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THE GLOBAL FUND
to Fight AIDS, Tuberculosis and Malaria



Short Report on Wilton Park Conference 714

“FINANCING GLOBAL PUBLIC GOODS FOR HEALTH”

16-19 June 2003

Introduction

1. International health practitioners, politicians, policy makers, and academicians gathered during the week of June 16 – 20, 2003 at the UK Foreign Office’s Wilton Park conference center to discuss international financing instruments for global public goods for health.¹ What mechanisms currently exist to finance global public goods for health, and what has been their track record thus far? What new mechanisms are on the horizon, and how might these add value to existing mechanisms, both in terms of scale and design? Can current levels of funding be sustained or even increased? What should the relationship be between the new global health initiatives and the broader health and

¹ The conference was organized by Wilton Park, in association with:
Bill and Melinda Gates Foundation
Global Fund to Fight AIDS, TB and Malaria
Institute for Global Health, University of California – San Francisco
and
Norwegian Agency for Development Cooperation (NORAD)
Swedish Ministry of Foreign Affairs
United Nations Development Programme (UNDP)

Relevant links:

Millennium Development Goals: <http://www.developmentgoals.org>
Commission on Macroeconomics and Health (chaired by Jeffrey Sachs) <http://www.cmhealth.org>
Bill and Melinda Gates Foundation: <http://www.gatesfoundation.org/default.htm>
Global Fund to Fight AIDS, TB and Malaria: <http://www.globalfundatm.org>
UNICEF for UN work with children: <http://www.unicef.org>
Global Public Goods – United Nations Development Programme (UNDP) work:
<http://www.undp.org/globalpublicgoods/>

development agenda? These were the kinds of questions that informed the debate and discussion of participants at the conference.

2. Participants at the conference were by and large familiar with the technical or academic definition of global public goods for health. The concept “global public goods” is a term derived from a relatively precise definition from economic theory. “Public” goods are distinguished from private goods (and other types of goods) by their tendency to generate large spillover effects, or externalities, when consumed. “Global” public goods, as opposed to regional, national, or even local public goods, are those for which the externalities have a global reach, and extend beyond the boundaries of individual nation-states.

3. Global public goods, as any other type of public good, have two unique properties: they are non-excludable and non-rival in consumption. The property of non-excludability means that it is either impossible or very costly to exclude non-payers from consuming the good (that means that “free-riding” is likely) once it is produced. The property of non-rivalry means that the availability of the good is not reduced by anyone else’s consumption. In general, these consumptive characteristics create a disincentive for suppliers to produce the good at the socially-desirable level. However, the potential for generating or, conversely, discouraging the production of these externalities may prompt governments or other international actors to conspire to pursue the collectively desirable outcome.

4. Despite a relative consensus around the definition of terms, there was less agreement among participants about what types of goods supported by international activities actually “qualify” as global public goods for health. Participants listed a number of non-controversial examples for which the global externalities can be identified, and possibly measured – e.g. basic research, global surveillance, and disease eradication. But they found that reasonable people may disagree about whether more “borderline” examples, such as the control of some communicable diseases, qualify. Although the measurable spillover effects may be small, efforts to control HIV/AIDS in any given Sub-Saharan African country may be compromised if neighboring countries do not also invest in effective strategies; and poorly-implemented TB control strategies in any single country may contribute significantly to the spread of antibiotic resistant strains around the world. Nonetheless, for these and other examples, it is likely that the primary health benefit from investments in control strategies will be to the affected country, not the global community.

5. Participants at the conference did not resolve the debate over what does and does not qualify as a global public good for health. However, they did reach agreement around two related issues. First, substantial investments are needed at the local, national, and even regional levels to ensure the provision of global public goods for health. Second, investments in global initiatives may be justified

by other equally or more convincing rationale, including humanitarian, cost-saving, or other efficiency criteria.

6. Some participants felt strongly that decisions regarding global initiatives should be informed by a debate around concrete goals and strategies (e.g. the Millennium Development Goals) rather than abstract ideas. With that in mind, participants focused on specific international financial mechanisms to support global health initiatives, regardless of how strictly they qualify as global public goods for health.

