

## Financing needs

The Stop TB Partnership is just beginning work on a comprehensive Global Plan to Stop TB II (2006–2015). Updated figures for the resources needed to achieve the target for tuberculosis (TB) in line with the recommendations of this report will be provided as part of developing this Global Plan. Having an integrated plan and budget is critical to guide donors and the global TB community on overall financing needs to control TB worldwide.

### **Why more resources are needed**

The 2004 “Progress Report on the First Global Plan to Stop TB” estimates an annual resource gap between what is needed and what is available of at least \$1 billion for global TB control and new tool development (Stop TB Partnership/WHO 2004c). These estimates were made with reference to a particular set of control targets to cover the basic essential needs. However, this report of the UN Millennium Project Working Group on TB advocates that countries adopt comprehensive TB control with mainstreamed TB/HIV and DOTS-Plus interventions. This means that the cost of TB control cannot avoid increasing, and the \$1 billion gap will underestimate resource requirements.

For DOTS expansion, cost estimates in the 2004 progress report focused on reaching the global target of detecting 70 percent of sputum smear-positive cases and successfully treating 85 percent of those detected. Although the estimates included treatment for new smear-negative and extrapulmonary cases as well, they do not allow for the costs of detecting and treating all cases.

For TB/HIV collaborative activities, earlier cost estimates were initially limited to just 12 countries and were made prior to greatly expanded plans to scale up AIDS testing and treatment, notably delivery of antiretroviral treatment. Recent provisional estimates for an expanded set of TB/HIV collabora-

**The Global Drug Facility has been remarkably effective**

tive activities suggest that costs will be at least double those projected in the original Global Plan, largely because of including antiretroviral treatment.<sup>1</sup>

In addition, significantly increased resources will be needed in the future to address the growing epidemic of MDR-TB, particularly as better methods to detect people with MDR-TB become available. Current estimates in the Global Plan Progress Report would cover just 10 percent of MDR-TB patients. The cost of drugs remains high. Even drugs obtained through the Green Light Committee cost up to \$1,000 per treatment, and without committee approval, the cost can be \$10,000–\$15,000.

TB high-burden countries, particularly the wealthier developing countries, currently shoulder most of the costs for DOTS expansion through national budgetary allocations or borrowings from the World Bank. A number of these countries have the capacity to provide additional resources to expand TB efforts. Funds allocated in the national budgets of high-burden countries for TB control programs are important indicators of political commitment.

Poorer high-burden nations are more likely to need external funding to supply a larger proportion of their national TB control efforts, especially as DOTS efforts are scaled up. In addition, the original Global Plan to Stop TB found that only a small portion of the costs for scaling up TB/HIV activities and treating MDR-TB were borne by national governments. Increased donor support is vital for expanding scale-up efforts and for accelerating new tool development.

About the critical issue of drug supply, the Global Drug Facility (GDF) has been shown by evaluations to be a remarkably effective mechanism for providing countries with supplies of high-quality, low-cost first-line drugs. Yet, despite its success in filling the drug gap, the GDF is facing a funding shortfall in 2004 and 2005. Overall, annual GDF spending was \$20.4 million cumulatively for its first two years of operation (2001 and 2002) and \$15.6 million in 2003. For 2004, the GDF projects a need of \$29.7 million and \$43.2 million in 2005 just to meet existing commitments and support its operation. Of the projected needs for 2004 and 2005, the GDF is facing a funding gap of \$13.6 million in 2004 and \$26.2 million in 2005. Ideally, the GDF needs \$50 million annually to approve new applications and award additional grants to countries in need.

The Green Light Committee, which addresses the gap for second-line drugs to treat MDR-TB using the DOTS-Plus strategy, has so far provided treatment to 4,500 multidrug-resistant patients, yet this covers less than 2 percent of the annual number of new MDR-TB cases estimated worldwide. Without greater priority to support the Green Light Committee and DOTS-Plus programs, the burden of MDR-TB will remain large and treatment will be much more expensive than necessary.

***Research and development***

The costs of research and development of new tools for 2004 and 2005 are estimated to be around \$210 million per year, compared with estimated TB

**Roughly \$150 million in R&D costs over five years is needed to develop new diagnostic tools**

treatment costs of almost \$4 billion worldwide annually. The R&D costs cover a broad range of activities, from basic research to registration, undertaken by a wide array of institutions. The majority of the costs is expected to be borne by the private-public partnerships (FIND, TB Alliance, and AREAS) as they take the lead in developing a core portfolio and catalyzing the global pipeline of diagnostics, drugs, and vaccines.

