



Title: IHP+: Expanding predictable financing for health systems strengthening and delivering results

Detailed Analysis of IFFIm

Author: Mark Pearson

Date: 21<sup>st</sup> October 2008

## Group Disclaimer

This document has been prepared for the titled project or named part thereof and should not be relied upon or used for any other project without an independent check being carried out as to its suitability and prior written authority of HLSP being obtained. HLSP accepts no responsibility or liability for the consequences of this document being used for a purpose other than the purposes for which it was commissioned. Any person using or relying on the document for such other purpose agrees, and will by such use or reliance be taken to confirm his agreement, to indemnify HLSP for all loss or damage resulting therefrom. HLSP accepts no responsibility or liability for this document to any party other than the person by whom it was commissioned.

To the extent that this report is based on information supplied by other parties, HLSP accepts no liability for any loss or damage suffered by the client, whether contractual or tortious, stemming from any conclusions based on data supplied by parties other than HLSP and used by HLSP in preparing this report.

## TABLE OF CONTENTS

<b>ACRONYMS</b> .....	<b>4</b>
<b>KEY MESSAGES</b> .....	<b>5</b>
<b>1. INTRODUCTION</b> .....	<b>6</b>
<b>1.1 The Case for IFFIm and its possible expansion</b> .....	<b>6</b>
<b>2. BENEFITS OF FRONTLOADING FOR HEALTH SYSTEMS STRENGTHENING</b> .....	<b>11</b>
<b>3. WOULD THE RATIONALE FOR IFFIM APPLY TO AN IFF FOR HSS?</b> .....	<b>13</b>
<b>4. IS THERE A DEMAND FOR FRONTLOADING FOR HSS?</b> .....	<b>15</b>
<b>5. WHAT MIGHT AN EXPANDED IFFIM BE PARTICULARLY SUITED FOR?</b> .....	<b>17</b>
<b>6. HOW MIGHT A SCALED UP IFFIM WORK? WHAT ARE THE MAIN OPTIONS?</b> .....	<b>22</b>
<b>Option 1: An Expanded IFFIm:</b> .....	<b>23</b>
<b>Option 2: Building on the Best of IFFIm</b> .....	<b>24</b>
<b>ANNEX 1: ESTIMATED HRH COSTS</b> .....	<b>27</b>
<b>ANNEX 2: A POSSIBLE TYPOLOGY OF HEALTH SYSTEMS INVESTMENTS</b> .....	<b>28</b>

## ACRONYMS

AMC	Advance Market Commitments
CMH	Commission for Macroeconomics and Health
DFID	Department for international Development
GAVI	Global Alliance for Vaccines and Immunisation
HIS	Health Information System
HRH	Human resources for health
HSS	Health systems strengthening
IBRD	International Bank for Reconstruction and Development
IFF	International Financing Facility
IFFIm	International Financing Facility for Immunisation
IHP	International Health Partnership
MDTF	Multidonor Trust Fund
NTD	Neglected Tropical Diseases
SARS	Severe Acute Respiratory Syndrome
SWAp	Sector wide approach
WB	World Bank
WHO	World Health Organisation

## KEY MESSAGES

Weak health systems are a key bottleneck slowing progress towards the health MDGs

A large increase in resources is required to address health systems constraints

An expanded IFFIm could have an important role to play in this

IFFIm's core comparative advantage is in terms of its ability to frontload resources

Many of the arguments in favour of IFFIm would also hold for an expanded IFFIm focusing on health systems strengthening.

Any decision needs to be informed by a detailed assessment of the costs and benefits of the approach and the potential roles played by other instruments (especially given that IFFIm is a relatively high cost funding source)

Areas that need further work and exploration include the need for

- an estimate of HSS funding requirements and a confirmation of the case for frontloaded support
- an assessment of the range of activities an expanded IFFIm is best suited to support
- a review of the various options for, and implications of different governance and management arrangements

## 1. INTRODUCTION

Weak health systems are seen as a key bottleneck preventing more rapid progress towards the health MDGs. More resources are required to support the strengthening of health systems although further work is needed to identify specific country level requirements. An expanded IFFIm – which offers the potential for greater predictability and frontloading of resources – is one of a number of potential mechanisms which could contribute to meeting any funding gaps related to the strengthening of health systems

An overview of IFFIm, and its possible links with other innovative financing mechanisms, is provided in the main background paper.

This paper:

- sets out the current case for IFFIm,
- assesses whether its rationale holds for an expanded IFFIm-type approach to support health systems strengthening,
- considers other interventions an expanded IFFIm might support and
- looks at possible management arrangements for an expanded IFFIm.

### 1.1 The Case for IFFIm and its possible expansion

**Frontloading can be justified if the benefits of bringing the investment forward exceed the costs of using IFFIm. The benefits of raising funds for development through a mechanism such as the International Finance Facility for Immunisation (IFFIm) are large and are likely to exceed the costs associated with using such an approach.**

The frontloading and greater predictability associated with IFFIm bring significant benefits. Using a stylized model and a series of reasonable assumptions, Barder and Yeh<sup>1</sup> find that “predictability adds about 11 percent to the health impact of spending, and front-loading adds an additional 10 percent”. They find that these estimates are fairly robust when tested against a range of alternative assumptions and that they always far exceed any extra costs associated with using the IFFIm route (which they put at around 3.5% of total costs<sup>2</sup>). The question as to whether this finding might also apply if the funds were spent on other interventions such as HSS is considered later.

**There may be some scope for increasing benefits but there are also likely to be costs associated with this.**

Other questions to consider are whether benefits of IFFIm could be increased if some of the current design features could be amended (without undermining IFFIm’s credit rating or its legal arrangements). The first might be to allow greater freedom over the timing of expenditure. Currently annual spending caps govern how much can be spent each year. This raises the question as to whether benefits could be increased if even greater frontloading, or any other profile of spending consistent with programme demands, were allowed. A second approach might be to review the gearing ratio limit<sup>3</sup> which would allow more funds to be committed at an

---

<sup>1</sup> Barder and Yeh, 2006 The Costs and Benefits of Front-loading and Predictability of Immunization CGD Working Paper Number 80

<sup>2</sup> more recent estimates suggests the actual figure is much lower (as shown later in the paper)

<sup>3</sup> The “gearing ratio limit” or “advance rate” is amount that IFFIm can borrow at any given time, expressed as a percentage of donor contributions. At this time the limit that has been approved by the IFFIm Board is 70.9%. This means that for every 100 EUR IFFIm

earlier stage if they are required. Again, the question is whether relaxing this constraint would allow IFFIm to increase benefits without compromising its credit rating and making it an unviable or unduly costly route.

**IFFIm is more expensive than some alternative approaches but the “IFFIm premium” appears to be fairly modest.**

The international community pays an “*IFFIm premium*” for accessing what Moss has usefully described as “a virtual pot of callable aid flows which allow more predictability”. Assessing the size of the premium is complex and depends heavily on the choice of alternative and an assessment of whether that alternative is feasible (see box).

**Measuring the “IFFIm Premium”**

The IFFIm premium is not simply the return paid to bondholders to encourage them to purchase IFFIm bonds plus the transactional costs related to maintaining and administering IFFIm. Rather, it is the difference between this and any alternative means of raising a similar amount of money. Thus, the IFFIm premium is made up of the borrowing premium (the extent to which it pays more to access its funds than other alternatives) plus any transactions costs over and above what would be incurred by raising funds through alternative means.

