



Independent observer
of the Global Fund

Domestic financial contributions to HIV, TB and malaria programs remain low in Global Fund ‘high-impact’ Asian countries

The role of domestic resources has taken centre stage as the Global Fund approaches the Replenishment Conference for the next implementation period, which will take place in October in Lyon, France. The Global Fund, in its [Investment Case for the Sixth Replenishment](#), projects that domestic funding for HIV, TB and malaria programs will grow by 48% to \$46 billion in the 2021-2023 implementation period. However, increasing domestic investments in health remains a tall order for some countries.

A [new analysis by Aidspan](#) assesses the domestic contributions to the health sector and to the three disease programs globally, focused on nine Asian countries, classified as ‘high impact’ by the Global Fund: Bangladesh, Cambodia, India, Indonesia, Myanmar, Pakistan, the Philippines, Thailand and Viet Nam. The Global Fund Observer published a [similar analysis for high-impact African countries in 2018](#).

The analysis found that domestic contributions to the HIV, TB and malaria responses remain low in high-impact Asian countries, particularly for malaria. Domestic resources accounted for 64% of the total available funding for HIV, 55% for TB and 46% for malaria, in the 2015-2017 implementation period. The share of domestic resources rose, in the 2018-2020 period, to 81% for HIV, 63% for TB and 65% for malaria. Despite this increase, the countries still face huge funding gaps in the current 2018-2020 period.

The high-impact countries have a high burden of one, two or all three diseases. They have low HIV prevalence – compared to sub-Saharan African countries – but the epidemic is growing, particularly among the key populations in some countries. All nine countries have a high burden of TB, according to the World Health Organization (WHO). Two countries – India and Pakistan – are also high burden for malaria; the rest of the countries are endemic for malaria. In addition, four of the nine countries – within the Greater Mekong region – have reported resistance to artemisinin, the chemical compound in some of

the best anti-malarials. Investments in the high-impact Asia countries account for 24% of the \$10 billion raised for the 2017-2019 funding cycle.

Data for this analysis came from three databases – the WHO Global Health Expenditure Database, the World Bank Open Data, and the Global Fund – as well as from Global Fund grant application documents, particularly the funding landscape submitted to the Global Fund by the sampled countries.

The funding landscape reports total funding needs, anticipated funding, and the resulting funding gap for each disease for the 2018-2020 implementation period; and disease-specific expenditures for the 2015-2017 period. Funding landscapes information was available for eight of the nine countries (Myanmar's was unavailable). The Philippines malaria funding landscape was also unavailable.

Countries spent less than 10% of domestic government expenditure on health

Most of the high impact Asia countries spent less than 10% of their total government expenditure on health in 2016, the most recent year for which data are available, except for Thailand – the only upper-middle income (UMI) country in the sample – which spent 15.3% (Figure 1, below).

Figure 1: Domestic general government health expenditure as a percentage of general government expenditure for the high impact Asia countries in 2016

No ideal target exists for what proportion of the total government expenditure countries should spend on health as this depends on the country's priorities. [However, researchers have proposed an alternative measure – government spending on health relative to the total economy](#) (the Gross Domestic Product; GDP) – which considers the affordability of health services within a country context. They also proposed that government should spend at least 5% of the GDP on health. None of the sampled countries reached this percentage. Thailand was the closest at 2.9%, closely followed by Viet Nam (2.68%). The proportion was lowest in Bangladesh (0.42%).

Private sources funded most health expenditures in 2016

Most of the high-impact Asia countries relied on private sources of funding such as out-of-pocket payments (OOPs) – as compared to domestic public and external resources – to finance the health sector in 2016. In fact, private spending dominated in eight of the nine countries (Thailand was the exception) as private sources paid for more than half of the current health expenditures: Private spending ranged from 50% in Viet Nam to 74% in Bangladesh, India and Myanmar (Figure 2, below). Only 22% of Thailand's national health expenditures came from private spending.

