



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

Background Paper

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ACRONYMS

ACT	Artemisinin Combination Therapy
ARVs	Anti retrovirals
BHCP	Basic Health Care Package
CMH	Commission for Macroeconomics and Health
DTP3	Diphtheria Tetanus Pertussis
EDF	European Development Fund
EHCS	Essential Health Care Services
GAVI	Global Alliance for Vaccines and Immunization
GBS	General Budget Support
GF	Global Fund
HEF	Health Equity Fund
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HRH	Human resources for health
HRITF	Health Result Innovation Trust Fund
HSS	Health systems strengthening
IBRD	International Bank for reconstruction and Development
IDA	International Development Association
IFF	International Finance Facility
IFFIm	International Finance Facility for Immunisation
IHP	International Health Partnership
KEPH	Kenya Essential Package for Health
KShs	Kenyan shillings
MBB	Marginal Budgeting for Bottlenecks
MBPI	Merit Based Pay Initiative
MDG	Millennium Development Goal
MDGc	Millennium Development Goal contract
MDTF	Multi Donor Trust Fund
MOF	Ministry of Finance
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
NHSP-IP	Nepal Health Sector Program - Implementation Plan
ODA	Official Development Assistance
P4P	Providing for Health
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PESS	Mozambique's Health Sector Strategic Plan
PRSP	Poverty Reduction Strategy Paper
RBF	Results Based Financing
SBS	Sector Budget Support
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
UN	United Nations
VSC	Voluntary Subscription Contribution
WDR	World Development Report
WHO	World Health Organisation
ZMK	Zambian kwacha

EXECUTIVE SUMMARY AND KEY MESSAGES

Key Messages

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

There is a need for additional resources to strengthen health systems

Current mechanisms for revenue raising and channelling of funds are not ideal and lead to fragmentation of assistance

A number of mechanisms offer significant potential to scale up efforts to strengthen health systems

They do this by bringing additional resources to the table or by providing support in different ways – including by frontloading resources and offering more predictability

Multiple channels for revenue raising are acceptable provided there are coordinated channels for disbursing funds to countries in ways which reduce transactions costs and maximize results

Areas that need further work and exploration include the need for:

- an assessment of what to fund and how to fund health systems in countries;
- an estimate of the total amount needed;
- a review of what the current governance arrangements are for different mechanisms and how these might be changed and improved; and,
- the relative costs and benefits of various options for both raising revenues and channelling resources to countries

Overview

Much progress has been made in improving the health of the world's poorest people but even today a child under the age of five still dies every three seconds... and a mother dies every minute in pregnancy or childbirth.

Stronger health systems are critical to saving these lives and to help achieve the health MDGs. Much of the additional

What are health systems?

"Within the political and institutional framework for each country, a health system is the ensemble of all organizations, institutions, and resources mandated to improve, maintain or restore health. They encompass both personal and population services and activities to influence policies and actions of other sectors to address the environmental and economic determinants of health"

Key sub components include: delivering health services through a primary health care approach; financing and social protection; health workforce; logistics and supply chains; information and knowledge; and governance.

donor support for health to date has been channelled into disease specific programmes which has placed a heavy demand on health systems whilst doing little to strengthen them. Programmes have often competed with each other for scarce health workers rather than trying to increase the overall pool of available staff.

Building stronger health systems will require more resources from the international community. These resources need to be made available in more sustainable and predictable ways. They need to be delivered through mechanisms which balance the accountability needs of both donors and government but also help strengthen national systems and, finally, they also need to support investments which are aligned with country needs and implemented efficiently.

Additional resources could come from a number of sources:

- bringing new resources to the table: air ticket levy and an expanded IFFIm
- efforts to leverage more aid for health to support health systems strengthening: UNITAID, GAVI, Global Fund, World Bank Trust Funds, bilateral donors
- efforts to leverage more non health development assistance to support health systems strengthening: EC MDG contracts and other general budget support
- efforts to leverage funding from other sources including domestic sources and the private sector

This paper identifies a series of criteria against which the performance of the various mechanisms might be judged. A number of financing instruments or mechanisms show particular promise and are looked at in some detail. Some are tried and tested, others variations on existing approaches (which still need to be proven) and others which are yet to be introduced. Many have notable strengths:

- **air ticket levy/UNITAID:** allocates additional resources, raised through an air ticket levy, to a range of health interventions and, as a result of the method of revenue mobilisation adopted, contributes to broader developmental goals as well as health goals
- **Multidonor Trust Funds:** can be used as a platform for attracting and pooling donor funds, leveraging additional resources both from donors and governments, using results based financing approaches to create stronger incentives for better performance and strengthening important links between health and finance ministries
- **EC MDG contract:** offers the potential to provide more predictable long term funding whilst retaining a performance based approach, address key bottlenecks which cannot be addressed by action at the sector level alone and to create a platform on which other donors could provide support
- **GAVI and Global Fund support for health system strengthening:** provide support necessary to protect and sustain benefits of investments aimed at improving access to essential services related to immunization and key communicable diseases
- **IFFIm:** has demonstrated its ability to transform how donor contributions may be used to frontload aid flows - where there is a strong case for doing so – and do so in a predictable way

The use of multiple revenue raising instruments seems to make sense (as this paper concludes that all the above approaches add value in some way). However, there should be no presumption that a particular revenue mechanism should be tied to any disbursement channel or use (although MDTFs highlight the advantage of an approach which is a disbursement platform but also leverages additional funding). The challenge is to create a “firewall”¹ between these multiple sources of funding and having as few disbursement channels as are needed at the country level. A better understanding is needed of which mechanisms are likely to work best in which settings and how different approaches might complement each other. This paper suggests some ways this might be taken forward.

Estimating financing gaps for the IHP health plans (let alone the individual HSS components) is problematic. The size of any gaps will depend heavily on domestic revenue efforts, the level of donor support and the extent to which donor support is aligned to Government priorities. But it also depends on how ambitious the plan is. There appears to be little consistency between countries in costing health plans or estimating financing gaps. What is clear it that the financing gaps are likely to be huge. For 6 of the IHP countries projected financing gaps for their health sector plans to 2015 is likely to be of the order of at least \$10bn, more using more ambitious scenarios; achieving the Commission on Macroeconomics and Health target of all low income countries spending at least \$35 per head on health would require an additional \$200bn by 2015 with a further \$300bn by 2030. Whilst, it might be preferable to focus only on meeting the HSS specific gaps data is not currently available to support such analysis. However, identifying HSS separately runs the risk of it being seen as another add on rather than a core component and a key bottleneck preventing effective implementation of the plans. Focusing on meeting funding gaps for health plans would, therefore, seem to be a better option. The challenge, therefore, is to develop sound health plans which fully reflect HSS concerns and to fund any outstanding funding gaps.

Health systems needs depend on the country context. Some HSS components will require up front support in certain settings – for some components needs are uncertain and funding requirements are likely to be unpredictable. Providing predictable aid is important for HSS investments as it is for most development interventions. Frontloading may be justified in some settings. The demand for frontloading, as set out in current plans, is unclear. This may reflect a “chicken and egg” situation – if countries knew there was a prospect of frontloaded support they might write plans which incorporate this. At present many do not – Ethiopia is a notable exception.

An IFF-type mechanism is the only one which offers the prospect of significant frontloading - albeit at a modest additional cost². An expanded IFFIm would be particularly suited to some aspects of the HSS agenda – especially ones that involve high up front costs. Evidence on the estimated costs of implementing the various health systems components is weak but what there is suggests relatively little demand for frontloaded support. (Tanzania’s Human Resources for Health strategy and the Ethiopian sector strategy did request significant up front funding – most reviewed did

¹ A phrase which has been used to stress the fact that how funds are raised is a completely separate issue to how they are channelled at the country level.

² the first bond had an estimated borrowing premium of 0.145% compared to an alternative to which any additional transactions costs should be added (see separate paper on IFFIm and GAVI background paper

not) The paper begins to draw up 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.

Most, but not all, of the arguments in support of IFFIm would also apply to a similar approach for health systems. However, other areas could also benefit from front loaded support (e.g. emergencies, public goods) which could also, indirectly, support the development of health systems. Any appraisal of an expanded IFFIm should, therefore, consider how it might benefit the sector as a whole rather than just the health systems aspects. As a higher cost funding mechanism IFFIm might be best considered as a funder of last resort - covering only outstanding funding gaps which cannot be met by other, more efficient mechanisms (such as the air ticket levy) which accesses additional funding at no extra cost . Given the size of the outstanding funding gaps it is highly unlikely that a single approach or even all available approaches will be sufficient. A number of approaches to expanding funding for HSS using an IFFIm or an IFFIm type mechanism are possible and will need to be fully examined. A separate paper on IFFIm reviews these options in some detail.

Key questions remain as to the extent to which plans are truly country owned – a cornerstone of the IHP process - and the extent to which they are currently being driven by existing, misaligned donor initiatives and whether this situation will change over time. The stakes are high – rapid scale up will inevitably increase aid dependency in many low income countries – but simply putting more money through the existing architecture will only have limited effect if past experience is anything to go by. Aid effectiveness is improving although perhaps not as rapidly as we might like which raises further questions on the case for frontloading (why frontload now when aid effectiveness is low?). There are also questions about the capacity of countries to absorb and utilise additional funds effectively (but also about the extent to which investment in health systems can help overcome such constraints). This may not be the immediate constraint but may become so. The effects of extra spending on macroeconomic variables (e.g. through the Dutch disease) will need to be continually reviewed. The benefits of sound investments in HSS are likely to far outweigh any such costs but it remains a risk especially given the large and often unprecedented increases in funding that could take place and will need to be monitored and, if necessary, managed.

The focus of this paper is very much on donor and domestic funding for health. Other areas needing some attention are the complementary role played by other sectors which contribute significantly to the development of health systems and the question of whether the private sector (including the non profit sector) may play a wide role in the financing and delivery of services

A high level Taskforce on Innovative International Financing for Health Systems was announced at the UN High Level Event in New York on 25 September 2008. It aims to:

- make recommendations on the mix of innovative international financing mechanisms needed to deliver the extra resources required;
- secure international support for these recommendations to ensure they are implemented.

This paper aims to support the work of the Task Force by identifying some of the issues it will need to address. These include the need to

- assess the amount of funds required to strengthen health systems in low income countries, identify possible constraints to scaling up and consider how these might be best addressed
- identify which health systems strengthening interventions offer the best value for money
- assess the strengths and weaknesses of different approaches to raising and channelling resources to countries
- examine which instruments might be suitable in which contexts
- explore options for increasing resources available for health systems strengthening
- assess the case for frontloading support for health systems strengthening and examine the feasibility of expanding IFFIm to achieve this
- develop working relationships with other relevant international initiatives
- consider how the private sector and actions in other sectors can contribute to HSS.

1. OVERVIEW AND CONTEXT

1.1 The Problem

Despite unprecedented increases in health spending in recent years, especially from external sources, and the availability of many simple, proven cost effective, technologies progress in improving health outcomes has been disappointing. Health systems have simply not been up to the task of translating these extra funds into better coverage of essential services – especially for poorer groups. Ensuring women have a skilled attendant present at delivery and have access to essential obstetric care should they need it is a key test how well health systems work. Progress has been slow – maternal mortality rates remain high and are even increasing in some countries which are otherwise enjoying improvements in other health outcomes.

There is increasing consensus on what an effective health system would look like but also mounting evidence that we are far from achieving it.