One alternative to IFFIm would be for the individual IFFIm grantors to raise the frontloaded money themselves and pool it. Most IFFIm donors are running budget deficits and would, therefore, have to borrow funds on the capital markets to do so. AAA-rated donors could do so at cheaper rates than IFFIm, others with lower credit ratings would probably pay more. For donors such as Norway, on the other hand, the alternative would mean reducing their contribution to the Government Pension Fund (or Oil Fund). In this case the opportunity cost would be the returns they currently earn from this source. This return varies over time but is likely to be considerably higher than the yield on IFFIm bonds.

Recent work by GAVI suggests that the borrowing premium paid for the initial bond issue was around 0.145% (i.e. IFFIm paid 0.145% more for its funds than its funders could have done individually by borrowing themselves on capital markets assuming they could have done so. For more detailed analysis see GAVI 2008<sup>4</sup>). This borrowing premium results from lenders’ perceptions of the risks that they will not be repaid. This will be determined, amongst other things, by lender perceptions of the risk that the donors will default, that the Treasury Manager will not fulfil its obligations and that recipients will fall into arrears (at a higher rate than they have historically).

---

holds, it can only borrow, and only disburses, 70.9 EUR in frontloaded disbursements. (Board approval would be required to disburse IFFIm resources in full. This adds to the opportunity costs as the bonds are effectively overcapitalised. At the same time it provides lenders reassurance that IFFIm is operating prudently.

<sup>4</sup> Incremental Financial Cost — IFFIm vs. Traditional Funding Sources GAVI June 2008

When estimated administration costs of \$5m per annum are added the total all-in cost IFFIm premium (described here as the IFFIm premium) is estimated to be 0.41% per annum<sup>5</sup> (GAVI, 2008). However, it should also be noted that the alternative of government borrowing also has administration and other related costs

In short, there is a modest IFFIm borrowing premium. It is unclear whether this increases or decreases when other transactional costs are considered. If a substantial expansion in IFFIm is being considered a more detailed analysis, including analysis of the non-borrowing costs, should be carried out (as a small premium on a large amount is still a considerable amount of money).

At the same time, borrowing premiums are constantly changing and any estimates would need to be recalculated for each bond issue to reflect market conditions at that time. At present the yield differentials between AAA supranational bonds (including IFFIm) and AAA benchmark government bonds are at an all time high reflecting the prevailing investors' flight to quality and liquidity in the financial markets. As such the borrowing premium may well be lower in future. If an IFFIm expansion does take place it will be important to monitor the borrowing premium over time to ensure it still offers donors value for money. The robustness of the findings should also be tested through sensitivity analyses. The analysis could also consider further alternative ways of raising funds (e.g. for IBRD to raise the funds backed by contributions from the IFFIm donors – a possibility outlined later in the paper). These might have lower all in costs than the alternative outlined above.

**If IFFIm is considered a relatively expensive funding option this would suggest that for a specific intervention donors should choose to provide support through alternative, cheaper means where possible.**

IFFIm might, therefore, primarily be seen as a funder of last resort. This is not to suggest an expanded IFFIm would have no role – given the size of the likely funding requirements it would almost certainly be required.... but the emphasis should be on identifying where it is most needed and where other alternatives cannot fill any outstanding funding gaps.

**There are real alternatives ...but they might involve difficult choices**

It has been argued that the alternative used (governments borrowing the money themselves) is only theoretical given that some contributors would not be able to do so without exceeding budget deficit targets. In practice, it is a real alternative but finding the fiscal space to support HSS without affecting the overall budgetary position would require Government to make cuts elsewhere. This may be difficult, especially in the current context of the global financial crisis, but is not impossible.

---

<sup>5</sup> "If amortized over the life of IFFIm and assuming that the entire USD 4 billion is actually raised. This is the cost to "buy" a mechanism which allows the donors to save lives and contribute to achieving the MDGs to fund USD 3 – 4 billion in development aid over 7 years while recognizing and paying for it over 21 years". GAVI estimates suggest that administration costs amounted the equivalent of 0.27% basis points (based on costs of \$5m and average outstanding bonds averaging \$2bn over IFFIm's life) with the borrowing premium a further 0.145%. Were IFFIm to be expanded the share of administration costs is likely to decline given that a proportion of the \$5m is fixed and does not vary according to the size of the operation. Costs are probably relatively high as IFFIm is a complex structure with two different Boards which has incurred up front costs - in establishing itself as a supranational both initially and in each new jurisdiction – which are large relative to its fairly small current size

**It might be possible for some of the benefits of IFFIm (better predictability) to be achieved by other funding mechanisms - if donors chose to do so**

It is far from clear why some individual donors, given sufficient political will, could not make legally binding commitments from their *existing* aid programmes. DFID, the major IFFIm funder does, after all, currently make 10 year commitments. It is not clear why such commitments cannot be made legally binding and why the IFFIm route needs to be taken to achieve this..

To the extent that other financing mechanisms do not make use of legally binding agreements IFFIm will continue to have a comparative advantage in terms of predictability in raising funds. However, it would also tend to suggest that IFFIm's core comparative advantage lies in its ability to frontload resources more than other mechanisms (and that there is a case for doing this in the areas funds are being deployed)

**IFFIm could, in principle, be used with greater flexibility with more frequent issues**

Having established a "market footprint" it would, in principle, be possible for IFFIm to issue a bond within a very short period of time<sup>6</sup>. It could, therefore, be a way of meeting relatively short term shortfalls whether they arise from increased demands (e.g. through an emerging health emergency such as SARS) or through unexpected declines in aid flows (e.g. by donors failing to meet their commitments). Clearly, there are trade offs between raising funds in advance of need (often unpopular with donors and often seen as inefficient – though this is debateable if surplus funds are invested securely) and regular, smaller bond issues which will imply slightly higher overall costs (as there are some fixed costs attached to each issue) but better fit actual funding requirements. Such an approach would be consistent with a "provider of just-in-time funding" role perhaps meeting any peaks in demand for aid resources (in the same way that electricity companies use the cheapest source to meet the base load and more expensive sources to deal with the peaks and troughs in demand).

The arguments against such a role for IFFIm is that it is actually easier and quicker (but more expensive) to raise larger amounts of resources than smaller amounts. This suggests that whilst IFFIm might have a useful role to play in terms of providing an aid buffer stock (see below for a discussion of its possible role in supporting an aid guarantee fund) it may not be the best instrument for fine tuning any small, short term imbalances between the supply and demand for aid funds.

**IFFIm could be much larger than it is now - but it is not clear how much larger – and it is not clear whether it could be large enough to fill funding gaps**

IFFIm, as it stands, is expected to raise a total of \$4bn although sufficient grantor support for this level of funding is not yet available. Initial bond issues have been fully subscribed and there are indications there would be a strong demand for further issues – if the price is right. Some of this relates to the fact that investors see a clear link between their investments and saving the lives of children. Whether this demand would be sustained were the money to be spent on health systems strengthening - a far vaguer concept even to those working in international health - is an open question. It is not clear how much this would influence potential investors. A less well-defined purpose may well diminish IFFIm's marketing clout - investors have, to date, responded very positively to IFFIm's clear immunization message.

---

<sup>6</sup> Given a sudden need for money unexpectedly, IFFIm could issue a bond efficiently in less than 2 months, but only if the requirement is of sufficient size to allow a benchmark bond – approximately \$1bn. Unless those funding requirements are of sufficient size to allow benchmark issues, then much more time for planning and encouraging dealers to find opportunities is needed. A very flexible, funder of last resort role deal with small amounts of funding would be more appropriate for a commercial bank or similar in the form of a line of credit. Freedom to raise larger amounts of liquidity could, however, enable IFFIm to act as buffer for short notice requirements.

