



The President's Emergency Plan for AIDS Relief (PEPFAR): Funding Issues After a Decade of Implementation, FY2004-FY2013

Tiaji Salaam-Blyther
Specialist in Global Health

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Summary

The President's Emergency Plan for AIDS Relief (PEPFAR) is the largest bilateral health initiative in the world. The 2003 pledge of President George W. Bush to spend \$15 billion over five years on fighting HIV/AIDS, tuberculosis (TB), and malaria was considered groundbreaking. The initiative challenged the international community to reject claims that large-scale HIV/AIDS treatment plans could not be carried out in low-resource settings. In December 2002, one month before PEPFAR was announced, only 50,000 people of the estimated 4 million requiring anti-retroviral (ARV) medicines in sub-Saharan Africa were receiving treatment. By the end of FY2004, 155,000 people were receiving treatment through PEPFAR.

As of March 2012, PEPFAR has supported

- the provision of anti-retroviral therapy (ART) for more than 4.5 million people (up from 155,000 in 2005);
- testing and counseling for more than 40 million people, including 9.8 million pregnant women;
- prevention of mother-to-child HIV transmission (PMTCT) services for more than 660,000 HIV-positive pregnant women, curbing some 200,000 HIV infections among infants; and
- care and support for more than 13 million people, including more than 4 million orphans and vulnerable children (OVC).

Congress first authorized funds in support of PEPFAR in 2003 through P.L. 108-25, the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act (Leadership Act). The \$15 billion authorization was to be spent on global HIV/AIDS, TB, and malaria programs from FY2004 through FY2008. Strong bipartisan support for PEPFAR in particular and global health in general led to annual appropriations amounts that exceeded authorized levels. During the first phase of PEPFAR (FY2004-FY2008), the Bush Administration spent \$18.1 billion on global HIV/AIDS programs.

As the expiration date of the Leadership Act approached, congressional support for PEPFAR remained enthusiastic. Members debated a range of issues (see CRS Report RL34569, *PEPFAR Reauthorization: Key Policy Debates and Changes to U.S. International HIV/AIDS, Tuberculosis, and Malaria Programs and Funding*), but ultimately authorized an extension of PEPFAR. The Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (P.L. 110-293, Lantos-Hyde Act) authorized \$48 billion to be appropriated from FY2009 through FY2013 for combating the three diseases. From FY2009 through FY2012, the Obama Administration obligated nearly \$26 billion on global HIV/AIDS programs.

As the September 30, 2013, expiration date for the authorization of the Lantos-Hyde Act approaches, it is unclear whether Congress will again authorize multiyear funding for PEPFAR. Bipartisan support for PEPFAR remains strong; nonetheless, congressional debate about key elements of the program has raised some concerns. For example, some Members question the extent to which family planning programs are integrated into global HIV/AIDS activities. At the same time, growing unease about the federal budget deficit minimizes the likelihood that past trends of ever-increasing appropriations for global HIV/AIDS programs will be sustained.

Fiscal pressures may have influenced funding amounts that fluctuated (but mostly remained level) throughout the Obama Administration—a departure from the steady growth in spending seen during the Bush Administration. Financial constraints in the global economy have resulted in similar outcomes during the Obama Administration. Whereas many international donors consistently increased their pledges for fighting global HIV/AIDS throughout the Bush Administration, resources made available by key contributors (such as European nations and the Global Fund) began to stagnate and in some cases declined during the past few years. While contributions by traditional donors have mostly stabilized, Brazil, Russia, India, China, and South Africa (BRICS) are playing a greater role in international HIV/AIDS assistance and are transforming from recipient countries into donor nations. At the same time, some aid recipient countries are increasing investments in their own national HIV/AIDS plans.

This report outlines U.S. spending on global HIV/AIDS programs since the inception of PEPFAR, analyzes global HIV/AIDS funding by other donors, and highlights key issues pertaining to funding that will face the 113th Congress as it considers the future of PEPFAR, including

- whether to reauthorize funding for PEPFAR following the expiration of the Lantos-Hyde Act in FY2013;
- engagement with emerging economies and other non-traditional donors who are increasing their participation in the global fight against HIV/AIDS;
- the impact of U.S. efforts to transition ownership of national HIV/AIDS plans to recipient countries;
- the appropriate funding level for the Global Fund;
- whether to support innovative fund-raising approaches for global HIV/AIDS programs, such as taxes on financial transactions and income; and
- developments that might increase HIV/AIDS treatment costs, including intellectual property rights and drug resistance.

Program implementation and authorization issues will be addressed more extensively in future related reports.

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Introduction

In January 2003, former President George W. Bush proposed that the United States spend \$15 billion over the next five fiscal years to fight three diseases worldwide—malaria, tuberculosis (TB), and HIV/AIDS—through the President's Emergency Plan for AIDS Relief (PEPFAR). The plan included \$10 billion for programs to combat HIV/AIDS in 15 focus countries; \$4 billion for bilateral HIV/AIDS activities in some 100 non-focus countries, global HIV/AIDS research, and international TB projects; and \$1 billion for the multilateral Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund).¹ In May 2003, Congress authorized \$15 billion in support of the initiative through P.L. 108-25, the U.S. Leadership Against HIV/AIDS, Tuberculosis, and Malaria Act (the Leadership Act).

Congress reauthorized the plan through P.L. 110-293, the Tom Lantos and Henry J. Hyde United States Global Leadership Against HIV/AIDS, Tuberculosis, and Malaria Reauthorization Act of 2008 (the Lantos-Hyde Act). The act authorized \$48 billion to be spent from FY2009 through FY2013 on fighting the three diseases; including \$5 billion for international malaria programs, \$4 billion for global TB efforts, and \$2 billion for a contribution to the Global Fund in FY2009.

