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Show Me the Money: Political Commitment, Resources, and Pricing
Kaiser Family Foundation
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KENT BUSE: Good morning. I am glad you could all squeeze into this very cozy and intimate room. However, I was wondering if you might want to come closer. If you want to just come a little closer so we can see some of you and see how you are reacting, whether or not you are getting your checkbooks out to show us the money. We are an all-male panel, and I apologize for that in advance, but we are not scary, so please, please do come forward.

My name is Kent Buse, I am from UNAIDS, and on behalf of my co-chair, Dr. Kemal Siregar, let me welcome you to this session, Show Me the Money: Political Commitment for Mobilizing Resources. Let me begin by thanking my good friend Dennis Altman from the IAS who is the architect of this session.

Mobilizing financing has been quite a hot topic during the conference, those of you who have been to any of the sessions with Professor Jeffrey Sachs will have heard that there are in fact no shortages of funds, there are no shortages, we just need to get them.

There is no shortage for AIDS, there is no shortage for health, there is no shortage for development, and that in fact the mantra of scarcity and the logic of austerity is in his words a big scam. Any financing gap is really a question of priorities, values, indeed greed, and ultimately politics.

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Some of the statistics I have heard this week are that 0.9-percent of the world's population control 39-percent of the world's wealth. The 1,200 richest people in the world control about US $4.2 trillion, if they were each to contribute 0.1-percent of their wealth, that would not only pay for the AIDS response, but it would pay for all of global health. The Tax Justice Network reports that the super-elite, the rich, has exploited gaps in income tax and cross-border tax rules to hide an extraordinary $21 trillion as much as America's and Japan's GDP combined. Jeffrey and others ask us to reject this scam.

But of course, the question is how do we access that wealth and how do we access other wealth? Demonstrators at this conference have called for a financial transactions tax. President Hollande of France, in his opening remarks, called for financial transaction tax, and my boss, Michel Sidibé has repeatedly called for it, and that a component of it, an element of it, a percentage of it, a small percentage of it be devoted to AIDS and health. Today's session will look at some of the options available.

Before we hear from the panelists, let me just remind you that the 2011 United Nations Political Declaration on HIV/AIDS, the document committed all countries by 2015 through a series of incremental steps and shared responsibility to close the financing gap for HIV that was estimated by UNAIDS between $22 and 24 billion. The question is: Where are we at?

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There is a slide behind me which gives some of the answers to that.

I think there has been some good news, that aggregate global spending for AIDS is in fact up last year. It was at $16.8 billion, and that was up 11.8-percent on the year before, so there is some good news, but of course as this slide shows there is estimated to be a gap of $7 billion in 2015, nevertheless, unless things change and change dramatically.

International investments for HIV are flat, they diminished, but they return to 2010 levels at $8.2 billion, and as we have heard over and over again at this conference, the United States is the largest contributor, contributing nearly 48-percent of all funds of international assistance for HIV/AIDS.

But, countries, low- and middle-income countries are increasingly financing their responses out of domestic resources. For the first time in 2011, domestic resources actually exceeded international investments in the AIDS response, so there was a tipping point in the dependency balance in 2011. 81 countries, in fact, increase their domestic investments for HIV by more than 50-percent between 2006 and 2011, so they are pulling their weight increasingly.

As African economies have grown, public investments in HIV and AIDS have grown as well. Domestic investments in sub-

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Saharan Africa, excluding South Africa, grew by more than 97-percent during that same period.

South Africa, as we have heard at this conference, invested $1.9 billion last year in the AIDS response, contributing more than 80-percent of the finances that it was spending, but of course there was a gap there, and there was a gap in all countries. In fact, international sources still account for over two-thirds of expenditure on AIDS in sub-Saharan Africa.

The BRICs, too, are increasingly taking ownership of their responses in a financial sense, China and India are moving towards 90-percent, Brazil and Russia are investing nearly 100-percent, although one might question what Russia is spending its money on and whether or not it is spending it wisely, but that is not what this session is about. Brazil of course has been a long time leader in health through its commitment to universal access, not just for HIV and AIDS but universal health coverage, and we salute them for that.

In other words, we are seeing, and we are entering into a new era of development cooperation, one increasingly of shared responsibility. But, one that needs to be met by global solidarity as well, continued and increasing global solidarity.

Secretary of State Clinton spoke of continued US commitment and shared responsibility in bringing about the end of AIDS, and at the opening ceremony, South Africa's Deputy

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President spoke about the African Union's new road map, not just for shared responsibility but a road map for shared responsibility and global solidarity.

What I would like to do now is to hear from our esteemed panelists about their proposals for showing us the money to make the implementation of that shared responsibility road map in Africa a reality, so as to achieve universal access in Africa, but also in every other region of the world. I think that is a fairly simple question, in a way, and the answer of course would be much more complicated.

There are questions, for example, that we expect the panelists to respond to in terms of how do we create the political incentives to generate and maintain leadership, to allocate funds to AIDS, and a series of other questions. Let me turn to my co-chair, to introduce our panelists, and we can come back to some of those questions in the question and answer period that will follow. Dr. Siregar

KEMAL SIREGAR: Good morning, ladies and gentlemen. This is really an honor to me, to introduce the first speaker, Professor Michel Kazatchkine. Professor Michel Kazatchkine has spent the last 25 years fighting AIDS as a leading physician, researcher, administrator, advocate, policymaker and diplomat. From 2005 to 2007, he served as the French ambassador on HIV/AIDS.

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He was both a member and Vice Chair of the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria, from 2005 until 2007. In 2007, Dr. Kazatchkine was elected executive director of the Global Fund, a position in which he served until March 2012. He will speak on the changing political environment and competition for resources. Ladies and gentlemen, please join me welcoming Professor Michel Kazatchkine.

MICHEL KAZATCHKINE: Thank you, Dr. Siregar. Let me say from the very beginning that I am speaking here in this panel today in a personal and not in any other capacity.

In the [inaudible] amidst the optimism we are expressing at this conference as the result of the progress we have made, I am going to bring a note of warning. This is because I am truly concerned about the funding landscape. I am particularly concerned about the financing in the short term, as we make our push to close the gap in which the 2015 targets. And, by doing so, position ourselves to turn the tide and control the epidemic.