**If IFFIm were to contribute substantially to closing any outstanding funding gaps in IHP countries it would have to increase considerably in size.**

The separate background paper suggests that up to \$13bn may be required by 2015 to allow 6 of the current International Health Partnership countries to fully fund their current health plans. This is roughly \$2bn per annum and is more than 3 times the current size of IFFIm. Moreover funding gaps would still remain post 2015. Achieving the much more ambitious Commission for Macroeconomics and Health target of each country spending at least \$35 per head on health would probably require over \$30bn per annum – orders of magnitude greater than IFFIm and more in line with the \$50bn per annum suggested in the original IFF concept.

**In principle an expanded IFFIm could fill funding gaps of this size but to do so it would require further capitalisation.**

This may be a constraint given that support has come from a limited pool of donors and the fact that in many countries their budgetary regimes and IFFIm's scoring structures do not allow their participation. Participation is also restricted by the need for a grantor to have a credit rating which rules out support from some potential investors such as the foundations<sup>7</sup>. The composition of grantors (and their respective credit ratings) would also have a bearing on the ability of IFFIm to issue bonds and on the borrowing premium.

Non financial constraints would include the availability of a pipeline of programmes to support and the capacity to appraise them properly. There is probably sufficient current capacity for IFFIm to be a \$5 to 10 billion per year funder without much risk. Larger than that (up to \$15 bn per annum) is more to take on, and would probably require additional Treasury Manager resources<sup>8</sup> to focus exclusively on IFFIm.

---

<sup>7</sup> For example the Bill and Melinda Gates Foundation could not participate although Microsoft could in theory. It is not clear that IFFIm couldn't accept other contributions the issue is more that such contributions might not increase the amount available for bond issuances

<sup>8</sup> ~1-2 capital market development staff

## 2. BENEFITS OF FRONTLOADING FOR HEALTH SYSTEMS STRENGTHENING

Table 1 outlines the case for frontloading investments in the various HSS components and outlines the conditions which would need to be met for benefits to be achieved.

**Table 1: Why would we want to bring forward HSS investments?**

<b>HSS DIMENSION</b>	<b>BENEFITS OF FRONTLOADING (BRINGING INVESTMENTS FORWARD)</b>	<b>ASSUMES THAT.....</b>
Delivering health services through a primary health care approach	Systems benefits achieved through effective services being delivered earlier than would be possible otherwise.	The right services are delivered/the essential health care package is appropriate
Financing and social protection	Systems benefits achieved through better use of resources and greater protection against the financial consequences of ill health at an earlier date than would be possible otherwise	Proposed approaches are appropriate
Health workforce	Systems benefits achieved through more health workers being available to provide essential services at an earlier date than would be possible otherwise	Health workers have the capability and adequate incentives to deliver essential services to the right people
Logistics and supply chains	Systems benefits achieved through more efficient use of resources (less wastage, expiry, storage capacity) at an earlier date than would be possible otherwise	The right products are entering the logistics and supply chain and that there is a demand for them
Information and knowledge	Systems benefits achieved through ineffective programmes being halted earlier/effective programmes being expanded at an earlier date than would be possible otherwise	There is an interest in implementing evidence based approaches
<i>Governance</i>	Systems benefits achieved through better use of existing resources e.g. through better strategic planning/resource allocation and reduced corruption than would be possible otherwise	There is broad national support and high level political commitment to improving governance

In some cases the effect would simply for good things to happen earlier than would be the case otherwise. In other cases there will be broader knock on benefits to the system as a whole. Support could allow accelerated provision of services with broader public health benefits e.g. immunisation. It could also result in greater efficiency in the use of resources – better allocation of resources, expansion of effective services, contraction of ineffective services, more efficient delivery of all services (including reduced corruption). Such benefits are ongoing rather than one off. These benefits will not necessarily be achieved automatically; realising this potential depends upon a number of conditions being met (set out in the far right column).

### 3. WOULD THE RATIONALE FOR IFFIM APPLY TO AN IFF FOR HSS?

Table 2 suggests that most of the arguments both in favour and against IFFIm would apply equally to an IFF for HSS.

The boxes shaded in green reflect arguments which apply to both – those in red are specific to immunisation and do not apply to HSS (although the footnotes raise some questions as to whether this is, indeed, the case). An IFFIm aimed at HSS would not enjoy benefits similar to those related to herd immunity which are specific to immunisation. They would, however, allow governments to make efficiency improvements through better planning<sup>9</sup>. In some cases the situation is not so clear and what might be an argument against an IFF-approach for immunisation might actually be an argument in favour when it is applied to HSS (these are shown in orange in the table). This is due to the different cost structures of the interventions in question<sup>10</sup>.

**Table 2: Pros and Cons of IFFIm – Do the arguments for immunization apply equally to health systems strengthening?**

	BENEFITS	COSTS
Predictability	Greater chance of key inputs (i.e. vaccines) being available and lower product prices <sup>11</sup>	Risk of donors committing themselves to actions which might not prove to be the most cost effective in the long term
	Allows Governments to make investments in improving service coverage	Legislative and administrative requirements make transactions costs involved in making long term commitments prohibitive (i.e. it is difficult for donors to make their own commitments legally binding commitments)
	Allows Government investment to be phased and sequenced in most cost effective manner	
	Impact on disease burden through herd immunity <sup>12</sup>	Additional financing costs of borrowing through IFFIm are high compared to alternative

<sup>10</sup> They are costs because the marginal cost of immunization increases as harder to reach groups are covered. If effect the availability of frontloading has a multiplier effect further bringing forward the need for additional funds. Were the marginal cost to decline they frontloading would actually bring benefits as lower marginal costs would be achieved earlier. This raises the empirical question as to whether the various HSS components face increasing or decreasing unit costs. There are strong reasons for thinking that this might be the case. Many HSS investments are likely to exhibit economies of scale – the average cost of training additional health workers is likely to go down as long as there is spare capacity; the marginal cost of collecting additional data in a Health Information System (HIS) is likely to be very low in relation to the cost of establishing the HIS in the first place. HSS investments may also reduce the marginal costs of increasing immunisation coverage. This issue needs further empirical work.

<sup>11</sup> Such arguments would probably not apply to HSS ... or would the private sector expand capacity if they thought there was a prospect for sustained predictable funding for contracting. Would an individual decide to train as a health worker if he/she were convinced that funds would be able to employ them when qualified???

<sup>12</sup> Investment in HSS would not necessarily have the same type of health impact as investment in vaccines. However, this is not so say HSS investments will not have a health nor that they are likely to be less cost effective that investing in immunization. In principle, there could be HSS investments which are both more cost effective and reduce recurrent costs by more than investment in immunisation

	BENEFITS	COSTS
Frontloading	Economic and fiscal benefits: More productive workforce, averted health costs	Profile of funding requirements moves forward (higher marginal costs associated with higher coverage are faced earlier)
	Reduced costs: More predictability in spending on programmes	Possible increase in unit prices in short term (if supply response is weak). Purchasing more products earlier before price has declined
	Greater benefits: Benefits today are worth more than benefits tomorrow (due to discounting)	

Adapted from Barder and Yeh 2005<sup>13</sup>

Key
General to all IFF
Depends
Specific to IFFIm

Another issue to consider is that if aid effectiveness increases over time, as we hope it will, the case for delaying spending to a point at which it can be used more effectively becomes stronger<sup>14</sup>.

A further issue to consider is the potential for frontloading to have a wider impact on health markets. It is quite possible that by concentrating investments over a short period of time unit costs might increase (if demand increases and there is no supply side response) which might be most obvious, for example, where Government contracts with private providers (increased demand plus constant supply equals higher prices). Frontloading may also draw human resources into the public delivery system which has implications for the private sector provision. Interactions between public and private sector are complex but cannot be ignored.

