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Financing the HIV response in sub-Saharan Africa from domestic sources: Moving beyond a normative approach

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ABSTRACT

Despite optimism about the end of AIDS, the HIV response requires sustained financing into the future. Given flat-lining international aid, countries' willingness and ability to shoulder this responsibility will be central to access to HIV care. This paper examines the potential to expand public HIV financing, and the extent to which governments have been utilising these options.

We develop and compare a normative and empirical approach. First, with data from the 14 most HIV-affected countries in sub-Saharan Africa, we estimate the potential increase in public HIV financing from economic growth, increased general revenue generation, greater health and HIV prioritisation, as well as from more unconventional and innovative sources, including borrowing, health-earmarked resources, efficiency gains, and complementary non-HIV investments. We then adopt a novel empirical approach to explore which options are most likely to translate into tangible public financing, based on cross-sectional econometric analyses of 92 low and middle-income country governments' most recent HIV expenditure between 2008 and 2012.

If all fiscal sources were simultaneously leveraged in the next five years, public HIV spending in these 14 countries could increase from US$3.04 to US$10.84 billion per year. This could cover resource requirements in South Africa, Botswana, Namibia, Kenya, Nigeria, Ethiopia, and Swaziland, but not even half the requirements in the remaining countries. Our empirical results suggest that, in reality, even less fiscal space could be created (a reduction by over half) and only from more conventional sources. International financing may also crowd in public financing.

Most HIV-affected lower-income countries in sub-Saharan Africa will not be able to generate sufficient public resources for HIV in the medium-term, even if they take very bold measures. Considerable international financing will be required for years to come. HIV funders will need to engage with broader health and development financing to improve government revenue-raising and efficiencies.

1. Introduction

Despite optimism about the end of AIDS, and remarkable progress towards this ambition, a sustained HIV response will be required for years to come. HIV remains the fifth global cause of morbidity and mortality, and ranks second in sub-Saharan Africa (Murray et al., 2012). Unprecedented resources have been mobilised in response to the epidemic, reaching US$19.1 billion in 2013 in low and middle-income countries. Yet, this still falls short of UNAIDS' previous resource needs estimates of US$22–24 billion by 2015 and its US$36 billion estimate for 2020 in the ambitious 'fast-track' scenario that would seek to reduce the number of new infections and AIDS-related deaths by 90% by 2030 (UNAIDS, 2014a).

With the success of antiretroviral therapy (ART), HIV infection is no longer a death sentence, and national governments face the challenge of how to sustain their growing obligations and duty to maintain people on life-long treatment (Lule and Haacker, 2012), alongside laudable commitments to continue scaling up treatment

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access for all those who are HIV-infected (UNAIDS, 2014a), and the need to continue investing in HIV prevention to reduce the rate of new infections. This challenge is substantial. A recent paper estimates the fiscal consequences of this moral duty to treat (Collier et al., 2015). The figures are stark. In a scenario where 81% of people living with HIV with CD4 counts below 350 mm^3 are on ART, the fiscal obligations of treatment alone until 2050 have been conservatively estimated at 21% of current Gross Domestic Product (GDP) for South Africa, and 80% of current GDP for Malawi, among others (Collier et al., 2015). The International Monetary Fund (IMF) sets the 'sound' threshold for the debt burden of countries at 40% of GDP, and therefore this hidden HIV-obligation is potentially of real economic concern for both governments and donors. Some now argue that HIV is a fiscal as well as a public health crisis, particularly in sub-Saharan Africa (Collier et al., 2015; Vassall et al., 2013).

To date, much of the HIV response across the region has depended on international financing: only 10%–22% of HIV expenditures in 2013 were financed from domestic sources in low-income and lower-middle-income countries respectively (UNAIDS, 2014a). However, with the flat-lining of external HIV funding commitments, optimistic economic growth forecasts and the prospects of increased revenues from natural resources (Vassall et al., 2013), several global and regional declarations have called for African governments to fund more of their own responses (Buse and Martin, 2012; Galarraga et al., 2013; Resch et al., 2015). This, it is argued, would allow donors to refocus their resources on countries that most need external support (Resch et al., 2015). In addition, there is a growing promotion of 'innovative financing' mechanisms – such as earmarked taxes or diaspora bonds (Atun et al., 2012; Katz et al., 2014b) – to create new sources of HIV financing. A withdrawal or re-allocation of donor financing, without a compensating domestic financing response, may affect the continuity of care for those on treatment, and/or have high opportunity costs by removing financing from other critical areas of domestic spending both within or beyond the health sector. Paradoxically, some of these other areas of spending may also be fundamental to the effectiveness of the HIV response, such as education or the strengthening of health systems (McIntyre and Meheus, 2014; Seeley et al., 2012). It is therefore important to understand the factors that influence countries' potential ability to sustainably fund their national HIV response, without negatively impacting on spending in other critical areas or undermining macroeconomic conditions.

