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In need of a new source of funds

By Andrew Jack
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With the approach of the management consultant he once was, Ernest Darkoh sketches out an organisational diagram of a network linking private doctors, a mail order pharmacy, a laboratory and a disease management group in order to bring antiretroviral therapy to hundreds of South African patients.

Over the past two years, BroadReach Healthcare, the company he founded, has run a programme called ARVCare that is extending treatment into rural areas beyond the reach of the government's programme at a cost he believes could be equivalent to or lower than that incurred by the state once it reaches greater scale. "We have 8,000 private doctors in South Africa with greater access to the community, so why not use them?" he says.

Mr Darkoh trained as a chemist, doctor and public health specialist before joining McKinsey and running the Botswana government's HIV treatment programme. He is one of a growing number of advocates of bringing private sector funds, skills and methods into health. "Why do we keep budgeting for $200m when we know it will cost $2bn, and are then surprised when it doesn't work?" he asks. "Successful models don't go around looking for the cheapest talent. If you budget for a third of a programme, you get less than a third of the results. We need to be brutally results-oriented."

Much debate has focused on a "funding gap" to meet needs estimated at more than $22bn for Aids prevention and treatment in the developing world by 2008 - nearly three times the current level of resources. Mobilising the private sector could raise new resources and better use existing ones. Despite the shortfall, financing for Aids has risen strongly in recent years. In 1996, UNAids estimated total resources - from donors, domestic sources and international groups -- were less than $300m. By 2005, they had risen beyond $8bn. That still leaves a large deficit if there is any hope of achieving the G8's aim of close to universal access to treatment by 2010.

The Global Fund to fight Aids, TB and Malaria, which alone has generated pledges from donors of $10bn in the past five years, has recently pushed ahead with a new $850m round of projects.

It is seeking new sources of government funding, including from the oil-rich states of the Middle East. It is also beginning to diversify into other areas. It won a $500m contribution from the Bill & Melinda Gates Foundation this year, and could usefully benefit from lifting its ban on in-kind donations, which offer a way for the private sector to give much more than it has to date.

It has received the first $10m earmarked for work with women and children with HIV in Africa from Product Red, the campaign through which companies, including American Express, Motorola, Armani and Gap, pledge a percentage of the profits from a special range of consumer products and services. The Wrld Bank's MAP programme for Africa, and loans and grants in other parts of the world, have provided more than $2.5bn for HIV/Aids. Bilateral support has risen too, most

notably from President George W. Bush's Pepfar programme which has earmarked $15bn to be spent during 2003-2008.

In addition, Unitaid, the new French-led international drug purchase facility, is just beginning operations. It is set to raise more than $400m a year from more than 19 countries that have pledged support, a number through an airline tax.

But for HIV programmes to reach a new scale, there is still a need for many of the most affected countries to do more for themselves. Examples include India, which spends little on health in the public sector, and much less still on HIV/Aids in particular. Some argue in favour of tapping into patients' finances too, through "co-payments" to complement national health schemes, notably in middle income countries such as Brazil where the relatively rich can benefit from free treatment.

"At some levels it seems tragic to ask someone with a debilitating disease to pay, but every little bit helps," says Shanta Devarajan from the World Bank.

"It can improve buy-in and there is a private good that should be worth something." Private health schemes deserve more attention. While many reject HIV positive people or charge them more for treatment, broad enough insurance systems would reduce the cost.

In Botswana, for instance, Associated Fund Administrators has offered cover without discrimination since 1990, and has found the costs of treating the 6,500 of its 165,000 clients with HIV manageable on a typical monthly premium of £60.

Kabelo Edineng, its managing director, says: "Doing nothing wasn't an option for us, so we took the risk. We predicted the pharmaceutical companies couldn't justify high prices on their drugs, so the price would come down over time. The cost is not as great as people thought."

Patients in many countries ultimately end up paying - either because they prefer the speed, and comfort of private health, or because they are forced in any case to pay bribes to gain access to a nominally public sector clinic. Failing to recognise, use and improve such systems for healthcare would be to neglect an important tactic in the fight against Aids.

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