New sources of income for HIV

As an alternative to donor support, innovative financing mechanisms to bridge the funding gap are gaining increasing support from governments. **Zimbabwe's AIDS levy** - a 3 percent income tax - generated more than US$26 million in 2011, UNAIDS reported recently. However, Albert Manenji, finance director of Zimbabwe's National AIDS Council, told IRIN/PlusNews that only 30 percent of Zimbabweans were in the formal sector and contributed to the levy, so they are looking at broadening the revenue base to include small businesses and the informal sector.

Rwanda and Uganda have begun to impose a levy on the use of mobile phones to fund health programmes, and Botswana, Gabon and Malawi, among others, are investigating such a levy specifically for AIDS financing.

Imposing a **"sin tax" on alcohol and tobacco to pay for universal access to ARVs** could be one of the most ambitious taxes to be implemented.

The idea of a **"sin tax"** has long been popular in developed countries, and now the **"fat tax",** a levy on **sugary drinks and other foodstuffs associated with obesity**, is also growing in momentum. But Hill admitted that enforcing these taxes in poorer countries would be difficult.

Schwartländer also suggested that the recent **fines imposed on large pharmaceutical firms** could **be set aside for health**

assistance, "rather than disappear in the general coffers of those countries".

In July 2012, British drugmaker GlaxoSmithKline pleaded guilty to criminal charges and agreed to pay $3 billion in fines for promoting its best-selling antidepressants for unapproved uses, and failing to report safety data about a top diabetes drug.

Schwartländer pointed out that "three billion dollars could easily pay for a year of drugs for all those on treatment today".

Funding universal access to antiretroviral treatment through a 'Global Health Charge' on alcohol and tobacco consumption: feasibility in the 20 countries with the largest HIV epidemics

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Background: Current funding levels from PEPFAR / Global Fund may be too low to ensure Universal Access to antiretrovirals (ARVs) in the long-term. Additional, sustainable sources of funding are required.

Methods: For the 20 countries with the largest HIV epidemics, the additional costs required to achieve Universal Access were

calculated, using WHO 2011 estimates of patient numbers requiring ARV treatment, combined with Clinton Foundation prices of ARVs, and PEPFAR estimates of cost of care/diagnostics. WHO estimates of adult population size, annual alcohol and tobacco consumption (commercially supplied) were used to estimate annual revenues from a **"Global Health Charge" of 1 US cent per 10mL unit of alcohol, and 10c per 20 cigarettes.** **Results:** In the 20 countries with largest HIV epidemics, 5.2/11.3 million eligible patients were receiving antiretrovirals (coverage 46%). The minimum cost of care was $861 per patient-year (antiretrovirals, $406, medical $300, diagnostics $155). Ten of the 20 countries (Botswana, Brazil, China, India, Nigeria, Thailand, Russia, Uganda, Ukraine and Vietnam), could fund 100% of Universal Access costs from National revenue using the "Global Health Charge": $2.57 of the total $17.97 billion of revenue collected per year would cover treatment of 3.0 million eligible patients in these countries. In the other 10 countries (Cameroun, Cote d'Ivoire, DR Congo, Kenya, Malawi, Mozambique, Tanzania, South Africa, Zambia, Zimbabwe) $937 million could be collected annually with the Global Health Charge: sufficient to treat 1.1 million eligible patients (35% of the additional $2.67 billion budget required for Universal Access). **Conclusions:** A "Global Health Charge" of **1 US cent per unit of alcohol, and 10 cents per 20 cigarettes, collected and spent at a National level,** would be sufficient to fund an additional 4.1 million patients per year with antiretroviral treatment and care; Universal Access could be acheived in 10 of the 20 countries with this

system. This would also contribute to reducing NCD linked to alcohol and cigarettes consumption

The WESS report

In the area of health, the report concludes that instead of an array of disease-specific funds, **it would be better to focus on finding new resources for more general budget support for health systems in developing countries in need and to consolidate the existing disease-specific disbursement mechanisms into a single "global fund for health".**

The report also highlights a number of technically feasible and economically sensible options to obtain considerable new funding, all which will be revealed at the launch of the report on 5 July at 11 am EST.

Without disclosing any of the details, Rob Vos, Director of UN DESA's Division for Development Policy and Analysis and the lead author of the report, says, "Realizing the potential of these mechanisms will require international agreement and corresponding political will, both to tap sources as well as to ensure allocation of revenues for development."

The WESS sums up **that the design of appropriate governance and allocation mechanisms is crucial for innovative financing to ultimately meet development needs and contribute to financing the post-2015 development agenda. It also concludes that realizing this potential requires strong political will to follow through on available proposals as well**

as transparency in the allocation and management of those resources.

Fiscal Space and Policy Space for Financing the Global AIDS Response to 2031

Jacques van der Gaag, Vaughn Hester, Robert Hecht, Emily Gustafsson, Natalie Menser & William McGreevey

Two of the countries appearing in figures above, Brazil and Mexico, have had considerable success in expanding support for HIV and AIDS programs through their **public health services and national social security systems**.12 In effect, the public sector agreed to finance services for all persons. Similar progress in assuring inclusion of essential prevention, care and treatment has emerged in other LAC region countries as well.

