gds_dmfas_bn02-09_en.pdf

⁹³ http://www.unitaid.eu/images/governance/utd_constitution_05-07_en.pdf

⁹⁴ UNITAID. 2009. Strategy 2010-2012: Improving Global Markets to Address HIV/AIDS, Tuberculosis and Malaria. http://www.unitaid.eu/images/governance/unitaid%20strategy%202010-2012web_28jan10.pdf

⁹⁵ UNITAID. 2009. UNITAID Patent Pool Initiative: Implementation Plan – Executive Summary. http://www.unitaid.eu/images/meetings/ForWebsite_UNITAID_Patent_Pool_Implementation_Plan_-_Executive_Summary.pdf.

In three years, UNITAID has raised more than US\$ 1.3 billion for priority diseases treatments in 93 low- and middle-income countries (85% of which goes to low-income countries). More than 70% of UNITAID finances comes from a solidarity levy on airline tickets imposed in eleven countries. The rest of its funding comes from multi-year budget contributions from select countries and the Gates Foundation. As stated in a preceding section, UNITAID is also scheduled to receive significant resources from MASSIVEGOOD's voluntary travel levies.⁹⁶ Because of the tax-based and long-term nature of its financial support, UNITAID is able to make more durable commitments to impact market dynamics. However, its strategy is also to transition out of particular areas of funding once market failure has been remedied.

UNITAID has acted proactively to ensure participation of civil society in its activities, but thus far primarily in terms of consultations on policy. Two of its Executive Board are representatives of relevant civil society networks (non-governmental organizations and communities living with HIV/AIDS, malaria or tuberculosis). UNITAID is currently supporting a CS communications focal-point person.

⁹⁶ <http://www.unitaid.eu/en/20100304249/News/UNITAID-STATEMENT-ON-MASSIVEGOOD-LAUNCH.html>.

EC MDG Contracts

European Commission Millennium Development Contracts are a longer term, more predictable form of general budget support that the EC launched for selected countries at the start of EDF 10. It is part of the EC's stated commitments to provide more predictable assistance to developing countries.

The key principles of the "MDG Contract" are that it will last for the full length of the programming period; provide a minimum, virtually guaranteed level of support each year; entail annual monitoring with a focus on results; assess performance in a medium-term framework; be targeted at strong performers; support processes of donor harmonization and alignment; and be simple.⁹⁷

An EC MDG Contract has the following key features:

- Up to a six year commitment (depending ultimately on when the contract is negotiated during EDF 10's six-year duration);
- 70% of the total commitment will be guaranteed as a *base component* assuming no breach of eligibility conditions or fundamental elements of cooperation;
- An additional 30% *variable performance component*, 15% of which would be used to reward performance against MDG-related outcome indicators (results, notably in health, education and water) and public financial management (PFM) reforms following a mid-contract review, and the other 15% of which would be an annual performance tranche linked to implementation of PRSP, performance data, PFM improvement, and maintenance of macroeconomic stability, which can thus be withheld for poor performance).

Eligible countries include those with general budget support programmed under the 10th EDF, that have a successful track record in implementing budget support, show a commitment to monitoring and achieving the MDGs and to improving domestic accountability for budgetary resources, and have active donor coordination mechanisms to support performance review and dialogue. The Commission signed MDG-Contracts in 7 countries (Burkina Faso, Ghana, Mali, Mozambique, Rwanda, Uganda, and Zambia) in the first half of 2009, and is about to finalise its agreement with Tanzania. Collectively these account for €1.8 billion, or about 50% of all General Budget Support commitments in EDF 10 national programmes. However, this is only 14% of all EDF 10 national programmes, meaning that 86% of EC DAH is non-MDG-contract based.

Despite the EC's enthusiasm for direct budget support, there is evidence that its DAH has been relatively ineffective, that the percentage of DAH had not increased as mandated, and that there was little or no focus on human resources for health and health system strengthening.⁹⁸ The Auditor's report ultimately concluded that health sector support might be superior to general budget support or at the very least that sector budget support has been more efficient and led to more resources for health as opposed to general budget support. This conclusion is still contentious with some officials and CSOs arguing that more general budget support is need and others arguing that health sector support is superior.

⁹⁷ EC, The MDG Contract: An Approach for Longer term and More Predictable Budget Support. (2008) http://ec.europa.eu/development/icenter/repository/MDG-Contract-Paper-0608_en.pdf.