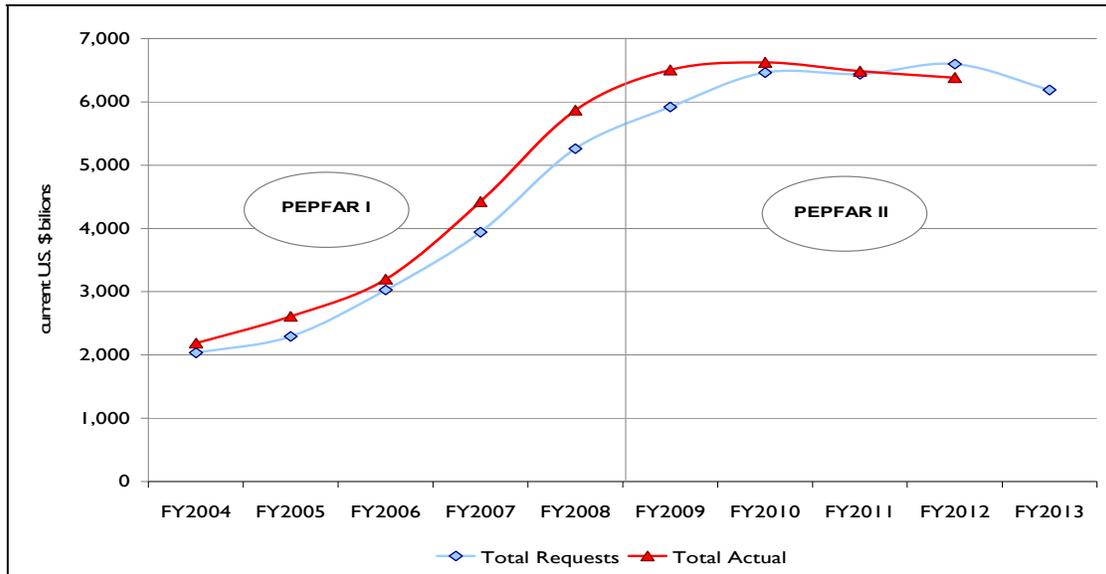
The Leadership Act and subsequent appropriations were considered groundbreaking. Congress had never authorized or appropriated such sums of funds for a global health endeavor. In the five years prior to the launch of PEPFAR, Congress appropriated approximately \$3.1 billion for global HIV/AIDS programs.² In the first phase of PEPFAR (FY2004-FY2008), the United States spent more than \$18 billion on global HIV/AIDS initiatives, including the Global Fund. From FY2009 through FY2012, U.S. spending on international HIV/AIDS assistance reached nearly \$26 billion. Since PEPFAR was launched, Congress has consistently provided more than the Administration requested for global HIV/AIDS programs (**Figure 1**).

Unless otherwise specified, references throughout this report to U.S. spending on global HIV/AIDS programs include contributions to the Global Fund. It is important to note, however, that U.S. contributions to the Global Fund support grants aimed at fighting HIV/AIDS, TB, and malaria. Donors contributions to the Global Fund can not be directed at any particular disease.

¹ White House Fact Sheet, "The President's Emergency Plan for AIDS Relief," January 29, 2003, at <http://georgewbush-whitehouse.archives.gov/news/releases/2003/01/20030129-1.html>, visited on October 3, 2012. The Global Fund is a multilateral organization based in Geneva, Switzerland, that aims to combat HIV/AIDS, TB, and malaria worldwide.

² See CRS Report RL33771, *Trends in U.S. Global AIDS Spending: FY2000-FY2008*, by Tiaji Salaam-Blyther.

Figure I. U.S. Global HIV/AIDS Funding, FY2004-FY2013
(U.S. current \$ millions)



Source: Created by CRS from Administration budget requests and communication with Adam Ross, Global Health Specialist, Office of Management and Budget.

Notes: Includes supplemental funds as well as spending on the Global Fund but not on bilateral malaria and tuberculosis programs. FY2012 funds are estimates.

In the first authorization cycle, spending on global HIV/AIDS programs and the Global Fund exceeded the President's proposal by roughly \$1.7 billion (**Figure 1** and **Table 1**). By the second phase, however, the trend reversed: requests outpaced spending levels, which no longer increased annually (**Figure 2**). In FY2011 and FY2012, actual spending on global HIV/AIDS programs was less than the previous fiscal year. It remains to be seen how much Congress will make available in FY2013. Many HIV/AIDS advocates hope larger debates about foreign aid and the federal deficit will not negatively affect PEPFAR funding in the 113th Congress.

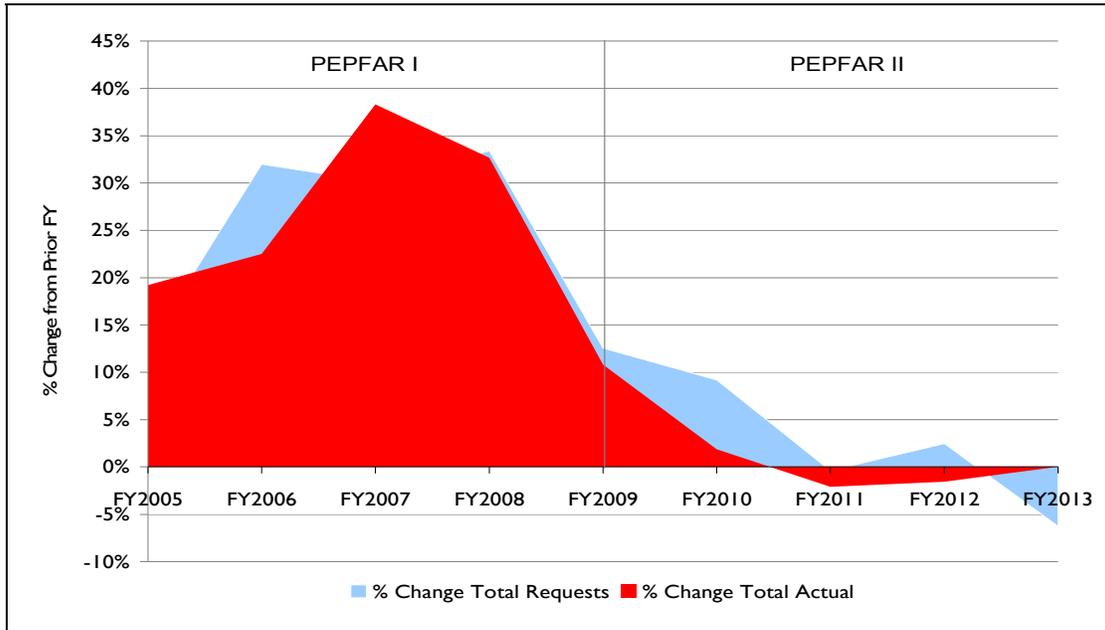
Table I. Global HIV/AIDS Requests and Funding, FY2004-FY2013
(current U.S. \$ millions)

