The GAVI Alliance
White paper

Building ownership and sustainability:
Country co-financing of vaccines

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Executive summary

Co-financing of vaccines is one of the ways that GAVI-eligible countries support immunisation, complementing national investments in health and immunisation systems and programmes. GAVI defines "co-financing" as *contributions by national governments to cover part of the cost of GAVI-funded vaccines.*

Country leadership and ownership are essential to enhance the long-term sustainability of immunisation programmes and to accelerate access to new vaccines. Co-financing requires a budgetary allocation for vaccines and reflects and instigates national ownership. This viewpoint informed the Alliance's initial work in 2000 around national financial sustainability plans (FSPs), as well as its 2008 decision to require vaccine co-financing by GAVI countries.

By 2010, GAVI countries were co-financing on average US$ 0.10 for every dollar they received in vaccine support. Furthermore, six countries had exceeded their co-financing requirements and were cost-sharing at a rate of US$ 0.20 for every dollar, on average.

In 2010, GAVI reviewed and revised its co-financing policy to better align with different countries' ability to pay. The objective of the revised policy is to guide the financial sustainability of vaccine programmes in those countries which are expected to "graduate" from GAVI support in the coming years, while enhancing national ownership of vaccine programmes in the lower income countries.

This policy change was informed by a fiscal space analysis that assessed the ability of GAVI countries to make budgetary resources available for immunisation over time. Combined with GAVI's focus on market shaping to decrease prices over time and GAVI's efforts to raise predictable financing, the co-financing policy is a key strategy to ensure long-term sustainability of immunisation programmes in countries receiving GAVI support.

China's Success Story

In a decade, China's vaccination programme has boosted hepatitis B coverage from 40% in the poorest regions to more than 90% nation-wide. The Government has immunised more than 11 million children in the nation's three poorest provinces alone. Continuing efforts are expected to help save some 250,000 lives each year from hepatitis B-related liver cancer and cirrhosis, and reduce the future global burden of hepatitis B and related liver cancer by 40%.

The breakthrough was the result of a five-year US$ 76 million project initiated in 2002, co-funded equally by the Government of China and the GAVI Alliance, and targeting initially the country's poorest and most remote provinces with free hepatitis B vaccines. In 2005, China's Ministry of Health designated hepatitis B as one of four high priority diseases for national control and developed a national hepatitis B control plan for 2006-2010, with the goal of reducing the hepatitis B carrier rate from 10% to 1% in immunised cohorts of children.

Today these achievements are being sustained without GAVI financial support, an example of a successful partnership and transition from co-financing to national sustainability in a country with rising GDP that is now a GAVI "graduate".

Fiscal space analysis

In 2010, GAVI supported a detailed fiscal space analysis to assess the affordability of its vaccine portfolio and inform the review of its co-financing policy and levels. The analysis allowed GAVI to address whether new vaccines are affordable in GAVI-eligible countries[1].

GAVI-eligible countries span a large income range, and while some GAVI-eligible countries enjoyed rapid growth in real GDP per capita from 2000 to 2008, others stagnated or suffered declines. GAVI-eligible countries also have large variations in public spending on health. With average per capita public spending on health ranging from US$ 9.6 to US$ 107.4, and with health's share of total government spending varied from 8% to slightly over 10% in 2008 (across three country groupings as illustrated in Table 1), there are very large differences in the ability to pay for new vaccines across GAVI-eligible countries, with low-income countries the most unable to assume new vaccine financing.

