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Commentary

Gavi's policy steers country ownership and self-financing of immunization

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ABSTRACT

This commentary examines the 2014 NIPH evaluation of Gavi's co-financing policy and comments on the appropriateness of the subsequent and most significant policy changes taking effect in 2016.

Vaccines are life-saving tools and with increased immunization coverage since 2000, vaccine-preventable deaths and diseases have declined significantly. Gavi, the Vaccine Alliance, (Gavi) has been instrumental in these achievements, contributing to the vaccination of 500 million children, with vaccines available for 73 of the poorest countries preventing seven million deaths by 2015 [1]. Recognising the importance of sustainable immunization programme financing for maintaining high immunization coverage, Gavi launched a co-financing policy in 2008 with the objective of preparing countries for an eventual phasing out of Gavi support and sustainably financing new vaccines using their own resources. Under the co-financing policy countries applying for new vaccine support are required to co-finance a portion of the cost of the vaccines. Today the co-financing policy is one of the key pillars of Gavi's operations, providing an impetus for Gavi-eligible countries to plan, forecast and decide on specific vaccine introductions, mobilise funding, conduct and manage vaccine procurement and distribution.

Gavi commissioned the Norwegian Institute of Public Health (NIPH) to conduct an independent evaluation of the revised (2012) co-financing policy in 2014 [2]. [Full report available here or via http://www.gavi.org/results/evaluations/co-financing-policy-evaluation/.] This evaluation was commissioned as part of the process to review and revise the policy in 2015. In June 2015, the Gavi Board approved (http://www.gavi.org/about/governance/gavi-board/minutes/2015/10-june/) an update to the co-financing policy effective January 2016. Drawing on the findings generated by the NIPH-led evaluation, this article comments on the appropriateness of the most significant changes made under the 2015 revision of the co-financing policy.

Under the original (2008) co-financing policy 32 countries had co-financed 39 programmes for pentavalent, pneumococcal, rotavirus, and yellow fever vaccines, under a tiered co-financing system classifying countries into fragile, poorest, intermediate and least poor. Newly developed vaccines have since been added to the portfolio (such as the human papillomavirus vaccine) and at the time of the evaluation, 68 countries were co-financing 143 vaccine programmes. Country groupings were re-classified from 2012 into low income, intermediate and graduating, based on a simplified metric of countries' ability-to-pay and a five-year timeframe for resuming full self-financing in the case of graduating countries. Evaluations and reviews of the co-financing policy that generate important learnings and evidence are crucial to maintain success of the policy, especially given the policy's continued prominence in the Gavi Alliance's Strategy and implementation model.

The evaluation of the revised (2012) policy concluded that the policy is an innovative, effective health financing mechanism; affordable for countries; equitable across different country groups; strengthening country ownership; and generally directing countries towards financial sustainability. The evaluation also identified areas that warranted further investigation or change to ensure the policy's success and longevity [2]. This paper focuses on recent

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policy changes and their expected impact on ownership and associated decision-making, financial commitments to co-financing, vaccine prices and their intersection.

Country ownership of vaccine financing is an intermediate objective of the co-financing policy. The evaluation found the **intent** of country ownership embedded in a raft of measures undertaken by the Gavi Secretariat, partners (UNICEF, WHO country offices) and countries. Two elements of country ownership warrant special mention from the NIPH evaluation. The first concerns countries' institutional capacities. The evaluation found only some co-financing countries have institutions and associated skills in place to perform priority-setting and evidence-based vaccine introduction decision-making. At the time of the evaluation, 29 countries (out of 68) had a National Immunization Technical Advisory Group (NITAG) structure in place and four countries were in the process of establishing one [2]. NITAGs are commonly the lead institutions / mechanisms in countries to support evidence-based decisions on vaccine introductions.

The second relates to domestic funding of vaccine and immunization programmes. In an analysis of country sources of funds for co-financed and traditional vaccines, the evaluation reported 17 Gavi countries had recently relied on donors for traditional vaccine payment, although some signalled a desire to move towards government financing prompted partially by the co-financing policy. Most countries used government sources to pay for co-financing (52/68), while some (14/68) relied on pooling mechanisms. Country EPI staff identified the specific inclusion of immunization-related budget line items as helpful to meet co-financing payments, but not effective in isolation [2]. Others have identified legislation to finance immunization sustainably [3] as the gold standard.

