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Innovation in global health

A spoonful of ingenuity

New ideas for raising money for medical care—and spending it

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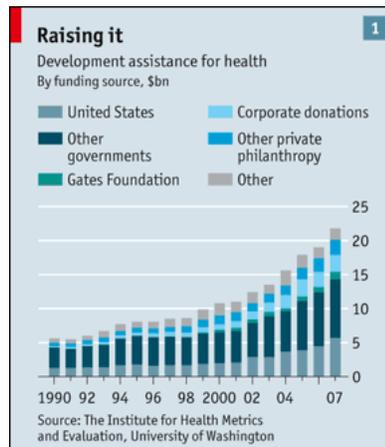
Reuters

IN THE old days, the job of eradicating disease fell to governments and inter-governmental bodies. Then charities, often led by celebrities or entrepreneurs, joined in. Finally, in the Western world at least, governments accepted the need to pool their efforts with those of private donors, big and small. The effort still seems unequal to the task. Every year, nearly 11m children die before the age of five because of a mixture of poor nutrition and preventable disease. Many of the United Nations' Millennium Development Goals (calling, for example, for a plunge in child and maternal mortality by 2015) look unattainable.

The good news is that more imaginative ways of raising and spending money are now on the horizon. How well they do will depend on many details—like the quality of information flowing between poor places and the governments, firms and individuals that want to help.

The change in funding is already dramatic. In 1990 more than two-thirds of the \$5.6 billion spent on global health assistance came from governments (see chart 1). By 2007, when total funding for health reached nearly \$22 billion, government spending still made up the lion's share. Look closer, though, and it emerges that the yeast which leavened this bread was "non-traditional" financing. In 2007 private money from firms and charities like the Gates Foundation eclipsed the total from all sources spent in 1990.

As a case of the new sort of money-raising, take UNITAID, an agency founded by France, Brazil and three other countries, which is hosted by the World Health Organisation in Geneva and calls itself a "facility" for the purchase of drugs to fight important diseases. UNITAID's main income comes from a charge on air tickets, levied by a dozen states; combined with cash contributions from other countries, this has raised \$1.5 billion in the past four years.



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This month, a private foundation linked to UNITAID will start raising money directly from the public. With help from most of the world's air-ticket issuers and internet-travel portals, passengers will be invited to give a couple of dollars, or so, to the fight against disease every time they book a flight online. UNITAID hopes that, within a few years, this plan will raise between \$600m and \$1 billion a year. If so, it will merit its name, MassiveGood.

Tiny private contributions are not just a complement to large donors, says Philippe Douste-Blazy, UNITAID's boss. In a new book*, he and a co-author argue that "building solidarity" by involving the general public will be an essential part of any successful effort to combat disease.

What else will be needed? Begging for more money will never work, argues Sir Richard Feachem, a British-born health specialist who is now a professor at the University of California. He should know: as the former boss of the Global Fund to Fight AIDS, Tuberculosis and Malaria, a big international agency, he often banged the drum for more donor money—and took flak from critics who said the fund was not transparent enough. In his view, the best way for any agency to get more money is to show that the sums it already spends are well used. He thinks that calls for clever fund-raising, cautious spending and the precise measurement of outcomes. And happily, there is progress on all three.

As well as appealing to the charity of ordinary people, agencies are finding new ways to raise money from lenders. A trail has been blazed by the GAVI alliance, a public-private partnership that funnels money towards vaccines for neglected diseases in the poor world. It has raised more than \$1 billion in short-term financing by issuing bonds backed by sovereign pledges of aid money in future years. By making a big sum available today, rather than promising a trickle over a long period, the project has helped to create the economies of scale that make widespread vaccination possible. The Global Fund also has new ideas; this year it will launch its own exchange-traded fund—based on an index of firms investing in health and development—aimed at both traditional investors and "socially responsible" ones.

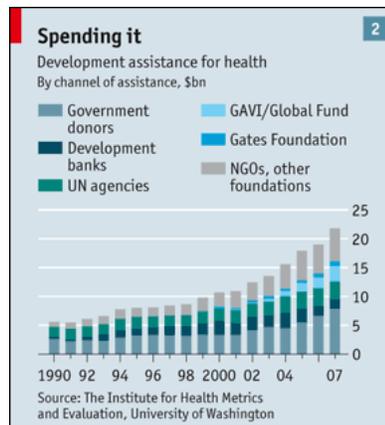
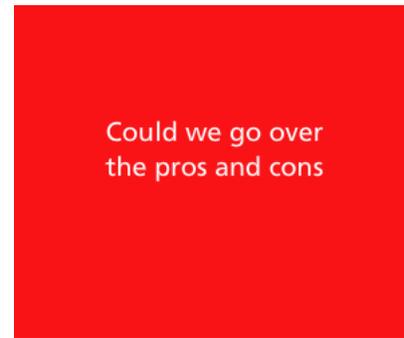
Another approach is to encourage firms to pool patents, which lowers the cost and accelerates the pace of drug development. Clever researchers at modest institutions may benefit from knowledge gained in more prestigious places. Under pressure from the WHO and anti-poverty activists, the drugs industry has started to relax its patent-protection policy. GlaxoSmithKline (GSK), a British drugs giant, said early in 2009 that it was ready to share certain patents (but not those for HIV). GSK and Pfizer, an American rival, then announced they would combine their patents for HIV into a joint research effort, called ViiV. In December UNITAID launched its own plan to create a global pool for HIV patents. The agency's board will hold a final vote on this in February; Mr Douste-Blazy expects ViiV and some other big firms to take part.