Table 1: Key indicators for GAVI eligible countries

2009 GNI per capita US$	Number of countries	Birth cohort, 2009	Average per capita public spending on health, 2008	Health as share of govt spending, 2008	Annual real growth public spending on health
< 500	18	15.4	US$ 9.6	10.4%	10.6%
500-999	18	11.5	20.0	9.7%	8.9%
1000-1499	15	17.9	35.9	9.1%	6.8%
1500+	16	6.9	107.4	8.7%	13.0%

There are no generally accepted benchmarks for the share of public spending on health that a country might be able to eventually afford to spend on vaccines. However, preliminary data from selected countries in Latin America show that for non-GAVI eligible countries which are largely early adopters of new vaccines, vaccines generally account for less than 1% of public spending on health. Of the countries examined, the highest share is 1.8%. In 2009, Latin American countries (excluding GAVI-supported countries) financed 98% of their national immunisation costs from national funds. The share of the national budget that Latin American countries spend on vaccines is one indicator of the percentage of national budgets that countries with strong commitment to immunisation could spend on vaccines.

Using the benchmark of vaccines costing 1% of public spending on health, it is clear than on average, GAVI-eligible countries with incomes below US$ 1,000 per capita cannot afford to bear the full cost of the life-saving vaccines they are planning to adopt in the coming years and will require sustained support. For countries with incomes between US$ 1,000 and US$ 1,500 per capita, assuming the full costs would put many of them at the outer limit of the benchmark. On the other hand, for GAVI countries with incomes above US$ 1,500 per capita poised to "graduate", it appears that paying for the full set of vaccines would be affordable for nearly all of them. This bolsters GAVI's view that "graduating" countries should be able to move to financial self-sufficiency.

[1] See Annex 1: Fiscal space analysis

In summary, financial sustainability is within reach for countries with growing GDP which will soon "graduate" from GAVI support, while in contrast for the least developed countries, self-sufficiency needs to be a longer-term goal.

GAVI's revised co-financing policy

Based on the analysis described above, and recognising the need to enhance country ownership of vaccine financing, GAVI identified three groupings for GAVI-funded countries and assigned them different priorities and levels of co-financing. This is because GAVI's policy recognises that the time frame for attaining financial sustainability will vary across countries.

- **Graduating countries (16):** the objective of co-financing is to quickly prepare these countries for financial sustainability after GAVI support ends. These countries have experienced growth and are now above the eligibility threshold of US$ 1500 of GNI per capita (2009 US$). As GAVI support is ending they will be required to steadily increase co-financing contributions to cover the full cost of vaccines by 2016.
- **Intermediate countries (33):** the aim is to prepare these countries for eventual graduation from GAVI support. Their GNI per capita ranges between US$ 1000 and US$ 1500 (2009 US$). They are requested to co-finance US$ 0.20 per dose the first year and increase this by 15% each year afterwards.
- **Low-income countries (18):** for these countries, co-financing aims to reinforce national ownership of immunisation financing, as self-sufficiency is a much longer-term goal. Low-income countries are defined using the World Bank threshold with GNI per capita below US$ 995 (2009 US$). They are requested to co-finance US$ 0.20 per dose.

The revised co-financing policy sets ambitious goals for recipient countries and the GAVI Alliance. Low-income countries are requested to co-finance to ensure national ownership. Intermediate countries will raise their share of the cost of the new vaccines each year. Graduating countries will need to almost double their contributions each year in order to phase out GAVI support by 2016. The fiscal space analysis noted above shows that for most countries this is an achievable, albeit ambitious, goal.

Immunisation and health financing dialogue

In its first decade, the GAVI Alliance built solid foundations to advance the financial sustainability of immunisation programmes in close partnership with countries. During its first five years, the Alliance's partners worked intensively to develop tools and guidelines, as well as to build the capacity of immunisation staff at country-level. In the second phase, with the introduction of a modest co-financing policy, GAVI helped improve country ownership of decisions to introduce new vaccines and increase funding for immunisation.

To deliver on its more ambitious co-financing policy and to advance the financial sustainability of immunisation and new vaccines programmes, the GAVI Alliance needs to actively engage in policy discussions with ministries of health and of finance, as well as others such as parliamentarians and civil society. Political leadership will be critical.

Considering the difficult policy decisions that low-income countries face, these conversations must be framed by the broader health financing agenda. This is particularly critical in light of

the need to scale-up efforts to achieve the Millennium Development Goals. A variety of stakeholders, including but not limited to national institutions, are involved. The national dialogue on health financing is essential to ensure the coherence and sustainability of vaccine investments.