Box 1: The Importance of Health Systems

Six essential building blocks of an effective health system

- **Good health service delivery**, i.e. the ability to efficiently deliver effective, safe, quality personal and non-personal interventions to those who need them;
- **A well-performing health workforce** that is responsive, fair and efficient in achieving the best health outcomes possible, given available resources and circumstances;
- **A well-functioning health information system** that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status;
- A well-functioning system for providing equitable access to quality essential **pharmaceutical and health products and technologies**;
- **Good health financing systems** to raise adequate funds for health, and to ensure protection for financial risks; and
- Effective **leadership and governance** to ensure strategic policy frameworks exist and are combined with effective oversight, coalition-building, the provision of appropriate regulations and incentives, and accountability.

Indicators of weak health systems:

- **lack of staff**: 57 countries face extreme shortages of health workers 36 of these are in Africa
- **poor information systems**: in over 60 countries less than a quarter of deaths are recorded by vital registration systems.
- **inefficient use of existing resources**: an estimated 50% of medical equipment in developing countries is not used, either because of a lack of spare parts or maintenance, or because health workers do not know how to use it.
- **weak financing systems**: around 50% of health aid is off budget thus completely bypassing government systems. Globally, only around about 20% of all health aid is provided as general budget or sector support

Source: WHO Framework for Action

In practice much of the additional donor support has been channelled into disease specific programmes. These have placed heavy demands on health systems but have done little to strengthen them. Programmes have often competed with each other for scarce health workers rather than trying to increase the overall pool of available staff. Requests for data to measure performance have often overwhelmed weak information systems. There is a further risk in that finance ministries seeing the large amounts of funding going to health are tempted to withdraw funds from the sector – the very funds which are currently supporting the broader system.

The Global Health Partnerships have long recognised weaknesses in health systems as a major constraint to progress against their key diseases and have adopted approaches which support broader health systems development. The GAVI Alliance refer to their support health systems investments as a way of *protecting* their investments in new and, often expensive, vaccines. This is certainly welcome but if more rapid progress is to be made a more systematic approach is needed with health systems strengthening issues mainstreamed into sector planning processes and fully reflected in national health plans.

1.2 Objective of this work

There is growing momentum to expand international financial support to strengthen health systems and deliver results in developing countries by scaling-up a variety of individual and population-based services that are key to reaching the health-MDGs. This is based on the recognition that there needs to be a considerable increase in predictable financing to improve health in developing countries if these global targets are to be reached. Weak health systems, and insufficient attention to delivering results, are now seen to be the critical barriers to the effective use of additional funding for improving health outcomes.

This paper:

- considers the case for removing health system bottlenecks through HSS investments and the link to improved results,
- provides summary estimates of global resources required based on already available actual health sector costings in IHP+ countries
- summarises the work done on expansion of mechanisms for expanding HSS investments

More specifically, it considers a number of financing mechanisms which contribute to, or have the potential to contribute to, HSS. It describes what each of the financing mechanisms actually does, clarifies their rationale and sets out what value added they bring. Looking forward it examines possible options for improving the existing instruments considering both country contexts and any necessary changes in management arrangements.

Finally, it considers which areas require further work which might be taken forward by the proposed high level Task Force on Innovative International Financing for Health Systems.

2. IDENTIFICATION OF THE KEY ISSUES: METHODOLOGY

2.1 Introduction

Financing Mechanisms in Context

It goes without saying that **financing is a means to an end not an end in itself**. The role of a financing mechanism is to provide funds efficiently to what are hopefully sound, country owned strategies. At present country plans, where they exist, are often driven by the availability of resources rather than country needs. The International Health Partnership – with support from a range of stakeholders - has a major role to play in promoting the development of genuinely country owned strategies and in validating those plans which achieve this. Unless strategies which meet these criteria are developed the effects of additional funding are likely to be, at best, limited and, at worst, harmful.

Breaking down financing mechanisms by function

It is important to focus on what a financing mechanism actually does – not what it is called. The analysis therefore focuses on the various mechanisms in terms of their respective roles. These are broken down in terms of:

- raising revenue (raising the money in the first place) :
- channelling and disbursing resources (getting the money to where it is needed efficiently)
- allocation and use of resources (spending money well and on the right things)

Whose perspective are we looking at this from?

It is also important to consider whose perspective we are looking at the issue from. Are we looking at it purely from a health systems strengthening perspective, from a health sector perspective or from a broader development perspective? This is likely to affect any conclusions. (As will be shown later some financing mechanisms have impacts beyond the health sector)

What would happen otherwise?

In assessing likely effects we also need to consider what the counterfactual would be. It is assumed that there will be continuing progress towards the use of programmatic forms of support in line with the Paris Declaration on Aid Effectiveness (though perhaps not as rapidly as we might like). The more rapidly existing approaches improve the less need we have for new or innovative approaches. Would there be a case for frontloading if aid in the future is likely to be much more effective than it is now? Do we need new mechanisms to improve predictability if existing approaches could be made more predictable – for example by making support long term and legally binding as is done for IFFIm and for advanced market commitments?

On what basis should we judge the performance of the different mechanisms?

In order to make judgements about how well different mechanisms perform in different settings we need some basis for assessing their respective strengths and weaknesses. The following tables set out a number of suggested criteria for analysing performance. In some cases it is fairly clear that more (or less) is better; in other cases the situation is far less clear cut – it may depend on the way the approach is designed and implemented or depend on the country context.

Table 1: Assessing Performance - Revenue Raising Mechanisms

DIMENSION	HOW DO WE JUDGE?
Potential scale	The larger the better – especially if the mechanism is to be a core funding source
Degree of additionality (e.g. spending is over and above other donor and domestic spending)	The more the better (assuming it is consistent with country needs and displaces ineffective investment)
Flexibility (e.g. ability to vire between years)	The more the better
Predictability: Long term nature and strength of commitment	The more the better
Cost (transactions costs - and borrowing costs (if appropriate))	The lower the better
Broader developmental impact	The more (positive impact) the better

Table 2: Assessing Performance - Fund Channelling and Disbursement to Countries

DIMENSION	HOW DO WE JUDGE?
Alignment with national processes and systems	The more use of Government systems (budgetary, monitoring use of national plans instead of specific proposals etc) the better If they are effective. Harmonisation with other funding systems/donors
Transactions costs (proposal development, reporting, management etc)	The lower the better (provided other concerns such as fiduciary risk are adequately catered for)
Accountability and transparency	Minimum standards (e.g. for fiduciary risks) need to be met
Allocation process (country led or global allocation)	Is there a reasonable balance in allocations between countries (when set against need)

Table 3: Assessing Performance - Fund Use within Countries

	DIMENSION	HOW DO WE JUDGE?
What is funded	Making New Things Happen or Supporting Good Things ³	Depends on country context
	Basis for Funding	Funding gap in national health plan, specific HSS activities
How it is funded	Degree of Earmarking	The less the better (if the aim is to align with country needs)
	Incentives for good performance	The stronger the better (if they are appropriate and they work)

There are clearly tradeoffs between some of these criteria:

- **Performance v Predictability:** A greater focus on performance based funding can be at the expense of predictability. (Are the two really inconsistent? If countries know exactly what level of performance is needed to ensure disbursements then isn't funding predictable. Put the other way around would you want to provide predictable funding if it doesn't lead to any results)
- **Additionality v Ownership:** A greater focus on additionality can be at the expense of country ownership. Requirements for additionality – if effective - serve to undermine Government resource allocation processes. This raises questions as to how long such approaches can be sustained.

In principal, there is no compelling reason why any revenue raising approach should be linked to any particular disbursement model or use of funds⁴. In practice, though, there may be some advantages in doing so. For example, the World Bank's Health Result Innovation Trust Fund provides a platform for pooling and disbursing donor support but through its link to IDA credits also leverages additional resources for health. Multi donor trust funds, in general, provide a means of channelling resources but also a platform for pooling resources from different donors. UNITAID also relies on revenue from the air ticket levy – a structural choice made during its establishment

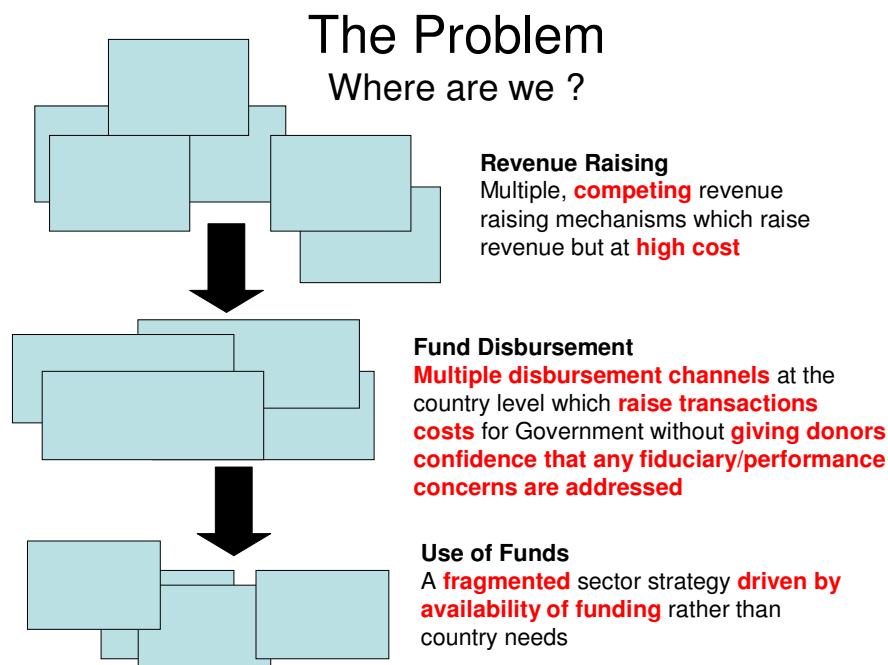
³ This criterion distinguishes between situation in which what is purchased has no broader effects (supporting good things) and those which make new things happen. The latter might include the provision of predictable funding which provides vaccine manufacturers with the confidence to invest in plant or produce products they might not otherwise do. Equally, it might mean strengthening support for strategic planning which would be expected to deliver improvement in overall system efficiency (although attribution here is much more difficult)

⁴ This separation between different functions raises questions as to whether it is possible to do a cost benefit analysis of different mechanisms as some have suggested. (It is possible to assess the relative costs of using different mechanisms. The benefits depend on what they fund. It is far better therefore to focus on assessing costs associated with the different mechanisms and the costs and benefits of any HSS interventions supported).

2.2 Overview of the Current Situation

The following two figures set out, in a stylised fashion, the worst case current situation of aid flows to the country level and a possible ideal scenario. The first presents a situation in which the available funding sources drive the pattern of resource allocation at the country level. Country plans reflect what donors are willing to provide rather than what countries actually need. There are a number of funding channels which raise and deliver funds through multiple channels resulting in high levels of inefficiency (through high transactions costs, duplication and fragmentation). Transactions costs are huge and little use is made of government systems which are undermined as a result. There may be large funding gaps yet execution rates may be very low. In short, donor support may be buying “the wrong things” at least from government’s perspective, and delivering them inefficiently.

Figure 1



We would hope gradually, over time, to move towards the scenario set out in figure 2. The key building block for such an approach is a sound, comprehensive country owned strategy. Without this little will change. The International Health Partnership is taking a lead on how this will be achieved and it is not discussed further in this paper. However, the extent and speed with which it is possible to establish this foundation will greatly influence the impact of any increases in support for the sector.