⁹⁸ European Court of Auditors. 2008. Special Report No 10/2008: EC Development Assistance to Health Services in Sub-Saharan Africa. Luxembourg. <http://eca.europa.eu/portal/pls/portal/docs/1/2020216.PDF>

According to the EC, it is committed to strengthening the role of civil society in development, both in Europe (on general policy issues) and in beneficiary countries (on programming and defining national priorities). It acknowledges that national development policy and programmes are generally more effective when civil society participates in and has a sense of ownership of policy processes and outcomes. In 2007, it set up a stakeholder advisory group to better structure its dialogue with European civil society bodies. At country level, EC delegations allegedly seek to encourage and facilitate dialogue between state and non-state actors, but leave ultimate accountability for CS consultation to national governments. A 2007 study of civil society involvement in ACP countries found variable and generally unsatisfactory levels of CS participation.⁹⁹ A more recent Mid-Term Review found continuing concerns at the country level and made multiple recommendations.¹⁰⁰

IHP+

The International Health Partnership and related initiatives (IHP+), was launched in September of 2007 by Gordon Brown and others and resulted in the signing of a foundational, IHP+ Global Compact.¹⁰¹ IHP+ had the stated intentions of achieving better health results by mobilizing donor countries and other development partners around a single country-led national health strategy, guided by the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, and by catalyzing sustained and adequate financing to fill developing-country partners' resource gaps. IHP+ processes were intended to rationalize a country-owned planning process, to strengthen financial transparency and accountability, and to improve the way international agencies, donors and developing countries work together to develop and implement national health plans. The IHP+ seeks to support inclusive national health planning processes, to encourage joint assessment of plans' strengths and weaknesses, to better harmonize donor funding commitments and other support via country compacts, to adopt a single results-based monitoring framework by which to track implementation, and to encourage mutual accountability and more inclusive health policy dialogue.

Joint assessment of national strategies (JANS) is a key feature of the IHP+ model and foresees a shared approach to assessing the strengths and weaknesses of a national strategy.¹⁰² The intention is that joint assessment should be accepted by all stakeholders and that it be used as the basis for both technical and financial support. Joint Assessment can be applied to an entire national health strategy (sometimes called the sector strategic plan) or to partial sub-sector strategies such as the national malaria strategy or multisectoral AIDS strategy. But the final strategy must be both strategically detailed and fully costed. An IHP+ inter-agency working group has finalized draft tools and guidelines for joint assessment, which include requirements on participation of relevant stakeholders and independence and expertise on the assessment team. Joint assessment teams will examine the strengths and weakness of five essential attributes of a national strategy plan: the situation analysis, and coherence of

⁹⁹ EC. 2007. Non-State Actors (NSA) and Local Authorities (LA) Consultation in the Elaboration of 10th EDF Countries Strategy Papers in ACP Countries. http://ec.europa.eu/development/icenter/repository/Consultation-non-state-Actor-and-local-Authorities-Public%20report_en.pdf.

¹⁰⁰ McCormick D, Rambaud Y & Minoia P. 2009. NSA-LA Mid-Term Review: Final Report.

http://ec.europa.eu/development/icenter/files/europa_only/consultation_non_state_actors_main_report.pdf.

¹⁰¹ <http://www.internationalhealthpartnership.net/en/home>.

¹⁰² IHP+. 2010. Joint Assessment of national strategies and plans: Frequently asked questions.

http://www.internationalhealthpartnership.net/CMS_files/documents/joint_assessment_draft_frequent_EN.pdf.

strategies and plans with this analysis ('programming'); the process through which national plans and strategies have been developed; financing, auditing and procurement arrangements; implementation and management arrangements; and results, monitoring, review and dialogue mechanisms. (Rollout of JANS has been postponed until June 2010.)

A charitable interpretation of the genesis of the IHP+ is that countries needed to have more coherent planning processes and better accountability, especially in monitoring financial flows, and that development partners, reassured by those efforts and through their participation in planning and assessment, would step forward to provide more stable and long-term commitments for health system strengthening. Although four compacts have been signed (Ethiopia, Mali, Mozambique, and Nepal), it is fair to say that money has been a problem in two senses. First, countries were encouraged to develop three resource-need scenarios, a needs-based, a realistic, and a pessimistic estimate, allegedly to allow flexibility, but with the predictable impact of dampening expectations, especially in light of the "pessimistic" scenario. Second, donors have simply not stepped up to the plate in any meaningful way to commit the money needed to fund identified resource gaps in country compacts.