National dialogues should be supported by international partners whose influence on the medium-term health financing picture can be significant. In this spirit, GAVI affirms the principle of country ownership of immunisation decisions, and is driving efforts to harmonise health system funding through the Health Systems Funding Platform, working with the Global Fund to fight AIDS, Tuberculosis and Malaria, the World Bank and the World Health Organization.

Conversations with health and economic leaders of developing countries are likely to centre on the demonstrated cost-effectiveness of immunisation as well as the wider health benefits derived from vaccine investments. At the same time, the GAVI Alliance will need to further shape markets to deliver lower vaccine prices, a key factor in accelerating affordability. GAVI must also demonstrate and secure enhanced, predictable support while continuing to strengthen its strong partnership with countries. These goals form the pillars of the GAVI Alliance 2011-2015 Strategy.

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See also: The GAVI Alliance co-financing policy:

http://www.gavialliance.org/vision/programme_policies/cofinancing_policy/

Annex 1: Fiscal space analysis

All current GAVI-eligible countries were included in the analysis with the exception of Somalia, Eritrea, the Democratic Republic of Korea and Zimbabwe due to data availability limitations. India was also not included because it is a very large country with small GAVI support relative to its size. A variety of data sources were used, including the WHO National Health Accounts (NHA) database, World Bank economic data and projections, as well as GAVI's vaccine demand and price projections.

National ability to sustain immunisation programmes after the end of GAVI support was measured as the ratio of projected total fully-loaded vaccine costs to total projected public spending on health, including the fully-loaded costs of traditional vaccines that the national vaccination programme provides routinely without GAVI support[2]. The analysis did not include other costs of immunisation programmes such as human resources and cold chain operation. Finally, the analysis focused on routine immunisation and did not include vaccines delivered through campaigns.

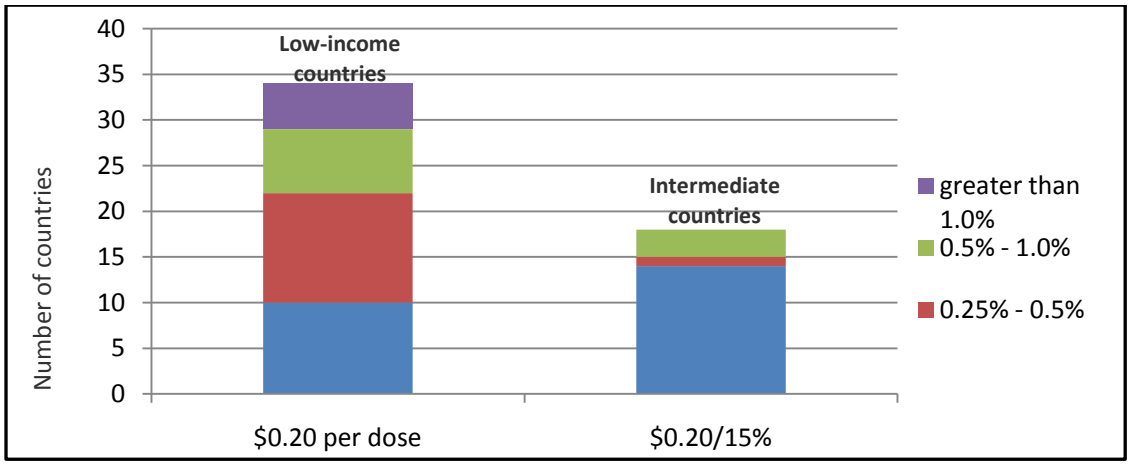
Previous work on fiscal space for the health sector suggests a strong correlation between economic growth per capita and increases in public spending per capita on health[3]. GAVI's analysis confirms this strong relationship. On the strength of this, projected GDP per capita growth rates from the World Bank were applied to recently updated NHA data, yielding projections of general government health expenditures per capita through 2020.

