

Financing the scale-up of MDR-TB prevention and treatment *in the 27 high MDR-TB burden countries*

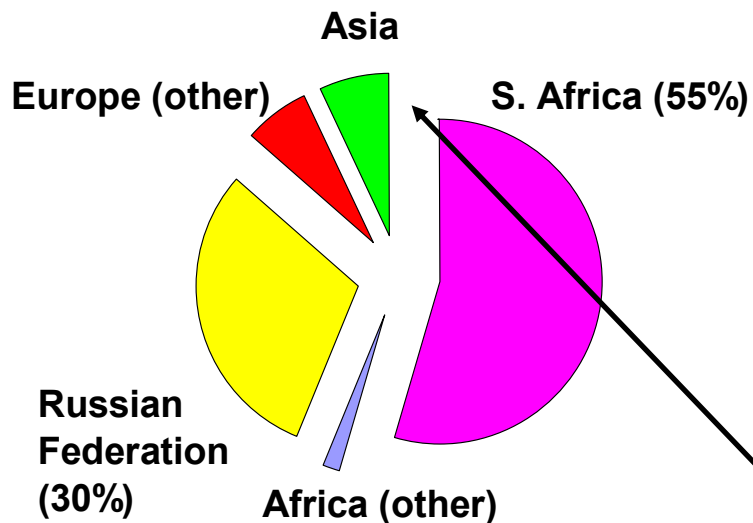
Katherine Floyd, Stop TB Department, WHO
*with thanks especially to Andrea Pantoja, Karin Weyer and
Matteo Zignol*

**Ministerial meeting, high M/XDR-TB burden countries
Beijing, China
April 1–3, 2009**

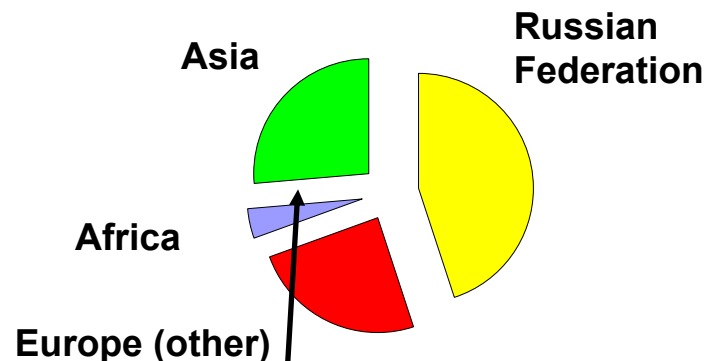
1. Budgets and funding for MDR-TB in 2009, as reported by countries

MDR-TB budgets and funding, 2009

Budgets, 2009 (total US\$ 438 million)



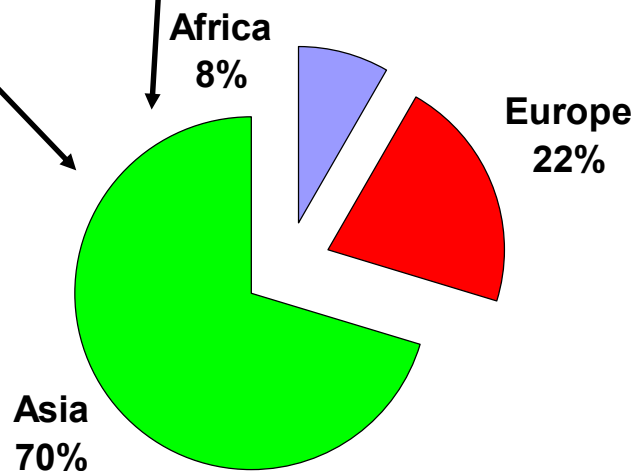
Funding, 2009 (total US\$ 72 million)



Patients to be treated = 20,000

< 5% of estimated total of 435,000 cases

Estimated cases, 2007 (total 435,000)