I am concerned because insufficient resources will affect our ability to reach our targets at the very time when countries in the global south have shown more than ever before their resilience and ability to scale up interventions and programs.

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Let me be clear, here, I do not doubt that we have the tools to achieve our goals for 2015, but we need the resources now, in the immediate next few years to consolidate and sustain our achievements and significantly scale up our treatment and prevention efforts.

It may be that at this particular time not all countries are under pressure, or I would say, yet under pressure. There are several reasons for that.

One is that the slowing down in international resources in some countries has been compensated by an increase in domestic spending on AIDS.

A second is that for the time being, existing programs are not at risk, existing international programs are not at risk as it has clearly been indicated by the Global Fund and PEPFAR.

Thirdly, we all know that there is a lack phase between a decrease in commitment and the time at which this would negatively impact on programs. But none, of course, of all of these reasons should lead to any complacency.

I would like to acknowledge and salute the good news on this significant increase in domestic public spending on HIV/AIDS in the last five years, reported by UNAIDS and just mentioned by Kent.

As a result, and as we just heard from Kent, domestic investments have now exceeded the international investments in

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the AIDS response, and we should not underestimate the political significance of these data. This is about country ownership. This is about sustainability, and above all, a strong signal that HIV/AIDS is given a true priority.

Let me also be honest, here, domestic funding, the numerator, has increased while the denominator, international funding, has remained stagnant since 2008, or decreased, and the majority of the increase in domestic public funding has taken place in BRICs countries. What I would wish to see is an increase in both the numerator and the denominator, in other words, a continuing increase in domestic public spending on AIDS, and the additional resources that we need from the international community to achieve our goals.

I would now like to focus on international funding in the remaining time. I wish to make five points.

First: International funding is and will remain critically needed.

Second: International funding is at high risk in the context of the economic crisis.

Third: I see political demobilization in dollar countries as a significant consequence of the global financial crisis.

Fourth: It is therefore more pressing than ever that we make the case for funding AIDS and health because it is the right thing to do.

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Fifth: More multilateralism is needed in global health, not less.

Let me elaborate on these areas. First: International resources are critically needed today, and will, I believe, remain needed for the years ahead. Continued increases in domestic funding and efficiency gains are important, but they will not be enough.

International resources, as just said by Kent, still account for nearly two-thirds of the resources in sub-Saharan Africa, and economists tell us that even in the best case scenarios where low- and middle-income countries would remain relatively protected from the crisis, annual spending per capita on health that is currently $25 US dollars in sub-Saharan Africa, and $35 in southeast Asia, is unlikely to exceed $100 by 2030, and will remain insufficient to achieve and consolidate global health targets.

My second point is that international funding is contracting and I fear it is at high risk in the near future, in the context of the continuing fiscal and economic crisis that the world is facing. Several countries including the Netherlands and Canada have announced decreases in ODA.

Italy and Spain are unlikely to come back with contributions at the level which they have been contributing before, and the Euro Zone crisis will continue to seriously threaten the capacity of European dollars that contribute at

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least 55-percent to the global fund commitments. Here, in the US, we cannot assume that the current aggregate amounts spent on development aid will continue.

The PEPFAR program which also includes the funding for the Global Fund is due to be reauthorized in 2013, next year, a reauthorization that will face difficult challenges in the economic fiscal and political context. Obviously, continuing bipartisan support will be critical to achieve any kind of success here.

Listening to what happens on the ground, there are already a number of worrying signals about the impact of the flattening or decrease in international funding and the consequences of the cancellation of round 11.

HIV testing is being slowed down, there are rationing and delays in treatment initiation, increasing risks of treatment interruption, and severe challenges to actually move to implementation of WHO guidelines when it comes to treatment, or to prevention of mother-to-child transmissions. Programs are being revised and scaled down, and I would like to draw your attention to a report that [inaudible] has issued for this conference, a document focusing on DRC Malawi, Guinea, Mozambique and Zimbabwe, that is of particular concern.

Communities and organizations as we hear, these days, from Eastern European and the central Asian region express

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various concerns that they are being neglected by the global community.

Which brings me to the third point: International funding is intimately linked with political will and leadership. Political leadership on AIDS and global health has, to me lately, been fading. The decrease in the engagement of the leaders in the traditional donor world has been, I would argue, a true collateral damage to the economic crisis. There has been little attention to global health and to AIDS at the last G8, and despite BRICs countries having become powerful global players and leaders, there is not yet an engagement of the G20.

To some extent, this demobilization is a paradox, after 10 years during which health has become an integral part of the foreign political agenda, but clearly in the end political leaders focused on domestic issues and balancing budgets.

Of course, that is understandable to some extend, but I believe in the globalizing world, introspection will not help us solve global challenges.

Interestingly, public surveys conducted in France and in Germany show continued support for foreign aid in health despite the economic constraints of the crisis. I should add that we, as an AIDS community, also have to take some responsibility for this decline in leadership, our message may

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have been too narrow, and needs much more to be linked coherently with broader development and human rights agendas.

Which brings me to my fourth point: We need to make the case for continued and expanding investments in AIDS ever more strongly and effectively because we know that AIDS money has been and is also health systems money, it is also building infrastructure, it is also about management supply chains, it is also about funding healthcare workers and increasing the availability of essential medicines, and because it is simply the right thing to do from a humanitarian and ethical perspective, from the perspective of health, seen as a human right with corresponding entitlements and national and global dues.

From a micro and macroeconomic perspective, as we learn now about the economic returns of investing into antiretroviral treatment, and from a political perspective, because we cannot build a globalizing world with increasing gaps between the rich and the poor.

More than ever, we need to demonstrate results, focus on epidemiologically relevant evidence-based interventions, increase efficiency, show the broader benefits of AIDS funding in countries, and we also need to search for new and innovative sources of funding. Denis will elaborate on that in a minute.

UNITAID of course provides a remarkable example of what can be done, and now we need others, and that includes a tax on

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financial transactions, for which many of you have been advocating and marched on on Tuesday, and I was gratified of course to hear President François Hollande announce in his address to the conference on Monday that a financial transaction tax will be implanted from August this year in France, and his call at the last G20 meeting for such a tax to be broadened to Europe and other countries.