The medicine goes down

Also in the pipeline are several market-based innovations that aim to make spending more efficient. That is one result of the emergence of the new sort of agency, GAVI and the Global Fund, and NGOs and charities (see chart 2). UNITAID and the charitable foundation of Bill Clinton, a former American president, have transformed the market in treatments for children with AIDS, by aggregating demand and encouraging suppliers to cut costs and develop formulations that are easier to take. Roughly three-quarters of the children now taking AIDS medicine get their supplies thanks to these two groups.

Another idea is the Affordable Medicines Facility-Malaria (AMFm), to be rolled out by the Global Fund by mid-2010. In Africa and southeast Asia malaria parasites have grown resistant to older drugs like chloroquine. Artemisinin, a drug made from a Chinese plant, does work but the ideal formulation (an Artemisinin Combination Therapy, or ACT, which involves other drugs too) can cost \$10 a treatment—ten or more times the cost of straight artemisinin or older drugs.

The Global Fund is going to spend \$216m over two years subsidising the cost of ACT to wholesale buyers who will then supply it to ten hard-hit countries. By insisting that the benefits be passed down the supply chain, it intends to reduce the retail price to only 20 to 50 cents. The fund will spend another \$127m on marketing, training and other support for the effort. ACT is already being produced by



private firms; the hope is that a dramatic expansion of the market will lead to big economies of scale and much lower costs.

Sceptics fear that middlemen will pocket the subsidy, or that there will be leakage to other markets; some fret that 50 cents is too pricey to compete with chloroquine for people earning \$1 a day. But pilot projects suggest the new policy may work.

Yet another incentive-based approach bubbling up is Advance Market Commitments (AMC). Because the victims of most neglected diseases are poor, drugs firms cannot count on enough profitable customers to recoup their investments. The AMC mechanism offer drugs firms a huge carrot by subsidising the initial purchase of new vaccines for the poor, if they vow to sell those vaccines cheaply in future.

Here too, critics abound. Some argue that such a system could reward mediocre, rapid inventions, while penalising possibly better ones that might take longer to get to market. Some economists question the price and volume assumptions used in developing the AMCs. In the end, though, much of this information is unknowable in advance. Arguing that a successful effort could accelerate vaccination by many years, GAVI has forged ahead. Last year it launched a \$1.5 billion AMC programme to reward the first firm to find an adequate vaccine for pneumococcal disease.

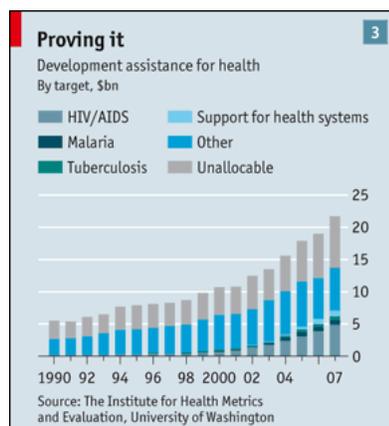
The hardest area to improve is measurement and evaluation. A lack of transparency has already led to several scandals. The Global Fund has been criticised for not checking on national-government spending. Product Red, a branding campaign cofounded by Bono, a rock singer, directs some of the cash raised by retail sales (Dell, American Express, the Gap and other big firms are members) to the Global Fund. But recently, questions were asked about how much of this money is spent on overheads.

To overcome such doubts, Mr Douste-Blazy wants the MassiveGood campaign to be more transparent. He wants online donors to be able to track their \$2 gifts right down to the pills received in a remote village. He says he is working with Google on ideas that could produce such a tracking system within two years. His co-author, Daniel Altman, a former *Economist* journalist, thinks that online monitoring, plus the network that MassiveGood has launched on Facebook, could tighten the link between donors and recipients.

Nobody opposes transparency, but some quibble with that heady vision. Prashant Yadav, a logistics specialist at Massachusetts Institute of Technology, says tracking pills may be a mistake. What if an NGO needs a lorry, or to spend money cultivating market demand for a useful drug? He thinks charities should link financing to health outcomes, rather as media firms link spending on advertising to verifiable changes in shopping behaviour.

The World Bank's Nicole Klingen advocates independent financial and technical audits; another good idea, she says, would be to simplify the hundreds of measurement and evaluation forms that donors demand from officials in poor countries. Several international bodies are working on a unified health-funding platform, to be rolled out in four or five countries this year.

Improving measurement will not be easy. Ask Christopher Murray of the University of Washington, whose team labours over an annual report on development spending on health. As Chart 3 shows, billions of dollars are impossible to allocate.



For all the new ideas, the problems of funding global health remain grave. The flurry of innovative schemes should help, both by persuading official donors that money is being spent wisely and by attracting funds from the vastly bigger pool of global private capital. But perhaps change will come only when poor countries themselves demand better ways to test the results of health spending. External funding can be a catalyst, but the developing world will have to mobilise its own money and willpower to tackle humanity's great scourges.

"Power in Numbers: UNITAID, Innovative Financing, and the Quest for Massive Good", by Philippe Douste-Blazy and Daniel Altman, Public Affairs, New York, Publication forthcoming

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