***New diagnostics***

The Global Plan to Stop TB 2001–2005 estimated a need of roughly \$150 million in R&D costs over five years to develop new diagnostic tools. Costs for 2004 and 2005 are estimated at around \$30 million per year.

***New drug development***

The Global Plan to Stop TB estimated the costs of drug development activities over five years to be close to \$350 million, as the first phase of an undertaking projected to last at least a decade. The total current funding gap is \$112 million for 2004 and 2005.

***Tuberculosis vaccine development***

The Global Plan to Stop TB projected \$420 million over five years in TB vaccine R&D costs. Costs for 2004 and 2005 are roughly estimated at \$100 million per year. These costs include approximately \$40 million each year to maintain current levels of preclinical research and a similar amount to maintain Phase I and II trials for five candidate vaccines. The remaining \$20 million per year is required to build capacity for Phase III trials for successful vaccine candidates.

Annual external aid for TB control in developing countries stood at \$210 million in 2002 (an increase from \$16 million in 1990 and \$40–\$50 million in 1995). Substantial new funding has become available since mid-2002, principally from increased investments from the Global Fund to Fight AIDS, Tuberculosis, and Malaria and from donors—including new World Bank loans for China and Russia, and greatly increased support for TB control from the United States Agency for International Development, the Canadian International Development Agency, and the U.K. Department for International Development. Additional resources from donors will be essential in order to fill the funding gap for treatment, especially in poorer countries, and for R&D.

Since its inception in 2001, the GFATM has made substantial funding contributions to TB control. By the end of 2003, the fund had approved a total five-year budget of \$608 million for TB proposals, and a further \$319 million for combined TB/HIV proposals. The projected outcomes from GFATM-approved programs over five years are an additional 3.5 million TB cases being treated under DOTS and 12,000 new DOTS-Plus treatments for MDR-TB.

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High-burden TB countries are the main beneficiaries; only three (Brazil, Nigeria, and Zimbabwe) have not received GFATM awards.<sup>2</sup>

The GFATM is a critically important new funder of TB control. However, although GFATM funding has filled some shortfalls in national TB program finances, it has still not increased commensurate with need and opportunity, and it is still an underused resource. Furthermore, the GFATM is itself facing severe resource constraints because of underfunding by external donors and may be unable to award new grants in 2005 and beyond.

On the implementation side, the case study on achieving the TB target in Kenya undertaken for this report found that disbursement of funds by the GFATM has been slow. From Kenya's first two-year grant of \$4.9 million, to date only an initial disbursement of \$839,416, in August 2003, has been made. Similar delays have been experienced in other countries, such as Bangladesh, Indonesia, and Myanmar. This has important consequences, as delays in disbursement are likely to hinder the implementation of proposed activities needed to reverse the trend in TB incidence.

### **Estimate of general health system requirements**

More generally, the 2001 Commission on Macroeconomics and Health estimated global funding needs for general health infrastructure and the necessary improvements to provide the essential package of care with full population access (CMH 2001). The estimated additional annual financing needed to deliver the essential package of care in 83 poor countries is \$57 billion in 2007 and \$94 billion in 2015. This includes both the costs of disease-specific activities and the costs of strengthening health systems to deliver these at scale. Clearly, achieving global targets for health, including TB targets, requires investment in the general health infrastructure as well as in disease-specific activities. Those concerned with TB control must join forces with those concerned with delivering the overall essential package of care to demand the necessary investments in general health infrastructure improvements.

### **Recommendations**

- The UN Millennium Project Working Group on TB endorses the recommendation of the WHO Executive Board to the 2005 World Health Assembly, encouraging all countries to fulfill their commitment to ensure the availability of sufficient domestic resources and of sufficient external resources to achieve the 2015 Millennium Development Goals target relevant to TB.
- Updated figures for the resources required to achieve the target in line with the recommendations of this report should be provided as part of developing the Global Plan to Stop TB II, 2006–2015. These estimates should be used to advocate for increased levels of funding for TB con-

trol and new tools research and development that are commensurate with the global burden of TB and will provide the full resources needed to reverse this epidemic.

- Adequate GFATM funding and increased GFATM support for TB and TB/HIV efforts need to be ensured.
- Technical support is needed to develop and implement GFATM-financed projects and programs supported by other sources of finance.
- Additional investment for the private-public research partnerships should be catalyzed, including investment from national governments and other sources.
- It will be important to ensure that funding for TB control becomes more predictable and that any new financing mechanisms, such as the GFATM, are truly additional to existing resources.