Technical Brief

hlsp institute

TB and malaria: trends in donor funding

The amount of donor assistance for TB and malaria is increasing. Drawing on three studies recently carried out by HLSP, this technical brief discusses the implications of this finding.

Introduction

The best way of improving health is through sustained and broad based economic development[1]. Other factors - such as access to education, especially for females, and providing better access to quality health care - can also make a difference.

Most ill health is caused by infectious and parasitic illnesses and within this most is caused by a relatively small number of conditions - especially TB, HIV/AIDS and malaria in sub Saharan Africa. Most of these conditions can be treated simply and at relatively low cost.

As 2015 draws ever nearer, the international community is becoming increasingly concerned that too little progress is being made towards achieving the health Millennium Development Goals (MDGs). In sub Saharan Africa, in particular, the performance is extremely patchy and in many countries health indicators are actually getting worse.

It is now well accepted that action at the country level alone will not be sufficient, and that complementary actions are required at both regional and global levels. As such the international community has begun to work more closely with other actors - notably the private sector and particularly the pharmaceutical sector.

A large number of global health partnerships (GHPs) have been established – around 90 at the last count. These focus mainly on communicable diseases and concentrate on a range of actions including development of new products, advocacy, and efforts to improve access and financing. The major GHPs, from a financing perspective, include the Global Fund to Fight AIDS, TB and Malaria (GFATM), GAVI (Global Alliance for Vaccines and Immunization), GPEI (Global Polio Eradication Initiative), Stop TB and Roll Back Malaria (RBM). These initiatives are mobilising and /or channelling large amounts of resources to low income countries. This raises a series of questions.

- Is funding for communicable diseases going up or down?
- Is the funding additional? How well is it being spent?
- Is support through GHPs improving or worsening the overall allocation of development assistance?
- Are global processes undermining country level process?
- What are appropriate governance arrangements?
- Is funding being channelled to countries and people in greatest need, and to the most cost effective interventions?

Focusing on some of the economic and financing issues related to a number of the GHPs, this technical brief attempts to shed light on some of these important questions.

Major findings

1. Donor surveys of TB and malaria funding

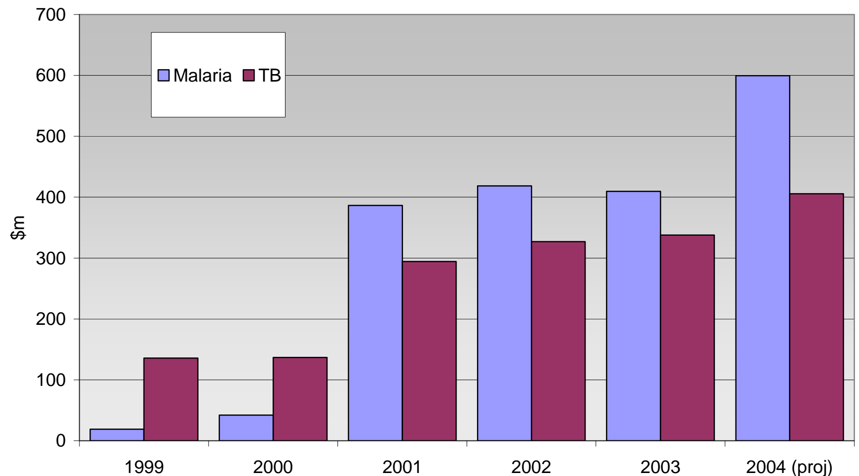
How much is being spent?

Almost two thirds of donors surveyed identified malaria as a key priority in its own right; around half of donors said the same for TB. The rest supported prioritisation of the two diseases on the basis of their contribution to overall disease control, poverty reduction and the MDGs.

[1] Filmer and Pritchett (1997) Child mortality and public spending on health: how much does money matter? World Bank

Commitments for TB and malaria appear to have increased markedly, especially for malaria (figure 1). However, many delays have been experienced in actually disbursing these commitments.

Figure 1: Reported donor financial contributions by disease



Where is the money going?

The geographic pattern of allocation is changing. For TB there has been steady growth in spending in Eastern Europe and Central Asia, and a slower rise in amounts for South East Asia and Sub Saharan Africa. For malaria the vast majority of funds are allocated to sub Saharan Africa. Relatively little is allocated for research and development (3% and 4% for TB and malaria respectively) raising concerns about long term sustainability of efforts to control the disease.

How is it being channelled?