The timeframe for front loading may also be an important consideration. An IFF style “spend now/pay later” type arrangement relies, to some degree, on the fact that when net disbursements turn negative Governments will have found the additional fiscal space to take the burden (either because they are raising more money themselves or the IFF investments have reduced costs). However, at expected rates of growth in donor and Government support it is likely that even by 2030 many countries will still be spending less than \$30 per head and well below CMH targets. Whilst it may be possible to sustain positive net disbursements for some period it is questionable whether it can be sustained for such a long period. It would certainly involve huge amounts of frontloading. In short, an expanded IFFIm of a size needed to close outstanding financing gaps would need to raise huge amounts of money and be sustained for a considerable period of time, This could reduce donor capacity to respond to other development challenges in future years.

<sup>13</sup> Working Paper Number 80 January 2006 The Costs and Benefits of Front-loading and Predictability of Immunization

by Owen Barder and Ethan Yeh

<sup>14</sup> This is not necessarily a case *against* frontloading but a case for *delaying* frontloading and a strong case for strengthening efforts to improve aid effectiveness.

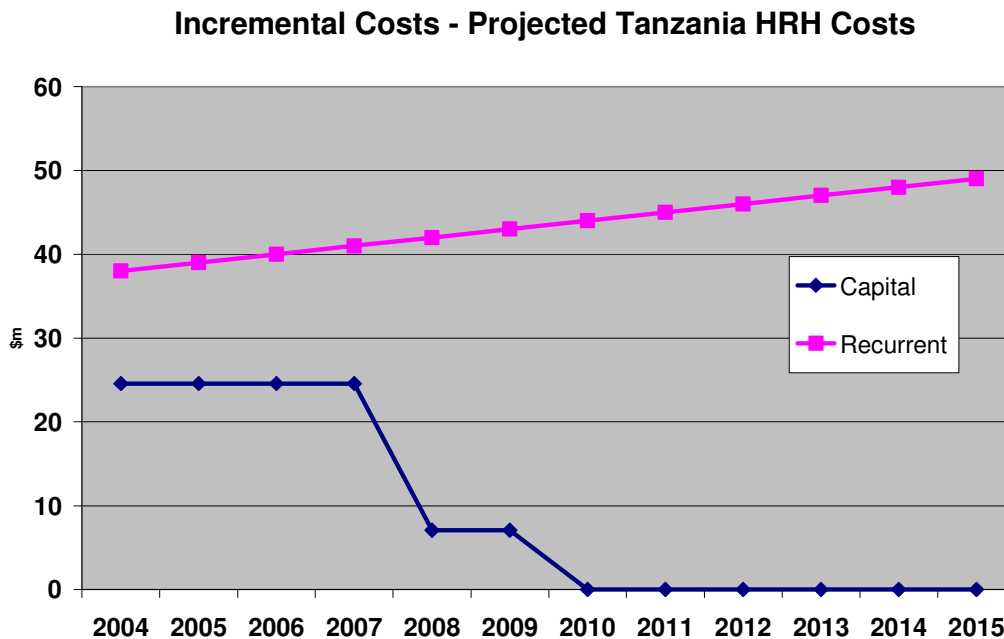
#### 4. IS THERE A DEMAND FOR FRONTLOADING FOR HSS?

Based on the fact that IFFIm brings both greater frontloading and, at least currently, greater predictability than other approaches, an expanded IFFIm should be most suited to those interventions requiring large upfront investments and those where funding requirements are unpredictable.

Unfortunately we know little about the actual levels and profile of funding needs for different HSS investments. Clearly, the approach will differ according to the country context and the costs will reflect this. Some work has been done to cost some elements of the HSS package in some countries but there has been no systematic effort to do this yet.

A quick review of a sample of Human Resource for Health Plans<sup>15</sup> reveals few patterns. In the case of Tanzania significant up front investment costs are required (see figure 3). In the cases of Ghana, Zambia and Lesotho, however, much of the additional investment is for recurrent spending on salaries or spending on training which is phased over time. On the basis of this **the current demand for frontloading appears weak**. This may be because countries are assuming that frontloaded support will not be available so they plan accordingly. **We cannot rule out the possibility that there is a latent demand, and therefore a need, for frontloaded support** for HSS. (see Annex 1). This issue should be reviewed in detail by the Task Force.

Figure 1



<sup>15</sup> Lesotho Health Sector Human Resources Development & Strategic Plan 2005 – 2025 Ministry of Health and Social Welfare 2004  
Costing estimates for the Ghana HRH Strategic Plan 2007-2011 October 2007 WHO  
Acting Now to Overcome Tanzania's Greatest Health Challenge HUMAN RESOURCES FOR HEALTH – TANZANIA Report from Field Visit (November 2003) April 2004  
Zambia Human Resources for Health Strategic plan 2007-2011 October 2007 WHO

Given the lack of hard data on costs the table below shows a typology of different approaches to addressing the various HRH components and their implications for:

- the funding profile,
- the extent to which funding requirements can be predicted and
- the extent to which the issue is best dealt with through project type support or through more flexible forms of programme support<sup>16</sup>.

The example of human resources is presented in the table below. The full version covering all HSS components is shown in **Annex 2**.

**Table 2: Example of Health Systems Strengthening Typology**

<b>HEALTH WORKFORCE: FINANCING TYPOLOGY</b>				
<b>This involves...</b>	<b>Which means...</b>	<b>Investment type</b>	<b>Suitability for Project v Budget Support</b> ←-----→	<b>Predictability of costs</b>
Employing more and better people	Recruitment, then employment	Mostly sustained but start up costs slighter greater to cover cost of recruitment. Must be linked to next line.	X-----X	High if well planned (depends on governance)
	Training and retraining	Initial high to cover initial training of new staff and updating training of old staff Then lower but sustained to cover retraining and new people coming in	X-----X If coupled with capacity building of training institutions	High if well planned (depends on governance)
Improving governance and management	Revising HR policies, workforce planning, updating terms and conditions etc	Lead in time to get political support so initial spending might be slow. Then higher to do leg work e.g. rewriting job descriptions, and then lower but sustained to maintain.	X----X Politically sensitive therefore buy in essential.	Some initial activities reasonably predictable, others less so as needs develop.
	Improving staff supervision	High at start for training and systems development, then lower but sustained to maintain, retrain staff, enhance systems etc.	X-----X Politically sensitive: needs buy in at all levels	Some initial activities reasonably predictable, others less so as needs develop.
	Supporting professional regulation	Start up costs higher. Then lower but sustained.	X or X-----X May need to be outside of government system	Low. May be contentious

<sup>16</sup> This is not particularly relevant to the choice of instruments. SWAPs or MDTFs can, and should incorporate, project type funding where it makes sense as well as unearmarked sector funding. The more important questions relate to the higher transactions costs – especially where the case for a project based approach is less clear

## 5. WHAT MIGHT AN EXPANDED IFFIM BE PARTICULARLY SUITED FOR?

Although the primary aim of this work is to explore the case for an expanded IFFIm to support HSS there may be other health investments which might benefit from such a facility. A balanced case for an expanded IFFIm should consider all possible uses

Starting from the perspective that IFFIm is currently the only way of achieving a large amount of frontloading, and that it can do so in a predictable manner, which forms of investment might this make it particularly suitable for?