Figure 2: Current Health Expenditure (CHE) by source (2016)

Most of the private resources came from cash payments by individuals at the point of health service delivery while others came from prepaid payments via voluntary health insurance – such as through an employer or non-profit community-based schemes. These out-of-pocket payments were as high as 74% of Current Health Expenditure (CHE) in Myanmar and 72% in Bangladesh. Share of the voluntary health insurance was highest in the Philippines (11% of the CHE), followed by Thailand (7%).

Domestic resources played a less significant role in funding national health expenditures relative to private resources in eight of the nine countries (Thailand was the exception) where public spending accounted for 78% of the national health expenditures (Figure 2, above). For the rest of the countries, the share of domestic public resources ranged from 15% in Bangladesh to 47% in Viet Nam.

External resources – including multilateral sources such as the Global Fund, and bilateral sources – contributed the least to countries' CHE. In fact, in two countries – Indonesia and Thailand – external

resources contributed less than 0.5% of national health expenditures. Top donors to the health sector in the Asia region, in general, include the International Development Association (IDA), which is part of the World Bank Group, the United States, and the Global Fund, according to the [Organisation for Economic Co-operation and Development \(OECD\)](#).

Domestic resources funded more than half of the expenditures for the three diseases

Domestic resources accounted for 60% of the \$4 billion raised by the high-impact Asia countries – where data was available – for the three diseases in the 2015-2017 implementation period (see Table 1, below). The Global Fund and other external sources accounted for 28% and 13% respectively (percentages do not add up to 100% due to rounding). Domestic contributions were highest for HIV (64%), then for TB (55%) and lastly for malaria (46%).

Table 1: Available funds (US\$) in the 2015-2017 implementation period for the High Impact Asia countries by source

	HIV (n=8)	TB (n=7)	Malaria (n=4)	Total
Total domestic resources (64%) (\$)	1,537,399,275	620,680,592	208,616,306	2,366,696,173
		(55%)	(46%)	(60%)
Total Global Fund resources (20%) (\$)	475,423,167	385,043,181	240,282,693	1,100,749,041
		(34%)	(53%)	(28%)
Other external resources (16%) (\$)	376,135,898	119,359,716	4,527,426	500,023,040
		(11%)	(1%)	(13%)
	2,388,958,340	1,125,083,489	453,426,425	3,967,468,255
Total (\$)	(100%)	(100%)	(100%)	(100%)

1. Countries:

HIV: Bangladesh, Cambodia, India, Indonesia, Pakistan, Philippines, Thailand and Viet Nam (funding request for Myanmar was unavailable)

TB: Cambodia, India, Indonesia, Pakistan, Philippines, Thailand and Viet Nam (TB funding data unavailable in the funding request for Bangladesh; and the funding request for Myanmar was unavailable)

Malaria: Bangladesh, India, Indonesia and Pakistan (Four other countries – Cambodia, Myanmar, Thailand and Viet Nam – received funding through the RAI; the funding request for the Philippines was unavailable)

1. Global Fund grants from the 2015-2017 implementation period (excludes amounts included in the 2018-2020 funding request)
2. Percentages represent column percentages (not row) i.e. the percentages are calculated from the

column totals

3. The 'Total' column percentages do not add up to 100% because of rounding.

Domestic contributions varied widely across countries

Domestic contributions varied widely across the countries for the three diseases. Some countries are doing better than others. For instance, Thailand and the Philippines funded most of the HIV response through domestic resources: 90% and 79% respectively, whereas Cambodia and Viet Nam funded less than a third – 23% and 29% respectively – in the same time period (see Figure 3, below).

Figure 3: Percentage of HIV funding by source for the 2015-2017 implementation period

Similarly, domestic contributions for TB were as high as 88% of the total available resources in Thailand but as low as 19% in Cambodia (see Figure 4, below).

Figure 4: Percentage of TB funding by source for the 2015-2017 implementation period

Malaria was the only disease component not to receive a huge share of funding from domestic resources. Domestic contributions accounted for more than two thirds (70%) of available funding in Pakistan but less than half in the three remaining countries: Bangladesh (14%), India (43%) and Indonesia (46%) (see Figure 5, below). The Global Fund was the main source of funding for malaria in these three countries: 85% in Bangladesh, 57% in India and 51% in Indonesia.