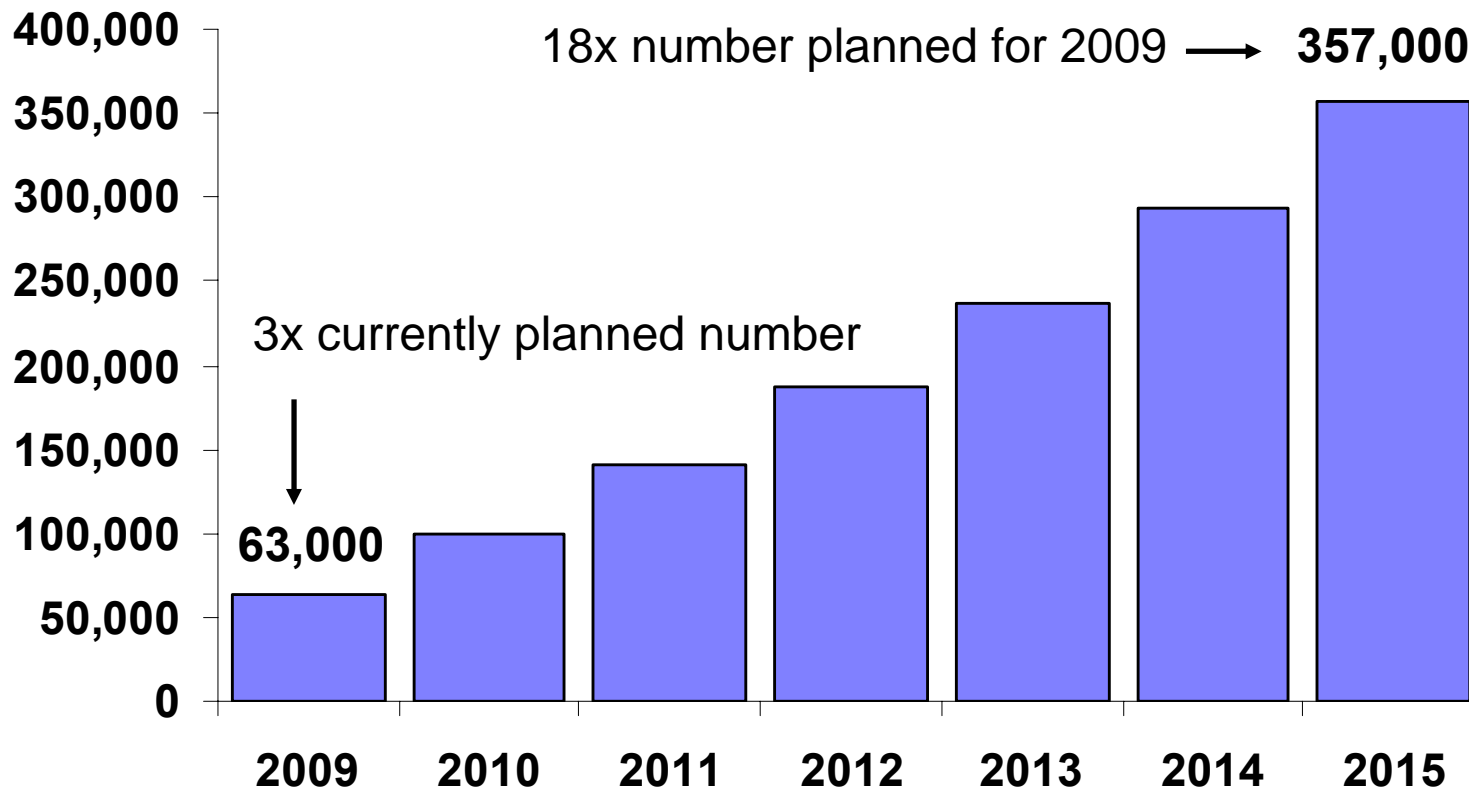


Source: WHO TB database

2. Global Plan projections of funding required for MDR-TB, 2009–2015

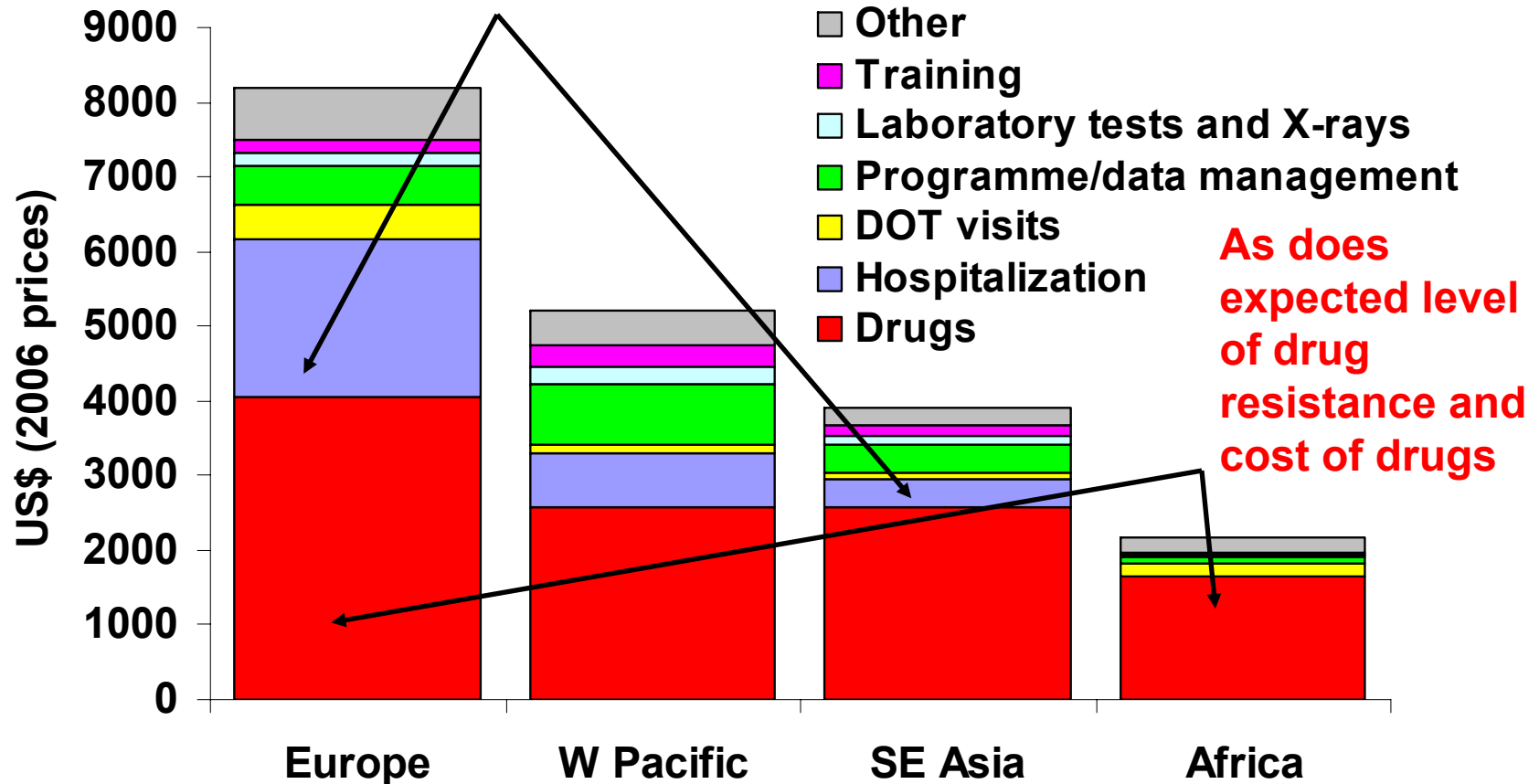
Number of patients to be treated

Target: to treat 80% of smear and/or culture-positive MDR-TB cases by 2015
Total patients treated over 7 years = 1.4 million