Civil society has struggled to break into IHP+ processes especially at the country level. Northern and Southern civil society reps were appointed to the IHP+ Scaling-Up Reference Group and have facilitated greater involvement by civil society in national strategic planning and joint assessment exercises, but much remains to be done in this regard. IHP+ has just committed additional resources to help strengthen in-county CS coordination and participation, which hopefully will have positive future effects.

Bilateralism in general

In addition to the multilateral mechanisms described above, which is by no means a complete list, revenues collected by countries could be dispersed through traditional bilateral means with predictable trade-offs:

<i>Benefits of multilateralism & resource pooling</i>	<i>Benefits of bilateralism</i>
<ul style="list-style-type: none"> • Reduced volatility because there are multiple contributors and opportunities to adjust to falling revenues from particular donors • Reduced transactions costs for resource mobilization, disbursement, reporting, and evaluation/monitoring • Greater ability to coordinate with country mechanisms and procedures • Opportunities for donor coordination and fair-share contributions analyses • Greater transparency about funding sources, commitments, and disbursements • Reduced conditionality (arising from individual national perspectives) • Credit is shared internationally • Results-based financing can be less focused on short-term and easily measured inputs/outputs and more focused on longer term and systemic performance measures and impacts. • Greater economies of scale and scope are possible (but not inevitable). 	<ul style="list-style-type: none"> • Political credit for political leaders and countries. • Increased operational control over policies and implementation • Increased focus on politically popular results that build long-term domestic support for donors' continued funding • Ability to draw on donors' institutional capacity to manage planning, granting, disbursements, and M&E. • Leadership by individual countries and political benefits of such leadership can encourage other countries to scale-up contributions.

There is great pluralism among donors about preferred forms of bilateral aid. For example, the UK's Department for International Development has recently focused on country-ownership, longer-term aid, direct budget support, and health system planning and strengthening, including educating and training an expanded health workforce and mitigating the brain drain,¹⁰³ though those priorities might change under the new government. DFID also focused on improving the effectiveness and coherence of international funding for health and was the prime mover behind IHP+, promising to spend £450 million to support 8 IHP+ countries once they had completed compacts.

Although the UK has stated a preference for general budget support, other bilateral donors prefer Sector Wide Approaches (SWAs) or health sector budget support and others prefer to fund specific programs or even projects. Most donors tend to grant health aid according to their own short-term budgetary cycles rather than provide longer-term aid¹⁰⁴ that is coordinated with partner country planning, budgeting, and reporting cycles and mechanisms. The overall proliferation of health aid channels, its non-coordination with country systems, its fragmentation into smaller and smaller grants, and its high degree of earmarking all increase the complexity and reduce the efficiency of DAH. Donor proliferation and fragmentation are particularly intense in the health sector where more than 140 global health initiatives are at work. This complexity greatly increases transaction costs for both recipients and donors, detracting from actual implementation. "Managing aid flows from many different donors is a huge challenge for recipient countries, since different donors usually insist on using their own unique processes for initiating, implementing, and monitoring projects. Recipients can be overwhelmed by requirements for multiple project audits, environmental assessments, procurement reports, financial statements, and project updates."¹⁰⁵

Not only is bilateral DAH highly fragmented, it is also highly volatile. Volatility affects both programming and delivery.¹⁰⁶ Some researchers estimate that official aid flows are 4 to 5 times more volatile than developing countries' national incomes, which can diminish the true value of aid to recipient countries by nearly 25%.¹⁰⁷ Even worse, a great deal of this volatility is pro-cyclical, meaning that donors pay less in recessions – exactly the time that developing countries are struggling, like now, with reduced revenues. The chaotic effects of volatility are exacerbated by even greater volatility and uncertainty in disbursements. Percentage changes in net disbursements can go up and down by as much as 20%. The Paris Declaration called on donors to provide reliable commitments of aid over a multi-year framework and to disburse aid in a timely and predictable manner according to agreed schedules, but progress

¹⁰³ Nigel Crisp. 2007. Global Health Partnerships: The UK contribution to health in developing countries. <http://www.dfid.gov.uk/pubs/files/ghp.pdf>; UK Department for International Development. 2007. Working Together for Better Health. <http://www.dfid.gov.uk/pubs/files/health-strategy07.pdf>.