### ***Investments which can benefit from frontloading***

Frontloading allows investments to be brought forward. However, spending more now means spending less (than would otherwise be the case) later. From an **economic perspective** frontloading can be justified if the benefits of bringing the investment forward exceed the costs of using IFFIm. The extent to which this takes place depends on how cost effective the investments being supported are and whether they exceed the costs of borrowing associated with IFFIm.

From a **financial perspective** it also requires a reasonable likelihood that any ongoing recurrent costs can be met (given that less resources are available later). This would suggest that an expanded IFFIm might have little role to play in funding large and continuing financing gaps. (In effect there is a risk that frontloading becomes a giant pyramid scheme with continuing bond issues required to fill ongoing funding gaps (all of which reduce funding flows in the medium to long term). At some point such an approach would undoubtedly collapse

This would suggest a strong case for supporting interventions where

**1. Long term recurrent costs are significantly reduced (or removed):** Typically this will mean upfront capital investments which have few recurrent costs or investments which are specifically designed to reduce recurrent costs. In the case of vaccines, the health benefits from achieving herd immunity far earlier than would be the case otherwise are, of course, extremely welcome. Also important from a financing perspective is the fact that once herd immunity is reached there is likely to be a huge reduction in costs associated with treatment. The fact that IFFIm means less resources later is not an issue, in these circumstances, as those resources are no longer required.

**Investments with global public goods characteristics or significant externalities which significantly reduce recurrent funding needs**

These might include investments in developing effective products that reduce disease burden, such as new vaccines which could significantly reduce treatment costs especially where herd immunity is achieved (as is the case for IFFIm)

Funding the acquisition of knowledge and information is another example. Piloting and evaluating innovative financing schemes and operations research that can contribute to global knowledge on what works in health systems strengthening are example of public goods which have the potential to improve efficiency.

Disease eradication is also a public good which can only be achieved by public intervention. Here, successful eradication removes the need for any recurrent funding other than routine surveillance. IFFIm could, therefore usefully invest in efforts to address selected neglected tropical diseases (NTDs) where eradication is feasible (e.g. Guinea Worm eradication is estimated to cost around \$88m over the 7-8 years with completion thought to be feasible by 2015<sup>17</sup>). For other NTDs new tools, products and diagnostics are required before eradication might become feasible which are likely to be extremely costly. All of these might be suitable for IFFIm support if there is a strong case for eradication

**Investments with high up front costs or a requirement for up front commitments:**

An expanded IFFIm could help finance high up front costs which could not otherwise be met from traditional sources as long as the return on investment is worthwhile. Of particular interest would be investments where such costs result in low recurrent costs freeing up resources for other uses. Such investments might be appropriate in many areas – in HSS but also other areas. Investment in infrastructure and developing human resource capacity through expanding training institutes are possible examples. An up front diagnosis of what the bottlenecks are at the country level would be required to identify financing requirements

Other uses might include approaches to developing new products e.g. through advance market commitments (AMCs). Here the issue is not necessarily about the need to actually make an up front investment - rather it is to make up front pledges which are considered to be credible by potential manufacturers. AMCs are also rather different in that they actually serve to increase recurrent cost requirements as they make available a product that would not otherwise be available. As such it would be important to demonstrate that any interventions supported are extremely cost effective or pro poor to justify meeting any ongoing costs. Alternatively, it might be possible to consider options in which IFFIm provides the guarantee to purchase products but only does so if alternative, cheaper, funding cannot be found. Effectively, IFFIm might underwrite an AMC but not necessarily fund the products it delivers. It is questionable, however, whether other donors would be willing to provide funds knowing IFFIm funding was already committed. The potential for expanding the scope of AMCs – for example to services delivered by the private sectors – could also be explored.

<sup>17</sup> It is understood that DFID and BMGF are likely to fund this

### **Countries facing large one-off transitional costs**

In many countries rapid economic, social or demographic transition may require significant one-off restructuring of their health systems. The Central Asian republics perhaps provide a good example in terms of the need to move away from a hospital based approach in the post-Soviet era. It might also apply to Asian countries facing rapid demographic changes and a rapidly aging population. This argument here is similar to those outlined above although here it applies to high fixed costs at the national level rather than for specific investments. Equally, one could also argue that an IFF could be used to invest in programmes likely to accelerate progress towards the demographic transition in low income countries – e.g. promoting accelerated access to family planning services an area which has seen a declining share of health ODA in recent years

**2. There is a reasonable likelihood that any recurrent costs can be met:** this might apply in setting where fiscal prospects are good and that even if there are significant recurrent costs we can be fairly confident that these can be met by Governments in the reasonably short term

### **Countries with good fiscal prospects**

An expanded IFF could accelerate progress in countries where economic growth and associated fiscal prospects are good such that investments could be made with the certainty that countries could take on any recurrent implications in the relatively short term. This might suggest greater focus on Asian countries (e.g. Cambodia, even India?? ...but also Botswana, South Africa etc??) which tend to be neglected given the current focus on sub-Saharan Africa. The basic premise would be “let's sort these countries out so we can focus on the rest”. The argument against this is that such countries have access to private capital markets and can often afford to pay market rates for loans. **Annex 8** (main paper) shows that the major financing gaps when current spending is compared to the CMH targets continue to be in South Asia (mainly India) rather than Sub Saharan Africa which would tend to support this approach (though this situation will reverse over time). The key argument against IFF is that more aid now means less than would otherwise be the case later would not be an issue in such countries. Having accelerated progress they would no longer need aid for health in the medium term. Such an approach would not be without its risks; given their higher income status a clear exit strategy would be essential

### **3. Exceptional cases**

#### **Fragile states/countries emerging from conflict**

In these settings there is likely to be a need for significant up front funding related to reconstruction but also a need for long term recurrent funding. There is little likelihood that these countries would be able to meet such cost from domestic resources. Ideally, IFF would only be used to fund the initial costs but there may be a case for funding longer term needs if alternative sources cannot be found.

### ***Investments which can support greater predictability***

#### 4. Investments which reduce the impact of unpredictability in funding needs

##### **Emergency situations requiring additional but temporary funding**

It is likely that over the coming decades developing countries will face health emergencies some of which can be predicted others which cannot. Having access to a call-able pool of resources might allow a more effective response and reduce time and effort expended in seeking resources at a time when limited capacity is better used elsewhere<sup>18</sup>.

#### 5. Investments which reduce unpredictability in disbursement of donor funds

##### **Insurance role (aid guarantee fund)**

Some have suggested the need for a fund to ensure that countries with sound health plans are not denied resources through unpredictable donor funding. (see Foster<sup>19</sup>). The idea is that such a fund would underwrite these plans and step in when donors do not fulfil their obligations. In the Foster design the proposed Aid Guarantee Fund is actually a revolving fund so beyond an initial injection of capital it would not need further funding (recipients would receive support when aid flows fall below an agreed level but would pay back the fund once support exceeds the agreed minimum level). IFFIm could, in principle, provide that initial cash injection.

Another approach would be for a fund which both removes unpredictability and increases funding. Such a fund would not revolve and would need some degree of ongoing support. A key problem here is that donors would face little incentive to provide support if they know any shortfalls would be made good by a guarantee fund. Any approach would have to be designed to take this into account.

