POLICY BRIEFS ON

ECONOMIC IMPACT OF HIV

11.

DOMESTIC PUBLIC FUNDING FOR HIV

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11.

DOMESTIC PUBLIC FUNDING FOR HIV

KEY POINTS

- **External funding has played an unusually large role in the financing of HIV programmes (compared with health or public spending overall), but the share of domestic financing has increased in recent years, especially in middle-income countries.**
- **Decisions on funding allocations are made largely independently of tax policies, and domestic funding comes from the government's general resource account. In this sense, there is no specific domestic funding for HIV, and the principal sources of additional resources for HIV and other purposes are increasing the tax base and improved public financial management.**
- **HIV-specific financing instruments – in the form of trust funds and earmarked taxes, borrowing or "innovative" financing – have played a minor role in the financing of HIV programmes, and generally do not represent additional funding.**

The issue of raising additional domestic public funding plays an important role in the HIV policy discourse, for at least two reasons. First, HIV strategies are often developed as stand-alone programmes, often accompanied by an "investment case" for additional HIV spending (Schwartländer et al., 2011), and identifying a funding gap that needs to be overcome to attain the projected objectives. Second, the ongoing shift from external to domestic HIV funding in many countries means that domestic funding challenges (HIV-specific as well as the wider fiscal context) become more relevant in developing coherent and realistic HIV policies.

Raising additional public resources, however, is only one of the options for meeting funding needs. HIV programmes could be financed by the reallocation of resources from elsewhere in the health sector (brief #12) or from outside the health sector (brief #10). Efficiency gains – by allocating HIV funding optimally (brief #16), or improving the efficiency of how HIV services are delivered, also play an important role by reducing funding required to meet objectives, or achieving more with the available resources. Concurrent policies towards achieving universal health coverage or establishing a national insurance could also have implications for domestic HIV funding.

Changing role of domestic funding

While external funding has played a relatively large role in the financing of HIV programmes, the role of domestic public funding is increasing across low-income and especially middle-income countries.

In the context of public expenditure or health financing, HIV stands out through the large role of external funding and a corresponding low share of domestic financing. Indeed, in various low-income countries, external funding has accounted for well over 90 percent of HIV funding, and HIV

also stands out in terms of external support to a number of middle-income countries which otherwise receive very little development assistance. A large share of external financing has implications for the policy discourse on domestic financing – HIV policies reflect the donors' priorities (through funding criteria or policy discourse) as well as those of the government, and domestic funding allocations may represent the outcome of a negotiation with donors to unlock external support. However, large external support can also result in less domestic health expenditure being allocated than otherwise, if foreign funding for HIV enables the government to allocate domestic expenditure to other, non-health purposes (Lu et al., 2010).

Such a displacement effect has been demonstrated, among others, by Dieleman and Hanlon (2014), showing that an additional US$ 1 in development assistance for health results in a net increase in health expenditure of only US$ 0.38. However, it is important to take into consideration that HIV is a shock that is highly unevenly distributed across countries, and external funding serves to alleviate the financial burden of responding to HIV, often playing a critical role in enabling an effective response.

The renewed focus on domestic financing is not confined to countries where domestic funding is playing a large role, but is also a reaction to the changing global landscape of HIV financing. Since 2011, global HIV funding has grown very slowly – from US$ 18.6 billion in 2011 to US$ 22.3 billion in 2017, and stagnated at that level through 2020 (UNAIDS, 2021; in 2019 U.s. dollars, adjusted for inflation). External funding declined over this period both absolutely (e.g., from a high of US$ 9.9 billion in 2013 to to US$ 8.5 billion in 2020) and in terms of its share (from about one-half to under 40 percent). As a consequence, a large number of countries had to disproportionately increase budget allocations to HIV. This trend is clearly visible in Figures 11.1 and 11.2 – the domestic funding share increased steeply across middle-income countries (Figure 11.1), and about one half of the global population living with HIV in low- or middle-income countries are located in countries which have experienced a steep increase in domestic funding share between 2010 and 2017 (roughly those between the 35th and 85th percentile in Figure 11.2).