¹⁰⁴ Dodd R and Lane C. 2010. Improving the long-term sustainability of health aid; are global Health Partnerships leading the way? *Health Policy and Planning*: 1-9. <http://heapol.oxfordjournals.org/cgi/reprint/czq014v1>.

¹⁰⁵ Radelet, S. 2006. A Primer on Foreign Aid. Center for Global Development Working Paper, No. 92. www.cgdev.org/files/8846_file_WP92.pdf.

¹⁰⁶ United Nations Conference on Trade and Development. 2008. Trade and Development Report, 2008. United Nations, New York and Geneva. http://www.unctad.org/en/docs/tdr2008_en.pdf

¹⁰⁷ Khara H. 2008. Short Term Fixes for Development Aid. http://www.brookings.edu/opinions/2008/0410_development_kharas.aspx?emc=lm&m=214650&l=53&v=24738.

has been slow¹⁰⁸ and likely to be worse in the aftermath of the financial and recessionary crisis.

From a civil society perspective, bilateral aid also tends to bypass indigenous CSOs. Civil society is rarely consulted in planning, e.g., in SWAps, and is frequently ignored in implementation as well. Bilateral health aid tends to be negotiated government-to-government and rarely provides direct financial support for civil society implementation. Not only is CS excluded from the governance and implementation of bilateral aid, it is frequently excluded from a meaningful role in oversight or M&E as well.

PEPFAR and the US GHI

PEPFAR is the world's largest bilateral global health initiative and could be used as a conduit for US-derived CTL/FTT revenues. Launched in 2003, PEPFAR was proposed as a five-year, US\$15 billion initiative, but Congressional appropriations FY 2004-2008 were actually higher totaling US\$18.8 billion. PEPFAR's initial targets were to support treatment of 2 million PWAs, prevent 7 million new infections, and provide care to 10 million, including orphans and vulnerable children. In its 2009 report to Congress, PEPFAR reported that it had exceeded its treatment and care targets, but was more circumspect in describing its prevention impacts.¹⁰⁹ PEPFAR was reauthorized by the so-called Lantos-Hyde bill for an additional 5 years (FY 2009-2013) at up to US\$48 billion, including US\$39 billion for HIV/AIDS, US\$4 billion for TB, and US\$5 billion for malaria (including therein support for the Global Fund). The reauthorization relaxed prior spending directives, modified some, but not all, ill-advised prevention policies, and emphasized longer-term country partnerships and health system strengthening, including the training and retention of 140,000 new health care workers. In 2009, President Obama introduced a US\$63 billion, 6-year Global Health Initiative (GHI) calling for a broader global health agenda that would include maternal and child health, sexual and reproductive health, and neglected diseases, and that would further emphasize country ownership, health service integration, and health system strengthening more broadly.¹¹⁰

PEPFAR is being flat-funded rather than expanded as promised in the US\$48 billion reauthorization. In FY 2008, the last year of PEPFAR I, bilateral AIDS received US\$4.6 billion and the Global Fund US\$850 million (not including NIH research). This represented more than a doubling of PEPFAR spending over five years. In the FY 2009 budget prepared by the lame duck Bush administration, bilateral AIDS received US\$ 5 billion and the Global Fund US\$1 billion, a modest 10% hike. In President Obama's first budget, FY 2010, bilateral AIDS received US\$5.1 billion and the Global Fund US\$1.05 billion, an increase of only 2%, not even matching inflation.¹¹¹ The proposed FY 2011 budget is equally dire – a US\$50 million cut to

¹⁰⁸ OEDC. 2009. Better Aid: A Progress Report on Implementing the Paris Declaration.

<http://www.oecd.org/dataoecd/19/39/42111907.pdf>.

¹⁰⁹ PEPFAR. 2009. Celebrating Life: The U.S. President's Emergency Plan for AIDS Relief: 2009 Annual Report to Congress. <http://www.pepfar.gov/documents/organization/113827.pdf>.

