

Viewpoint

Unsustainable funding of high-burden tuberculosis control programmes: who is responsible?

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Abstract

The literature suggests that crowding-out effects of government funding for health happen in low-income countries with a high HIV burden. In a survey, we investigated the hypothesis that domestic funding for TB control has fallen in 11 low-income, high-TB-burden countries in the context of changes in gross domestic product (GDP), development assistance inflows and national health expenditures. We found that despite rises in GDP per capita between 2003 and 2009, health expenditure as per cent of GDP fell or stayed the same for the majority of these countries. Although TB control budgets increased for all 11 countries in absolute terms, 6 countries reduced government contribution to TB control. For health programmes to become sustainable in the long run, we suggest increases in donor funding for health to be accompanied by requirements to increase domestic funding for health. We thereby attribute responsibility to avoid crowding-out effects to donors and governments alike. Moreover, it is the responsibility of both to ensure essential items to be funded by government sources to avoid a collapse of programmes once aid is withdrawn.

keywords tuberculosis, funding, sustainability, aid

Introduction

In the past 10 years, funding for tuberculosis (TB) control has substantially increased, mainly because of the establishment of The Global Fund and increasing financial commitment to TB by large donors such as USAID and the Gates Foundation. After a first hurray welcoming the influx of funding into previously largely neglected programmes running on tiny budgets, questions about the sustainability of these inflows quickly arose within the TB community. Soon, TB programme managers and project administrators sighed about pressures to spend large amounts in short periods of time. In 2010, Lu *et al.* (2010) demonstrated widespread crowding-out effects of government funding for health, with the greatest reductions in government spending in sub-Saharan countries with large HIV epidemics and comparatively large contributions of development aid for health to governments. In an accompanying article, Ooms *et al.* (2010) suggested that the reductions in domestic funding on health despite increases in gross domestic product (GDP) and development assistance were deliberate policy choices. With World TB Day just passed and The Global Fund's announcement to cancel a new

round of grants (Moszynski 2011), we asked ourselves whether this might apply specifically to low-income countries facing a high TB burden. As HIV and TB epidemics go hand in hand because of coinfection, we expect a similar picture in the high-TB-burden countries. Specifically, our question was whether domestic funding for TB has increased in the past years in the context of changes in GDP, development assistance inflows and national health expenditures.

Methods

For this purpose, we conducted a survey of World Bank (2011a,b) data from 2003 to 2009 (later data were not available) and WHO data from 2003 to 2011 for countries that fulfil all of the following criteria: high-TB-burden country as defined by WHO (2009, 2011), listed as least-developed country by the OECD Development Assistance Committee (2011) and listed by the World Bank as low-income country (2011). This yielded a list of 11 countries: Afghanistan, Bangladesh, Cambodia, DR Congo, Ethiopia, Kenya, Mozambique, Myanmar, Tanzania, Uganda and Zimbabwe. To answer our question, we chose to review the following indicators for each country: GDP per capita,

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net ODA and official aid inflows, net ODA as per cent of gross national income (GNI), government health expenditure per capita, government health expenditure as per cent of GDP, TB control programme budget in million USD and per cent of TB budget funded by domestic sources.

Results

Of these 11 countries, 4 are listed by the World Bank (2011) as fragile: Afghanistan, DR Congo, Myanmar and Zimbabwe. Data for these countries were not always available for the selected indicators, and as they are in conflict, difficulties in collecting quality data are to be expected. Our findings for the high-TB-burden countries support Lu *et al.*'s (2010) findings for the wider health sector. Although GDP per capita increased in all 11 countries in the years 2003–2009, health expenditure as

proportion of GDP decreased or stayed the same (defined as an increase <1%) in all but one of the 11 countries. Contrary to Lu *et al.*'s trend of increasing aid flows, almost all high-TB-burden countries experienced a decrease in development aid inflows as proportion of GNI, although development aid inflows in absolute numbers increased in all countries. Kenya is the only country that experienced an increase in net development aid inflows (+2.6% of GNI), but did not increase its health expenditure as proportion of GDP (zero), despite the largest increase in GDP/capita (+350 USD) compared with the other 10 countries.

As far as data were available for TB control budgets over time, we found increases in TB budgets in absolute terms (million USD) in almost all countries (Figure 1, numbers include budget gaps). However, domestic funding spent on TB control diminished or stayed the same for all countries except for Ethiopia, Kenya, Mozambique and Tanzania.