Figure 11.1: Domestic government share of HIV funding and GDP per capita

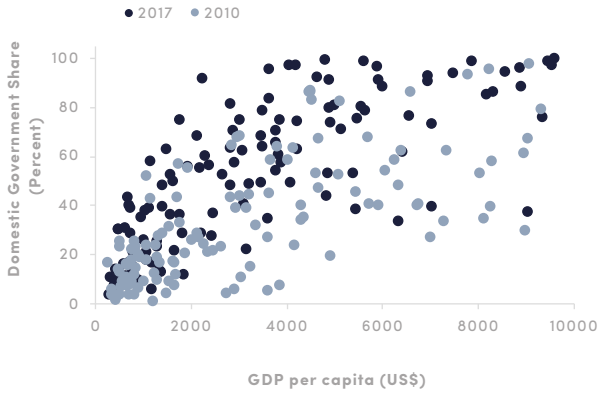
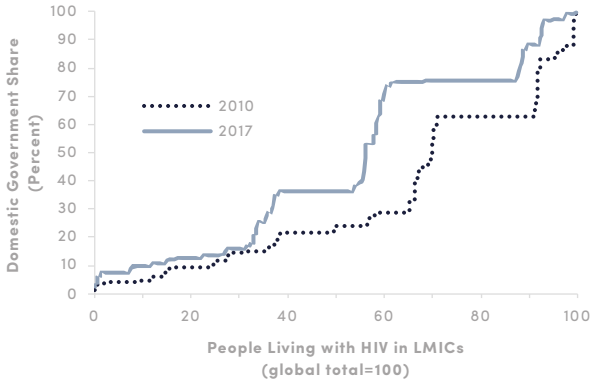


Figure 11.2: Domestic government share of HIV funding across population living with HIV



Source: IHME (2020) for expenditure data and PLHIV, IMF (2021) for GDP per capita. For 2017, GDP per capita has been adjusted using US CPI to control for inflation between 2010 and 2017.

A fiscal perspective on domestic HIV financing

Domestic public HIV financing implies that HIV programmes are funded either through taxes or borrowing. However, in public finance, most decisions on spending are separate from decisions on taxation or borrowing.

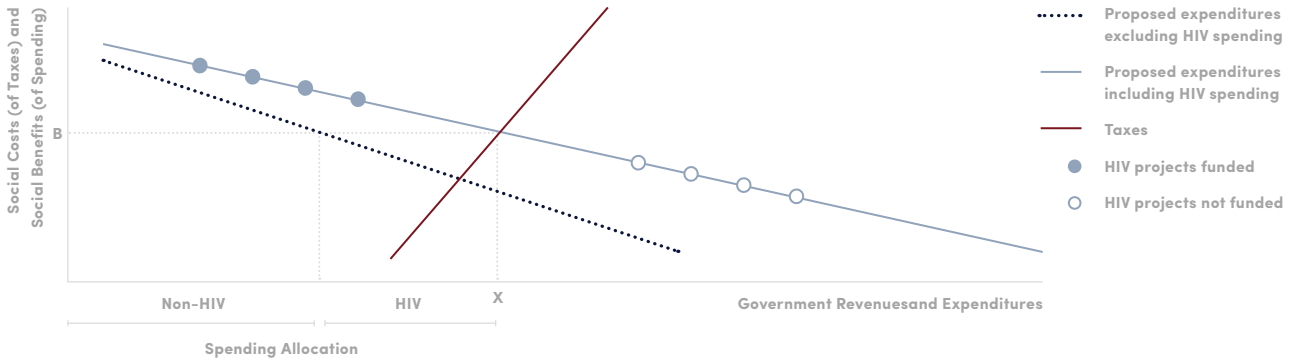
Fiscal policy involves choices about raising revenues and allocating available resources. In a much-simplified manner, these choices are illustrated in Figure 11.3, which draws from a more extensive discussion by Haacker (2016). Higher tax collection comes at increasing social costs, in terms of the costs of collection and the private expenditures it crowds out (represented by the tax curve – the upward sloping line). Optimal choices on allocation of funding reflect the social benefits of alternative spending options.