Cost per patient treated

N.B. "model of care" has major impact on treatment costs

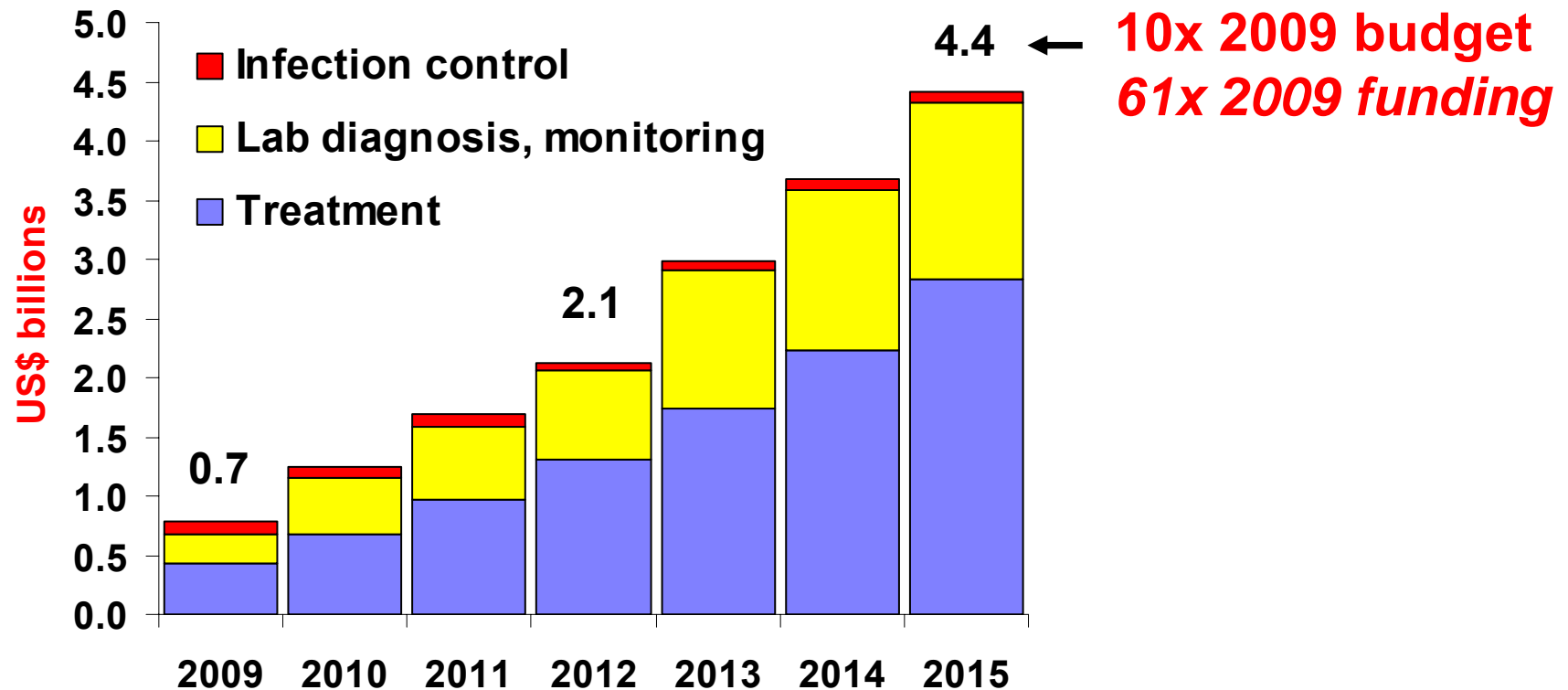


Costs estimated from detailed costing studies in Tomsk (Russia), Estonia, the Philippines and Peru, adjusted for pattern of drug resistance, country income level, anticipated use of hospitalization

Laboratory tests + infection control

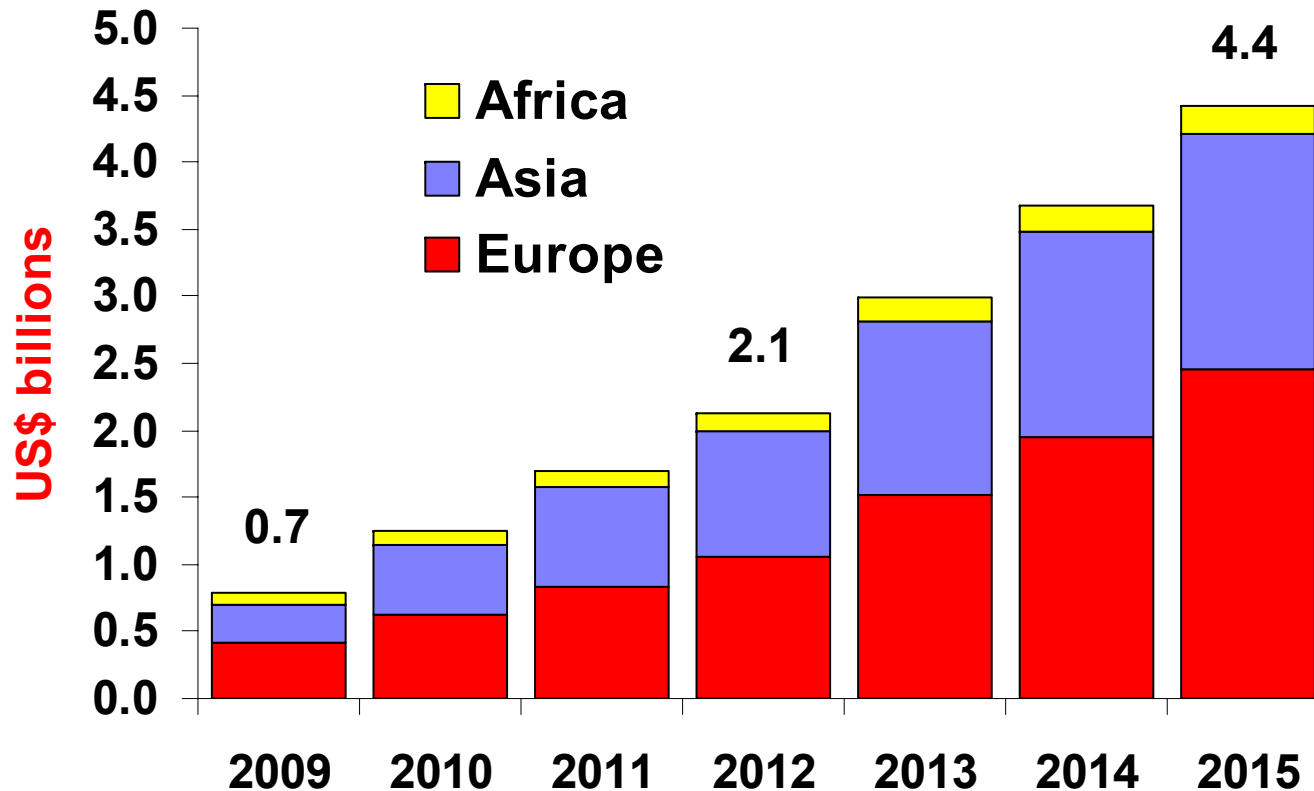
1. Laboratory costs assume average of 5 MDR suspects tested for every diagnosed MDR case, plus phasing in of liquid culture and line probe assays
 - ◆ Ratio of 5:1 will vary by country, depending on policy for screening cases for MDR-TB
2. Infection control costs are for facilities treating ≥ 10 MDR cases per year