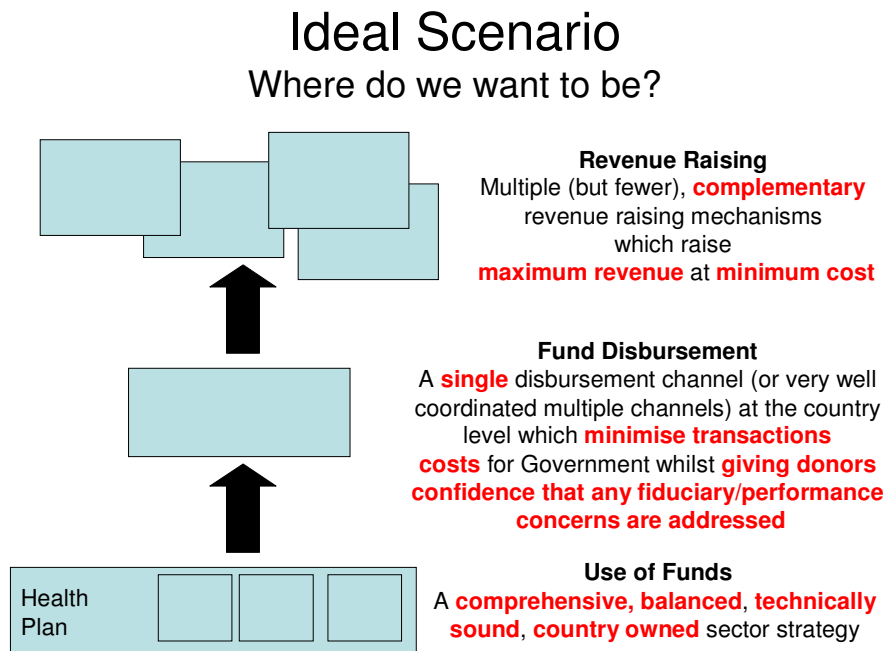
The scenario suggests that as long as the different revenue raising mechanisms add value in some way there is likely to be a strong case for multiple approaches. Crucially, however, it suggests that these resources need to be channelled ideally through a single disbursement channel (or, more likely perhaps, through a small number of coordinated channels). These could differ according to the different country context. (In practice, this suggests a rather static picture. In reality we would hope to see a gradual progression

from the common use of a parallel system to provision of support directly through Government systems as capacity increases. Multiple platforms, where they exist, need to be well coordinated and designed in ways which minimise transactions costs).

This could allow for twin track approaches in which less risk-averse donors are more willing to test Government systems whilst other, more risk-averse, donors would wish to be convinced first and use more tried and tested routes with higher fiduciary standards at least at the outset. It also raises the question as to whether some donors would ever be willing to provide money through Government systems – (if so, under what conditions?).

Where support is being provided outside of Government systems this raises questions as to whether the system reflects country realities and whether adequate steps are being taken to “shadow align” approaches with Government systems.

Figure 2



In practice, there are many reasons donors may not wish to pool resources or even provide support which is consistent with national strategies. Some donors simply cannot join pools. There may be cases where support should be given in parallel or even run counter to stated government priorities. In some cases this might be because governments may support a policy implicitly but may not wish to be explicitly linked to it (e.g. some sexual and productive health services). In some cases donors may wish to support programmes which run counter to government programmes but are aimed at influencing government policy. Some donors may also wish to fund NGOs directly where they feel that governments would be unlikely to provide support

3. REVIEW OF KEY INSTRUMENTS

3.1 Description of Key Mechanisms

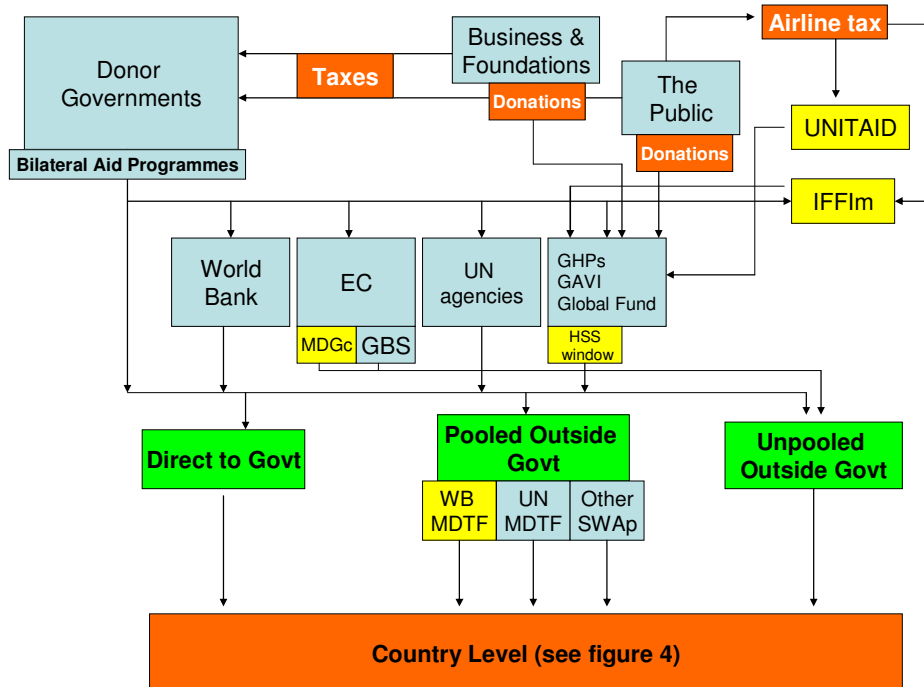
Current Flow of Funds

Figure 3 presents a simplified flow of funds analysis illustrating the various channels of support for health systems⁵. It distinguishes between:

- **primary funding sources:** the public and businesses
- **revenue raising instruments:** general taxation (to fund aid programmes), advocacy (to solicit donations from the public and business sectors) and the airline ticket levy
- **financing intermediaries:** the donor community, including the global health partnerships, IFFIm and UNITAID
- **disbursement channels or platforms:** ranges from direct support (with no intermediary channel), through pooled arrangements using parallel systems (which could be World Bank or UN trust funds or alternative arrangements, to the used of unpooled parallel arrangements
- **use of funds:** dictated by what is in the country plan (ultimately validated health plans supported by IHP compact)

This paper focuses on those mechanisms highlighted in yellow which are discussed in more detail below. The Task Force might also wish to consider further mechanisms

Figure 3

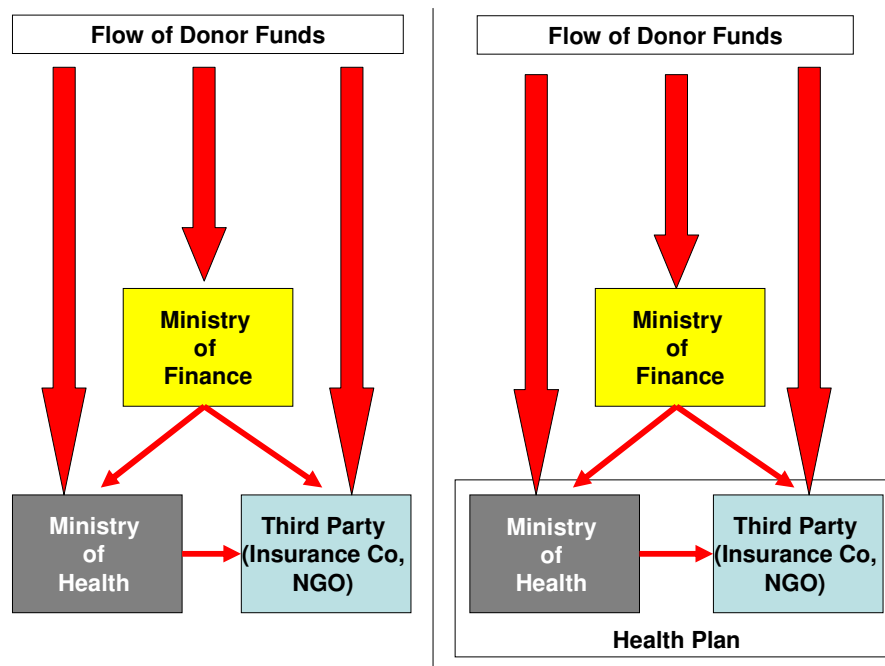


⁵ It does not reflect the provision of general budget support which is a further important mechanism for supporting health systems strengthening but omitted here for lack of space

Figure 4 illustrates the various ways of channelling resources at the country level. Funds could go directly to the Ministry of Finance, the Ministry of Health or any third party such as NGOs. This can take place as part of an overall programme (on the right) or not. The Ministry of Finance can subsequently allocate resources to the Ministry of Health or a third party. They may do this as a condition of the donor support or may do so because they think it is the right thing to do. It is also possible that resources for third parties are released through the Ministry of Health⁶.

The choice of channel clearly has implications for accountability. If the aim is to promote the use of government systems funds should ideally be channelled initially through the Ministry of Finance then through the line Ministry to its final destination. This makes the most use of government systems and promotes the challenge function role⁷ of the Ministry of Finance.

Figure 4



⁶ From an accountability point of view if the health Ministry is responsible for achieving sectoral health goals funds should ideally be channelled through it even if they are subsequently used by other actors such as NGOs

⁷ In which the Ministry of Finance has the competence to arbitrate between the competing claims of the various line Ministries and ensure the overall allocation of resources reflects country needs.

3.2 Review of Specific Mechanisms

a) Revenue raising mechanisms

There are two possible sources of additional financing for health systems that are examined in this paper: IFF/IFFIm and the air ticket levy/UNITAID. (In practice, IFFIm provides additional resources in the short term but less resources in the longer term as bondholders are repaid.

International Finance Facility for Immunisation (IFFIm)

The International Finance Facility for Immunisation (IFFIm) is a pilot for the concepts behind the International Finance Facility, which was developed to fill gaps in development assistance. The IFFIm is an international development financing institution that raises funds on the international capital markets at relatively low cost (given its AAA rating⁸). It does this based on legally binding commitments made by a number of sovereign donors⁹. IFFIm resources can be raised and disbursed in predictable amounts, and allow for frontloading¹⁰ of development support. Revenues generated in the capital markets are channelled through the GAVI Alliance in order to encourage the development of new vaccines and promote mass vaccination.

IFFIm's inaugural bonds were issued in November 2006, with a second issue in March 2008 and more to come shortly. Its aim is to allow the frontloading¹¹ of GAVI country support as well as greater predictability in the release of funds. Much of the disbursements are supporting the GAVI HSS window. The current aim of IFFIm is to raise around \$4bn on international capital markets (the exact figure will depend upon the level of pledges) with repayments made through to 2026. A considerable share of the funds raised to date have been used to fund activities under the GAVI Health System Strengthening (HSS) window. Total approved IFFIm disbursements amounted to \$861m in 2006 and \$186 m in 2007 and are expected to be around \$400m in 2008. Of those funds, by March 2008, IFFIm had spent \$109m on health system strengthening support through GAVI's HSS window.

A key question addressed as part of this work (see separate IFFIm paper) is whether there is a case for creating a specific International Financing Facility for health systems strengthening.