Existing Financing Mechanisms

7. The past decade has witnessed a proliferation of global health initiatives supported by a variety of different financing mechanisms, and participants at the conference heard presentations on three major and recent initiatives. The Global Polio Eradication Initiative, the earliest of the initiatives discussed at the conference, supports surveillance activities, National Immunization Days (NIDs), and emergency response “mop ups.” The Global Alliance for Vaccines and Immunizations (GAVI) was created in 2000 to increase immunization coverage of children in the poorest countries, bring vaccine products quickly to market, and accelerate the development of new vaccines. In the following year, the TB Drug Facility was created to expand access to, and increase the availability of, high quality TB drugs to facilitate DOTS (directly observed therapy) expansion.

8. Of the existing global health initiatives under discussion, *polio eradication* was viewed to be the closest example of a “pure” global public good. However, in practice, the eradication initiative consists of a gradual and sustained accumulation of national-level achievements. Over the past 19 years, the number of polio endemic countries has dropped to seven (India, Nigeria, Egypt, Pakistan, Afghanistan, Somalia, and Niger), down from 125 in 1988. The initiative has cost an estimated \$7.7 billion, and stands out as a remarkable example of a multi-sectoral partnership involving governments and communities from the north and the south, for-profit entities, private foundations, NGOs, and the technical and financial support of a large number of the international agencies.

9. Discussion focused on whether or not and how polio eradication confers different costs and benefits to different countries. It is anticipated that the developed countries stand to benefit the most from eradication, since they will be able to forego the cost of their ongoing immunization programs. On this basis, there is concern that developing countries are contributing more than their “fair share” in light of their limited capacity to pay, and the opportunity costs of their investments in polio *vis-à-vis* other diseases.

10. As the polio eradication initiative approaches the “end game,” equity concerns become all the more pressing. The success of the entire global effort depends increasingly on the engagement of a handful of countries where polio remains endemic. Yet, because so few polio cases remain, and absent international pressure, these countries might be inclined to spend their limited health resources on diseases other than polio. An innovative financing program – the Investment Partnership for Polio – was launched this year by the World Bank, the Bill and Melinda Gates Foundation, Rotary International, and the United Nations Foundation to provide targeted resources to address the incentives gap, and encourage the endemic countries to continue to invest in polio eradication. In recognition of the global public good implied, the “buy down” program essentially offers countries the opportunity to convert loans into grants upon successful completion of their polio projects. Because of the generous loan terms, countries will receive an additional \$2.50-\$3.00 per donor dollar to support their polio projects. To fund the buy-downs, the partnership has established a trust fund with \$25 million from the Gates Foundation and \$25 million from Rotary International/UN Foundation. The program was launched at the end of April 2003 with the approval of a \$28 million no-interest loan for the purchase of oral polio vaccine (OPV) in Nigeria, Africa’s most polio-endemic country. A \$20 million loan for eradicating polio in Pakistan was approved in May 2003.

11. Eradication is not technically feasible for most diseases, but lives can be saved with the remarkably effective tool of vaccination. GAVI’s work is organized around three central goals that reflect a commitment to expand the number of children immunized in the world’s poorest countries. The goals are to increase immunization coverage, focusing on the capacity of local health facilities to design and implement effective programs; to shorten the time span between market registration of a vaccine product and its full-scale use in the developing world (e.g. hepatitis B and Haemophilus influenzae type b); and the acceleration of the development and introduction of new vaccines (e.g. rotavirus, pneumococcus, and meningococcus type A).

12. In 2000, GAVI invited the 74 eligible countries having incomes of less than \$1000 per capita GNP to submit proposals for financing. China, India, and Indonesia were also included in light of the very large, poor populations in need of coverage in those countries. By the end of 2002, nearly 90% of those countries had received commitments from GAVI and The Vaccine Fund (essentially, GAVI’s financing arm). 55 countries received vaccine supplies and/or case from GAVI/Vaccine Fund. These investments resulted in the delivery of over 150 million doses in 2002. This level is projected to reach 400 million by 2006.

13. Discussion at the conference focused on GAVI’s recent experiences with performance-based grant-making. The basic principles underlying the overall approach is that countries will set their own targets to increase immunization

coverage; actual coverage rates will be externally audited by a newly developed management tool, the “data quality audit,” and countries will be “rewarded” at the rate \$20 for each additional child immunized. Nonetheless, implementation of the performance-based system was delayed in 2002 when the audits revealed serious weaknesses in countries’ information systems.

14. The Global TB Drug Facility (GDF) is a project of the Stop TB Partnership which aims to promote a wider and wiser use of existing strategies to interrupt TB transmission through increased access to drugs and treatment; to adapt existing strategies to meet new challenges posed by emerging threats, such as multi-drug resistance and HIV-related TB; and to accelerate the elimination of TB through research for new diagnostics, drugs, and vaccines. The GDF was created to assist countries with the specific challenge of securing access to high quality drugs for the purpose of accelerating DOTS expansion.