	FY2004 Actual	FY2005 Actual	FY2006 Actual	FY2007 Actual	FY2008 Actual	FY2009 Actual	FY2010 Actual	FY2011 Actual	FY2012 Estimate	FY2013 Request
Bilateral Request	1,835.0	2,095.0	2,729.0	3,642.0	4,958.5	5,419.4	5,563.0	5,739.0	5,599.0	4,536.7
Bilateral Actual	1,643.0	2,263.4	2,653.7	3,699.2	5,027.8	5,503.0	5,574.0	5,439.6	5,083.1	
Global Fund Request	200.0	200.0	300.0	300.0	300.0	500.0	900.0	1,000.0	1,300.0	1,650.0
Global Fund Actual	546.6	347.2	544.5	724.0	840.3	1,000.0	1,050.0	1,045.8	1,300.0	
Total Requests	2,035.0	2,295.0	3,029.0	3,942.0	5,258.5	5,919.4	6,463.0	6,739.0	6,899.0	6,186.7
Total Actual	2,189.6	2,610.6	3,198.2	4,423.2	5,868.1	6,503.0	6,624.0	6,485.4	6,383.1	

Sources: Compiled by CRS from Administration budget requests and communication with Adam Ross, Global Health Specialist, Office of Management and Budget (OMB).

Note: Does not include funding for bilateral malaria and tuberculosis programs.

Figure 2. Annual Changes in Global HIV/AIDS Requests and Spending, FY2004-FY2013



Source: Created by CRS from Administration budget requests and communication with Adam Ross, Global Health Specialist, Office of Management and Budget.

Notes: Includes funding for the Global Fund but not bilateral malaria and tuberculosis programs. FY2012 funds are estimates and FY2013 funds are requested.

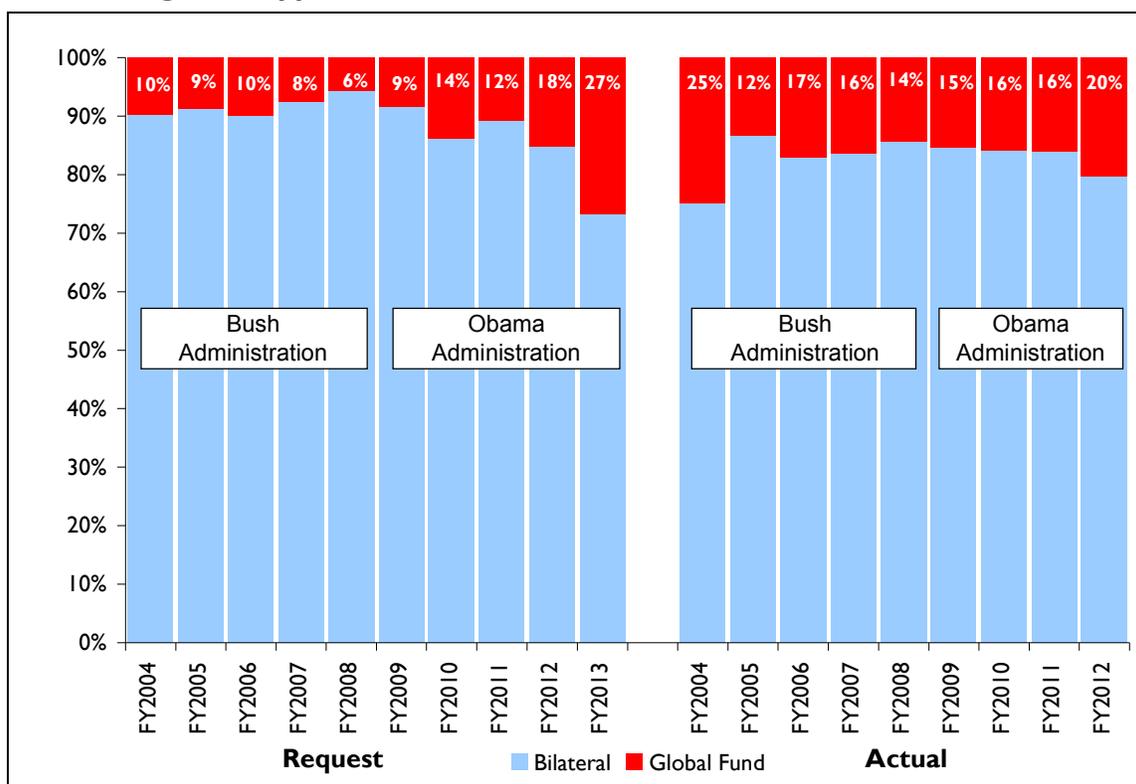
U.S. Contributions to the Global Fund

During the second phase of PEPFAR (FY2009-FY2013), Congress continued to debate the role of the Global Fund. Some observers are particularly concerned about the growing share of global HIV/AIDS resources allocated to the Global Fund (**Figure 3**). Although bilateral HIV/AIDS funding has consistently exceeded Global Fund levels, skeptics question whether U.S. priorities can be maintained through an ever-deepening commitment to the Global Fund. Critics also point to concerns about mismanagement of Global Fund resources by some grantees. Supporters, on the other hand, assert the Global Fund complements U.S. efforts by leveraging contributions from other donors and is an important partner in the U.S. fight against global HIV/AIDS.³ Prompted in part by U.S. concerns, the Global Fund is undergoing reforms. The Board approved the reforms at its 27th board meeting on September 2012.⁴

³ For more information on the Global Fund and congressional discussions about the organization, see CRS Report R41363, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Issues for Congress and U.S. Contributions from FY2001 to FY2013*, by Tiaji Salaam-Blyther.

⁴ See Global Fund, *Report of the General Manager to the Board*, September 13-14, 2012, http://www.theglobalfund.org/documents/board/27/BM27_02GeneralManager_Report_en/.