In both of these cases the approach could be adopted at the sector level or more broadly. Emergencies are not only in health; predictability is a problem in many sectors. This does raise the further question as to whether the approach might be considered at the sector level only, or as a sector pilot for possible wider introduction or broadly from the outset. It is proposed that the Task Force considers this option in detail

---

<sup>18</sup> Given the costs associated with IFFIm there would be little sense in raising funds in advance of need without a commitment for early disbursement. This raises the questions as to whether IFFIm would be able to call down funds quickly enough to deal with most types of emergencies

<sup>19</sup> Foster Improving the Medium to Long-term Predictability of Aid January 2005

In summary, there are a number of uses to which IFFIm funding could potentially be put. Only some are related specifically to health systems strengthening. Others would presumably support the HSS agenda indirectly, if not directly, by protecting it against sudden shocks (in emergencies all the attention become focused on meeting immediate needs with longer term systems development issues neglected) or by releasing resources for HSS in the long term (by accelerating the transition of high performers to a position where they no longer need aid). Some of the potential uses are determined by the country context - others by the nature of the specific intervention. This would tend to emphasise the importance of looking at the issue from a sector development perspective rather than just an HSS perspective.

The Task Force should consider these options and investigate possible additional uses of an expanded IFFIm. These will need to be clearly spelt out as market investors will need to fully understand what they are committing their money for and how it will be used

## 6. HOW MIGHT A SCALED UP IFFIM WORK? WHAT ARE THE MAIN OPTIONS?

If there is a case for a scaled up IFFIm how would it work given that its focus might be very different? Could the existing arrangements be retained or would new approaches be required? If so what would the implications be? A number of possible approaches are set out below for discussion.

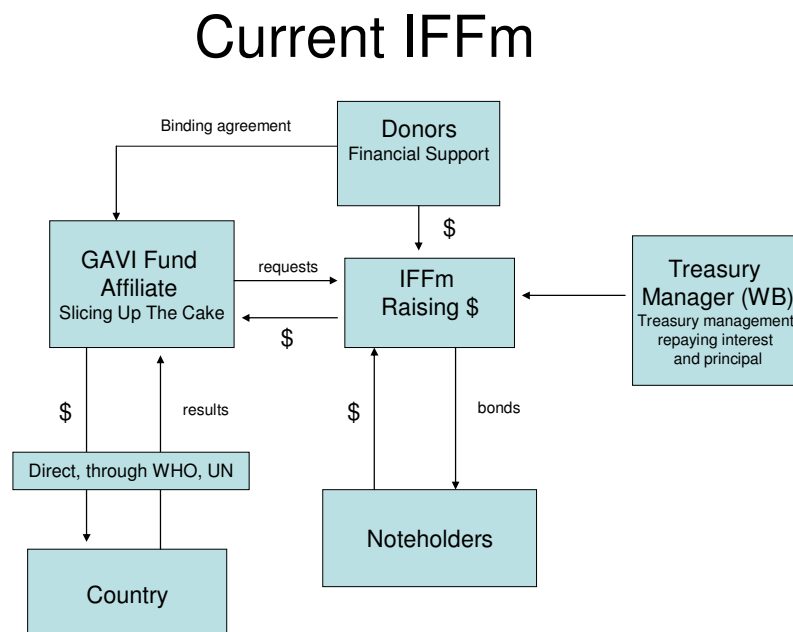
The two crucial features underpinning the IFFIm model are:

- **achieving and maintaining status as a AAA-rated supranational.** This allows it to raise funds relatively cheaply, and protects that ability even in times of financial turmoil; and
- **agreement that donor contributions are off budget.** Eurostat has ruled that donor contributions remain off budget and are only counted as public spending when it is spent as opposed to when it is committed. Not having to fully provision against IFFIm commitments is a critical element of participation for some donors. This is due, in part, to the fact that donor support is conditioned on recipients not being in arrears with the IMF under IFFIm's "high-level financing condition". This ruling makes support attractive (and affordable) for some donors.

Any analysis of other options would, therefore, need to consider the extent to which these key features would be compromised.

IFFIm's current institutional arrangements are set out below:

Figure 2



**Possible approaches to scaling up the IFFIm type approach to support Health Systems Strengthening**

**Option 1: An Expanded IFFIm:**

This approach would use existing structures with minimal amendments. Firstly, more donor funds would be needed to adequately capitalise an expanded IFFIm. More health systems strengthening expertise might be required to support the GAVI Fund Affiliate and advise the GAVI Board on allocation decisions (although all key stakeholder groups are already represented on the GAVI Board). Ensuring a results based focus might also pose further challenges given that assessing impact for health systems strengthening is likely to be more difficult than for immunisation.

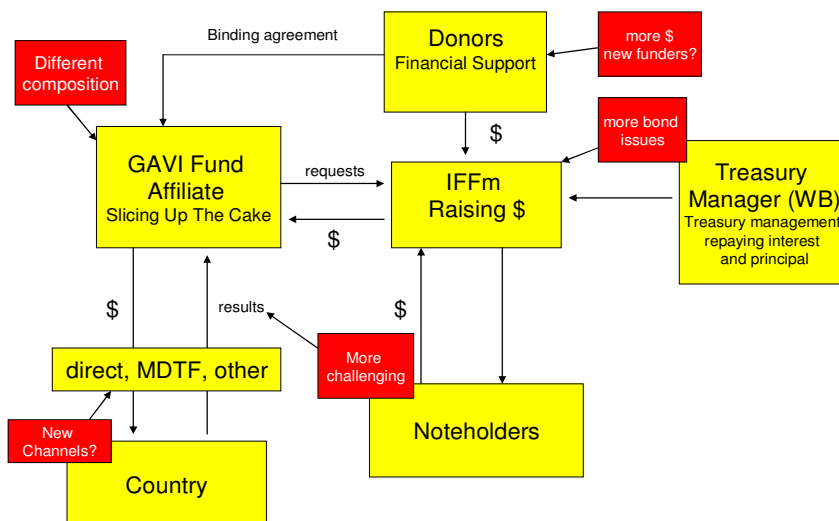
It might also be possible for an expanded IFFIm to channel resources in different ways – including through a World Bank Trust Fund where appropriate.

The main advantage of this approach is that it builds on existing, proven arrangements and would require the smallest amount of amendment to IFFIm’s establishing documentation. Further work would be required to assess quite how effective current arrangements are and whether any of the changes suggested here could be made without affecting IFFIm’s AAA credit rating and ensuring donor contributions remain off budget (which will depend, in part, on who the funders of an expanded IFFIm actually are). Another possible advantage would be that the transaction costs of expanding IFFIm would be less than other alternatives outlined below. This issue would have to be examined in detail – it is quite possible that much of the legal documentation would have to be amended and that an expanded IFFIm might still incur significant costs.

One approach might be to adopt this approach at the outset on the premise that it can be done cheaply and quickly with a view to considering and adopting alternative methods later if they can be shown to offer better value for money.

Figure 3

**Option 1: Keeping the Current Arrangements**



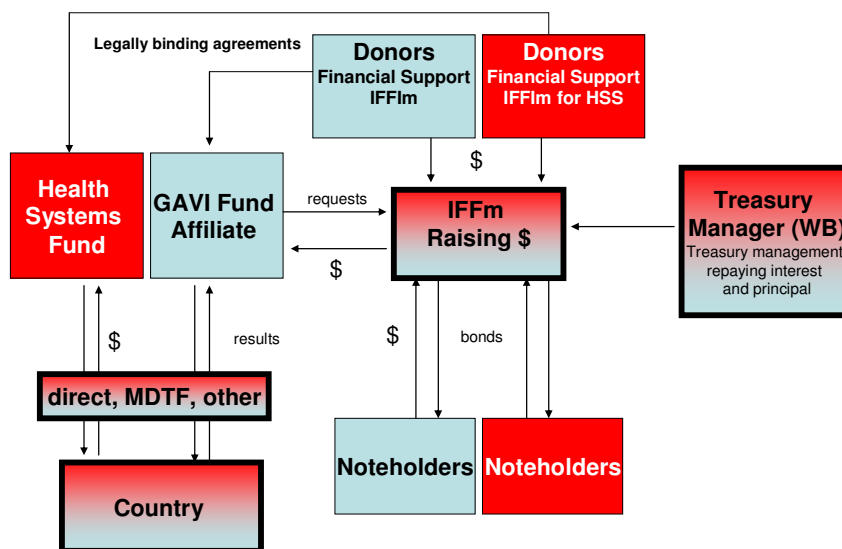
### Option 2: Building on the Best of IFFIm

Under this approach IFFIm would still be used as the mechanism for raising resources. However, funds for HSS might then be transferred to a separate “Health Systems Fund” (alternatively they could be channelled through the GAVI Fund Affiliate if donors do not wish to earmark their support for particular purposes).. There are also questions (raised elsewhere in this paper) as to whether such a Fund would adopt a narrow focus (covering health systems needs) or be broader in scope (covering a range of funding gaps as suggested earlier in this paper). There are further questions as to how such a Fund would be managed. A World Bank Trust Fund might be one of a number of options.