¹¹⁰ *Statement by the President on the Global Health Initiative*. 2009.

http://www.whitehouse.gov/the_press_office/Statement-by-the-President-on-Global-Health-Initiative/.

¹¹¹ Kaiser Family Foundation. 2010. Budget Tracker: Status of U.S. FY10 Funding for Key Global Health Accounts. Available at <http://www.kff.org/globalhealth/upload/8045.pdf> accessed February 3, 2010.

the Global Fund and only US\$141 million in additional funding for bilateral AIDS,¹¹² US\$100 million of which is diverted to a new undefined Global Health Initiative Plus Fund. Because of its 6-year time frame and larger mandate, the GHI actually projects a decrease in per year AIDS funding compared to Lantos-Hyde.

The first-phase of PEPFAR was heavily reliant on international NGOs as implementers, and fundamentally adopted off-budget, project/program style funding. In PEPFAR's initial 16 focus countries, U.S. embassies were required to develop annual "Country Operational Plans," which define anticipated results. Under Lantos-Hyde, there is a new emphasis on country-ownership and plans for five-year Partnership Framework agreements to guide mutual responsibilities and performance reviews. A troubling feature of the new strategic plan for PEPFAR is its emphasis on "sustainability," which is being interpreted to mean that countries will be expected to take over both operation and funding responsibilities in the near future, with the U.S. retreating to role of technical assistance.¹¹³

PEPFAR has historically excluded CS from its formal governance and consultative mechanisms, though AIDS activists have had considerable impact in the creation, funding, and evolution of PEPFAR over time. Because of its reliance on INGOs and their local NGO sub-contractors, PEPFAR has funneled the majority of its resources to non-governmental implementers. Civil society is being afforded a stronger role in Partnership Framework negotiations than in the past, though it is still on an ad hoc basis.

The New Joint HSS Platform

In response to recommendations by the High Level Taskforce on Innovative International Financing for Health Systems and under the convening leadership of the WHO, the Global Fund, GAVI, and the World Bank have jointly proposed two preliminary options for a Joint Health System Strengthening Platform. Under Option 1, the Single HSS Funding Application, the three entities would agree on an HSS definition and on conditions of applicant eligibility, develop a common M&E framework, align performance-based funding frameworks, and coordinate program implementation including technical assistance and capacity building. The Global Fund and GAVI would develop common documents and a shared call for HSS funding proposals. There would be a joint assessment or review of the funding proposal and a decision about how to apportion or allocate funding between funders, but the actual funding would still be provided separately by each agency. Under Option 2, funding based on Jointly Assessed National Strategies, countries would initially submit a costed National Health Strategy that includes distinct sections on disease- or program-specific strategies, on cross-cutting HSS, and on an M&E framework. The entire Health System Strategy application would be jointly assessed by designated experts using the joint assessment approach developed by IHP+. Once the National Health Strategy was approved, countries would submit a second and briefer joint application for HSS funding to the three funding agencies. The respective Boards would be expected to act in concert in approving or disapproving the joint funding request. If jointly approved, the funds could be placed in a health sector financing pool (like a SWAp) if requested by the country.

¹¹² Kaiser Family Foundation. 2010. Policy Tracker: White House Releases FY 2011 Budget. Available at <http://globalhealth.kff.org/Policy-Tracker/Administration/Actions/2010/February/01/FY11-Budget-Request.aspx> accessed February 3, 2010.

¹¹³ PEPFAR. 2009. The President's Emergency Plan for AIDS Relief – Five-Year Strategy. <http://www.pepfar.gov/documents/organization/133035.pdf>; Annex PEPFAR and Prevention, Care, and Treatment. <http://www.pepfar.gov/documents/organization/133434.pdf>.

These two options can be compared according to their three functional attributes: joint application, assessment, and funding:

	Option One	Option Two
Joint application	Common HSS Application	National Health Strategy Application & shorter Joint HSS Application
Application assessment	Common Assessment	IHP+ Joint Assessment Approach & coordinated assessment by funders
Funding	Apportioned but separate funding	Separate funding or pooled funding to a health sector financing pool

The Joint HSS Platform’s preliminary documents suggest that the lead partners believe that the World Bank could have a significant role in so-called upstream HSS activities including governance, financing, and inter-sectoral linkages. The Joint HSS Platform will be adapted and piloted in several countries later this year.