Figure 3. Apportionment of HIV/AIDS Resources, FY2004-FY2013



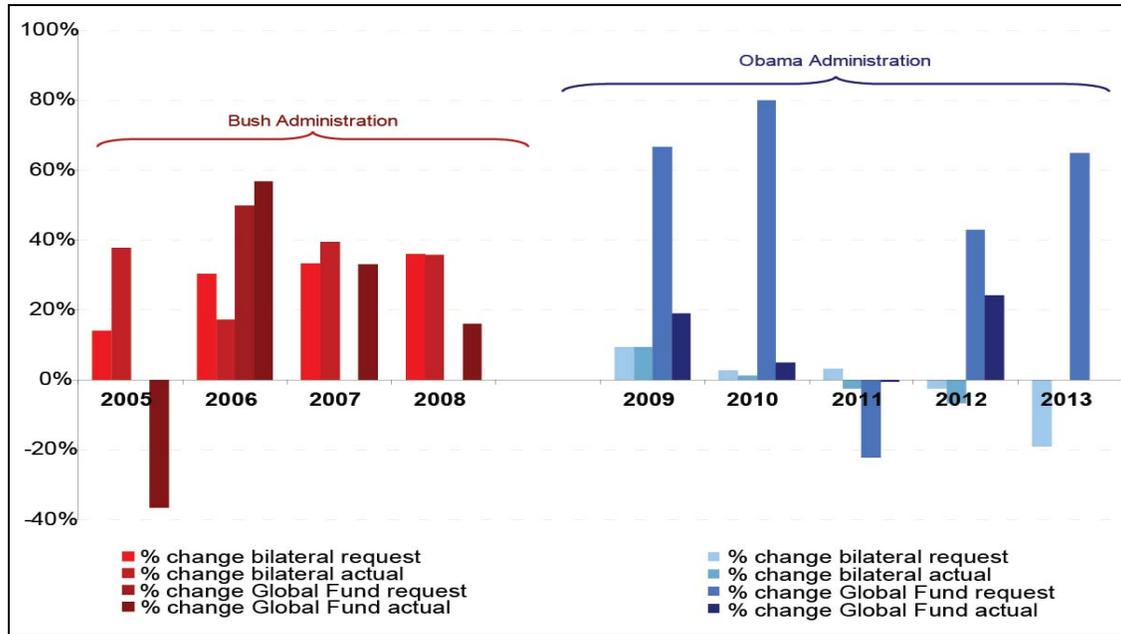
Sources: Created by CRS from Administration budget requests and communication with Adam Ross, Global Health Specialist, Office of Management and Budget.

Notes: Includes supplemental funding, but not spending on bilateral malaria and tuberculosis programs. FY2012 funds are estimates.

Congressional appropriations for the Global Fund exceeded requested levels during the Bush and Obama Administrations. The gap between requested and actual spending was the most pronounced, however, throughout the Bush Administration. Presidents Bush and Obama had different views on apportioning bilateral and multilateral HIV/AIDS funds. President Bush never requested that more than 10% of global HIV/AIDS funds be spent on the Global Fund, whereas President Obama requested that up to 27% of global HIV/AIDS funds be reserved for the Global Fund (**Figure 4**).

Despite this difference, both Presidents demonstrated support for the Global Fund. President Bush offered the inaugural pledge, and President Obama made the first U.S. multiyear pledge. The two presidents, however, suggested different funding levels for the Global Fund. While requests for the Global Fund did not exceed \$300 million during the Bush Administration, President Obama requested the highest ever pledge to the Global Fund—\$1.65 billion in FY2013. The FY2013 request is the final amount of the three-year pledge made by the Obama Administration in 2010 to contribute \$4 billion to the Global Fund from FY2011 through FY2013.

Figure 4. Spending on Global HIV/AIDS Programs and the Global Fund by Administration, FY2004-FY2013
(% change by fiscal year)



Source: Created by CRS from Administration budget requests and communication with Adam Ross, Global Health Specialist, Office of Management and Budget.

Notes: Includes supplemental funding, but not spending on bilateral malaria and tuberculosis programs. FY2012 funds are estimates.

Emerging Global HIV/AIDS Funding Trends

Enthusiasm by donors to consistently increase spending on global HIV/AIDS projects has waned, due in part to a weak global economy. Overall spending on HIV/AIDS worldwide, however, has increased. Funding boosts have been driven primarily by budgetary increases among recipient countries. Between 2010 and 2011, funding from domestic public sources grew by more than 15%.⁵ Roughly 41% of that growth occurred in sub-Saharan Africa. Of the estimated \$16.9 billion spent on fighting HIV/AIDS worldwide in 2011, roughly half was funded by lower- and middle-income countries (LMIC) and LMIC private entities (**Figure 5**).

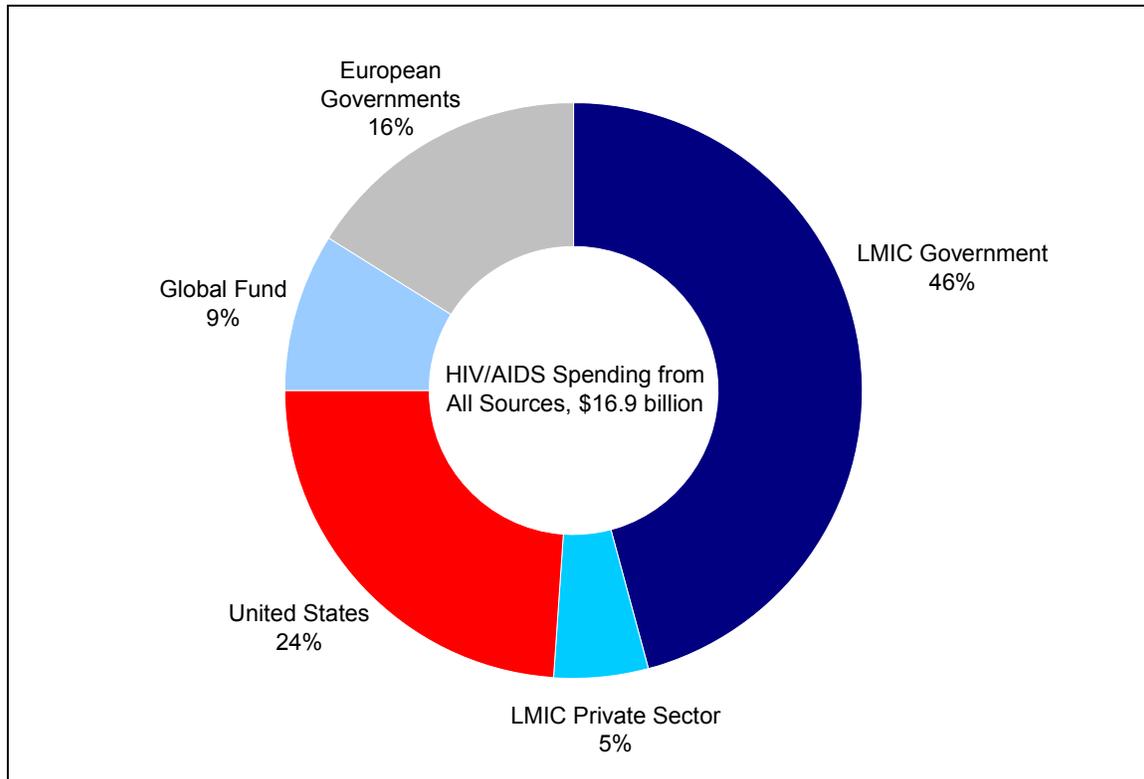
Despite a more austere funding environment, the United States has remained the largest single donor in the world.⁶ Of the \$16.9 billion spent worldwide on HIV/AIDS in 2011, the United States accounted for 24% of spending from all sources. Among donor countries, the United States provided roughly 60% of all funds for HIV/AIDS assistance contributions. When resources from