Air Ticket Levy and UNITAID

UNITAID was established in 2006; it is hosted by WHO and operates through a UN Trust Fund. It focuses on improving access to products needed to improve HIV/AIDS, TB and malaria services and does not deal with issues of health system strengthening directly. It attempts to add value by creating a sustainable and predictable market for drugs; reducing prices so that more drugs can be purchased within tight budgets; improving the quality of drugs through the WHO drug pre-qualification programme which encourages

⁸ there is a small additional premium involved in IFFIm financing, which is discussed in later sections.

⁹ France, Italy, Norway, South Africa, Spain, Sweden, the United Kingdom and Brazil.

¹⁰ 'front-loading' is defined as changing the phasing of a program so that it uses the same total inputs, but uses them more quickly so that outputs are realized sooner. Barder and Yeh

¹¹ 'front-loading' is defined as changing the phasing of a program so that it uses the same total inputs, but uses them more quickly so that outputs are realized sooner. Barder and Yeh

manufacturers to invest in both new products and in niche areas; manufacturing drugs that are better adapted to patient needs – for example, fixed-dose combinations; and delivering drugs faster to places where they are most needed.

It raises money primarily through a levy on airline tickets which accounts for around 82% of its revenue¹². There are strong arguments in favour of this approach. The tax is easy to collect, the sector is relatively untaxed, the burden of taxation falls primarily on higher income groups and the approach has been designed in such a way that market distortions are minimised, The tax is currently implemented in a number of developed and developing countries with others in the process of joining¹³. Some countries such as the UK and Norway make direct contributions. Estimated funding for 2008 is around \$370m and the budget may exceed \$500m in 2009.

The UNITAID Board has approved the introduction of a Voluntary Solidarity Contribution Scheme (VSC)¹⁴ which, it is estimated, could contribute up to \$2bn per annum. This will be piloted in 2009 and should be fully operational in 2010¹⁵.

Funds are spent exclusively on the purchase of drugs and diagnostics (with a focus on paediatric and second line ARVs, acceleration of PMTCT coverage, expanding ACT coverage for malaria and treatment for TB). At least 85% of funds must be spent in low income countries. The programmes supported have been associated with significant reductions in the cost of drugs (from \$196 to \$60 for the fixed dose paediatric formulation of the ARV combination used by most adults and 25%-50% reductions in the price of second line ARVs though bulk purchasing.

UNITAID's scale is limited by increase in air travel and levy per ticket. Prospects for increased passenger travel, in the short term, appear weak¹⁶. The revenue is additional (paid for by air passengers not from aid budgets) and administration costs are zero as the collection costs are met by the airlines. The approach should also have a positive environmental impact by reducing airline travel. The extent to which the approach increases countries' fiscal space – and their ability to fund the strengthening of health systems - is unclear. Whilst it might have reduced the costs of existing products this may

¹² Source: UNITAID website. The revenue is also used to support IFFIm

¹³ France, Chile, Côte d'Ivoire, Congo, Republic of Korea, Madagascar, Mauritius, Niger currently contribute. Norway pays part of its tax on CO2 (kerosene) to UNITAID and the UK makes a direct contribution from its aid budget Benin, Brazil, Burkina Faso, Cameroon, Cyprus, Gabon, Guinea, Liberia, Mali, Morocco, Namibia, Central African Republic, Senegal, Sao Tome & Principe, Togo are currently in the process of implementing such a tax. Source: UNITAID website

France employs a graded approach with the tax set at 1 euro for a flight within Europe in economy class and 10 euros in business or first class and 4 euros and 40 euros respectively for flights outside Europe. It allocates around 90% of the tax revenue collected to UNITAID. Other countries use different approaches e.g. a flat rate.

¹⁴ This gives passengers the option to make further voluntary contributions

¹⁵ It will be established in the form of a Swiss Foundation with funds pass on to UNITAID

¹⁶ "The global economic turbulence clearly shows in the 0.8% drop in freight volumes compared to last year. Although the passenger demand grew by 3.8%, this is the slowest growth that we have seen since the industry was hit by the SARS crisis in 2003. With consumer and business confidence falling and sky-high oil prices, the situation will get a lot worse," said Giovanni Bisignani, Director General and CEO of IATA. <http://www.iata.org/pressroom/pr/2008-08-04-01.htm>

be partially or fully offset by the costs associated with accessing products which would not otherwise have been available. Although the approach does seem to have contributed to reductions in the unit costs of health services there are questions as to whether the resources have been channelled into areas – particularly HIV/AIDS - that are already relatively well funded (Shiffman 2007, MacKellar 2005) and whether they would have been better spent in other areas. UNITAID support creates recurrent costs obligations which will compete for limited available resources in the future which might further crowd out other areas.

b) Revenue Channeling and Disbursement Platforms

Global Fund support to health systems strengthening

The Global Fund has long recognised the key role health systems play in supporting progress towards its corporate goals. “The Global Fund's major objectives in providing funding for health systems strengthening are to: (i) improve grant performance, and (ii) increase overall impact of responses to the three diseases. (The Fund) recognize that supporting the development of equitable, efficient, sustainable, transparent and accountable health systems furthers achievement of these objectives (and) that non-government organizations, the private sector and communities affected by the disease(s) are each an integral component of the health system, as is the government sector”.(Global Fund proposal guidelines)

The Global Fund’s approach to supporting HSS has changed over time. In round 5 separate HSS proposals were allowed. Thirty proposals were received; the key priorities identified in the proposals received, in order of importance, were human resources, information systems development, facility, lab and equipment upgrade, management strengthening, institutional strengthening and procurement and supply systems. Three proposals – those from Cambodia, Rwanda and Malawi - were successful and this HSS-specific approach was subsequently dropped. Currently the Global Fund allows applicants to apply for funding to respond to health systems weaknesses “either through a program (by-disease) approach, or by a cross-disease approach” recognising that the response may differ substantially in different settings. The Fund plans to accept national health strategy applications provided that they have been properly validated and that civil society and the private sector have participated in the development of these strategies.

GAVI Alliance support to health systems strengthening

By the end of 2005 the GAVI Board recognised that further progress in expanding immunisation coverage could not be sustained without addressing broader health systems constraints and approved the establishment of a separate Health Systems Strengthening (HSS) window. An initial allocation of \$500m was set aside to cover the period to 2010. Countries are eligible to receive \$5 per birth cohort (in low income countries with an average per capita income >\$1 per day) or \$2.50 (for countries up to \$1000 per capita income per annum). The GAVI Board recently approved a further \$300m which should allow all eligible countries to benefit from this funding stream. Countries must have prepared a Comprehensive Multi Year Plan for Immunisation in order to apply for GAVI HSS.

Proposals generally focus on three main priority areas – health workforce mobilisation, distribution and motivation, organisation and management of health services and supply, distribution and maintenance systems for drugs equipment and infrastructure. Funds are

targeted on the district-level and below in most proposals. However, other areas can be supported if a case is made. GAVI HSS support aims to align with the period of national plans so funding is typically for a period of 3-5 years. GAVI is considering providing support directly to health plans where a compact and validated plan is in place (therefore dropping the need for a formal HSS application). The GAVI HSS window of support will be evaluated in 2009.

European Commission MDG contracts¹⁷

European Commission aid to ACP (Africa, Caribbean and Pacific) countries under European Development Fund (EDF) 10, which covers the period 2008-2013, is budgeted at some 22.8bn euros. Of the 11.6bn programmed to date to country programmes¹⁸ around 31% has been for general budget support and a further 16% for sector budget support (which has many of the same features as general budget support). This represents a major increase on the 31.7% committed through these instruments under EDF 9.

During EDF 10 the EC also proposes to introduce a new instrument, the MDG contract (MDGc), which builds on its current budget support arrangements. The MDG contract aims to increase predictability by adopting a longer time frame and also by changing the way it measures progress and therefore makes disbursements.

The commitment period for MDG contracts will be 6 years (this compares to 3 years under normal EC general budget support). As is the case for general budget support the MDGc will be made up of a fixed and a variable tranche. The former, typically 70% of the total (but subject to negotiation at the country level), is virtually guaranteed thus ensuring a high degree of predictability. The remaining 30% will be released in the form of a variable tranche as a reward for good performance. Half of the variable tranche will be based on the results of an annual review of performance along the lines of current budget support practice. This will focus on PRSP implementation, performance monitoring (especially related to the availability of data), improvements in public financial management, and macroeconomic performance. The other half of the variable tranche – the MDG tranche - will operate differently. It will be released if satisfactory progress is made against selected outcome indicators after a mid contract review. This suggests that at least part of the support will be *backloaded* rather than frontloaded. It also means that reliance on annual performance reviews has been reduced and a longer term perspective of progress is being used.

Seven African countries - Malawi Mozambique, Zambia, Ghana, Burkina Faso Rwanda and Uganda have been identified as initial MDGc countries. The intention is to expand this number over time as experience is gained. These will typically be the good performers. This support will account for roughly half of the EC's budget support

¹⁷ Why treat EC MDGc separately from GBS as a whole? In principle, there are no different fundamentally from GBS provided by other bilaterals. They are considered separately here because of their potential size, but more importantly because of their "special characteristics"

¹⁸ Out of a total of 13.5bn euros which has been allocated to country A-envelopes

Multi-donor trust funds (MDTFs)

a) General Overview

Trust Funds are a way of coordinating and harmonising donor support without directly using Government systems (see box 2). They can be managed in a number of ways - by the World Bank, by the UN or arrangements developed by bilateral donors in SWAp settings. They can also be established at global, regional and country levels. They have fiduciary oversight and reporting arrangements designed to meet donor demands

Box 2: What is a Trust Fund?

A trust fund is a fund established to support development-related activities or programs, with administration by the World Bank and contributions from one or more donors. Through the use of trust funds, the Bank can mobilize and direct concessional resources to key strategic development priorities at country level, and as a vehicle for supporting partnerships with other development actors on global or regional challenges". (World Bank 2006 Trust Fund Report).

MDTFs are not, in themselves, a revenue mobilisation instrument. Rather they provide a platform for attracting resources from a range of donors. In principle, they could receive funds from any source (including IFFIm, EC MDGc). This pooling of funds can help reduce the volatility in disbursements a government might face were the same funds to be disbursed individually by the various donors. For example, the Health Result Innovation Trust Fund (HRITF) has received a \$105m grant from the Norwegian Government but is structured to accept contributions from other donors. The rigorous fiduciary oversight arrangements which can be incorporated into MDTFs can be particularly attractive to more risk averse donors who might otherwise adopt separate parallel arrangements and increase transactions costs

b) World Bank Trust Funds

The World Bank is currently managing a total of \$21.4bn through trust funds – this represents an increasing share of World Bank allocations to IDA eligible countries. World Bank Trust Funds can be structured in variety of ways depending on objectives and donor needs. Approaches include:

- **Programmatic Trust fund** – Bank has responsibility for activities supported by the trust fund
- **Fiduciary Trust fund** – the Bank is only responsible for managing the resources. Funds are disbursed as requested by donor entity without programmatic input from the Bank (e.g. Global Fund and GAVI trust funds)
- **Buy-down Trust Funds** – funds used to reduce the cost of IDA credits to grant levels for polio eradication if country achieves agreed performance targets
- **Co-financing** – funds provided in parallel with IDA or IBRD resources to support an agreed national project or plan

A Trust Fund can also be designed to leverage additional resources. Access to the HRITF, for example, depends on the presence of an ongoing IDA health credit. The Rwandan government actually took out an IDA benefit so it could benefit from the HRITF

Box 3: Health Result Innovation Trust Fund (HRITF)

The Health Result Innovation Trust Fund (HRITF) was established in November 2007 with financial support from the Norwegian Government as part of the Results Based Financing Initiative. It is focused specifically on strengthening health systems by working with governments to establish incentives systems which reward good performance. Technical support is being provided and implementation will be closely monitored and evaluated. Successful countries in the initial round were Afghanistan, Eritrea, Zambia and Rwanda.