Funding required, 2009–2015



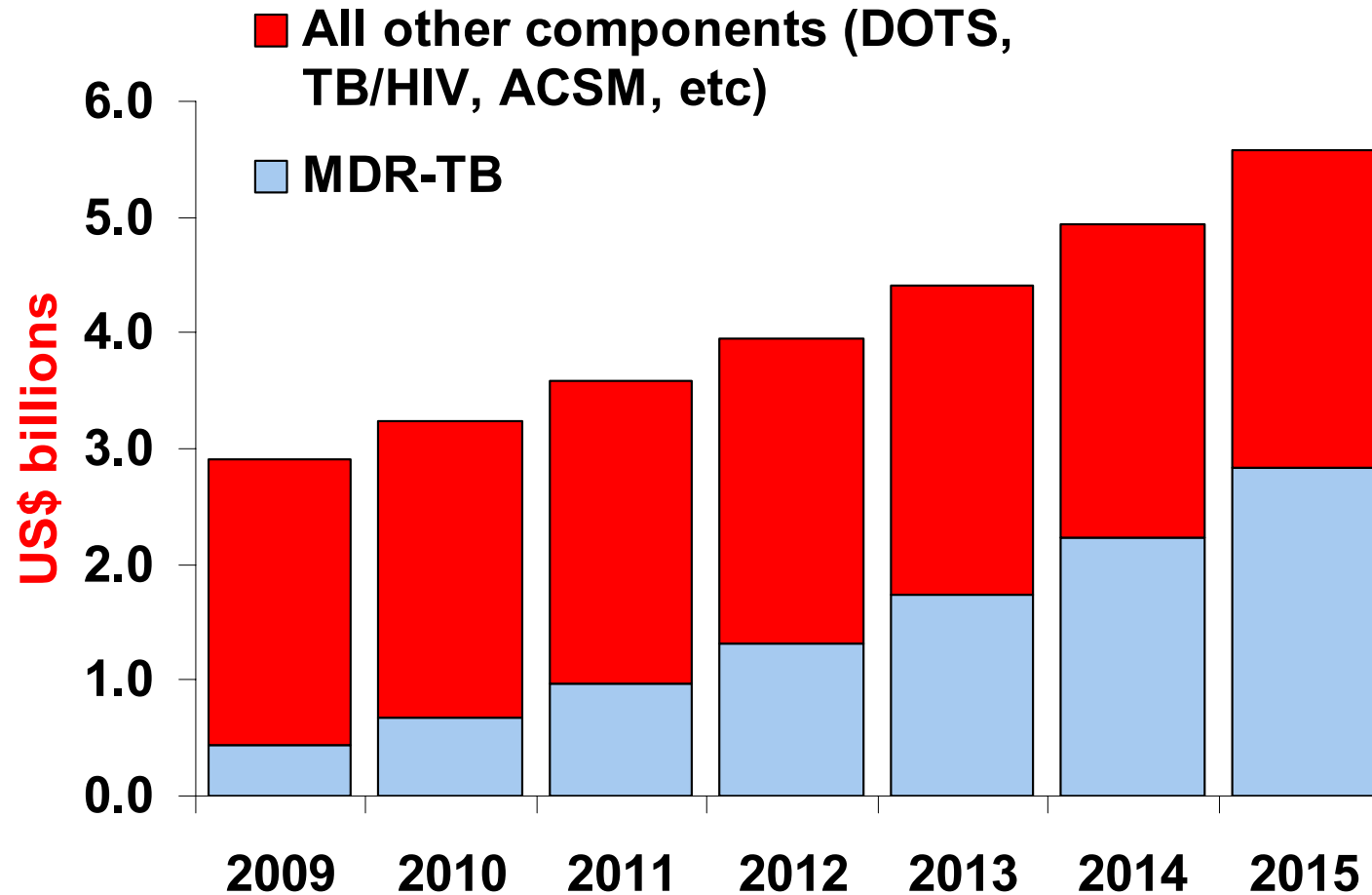
Total US\$16.9 billion over 7 years, average US\$2.4 billion per year
Much higher than existing budgets and funding