⁵ UNAIDS, *Together We Will End AIDS*, 2012, p. 104, http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2012/20120718_togetherwewillendaids_en.pdf.

⁶ Jennifer Kates et al., *Financing the Response to AIDS in Low- and Middle- Income Countries: International Assistance from Donor Governments in 2011*, Kaiser Family Foundation and UNAIDS, July 2012, <http://www.kff.org/hivaids/7347.cfm>.

multilateral organizations are considered, U.S. contributions account for roughly 48% of all foreign aid for HIV/AIDS and 32% of all Global Fund contributions.⁷

Figure 5. Global Spending on HIV/AIDS, All Sources, 2011
(U.S. billions)



Source: Created by CRS from correspondence with Anja Grujovic, Technical Officer, UNAIDS, September 18, 2012.

Note: Lower- and Middle-Income Countries (LMIC).

Greater spending by recipient countries on HIV/AIDS in recent years might have been precipitated by congressional mandates for stronger country ownership. In the Lantos-Hyde Act, Congress called for the creation of partnership frameworks to bolster country ownership and enhance the sustainability of U.S. investments.⁸ Per the legislation, the frameworks are to outline plans for increasing country ownership of the operation and funding of national HIV/AIDS plans. The U.S.-South Africa Partnership Framework Implementation Plan, for example, envisions gradually reducing PEPFAR aid from the FY2012 level of roughly \$484 million to \$250 million by FY2017.⁹ The framework is based on consistent increases in HIV/AIDS spending by the South African Government (SAG). According to the framework, SAG has raised its national HIV/AIDS

⁷ Ibid., p. 4, and UNAIDS, *Together We Will End AIDS*, 2012, p. 10.

⁸ P.L. 110-293, Section 301.

⁹ Department of State, *Partnership Framework Implementation Plan in Support of South Africa's National HIV, STI & TB Response*, 2012/13 - 2016/2017, August 2012, p. 33, <http://www.pepfar.gov/documents/organization/196651.pdf>.

budget from \$576 million in 2008 to roughly \$1.25 billion in 2012.¹⁰ As of August 8, 2012, OGAC has signed partnership frameworks with more than 20 countries.

Emerging Donors

Processes for funding global HIV/AIDS programs are changing. Financial contributions from traditional donors are fluctuating, and some global health advocates fear international support for the Global Fund is waning. In November 2011, the Global Fund Board announced that inadequate resources from donors caused it to cancel the scheduled 11th round of funding. The Global Fund does not expect to offer new funding for grants until 2014, after revisions of funding procedures have been completed.¹¹

While there is some uncertainty about future funding levels from traditional donors, Brazil, Russia, India, China, and South Africa (BRICS) are playing a greater role in international HIV/AIDS assistance and are transforming from recipient countries into donor nations.¹² Brazil, for example, is helping developing countries manufacture anti-retroviral medicines (ARVs). Russia is donating funds to its neighbors; in 2011, Russia donated \$13 million for fighting HIV/AIDS (primarily to border states), and from 2007 to 2010, it contributed \$88 million toward AIDS research. India is playing an increasingly important role in offering generic ART to developing countries and is accelerating technology transfer between its pharmaceutical sector and African manufacturers. China is emerging as one of the top five donors for HIV/AIDS research and development (R&D), having provided roughly \$18.3 million for research on AIDS vaccines in 2011. South Africa is also increasing its investments in R&D, having spent \$10 million on related research in 2011.

At the same time, BRICS have increasingly assumed control over their own national HIV/AIDS programs. Over the past five years, the South African government has boosted its national HIV/AIDS budget fivefold, reaching \$1.25 billion in 2012. The Brazilian government has paid for all ART provided through its national programs. India committed to cover at least 90% of all HIV/AIDS expenses related to Phase IV of its National AIDS Control Program (2012-2017). China reportedly paid for roughly 80% of all national HIV/AIDS costs in 2011 after having increased spending on HIV/AIDS programs fourfold from \$124 million in 2007 to \$530 million in 2011.¹³

Issues for Congress

The international community has made tremendous advancements in the fight against HIV/AIDS, with the pace accelerating in recent years. In December 2002, one month before PEPFAR was announced, only 50,000 people of the estimated 4 million requiring anti-retroviral (ARV) medicines in sub-Saharan Africa were receiving treatment. By 2011, more than 8 million people living with HIV/AIDS in low- and middle-income countries were receiving antiretroviral

¹⁰ Ibid., p. 9.

¹¹ Global Fund, *Transitional Funding Mechanism (TFM) Information Note*, December 12, 2011.

¹² Information in this paragraph was summarized from UNAIDS, *Together We Will End AIDS*, 2012, pp. 111-112.