Unlike results based aid which focuses on the performance of governments at national level the Health Result Innovation Trust Fund supports governments to design results based financing mechanisms at the sub national level which suit the local context and meet country needs. Mechanisms include both supply side approaches such as contracting, fee for service, output based aid but also demand side measures such as conditional cash payments and transfers and vouchers)

Given its comparative advantage in macroeconomic analysis and public finance and financial management systems the World Bank has traditionally had strong links with Finance Ministries. The RBF initiative can build on this to help leverage increases in allocation of domestic resources from finance ministries who want to support the social sectors more but are reluctant to do so unless they know what they are buying.

3.3 Analysis of Key Mechanisms

The following tables attempt to map the various mechanisms against the performance criteria outlined earlier. They are the authors conclusions based on discussions with key stakeholders and could usefully be reviewed as part of the Task Force’s work.

How do the mechanisms add value?

Table 4 attempts to set out what value is added by each of the different approaches.

Table 4: Value Added by Different Instruments

		ADDED VALUE (COMPARED TO CURRENT METHODS)
Revenue Raising	IFFIm	Flexibility (frontloading) + predictability + making new things happen
	(Potential) IFFHSS	Flexibility (frontloading) + predictability
	Air Ticket Levy/ UNITAID	Additional resources (including from sources in the south)+ wider development benefits + making new things happen
Revenue Channelling and Disbursement	MDTF (World Bank)	Flexibility to structure according to needs of donors and Govt. Additional resources (can be linked to IDA credits and country plans) Can result in World Bank TA available to countries which wouldn’t otherwise be the case Strengthens links between health and finance ministries Predictability (through pooling of donor resources) Fiduciary safeguards in place Linking of MoH and MoF in fund allocation and use
	MDTF (Health Results)	Additional resources (linked to IDA credits and country plans) World Bank TA available to countries which wouldn’t otherwise be the case

Platforms	Innovation TF)	Strong results orientation Strengthens links between health and finance ministries (key for resource allocation and use) Potential for pooling funds (currently only one donor)
	GF HSS	Some additional resources (including from sources in the south) + strong performance based approach
	GAVI HSS	Some additional resources; Based on nationally produced proposals (strong country ownership); Flexibility in use of resources
	EC MDG Contract (EC GBS)	Maximum use of country systems + wider development benefits + strong performance based approach (taking a longer term perspective) (+working in difficult environments)

Is suggests that all mechanisms add value in different ways. IFFIm brings the potential to frontload (though some of the arguments which support IFFIm might not apply for an IFFIm which addressed HSS). UNITAID and the EC MDGc contract bring wider developmental benefits. UNITAID, GAVI and the Global Fund bring additional resources to the table.

This table might be used as a basis for addressing the following questions.

- Can the value added be increased?
- Can the weaknesses be addressed?
- Can other instruments achieve the same value added?
- If that is the case would some mechanisms become redundant?

How do the mechanisms perform in terms of revenue raising?

It is important to distinguish between mechanisms which actually raise new money (air ticket levy/UNITAID), with those which are a mechanism and have dedicated funding sources (GAVI Alliance, Global Fund, multilaterals) and those which are a mechanism which are designed solely to channel support from a range of donors but have no dedicated funds (World Bank Trust Fund).

Different mechanisms have different strengths. In terms of providing *additional* donor support the air ticket levy performs best. IFFIm performs best in terms of possible scale and scope for frontloading. The EC MDG contract and UNITAID perform best in terms of achieving other development (i.e. non health) objectives. For a detailed analysis see the table at **Annex 1**

How do the mechanisms perform in terms of revenue channeling?

Funds can be channelled in three main ways:

- direct to government,
- pooled but outside government (through a World Bank or UN trust fund or alternative arrangement) and
- unpooled and outside government.

The first method tends to have high fiduciary risks but is likely to have lower transactions costs at least in the medium to long term and make the most use of government systems. The last makes little use of government systems and is likely to have high transactions costs.

A detailed mapping exercise would be required to establish the full picture. In broad terms, however, EC MDG contracts will be delivered direct to governments, whilst UNITAID, GAVI HSS and Global Fund HSS support is primarily delivered through unpooled approaches outside government systems - although GAVI and the Global Fund are making efforts to participate more widely in pooled SWAp arrangements. In terms of the other mechanisms reviewed World Bank MDTFs are a disbursement channel (the World Bank as an institution also channels resources through other channels – notably through general budget support). For a detailed analysis see the table at **Annex 2**

How do the mechanisms perform in terms of use of funds?

The different mechanisms adopt different approaches. UNITAID is trying to influence the market (making new things happen) whilst other mechanisms generally attempt to purchase what is available (buy good things). In some cases there is a top down approach to resource allocation in others it is country led. GAVI Alliance resources are allocated through a transparent country allocation formula – the Global Fund requires country proposals where countries set out their own needs. Without suggesting one is better than the other they do have different implications for predictability. The degree of earmarking varies from none (in the case of the MDG contract) to very high (for UNITAID). For a detailed analysis see the table at **Annex 3**.

Table 5 shows how the various mechanisms contribute to systems strengthening, performance based approaches and the extent to which they try and supplement domestic resources. Most approaches adopt a results focus (although in different ways) and attempt to ensure support is additional to domestic resources

In terms of revenue raising mechanisms the key distinction is that IFFIm current focuses some of its funding directly to HSS (through the GAVI HSS window) whilst UNITAID does not support HSS directly.

In terms of channelling and disbursement platforms approaches differ in the degree to which they focus on HSS – ranging from a broad HSS focus (HRITF), to a disease based HSS focus (GAVI, Global Fund) to unearmarked approaches (EC MDGc).

Table 5: Contribution of Different Mechanisms to Key Objectives

		CONTRIBUTION TO ...		
		Health Systems Strengthening	Performance Based Funding	Leveraging of Additional Funds from Domestic Sources
Revenue Raising Mechanisms	IFFIm	Depends on what is being funded. Currently some support for GAVI HSS	Depends how channelled	Should be additional
	Air Ticket Levy/UNITAID	No – not directly	Depends on programme	Should be additional
Revenue Channelling and Disbursement Platforms	MDTF (Health Results Innovation Trust Fund)	Yes - linked to IDA and national plans for strengthening health systems	Yes (results-based orientation)	Usually a requirement
	GF HSS	Yes – but only HSS components related to 3 disease goals	Ongoing review process – initial approval for 2 years – subsequent 3 years dependant upon performance	Should be additional
	GAVI HSS	Yes – but only HSS components related to immunisation goals	Not in practice	Unknown at present time
	EC MDG Contract	Yes – but only if HSS is prioritised by country	Yes – two tranches based on performance against MDGs and implementation of programme	Discussions about priorities part of appraisal process
Traditional Mechanisms (the counterfactual)	GBS/SBS	Yes - indirectly	Yes	Discussions about priorities part of appraisal process
	Project	Depends	Yes – project level performance	No

Issues related to Predictability

Predictability can be viewed from a number of perspectives. There can be uncertainty in terms of:

- **how much revenue can be raised:** this can range from donations which are at the total discretion of the donor concerned¹⁹ to legally binding commitments
- **how much will be allocated to countries:** this can be left open (as in the case of the Global Fund which allows countries to identify their own needs) or prescribed by a formula (as is the case of the GAVI Alliance where allocations are formula based)
- **whether committed funds will be disbursed (in full and on time)** Little ODA is unconditional. The uncertainty here relates to the possibility that funds will not be released even if Government meets any agreed performance targets or indicators (or if performance targets are so vague as to allow a large degree of ambiguity over whether funds should be released)
- **financing needs:** there is also uncertainty as to what financing requirements are. Health plans estimate costs at a point of time but priorities develop and new challenges emerge

In terms of revenue raising IFFIm and the EC are the most predictable (the former because of legally binding commitments the latter because contributions from member states are guaranteed). For GAVI and the Global Fund revenue is pretty secure once commitments are made. For MDTFs the same is true although resources are raised on a case by case basis and will depend on donor interest at the country level. Predictability in terms of allocation by countries varies from very high (for GAVI where allocations are formula based) to low (where decisions are made on a case by case basis (Global Fund, MDTF). Disbursement predictability depends on how performance is measured and implemented.

¹⁹ However, whilst there may be uncertainty as to whether a particular individual might contribute a donation it is possible to predict donations by larger populations with a greater degree of accuracy (as would be the case for UNITAID's Voluntary Subscription Contribution)

Table 6: Implication of Different Financing Mechanisms for Different Types of Predictability

		DEGREE OF PREDICTABILITY		
		Revenue Raising	Level of Allocation	Disbursement in Full
Revenue Raising Mechanism	IFFIm	Very high – once commitments made - legally binding	No specific country allocations	Performance based (results based aid)
	Air Ticket Levy/ UNITAID	Medium – depends on passenger numbers (VSC – uncertain as it depends on passenger discretion)	No specific country allocations	Performance based (results based aid)
Revenue Channelling and Disbursement Platforms	MDTF	Flexible – depends on donor interest	High once commitments made. Can incorporate support from additional sources	Depends
	MDTF – Health Results Innovation Trust Fund	Low until donor interest then high once donor commitments made	High once selected for funding	Results based finance
	GF HSS	High – once donor commitments are made. Support from non traditional donors can be unpredictable	Based on country assessment of need and on approval of proposal	Performance based (results based aid)
	GAVI HSS	High – once donor commitments are made. Support from non traditional donors may be more unpredictable	Very high - formula based – based on approved proposal	Performance based (results based aid)
	EC MDG Contract	Very high – assessed contributions from member states. Any top ups less predictable	High – agreed through country level discussions	Performance based (results based aid – longer term perspective of performance)

Issues related to Transactions Costs:

Key questions here are:

- **level of additional transactions costs:** these may range from low - where no new proposal is required and existing documentation, such as a health plan, can be used - to high where a new proposal requiring significant inputs is needed. It should be noted that start-up/establishment costs are part of the package for any approach, tend to be much more substantial for more complicated approaches (e.g. UNITAID simpler to set up and administer than IFFIm with its multiple Boards and functions).
- **burden of transactions costs:** faced by Government or other development partners?
- **financing of transactions costs:** ranges from unfunded where costs must be met from existing resources to fully funded where dedicated funding is made available to cover the cost (analysis might be required to confirm it does cover the full cost). In this case Government could hire extra capacity and continue to focus on its own priorities
- **profile of transactions costs:** are they constant or are there high upfront costs with low ongoing transactions costs

From a country perspective the ideal scenario would be one in which there are no additional requirements and where there are that much of the burden can be delegated to others and where any remaining costs are reimbursed. This contrasts with present arrangements where governments are often asked to prepare detailed documentation using existing resources (at what expense to their ongoing work?)

Issues related to Performance Based Funding

Donors are, quite rightly, increasingly interested in performance and in using mechanisms which promote better performance. There is also demand from country finance ministries who are often keen to allocate more to the social sectors but want to know what it will buy.