As the number of available vaccines increases, the number of countries introducing multiple vaccines also grows, in turn increasing their co-financing commitments. In additional analysis by authors, in 2012 just one country co-financed four vaccines for routine vaccination programmes, but by 2014 the number of countries programmed to co-finance four vaccines had increased to nine [5]. However, this rising expense has not always led to commensurate growth in government vaccine expenditure (GVE) as observed over the 2008–2012 period in the evaluation. For 28 countries with available data and using previous co-financing terminology, the evaluation team found co-financing amounts as a proportion of GVE grew from 2.8% to 50.4% for graduating countries, from 14.5% to 42.3% for intermediate countries and from 28.9% to 42.3% for low-income countries. Government health expenditure (GGHE) increased over this period, yet GVE stagnated as a share of GGHE. This suggests that as countries are not increasing their vaccine budgets proportionally to increases in GGHE, increasing co-financing requirements create fiscal challenges and add pressure to traditional vaccine expenditures.

Furthermore, additional analysis by authors found that while countries are increasing their EPI budgets as they take on more vaccines, they are doing so at a rate slower than the increasing costs of new and underused vaccines, pushing up the proportion of EPI budget going towards new and underused vaccines to 62% in 2013 (see Fig. 1). In 2010, 26 countries co-financed 28 vaccine programmes (utilising 35% of EPI budgets), by 2013 the same countries co-financed 48 vaccine programmes.

The above findings demonstrate that countries need to consider both the full financial costs (i.e. vaccine prices and associated introduction and operational costs) **and** the accessibility and reliability of increases in domestic funding to be able to match GVE. We already know that improving financial planning for routine immunization and new vaccine introductions depends on countries' ability to estimate the total vaccine introduction-associated costs of programmatic start-ups, vaccine administration and delivery for routine immunization [6], which are often overlooked [7].

While the fiscal challenge countries face in relation to vaccine purchases and co-financing was further explored as part of the broader 2014–2015 policy review by the Gavi Secretariat [8], each country needs to conduct their own analysis of the financial implications of new vaccine rollouts including introduction costs; and each country needs to determine the best path to securing sustainable financing.

The review team projected costs to countries of Gavi-supported vaccines over the 2016–2020 period relative to general government expenditure [8]. Findings show some low-income countries facing greater fiscal pressure than higher GNI per capita countries. One policy implication here has been a reconfirmation of the decision to keep co-financing levels for low-income countries at US $0.20 per dose, with no mandatory annual increases, and no link to vaccine prices for this country group.

Demand for vaccine introductions by countries cognizant of the co-financing requirements, demonstrates the policy's success at balancing goals of country ownership and financing of vaccines with addressing health needs. However, it is impossible to know the extent to which demands would have been different under different co-financing requirements. During interviews with health policy and financing experts associated with Gavi's remit, the evaluation team found volunteered opinion was divided on the benefits of linking co-financing to vaccine price. Some interviewees arguing doing so would slow down the rate of adoption for low and intermediate countries undermining public health goals, and so the previous version of the co-financing policy did not pursue this linkage [2]. However, the 2015 policy revision introduces these links for phase 1 countries[2] to *help countries prepare for the transition to full financing, by increasing awareness of vaccine costs and implications of presentation choices, improving ownership and decision-making*. Specifically, the revised co-financing levels are determined based on current individual country co-financing levels, but converted to a proportion ('price fraction') of the total cost of the weighted average prices of the vaccine presentation used by the country. In year one of the new policy, the dollar amounts for each phase 1 country's co-financing remain the same, but the 'starting fraction' is determined. The year following that the 15% increase applies, as it did under the previous policy [8].

This price-linked approach is likely to generate a smoother transition for countries from co-financing to fully self-financing through more gradual co-financing ramp-ups [8], with the graduation timeframe held at five years. The price-linked approach under the new policy revision can add to countries' awareness of different vaccine presentations, improving countries' ability to assess the financial implications of vaccine introduction decisions.

Gavi is conscious of potential confusion in introducing multiple changes, and is responding by providing clear and timely communications with countries and training of Gavi staff [8]. Gavi will also play a role raising countries' awareness on vaccine product profiles, including prices. Sharing manufacturer pricing information gives countries more market information than the price fraction calculations alone as these are based on the weighted average price per presentation.

Pricing is also an issue for countries no longer eligible for Gavi support. Gavi's proposal has been to offer these previously Gavi-supported, now fully self-financing countries (phase 3), five years of access to Gavi or similar prices by inclusion in UNICEF tenders for specific vaccines. UNICEF's Vaccine Independence Initiative, an already existing revolving fund, would offer short-term financing to meet payment terms bridging the timing gap between procurement and availability of country funds [9].

[2] Previously called intermediate countries, see Table 1.

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