How A New Funding Model Will Shift Allocations From The Global Fund To Fight AIDS, Tuberculosis, And Malaria
More Health for the Money

Putting Incentives to Work for the Global Fund and Its Partners

A Report of the Center for Global Development Working Group on Value for Money in Global Health

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Background on Global Fund

• Total contributions: US 34%, FR 16%, DE 9%, UK 8%, CA 6%, BMGF/EC each 5%, JP 4%, SE/NO/NL each 2-3%
• Total disbursed: >$21bil
• Dec 2013: successful replenishment conference secured $12b in pledges for 2014-16
• US allocations to the Global Fund > World Bank
• Staff: 585 based in Geneva
• Unique governance structure as a PPP – includes donors, recipients, civil society, private sector
• Director: Mark Dybul (formerly of PEPFAR)
How much money should each country get from the Global Fund for HIV/AIDS?

Are Global Fund allocations across countries optimal?
Are cross-country aid allocations optimal?

- Many have examined impact of aid on growth and optimal aid allocations.
- Burnside & Dollar (2000) found that aid effectiveness may depend on quality of the policy environment.
- Leo (2010) examined the World Bank’s IDA ‘performance-based allocation’ based on (1) country performance, (2) population, and (3) GNI per capita and found that IDA’s ad hoc allocations only modestly reach neediest, most vulnerable countries.
- Few studies test whether health aid improves health; a prevailing view that it does.
- Few studies on optimization of cross-country health aid allocations or donor allocations to maximize health.
Global Fund’s allocation challenge

- Historically, the Fund allocated money based on country requests, leading to discretionary, ad hoc, and inconsistent allocations.
- The Fund’s “New Funding Model” developed a new allocation formula based on two factors – disease burden and ability to pay.
- Yet various principles expressed in its founding documents have implications for allocation formula:
  - “Give due priority” to:
    - “the most affected countries and communities”;
    - “to those countries most at risk”;
  - Ability to pay and additionality;
  - Country capacity;
  - Performance-based financing.
- In addition, the Board has set certain goals on lives saved by disease.
Three model-based approaches to optimal allocations

1. Production function approach: Model maximum reduction in HIV incidence or increase in ARV coverage given

2. Budget approach: Cost of treatment (or prevention) by choosing most cost-effective interventions

3. Spending functions: Models historical funding as a function of various criteria (similar to IDA)
   - New Funding Model
Historical Global Fund Allocation Of HIV Funding to Top 25 Countries in Funding and their Number of HIV Cases
Global Fund spending per HIV case

Average: $358 (SD $1081)
5000-fold differential between highest and lowest countries

Countries with the highest spending per case:
- Timor-Leste ($9,562)
- West Bank and Gaza ($5,225)
- Maldives ($3,360)
- Mongolia ($2,994)
- Cape Verde ($2,057)

Countries with spending below $10 per case:
- Malaysia ($1.85)
- Botswana ($2.56)
- Panama ($2.98)
- South Africa ($4.54)
- Nigeria ($7.18)
- Uganda ($8.91)
- The Democratic Republic of the Congo ($8.91)
- Mexico ($9.34)
- Uruguay ($9.46)
Global Fund New Funding Model: Predicted Allocation Of HIV Funding to Top 25 Countries in Funding and their Number of HIV Cases
Biggest winners and losers

Difference between predicted new and historical HIV/AIDS funding (%)

- Nigeria
- South Africa
- Mozambique
- Kenya
- Uganda
- Zimbabwe
- India
- Cote d'Ivoire
- Cameroon
- Cuba
- Dominican Republic
- Namibia
- Russian Federation
- Haiti
- Ukraine
- Cambodia
- Rwanda
- Ethiopia
Findings

- Substantial variation in historical allocations vis-à-vis disease burden and per capita income
  - Disease burden slightly correlated with allocations
  - Per capita income not correlated

- We compared historical approach to a new approach under explicit formula
  - Disease burden will likely account to 89% of variation in allocations (compared to 35% under historical allocations)
  - Per capita income account for remaining 11% of variation (compared to no correlation historically)
Discussion

- Two variable model misses many other factors
- Concern about lack of transparency of the weights
- Potential for ex post discretionary adjustments
- Mismatch between ‘ability to pay’ weights and counterpart financing weights
- Mismatches between eligibility and optimal allocations
ABSTRACT Policy makers deciding how to fund global health programs in low- and middle-income countries face important but difficult questions about how to allocate resources across countries. In this article we present a typology of three allocation methodologies to align allocations with priorities. We then apply our typology to the Global Fund to Fight AIDS, Tuberculosis, and Malaria. We examined the Global Fund’s historical HIV allocations and its predicted allocations under a new funding model that creates an explicit allocation methodology. We found that under the new funding model, substantial shifts in the Global Fund’s portfolio are likely to result from concentrating resources in countries with more HIV cases and lower per capita incomes. For example, South Africa, which had 15.8 percent of global HIV cases in 2009, could see its Global Fund HIV funding more than triple, from historic levels that averaged 3.0 percent to 9.7 percent of total Global Fund allocations. The new funding model methodology is expected, but not guaranteed, to improve the efficiency of Global Fund allocations in comparison to historical practice. We conclude with recommendations for the Global Fund and other global health donors to further develop their allocation methodologies and processes to improve efficiency and transparency.
Thank you

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