The majority of the earmarked malaria funding was allocated directly to countries. However, the trend is to shift away from projects towards sector or general budget support. An increasing share of funding is allocated through global mechanisms (particularly GFATM). For TB, the share channelled to the Global Drug Facility (part of the Stop TB Initiative) and GFATM overtook direct allocations to countries in 2004 (figure 2). As a result of these trends, country based tracking surveys and national health accounts (rather than donor surveys) are more appropriate tools for tracking countries' health expenditures.

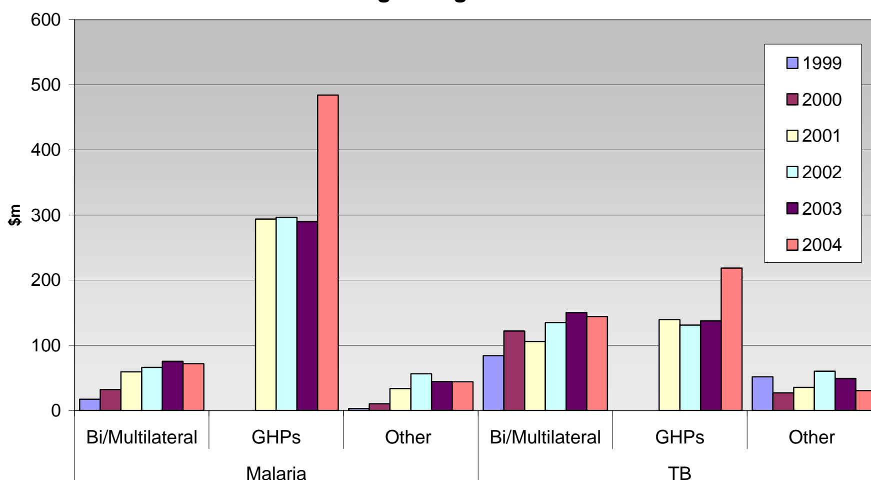
Where does it come from?

The majority of funding for malaria control identified in the survey came from bilateral donors. For TB 90% of the funding identified in the recent surveys came from development agencies, with a further 10% from foundations.

Is it enough?

Despite the considerable growth in funding, TB and malaria are still relatively poorly funded. This highlights the importance of donors working closely with key officials at country level, to advocate for greater attention and funding for malaria and TB within general health systems. The RBM and Stop TB Partnerships were seen as having a key role to play in this. There may also be ways to support the malaria and TB communities in understanding how to work within an environment where substantial aid flows are linked to PRSPs or broader health plans and not earmarked for specific diseases (or even to health).

Figure 2: Increase in donor support for TB and malaria by source: the growing role of GHPs



2. Review of Global Health Partnerships

On the whole Global Health Partnerships (GHPs) have had a positive impact and have been welcomed at the country level.

Resource flows and sustainability

GHPs have brought welcome additional resources, though the amounts have still been insufficient to provide countries with the financial means to deliver even a basic level of services. GHPs play a major funding role in some countries - particularly low income countries. Sustainability is a crucial issue but receives little attention from most GHPs. Increased aid dependency is an inevitable result. The funding approach adopted, where the GHP provides up front costs and introduces a new product, and the country takes over the operational costs over time, also poses a major risk. This is because the country's future spending patterns is likely to be dictated by the GHPs rather than by its own priorities, if the two differ, as they may.

The need to manage the macroeconomic effects of increased aid flows (associated in part with the GHPs) will become increasingly important. Volatility in flows rather than the magnitude of support causes more problems at the country level. The demand based approach to proposals adopted by GFATM (by far the largest financial GHP), and the fact that it only guarantees funding for two years, has its strengths but is not necessarily conducive to greater predictability in funding.

Consistency with country level processes

It is perhaps too soon for countries to have adapted to the GHP financial inflows and reflected these in changes in strategic plans and expenditure frameworks. It may be worth revisiting this issue in two or three years' time. There are some concerns though that increased support for the GHPs has been at the expense of support for key interventions such as water and sanitation and family planning, and that spending on HIV treatment has been at the expense of other support for the health sector. In some cases GHP proposals have run counter to government policies e.g. user fee policy and decentralisation in Zambia.

Additionality

The growth of GHPs needs to be seen against a backdrop of strong growth in development assistance for health and population activities which has been sustained over the last three decades, and has seen significant increases in real donor spending on health and population (of the order of 3% per annum since 1975).

