Aidspan
Independent observer of the Global Fund

India plans to transition away from Global Fund support over the next nine years

India is a lower-middle-income country (as classified by the World Bank) with an extreme burden of malaria, a severe burden of TB and a high burden of HIV (as categorized by the Global Fund). There is no indication that India will change its income classification any time soon. And the country does not have any components on the Global Fund's list of components projected to transition by 2025. Nevertheless, the Global Fund has informed the Government of India that support from the Fund will "transition out" over a nine-year period from 2018 to 2026.

The nine-year period covers the current allocation period (2017–2019) and the next two allocation periods (2020–2022 and 2023–2025).

The Global Fund has asked India to prepare a transition and sustainability plan confirming its commitment to gradually take over the financing of the HIV, TB and malaria programs during this period. According to grant documents related to India's 2017 funding requests for HIV, TB and malaria, the latest version of the transition and sustainability plan was submitted by the government on 6 November 2017 and is currently under review by the Global Fund Secretariat.

The grant documents provide some insight into the measures India has implemented or is planning to implement to move in the direction of sustainability for its HIV, TB and malaria programs. The measures include (a) increases in domestic resources for the three disease programs and for health systems; and (b) moves by the government to assume greater responsibility for funding portions of the disease programs.

According to the grant documents, given the increased domestic funding commitments for its disease

programs, India is on the right track to transition from Global Fund support over the next nine years.

TB AND HIV

The grant documents described developments in a number of areas related to the national TB and HIV programs:

- planned increases in health spending;
- high-level political commitment regarding TB;
- increasing domestic financing;
- use of domestic resources to fund key population interventions;
- government absorbing a progressively larger share of funding for antiretrovirals and first-line TB drugs;
- greater integration of the HIV program with general health services.

In the following sections, we examine each of these developments. (We discuss the malaria program in a separate section below.)

Health spending

In 2017, India adopted a National Health Policy (NHP 2017) which seeks to increase health expenditures by government as a percentage of gross domestic product (GDP) from the existing 1.15% in fiscal year 2014–2015 to 2.5% by 2025; and to increase health spending by states from 2.0%–6.3% of their budget in 2014–2015 to over 8% by 2020. In India, states have jurisdiction over health and so they account for most of the spending on health. The national government plans to incentivize states to increase their health budgets by increasing the share of taxes devolved to state governments from 32% to 42%. The national government also plans to introduce higher cost-sharing requirements for national programs (now that increased funds will be flowing to the states).

General taxation will remain the predominant means for financing healthcare, but the government is also considering raising more revenues by adopting “sin taxes” on commodities such as tobacco and alcohol; a pollution levy; and taxes for extractive industries. In addition, the government is considering leveraging funding through “corporate social responsibility (CSR).” This might take the form of incorporating CSR provisions in the India Companies Act — provisions such as requiring that companies over a certain size form CSR committees; and that at least 2% of profits before tax be directed to CSR-related programs.

Free primary care provision by the public sector, supplemented by strategic purchase of secondary care hospitalization and tertiary care services is envisaged as the main strategy for universal health coverage (UHC). Progress on UHC is key to sustainability of Global Fund–supported programs. While the exact details of the UHC program in India are still being worked out, the government, through its 2018–2019 budget, has announced the launch of a new flagship National Health Protection Scheme, to insure about 500 million citizens, which will be the largest social health insurance program in the world.

As explained in an article on the website of the World Health Organization (WHO), “strategic purchasing”is “one of the main principles guiding health financing reforms to accelerate progress towards UHC.Seeking to align funding and incentives with promised health services, strategic purchasing involveslinking the transfer of funds to providers, at least in part, to information on aspects of their performance orthe health needs of the population they serve. The objectives of strategic purchasing are to enhanceequity in the distribution of resources, increase efficiency, manage expenditure growth and promotequality in health service delivery. It also serves to enhance transparency and accountability of providersand purchasers to the population.”

Examples of “strategic purchasing” actions include:

- negotiating the price of medicines;
- linking some part of payment to performance;
- using incentives to limit the provision of high-cost services; and
- introducing co-payments for patients who self-refer to hospitals or specialists, bypassing primary care.

The NHP 2017 calls for major reforms in financing for health facilities — where operational costs would be in the form of reimbursements for care provision and on a per capita basis for primary care.

A robust National Health Accounts (NHA) System is being operationalized to improve public sector efficiency in resource allocation and payments. NHAs enable countries to learn retrospectively from past expenditure, improve planning and the allocation of resources and increase systems accountability.

Political commitment

In its 2017–2018 budget, the government identified the fight against TB as a priority. The 2018–2019 budget saw a further substantial augmentation of resources for TB control, including a new allocation of $92 million for nutritional support for TB patients. The Office of the Prime Minister, and the Prime Minister himself, have had considerable input into the TB program.

Domestic financing

Domestic funding for HIV has gone up from $670 million for the fiscal years 2015–2016 to 2017–2018 to $1.32 billion for the fiscal years 2018–2019 to 2020–2021, an increase of 97.6%. Domestic funding already covers 61% of the costs needed to implement India’s National Strategic Plan (NSP) for HIV/AIDS and Sexually Transmitted Infections 2017–2024 and will account for more than 90% of available funding in the next implementation period of India’s TB and HIV grants. The India fiscal year runs from 1 April to 31 March.