Funding required by region



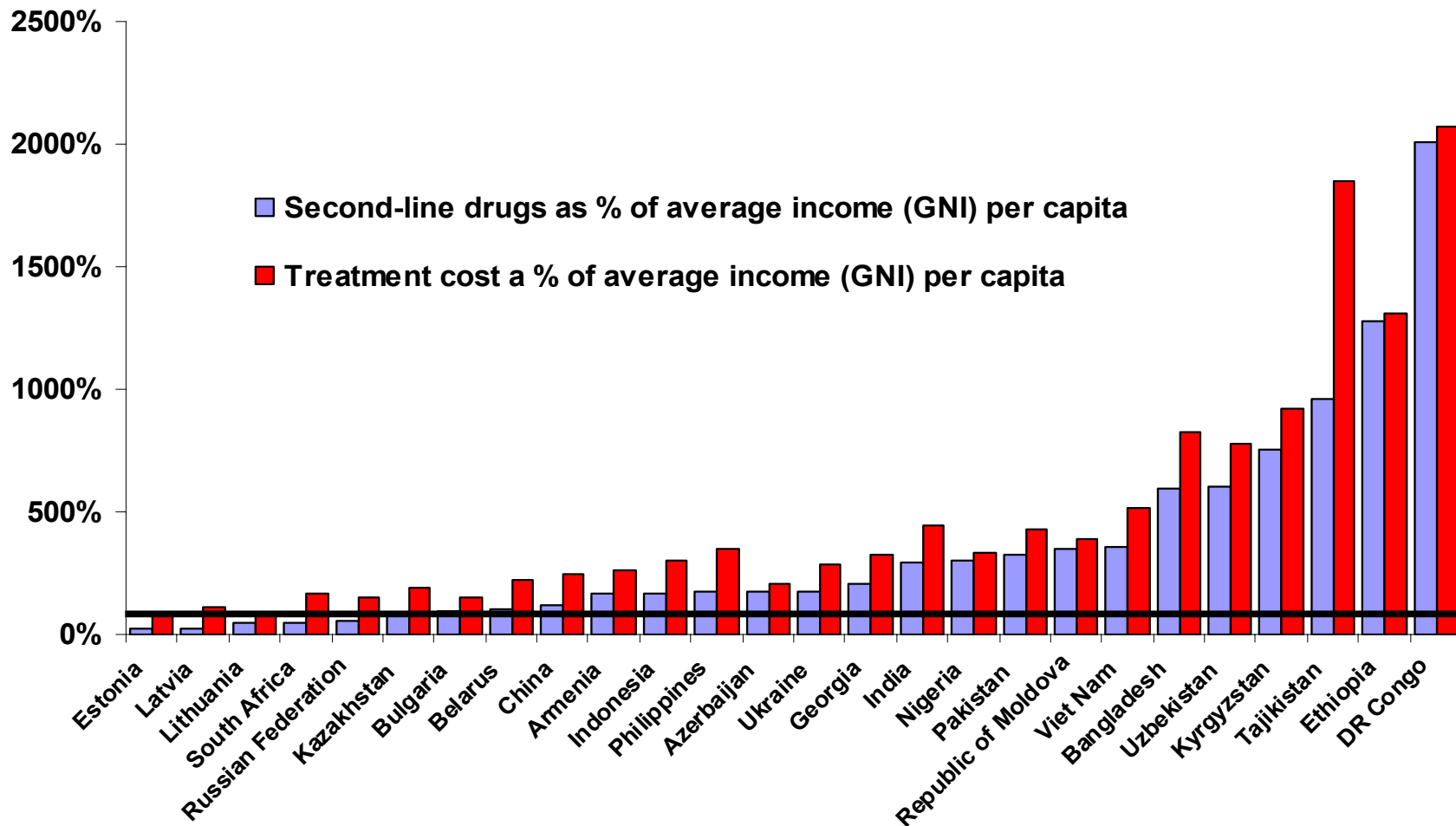
Most of the funding required is in Europe (total US\$8.9 billion), followed by Asia (US\$7.1 billion, mostly in China and India)