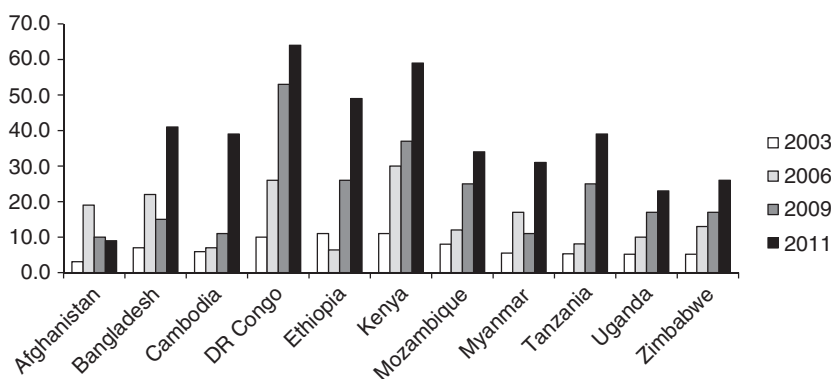


Figure 1 National TB control programme budgets (million USD). Source: WHO 2009, 2011 Zimbabwe data for 2003 were not available, instead data for 2004 was used.

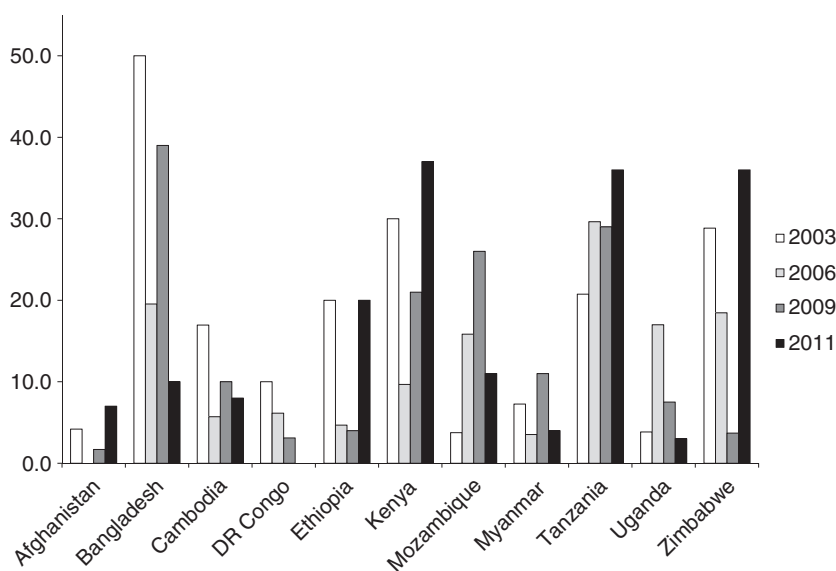


Figure 2 Government contribution to national TB control programme budget (%). Source: WHO 2009, 2011; Zimbabwe data for 2003 were not available, instead data for 2004 was used.

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The largest reductions happened in Bangladesh and Zimbabwe. Moreover, the percentage of National TB Program budgets funded by government sources decreased or stayed the same in 6 of 11 countries, with the greatest reductions in Bangladesh, DR Congo and Cambodia (Figure 2). Government contributions substantially dropped between 2003 and 2006 in eight countries and rose again thereafter in five. The only country that increased its domestic funding for TB control between 2003 and 2011 steadily and substantially was Tanzania (+15%).

Discussion

Our survey confirms the hypothesis that domestic funding for most NTPs decreased in the past years. These findings are not surprising in the context of Lu *et al.*'s detailed analysis; however, we wonder about the implications and future outlook for these programmes, as many of them seem to be built on sand in the long run. We did not investigate on which items domestic and external funding were spent by the programmes. It would be desirable for essential items such as drugs and laboratory supplies to be funded by domestic sources to guard the programme's stability from external changes in funding. The worst case scenario is for programmes to collapse once aid is withdrawn. This could be already witnessed to some extent with the advent of the financial crisis when global funding for development decreased suddenly (Kirigia *et al.* 2011) with resulting financial gaps (The Global Fund 2009). The situation might worsen with the final year of the Millennium Development Goals to come in 2015 and a potential decrease in aid funding thereafter because of a possible shift in global attention to other urgent topics.

Conclusion

Flooding programmes with money without securing sufficient parallel domestic funding sets wrong incentives and may be counterproductive in the long run. Increases in donor funding for health need to come with requirements to increase domestic funding for health. This would set national TB control programmes under pressure to face their own governments instead of looking for outside

sources to fill gaps. In this respect, donors are just as responsible to avoid fungibility of funding as national governments.

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