Previous investigations into the amount of domestic financing available for the HIV response have not been comprehensive or formally adjusted for past patterns of financing. These analyses may have been overly simplistic; providing a partial understanding of the overall potential financing available. Some have analysed the determinants of domestic financing for HIV or the potential of specific financing sources (Avila et al., 2013; David, 2009; Galarraga et al., 2013; Katz et al., 2014b; Resch et al., 2015; van der Gaag et al., 2009; Zeng et al., 2012). However, none of these studies considered options under all of the potential sources for generating new resources (revenue mobilisation); sharing existing resources differently (reallocation); and spending existing resources better (efficiency gains). Previous analyses have only considered spending for services within the health or HIV boundaries, and do not consider how spending in other sectors that also influence health or HIV may contribute to effective financing of the HIV response. Finally, most estimates of domestic financing for HIV to date have used normative targets in areas such as allocations to the health sector and general revenue generation capacity, assuming that these norms can be reached (Resch et al., 2015), although there is one previous study that examines whether countries can achieve levels of spending observed among their peers (Galarraga et al., 2013), but does not examine whether these levels are optimal.

Focusing on the 14 most HIV-affected countries in SSA, this paper explores the potential to expand domestic financing for HIV from a comprehensive range of domestic sources, including general health and cross-sectoral financing streams. We examine the financing system as a whole, incorporating changes in efficiency of spending, as well as revenue-raising. We use two approaches: one focused on achieving a range of financing targets - our 'normative' approach; and the other that incorporates previous fiscal behaviours, to try to incorporate the 'real world' constraints on domestic financing. For the latter, we examine historical fiscal data to explore how much changes in key characteristics of domestic public finance (such as proportional spend on health care) have led to changes in HIV expenditure. In doing so, we aim to demonstrate a comprehensive empirical approach to estimating the available domestic financing for HIV, and provoke discussion on the appropriate policy response and allocation of international financing for the HIV response in the coming years.

2. Methods

We applied the concept of 'fiscal space' to explore how much additional public financing could be made available for HIV in the next 5 years, in the 14 sub-Saharan African countries with the largest HIV epidemics and expected fiscal burdens (Lule and Haacker, 2012; UNAIDS, 2014b)– South Africa, Nigeria, Kenya, Mozambique, Uganda, Tanzania, Zimbabwe, Malawi, Zambia, Ethiopia, Lesotho, Botswana, Namibia and Swaziland. These include the 10 countries with the most people living with HIV (PLHIV) and all hyperendemic countries, with adult prevalence above 15%. Together they account for 85% of the disease burden in the region, in terms of number of PLHIV (UNAIDS, 2014b). Our analysis focused on the medium-term, i.e. the next 5 years, given the uncertainty around the macroeconomic and political context in the longer run, but we discuss the implications for addressing the substantial economic challenge of HIV financing in the coming decades.

In public finance, 'fiscal space' is used to describe the budgetary space available to allocate public resources to a specific objective, without damaging other developmental or macroeconomic objectives (Roy and Heuty, 2009; World Bank and IMF, 2006), including fiscal sustainability. The potential sources of fiscal space for HIV are similar to those for health services generally, but may vary across countries. Theoretically, domestic sources include: (1) conducive macroeconomic conditions through economic growth, (2) improved taxation/revenue generation, (3) borrowing, (4) reprioritisation (within the government or health budget), (5) sector-specific earmarked sources of revenue, and (6) efficiency gains (Heller, 2006; Powell-Jackson et al., 2012; Tandon and Cashin, 2010). An additional external source is external grants.

To explore which financing policy options have the most potential to create fiscal space for HIV – measured as increased public HIV spending – we followed two approaches. The first 'extended normative' approach considers what countries *could be spending*, given their fiscal position, health system and epidemic context. We estimated how much fiscal space could be created for HIV in a specific country by reaching a normative target or benchmark, using a comprehensive set of fiscal space sources, and holding all other factors constant. For example, how much more could a country spend on HIV if the health share in government spending was increased to the so-called Abuja target of 15% that was agreed upon in 2001, and HIV spending increased proportionately? These estimates are likely to be optimistic and can be seen as representing an upper bound estimate of fiscal space.

In the second approach, we seek to challenge these optimistic estimates to reflect some of the uncertainty around the impact of