A well-designed Joint HSS Platform might offer several potential advantages that would: (1) increase country ownership, lower transaction costs, and improve harmonization/alignment; (2) lead to increased and high-quality country demand for HSS from governmental and non-governmental service providers; (3) catalyze additional, adequate, and sustained sources of financing sufficient to expand and improve health system functioning; (4) ensure that HSS efforts are effectively and measurably focused on expanding the quality of health service delivery for the three priority diseases, immunizations, and for health needs more broadly; and (5) provide linkages and synergies between the Joint HSS Platform and National Strategy Applications, PEPFAR Partnership Frameworks, IHP+, and other complementary initiatives.

Although the Joint HSS Platform has many potential benefits and opportunities, it also contains potential risks and concerns that might need to be weighed and, if possible, mitigated. These include: (1) whether the selection of countries for inclusion in the Joint HSS Platform and a possible focus on low-income countries only is appropriate; (2) whether the Joint HSS Platform will induce additional donor funding; (3) how to structure the Joint HSS Platform so that quality country demand for HSS is increased; (4) the risks and benefits of SWAs, budget support, and other modalities of finance pooling in terms of accountability, multi-stakeholder involvement, and results-based financing objectives; and (5) the role of the World Bank, given its markedly different governance and disbursement structures and its questionable HNP performance.

A Proposed Global Fund for the Health MDGs

Gorik Ooms, a former director of MSF Belgium and now an academic at the Antwerp Institute of Tropical Medicine, and others have been promoting the idea of a Global Fund for the Health MDGs, essentially via an expansion of the mandate and of the funding of the Global Fund and GAVI and their eventual merger.¹¹⁴ Deploring the proliferation of donor health initiatives, recognizing the benefits of pooled donor funding in reducing aid volatility, and championing a right-to-health and international-solidarity perspective on sustainability, Ooms and his colleagues are urging a step-by-step realization of a Global Fund for Health that will

¹¹⁴ Cometto G, Ooms G, Starrs A, Zeitz P. 2009. A global fund for the health MDGs?. *Lancet*; **373**: 1500–02.

specifically address child and maternal health and sexual and reproductive health as well as priority infectious diseases. In fact, according to its proponents the new Global Fund for Health should address human resources for health first and health system strengthening more broadly while it eventually funds a comprehensive primary-health-care integration. Even though the mandates of the Global Fund and GAVI would be expanded, Ooms et al. urge retention of the participatory governance, results-based financing, and country-directedness of the Global Fund. More recently, recognizing the problem of purely voluntary replenishment mechanisms, Ooms has advocated for the adoption of a formal contribution framework agreement for the proposed Global Fund for Health.

The Lancet has endorsed the call for a Global Fund for Health MDGs both in the context of Global Fund replenishment¹¹⁵ and in response to new evidence on some progress in reducing maternal mortality¹¹⁶. Jeffrey Sachs, one of the early proponents of the Global Fund has also called for it to expand its mandate.¹¹⁷ The prospects for this proposal are uncertain and its benefits and risks must be carefully assessed against other alternatives in term of its health-systems/all-health-needs focus, its potential to generate new resources, and its administrative feasibility.

<i>Benefits of health system focus</i>	<i>Benefits of priority disease focus</i>
<ul style="list-style-type: none"> • More consistent with new focus on comprehensive primary health at WHO, in European countries (especially Scandinavian), and US Global Health Initiative. • More consistent with stated goals of developing country partners to strengthen health systems more broadly to be able to respond to local epidemiological needs and priorities. • Serves as a platform to emphasize need for increased and better-trained HRH. • Allows simplified support for national health plans through health sector or general budget support (contested). • Likely to increase country-ownership and stewardship of HSS. • More likely to result in better integration of services and more robust and durable primary health care service delivery. • Can direct resources to less sexy health systems needs – labs, health information, procurement and supply, health sector planning/management, etc. • Can increase attention to health facilities needs, transportation infrastructure, etc. 	<ul style="list-style-type: none"> • Better able to draw on mobilized health movements, especially those consisting of infected patients and affected communities. • More effective at mobilizing demand from affected constituencies. • Better messaging that mobilizes political support and sways decision-makers. • Results in sharper focus, speedier and more results-based implementation, and ultimately greater accountability. • Greater potential for learning and dissemination of best practices. • May result in a greater focus on service quality. • GHIs are already a fact on the ground and can be used for diagonal strengthening of health systems and service integration with related health needs including MCH, SRH, and even neglected diseases.