Two scenarios for future general government health expenditures per capita were modelled. In the first scenario, public spending on health per capita was projected to grow at the same rate as GDP per capita. The second, more optimistic scenario, was inspired by the 2001 Abuja Declaration committing African Heads of State to gradually increase the share of government spending for health to 15%. For countries now below 15%, this scenario accelerated growth by an additional 5% a year until the 15% level was reached; thereafter, subsequent growth in public spending on health per capita was linked solely to GDP growth per capita.

Low-income countries are requested to pay US$ 0.20 per dose and intermediate countries to increase from that level by 15% each year. At these levels, over 60% of low-income and intermediate countries would be required to spend up to 0.5% of their health budgets in co-financing, which could be considered a reasonable amount for most countries. However, five low-income countries will face a more challenging prospect to co-finance as they will need to spend more than 1% on co-financing.

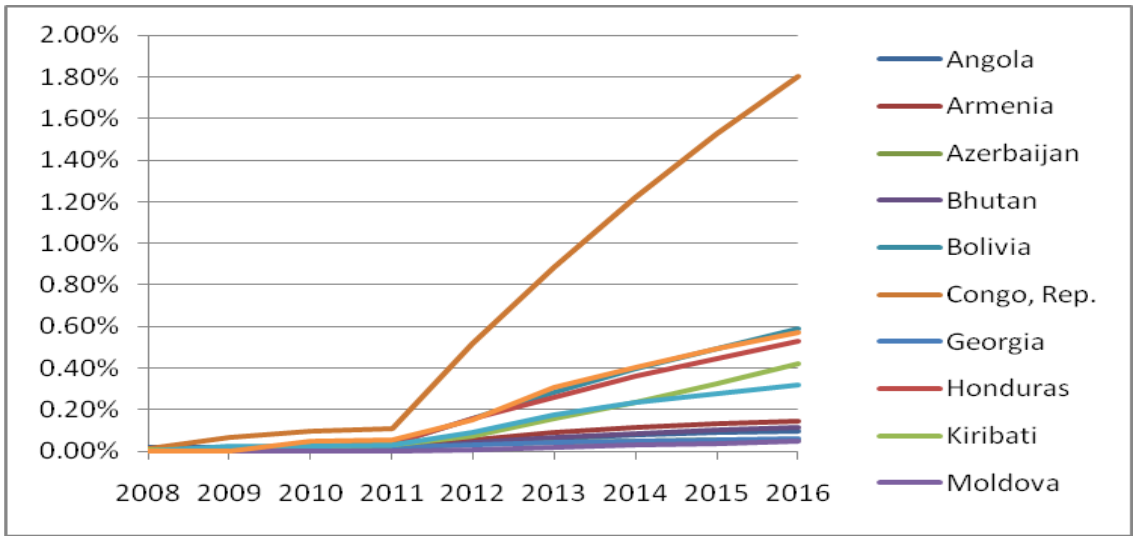
[2] In most countries this includes BCG (tuberculosis), oral polio and measles, as in many countries DTP3 (diphtheria-tetanus-pertussis) is included in the pentavalent vaccine that GAVI supports.
[3] Tandon A, Cashin C. Assessing public expenditure on health from a fiscal space perspective [Internet]. HNP Discussion Paper. Washington, DC: WBG. 2010 Feb [cited 2011 Mar 15]. Available from: http://bit.ly/acGo2t

Figure 2: Projected 2015 co-financing as percentage of public spending on health for low-income and intermediate countries



For graduating countries, co-financing is designed as a steady ramp-up to reach the full cost of vaccines to put them on the path to reach financial sustainability in 2016. This rapid rise in co-financing is also considered reasonable for almost of all of the graduating countries. As illustrated in Fig. 3, all countries except one (the Democratic Republic of the Congo) would have to spend up to 0.5% of their health budgets in co-financing and 0.8% in 2016, the year that they are expected to assume full financial responsibility for vaccine purchases.

Figure 3: Projected co-financing as percentage of public spending on health for graduating countries to 2016



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