

A Conversation with Amanda Glassman on December 13, 2013

Participants:

- Amanda Glassman – Director of Global Health Policy and Senior Fellow, Center for Global Development
- Elie Hassenfeld – Co-Founder and Co-Executive Director, GiveWell

Summary

GiveWell spoke with Amanda Glassman about the current state of funding for HIV treatment and prevention. She described the difficulty in identifying where money is spent, and discussed the problem that much funding may go to ineffective or inefficient programs. She also suggested some ways in which funders could attempt to improve the allocation of spending.

Note: This set of notes was compiled by GiveWell and gives an overview of the major points made by Amanda Glassman.

Funding for HIV treatment and prevention

It is not possible to track spending on HIV treatment and prevention by intervention, since large organizations working on HIV don't collect or share sufficient information and the field has poor reporting standards. For instance, the President's Emergency Plan for AIDS Relief (PEPFAR) doesn't have good data on the characteristics of the people that have enrolled in treatment, and the retention rate or quality of their treatment program.

Inefficiencies in HIV spending

Much HIV funding is likely spent inefficiently. Clear examples of this include the fact that interventions often are not targeted to critical groups, such as to concentrated epidemics in key populations, and the fact that much spending goes to a variety of non-treatment programs, especially the spending of The Global Fund to Fight AIDS, Tuberculosis and Malaria. While all acknowledge that behavioral interventions to prevent HIV are important, few trials have yielded evidence on high impact interventions. The exception is male circumcision which remains very under-financed and limited in scope. It is possible that some other spending is also ineffective since many programs have not been evaluated, such as abstinence education. A bigger problem is that it is unknown whether certain interventions have any effect, such as targeted communications and some community-based projects. Such programs are relatively common, but it isn't possible to identify how much funding they have. Overall, a significant amount of funding goes to things other than proven, cost-effective interventions.

There is wide technical consensus on which interventions work for treating tuberculosis and malaria, which is clear in the budgets for programs which work on those diseases, but it is still common for HIV programs to buy services and products which represent poor value for money.

If the objective of these monies is to maximize impact on HIV incidence, a specific example of non-optimally allocated funds is that funders are buying second line medications for HIV to deal with resistant cases while about half of people who are eligible for the more affordable first line treatment are not receiving it (something similar occurs for tuberculosis as well).

While it is hard to move to the necessary new places and may require strengthening capacity, it is not a case of a last-mile problem where those new places will be extremely difficult and expensive; rather, half of the population is currently uncovered. This is a tradeoff between two medical interventions that are known to work. Expanding to new areas in order to expand first line treatment may be more costly in the short term than switching existing patients to second or third line treatment, but is better value in terms of disease control in the long run, and likely more equitable as well. This information is in the report from the Center for Global Development's Value for Money Working Group. [Of course, many funders –governments and donors- take other considerations besides value for money into account when allocating resources. Ethical considerations, for example.]

Inefficient or unknown efficiency spending persists in the HIV funding space in part because many have viewed critical analyses of current allocation and utilization patterns as a possible threat to advocacy and fundraising efforts. However, it is important to see demonstrations of effectiveness, both to improve the quality and impact of spending, and to better make the case for greater funding. Increasingly, advocacy groups are coming around to the view that effectiveness should be evaluated, but most still are uncomfortable with specifically modeling different possible allocations of money, or directly reallocating to interventions and products –or service provider agencies- known to be better value for money.

[In some forthcoming research from a colleague, we are finding that low governance countries lose about half the expected effectiveness of the ARV that they receive from all sources. This suggests that both PEPFAR and Global Fund should take governance of recipient countries into account in their allocation formulae – something thus far resisted by Global Fund, for example.]

Politically, reallocating funds is difficult, although it may become easier to pursue more efficient spending now that the Global Fund funding replenishment has passed and PEPFAR has received a re-authorization.

PEPFAR

PEPFAR is committed to restricting funding to interventions that are effective against AIDS, but it isn't currently possible to see that that happens in practice. It remains to be seen whether the new leadership of the organization will put money behind performance verification. PEPFAR collects lots of data that it doesn't share with the public.

The program may lose money through their reliance on high-cost US contractors to deliver services, which is a problem the organization acknowledges, and so it is trying to move towards working with country-based organizations. It will be important for that move to be monitored to determine whether the work becomes more efficient and effective.

Improving HIV spending

Outside organizations could take a couple of approaches to change the state of HIV funding:

- Support open government and budget watchdog groups on the ground, such as civil society groups or groups doing data audits, to follow intervention coverage and quality.
- Pressure the organizations involved, possibly by donating enough to secure a seat on the board of e.g. the Global Fund, to measure their results and prepare budgets which connect money to interventions and track the results.
- Improve epidemiological data to know where people are affected geographically so that the interventions which are known to work can be targeted more effectively.
- Push for specific interventions that are well-supported by evidence. A possible example is male circumcision, which may be underinvested in relative to its evidence base because of low donor interest, cultural objections, and the difficulty in extending the intervention to adult men. PEPFAR has become interested in male circumcision recently.
- Pressure the HIV community via the Center for Global Development. The Center has had some success in pushing the World Bank and the Global Fund to do results-based funding.

The Global Fund and PEPFAR are interested in more closely tracking the costs of interventions, and are starting to do so. Ideally they will prioritize products that are the best value for money rather than the cheapest. That said, there hasn't been much progress on increased performance verification, which may be the most important thing, nor has there been much progress on making budgets more transparent so that it is possible to identify how much is allocated to each intervention.

In general, making progress on these issues would be difficult but may be possible.

Organizations involved

The American Foundation for AIDS Research did a study examining the issue of population targeting for HIV interventions.

There are a handful of HIV civic groups that watch what's happening with HIV treatment within African countries, including South Africa. Here is a short list: itpcglobal.org ; aidspace.org ; aidsaccountability.org (South Africa)

The World Bank also does some related work on public expenditure tracking surveys, although does not focus specifically on AIDS. It conducts surveys and identifies bottlenecks

in spending, normally for the public sector rather than for non-governmental organizations. The surveys for the expenditure tracking are put out by the World Bank's Poverty Reduction and Economic Management team, and their use in different sectors depends on each in-country team. There is also an interesting initiative on measuring and mapping service delivery, which could include greater work on HIV-related issues.

The International Budget Partnership project at the Center for Budget and Policy Priorities, based in DC with some in-country affiliates, does some budget watching and creates report cards for frontline service providers. However, it does not have a particular focus on HIV. It largely focuses instead on maternal health, mainly because maternal health doesn't receive much funding.

The Institute for Health Metrics and Evaluation has done some work on the efficiency frontier of health spending.

The United Nations Programme on HIV/AIDS (UNAIDS) founded an economics reference group with money from the Gates Foundation that is supposed to focus on allocative efficiency, sustainability and costing.

Academics who have worked on efficiency issues in AIDS spending

- Stefano Bertozzi, UC Berkeley
- Tim Hallett, Imperial College London
- Paul Revill, University of York
- Gesine Meyer-Rath, Boston University (based in South Africa)
- Nicolas Menzies, Harvard
- Josh Salomon, Harvard
- Alan Whiteside, University of KwaZulu-Natal
- Mike Hammond, IHME
- Markus Haacker, London School of Hygiene and Tropical Medicine
- Robert Greener, Oxford
- Damian Walker, Gates Foundation

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