Finally: I believe more multilateralism is needed in our international efforts, not less. Multilateralism decreases transaction costs, it aligns financing with global goals, and it is consistent with the spirit and this concept of shared responsibility that Kent mentioned, and that is being so often expressed at this conference.

Multilateralism is the logical platform for delivering on global public goods. Multilateral approaches achieve more than the sum of their parts. I know these views are not shared by every country, it is clearly more strongly seen and perceived in Europe, and less here in the US, where aid is delivered through bilateral channels for over 80-percent. But, I think that in the 21st century, and in the evolving economic and political context, we need to review our conception of multilateralism.

We need to adapt it to accommodate the needs of the G20 countries. We need to look at the multilateralism that would involve the trend to regionalization of the funding of the AIDS

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response. Multilateralism, I said, is the right way to deliver on global public goods, and on global solidarity. And, global solidarity is not just about how you and I and all of us will friendly interact and renew our friendships at the occasion of this conference, it is also about how all of us commit and fight for the resources to end the AIDS epidemic. Thank you.

KEMAL SIREGAR: Dear participant, what I should mention in the introduction of Professor Michel Kazatchkine, he is currently the UN Secretary General, Special Envoy for HIV/AIDS in Eastern Europe and Central Asia, a post of which he was appointed last week.

Now, allow me to introduce the second speaker, Mr. Denis Broun, who will speak on overview of global financing. Denis Broun is the Executive Director of UNITAID. He has been working in the field of public health and health economics for the past 25 years and has established strong links with a large network of partners in government, civil society, private sector, foundations, and international organizations. So we welcome Denis Broun.

DENIS BROUN: Thank you, thank you very much. Speaking after the eloquence of Mr. Kazatchkine is particularly difficult, especially as I am going to speak a bit more on figures and financial technicalities, it might not have the same breath of inspiration as his talk.

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I am going to talk to you about the perspectives that intersessional financing and innovative funding, in particular, offer for the future of HIV financing, with a couple of examples, a couple of ideas on the current debates, and try to see also what are the issues we are facing today, when there has been progress on innovative financing, but we still have serious questions about how it is going to unfold.

It is not new to speak of innovative mechanisms for financing, what we call innovative would be mechanisms by which people would contribute to international solidarity without using this most standard way of disbursing from overseas development money.

It has been, I would say, conceptualized in a pretty comprehensive paper, which was produced by a French Inspector of Finance [inaudible] in 2003 which was looking at mechanisms by which there could be money raised that would be less sensitive to economic up and downs and that would be also less sensitive to political fluctuations that would be levied from new sources and be independent from the problems that face international development money.

The principal was to try to seek contributions from economic activities that had most benefited from globalization and were least contributing to international solidarity.

These activities were the ones which had a major growth in the years of globalization, it was the international trade,

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it was international transport, in particular airlines, it was international finance, it was internet and telecoms. These were activities which had become global which raised money worldwide and contributed little to international solidarity.

The idea was, of course, to try to raise taxes from them, but it is not only taxes that were looked at, you had also other mechanisms that were considered to mobilized voluntary funding from private sector entities, and you know that at that time also new mechanisms for funding were also developed using development assistance money more strategically.

One example that is often given in inventive financing is the IFF, International Finance Facility for the introduction of new vaccines which is a sense a mechanism to frontload external aid in favor of introduction of new vaccines for poor countries. Then the countries that guarantee this frontloading repay this money from the development aid over the next 10 years. In a sense, it is a mechanism to earmark ODA early so that countries which contribute today will have to pay for 10 years, but it does not generate new funding, it is a mechanism of reallocating existing money.

The idea of innovative finance got through a lot of discussions and it started to get implemented in 2005/2006. That was the moment UNITAID was created.

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What was found is the easiest to start with was the air ticket levy which was first implemented in Chile, then in France, and is now implemented by more countries which I will tell you about.

So why did we take the air ticket levy? It is easy to collect, airlines are already collecting all sorts of taxes, [inaudible] tax, airplane maintenance, airport, et cetera, and they do it in the name of the government, the mechanisms exist, adding a nominal tax on an air ticket did not represent any additional cost in terms of collection.

It was cheap, the air ticket levy is between $1-4 in general, it is painless because in comparison to the total price of the ticket, it is negligible. And it is, in a sense, equitable. It is a levy taken from people who can afford to pay for a plane ticket, who can show some solidarity to those who cannot afford basic medicines.

Today, nine countries contribute to UNITAID with the air ticket levy, so besides Chile and France, it is Korea, and African countries who directly contribute to this international solidarity. Cameroon, Congo, Niger, Mali, Madagascar, and Mauritius. Four more countries are on the way of implementing the ticket levy.

But, what has it done? It is not huge amounts of money, over five years it has collected $1.2 billion, so it is not amounts that would take care of the HIV gaps, but these are

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new funds, these are funds which would not have existed if this mechanism had not been set in place.

The money does not all go to UNITAID, actually, and many countries allocate some of the money to UNITAID, some to other things they do including, for instance, in Cameroon, a national AIDS fund.

This is one area where there was the generation of new money. You know that one area which has been alluded to by the other speakers which is considered very promising is the financial transaction tax. Let me tell you a little bit where we are on that.

You know that it is not completely a new idea, the financial transaction tax was first quoted by John Maynard Keynes in 1936, so we are really looking at an old idea. It was completely structured by Tobin in '72, and at that time it concentrated mostly on having a levy on exchange transactions. Now, things have evolved, a lot of economists including Nobel Prize delegates have been working on that, and we are looking now at how it is possible to collect a financial transaction in general which would be a transaction on shares, futures, and derivatives at a very low level of a transaction.

We commissioned some months ago a paper, which is available on the UNITAID site in French and English, which describes how a financial transaction tax can be implemented,

and can be implemented even one country at a time. It does not have to be implemented worldwide.

The type of rate which is considered is 1/500th of a percent, on average, on the transactions, which is extremely low. Now, why is it considered at this point? It is that financial transactions have taken a size which is absolutely huge.

It is interesting to compare when we had the crisis in 1929, financial transactions represented 30-percent of the amount of the GDP of the real economy. Today, at the crisis of 2008, it was 7000-percent of the real economy. So we are looking at amounts which are absolutely huge, very often artificially pumped up by electronic transactions which are computer generated which do not create any value at any point for people.