Figure 5: Percentage of malaria funding by source for the 2015-2017 implementation period

Large funding gaps for TB and malaria in the 2018-2020 period

The sampled countries require \$5 billion, \$5.3 billion and \$1.6 billion (for four countries) to fully fund the HIV, TB and malaria strategic plans, respectively, during the 2018-2020 implementation period.

At the time of submission of each of their funding landscape, the countries collectively had raised \$3.9 billion for HIV, \$2.7 billion for TB and \$617 million for malaria, creating a funding gap of 23% (HIV), 49% (TB) and 61% (malaria) (see Table 2, below).

The majority of the countries raised more than two-thirds of their total HIV and malaria funding needs from both domestic and external sources. For TB, five of the eight countries raised at least half of the total funding needs.

Table 2: Funding needs and availability for the 2018-2020 period for the sampled countries

Disease component	Total Funding needs	Total anticipated resources	Funding Gap US\$	%
HIV (n=8)	5,027,796,909	3,870,467,926 ^a	1,157,328,983	23%
TB (n=8)	5,260,591,834	2,689,189,527	2,571,402,307	49%
Malaria (n=4)	1,585,094,422	617,286,109	967,808,313	61%

Share of domestic resources rose in the 2018-2020 implementation period

Shares of domestic resources for the three diseases rose in the 2018-2020 period as compared to the

2015-2017 period. Of the total estimated available funding for 2018-2020, domestic contributions for HIV accounted for 81% (vs. 64% for 2015-2017), for TB 63% (vs. 55% for 2015-2017), and for malaria 65% (vs. 46% for 2015-2017) for malaria (see Figure 6, below).

However, the proportions may change as more funding becomes available in the course of the implementation period. In the long run, the proportions will also depend on the actualization of the financial commitments by the government, Global Fund and other donors.

Figure 6: Comparison of sources of funding for the 2015-2017 and 2018-2020 implementation periods for the sampled countries

Economic growth and fiscal expansion drive public spending on health

This analysis suggests that countries with a stronger economy are more likely to invest more of their domestic resources on health. Thailand – the only UMI country in the sample – is the only country to fund more than half of its current health expenditures using domestic public resources. In addition, at the disease level, Thailand funded 90% and 88% of the HIV and TB programs domestically, respectively, in the 2015-2017 implementation period.

Available literature found that economic growth and fiscal expansion increase public spending on health, particularly in middle-income countries. Political leadership and will also influence domestic investments in health. Indeed, increasing budgetary allocations to the health sector – at the expense of other social sectors and other spending priorities such as infrastructure and defence – is often a difficult political process. Political leadership, especially at the highest levels, could push for increased domestic investments in health.

Conclusion

Most of the high-impact Asia countries rely on private sources of funding for health, particularly out-of-pocket payments. External resources play a limited role in financing the health sector of these high-impact countries, and they are likely to reduce as the economies of these countries continue to grow. In the absence of adequate domestic investments on health, individuals may need to pay more to offset the decrease in external resources.

The onus is, therefore, on the governments of these high-impact Asia countries to invest more within the health sector and on the three diseases. The countries can embrace more sustainable sources of financing such as budgetary allocations and compulsory health insurance. They can also leverage existing innovative financing mechanisms such as impact bonds and debt swaps, which are managed by the Global Fund and other partners.

Further reading:

- The 'Funding Landscape' is part of a downloadable package of grant application (funding request) documents; To access the documents, visit the Global Fund website at <https://www.theglobalfund.org/en/>. Under the Funding & Implementation tab, open the Global Fund Data Explorer <https://data.theglobalfund.org/home>. Select the country of interest using the Location filter or the map. Click on the Documents tab at the top right of the page. Under the Documents page, click on the Country name and select Applications. The application documents are found in this Applications folder.
- Aidspace's report, published 30 July 2019: ['Domestic Financing for AIDS, TB and malaria in Global Fund high-impact Asia countries'](#)

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