

Financing tuberculosis control: promising trends and remaining challenges



The financing of essential health services for the world's poor is changing. Development assistance to health (DAH) seems to be flat-lining, and use of domestic resources and value for money are increasingly emphasised.^{1,2} Many development agencies are re-examining thematic and geographic priorities and implementing new cofinancing agreements. The Global Fund to Fight AIDS, Tuberculosis and Malaria, for example, now requires 5–60% counterpart financing, depending on a country's income.³ Ensuring that scarce development funds flow at a sufficient scale to effective interventions that serve people who need them most remains a challenge.

Much previous work highlights the rapid increases in DAH in the past decade,⁴ but in *The Lancet Global Health*, Katherine Floyd and colleagues⁵ report that, in the case of tuberculosis, growth in domestic financing has been equally impressive. Their findings are convincing, especially in view of the fact that their study might underestimate domestic contributions because some health systems expenditures and costs incurred by patients outside formal tuberculosis services are excluded. Domestic funding for tuberculosis increased by more than 160% in 9 years to reach US\$3.9 billion in 2011, driven mostly by Brazil, Russia, India, China, and South Africa (BRICS), which, in 2011, paid for more than 95% of their yearly tuberculosis bills. UNAIDS reports a similar trend in HIV spending—BRICS increased domestic expenditure by more than 120% between 2006 and 2011, and now fund more than 75% of their HIV responses.⁶ These findings are important and support the reorientation of DAH towards the poorest countries, although much work remains to be done to reduce the costs of tuberculosis borne by poor patients and their families in middle-income countries.⁷

This encouraging global picture needs to be balanced with the substantial resource gap that remains (mainly in low-income countries). Floyd and colleagues estimate that an additional \$1.6–2.3 billion of DAH a year is needed for a comprehensive global response to the tuberculosis epidemic, and even this amount might be an underestimate. Countries might not be able to expand health expenditure at the same pace as general

government expenditure, and much of the domestic contribution to tuberculosis services is funding for general health services. Core health systems can take time to expand because of investment constraints, such as the time needed to train new health workers. Furthermore, although costs might be reduced as coverage expands (economies of scale), detection of cases of tuberculosis that are not being reached through the health system and incorporation of new technologies might increase costs. Finally, increasing DAH could substitute for and reduce domestic funding.⁸ Floyd and colleagues' data suggest that, in low-income and lower-middle-income countries, domestic funding as a proportion of total funding fell by 6–10%, supporting the need for cofinancing agreements in the future.

The investment case for tuberculosis control is as sound as ever. The foundations are strong. Floyd and coworkers' findings emphasise that tuberculosis services are highly cost-effective, not only in trial settings, but also on a global scale. At a cost as low as \$100 per patient successfully treated in high-burden countries, tuberculosis control remains as good value as ever. However, for a disease that still causes more than 1.2 million deaths every year, funding for tuberculosis fares badly compared with the \$16.8 billion spent on HIV/AIDS, which caused 1.47 million deaths in 2011.^{6,9} Global and national institutions working in tuberculosis therefore have much to do to ensure that DAH is allocated on the basis of the best available evidence for cost-effectiveness. Making the case for further expansion of treatment for multidrug-resistant tuberculosis and more intensive screening will not necessarily be easy. Although both might be cost effective, arguing for more resources to expand the the package of tuberculosis services will be challenging for countries struggling to ensure effective case detection and DOTS coverage.

Lessons can be learned from work in HIV, in which increased attention is focused on the potential benefits of releasing additional funding for service delivery through increased efficiency.¹⁰ Floyd and colleagues suggest that tuberculosis costs are driven mainly by country income level and caseload. However, within

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countries, cost variation in health services can be substantial,¹¹ yet little is known about the extent of inefficiency within tuberculosis services. Furthermore, in the future, new, shorter drugs regimens, if proven efficacious and appropriately priced, could reduce costs to both the health system and patients. Although Floyd and colleagues should be congratulated for their succinct summary of the financing of tuberculosis control, much work remains to ensure that poor people no longer have to bear both the economic and health burden of this preventable and treatable disease.

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