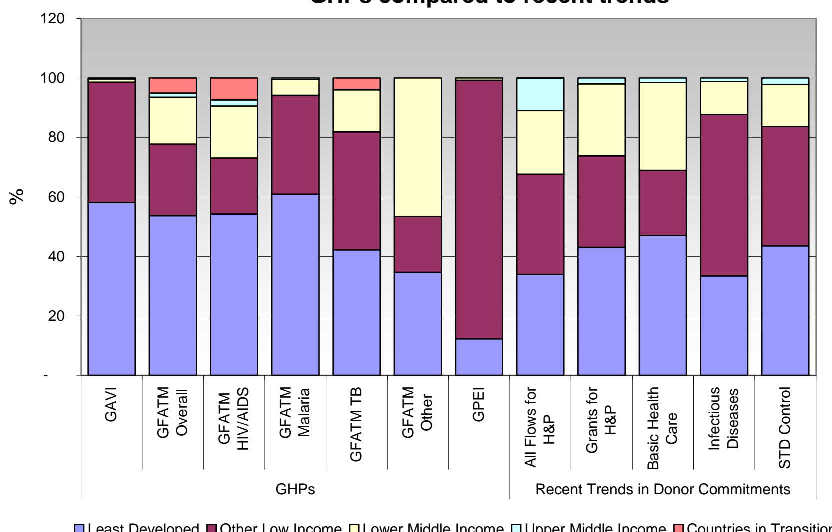
There is little evidence that GHPs have been able to leverage additional funds from new sources (with the exception of the foundations – especially the Bill & Melinda Gates Foundation). In some cases they have provided important seed money to establish GHPs which have subsequently attracted additional resources from traditional donors.

Impact on allocation

GHPs are distortionary as additionality is often a conditional for their support. The key issue is whether the distortions they introduce improve the global allocation of resources, and more specifically whether such distortions are a price worth paying. The financing GHPs do appear to improve the overall allocation of resources. They are relatively well targeted towards diseases which present the largest burden of ill health and to countries in greatest need (in terms of socio-economic status) and especially so when compared to past donor practices (figure 3).

However, GHPs often operate within systems which are far from pro-poor. It will be important therefore to ensure that investment in GHPs is not at the expense of investments in system strengthening.

Figure 3: Allocation by income group: GHPs compared to recent trends



Interventions supported

Most interventions funded by GHPs are potentially highly cost effective. For example, the newer vaccines promoted by GAVI are costly, but are also likely to be cost effective in many settings. Antiretroviral therapy is an exception, though there may be other compelling arguments in favour of this approach.

There is little clarity on future funding needs or the timing of these needs. Approaches to financial management and strategic planning differ significantly between GHPs, making assessments of where, and when to invest extra resources problematic.

Risks of perverse incentives

There is a danger that short-term incentives may compromise long-term development objectives. For instance, in the run-up to 2015, there is a risk that donors may become less willing to fund R&D GHPs whose products are unlikely to be widely adopted before 2015, but which have enormous potential in the longer term. It will be important to take a balanced approach and, if necessary, ensure neglected areas are adequately are covered. The International Financing Facility (IFF) will also have the effect of increasing expenditure in the short term at the expense of expenditure in the long term.

Implications for donor support

GHPs are here to stay – but donors are still faced with choices about how to channel their support between competing uses and channels. Key questions for donors include whether they should focus efforts on GHP expansion or whether they should seek to assist countries in consolidating earlier efforts through budget or sector support where appropriate. Key factors in this decision will include:

- the overall performance of the GHP in question against its own objectives but also against broader development objectives;
- the specific programmes or directions being promoted by the GHP;
- the extent of any existing funding imbalances;
- the relative merits of country v global funding approaches;
- the political fallout from not supporting or reducing support to a particular GHP.

Resources

This brief draws on three studies recently carried out by HLSP:

Trends in International Funding for Malaria Control (prepared for the Roll Back Malaria Partnership)
http://rbm.who.int/docs/hlsp_report.pdf

Trends in International Funding for TB Control (prepared with the Stop TB Partnership)
http://www.stoptb.org/cb/meetings/20051110_Assisi_Italy/default.asp

Economic and Financial Aspects of the Global Health Partnerships (commissioned by DFID as part of an overall review of GHPs carried out by the DFID Health Resource Centre)
http://www.dfidhealthrc.org/shared/publications/GHP/GHP%20Finance%20Dec%2023.pdf

www.hlspinstitute.org

January 2006

The HLSP institute aims to inform debate and policy on global health issues and national health systems in order to reduce inequalities in health