¹³ UNAIDS, *Together We Will End AIDS*, 2012, p. 107.

treatment, some 20% more than 2010 levels (6.6 million people).¹⁴ Progress has been made as well in preventing mother-to-child transmission of HIV/AIDS. In 2011, approximately 57% of HIV-positive pregnant women in those regions received drugs to prevent HIV transmission; 48% had access to the therapies in 2010.¹⁵

PEPFAR has played an important role in the global fight against HIV/AIDS. UNAIDS estimates roughly half of all international assistance for combating HIV/AIDS was provided by the United States.¹⁶ Worldwide contributions for countering HIV/AIDS has remained strong even with the global recession and slight declines in HIV/AIDS assistance in 2009 and 2010. Nonetheless, observers question whether global funding for addressing HIV/AIDS will be sustained. Several issues may affect future support for PEPFAR and the global fight against HIV/AIDS, including:

- **PEPFAR Reauthorization.** The PEPFAR program has been authorized under two successive authorization acts: the Leadership Act,¹⁷ P.L. 108-25, and the Lantos-Hyde Act, P.L. 110-293. The acts authorized the provision of \$15 billion and \$48 billion, respectively, for fighting HIV/AIDS, TB, and malaria. Authorization for PEPFAR is set to expire at the end of FY2013. The U.S. Congress has become more divided over issues related to foreign aid in general since Lantos-Hyde was enacted. At the same time, key elements within the act remain controversial, including those related to family planning.¹⁸ It is uncertain whether these issues will be sufficiently resolved as to enable reauthorization in the 113th Congress. If Congress does not extend authorization of PEPFAR, the program could continue to be funded through annual appropriations, but Congress could lose some of its opportunity to direct how its priorities are implemented.
- **Increased Spending by Emerging Economies.** The Lantos-Hyde Act emphasized country ownership. It is unclear whether U.S. funding levels for global HIV/AIDS programs will continue to rise as the United States and other donors continue to call on recipient countries to increase their contributions to national HIV/AIDS plans. Secretary of State Hillary Clinton has stated at a number of public events that the United States is invested in PEPFAR “for the long haul.”¹⁹ Nonetheless, several AIDS advocates are concerned that growing emphasis on transitioning ownership of programs implies declining support for PEPFAR programs. In 2011, fluctuations in donations for global HIV/AIDS were deflected by heightened spending within national coffers. BRICS countries and other emerging economies might also help to increase the global pool of

¹⁴ UNAIDS, *Together We Will End AIDS*, 2012, p. 9.

¹⁵ Ibid.

¹⁶ Ibid., p. 10.

¹⁷ Department of State, *The President's Emergency Plan for AIDS Relief: First Annual Report to Congress*, 2005, p. 5, <http://www.state.gov/documents/organization/43885.pdf>.

¹⁸ For more information on the debate surrounding the Lantos-Hyde Act, see CRS Report RL34569, *PEPFAR Reauthorization: Key Policy Debates and Changes to U.S. International HIV/AIDS, Tuberculosis, and Malaria Programs and Funding*, by Kellie Moss.

¹⁹ UNAIDS, “Secretary Clinton calls for shared responsibility at AIDS 2012,” press release, July 23, 2012, <http://www.unaids.org/en/resources/presscentre/featurestories/2012/july/20120723aclinton/>, and Department of State, *Remarks at a Visit to Delft South Clinic and PEPFAR Transition Signing*, Cape Town, South Africa, August 8, 2012, <http://www.state.gov/secretary/rm/2012/08/196186.htm>.

available resources, as well as reduce the pressure on existing donors for fighting HIV/AIDS.

- **Elevated Political Will Among Recipient Countries.** In 2011, the United Nations General Assembly adopted a resolution on HIV/AIDS that, among other things, committed member states to ramp up investments aimed at eliminating HIV/AIDS and work toward closing the estimated \$6 billion annual funding gap for combating HIV/AIDS.²⁰ The declaration called particularly on African countries to allocate at least 15% of their national budgets to the health sector, per the Abuja Declaration and Framework for Action.²¹ Some countries, as discussed earlier, have made advancements in this area. Other countries, like Kenya, however, remain heavily reliant upon donors to fund their national HIV/AIDS plans. In 2011, 81% of Kenya's \$709 million national AIDS plan was financed by development assistance.²²
- **Support for the Global Fund.** HIV/AIDS advocates are concerned about the fundraising challenges facing the Global Fund and fear that advancements made through the Global Fund and other donors will be compromised should it scale back operations. The Global Fund accounts for roughly 18% of spending by donors on HIV/AIDS in low- and middle-income countries.²³ While the Global Fund did not collect sufficient capital to launch a new round of grants in 2012, support from the United States has not abated; it has grown. Since the United States offered the inaugural \$200 million pledge for the Global Fund in 2001, U.S. pledges and contributions have increased significantly. In FY2012, Congress appropriated \$1.3 billion for the Global Fund and the Administration requested \$1.65 billion for the organization in FY2013. Although Congress has continued to increase resources for the Global Fund, it has included language in annual appropriations restricting portions of the contributions, citing concerns about transparency and fiscal malfeasance.²⁴ Members of Congress continue to debate the appropriate roles of the Global Fund and PEPFAR. This debate is expected to continue in the 113th Congress.
- **Alternative Funding Streams.** Several low-income countries are increasingly considering alternative approaches to financing their national AIDS plans. In January 2000, Zimbabwe launched an AIDS levy that collects a 3% tax on individual and corporate income.²⁵ In 2011, some \$26 million was collected through the AIDS levy, and an additional \$30 million is expected to be raised by

²⁰ United Nations, Sixty-Fifth Session, Resolution A/65/L.77, *Political Declaration on HIV and AIDS: Intensifying Our Efforts to Eliminate HIV and AIDS*, June 10, 2011, http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf.

²¹ For more information on the Abuja Declaration, see http://www.who.int/healthsystems/publications/abuja_declaration/en/index.html.

²² UNAIDS, *Together We Will End AIDS*, 2012, p. 109.

²³ *Ibid.*, p. 110.

²⁴ For more information on this action and other Global Fund issues, see CRS Report R41363, *The Global Fund to Fight AIDS, Tuberculosis, and Malaria: Issues for Congress and U.S. Contributions from FY2001 to FY2013*, by Tiaji Salaam-Blyther.