In one sense all donor support is performance related. (If it wasn't there would be little need for donor agencies – donor Governments might as well just give the money away). If results and targets are not achieved aid will, in most cases, be stopped at some point. The real question is which result and targets are payments based on and what happens if they are achieved or not achieved. A truly performance based system would be one in which additional payments are made as a reward for good past performance and this reward money can be spent as the recipient sees fit (along the lines of the GAVI ISS approach). Some might argue that this undermines predictability. In reality, though, if well designed this should not happen – donor disbursements will be entirely predictable as Government will know exactly the basis on which resources would be released.

Figure 5

Encouraging Better Performance

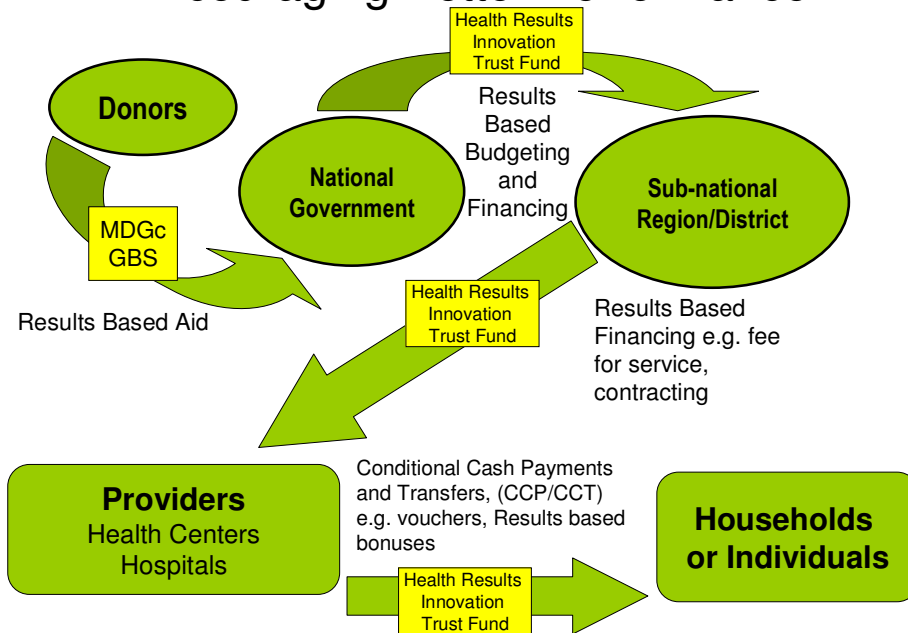


Figure 5 shows the distinction between **results based aid** (RBA) and **results based financing** (RBF). Results based aid, the more typical form of donor support focuses on performance at the national level. It does not necessarily get involved in issues of incentives at the sub national level (although there is nothing in principle preventing a national Government from implementing such approaches themselves – indeed they may have to if they want to achieve national objectives). By adopting a results based financing approach the Health Result Innovation Trust Fund supports the Government to address sub national incentive issues directly through a number of possible approaches at different levels. There is nothing, in principle, inconsistent with adopting both approaches simultaneously in the same country. Equally, there is no reason why such approaches need to be supported through trust funds.

Neither RBA nor RBF is a panacea. They can only go so far - providers can be paid but this will achieve little if there are no drugs. Close monitoring and evaluation are essential and where both approaches (or others) are being adopted in a particular country it would be preferable to try and establish common reporting and evaluation approaches.

Relevance of Results Based Financing for HSS

There have been few rigorous evaluations of results/performance based financing in low and middle income countries and the evidence of its effects is weak (Oxman 2008 Key messages are at **Annex 4**). Results appear to be positive in the short run for simple and distinct, well defined behavioural goals. There is less evidence that such gains can be sustained in the long term and can be applied to more complex interventions such as HSS. Part of the problem is that results based financing is often provided as part of a package and it is hard to disentangle the effects of the different interventions. The approach, if not designed appropriately, has also been shown to have some undesirable effects – promoting unintended behaviours, distorting efforts (rewarding what can be measured rather than what is important), misreporting results (i.e. cheating), focusing on easy to reach groups rather more difficult and more important harder to reach ones amongst others.

The report stresses the importance of a good understanding of the underlying problems and the mechanisms through which financial incentives will operate with close attention paid to the choice of target, the type and size of the incentives provided and the share of payment which is results based. Any approaches adopted are likely to need technical support and continued monitoring to ensure their continuing relevance.

This would suggest that using result based financing for health systems strengthening should be approached with some caution. There is little consensus on what HSS actually is and whilst some of the components might be more quantifiable than others (e.g. number of staff trained/number of services delivered) others are far vaguer and context specific and will require greater emphasis on harder-to-measure dimensions such as quality and equity. Given that traditional approaches to HSS have had little impact using RBF for HSS is certainly worth trying – but it will need to be closely monitored and evaluated before wider implementation should be considered

The GAVI ISS experience is highly relevant in this context (Box 4).

Box 4: The GAVI Alliance ISS Experience with Performance Based Funding

GAVI makes an upfront investment in a country's immunisation services, disbursed as a cash grant over a three year period. Thereafter, countries are eligible to receive US \$ 20 for each additional child they reach with three doses of diphtheria-tetanus-pertussis (DTP3) vaccine, as compared to the previous year's target. (GAVI website). Results are unclear²⁰.

Experience with implementation to date²¹ highlights the importance of:

- having **clear and measurable performance targets**; DPT3
- **monitoring progress against other targets** e.g. measles coverage – to ensure that effort is not being unduly skewed towards what is being measured
- providing the **right type of incentives** – the need to allow performance payments to be used flexibly in setting where there is no blueprint approach which appears in all settings – the GAVI external evaluation could find no statistically significant correlation between what the money was spent on and what results were obtained
- providing the **right level of incentives** – improvements in performance in countries with higher coverage rates were far lower in countries with higher coverage rates. In these countries the cost of immunizing a child was actually found to be higher than the incentive payment received.

Achieving similar levels of success when applied to HSS would require greater clarity on the relationship between inputs and outputs (precisely which results are expected from the support) – specifically:

- **what do HSS investments cost?** There is some data on human resources and on information systems. WHO is working on a health systems backbone costing analysis but there has been no systematic analysis of overall HSS needs and their associated costs.
- **how do we measure performance?** The Health Metrics Network has developed a dashboard which sets out a menu of indicators which might be used to assess performance
- **to what extent can we attribute HSS outcomes to HSS investments (the attribution problem). What are the most cost effective HSS investments? In**

²⁰ One external review found that "ISS had a significant positive impact on DTP3 coverage rates from 2001-2005²⁰. A \$1 influx of ISS funding per surviving infant increases the odds of immunization by approximately 10% in the year funding is received, and by another 10% in the next year" and that this held for countries with both low and high initial coverage rates²⁰. A World Bank country-specific analysis of ISS investments, however, showed no impact on coverage rates (Reference?).

²¹ Lu, Chunling, Catherine M Michaud, Emmanuela Gakidou, Kashif Khan, Christopher J L Murray. *Effect of the Global Alliance for Vaccines and Immunisation on diphtheria, tetanus, and pertussis vaccine coverage: an independent assessment*. Lancet 2006; 368: 1088–95.
Evaluation of the First Five Years of GAVI Immunization Services Support Funding
Chee, Hsi, Carlson, Chankova and Taylor September 2007

which settings? Why? There is very little evidence on this. Any design has to consider the possibility of perverse effects and will need systems to identify where this takes place. It would also require donors to show flexibility and not earmark how any performance payments are spent. Although these approaches pose challenges and need to be proven they do have the potential to attract some funders who would not otherwise be interested in harmonised approaches.

The suggestion that little is known about the unit costs of HSS investments, that there are no clear expectations of what the results of any investments should be and that there is little understanding of the extent to which results can be attributed to the inputs provided would tend to reinforce the need for a cautious approach.

4. LOOKING FORWARD

4.1 How much is needed?

Most countries have costed health plans though they generally do not specify how much is needed for health systems strengthening. This raises the question as to whether we are interested in filling gaps in specific health systems components or whether we are interested in funding gaps in health plans. In practice the availability of data currently forces us to choose the latter ... but there are also advantages to this. It means that HSS is not another gap to fill like any other disease. It also reinforces the importance of the health plan as the framework for providing support and, in doing so, makes it increasingly important that health plans are sound, balanced and country owned. It is suggested, therefore, that the emphasis should be on identifying funding gaps for health plans. A large share of this gap is likely to relate to health systems strengthening activities. The Task Force may wish to revisit this.

Many countries specify financing gaps in their health plans. These are often based on what are often very conservative assumptions about likely future donor support – typically it will only refer to support that has already been committed. This is, perhaps, quite reasonable given the current unpredictability of donor funding. In the case of Ethiopia, for instance, no attempt was originally made to estimate donor funding flows – the plan presents simply estimated needs and anticipated Government spending.

Even where financing gaps are estimated their actual size is likely to remain extremely uncertain. It will depend on a number of factors:

- governments domestic revenue mobilisation efforts (recognising the fact that the tendency is often towards making overoptimistic assumptions)
- the ability of Government to direct additional resources to priority needs (given that considerable amounts of fiscal space may be required to sustain interventions funded by donors which are poorly aligned to Government priorities)
- the level of funding from donor sources (reflecting unpredictability in disbursements)
- the extent to which donor support is aligned to Government priorities
- the potential for efficiency gains
- the level of ambition in the Plan

The World Bank has been carrying out a number of fiscal analyses to assess whether it is possible to assess future requirements with any degree of accuracy. Outputs from this should feed into the Task Force work.

4.2 Analysis of IHP Country Health Plans

A quick desk review of the current strategic health plans in IHP countries was carried out. The aim of this analysis was not to put a precise figure on the size of the financing gap – rather it was to identify the rough order of magnitude of resources required to given an idea of the scope and range of mechanisms which might be needed to fill the gaps

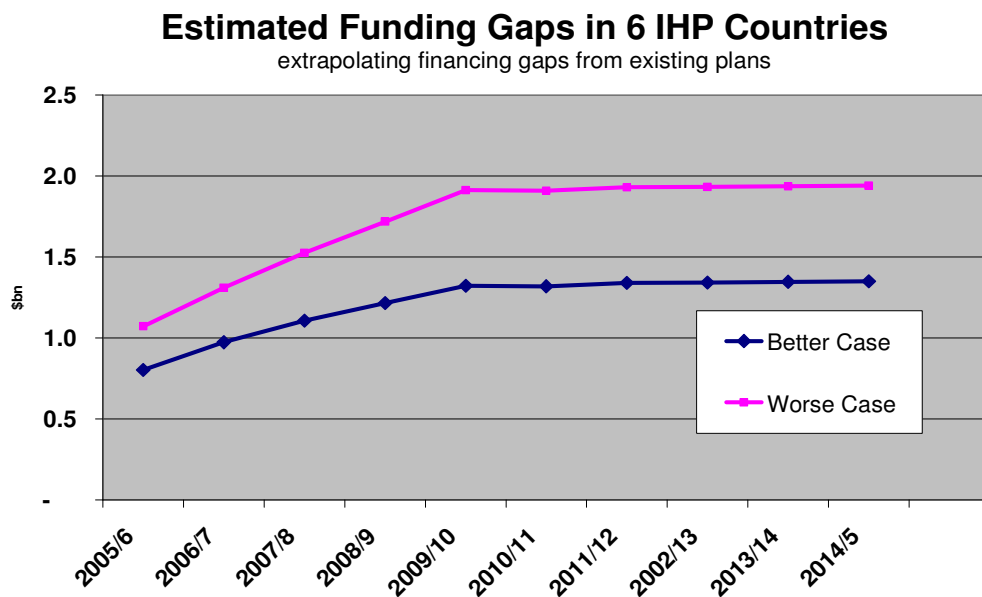
The focus was on reviewing existing health plans (i.e. what they said when they were written). There are strong reasons for thinking the figures presented here may be underestimates (the figures do not account for revisions during the plan period as has happened in the case of Ethiopia).