So with these types of amounts, it is possible to look at extremely low percentages which would bring large amounts of money. A simulation was done with, as I told you, 1/500th of a percent; on average on these transactions would bring $300 billion in the G20 economies. So we are looking at amounts which of course are not at all commensurate with what we look at when we speak of air ticket levies.

Now, why should that happen? Is it right to do that? You know, 42 countries today have financial transaction taxes, and it is interesting to see that one of the countries, which

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is most adamant against the approach of the financial transaction tax which was proposed for the European Union, the United Kingdom, has had for the past 30 years a stamp duty reserve tax which is typically a financial transaction tax on all shares exchanges.

One country, Taiwan, has the full range of tax on financial transactions; at the very least we can say that it has not hampered its economic growth.

This could bring additional money, but it is not probably the answer that countries in development could consider as being a source for bringing up their national money. When ewe looked at the simulations, the largest beneficiary was South Africa, and South Africa could expect to raise $2 billion at most from it per year, and for most African countries it would be much lower amounts of money. So, it is in the countries where you have the largest number of financial transactions that these types of taxes could be considered.

Now, what is the future of it? Both Kent Buse and Michel Kazatchkine talked about the speech of François Hollande, the French President, who indeed will implement a financial transaction tax starting the 1st of August, the most important thing that François Hollande said is not so much that this financial transaction tax will exist, but that 10-percent of its proceeds will be allocated to development.

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This is one of the biggest difficulties, raising more money through innovative taxes is one thing, allocating this money to development issues is another. Within development is allocating it to HIV, it is still another one.

I was at the Rio Summit; I can assure you that most people working on climate change are looking at the financial transaction tax to finance the activities which are necessary to take care of the environment and the climate. We also have to consider Michel Kazatchkine was talking about the difficulties of solving European economies.

Countries like Spain and Italy or Greece, if they put such a tax in place, would first try to reduce their debt burden, because they borrow at rates which are asphyxiating their economies, and also would look at how can they keep their social safety net in place? When you have countries which are wondering if they are going to continue paying their pensions for old citizens, it is very difficult to advocate for support for HIV or development activities.

This is where we really have to be very strong in our advocacy in explaining how the fight against HIV is something which is not country-specific, which is in the interest of all, which is global, and financial transaction taxes which should be implemented globally will then naturally come in support of the fight against HIV. Thank you.

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KEMAL SIREGAR: The next speaker is Dr. Faustine Ndugulile. He will speak on responsibilities of recipient countries. Dr. Faustine Ndugulile is a medical doctor, and he has specialized in medical microbiology and public health. Dr. Ndugulile was elected to parliament in October 2010. He is the Vice Chairman of Social Service Committee and the Secretary General of the Tanzanian parliamentary Forum on AIDS. Dr. Ndugulile is also a member of the Governing Council of the IAS. Welcome Dr. Ndugulile.

FAUSTINE NDUGULILE: It is an honor to be part of this distinguished panel that is discussing some very pertinent issues. During the course of this conference, we have seen presentations on the knowledge of the different interventions against HIV/AIDS, we have seen results of how well these interventions are working, but all these efforts are being threatened by the uncertainty about the funding. This particular discussion today is very important as to figure a way for it.

Just to put things in context about the situation of the country that I come from, Tanzania. Currently, the national prevalence of HIV is around 6-percent. HIV/AIDS accounts for about 10-percent of the national budget. The national response requires about 1 trillion Tanzanian shillings, the conversion factor hers is 1,500, so you can figure out how much money is needed. But [inaudible] we are

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only receiving almost 50-percent of that money. Again, the most disturbing factor is that donor dependence, HIV programs is depending 97-percent of its funds from external donation.

What is the government doing? Annually, the government of Tanzania is providing about $20 million US dollars towards HIV/AIDS activities and a huge chunk of that goes into financing the ART program. We have a decentralized health system in Tanzania, the rest of that fund goes into other MDAs, and some of the activities I will highlight them later.

But also, some of the efforts in the [inaudible] have been supplemented by NGOs and SSOs

Who is funding the HIV/AIDS activities in Tanzania? We have a number of donors, but 91-percent of this funding comes from two major donors: The Global Fund accounts for almost 20-percent, and PEPFAR about 71-percent. The rest comes from other multilateral and bilateral donors. Some other major donors which are not mentioned here are financing the HIV activities through the Basket Fund.

This budget highlights who are major funding, and as you can see as mentioned earlier, it is mostly the PEPFAR and the Global Fund.

How do we use that money? Most of the money goes into the care and treatment program, and the little 20-percent into prevention, less than 10-percent into impact mitigation, the remaining money goes into the [inaudible] environment.

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This shows the current general financial trends in Tanzania, we had a peak around 2008, 2010, but the funding has been declining, and I think we all know the reasons. Global Fund, around 11 [inaudible] there has been a capping on some of the PEPFAR fund, some donors have been pulling out, and some donors have been reducing their contribution towards funding of HIV/AIDS in Tanzania.

On the local government side, most of the money goes to support community interventions, [inaudible], commissioned sex workers, people living with HIV/AIDS, organizations of people living with HIV/AIDS, and also the local government councils and their sexual AIDS committee in different ministry.

In Tanzania, we have more than 10,000 SSOs and NGOs, and this is an area that is presenting a huge challenge to us right now. We are seeing more direct funding to NGOs and SSOs, actually 70-percent of all the HIV/AIDS funding coming outside of Tanzania goes to NGOs and SSOs.

But we are having a challenge, here, we have international SSOs and NGOs that are registered locally, but this money is not going to the local NGOs, but it is going to international NGOs, and there is no accountability for the money that is coming in, we do not know how much is coming, we do not know how that money is being used, and we do not have clear understanding of what role these SSOs are doing. Are they doing [inaudible], are they doing service provision? And

how much of that actually goes into the main intervention has been a challenge.

I remember sometimes back when I was working for the government, I was given a task by my government to account for the contribution towards HIV/AIDS of a county [Misspelled?] where my presence was opposed to God [Misspelled?]. It took me almost two weeks to try and extract information from that particular county, and even then I was not ever to get the information, so I had to go around, go into different organization, different department [inaudible] trying to get that information. So you can see that this is very difficult to get to know how much money is coming to SSOs. This is the chunk of the money that is coming into the country.

