Bridge Financing:
Building on the financial sustainability plan analysis and country feedback

At its July 2004 meeting, the GAVI Board agreed to pursue the principle of bridge financing for countries that have introduced "immature"[1] vaccine products but are facing major financing challenges. Such a mechanism would imply that GAVI and the Vaccine Fund would mobilize additional resources. The Board further requested that the GAVI Financing Task Force engage in a consultative process and explore options around cost sharing and co-financing of immature products for the Board's consideration. Following extensive consultations with individuals and groups across the health sector and with experts in public finance, the FTF herewith proposes two options for further analysis and requests the Board's approval of an overall resource ceiling. Based on proposed and additional analyses and consultations, the Board will be requested to select one bridge financing option to be offered to the 24 countries that have been approved for the introduction of combination vaccines as of 31 December 2004. The two options under consideration are:

> **Option 1: Phased-in co-payment** for gradual and step-wise increases in national and partner contributions, whereby countries and national partners contribute an increasing percent of vaccine costs on an agreed annual or bi-annual basis over a five- or 10-year period (time to be determined) and the Vaccine Fund pays the difference between the government/partner contribution and the total cost.
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> **Option 2: Fixed co-payment** whereby countries and national partners provide a standard co-payment for each dose of vaccine and the Vaccine Fund assumes responsibility for the difference between the fixed co-payment and the market price of the new product over a five- or 10-year period (time to be determined).

Estimating the Cost of Bridge Funding

Based on preliminary assumptions around number of countries (24) and taking into account Vaccine Provision Project (VPP) projections for country uptake, price scenarios (both fixed at the 2005 level and declining), and time frame (5 or 10 years), cost estimates of an overall bridge financing strategy are presented in Annex 1. The estimated cost of bridge financing to the Vaccine Fund ranges from $282 million to well in excess of $1.0 billion depending on assumptions used. At this time, the FTF requests the Board to authorize an overall working envelope of $300 million, which is considered to be a workable resource level for providing bridge financing under either option to the 24 early adopter countries (see Annex 1). **Irrespective of options and scenarios, it is important to note that approximately 95 percent of the total costs to the Vaccine Fund relate to the cost of the pentavalent vaccine, with only minimal influences (less than 5%) from the estimated costs of DTP-Hep B and DTP-Hib vaccines.**

Among the key considerations for each option:

(1) defining contribution levels – There are two schools of thought with regard to contribution levels for the additional antigens. Some stakeholders argue that the co-payment must be set deliberately low (with the Vaccine Fund absorbing much of the risk and probably over an extended time frame) so as to ensure that country demand is maintained, which will, in turn, encourage the entry of other product

suppliers, and thereby contribute to greater price competition. A majority of stakeholders consulted to date argue, however, that there has been a major paradigm shift in the economics of immunization, that the days of "pennies per dose" vaccines are over, and that countries and partners must confront the reality that new lifesaving vaccines are more costly. These stakeholders argue that bridge financing must be a true transitional support mechanism, not merely an effort to postpone addressing an inevitable and possibly insurmountable gap. As such, they suggest that the co-payment portion of the hep B and Hib components be established at a level that places countries and their national partners on a trajectory to assuming responsibility for financing new vaccine introduction in the foreseeable future.

(2) country eligibility - As currently configured, bridge financing is limited to those 24 countries that have been approved and/or have introduced combination products as of December 31, 2004. As described in the previous Board paper, Analysis of 22 Financial Sustainability Plans, these early adopter countries have shouldered much of the risk in introducing new vaccines, and will find it difficult or impossible to sustain program improvements under current conditions of government and partner commitments, Vaccine Fund grant volume and duration, and product price.

Although there has been some discussion of GAVI continuing to provide 5 years of vaccine free with an opportunity for subsequent bridge financing to all GAVI/VF eligible countries, there is a unique opportunity now to amend a number of current GAVI practices and policies to address some of the challenges that the early-adopter countries are currently facing. Some of the proposed modifications to the current country application and financial support processes that would greatly facilitate national decision-making around future financing of immunization are to ensure that:

a. applications to GAVI from here forward fully document the cost of expanding national programs to include new vaccines and describe plans for future financing;
b. applicants are made fully aware of all financing options at the time of application;
c. the costing and financing sections of the application are considered essential by the Independent Review Committee in their review; and
d. methods used to finance the introduction of new vaccines in the future are revised based upon experiences to date.

(3) time frame for bridge support – The FTF is exploring the possibility of five or ten years for the provision of bridge support. Based on current estimations, providing 10-year bridging may well be prohibitively expensive (see Annex 1).

(4) mechanisms for implementation – The implementation details are likely to be complex and challenging with either option. If requested, the FTF will, based upon country and partner consultations, provide the Board with recommendations at the March 2005 meeting.

The immediate next steps are:

1) Based on some preliminary assumptions regarding number of countries (24), vaccine prices, and a range of co-payment levels (see Annex 1), the FTF requests Board approval to adopt US $300 million as a working number for a resource ceiling. Based on this funding level, different scenarios for Options 1 (Phased-in co-payment) and Option 2 (Fixed co-payment) will be analyzed.