15. The GDF relies on two funding mechanisms – grants-in-kind and direct procurement. The grants-in-kind mechanism is similar to the country-specific support offered by GAVI and the Polio Initiative in that the primary function is to facilitate the production of a national public good. Direct procurement has a greater degree of “globalness” associated with it, because of its potential to reduce transaction costs and achieve price reductions.

16. Since its inception, the GDF has processed nearly 70 applications from countries, NGOs, states, and public-private partnerships. 46 applications have been approved for support, and two are pending. Drugs have been ordered for 37 countries, and delivered to 27. GDF’s activities have contributed to a reduction in the prices for TB drugs – down by approximately 30 percent in two years. Progress has also been made toward product standardization. There has been evidence of substantial synergism through the bundling of grant-making, procurement, and networking.

17. Participants were struck by the degree of variation among the existing financing mechanisms created to support the global health initiatives discussed at the conference. They vary in terms of overall financing strategies, the nature of the global partnership, and the degree of “globalness” of the public goods supported by the initiatives. These differences lent support to the general observation that “financial” instruments can be used to provide either direct (monetary or commodity) or indirect support (achieving price reductions, improving quality, strengthening supply chains, etc), or any combination thereof. The distinguishing feature is that the initiatives serve as catalysts for channeling resources toward a specific health area of global import and/or concern.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

18. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) is the most recent of the financing mechanisms which were discussed at the conference. Created in 2002 in the wake of a ground swelling of political support inspired by G-8 discussions, the Global Fund functions almost exclusively as a financing instrument, unlike other initiatives that are also involved in supply and delivery activities, as well. Simply put, the Global Fund exists to mobilize resources and channel them directly to countries in response to applications. It does not assist countries in preparing their applications, it does not participate in the implementation process, and it does not step in to “fix” any programs that fall off track. The Global Fund – and more specifically, the countries themselves – must rely heavily on the technical support and other assistance of the specialized international agencies and partnerships (e.g. UNAIDS, Roll Back Malaria, Stop TB).

19. Other distinguishing features include: an emphasis on country-driven processes, both in the design and implementation stage; an unprecedented support for both public and private sector involvement at the country level; a willingness to invest in capacity development and health systems; an ability to invest in cross-border and regional health initiatives; and the reliance on a performance-based funding system. Regarding the latter, the plan is for grants to be disbursed in phases that are contingent upon demonstrated progress of the recipient country. How this actually plays out in practice remains to be determined, since most countries do not yet have the health information systems in place to provide evidence of actual health outcomes. Instead, in an initial phase, the focus is likely to be on process indicators measuring work effort, and auditing practices to show that the resources are being spent in the manner they were intended.

20. Since its inception in January 2002, the Global Fund has approved a total of \$1.5 billion over a two-year period to more than 150 programs in 92 countries. At the time of the conference, \$37 million had been disbursed (the figure by the end of July was over \$70 million, with a target of \$200 million by the end of 2003). Participants at the conference recognized that the sheer scale, and the potential for scale, of the Global Fund is enormous. The Global Fund has pledged totaling \$4.7 billion through 2008. It needs as much as \$3 billion to cover grants through the end of 2004, and this year’s shortfall was expected to be about \$500 million. Nonetheless, the hope is that the Global Fund will reach a “cruising altitude” that fully leverages its economies of scale, perhaps \$6-\$7 billion in annual disbursement commitments by 2008. This would represent nearly 40 percent of required donor finance to fight AIDS, TB, and malaria, as estimated by the Commission on Macroeconomics and Health in 2001.²

² See the website of the Commission on Macroeconomics and Health at: <http://www.cmhealth.org/>.

21. While most participants welcomed the new opportunities in financing presented by the Global Fund, a few also asked whether the Fund is bringing true value-added to the plethora of existing global initiatives and activities already supported by bilateral and multilateral donors. Thus far, the Global Fund has demonstrated a capacity to move resources quickly, but some participants noted that the jury is still out on whether actual project disbursement rates over time will be superior to that of other disbursing agencies. Some felt it would be possible for the Global Fund to play a central role in coordinating the disbursements of the bilateral agencies, thus lowering transaction costs for recipient countries, although they acknowledged that political resistance among some donor countries would likely be high. Other participants seemed interested in exploring the extent to which the Fund's role could eventually be expanded to contribute to the production of global public goods for health – e.g. facilitating drug procurement, sharing best practices, and addressing the spread of drug resistance worldwide.