But, this also begs another question, if you are going to be funding external international SSOs, how are we going to build sustainability locally?

We have also a small private sector, but they are only contributing about 4-percent, and mostly these are contributing towards the workplace intervention for their own staff, we have seen this and I think the government is working to establish a better mechanism of getting the private sector to be more engaged and involved in the provision of care for the HIV/AIDS programs.

You also of late health insurance schemes, but also the pension funds have played a critical role in trying to

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supplement the government efforts. We have not been able to quantify, but we have a substantial contribution from these organizations.

What challenges are we currently facing? We are seeing that the funding is not enough, this capping of funds from PEPFAR, the reduction of funds from Global Fund, some other countries are also reducing funds, but also we have not been doing enough in terms of our own domestic funding of HIV/AIDS. We have so many donors who are bringing money into the country, but each of these donors sometimes come with their own priorities.

We have multiple reporting and accountability mechanism, I was talking to a colleague, each of the requirements to get funds takes about three to six months. So you can see that people actually are working most of the time trying to address the reporting structure, the accountability structures that are required of these funds that are coming into the country. But again, the preference of NGOs to the government as I said, 70-percent of the money goes into NGOs.

What should the government do? I think with the current situation that we are currently facing there is no other way; the government needs to take ownership.

We understand as they are competing interests, case of Tanzania is developing countries, there are so many competing interests, but even within the health center, there is so much

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that is going on. Apart from HIV/AIDS we have a huge burden of malaria, we have a huge burden of TB, and now it is increasing burden of non-communicable diseases, the little health budget that we have, we have to share.

As host countries we need to set our own agenda and priorities. And these should be country-driven. We should have a policy environment and a sound monetary policy that would ensure effective and efficient use of local resources but also the external funds that are coming into the country.

Again, we should also have a mechanism to ensure accountability and transparency of these funds. Also, we need to rethink of the different [inaudible] that you have in place, we should aim for high-impact and a low overhead cost for these particular interventions.

As a member of parliament, and I am glad that you have some colleagues here with me, we also have a role to play. We can provide the political leadership. I sit on the Social Services Committee, but you also have a parliamentary AIDS Committee. We sit in committees and look at the priorities, but also we play a critical role in resource allocation.

Once we as members of parliament understand the situation, it is very easy to advocate for increased local resources towards health, so it is very important for government officials, and I am glad some of them are here, to involve us, we are your friends, your colleagues, and we are in

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the same boat. Once we understand, it is very easy to also contribute.

As a member of parliament, we are in a position to establish registration of political framework that would commit more resources and create alternative funding mechanisms.

As a member of parliament, we have an oversight role over the government and we can oversee the implementation of the budget activities, make sure that we get value for money for different HIV/AIDS programs which are locally funded but also funded by donors.

What mechanism can we use to reduce dependence? The only solution is government to commit more local resources, we have our [inaudible] declaration that requires host countries to set aside 15-percent of their budget towards health. Many of the African countries are still struggling at that. In Tanzania, we are almost around 10-percent on this, we need to do more.

Tanzanian government is in the process of establishing AIDS trust fund, a fund that would tax certain products to fund HIV/AIDS activities. This being right now is at a level of cabinet, and I think the indication that we are getting is very encouraging. We hope that once this is in place, it is going to really give us a platform to engage and to have our own resources that would finance the HIV activities. We still need

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to engage the private sector; we have a good policy [inaudible] on private partnership.

There are some roles that we can play, but donor countries can also help us. You can help us by funding according to our national priorities. You can help us by streamlining funding and the reporting mechanisms. You can help us by funding transparencies, to show that we know how much money is coming in, where it is going, and what it is going to do. We need to have a better oversight and the coordination of the money that is going to SSOs.

Before I finish, I would like to thank the Tanzania AIDS Commission, the National AIDS Control Program, the Minister of Health of Tanzania, my fellow colleagues the MPs, and other colleagues who have contributed in any way on this presentation. Thank you very much, [inaudible]

KEMAL SIREGAR: The speaker now is Professor Gorik Ooms. He will speak on the future global priorities. Professor Gorik Ooms is a human rights lawyer and former Executive Director of Médecins Sans Frontiéres Belgium. At present, he is the Executive Director of the Hélène De Beir Foundation, researcher at the Institute of Tropical Medicine of Antwerp, and Adjunct Professor of Law at Georgetown in Washington DC. Now I call Professor Gorik Ooms.

GORIK OOMS: Hi everyone. I have been hired as the fortuneteller for this session. I am supposed to tell you what

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will happen after 2015. Usually fortunetellers tell nice stories because that makes clients come back. Unfortunately, I am a bit too worried to do that, but I will try.

We all know these, the millennium development goals to be achieved by 2015; we know that they will not be achieved. Certainly not in many low-income countries, but we are already in the phase of negotiating what comes after 2015.

There are three specific health-related goals in there, and people who are involved in these negotiations which have begun already say that there will probably only one health goal in the next version.

Of course, we do not know, we can try to fight this, we can try to change this, but that is what most people seem to agree on, only one goal, and that it probably will be something like universal health coverage, heavily promoted by the World Health Organization and by many other countries.

Universal health coverage, if that is the goal after 2015, is it good news or bad news for the fight against AIDS? I think it could be bad news, because to me, universal health coverage sounds like health for all by the year 2000, but then by the year 2100 or so.

It may include the fatal flaw that was in the Alma-Ata Declaration, and I am reading it: "Primary health care is essential health care made universally accessible at a cost that the community and country can afford to maintain at every

stage of their development in the spirit of self-reliance and self-determination."

What that meant for people with AIDS in low-income countries, it was a death sentence. A death sentence for the sake of self-reliance because a lot of countries could simply not afford AIDS treatment, and during a number of years around the year 2000, that was the prevailing idea of development assistance with regards to AIDS in low-income countries.

Focus on prevention, no treatment, because it is not sustainable. If that is going to be the future, if the new version of universal health coverage does not move away from this idea then we are in trouble.