²⁵ Unless indicated otherwise, information in this paragraph was summarized from UNAIDS, "Zimbabwe: AIDS levy generates new resources for treatment," press release, February 21, 2012, <http://www.unaids.org/en/resources/presscentre/featurestories/2012/february/20120221zimbabwe/>.

the end of FY2012. Finances collected through the AIDS levy initiative and from key donors (PEPFAR, Global Fund and the British aid organization Department for International Development [DFID]) is expected to enable Zimbabwe to achieve universal coverage (defined as at least 80% of people in need of treatment) by the end of 2012.²⁶ Tanzania, Kenya, and Zambia are reportedly considering similar measures. Rwanda and Uganda have also imposed levies to fund national HIV/AIDS plans, but on mobile phone use.²⁷

A non-governmental organization called UNITAID has partnered with several countries to develop innovative mechanisms for funding the global fight against HIV/AIDS. Partnering countries, for example, have agreed to invoke taxes on airline tickets, ranging from \$1 for economy tickets to \$40 for first-class travel. Roughly 70% of UNITAID's revenues are derived from the air levy for distribution in needy countries.²⁸ UNITAID and other global health groups also advocate raising funds for global health and HIV/AIDS programs by taxing bonds and derivatives. It estimated that nearly \$352 billion (€265 billion) could have been raised in 2010 had G20 nations instituted the levies.²⁹ H.R. 755, Investing in Our Future Act of 2011, proposes excising a 0.005% levy on currency transactions, in part to fund global health programs, including HIV/AIDS. The bill awaits action by the Committees on Ways and Means and on Foreign Affairs.

- **Cost of Treating HIV/AIDS.** While the world has made tremendous advancements in expanding access to HIV/AIDS, two phenomena may raise the cost of treating HIV-positive people: (1) drug resistance and (2) changes in intellectual property rights. Growing resistance to ART medicine may increase the cost of treating HIV/AIDS as people graduate onto more expensive second-line treatments. In the 2012 UNAIDS report, the organization conceded one of the greatest challenges facing the world is “the inevitably rising costs of drug resistance and the need to provide chronic care for people living with HIV over their lifetimes.”³⁰ Despite these concerns, the World Health Organization (WHO) maintains drug resistance rates remain relatively low in low- and middle-income countries at roughly 6.8%.³¹

The cost of anti-retroviral treatments has fallen tremendously in developing countries over the past decade, from an average annual price of over \$10,000 per person to \$116 per person for WHO pre-qualified ART.³² This decline is a key reason global access to

²⁶ Global Fund, “Global Fund Investments Secure Treatment for an Additional 10,000 People,” press release, October 2, 2012, http://www.theglobalfund.org/en/mediacenter/newsreleases/2012-10-02_Zimbabwe_to_Attain_Universal_Coverage_of_AIDS_Treatment_by_the_End_of_the_Year/.

²⁷ UNAIDS, *Together We Will End AIDS*, 2012, p. 107.

²⁸ See UNITAID website at <http://www.unitaid.eu/how/innovative-financing?id=163>.

²⁹ Using \$1 = €0.7531 conversion rate. UNITAID, *Tax on Financial Transactions*, An Implementing Guide, September 2011, p. 11, http://www.unitaid.eu/images/NewWeb/documents/Finance/UTD-Report-TTF_en.pdf.

³⁰ *Ibid.*, p. 11.

³¹ WHO, *WHO HIV Drug Resistance Report 2012*, 2012, p. 7, http://apps.who.int/iris/bitstream/10665/75183/1/9789241503938_eng.pdf.

³² UNAIDS and UNDP, *The Potential Impact of Free Trade Agreements on Public Health*, Issue Brief, 2012, http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2012/JC2349_Issue_Brief_Free-Trade-Agreements_en.pdf.

HIV/AIDS treatments has expanded. Indeed, per-patient spending on ART within PEPFAR programs has declined, due in large part to increased use of generic treatments (**Figure A-1**).³³ In FY2009, roughly 90% of all anti-retroviral drugs (ARVs) purchased in PEPFAR programs were generic formulations, up from approximately 15% in 2005.³⁴ It is important to note, however, that several factors affect U.S. spending on treatment beyond purchase of anti-retroviral treatments, including investments in building renovation and construction, laboratory and clinical equipment and training of ARV providers (**Figure A-2**).

Generic ARVs that are widely used in low-income countries are manufactured primarily in Brazil and India. Some groups, including UNAIDS, are concerned that emergent bilateral and multilateral trade agreements threaten special intellectual property laws that permitted the proliferation of generic ARVs.³⁵ Of particular concern are developing agreements between the European Union and India that may limit India's capacity to continue producing generic ARVs.³⁶

Questions about the pricing of newer, more effective treatments have also prompted some consternation. Members of Congress wrote a letter to the Chairman and Chief Executive Officer of Gilead—a pharmaceutical company that manufactures ARVs—urging them to consider the impact of elevated ART prices in light of the current economic climate.³⁷

³³ See Department of State, Report to Congress by the U.S. Global AIDS Coordinator on the Use of Generic Drugs in the President's Emergency Plan for AIDS Relief, May 2008, <http://www.pepfar.gov/documents/organization/105842.pdf>.

³⁴ Department of State, *Making Smart Investments to Increase Impact and Efficiency and Save More Lives*, Fact Sheet, July 2012, <http://www.pepfar.gov/documents/organization/195478.pdf>.

³⁵ For more information on international intellectual property rights agreements and HIV, see CRS Report RL34292, *Intellectual Property Rights and International Trade*, by Shayerah Ilias and Ian F. Fergusson.

³⁶ Patralekha Chatterjee, "India-EU Free-Trade Pact Could Stifle Generics Industry," *The Lancet*, vol. 377, no. 9774 (April 16, 2011), pp. 1305-1306.