Proposed New Financing Mechanisms

22. An initial objective of the conference was to evaluate additional mechanisms or types of mechanisms that would be needed to finance still-neglected areas of global public goods for health. However, it became apparent in discussions that many of the proposed new financing mechanisms – as with the majority of the existing mechanisms – address national or local, but not necessarily global, public goods.

23. For example, the UK government has proposed to create an International Finance Facility (IFF) to make available an additional \$50 billion per year to contribute toward the internationally agreed-upon Millennium Development Goals (MDGs). The IFF would thus provide a temporary framework for raising global health resources in the years leading up to 2015. The mechanism would make long-term, conditional transfers from rich to poor countries based on long-term donor commitments to provide regular annual payments to the IFF. On the basis of these commitments, the IFF would leverage up additional resources by issuing bonds in the international capital markets. The IFF in effect would “front load” aid during the critical period leading up to the target dates for meeting the MDGs.

24. Also currently under discussion is the US government proposal to create a Millennium Challenge Account (MCA). The MCA would allocate an additional \$5 billion per year of bilateral development assistance by 2006. The proposal is to select a relatively small number of recipient countries based on their demonstrated commitment to “sound” policies, to provide them with larger sums of money than traditional overseas development assistance currently allows, to allow greater independence in program design, and to hold them accountable for

results. Under current eligibility requirements, one estimate is that approximately twelve countries would qualify in the first year of the program, and up to eighteen or twenty countries would qualify by the year 2006.

25. The creation of the MCA is a separate discussion from the US government proposal, now signed into law, to allocate \$15 billion over the next five years to address the global AIDS crisis. Independent estimates suggest that of the \$15 billion, approximately \$10 billion would represent new spending. \$1 billion has been allocated to the Global Fund, although the full amount is unlikely to be allocated since the legislation stipulates that it should represent only 1/3 of total funding.

26. Finally, it is possible that the Investment Partnership for Polio will expand to eventually include other communicable diseases within its mandate, such as AIDS, malaria, tuberculosis, and other childhood communicable diseases. Whether or not this occurs will depend partly on how expansively the concept of global public goods for health is understood. It is believed that many developing countries tend to under-invest in communicable disease control because they are not rewarded for the cross-border or global benefits that would result. The buy-down mechanism is one way to re-structure the incentives so that countries are persuaded to invest in the global public good.

Challenges to Global Strategies

27. The focus of participants was on making good use of existing funding mechanisms, rather than the creation and development of new ones. Specific challenges were viewed to be: potential bottlenecks with respect to the limited absorptive capacity of countries and human resource constraints; weaknesses in health information systems, undermining collective efforts to demonstrate the immediate and medium-term health impact the new initiatives; and inefficiencies relating to the inability of countries and donors to learn from the experiences of others in overcoming capacity constraints and scaling up.

28. The Thai government's experience in training and retaining health care professionals to support public health programs and initiatives was highlighted as an example of the type of bottlenecks that countries and donors may encounter in their efforts to scale up quickly. Despite many examples of new policies and incentives to attract and retain high quality professionals in the health sector, staffing problems and labor shortages persist and are expected to worsen as health programs, such as ARV treatment programs, are brought to scale. Extrapolating from the Thai experience, some participants wondered whether labor constraints alone could slow progress in health, undermining recent achievements at the global level. Others felt that these constraints can be

constructively addressed by engineering creative solutions, backed with sufficient resources to make them viable.

29. Weaknesses in health information systems were viewed as another significant challenge to global efforts, particularly with respect to the sustainability of current levels of funding. The continued flow of resources into global health depends on the credible demonstration of results in the very near term. Yet, there are few reliable systems in place to collect the necessary information, and what limited data exists is generally considered unreliable and of relatively poor quality. Participants noted that the additional demands for data from the global initiatives are placing new burdens on the already under-funded information systems of recipient countries. Also, the emphasis on performance-based funding, however laudable, simultaneously creates incentives for the inaccurate reporting of data. Evidence of recent activity and interest in harmonizing the reporting requirements of donors and investing collectively in the health information systems of recipient countries was viewed favorably by participants.