Universal health coverage could also be good news for the fight against AIDS. I think AIDS exceptionalism as we have known it has run its course. I think we have to prepare for a world in which AIDS will be considered as any other disease. If we are lucky, that means that other health issues will receive the same commitment, the same energy and the same resources as AIDS has received, but if we are unlucky, it means something else.

We have to understand how truly exceptional this global AIDS response has been, it has achieved to a certain extent a true paradigm shift, a Copernican change of looking at things, from national responsibility as expressed in the Alma-Ata

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Declaration, with some external assistance, but temporary assistance.

The global AIDS response moved towards human responsibility, or national and international responsibility. It may have had some negative side effects in the sense of national de-responsibilitization, but in general, it allowed to provide AIDS treatment in countries that would not be able to pay for it themselves.

This new paradigm is implicit, it is not very clear, there are no binding commitments, and it is fragile. There is a way to strengthen this, to give it a more solid foundation and that is to ground it in the right to health, or health seen as a human right with corresponding entitlements and national and global dues. That is something that Michel Kazatchkine mentioned, and that is really what happens but only for HIV/AIDS so far, and it is not very safe, it is still fragile.

We see that the AIDS movement is moving in this direction, this was the invitation for the march. We can end AIDS via mobilization for economic justice and human rights, seeing health as a human right.

If you do see health as a human right, the right to health does not really support the prioritization of a single disease. It is very difficult to argue or to support from a right to health position that antiretroviral treatment is available in places where cesarean sections are not. So

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perhaps universal health coverage could be the practical translation of the right to health.

How do we make sure that universal health coverage really is a translation of the right to health? I think my most important point is that we have to question or challenge the notion of sustainability. It comes back again and again, I have heard at this conference several people who said that even the present AIDS response is not sustainable, it is a bubble, but sustainability is not an absolute concept, it is relative, it is related to political choices.

Imagine that we agree that the responsibility for school is at the level of a city, then the sustainability of that school depends on what the people of that city can afford. Now, if you decide that the responsibility for education is a national responsibility, then the level of education that you can provide is different, then it depends on the wealth of that nation. You can have a similar reasoning with health if you think politically the responsibility for health is only a national one, then sustainability means what that nation can afford in the long run.

If we agree that the responsibility is also an international one, is also a global one, then sustainability means something else. Then, sustainability means what the global community can afford, and that is a much higher level in a lot of countries in the world. We really have to challenge

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that, the word sustainability is too frequently used without being specific on what we mean by it.

We have to clarify what we mean with shared responsibility. We'll have to move to some kind of global convention or agreement where governments and civil society make binding commitments where we no longer toss around the Abuja Declaration and the 15-percent and the 0.7-percent of the high income countries, etcetera, where we make clear commitments towards each other because that's the only way of making the resources more reliable in the long run and to allow to plan for the future response.

The third point: this is an old paper and I presented it in Mexico already, but I think it's now more valid than ever. We have to move away from a purely vertical approach to a diagonal approach and I'm very worried when I hear for example that the Global Fund is becoming more focused on the three diseases because ultimately, that will be an excuse for many governments to reduce support to the Global Fund, so we have to show that the fight against AIDS is supporting universal health coverage, is supporting a broader fight for global justice and health for all.

Conclusion, and this is my personal opinion, I think universal health coverage will work for the fight against AIDS, but if and only if AIDS fighters work for universal health coverage and make their own. [Applause.] I think that can be

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and should be and will be the legacy of the fight against AIDS, real health for all, real universal health coverage, not what we had 15 years ago. Thank you. [Applause.]

KENT BUSE: I'd like to thank all the speakers for the content and their presentations, but also for sticking to the 15 minute time allocation, which provides us a good amount of time for some questions and comments, which I would now welcome. There are some mics as you well know behind you. Yes, Mic Number 4, Allen Whiteside, please introduce yourself.

ALAN WHITESIDE: Thank you very much, I'm Alan Whiteside. I run the health economics and HIV/AIDS research division at the University of KwaZulu-Natal in Durban. Thank you very much for the four very good presentations. Gorik, I think you need to perhaps expand a bit and tell us what it will cost for universal health coverage and what happens if we don't get it.

KENT BUSE: Thank you. Mic Number three please.

STEFAN ORLANDO: Thank you very much, I'm Stefan Orlando from the Community of Sant'Egidio [misspelled?] Program. My question is about public/private partnership that's been mentioned in different presentations, because usually this term is related to finance and investment in health, bill facilities with a return on the part of the private companies who finance these investments. I guess, how which mechanism can be used to apply this to the fight of AIDS?

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We are going to finance running cost, not the building and the clients will not be because we know that we cannot put a fee on the patients for the treatment of AIDS. Thank you.

KENT BUSE: Can we go back to Mic Number four please?

ADAM TAYLOR: Sure, thanks again for the presentations. I'm Adam Taylor, I work with World Vision. My question is around innovative sources of finance for HIV/AIDS programs and even more broadly to strengthen health systems, particularly the global financial tax has been to a certain extent a non-starter issue here in the United States as well as some other key global capitals and I'm curious what arguments need to be made or what arguments need to be dispelled in order to gain greater political traction, not just for the innovative source but for others in the US but also beyond.

KENT BUSE: Thank you. Mic Number three.

PAUL ZEITZ: Hi, my name is Paul Zeitz with Act V: The End of AIDS. My question for the panelists and particularly Professor Michel K., is the global health architecture is evolving, it's not static, it's a dynamic evolution of that architecture. This week Peter Piat spoke at an event and he said, "Institutions have to be acquired or consumed, that coordination is not viable."

In the push for universal healthcare, that Margaret Chan is leading, Michel Sidibe is supporting, we have Jim Kim at the World Bank. We have a Global Fund that's in transition.

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Is this the moment for a re-think of the global health architecture? Because universal health coverage will require external support according to Gorik's concept from the international community to meet the needs in middle and low income countries so how's that money going to be channeled to support the push for universal healthcare? And will AIDS treatment be able to be scaled up to get universal access as part of that? That's where we don't know the answer to that. We hear Margaret talk about universal health coverage. Where's AIDS treatment in that? Thank you.

KENT BUSE: Thank you, Paul. I think we'll take a few more questions and then we'll allow the panel to respond. Mic Number four please.