The plans do not give much of a forward perspective as many if them are now nearing completion (Cambodia is an exception with a recently approved Strategic Plan covering the period 2008-2015). Thus the approach taken is to extrapolate past financing gaps forward into the future which is a reasonable assumption to make but may not necessarily be realistic. Much closer analysis of the current situations in country would be needed to arrive at firm estimates of the funding gaps.

The Task Force could, therefore, usefully work with development partners in country to review progress against these plans and, more importantly, to ensure that future plans are presented in ways which help the donor community to clearly identify outstanding needs including those specifically related to HSS if this is required.

Figure 6 below pulls together the results from the 6 IHP countries reviewed²². It shows an annual shortfall up to \$2bn per annum and a cumulative shortfall of between \$9bn and \$13 between 2008 and 2015 – depending on which country scenario is chosen²³.

Figure 6



The plans reviewed and a summary of the key findings are outlined in **Annex 5**. It finds little consistency in the approaches adopted with large differences in the degree of ambition (as reflected by large variations in the per capita cost of the plans).

²² As all the plans cover different period the gaps are extrapolated to 2015 by assuming they will stay at the same level as the last year of the Plan. It therefore only be treated as indicative

²³ some countries present alternative funding scenarios – either based on different costs or assumptions about available resources

4.3 Cambodia Case Study

The Cambodia situation is looked at in some detail in **Annex 6** (and could be developed further if needed). Cambodia has identified and costed its strategic priorities and these are set out in its Strategic Health Plan 2008-2015. Very little frontloading is envisioned – the issue is more paying existing health workers more (salaries account for only around 15% of the health budget – extremely low by international standards). A financing gap of some \$300m over the period to 2015 has been identified. This is well below the level of likely donor support based on present levels (currently just over \$100m per annum). Thus, if donor support were aligned more closely with the priorities there would be no outstanding financing gap. In practice, though, recent decisions by key donors suggest that such realignment is not likely to take place

4.4 Global Estimates

The Commission for Macroeconomics and Health estimated that countries would need to spend of the order of \$35 per head to achieve the health MDGs. Taking into account likely increases in both Government and donor spending on health (based on a series of plausible assumptions set out **Annex 7**) it is still estimated that there is a financing gap of over \$35bn by 2015 and still at around \$13bn in 2030 (by which time economic growth should have strengthened domestic resource mobilisation). This implies a cumulative funding gap of around \$200bn by 2015 and around \$500bn by 2030. It is notable that the majority of the shortfall is in South Asia (especially India) though its share does decline significantly over time (see **Annex 8**). More recent work carried out as part of the Millennium Project suggests that the financing gaps may be higher still - especially in sub Saharan Africa (Table 7)

Table 7: Estimated Health Investments required to achieve MDGs

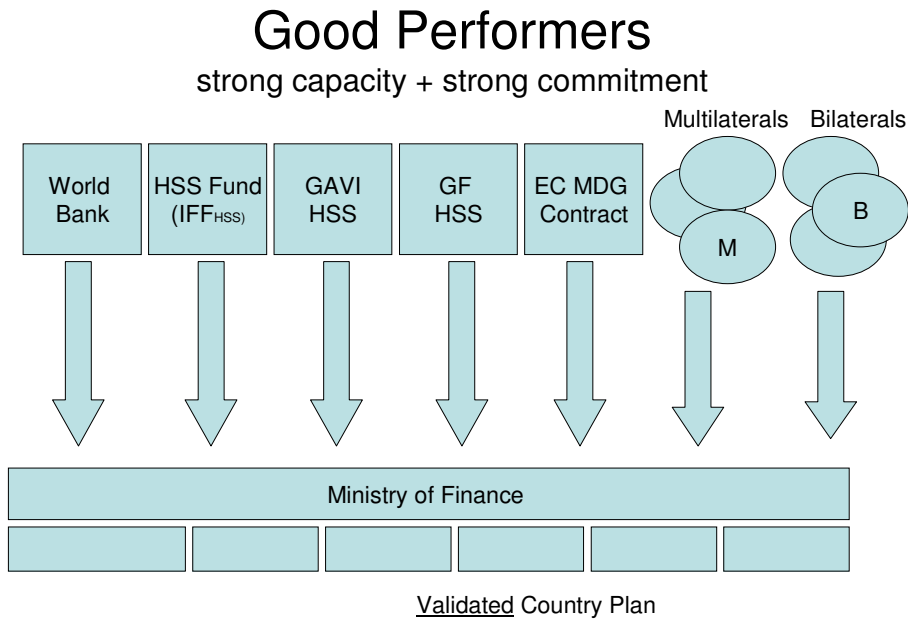
	\$ per capita
Bangladesh	30
Cambodia	32
Ghana	34
Tanzania	48
Uganda	44

Source: Millennium Project 2005

4.5 What might work where?

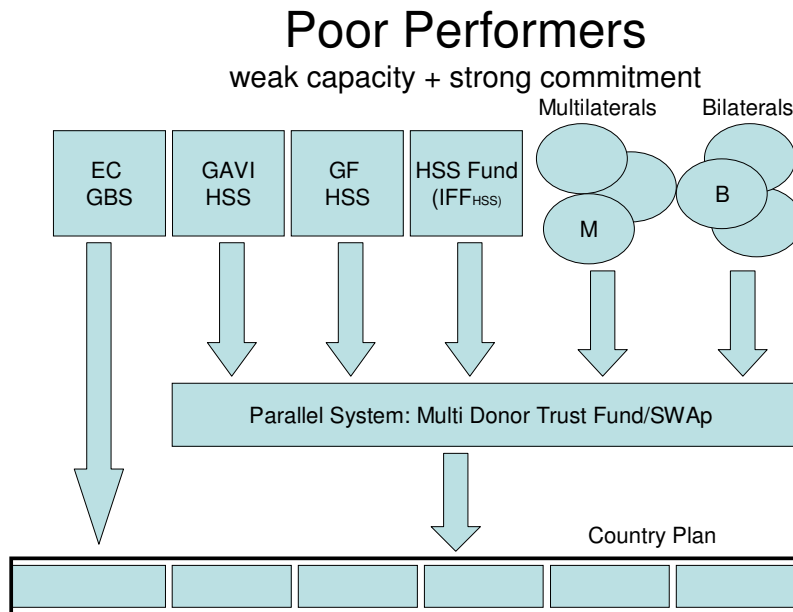
The following figures represent possible configurations of donor support in different settings. They might form a useful basis for mapping the current situation at the country level and also for identifying possible approaches in different country contexts - exercises which the Task Force might wish to commission.

Figure 7



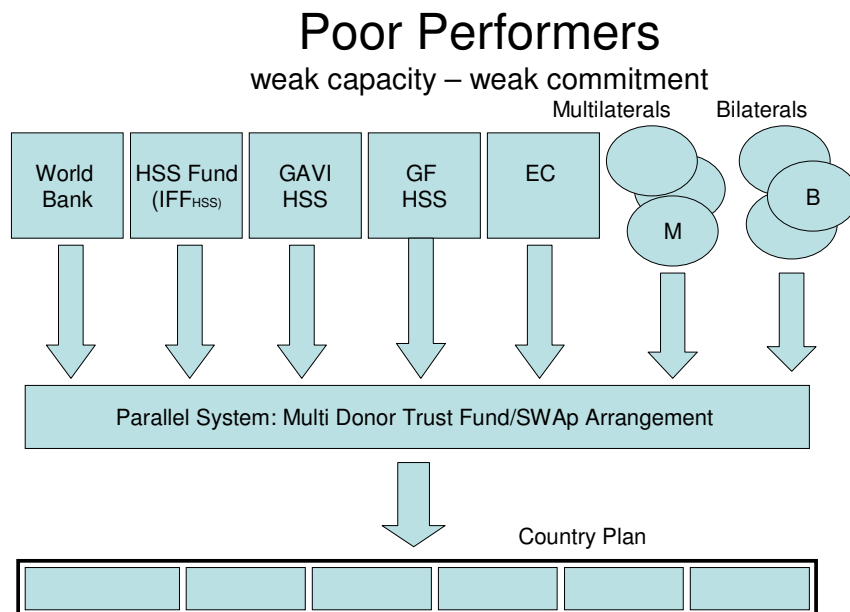
In countries with strong commitment but weak capacity less risk averse donors may be willing to pioneer a shift toward direct funding

Figure 8



In settings where both capacity and commitment are weak the focus might be on shadow alignment with pooling outside Government systems.

Figure 9



4.6 What changes might be made? What further work is required?

World Bank MDTFs

Demands from donors to establish new trust funds continue to increase. The Bank is currently considering how it should respond to this. In terms of their application further work is required to:

- **assess the impact of results based financing approaches:** The concept of results based financing –as support by HRITF - is particularly attractive to many donors. However, it is important to be sure that the approach actually works on the ground. A significant component of the HRITF is to monitor and evaluate performance. It remains to be seen whether the lessons of experiences have been learnt and adopted and whether the approach is feasible in lower income settings.
- **to get a better understanding of the settings in which RBF might work and how it might complement other efforts.** Results based financing is not a panacea. Its success is likely to be highly dependent on the national context and broader public service reforms including civil service reform and giving facilities autonomy at facility level to receive and use funds as they see fit. The approach may also complement results based aid which operates at the national level. Further thought will be needed to see how best to achieve this.

UNITAID

UNITAID does not currently provide direct support for the strengthening of health systems. The Board has been keen to retain UNITAID's focus and not expand its activities into new areas. However, one option might be to consider the case for earmarking some part of the VSC revenue to health systems strengthening activities.

European Commission: MDG Contracts and General Budget Support

The MDGc is an untried and untested mechanism which offers considerable potential to provide unearmarked, long term predictable funding. Although it does not directly earmark funds to health systems strengthening it can still provide support indirectly through the government budget if countries wish to prioritise such activities. Much will depend on how the contract is designed at the country level, If the performance framework used includes measures of health inputs – for example the level of health spending or the share of the budget to health – it could ensure additional resources are available to help finance health systems investments. The same would be true if the framework includes key health output or outcome indicators which rely on strong health systems such as access to safe deliveries. Further work is needed to:

- **understand how the approach is being applied:** To map country level practices the extent to which HSS activities are being supported and/or reflected in any monitoring and evaluation frameworks
- **evaluate its overall development impact and apply any lessons that emerge.** In relation to the health systems agenda it will be important to review how the contracts are actually designed and how performance progresses against the key health indicators. Efforts should be made to see how HSS related indicators could play a more prominent role in the performance framework. This will require continued efforts to demonstrate that investment in health systems should, indeed, be a priority and that any evidence is widely disseminated especially to the country level to inform resource allocation decisions.
- **assess whether the MDGc approach can complement results based financing approaches** such as those supported by the World Bank and others which use different methods to encourage good performance.
- **assess the potential for promoting greater harmonisation.** Should the approach prove successful it could create a platform for additional voluntary support from other donors which might wish to provide parallel financing within the MDGc framework. A number of options could be possible including supplementing the fixed tranche to increase the availability of predictable funding or to supplement the MDG tranche to reward progress against key indicators of interest.