30. Finally, many participants expressed frustration with the difficulty that countries face in accessing information about other countries' experiences that may be useful to them in developing program strategies, bringing programs to scale, and finding creative solutions to common capacity constraints. The lack of systems to support shared learning across countries and regions was viewed as an important potential stumbling block to scaling up, globally. Participants noted that countries are repeatedly forced to "reinvent the wheel," and that this process generates substantial inefficiency and waste. It was noted that this function was not directly in the mandate of any of the existing global initiatives. Nonetheless, some positive experiences in this area were reported – e.g. the Brazilian International Technical cooperation program for the Prevention and Control of HIV/AIDS – although they were not considered sufficient in light of the apparent need.

Lessons from Other Sectors

31. Discussion eventually turned to the relevance of the financing experiences of other sectors, such as agriculture and the environment. However, participants were also interested in exploring lessons learned from the less obvious suspects, such as business and the financial sector.

32. Agriculture has tended to attract the interest of the international health community because of its experience in developing research centers of excellence in the developing world. The Consultative Group on International Agricultural Research (CGIAR) is often cited as a potential model for organizing and financing global health research. The CGIAR is an informal association of sixty-two members that was created in 1971 by the World Bank and other

international agencies to promote, through research, sustainable agricultural practices and food security in developing countries. The CGIAR supports sixteen International Agricultural and Natural Resource Research Centers (IARCs), thirteen of which are located in developing countries. The Centers in the developing countries are devoted to a wide range of agricultural and natural resource research (including water management, fish, and forestry). The remaining three Centers focus on policy research, institutional development, and genetic resources.

33. The CGIAR is financed by members' contributions. Individual members support centers and programs of their own choosing. The Centers control and administrate their own budgets, but are subject to external audits on a periodic basis. In 2001, contributions from CGIAR members totaled \$337 million. While modest in size, the CGIAR is considered one of the largest public international research organizations in existence.

34. Participants at the conference were especially interested in a relatively new model of financing which supports global environmental policy. The Global Environmental Facility is a mechanism that encourages developing countries to adopt policies that contribute to the global environmental good. Although the financial mechanism used is not the same, the concept is similar to that which drives the Investment Partnership for Polio. That is, developing countries are offered new, and additional grant and concessional financing to cover the incremental costs of projects designed to benefit the global environment. Program priorities are established by intergovernmental political processes and have focused on the following areas: biological diversity, climate change, international waters, ozone layer depletion, persistent organic pollutants, and land degradation. The GEF began with \$1 billion in 1991, and has been replenished three times – in 1994 (\$2 billion), in 1998 (\$2.75 billion) and in 2002 (\$3 billion). The GEF tends to play a significant role in the development and implementation of funded projects – a characteristic which differs from the role played by other global health financing tools, such as GAVI and the Global Fund.

35. Finally, participants explored lessons from finance, drawing on work supported by the Capital Markets Working Group, a new working group convened by the World Bank, the Gates Foundation, and the Vaccine Fund. Dedicated to exploring how capital market tools may be applied to reduce vaccine market inefficiencies and create new systems for global vaccine financing for the developing world, the group includes experts in concepts such as securitization, project finance, derivatives, and tax-exempt debt. Their work is motivated by the belief that innovative financing techniques that have proved valuable in other industries may likewise generate significant progress in the area of vaccine financing.

Looking Ahead

36. Discussion at the conference quickly shifted away from a focus on financing mechanisms to support global public good for health and toward global financing mechanisms, more generally. Global financing mechanisms were described by participants as a tool to guide investments in the entire “production function” for global public goods for health, which clearly require substantial investments in local, national, and regional public goods. Humanitarian and other goal-oriented rationale were viewed to be equally if not more compelling reasons to invest in global health.

37. Although the appetite for new global health initiatives is clearly waning, it was clear from discussion that interest in supporting and strengthening existing initiatives remains high. Nonetheless, several participants emphasized that this remarkably high level of interest can only be sustained if the new global initiatives can demonstrate their value-added over the more traditional financing mechanisms of the bilateral and multilateral agencies. The specific hurdles that participants identified were largely operational, involving supply and delivery (rather than solely financial) constraints. Thus, the focus in the near to medium term of the global initiatives will be on achieving impact through innovative implementation strategies, and learning by doing.

38. Finally, most participants expressed confidence that the shift in debate away from financing (“raise it”) and toward implementation and validating results (“spend it, prove it”) represented a clear step forward for the global health initiatives. It was further confirmation of the progress that has been made over the past five years to bring health from the sidelines to the center of the international development agenda. While the need to show results quickly represents a significant challenge, it was viewed optimistically by many as an equally significant opportunity for which full advantage must be taken.

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