Domestic funding for TB dramatically increased from $47.0 million in fiscal year 2011–2012 to $149.0 million fiscal year 2017–2018. Additional commitments for the TB program from the central government in the 2018–2020 fiscal years are $407 million, which represent a 122% increase compared to government spending in the 2015–2017 fiscal years.

Significant scale up of TB services and absorption of historic Global Fund support is envisaged through domestic budgetary resources. In the next implementation period, government funding will support procurement of 60% of all first-line TB drugs, other health products and diagnostic materials.

Human resources, laboratory consumables and annual maintenance contract services for culture and

drug sensitivity testing (C&DST) laboratories supported by the existing Global Fund grants will be progressively transitioned to government funding over the new grant implementation period. Domestic funding will also progressively absorb existing Global Fund support for the WHO's Technical Support Network from 2019 onwards.

The Ministry of Finance has implemented a new Public Finance Management System (PFMS) which will allow real-time tracking of program expenditures.

Key population interventions

Unlike in other countries in the region, in India domestic resources are the primary source of funding for key population programs. The GAC stated that over the next implementation period, key population interventions will be almost entirely funded by the government.

Funding for ARVs and first-line TB drugs

With support from the Global Fund, over one million people living with HIV are receiving antiretrovirals (ARVs). Until recently, the Global Fund was the only source of funds for the procurement of ARVs. Starting in 2016–2017, the domestic budget has been incrementally absorbing the costs of the ARVs. The GAC said that India is well placed to meet the government's commitment to finance the major share — i.e. 90% — of ARV procurements in the next implementation period.

Also in the next implementation period, Global Fund grants will catalyze scale-up of differentiated ART service delivery mechanisms and HIV testing services, as well as address M&E and procurement and supply chain management (PSM) bottlenecks. Differentiated service delivery is an approach that simplifies and adapts HIV services to better serve the needs of people living with or at risk of acquiring HIV and reduce unnecessary burdens on the health system. (See here.) Scaling-up differentiated ART service delivery mechanisms and HIV testing services, and addressing M&E and PSM bottlenecks, promote sustainability by strengthening systems and better integrating services within country systems.

Similarly, for TB, during the next implementation period, the government will fund the procurement of all first-line TB drugs, cover 60% of the costs for diagnostics and treatment of drug susceptible TB (DS-TB) and diagnostics and treatment for multi-drug resistant TB (MDR-TB). In previous implementation periods, India was dependent on the Global Fund, to various degrees, for both first-line TB drugs and MDR-TB diagnosis and treatment.

Integration with health services

According to the grant documents, recent years have seen increased integration of the HIV program with general health services. This augurs well for longer-term sustainability of HIV-related services. The Department of AIDS Control has been merged with the Department of Health and Family Welfare. In addition, the GAC said, there are good examples of integration of HIV testing, and provision of care and treatment, as a part of larger health systems with minimal support being required from the National AIDS Control Program. The National Strategic Plan on HIV/AIDS calls for HIV testing and treatment services to be fully integrated within the general health systems by 2024.

The grant documents stated that the TB program is fully integrated with the general health services.

Constraints

According to the grant documents, the main constraints for the sustainability of the TB and HIV programs in India are: historic low spending on health; administrative and systemic inefficiencies; procurement and supply chain bottlenecks; poor absorption capacity at the state level; and weaknesses in M&E systems.

MALARIA

Some of the developments towards sustainability related to TB and HIV — such as increased spending on health — also apply to malaria. But the following developments are specific to malaria.

National government commitments have gone up from $97 million in 2015–2017 to $222 million in 2018–2020, an increase of 129%. Unlike the HIV and TB programs, the malaria program had historically run on a 50:50 cost sharing basis between the central and state governments (with the exception of the northeastern states), with state governments financing a large share of the operational costs. Available evidence indicates that currently combined state government spending on malaria is much higher than that of the central government.

More than half the funding need and a major share of the funding gap are attributable to human resources. To accelerate the efforts of malaria elimination, a large investment in human resources is required, the grant documents state. A significant share of the human resource costs goes to paying the salaries of multi-purpose workers (MPWs) who are key to malaria surveillance and control of vector-borne diseases at the community level. The central government has been directing state governments to absorb the costs of MPWs. Support for human resources is also a major focus of the Global Fund malaria grant. With longer-term sustainability considerations in mind, the GAC has recommended a gradual shift of human resources costs to domestic funding — specifically, to reduce funding for human resources from the Global Fund to 70% in Year 2 and 50% in Year 3. This “transition” schedule is more ambitious than what had been proposed by the CCM; however, Aidspan understands that this schedule has been built into the final budget of the malaria grant.

The information for this article came from documents related to the recent approval of HIV, TB and malaria grants to India, supplemented by information obtained from the Global Fund Secretariat.

Recently, Aidspan has published two articles on the comments from the Technical Review Panel and the Grant Approvals Committee on grants to India that were approved by the Board for TB (see GFO article) and HIV (see GFO article).

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