Funding requirements in context



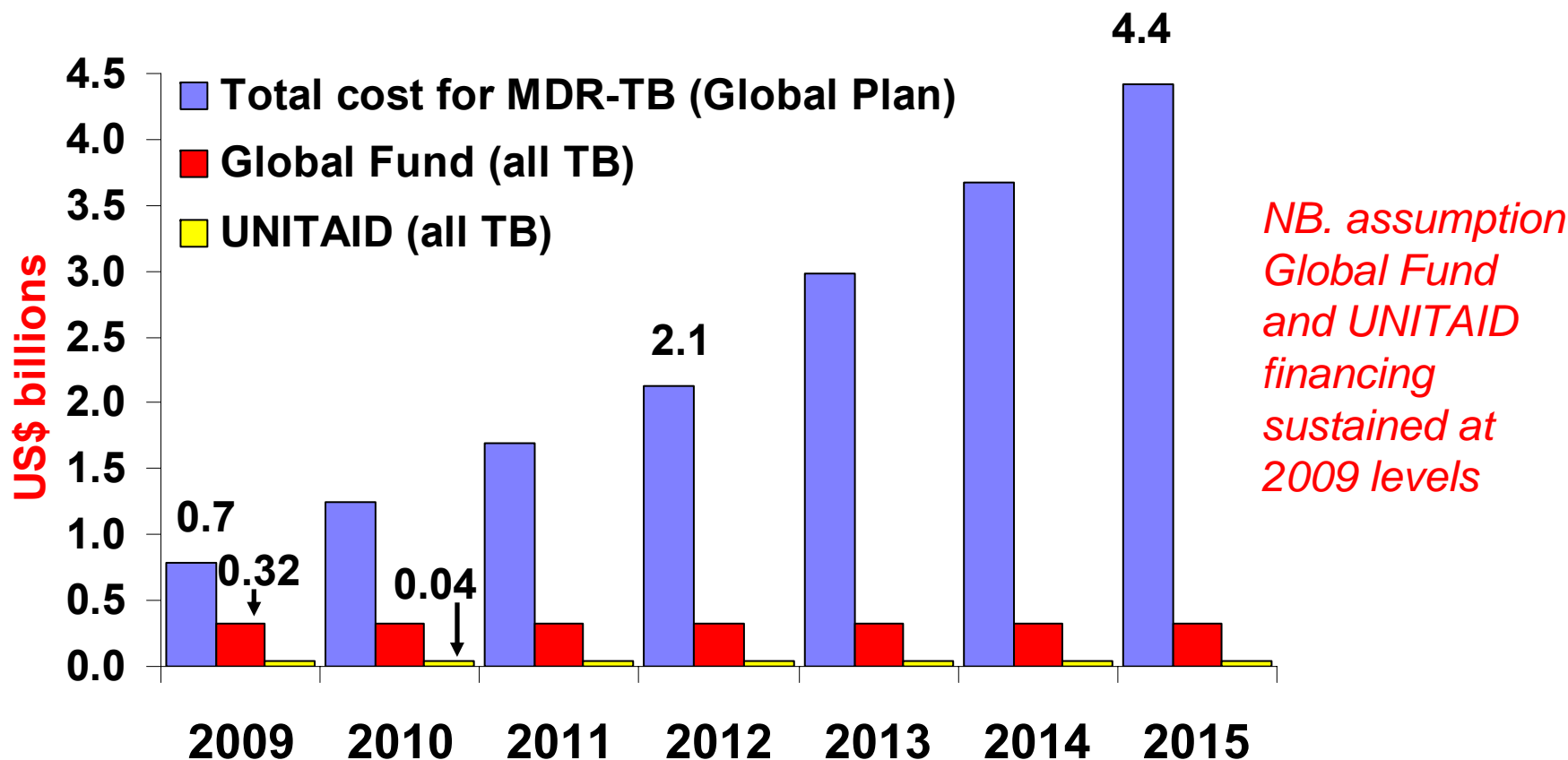
**3. How can the required
funding be mobilized?**

Can patients pay?