¹¹⁵ Editorial. 2010. The Global Fund: replenishment and redefinition in 2010. *Lancet*; **375**: 526.

¹¹⁶ Horton R. 2010. Comment: Maternal mortality: surprise, hope, and urgent action. *Lancet Early Online* doi:10.1016/S0140-6736(10)60547-8

¹¹⁷ Sachs J. 2010. Funding a Global Health Fund. *Guardian*.

<http://www.guardian.co.uk/commentisfree/2010/mar/25/global-health-fund-funding-tb-aids>.

<ul style="list-style-type: none"> • Emphasizes need for recurrent expenditures and sustained financing. • Internalizes competition between health needs and results in more rational priority setting (contested because short- and narrow-sighted cost-effectiveness analyses are likely to predominate) 	<ul style="list-style-type: none"> • GHIs are more multisectoral (especially HIV/AIDS) than many HS focused activities. • May be a better platform to argue for community system strengthening and community health workers (contestable).
<i>Benefits of “show us the money” – money first</i>	<i>Benefits of expanding mandate first</i>
<ul style="list-style-type: none"> • Won’t get tricked into a zero-sum game, split-a-shrinking-pie game by stingy donors. • Can reduce competition between health advocacy groups and help build a more unified movement for global health justice. • Forces donors and governments to make commitments that can be enforced later. • Avoids piling on new activities at the Global Fund, when it is already out of money for Round 10 and other 2010 funding needs. • Could establish preconditions for the expansion of the Global Fund mandate. 	<ul style="list-style-type: none"> • European donors and US GHI are already moving in this direction. • The GF Secretariat is already on record supporting the inclusion of MCH and of possible merger/ greater collaboration with GAVI. • Would show evidence of a unified global health movement creating a broader and more united coalition for complementary advocacy. • Donors might not be willing to put more money on the table until they have a mechanism to do so. • Because of a huge reluctance to create yet another separate mechanism, broadening the mandate of the Global Fund might be the most palatable alternative.
<i>Additional concerns/questions about a Global Health Fund</i>	
<ul style="list-style-type: none"> • Is the Global Fund model, especially its rounds-based funding, a good model for funding MCH, HRH/HSS, and comprehensive primary care more broadly? • Even if the model is morphed to fund national strategy applications, is the CCM, TERG, PR, LA model an effective model? • Are there diseconomies of scope within a single funding mechanism? • Can a single fund for health amass the necessary technical expertise to address so many diverse health needs? • How will the participation of civil society/patient groups representing diverse health needs be handled? Will the civil society voice be more or less united in fact? • Already the move to national strategy applications, budget/sector support, and HRH/HSS has resulted in greater, not lesser, inclusion of civil society. Is there any reasonable version of a global health fund that actually preserves the inclusion of health activists? • Will there be a backlash against health exceptionalism because of all of the attention and resources devoted to health compared to other pressing human development needs such as education-for-all, food security, water/sanitation, and climate control/mitigation? 	

4. Conclusion

Prospects for a comprehensive, universally adopted CTL-for-health or an FTT-with-health may have dimmed slightly over the past two months, but the merits of such proposals are clear-cut. However, donors, partner countries, and activists will want to know where the

money will be directed and how it will be spent. Old-fashioned arguments about verticalism vs. horizontalism, multilateralism vs. bilateralism, budget support vs. dual-track financing, and dead-aid vs. aid effectiveness abound. Global health advocates must make decisions about which attributes of a financing mechanism are most important to them and how multiple factors should be weighed. This paper has tried to provide relevant information about each major mechanism's past performance, priority focus, coordination with countries, engagement with civil society, and political reputation. Ultimately, the selection of destination financing mechanisms might influence both the political prospects and the ultimate effectiveness of a CTL/FTT. Accordingly, health advocates, especially those in Europe where experiments with a CTL-for-health or FTT-with-health are more likely to be undertaken, should carefully weigh the pros and cons of various alternatives. They would probably also be wise not to put all of the revenues into one basket unless it is clearly superior in terms of acceptability, efficiency, and equity.

The following charts seek to capture some of the relative strengths and weaknesses of different options. Readers should draw their own overall assessments.