2) Given an overall resource envelope of $300 million, the FTF through GAVI partners will systematically consult with decision makers in Vaccine Fund recipient countries and other GAVI partners (particularly vaccine manufacturers) about their preferences and the advantages and disadvantages of each of the options with an effort to attain consensus on a preferred bridge financing option. In addition the FTF will work with government and partner staff to identify major implementation challenges and develop recommendations for addressing them.

3) Using the finding of the above consultations the FTF will analyze the potential advantages and disadvantages of current options with regard to their ability to:
    a. provide an incentive for increased government and partner commitments to the immunization program;
    b. be a means of sharing responsibility between governments and partners at the country level;
    c. ensure fulfillment of any pledges by government or partners;
    d. stimulate downward movement of vaccine prices;
    e. provide incentives for delivery of services; and
    f. limit potential transaction costs.

4) Report findings of the above to the GAVI Board in March 2005, along with a recommendation for approval of a specific bridge financing mechanism, with the intent to implement immediately upon approval.

Countries other than those that have applied and received approval for new combination vaccines as of December 31, 2004 will be ineligible for bridge financing but will benefit from improved GAVI policies and practices, and potentially revised strategies for the financing of new vaccine introduction.

The GAVI Board is requested to endorse the next steps on bridge financing, in anticipation of approval of a bridge mechanism in March 2005.

ANNEX 1: Crude estimates of bridge financing options for 24 countries given both fixed and declining price scenarios[2]

			Total Cost to Vaccine Fund (millions of USD)[3]	
Option	**Duration**	**Co-payment level**	**Assume 2005 Vaccine Prices Unchanged[4]**	**Assume Declining Vaccine Prices[5]**
1. **Phased-in co-payment**				
	5 years	Year 1 – 10%[6] Year 2 – 20% Year 3 – 40% Year 4 – 60% Year 5 – 80% Year 6 – 100%	417	299
	10 years	Year 1 – 5%[7] Year 2 – 10% Year 3 – 20% to Year 9 – 80% Year 10 – 90% Year 11 – 100%	824	537
2. Fixed Co-Payment				
Minimal co-payment[8]	5 years	Pentavalent $0.30 DTP-hep B $0.15 DTP-Hib $0.20	676	444
	10 years	Pentavalent $0.30 DTP-hep B $0.15 DTP-Hib $0.20	1,441	819
Moderate co-payment[9]	5 years	Pentavalent $1.10 DTP-hep B $0.50 DTP-Hib $0.70	513	282
	10 years	Pentavalent $1.10 DTP-hep B $0.50 DTP-Hib $0.70	1,095	474

ENDNOTES

[1] The term "immature" refers to products for which there is only one supplier and for which demand does or may soon exceed available supply A "mature" product is one in which there is relatively broad competition among multiple suppliers and where there tends to be an excess of supply.

2 In the absence of a bridge financing mechanism, a number of countries have indicated that they will either drop the combination vaccines and revert back to the provision of basic vaccines or will scale-back efforts to immunize additional children with combination vaccines. It is estimated that as a result of bridge financing a total of 63.5 million children will be vaccinated with combination vaccines who might otherwise not have been. Of the 63.5 million children, 58.4 million children will be vaccinated with DTP-hep B+ Hib, 4.8 million with DTP-hep B, and 0.4 million with DTP-Hib.

3 Irrespective of the different scenarios included in Annex 1, it is important to note that roughly 95 percent of the total costs to the Vaccine Fund relate to the pentavalent vaccine. The cost of DTP- hep B represents approximately 4 percent of the total and DTP-Hib generally accounts for less than 1 percent of total cost.

4 Current 2005 vaccine prices: pentavalent - $3.65/dose; DTP-hep B - $1.30/dose; DTP-Hib - $3.00/dose.

5 For the pentavalent vaccine, the declining price calculation is taken from Unicef Supply Division: Report to Hib Task Force, November 2004 and ranges from current price of $3.65 to an estimated $2.20 in 2012. For DTP-hep B and DTP-Hib, declining prices have been estimated based on expert opinion and range from $1.30 for DTP-hep B in 2005 to $0.65 in 2012, with the prices for DTP-Hib ranging from $3.00 in 2005 to $1.50 in 2012.

6 This refers to the given percent of the market price in a given year

7 This refers to the given percent of the market price in a given year

8 With the minimal co-payment, countries would essentially be covering the cost of the DTP vaccine with a small premium added for the additional antigen(s). Some constituents argue that maintaining a deliberately low co-payment level is essential towards maintaining product demand and thereby ensuring multiple suppliers and price competition.

9 Moderate co-payment is hereby proposed at a level that places countries and their local partners on a trajectory to assuming responsibility for financing new vaccine introduction in the foreseeable future, albeit recognizing that there may be a gap at the conclusion of the bridge financing.