The main advantage would be that the establishment of distinct entities would allow the respective bodies to focus on their own areas of expertise. The key disadvantages would be the potentially large transactions costs and time involved in setting up such an approach and the extent to which it is feasible within IFFIm's current legal arrangements. More work would be needed to review this. It would also add complexity to the international health architecture when there is considerable pressure to simplify it. However, whilst it would add complexity at the global level it would not necessarily have any effect on flows and transactions costs at the country level.

Figure 4

### Option 2: Building on the Best of IFFIm



Note: Common arrangements have dual shading and bold outline

**Option 3: New Arrangements for a “Health Systems Fund” :**

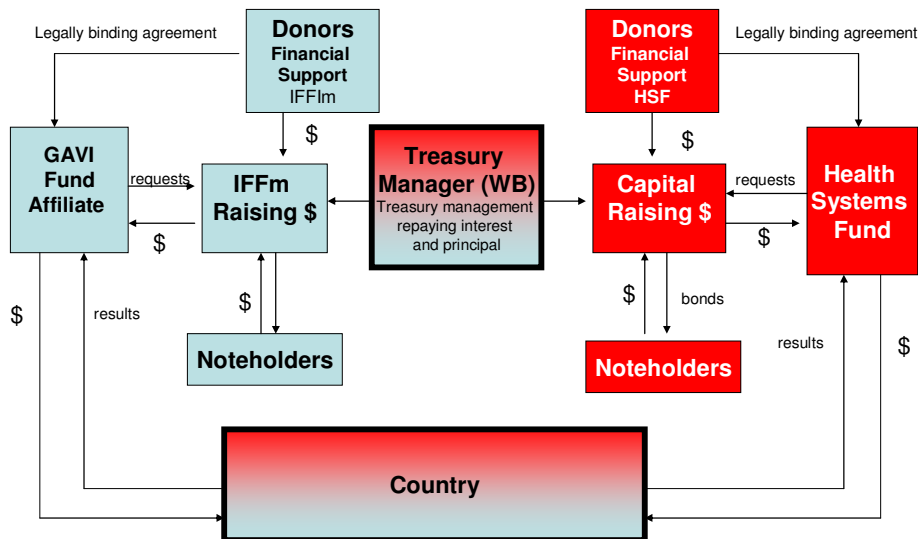
A third option might be to develop completely new IFF type arrangements, rather than an expansion of IFFIm. This could allow the use of alternative, and possibly more cost effective, approaches to raising revenue. Using IBRD to issue bonds might be one approach given its vast capital market experience and ability to access funds through bond issues at a highly competitive rate. This would, of course, again require further donor commitments and agreement from all parties.

The World Bank might still act as the Treasury Manager and, as in option 2 above, funds could be channelled to a Health Systems Fund the scope of which would need to be defined. Another option would be to raise the money separately from IFFIm but still channel funds through the GAVI Fund Affiliate.

The main advantage of this approach would be its focus on health systems. There would be costs involved in establishing any Fund (as in option 2). Issuing bonds could be done through existing mechanisms and would incur some costs but not as high as if a separate entity were being established; it is not clear whether they would be higher or lower than IFFIm. The key disadvantage would be the potential for a new Fund to further complicate the already complex health architecture by adding new structures (shared with option 2). Further work would be needed to assess the feasibility and costs of such an approach.

Figure 5

**Option 3: A New Approach**



All of the options would need to consider how funds are channelled at the country level. They could be allocated through an IHP “validated” mechanism at the country level – direct to Government, through World Bank Trust Fund or other similar arrangement such as SWAp pooled arrangements or in parallel. Indeed the GAVI Alliance is also considering how to change its approach to supporting HSS in IHP countries – an issue which would require Board decision.

## ANNEX 1: ESTIMATED HRH COSTS

### Zambia: Incremental HRH Costs

	Training Costs	Salary Costs
2006	0	14
2007	36	29
2008	55	45
2009	69	62
2010	69	82

### Tanzania: Incremental HRH Costs

	Productivity Gains for Existing Staff		Increasing Training Output by 50% over 10 years	
	On the Job Improvements	Improving Continuous Education	Cost of Expanded Training	Cost of Salaries for New Hires
Capital	\$55-60m over 3-5 years	\$10-15m over 3-5 years	\$40-45m over 6 years	zero
Recurrent	\$14m per annum	\$11-12m per annum	\$12-13m per annum	\$3m per annum growing at \$1m per annum

### Ghana: Incremental HRH Costs

	2007	2008	2009	2010	2011
MoE Training Costs	0.4	1.1	2.3	3.9	5.9
MoH Training Costs	1.7	4.7	8.5	12.7	17.7
Salary: New Graduates and Other Recruits	9.4	14.0	27.8	26.4	30.4
	11.5	19.8	38.6	43.0	54.0

## ANNEX 2: A POSSIBLE TYPOLOGY OF HEALTH SYSTEMS INVESTMENTS

THIS INVOLVES...	WHICH MEANS...	INVESTMENT TYPE	SUITABILITY FOR PROJECT V BUDGET SUPPORT ←-----→	PREDICTABILITY OF COSTS
<b>1. Delivering services through a primary health care approach</b>				
Development of policy and strategy framework	Development or revision of appropriate PHC policy	Sustained.	X-----X Gov't commitment essential	Low. Could be drawn out and politically contentious
	Assessing current configuration of primary, secondary and tertiary care, and adjusting provision and funding	Apart from high investment in infrastructure (see above) funds needed to support political processes to achieve it (much lower).	X-----X Gov't commitment essential	Low. Could be drawn out and politically contentious
	Agreeing a basic health care package	Sustained	X-----X Gov't commitment essential	Low. Could be drawn out and politically contentious
	Contracting with other sectors: Assessing need, developing and managing contracts, ensuring ongoing service planning, channelling funding	Initially high to set up systems, then could be v high to channel funds through NGOs and private sector.	To set up with Government: X-----X  To implement through NGOs/private sector X-----X	Reasonably high once contracts set up.
Developing infrastructure	Planning, and building / renovating clinics, and essential services (power, water); then maintenance.	V high upfront costs if building new; also likely to be high for renovation. Then lower to maintain but sufficient investment needed for standards to be maintained.	X-----X Gov't commitment essential for maintaining standards	High if well planned at outset and subsequently