In Figure 11.3, this is represented by an expenditure curve (the downward-sloping solid line) in which these options are ordered by social benefit per expenditure unit. In this setting, the government would want to raise taxes up to a point "X" where the social costs of taxes equal the social benefits derived from additional public expenditures (at level "B").

HIV interventions which yield social benefits of at least "B" per expenditure unit would then be implemented, and interventions which do not meet this threshold would not. This means that funding decisions almost always involve choices among spending options, and there is no direct link to revenue measures. A severe health shock may shift the expenditure curve to the right by introducing new high-priority spending needs. Even then, decisions on revenue measures would be made not on the basis of the high social benefits of the HIV interventions being implemented (represented by the solid dots along the expenditure curve in Figure 11.3), but based on the benefits of the marginal programmes (at level "B", located on the expenditure curve around the point of intersection with the tax curve), on which there is a debate on whether the benefits justify the social costs of raising additional public revenues.

From this perspective, the issue of domestic financing of HIV programmes boils down to one of effective allocation between the HIV programme, other health programmes, and across government sectors. There are, however, a number of issues regarding domestic public financing of HIV programmes where decisions on funding allocations and revenue measures may be linked directly. These include the earmarking of taxes and of revenues from innovative financing measures for the HIV response. In addition, borrowing – while not an instrument that creates additional public resources as it needs to be repaid – may contribute to public funding by making resources available at a time when the government is facing particularly pressing spending needs.

Figure 11.3: Fiscal Perspective on HIV/AIDS Spending and Financing



Source: Adapted from Haacker (2016).

Taxes and trust funds

While the bulk of domestic public spending is financed indirectly through taxation (via the government's general resource account), there are examples of, and ongoing discussion about, taxes specifically dedicated to support the HIV response, typically in combination with some "trust fund" arrangement.

The best-known example of a tax in support of an HIV programme is Zimbabwe's "AIDS levy", which is a surcharge of 3 percent on personal and corporate income taxes that has been collected since 2000. The "AIDS levy" is administered through the National AIDS Trust Fund of Zimbabwe (NATF), and supports the National AIDS Commission. In 2014, the AIDS levy raised US$ 38.7 million, equivalent to about 0.3 percent of GDP and about 15 percent of the costs of the national HIV/AIDS response (Bhat et al., 2016). Other examples include the AIDS Trust Fund of Uganda, supported by a portion of a tax on beer and other alcoholic beverages, which however covers only an insubstantial portion of the costs of the HIV response. A substantial trust fund in support of the HIV response (or for both HIV and non-communicable diseases) has been under discussion in Kenya for several years, but it has not yet been legally established or launched (Saleh et al., 2018).

Reasons proposed for establishing a trust fund for HIV financing include prioritisation and achieving a more reliable source of funding, compared with allocations

through the annual budget (Haacker & Alkenbrack, 2019). From the scant evidence, it is unclear if these objectives have been met. For example, through the economic crisis in Zimbabwe from about 2000, the funding of the NATF – linked to income taxes – collapsed similarly to government revenues overall (IMF, 2021).

In sum, the evidence on positive contributions of trust funds to the domestic financing of HIV programmes (or health programmes) remains thin. There are only a few examples of such trust funds operating (unlike funds designed to pool external financing, including health-sector financing in conflict or post-conflict situations). Positive contributions in terms of additional resources or prioritisation are unclear, although they may play a role in improving transparency and accountability of the use of funds. In contrast, there are a number of drawbacks. Where the revenues raised through earmarked taxes are small in relation to the expenditure they support (and need to be topped up by general resources), it is unclear whether they result in additional funding – having a dedicated financing instrument may backfire if there is a perception that funding has been taken care of. Moreover, revenue is not necessarily more secure and predictable, because any specific tax the trust fund is tied to is likely to fluctuate more than government revenue overall.

Borrowing

Borrowing does not create fiscal space, because it binds future financial resources as the loan needs to be repaid, but it may play a role in accommodating spikes in spending or revenue shocks.

Borrowing does not play a large role in the policy discourse on HIV financing. External funding predominantly comes in the form of grants, and ministries of finance are wary of embarking on a programme of spending without a clear understanding of how it will be funded. However, borrowing is one regular aspect of public HIV financing at least indirectly, when HIV spending is financed from the government general resource account, which in turn is funded by a mix of taxes and borrowing.