There are two potential sources of revenue that, if tapped in the right way, could provide net additional aid for HIV/AIDS prevention and treatment (or for health services overall): **the corporate sector and the household sector.** In many Sub-Saharan countries **multi-national corporations and large domestic companies already provide employment based health insurance, the premium of which is partly paid by the corporation and partly by the employee. There is no particular reason for these arrangements to be limited to large formal sector companies.** Indeed, in Namibia, when 25 smaller local companies were recently asked to join specially developed low cost health insurance coverage plans for low-income workers, all but one company signed up all their

workers, with a 50:50 sharing arrangement for the payment of the premium.

There is also no reason to limit these types of employment based voluntary insurance arrangements to the formal sector. In Lagos, Nigeria, market women have been invited to join a low-cost health insurance scheme (covering the women and their families) on a voluntary basis. In general, these women are too poor to be able to pay for the total premium. **This in turns opens up an opportunity for donors to provide additional resources (to subsidize the premium) without running the risk of crowding out the private resources that are already used in the health system.** In this case, the Dutch government provided a large grant to the Health Insurance Fund, a Dutch NGO, to provide these subsidies. The Dutch NGO PharmAccess is implementing the program, which includes upgrades for local health care facilities and quality control of the health care delivery in addition to the insurance. The Nigerian HMO Hygeia, which already has large numbers of formal sector workers insured, is the local partner to pioneer this new approach.

In Kwara State, Nigeria, the same approach sponsored by the same foundation and implemented by the same NGO and HMO has been used to insure poor farmers and their families and to improve the quality of the available local health infrastructure. Already 40,000 individuals are insured and the governor of Kwara State has asked to implement a similar project elsewhere in the state. He has also committed himself to funding this second project, once it has been

implemented, entirely out of local resources, thus underscoring the potential sustainability of this approach. In the meantime, the World Bank and IFC have provided funding to PharmAccess to expand the efforts in Lagos to include coverage of a group of self-employed IT workers.

Many other projects are underway in Sub-Saharan Africa that are variations on this same theme.

Sometimes they are government driven (e.g. in Uganda and Ghana), other times they are private sector initiatives that aim to augment government efforts. For instance, PharmAccess is currently developing three new projects in Tanzania, covering workers at a fish market, organic coffee growers, and participants in a micro-credit scheme. While these schemes are experimental, they hold much promise, also for other donors. **PEPFAR is currently considering participating in the Tanzania projects and to cover the costs for HIV/AIDS, thus helping to strengthen the overall health care system, while keeping its focus squarely on HIV/AIDS.**

There is a growing literature to estimate the potential scope for these and other voluntary insurance schemes. Given that out-of-pocket payments already make up a large share of overall resources in low-income countries (**often more than 50%), the potential for harnessing these resources and using them more efficiently (and more equitably) through health insurance mechanisms is significant**. So called "Willingness-to-Pay" for health insurance studies also point out the large potential. Typically, these studies find that households are willing to pay premiums that amount to

30% to 60% of a country's overall expenditures on health (see Barnighousen et al, 2007, for rural China, Asenso-Okyere et al 1997, for Ghana, Asfaw et al. 2009, for Namibia). One such study, for Ethiopia, concludes that the extra resources that may become available actually exceed total current outlays (Asfaw et al, 2004).

In all cases, the premiums that poor households are able and willing to pay will still be insufficient to cover the total cost of a reasonable comprehensive package. **But donors may find these new approaches to provide low cost health insurance to the poor, while simultaneously keeping private payments within the system, sufficiently attractive to subsidize the premiums.**

A task for the future will be to assess and identify the strengths and weaknesses of these and additional experiments that aim to enhance effective spending for health care in general, and HIV and AIDS programs in particular.

THBS01 - Show Me the Money: Political Commitment, Resources and Pricing

- The mobilisation of finance for the HIV response is a hot topic. Global investment in HIV has been flat since 2008, although countries are increasingly financing with domestic resources. Additional wealth exists and could be accessed: the 1200 richest people in the world control 4.2 trillion dollars and 1% of their wealth would pay for all of global health, including HIV.

- Michael Kazatchkine sounded a note of warning given the changing political environment and competition for resources which threaten ability to meet targets, particularly to 2015. International funding will remain critically needed, but is contracting in the context of the economic crisis. Political commitment has been fading. The AIDS community now needs to broaden its message to be linked with development and human rights agendas.

- E. t'Hoen, the executive director of UNITAID spoke of the need for funding mechanisms that raise money but are less sensitive to economic and political fluctuations. **Taxes such as the airline tax established in 2005 and raising 1.2 billlion USD, seek contributions from activities that had most benefitted from globalisation but least contributed to global solidarity. Very strong advocacy will be needed for the Financial Transaction Tax, emphasising the HIV fight as being in the global interest or countries may spend money raised on domestic debt and social safety nets.**

- Dr F Ndugulile, a medical doctor and Member of Parliament from Tanzania, gave the country example which has a funding gap of about 50% and an HIV programme that is 97% dependent on donor funds. He spelled out clear roles for recipient governments and donor countries, with ways to reduce dependency including government committing more local

resource to HIV/AIDS, establishment of alternative funding mechanisms and engagement of private sector.

- **Mr G Ooms raised the issue of what will come after 2015 and the end of the Millennium Development Goals. He suggested there may only be one health goal in the next phase, that of achieving Universal Health Coverage (UHC). This could be good or bad for the AIDS response, depending on how it is approached. The right to health could provide a solid foundation for UHC. UHC will work for the fight against AIDS, <u>only if</u> AIDS fighters work for UHC and make it their own.**

- In conclusion, shared responsibility is needed during the coming years to create global solidarity and raise sufficient funds for HIV and global health more broadly.