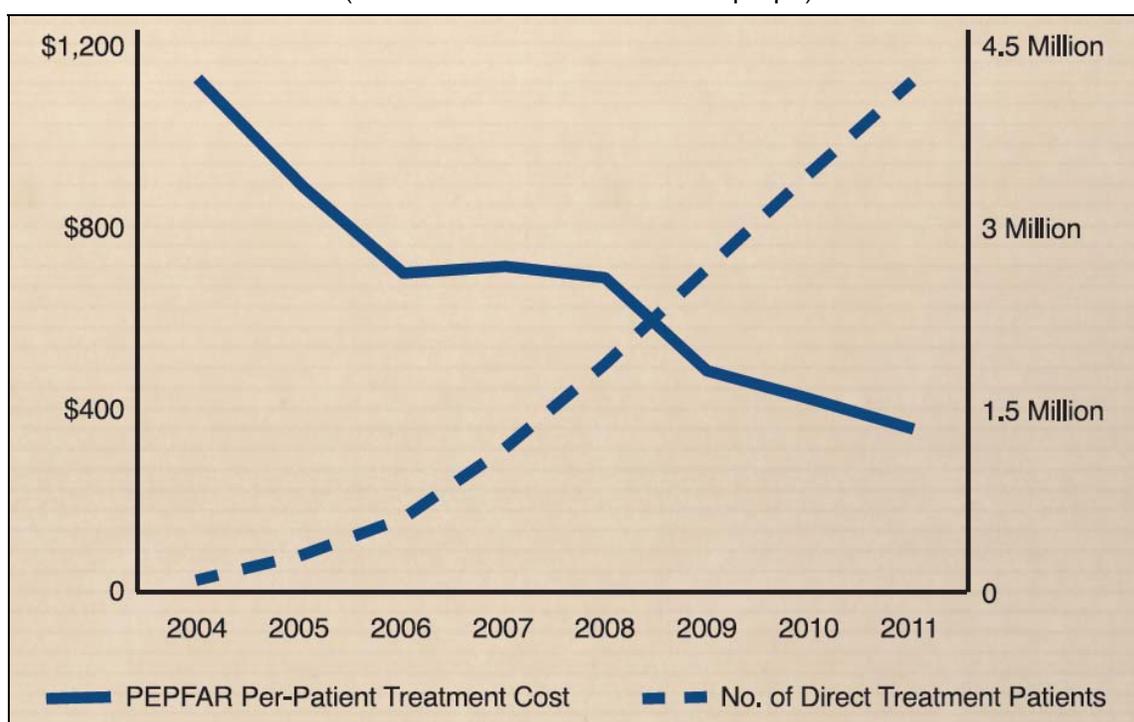
³⁷ Letter from Alcee Hastings, Member of Congress, et al. to Dr. John C. Martin, Chairman and Chief Executive Officer, Gilead Sciences, Inc., August 1, 2012, http://alceehastings.house.gov/images/stories/PDFs/Rep._Hastings_-_Letter_to_Gilead_-_8.1.12.pdf.

Appendix. Spending on HIV/AIDS Treatment in PEPFAR Programs

One of the greatest accomplishments of PEPFAR has been to increase the number of people receiving anti-retroviral (ARV) treatments worldwide, due in large part to increased use of generic formulations. In FY2009, roughly 90% of all ARVs purchased in PEPFAR programs were generics, up from approximately 15% in 2005.³⁸ Annual per-patient spending in PEPFAR on ART fell from over \$1,100 in 2004 to roughly \$335 in 2011 (**Figure A-1**).³⁹

Figure A-1. PEPFAR Per-Patient Spending on ART, 2004-2011

(current U.S. dollars and millions of people)



Source: Department of State, *PEPFAR Saving Lives Infographic*, Fact Sheet, July 2012, <http://www.pepfar.gov/documents/organization/195545.pdf>.

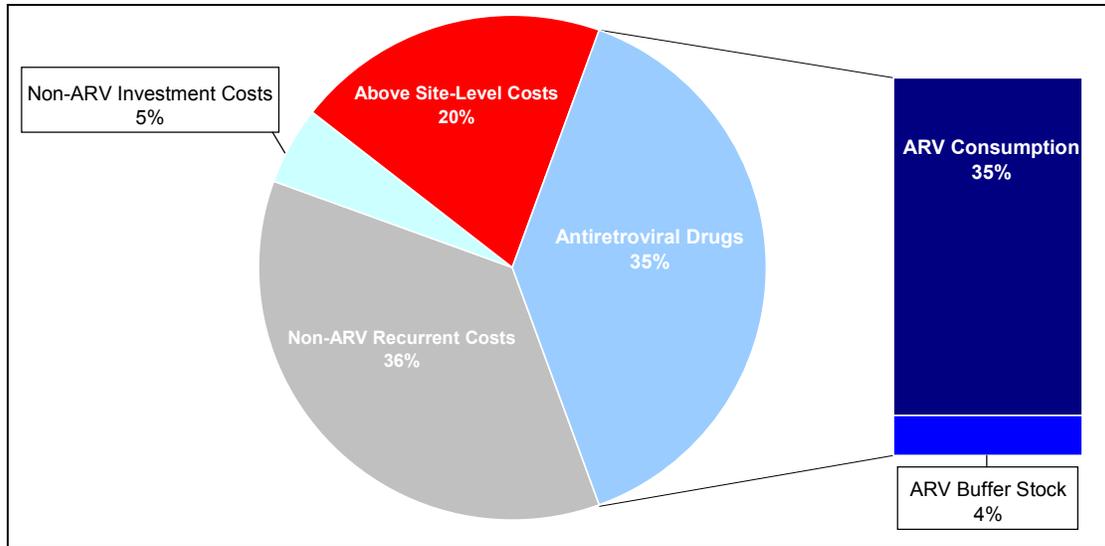
It is important to note that spending on anti-retroviral therapy includes a range of activities. The purchase of ARVs comprises roughly 40% of all spending on HIV/AIDS treatment (**Figure A-2**). Non-ARV recurrent costs include clinical staff salaries and benefits; laboratory and clinical supplies; non-ARV drugs for opportunistic infections; building utilities; travel; and contracted services. Investment costs include building renovation and construction; laboratory and clinical

³⁸ Department of State, *Making Smart Investments to Increase Impact and Efficiency and Save More Lives*, Fact Sheet, July 2012, <http://www.pepfar.gov/documents/organization/195478.pdf>.

³⁹ Department of State, *The President's Emergency Plan for AIDS Relief Eighth Annual Report to Congress*, 2012, p. 3, <http://www.pepfar.gov/documents/organization/188019.pdf>.

equipment; in-service training of ARV providers; and ARV buffer stock to support a reliable supply chain.

Figure A-2. ART-Related Expenses, 2010



Source: Department of State, Report to Congress on Costs of Treatment in the President's Emergency Plan, July 2010, p. 3.

Author Contact Information

Tiaji Salaam-Blyther
Specialist in Global Health
tsalaam@crs.loc.gov, 7-7677