Nevertheless, there are circumstances when borrowing may play an enabling role in responding to acute health challenges (Haacker, 2015), when there is a large health shock which disrupts economic activity and government revenues, and/or results in large immediate spending needs. One obvious example is the fiscal response to Covid-19, where additional spending needs, and drops in tax revenues, were in part accommodated by increased borrowing. Similarly, the Ebola crisis in Sierra Leone (2014-2016) resulted in a steep drop in the growth of GDP and of government revenues, while necessitating additional public expenditure (Haacker, 2015). In addition to external grant support, this was met by increased borrowing. In these examples, borrowing plays a role in mitigating disruptions in government spending allocations arising from a health shock.

The economic implications of HIV, though, are different from those of Covid-19 or Ebola: HIV does not result in acute macroeconomic disruptions, and spending needs, in particular for treatment, persist over many years or even decades. From this perspective, there is no obvious role in HIV financing for borrowing to mitigate acute fiscal disruptions. However, proposed HIV policies typically assume a spike in spending early on, followed by a gradual decline. In this case, borrowing in years when HIV expenditures peak could make a positive contribution by mitigating the shifts in spending allocations required to sustain the changing funding needs of the HIV response. In most cases, though, the magnitude of such spikes is not significant from the perspective of government revenue or expenditure overall, so that financing decisions are made separately as part of the overall budget.

The economic case for borrowing (or otherwise accommodating a spike in expenditures) to support rapid scaling-up of HIV interventions is strongest for one-off interventions like male circumcision, which are one-off investments whose health benefits (reduced HIV infections and their consequences) and financial benefits (notably, reduced treatment costs) extend over many decades (Haacker et al., 2016). These time lags also bring in an intergenerational aspect, with borrowing as a vehicle to make the main beneficiaries (the next generation) contribute to the costs. Such properties have motivated funding vehicles involving borrowing in non-HIV areas, for example, to "front-load" funding for immunisation (World Bank, 2009). Moreover, in the case of HIV, front-loading of prevention and treatment programmes has been shown to result in higher effectiveness and reduced longer-term costs (Anderson et al., 2018, Schwartländer et al., 2011, Chiu et al., 2017). The reason for this is that the effectiveness of interventions in terms of preventing HIV infections depends on the underlying risk of contracting HIV, and this risk declines over time with increased treatment coverage, increased viral suppression rates and eventually declining HIV prevalence.

Innovative financing

Innovative financing mechanisms have played a considerable role in the global HIV policy discourse on raising domestic public HIV funding, but their actual and potential contributions appear very small.

"Innovative" financing mechanisms have been promoted as a means to increase fiscal space, and – by topping up government revenues from traditional sources – as contributions to closing funding gaps in HIV programmes (UNAIDS, 2013).

International instruments are outside the scope of this brief, but a brief pointer is in order in light of their role in the policy discourse on "innovative" financing. These include Product Red (a contributor to the Global Fund), an airline levy (an important contributor to UNITAID), social impact bonds, and innovative arrangements like the International Finance Facility for Immunisation (World Bank & GAVI Alliance, 2010).

Proposals on domestic "innovative" financing instruments include instruments for borrowing and revenue-creating measures. The principal "innovative" instrument for borrowing by the domestic government is a diaspora bond. Most "innovative" instruments proposed for domestic financing include taxes hitherto not considered by the government, such as taxes on remittances or on mobile phone airtime (Booth & Whiteside, 2016). However, the contributions of such "innovative" financing tools to domestic HIV financing have been minimal so far, and their potential contributions are considered small (Booth & Whiteside, 2016), in part because of the limited base of the various new taxes proposed. Government officials, in a well-documented survey in Malawi, have gravitated to more traditional taxes rather than innovative ones (Chansa et al., 2018), which may reflect a reluctance to single out specific transactions (rather than broad-based taxes) as sources of public revenues. Instead, discussions on the potential role of "innovative" financing consistently emphasise the importance of raising taxes overall and improving public financial management as primary sources of fiscal space for HIV or any other government programmes (Atun et al., 2016; Booth & Whiteside 2016; Chansa et al., 2018).

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