KAYA MARBOSA: Good morning, Thank you again for the presentation from the panelist. My name is Kaya Marbosa [misspelled?]. I'm working for the Southern Government of National AIDS Council in [inaudible]. I have a specific question to the last presenter, Professor Ooms, about the universal health coverage.

My worry is that if we intend to be very health specific when it comes to HIV and AIDS, we seem to be losing the effects of what AIDS has done to communities, more in particular, we should not, people have died and are still dying, what about the orphans? What about the elderly who are now taking care of the orphans? Because if we intend to be

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more health oriented when it comes to HIV/AIDS, we're going to lose focus completely. I've very worried about that focus. Thank you very much.

KENT BUSE: Thank you. Mic three please.

BROOK BAKER: Hello, my name is Brook Baker, I'm from Health Gap. It seems that the discussion from donors is based on three ideas all of which have dangers. First is scarcity, the false scarcity that Sachs has talked about, which of course is not true, there's plenty of money in the world.

Second is what Gorik talked about, which is sustainability. The idea that poor countries can easily take over or even if they can't easily take over, but that they must take over the funding and stand on their own feet. The third that needs to be tied in is the efficiency. It too is part of the global discussion now, that we can do more with less indefinitely and in particular with respect to efficiency, because I think we haven't talked about that enough.

Doesn't the panel agree that there is going to be some cost drivers in the future to reach vulnerable children, to reach infants, to reach men who are currently under reached? To build up health systems and increase health work force. To reach rural populations, to add viral load, to have second and third line medicines. These are all going to be cost drivers. We have efficiencies to gain but we also have cost drivers that need to be addressed.

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KENT BUSE: I'm going to go back to Mic Number four.

NANCY SCHWAI: Thank you very much [inaudible]. My name is Nancy Schwai [misspelled?]. I come from the Eastern Cape in South Africa and Nelson Mandela Bay Metropolitan Municipality.

I want to appreciate the presentation of today in terms of making a critical analysis of the contribution and also the distribution of the Global Fund and its challenges, but I wanted to raise two areas. The representation as I listened, they focus more on the outcome of the social ills within the communities, it loses a particular view that says, how does it happen that there's an HIV/AIDS within the communities? My argument is that the lack of resources and developmental programs are the causes of HIV and AIDS.

Now the consideration therefore of reviewing the target of 2015 would need to be given a particular guideline that says a motivation that speaks more on what is developing of character of a particular province or a country in terms of the needs of the finding. I do want you to appreciate that end. HIV and AIDS should not be targeted for a particular year. It's a continuous sickness that is caused by the character and the nature of particular countries. Thank you so much.

KENT BUSE: Thank you very much and finally, Mic Number three please.

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MONICA MARIANI: Hello, Monica Mariani [misspelled?], I work for Oxfam. It's just two points, one is of the lessons that we learned from the successes we've had so far in HIV is the fact that providing treatment free to people. If you talk about universal coverage, one of all of our universal coverage, but presumably means access as well and if you talk about access, what are you going to charge people, whether user fees or pre-payment or whatever direction in particularly in the country environment of lack of resources.

You know, if my government is forced to pay for me, expect me to be rich enough for myself, it doesn't make sense, so I think I would like your comments about universal coverage and removing universal fees and making them available in public sector and free.

From Uma Ater [misspelled?] lessons learned, I think when Uma Ater was received, there was this focus on community workers, which is obviously fine, but I think it was seen as a cheap way providing services, you know, get these women, get them better workshops and they can come sit under a tree and tell people how close they're at, and that's how it works.

Again, what went one is this is not the case, if you want to commit your workers to provide service and they should be a part to do that, so that means we should spend money on proper training and continuous support.

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KENT BUSE: It looks like we have one more final question, Mic Number four please.

CALVIN SURREY: Thank you very much. My name is Calvin Surrey [misspelled?] and I'm working for an organization in Eastern and Southern Africa, the [inaudible] Network. I'd like to point to the professors and honorables that are here that I feel that the last presentation also gives us a hint that is very likely that you could make the mistakes that we did for the health for all for the 2000, where we start now generalizing the response to health and needs in some areas like eastern and southern Africa.

I feel that if we do not start specifying for interventions that are producing high returns, like HIV specifically, I think we'll start now losing the whole new direction for a simple reason. We started focusing on HIV /AIDS when we looked at the political economy for HIV.

It was almost running into the whole fabric of the economies mostly in the sub-Saharan Africa and I believe that still HIV and AIDS remains a priority that solves most of the problems in that region and therefore if we start moving from HIV as a specific intervention while we are appreciate that it has to be into integrated into all the other areas of the health and response, I think we'll be losing your point and it's very important that as we reshape the global health structure, we need to think about the importance or specificity

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given the context of HIV and I think the last presentation said it well, if we talk about sustainability, it has to be context specific. Thank you.

KENT BUSE: Thank you very, very much. Great set of questions and comments and some of the questions were targeted to specific panelists, but a number of the comments and questions were broader and so what I'd like to do now is to provide each of our panelists between two and three minutes each to either respond to one or two of the specific questions or to make some concluding comments based on some of the thoughts that have been raised. Thank you. Michel.

MICHEL KAZATCHKINE: Thank you. You're right, you had many very interesting comments and complex questions raised. I'll just try to briefly address Paul's comment.

I agree with you that the times in which we are maybe to question the current governmental health architecture because it is facing and confronting the challenges of reaching our targets, it's confronting the crisis in resources, it's confronting the good and the bad of verticalization, although as I argue, verticalization in AIDS has actually brought a lot of benefits beyond AIDS and this is a message that we haven't been able to convey strongly enough.

In the Global Fund model, or I should say, Paul, in the original Global Fund model, where demand was strictly counter driven, interestingly enough, when it comes to AIDS, countries

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as a whole were asking for 30-percent of their money to go to prevention and 30-percent to go pre-treatment and 30-percent of their money to go to strengthening health systems and so on, so verticalization is a bit of a slogan and one should look particularly what is behind.

It's confronting to competing priorities, to a political context and, as I see now, with the BRICs taking a very regional approach to the funding of their own academics and to funding the epidemics in around them, I see the whole global concept somehow challenged by, somehow a geographic fragmentation and my approach to that is different. My approach is really that of delivering on global public good and they would like all of us to think more about these global public goods that has defined them.