Mechanism	Past Performance	Priority Focus	Country Ownership/ Coordination/ Harmonization
Global Fund	Strong: results-based funding, long-term commitments, reduced volatility, equity	HIV, TB, malaria, HSS	Country-led but behind on harmonization
GAVI	Strong: long-term commitment, low volatility, equity	Immunization and HSS	Country-led but behind on harmonization
World Bank	Weak: poor performance-based funding, conditionalities and debt-based financing, not focused on the poor	Health Finance, multi-sectoralism, health systems	Engages with Ministries of Finance but behind on harmonization
UNITAID	Strong: Market impact, secure sources of revenue, value for money, medium-term commitments	Medicines and diagnostics for HIV, TB and malaria	N.A. in general but patent pool will make it easy to procure affordable meds
EC MDG Contracts	Mixed: Has underemphasized health,	HSS, general budget support (in theory)	Strong in theory, but mixed
IHP+	Weak: Only 4 compacts to date, has not been able to raise money	National health planning and financial accountability	Strong
Bilateral Aid	Mixed: Varies by donor in terms of volatility, duration, disbursement/commitment ratio, and conditionality	Varies by country, US historically focused on priority diseases; European donors focus more on child and maternal health, and HSS	Varies by country, generally very weak
Joint HSS Platform	Just being piloted now	HSS re priority diseases and positive synergies re health systems more broadly	Expected to be strong
Proposed Global	NA, but plans to use Global	Comprehensive primary	Undeveloped at present;

Fund for Health	Fund model	health care, human resources for health, and HSS	potential for reduced transaction costs
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Mechanism	Civil Society Engagement	Political Reputation	Overall
Global Fund	Very strong, funding for CSS, but persistent weaknesses in CCMs	Mixed: dwindling support	
GAVI	Strong: growing role in governance, funding for CSS	Strong: Private sector support	
World Bank	Weak and contentious at global level; lack of knowledge at country level, history has funded CS capacity building	Some European donors like it	
UNITAID	Strong at global level	Strong but not well known	
EC MDG Contracts	Weak		
IHP+	Mixed at first, still hard at country level but now funding local CS strengthening	Best in UK; failure to deliver funding is very problematic	
Bilateral Aid	Generally weak but mixed, PEPFAR allows informal consultation, funds local NGOs	Governments like to control the purse-strings, but developing countries are deeply ambivalent	
Joint HSS Platform	Weak at beginning, will be important at country level	Boosted by High Level Taskforce on Innovative Financing	
Proposed Global Fund for Health	Strong role proposed, but may be difficult to coordinate so many diverse health advocates	Just starting to be debated	

Acronyms

ACP	African, Caribbean and Pacific Group of State (EU)
AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretroviral
CBO	Community-Based Organization
CCM	Country Coordination Mechanism (Global Fund)
CMH	Commission on Macroeconomics and Health
CHW	Community Health Workers
CS	Civil Society
CSO	Civil Society Organization
CSS	Community System Strengthening
CTL	Currency Transaction Levy
DAH	Donor or Development Assistance for Health
EC	European Commission
EU	European Union
EDF	European Development Fund
FBO	Faith-Based Organization
FTT	Financial Transaction Tax
GAVI	Global Alliance for Vaccines and Immunisations
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative (US)
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
HSS	Health System Strengthening
IEG	Independent Evaluation Group (World Bank)
IHP+	International Health Partnership and related initiatives
IFFIm	International Finance Facility for Immunisations
IMF	International Monetary Fund
IP	Intellectual Property
JANS	Joint Assessment of National Strategies
M&E	Monitoring and Evaluation
MAP	Multi-Country HIV/AIDS Program for Africa
MBB	Marginal Budgeting for Bottlenecks
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MDR-TB	Multi-Drug Resistance Tuberculosis
NGO	Non-Governmental Organization
NIH	National Institutes of Health (US)
NSA	National Strategy Application (Global Fund)
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
PEPFAR	President's Emergency Plan for AIDS Relief (US)
PMF	Public Financial Management
PMTCT	Prevention of Mother-to-Child Transmission
PRSP	Poverty Reduction Strategy Paper (World Bank)
TARP	Troubled Assets Relief Program
TB	Tuberculosis
WHO	World Health Organization
XDR-TB	Extensively Drug Resistant Tuberculosis