THIS INVOLVES...	WHICH MEANS...	INVESTMENT TYPE	SUITABILITY FOR PROJECT V BUDGET SUPPORT ←-----→	PREDICTABILITY OF COSTS
	Providing equipment – medical, lab, patient transport. Then maintaining, which includes developing maintenance plans and training staff to use equipment	High upfront, then lower but sustained.	X-----X Gov't commitment essential for maintaining standards. Initial investment could be project based but.	High
Providing appropriate inputs	Ensuring the right staffing, including admin support (see HR section)			
	Ensuring essential supplies (see logistics section)			
Setting up systems	Developing and setting up systems for quality assurance system, patient records, information (see Information and Knowledge section) staff and activity management, and patient referrals. Needs to include staff training.	High at start, then lower to maintain.	X-----X for start up  X-----X For implementation	Medium
Setting up services	Designing and implementing appropriate service delivery models services to meet local needs e.g. community outreach services.	Implementation costs high throughout, plus additional set up costs.	X-----X	Overall medium
Community participation in governance	Setting up and implementing systems to engage the community. Changing attitudes of service providers and local politicians.	Initially high, then lower	X-----X Gov't commitment essential	Low/medium
Innovative financing arrangements e.g. RDF	Develop and implement systems. Possibly also provide finance through these systems.	High to start up. Then much higher if used to channel funds	X-----X	Low/medium to set up High to use for funding
	Health information system (see below)			

THIS INVOLVES...	WHICH MEANS...	INVESTMENT TYPE	SUITABILITY FOR PROJECT V BUDGET SUPPORT ←-----→	PREDICTABILITY OF COSTS
<b>2. Financing and social protection</b>				
Identifying and implementing the most appropriate funding mechanisms for the health system	Identify and agree appropriate funding arrangements	High to identify mechanisms. Lower but protracted to establish them	X-----X Gov't commitment essential	Low. Politically contentious
	Developing enabling policy to establish financing basis and exemptions.	Sustained.	X-----X Gov't commitment essential	Low. Politically contentious
	Developing and implementing financial protection mechanisms.	High at start then lower when maintaining systems	X-----X	Medium, assuming consensus at the start
	Building capacity in MoH and at lower levels of health system to manage financial system.	High then lower but sustained	X-----X	Medium
Financing safety nets for poorest	Identifying modalities and funding them	High and sustained	X-----X	High once set up, except for major natural disasters.
<b>3. Health workforce</b>				
Employing more and better people	Recruitment, then employment	Mostly sustained but start up costs slighter greater to cover cost of recruitment. Must be linked to next line.	X-----X	High if well planned (depends on governance)
	Training and retraining	Initial high to cover initial training of new staff and updating training of old staff Then lower but sustained to cover retraining and new people coming in	X-----X If coupled with capacity building of training institutions	High if well planned (depends on governance)

THIS INVOLVES...	WHICH MEANS...	INVESTMENT TYPE	SUITABILITY FOR PROJECT V BUDGET SUPPORT ←-----→	PREDICTABILITY OF COSTS
Improving governance and management	Revising HR policies, workforce planning, updating terms and conditions etc	Lead in time to get political support so initial spending might be slow. Then higher to do leg work e.g. rewriting job descriptions, and then lower but sustained to maintain.	X----X Politically sensitive therefore buy in essential.	Some initial activities reasonably predictable, others less so as needs develop.
	Improving staff supervision	High at start for training and systems development, then lower but sustained to maintain, retrain staff, enhance systems etc.	X-----X Politically sensitive: needs buy in at all levels	Some initial activities reasonably predictable, others less so as needs develop.
	Supporting professional regulation	Start up costs higher. Then lower but sustained.	X or X-----X May need to be outside of government system	Low. May be contentious
<b>4. Logistics and supply chain</b>				
Improving the legislative framework	Development of appropriate policy, law and other regulation	Same throughout though may have lower lead in time due to delays.	X-----X Gov't commitment essential.	Medium- though politically contentious so may drag on.
Improving systems	Development of a rigorous procurement system which enables access to national and international markets.	Up front costs higher. Some lower on going costs to improve system	X-----X	Medium – procurement politically contentious
	Development and maintenance of an essential drugs list	Up front costs higher. Some lower on going costs to improve system	X-----X	Medium
	Developing and implementing quality assurance systems. Possible legal changes.	Up front costs higher. Some lower on going costs to improve system	X-----X Gov't commitment essential for legal changes	Medium though legal changes will increase unpredictability
	Development of stock forecasting, management and distribution systems throughout health public health service. Also some provision to non-gov't service providers.	High at start, then lower to maintain and amend.	X-----X	Medium

THIS INVOLVES...	WHICH MEANS...	INVESTMENT TYPE	SUITABILITY FOR PROJECT V BUDGET SUPPORT ←-----→	PREDICTABILITY OF COSTS
Developing staff capacity to implement system at all levels	Staff employment, and training.	High at start and as new systems develop. Lower when just retraining.	Training: X-----X  Employment: X----X	Medium - but will depend on speed of systems development
Developing capacity to work with non-gov't sector	Supporting social marketing.	High at start then low.	X-----X	Medium
	Increasing in country production by encouraging private sector to invest and possibly providing some direct investment in production.	High at start if providing part funding, then low.	X-----X	Medium
Developing infrastructure	Building or renovating facilities for storage. Providing and maintaining essential storage equipment e.g. fridges.	V high if infrastructure poor then lower but sustained.	X-----X	Medium/high
	Building and maintaining in-country testing facilities	High at start, then medium for maintenance and running costs	X-----X	High
	Providing and maintaining transport for distribution.	High at start, then medium for maintenance and running costs	X-----X	Medium/high
Purchase of drugs and supplies	Funding procurement	Sustained	X-----X	High if forecasting and procurement are systems are good; otherwise medium/low
	Looking at options for innovative financing systems e.g. RDF (see above). Then piloting, & implementing.	Higher at start. Level afterwards depends on degree of external financing	X-----X	Low at outset then reasonably high

THIS INVOLVES...	WHICH MEANS...	INVESTMENT TYPE	SUITABILITY FOR PROJECT V BUDGET SUPPORT ←-----→	PREDICTABILITY OF COSTS
<b>5. Information and knowledge</b>				
Identify information needs for health determinants, monitoring of systems performance and health status.	Analysing information needs and capacity of current system to deliver on them.	Sustained.	X-----X	Medium
Develop appropriate HI systems	Upgrading systems.	High at start then lower but sustained to maintain systems	X-----X	Medium
Develop capacity of staff throughout health system to use information for evidence based decision making	Staff familiarisation, training, engagement with information systems	High at start then lower but sustained	X-----X	Medium/low
Develop capacity of organisations outside MoH to provide appropriate health systems analysis, evaluations etc.	Capacity building, training of independent research institutes	High at start then research grants needed to sustain engagement	X----X	Medium/low
<b>6. Governance</b>				
Ensuring strategic policy frameworks exist	Reviewing existing policies, and developing new ones where necessary	High at start, with some investment later for review	X-----X	Medium/Low
Providing effective oversight	Staffing and capacity building of MoH and lower levels	High at start for new staffing and training, then lower but sustained for retraining, support and training new staff	X-----X	Low
Regulation	Improving legislation and regulatory bodies to provide effective regulation	Initially high then lower but sustained to support ongoing	X-----X	Low

THIS INVOLVES...	WHICH MEANS...	INVESTMENT TYPE	SUITABILITY FOR PROJECT V BUDGET SUPPORT ←-----→	PREDICTABILITY OF COSTS
		regulation.		
	Investment in legal system to enable regulation to be meaningful for all.	Initially high, and then lower but sustained.	X-----X	Low
Attention to system-design	Ongoing review of systems, implying staff capacity, and reliable information for decision making (see info section)	ongoing	X-----X	Medium/low