You know that well, Paul, our goods cannot come out from just American dynamics and cannot come out of the sum of the individual governments and bilateral efforts and so I would see universal coverage basically as a global public good or as a way of expressing the access to health that is a global public good.

Then obviously we would have to define as Gorik said, what do we mean by that, but I wouldn't they're going into what I would put in that definition, but the thing I want to convey is that there are some fundamentals that go with it which we

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have it keep. This mean global governments. This means shared accountability.

This means strong partnerships and when it comes to the evolving global fund model. To me this means keeping the fundamentals where the demand is not centered by what the country would know as the available funding, but where the demand is really driven by public health needs and that this will confront supply on that basis.

A final point I'd like to make is that I'm not sure this will all emerge from expert or academic discussions. Actually, the Global Fund emerged somehow because o the failure of the architectural delivery and I'm not sure we're, so I really put more hope in a political move there and that's why I'm particularly concerned these days, as I mentioned in my remarks, about the political demobilization which because politically there's, you know, sort of looking inwards and introspectively because of the crisis, have lost the enthusiasm of being leaders on global issues and on global public goods.

KENT BUSE: Thank you, Michel. Denis?

DENIS BROUN: Thanks, it's not easy answer so many of the questions because they were very thorough and general. Maybe I was asked a question on innovative finance. Is there a global financial tax? Definitely not yet. We are far from it. It hasn't been announced. It's something that many groups, you

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have here the Robin Hood groups who have demonstrated here are fighting for it. It's difficult to set this in place.

The question how to get political traction is an interesting one. We're looking here at interest groups. You know, when France set their etiquette tax in 2006, Air France brought full pages in newspapers saying if it was implemented, they would go bankrupt, that France would no longer be a tourist destination, that passengers would fly through other countries, etcetera, I mean, all sorts of arguments were used and five years later, they're actually pretty proud that they've set up this system, that this system was set up, rather. They were not the only ones paying for it. All the airlines that take off from France pay this one and it has worked perfectly. It hasn't had any impact on competition, on the air traffic, on anything.

We're going to face the same issue on the financial transaction tax. The brokers, the bankers, the financial operators all say that it is going to sink the economies, I heard that there's going to increase the cost capital in countries beyond reach, I mean, all sorts of arguments are going to be reached.

This is bogus. We know it. But trying to get the militancy and elements of the public fight against it, it is really difficult. You have seen at this conference the number of discussions that have been taken place on the issue of

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access to medicines and the problems created by intellectual property. The question of how medicines can be licensed so that they can remain affordable for the fight against HIV.

It is a pharmaceutical industry has been in a sense less formidable than the financial one, and there are a little more amenable to reason and they know what is happening in the countries and we know that they have participated in several partnerships.

When we're looking at financial operators, it is much worse and much more difficult fight, so it's definitely setting in place a whole set of mobilization and learning how all these mechanisms work to be able to convince politicians that this is one way of supporting international development indeed better health, better coverage and the fight against HIV, which depending on who speaks, is included on it.

There are elements and I was listening to what Brook Baker was saying. Definitely it is possible to be more efficient, you know, we see the first slide that was shown by Kent Buse, saying we need $25 billion for the fight against HIV. If he had showed the same figure two years ago, he had said, he would have said we need $31 billion. This was the figure that we had three years ago.

So we know that efficiencies can be found, we know that costs can be reduced, we know that better targeting bettering priority setting reduces costs and this is something which is

incumbent of all our first, that we have to make sure that whatever resources are used as wisely as possible and that the costs are decrease and I would say the two go together.

We cannot always ask for more money without showing that we are making efforts so that this money is best used and the fact that the figures from two years and today are so different shows that we're going in the right direction and we should use that more.

FAUSTINE NDUGULILE: I'll be very brief. I just want to tackle one area that one of the — discussed information about the role of the private and public partnership. I think the private sector can have a good role to play in the covering or bridging the gap where the governments are not able to get to, and not only on the manufacturing side, but looking at freeing some of the resources that the government would put into, for example, training of the human resources for health, from HIV facilities, the private sector can take over that role, looking for research and equipment, but also in areas of provision of care and treatment and prevention, so if the private sector can contribute toward that, that will free up for the resources for the government to focus on other areas.

GORIK OOMS: Is it working? Yes. Okay, so I'll try to a bit more and let me first explain that for me, universal health coverage is the next step towards an even further goal

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that I consider as global social protection and let me try to explain the vision fist.

The whole development assistance paradigm or language is riddled with expressions the reject global responsibility. For example, when I pay taxes at the end of the month to finance healthcare for other people living in Belgium, I am not a donor, nobody considers me as a donor, when I go to the hospital in Belgium and I receive healthcare, I am not a recipient of aid, I pay my dues and I receive my entitlement.

At the international level, we use these words donor and recipient and they mean that there is one country donating something, giving something and that is denying responsibility. If you have a due, then you are not donating, then you are paying your due. If you have an entitlement, then you are not a recipient, you are just getting your entitlement and for me, that's the vision that we have to achieve.

Now practically for universal health coverage if the estimate of WHO is $50 per person per year is correct, well, that requires is a transfer in the order of 0.1-percent of GDP, of high income countries to low income countries. That is ten cents out of every $100. It is ridiculously low. If we cannot do it, it means we reject global responsibility. Now what would be the consequences of that?

First of all, practically, in the fight against AIDs, I fear that a number of countries will abandon the objective of

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universal access, that they will try to reduce the amount specifically for AIDS treatment by reducing testing facilities or by imposing user fees for CD4 counts, etcetera, so that some people will no longer demand the treatment because they cannot afford the little things that they have to pay themselves. I think that for humanity as a whole, the consequences are far great, or deeper.

If we reject global responsibility for health, if we consider that it’s a national responsibility, then we have to accept that other countries, that all countries can reject global responsibilities for climate change, global responsibilities for drug trafficking, global responsibility, and if countries start rejecting global responsibilities, we’re all in trouble. So I hope it will not happen and I think it’s a question of articulating what global responsibility means. [Applause.]

KEMAL SIREGAR: Thank you so much to all speakers, the chair persons and to all of us. Thank you. [Applause.]

[END RECORDING]

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