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The Allocation of Responsibility

Who lives? Who dies? Who is responsible? As the Global Fund Board convenes for its 40th Board Meeting where it is expected to discuss the 2020–2022 allocation cycle, no doubt members will prefer the first of these questions. Even so, it will not be easy. Allocation is one place where intention is converted into action; a rare thread binding inclusive rhetoric to difficult rationing decisions that prioritize some needs and deny others. Throughout the history of the Global Fund, allocation discussions have tried to forecast the conversion of resources into preventative, curative, or therapeutic actions that directly reduce burden. The quest to allocate toward efficiency is cast often as a matter of maximizing the number who live and minimizing the number who die. This conceptualization distracts from the third question, but in fact responsibility looms largest at the center of allocation.

Allocation begins with the Global Fund's defining responsibility to address HIV/AIDS, tuberculosis, and malaria. This mission was driven by rights arguments, reflecting the approach pioneered early in the HIV epidemic by the gay men's communities of New York and San Francisco. Activism by and for people living with HIV transformed a stigmatized, denigrated individual condition into a collective, enthusiastic, and audacious bid to realize the right to health on a global scale. Within the confines of its three diseases and a financial focus, the Global Fund was launched as the institutional embodiment of this ambitious responsibility: to provide access to urgently needed treatments and services for millions of people in low- and middle-income countries (LMICs).

Under the initial allocation system, Global Fund processes would have been more recognizable to the advocates whose movement it embraced. Funds were allocated based on proposal quality and in the early years, there were enough resources to support all of the ones judged adequate. But over time allocation processes drifted further from this ideal for various reasons, including more limited resources, a greater appreciation for the enormity of the original ambition, and concerns that expansion might threaten

existing programs under some circumstances. All of these factors pointed in the direction of more challenging rationing exercises.

Current allocation practices are based on a formula, which was intended to make the process more consistent and more equitable. However, this approach also obscures the original, rights-driven imperative to provide all needed interventions for all who need them. Against that standard, the allocation process is not so much a question of who will get what as it is an exercise in assigning responsibility away from the Global Fund and then looking after the remainder. There are times when the Global Fund can and should decline some responsibility, but upholding its core principles means that every such instance must be considered carefully and rigorously justified. Further, the Global Fund needs to consider how it can advocate for those in need, even if it decides not to provide financial resources.

Each element of the current allocation formula includes responsibility questions that require examination. To clarify this proposition and its consequences, this article offers four examples, beginning with the quantification of burden. For HIV, it is calculated based on the number of people infected, with some adjustments for the difficulty of reaching key populations. For malaria, the number of cases is used with an adjustment for incidence and mortality as reported in data from the year 2000. Neither captures the dynamics of introducing or expanding programs, which usually is more resource intensive than maintaining. Trends in both infection and response capacity must be considered for a more accurate picture. By neglecting to account for this variation, the allocation process shifts responsibility for scaling up away from the Global Fund without clearly assigning it to any other party.

For years the Global Fund (and others) have considered Gross National Income (GNI) per capita as an indication of ability to pay, but in practice it is used to determine responsibility to pay, with the assumption that countries with greater income can and will attend to the needs of their populations. Without rehashing the many well-known measurement problems with GNIpc, the operative question is this: what responsibility does the Global Fund have toward people affected by one or more of its three focus diseases, regardless of the income of the country in which they live? There are many opportunities for the Global Fund to help people obtain the services they need, even if financial resources are better concentrated elsewhere. To name three options, this might include advocating with governments, providing advice to civil society, or extending access to pooled procurement mechanisms. These and other options are critical to the lives of many in countries with actual (or calculated) incomes rising beyond Global Fund eligibility thresholds. Similarly, the responsibility to provide access calls for greater flexibility in allocation and partnership arrangements, which might help quell rising HIV in Russia even though national income is ostensibly too high, or address the TB epidemic in North Korea, where the Global Fund has ceased operations, citing transparency and risk management issues. Both of these cases represent humanitarian disasters of epic proportion and global significance—precisely the scenario the Global Fund was designed to address.

A similar issue arises from the cap on country allocations, which limits Global Fund responsibility if affected groups are large, as might be expected in populous countries such as Nigeria or India. Similar caps by disease disadvantage people suffering from concentrated burdens, as with malaria in the DR Congo. What logic justifies these limits? Especially where national boundaries were drawn by exploitative colonizers, it seems particularly unfair to further punish those contained within on the grounds that their needs are either too large in the aggregate or too large within a given disease. Returning to the greater sense of responsibility toward all victims of the three diseases reveals that the abject inequity of these caps.

Finally, the Global Fund allocation formula is subject to non-transparent qualitative adjustments as well, which raises the troubling scenario of downward revisions. High-burden settings further disadvantaged by a government unwilling or unable to help may receive only minimal resources. Partly, this decision can be justified by the expectation that resources would not be converted into health. But once again, this is an

assignment of responsibility away from the Global Fund and toward a government that is expected to default. How can the allocation process better protect the entitlements of these citizens?

As illuminated in these examples, a discussion of allocation rests on an underlying determination of responsibility. The founding intention of the Global Fund is that it serves as the ultimate guarantor of access for anyone affected by HIV/AIDS, tuberculosis, or malaria. Accordingly, the Board must meet a very high bar to decline assistance where it is demonstrably needed. This is not about the precise variables or coefficients used to weight them; it is a question of whether Board members can feel confident in the reasoning behind every negative decision. Whenever full support is not provided they must complete the sentence in plain language:

"We will not help you because…"

Is it acceptable to deny access to HIV therapies for marginalized migrants "because you are in Russia, an upper-middle income country?" Is it defensible to deny TB treatments to North Koreans "because you live under an autocratic regime incapable of managing a complex emergency on its own?" Or is there a justification for reducing support for malaria treatment and control in the Democratic Republic of Congo "because we do not want to exceed 10% of our malaria budget in one country?" Whenever such answers are uncomfortable, make the right decision—find a way to assure access for all who need it.

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