Catastrophic health expenditure defined as 40% of household "capacity to pay"
"Capacity to pay" based on income after basic subsistence needs are met

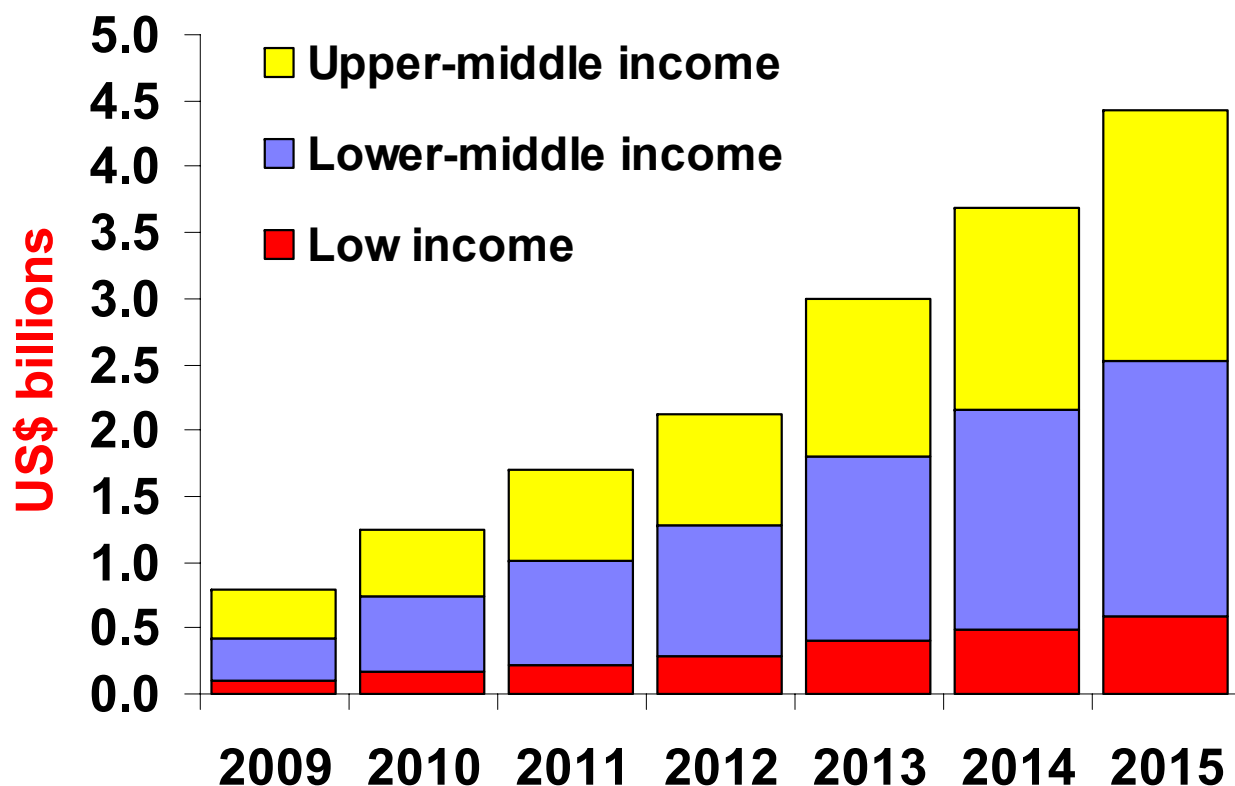
The Global Fund and UNITAID



Unlikely to finance more than a relatively small share of the costs of MDR-TB diagnosis and treatment, unless either

- both agencies mobilize substantially more funding *and/or*
- the cost of MDR-TB diagnosis and treatment can be reduced

Can HBC governments pay?



Commission on Macroeconomics and Health (2001) suggested middle-income countries could finance 96–100% of health care needs

High Level Taskforce (HLTF) on Innovative International Financing for Health Systems is focusing on low-income countries

Low Income (GNI <US\$ 936 per capita)	<i>Bangladesh, DR Congo, Ethiopia, Kyrgyzstan, Myanmar, Nigeria, Pakistan, Tajikistan, Uzbekistan, Viet Nam</i>
Lower-middle income (GNI US\$ 936–3705 per capita)	<i>Armenia, Azerbaijan, China, India, Indonesia, Philippines, Moldova, Ukraine</i>
Upper-middle income (GNI US\$ 3706–11455)	<i>Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Latvia, Lithuania, Russian Federation, South Africa</i>

Conclusions

1. **Substantial increase in funding is required to achieve treatment targets set in Global Plan**
2. **As the basis for resource mobilization, more precise country-specific estimates of funding requirements are needed, based on national strategic plans to scale up MDR-TB diagnosis and treatment**
 - ◆ **Targets and rate of scale-up, model of care, cost of second-line drugs and policy for which TB cases are screened for MDR-TB will have a big influence on funding requirements**
 - ◆ **WHO TB planning and budgeting tool* is available to cost the strategic plan**
3. **Particular attention needs to be given to domestic funding in middle-income countries**

http://www.who.int/tb/dots/planning_budgeting_tool/en/index.html