Global Fund and GAVI Support for Health Systems Strengthening

Despite the fact that countries are given flexibility in how they allocate resources support is ultimately tied to progress against the diseases and not against the performance of health systems as a whole. This raises the question as to whether it makes more sense for GAVI and the Global Fund to deal with HSS separately or whether it might make more sense to top slice spending (for example by setting aside say 10% of total contributions to the Global Fund and the GAVI Alliance before country allocations are made) and make these funds available in an unearmarked fashion to support HSS. Such an approach might apply to all donor financing for health – not just that to GAVI and the Global Fund

International Finance Facility for Immunisation (IFFIm)

Consideration is currently being given to expanding the IFFIm model to provide additional support to health systems strengthening. There is certainly the potential to do so. IFFIm is now an established borrower and could – with further donor support - raise substantially more than it does at present. Indeed, it would actually be easier and quicker to raise much larger amounts of funds than IFFIm has to date. The key question is whether this is needed and whether it is a good use of donor resources:

Further work is required to:

- **clarify the rationale for using an expanded IFFIm to support health systems strengthening:** Some, but not all, of the arguments in support of IFFIm also apply to health systems strengthening. IFFIm is best suited to interventions which are highly cost effective in terms of health impact but also ones which have no long term recurrent costs, significantly reduce long term funding requirements or bring about large efficiency gains. It will be important, therefore, to consider any possible areas for support against these criteria.
- **determine the health systems strengthening components which could most benefit:** Appropriate actions will need to be country developed and owned and fully reflected in health plans – a process which the IHP partnership is supporting. In some settings frontloading could allow countries to make necessary up front investments in institutions to increase the production of health workers and also in systems which allow sector progress and performance to be monitored. Strengthening governance including building strategic planning capacity in the sector, strengthening supply chains and logistic systems and establishing public private partnerships may also require large amounts of up front funding and could, if well designed and implemented, lead to major and sustained improvements in the efficiency.
- **understand how an expanded IFFIm would complement other funding mechanisms and what it is best suited for.** IFFIm is probably not best suited to meeting long term recurrent costs such as salary costs. Other mechanisms such as general budget support are likely to be far more effective. Coordinated approaches to funding need will to be incorporated into countries' health plans
- **clarify other potential areas which could benefit:** There are a number of further possible uses for IFFIm funding which. although not specifically health systems strengthening actions may be highly complementary. These might include sustained support in fragile states, countries undergoing major transitions requiring one-off restructuring costs, meeting the costs associated with emerging threats (for example any future SARs–type challenge), providing an insurance type mechanism (or aid guarantee fund) to reduce volatility in aid flows or even support for countries with good fiscal prospects where long term aid funding will not be required. These, and other possible uses, need to be fully evaluated

- **agreement on the best management arrangements:** If the case for an expanded IFFIm can be made it is important that the management arrangements are appropriate. There is a need, therefore, to evaluate the current management and governance arrangements to see whether they are lowest cost and best suited for IFFIm expansion, or if other arrangements would be more suitable. It will also be important to ensure that the model adopted does not add further complexity to the current health aid architecture. Options might include expanding IFFIm in its current form with as few as possible changes to its governance arrangements, using some of IFFIm's structures but allocating and channelling resources in different ways or, thirdly, adopting a completely new approach

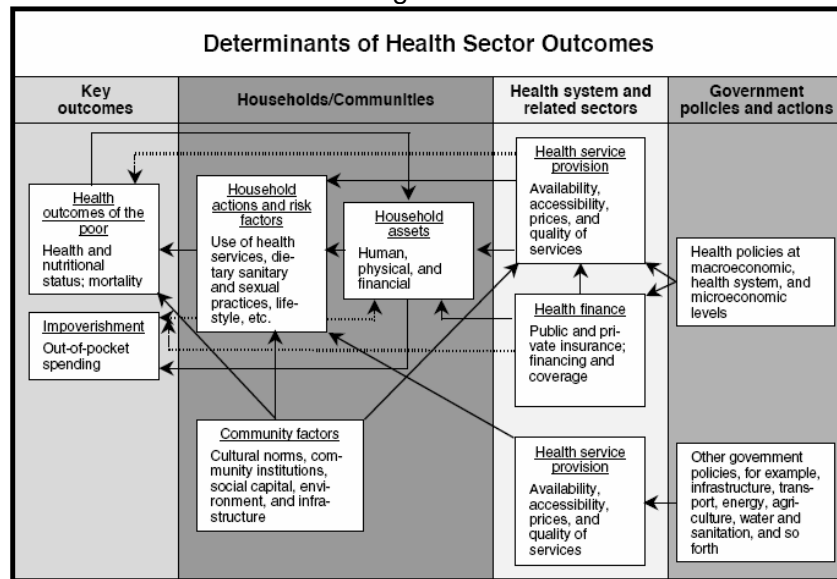
These issues are discussed in more detail in the separate paper on IFFIm

5. OTHER ISSUES TO CONSIDER

5.1 Supporting Investments in Other Sectors

It is well accepted that action in the health sector is a necessary, but not a sufficient, way of accelerating progress towards the health MDGs. Investments in others sectors are often a more cost effective way of improving health than health sector interventions. (see Figure 10 below)

Figure 10



Source: PRSP Source Book World Bank 2002

A key role of the Task Force could be to identify specific areas which might have major implications for health systems and consider what options might be possible for strengthening links. Possible areas might include:

- **human resources:** Investment in basic and secondary education to help create a potential pool of health workers
- **information systems:** Investment in national statistical capacity and research capacity
- **logistics and supply chain:** Investment in transportation systems:
- **governance:** public sector reforms, decentralisation
- **financing systems**

5.2 Role of the Private Sector

The Task Force could also consider the role of the private sector in terms of financing and delivering the products and services required to strengthen health systems. Possible areas for review might include:

- role of the private sector in training health workers; potential for tapping oversupply of health workers in some countries
- the role of the private sector in strengthening logistics and supply capacity
- assessing how private funding for health and how remittances might contribute to stronger health systems
- assessing the scope for private contributions to the key financing mechanisms (currently this is possible for the GAVI Alliance, MDTFs and the Global Fund but not for IFFIm unless the contributor has a credit rating)

5.3 Links with other international financing initiatives

The Task Force needs to consider its role in relation to other initiatives such as **Initiative on Action against Hunger and Poverty and the Leading Group on Solidarity Development Levies** which are looking at options for raising funds for development at the global level and the Providing for Health initiative which is considering how health financing systems can be strengthened at the country level including the question of how to raise funds. A key aim of the Task Force should be to outline credible proposals on how the additional funds being identified can best be used.

Box 5: Global Efforts: Innovative Development Funding

A technical group has been working on a series of nine proposals under the **Initiative on Action against Hunger and Poverty**. This initiative was established in 2004 by Brazil, Chile and France and later joined by Spain, Germany, Algeria and South Africa and is currently exploring a number of options. A larger group of 45 countries which include the original seven - the **Leading Group on Solidarity Development Levies** – was established in 2006 with a view to identifying and implementing solidarity levies with a pro development focus

Options being considered include

- **Mandatory Mechanisms:** Taxation of Financial Transactions, Taxation of Arms Trade, International Financial Facility, SDRs for Financing Development
- **Political Coordination:** Tax Evasion and Tax Havens, Increasing Remittance's Benefits, Solidarity Levies on Air Flights
- **Voluntary Mechanisms:** Voluntary Contributions through Credit Cards, Socially Responsible Investing or "Ethical Funds", Solidarity Lottery

The **Providing for Health (P4H) Initiative** is a result of a continuous process initiated at several G8 summits in which the G8 underlined the necessity to strengthen (national) health financing systems as the overall basis for accessible and pro-poor health systems. Its three key themes are:

- reducing out-of-pocket payments by increasing the extent of prepayment and risk pooling
- improving the efficiency and equity of available resources, and
- supporting countries to raise more funds for health, where necessary.

5.4 Constraints to Scaling Up: Absorptive Capacity and Macroeconomic Consequences

There appears to be general consensus that there is scope for a further scaling up in health spending without attracting the adverse macroeconomic consequences caused through the so-called Dutch disease or other mechanisms. There also seems to be some agreement that there is some way to go before diminishing returns to aid set in to the point that further aid ceases to have a positive effect. There is also consensus that sound policies can help manage these problems and can support even higher aid inflows. However, the levels of support required for health – especially if set alongside aid for other purposes – is likely to lead to unprecedented increases in aid flows and, in many low income countries, high levels of aid dependency. As such evidence of the impact of aid *at current levels* is only of limited relevance. Foster and Killick²⁴ argue that at current levels of aid funding there is little evidence of an adverse impact. However. They add that “the issue of whether a large scaling-up of aid is likely to induce Dutch Disease problems (is) unresolved”.

This issue is of particular relevance given the type of inputs funded in HSS investments (many of which are for human resources which, as non tradeable goods, could be more likely to contribute to Dutch disease). The issue remains a risk and will need sustained efforts to ensure it does not occur. The Task Force should consider the likely benefits of HSS investments, assess the potential risks associated with the scale up and suggest measures needed to protect any gains.

²⁴ Foster and Killick 2006 Economic Management in Africa: what would be the effect of doubling aid? Commonwealth Ministers Reference Book 2007

6. PRIORITIES FOR FOLLOW ON WORK BY A TASKFORCE ON INNOVATIVE INTERNATIONAL FINANCING FOR HEALTH SYSTEMS

The establishment of a high level Taskforce on Innovative International Financing for Health Systems was announced at the UN High Level Event in New York on 25 September 2008. This section elaborates on the summaries of the proposed Terms of Reference circulated to date.

The goal of the Taskforce will be to mobilise additional resources to help reach the health MDGs through:

- making recommendations on the mix of innovative international financing mechanisms needed to deliver the extra resources required;
- securing international support for these recommendations to ensure they are implemented.

Specifically, the Task Force should:

Develop a clear and agreed statement on what health systems strengthening is why it is important

To consider how best to raise the profile of HSS as an issue

Assess the amount of funds required to strengthen health systems in low income countries, identify possible constraints to scaling up and consider how these might be best addressed

To review the relevance of existing international spending targets e.g. Commission for Macroeconomics and Health, Millennium Project, Abuja Declaration targets, suggest alternatives where justified and consider the case for setting intermediate targets.

To update estimated financing gaps in LDC countries distinguishing between overall financing gaps and those related to HSS. To identify the steps needed to carry out such an analysis in all low income countries and consider the case for commissioning such work

To review the current evidence on the capacity of countries to absorb and utilise additional resources effectively and assess the risks that scaled up spending on health (in the context of likely scaling up in other sectors) might have adverse macroeconomic consequences. To advise on any measures that may need to be implemented to minimise such consequences

Identify which health systems strengthening interventions offer the best value for money

To improve understanding on where different HSS investments have worked and why.

To further develop work on typologies for different HSS investments

Assess the strengths and weaknesses of different approaches to raising and channelling resources to countries

To undertake further work to agree criteria for making assessments on the effectiveness of financing mechanisms and review options based on these criteria

To consider additional options for raising funds where relevant

Examine which instruments might be suitable in which contexts

To undertake a mapping of the current situation in relation to funding for HSS at the country level, develop of a typology of different country setting and analyse which approaches are likely to be appropriate where based on the known strengths and weaknesses of the different approaches

Explore options for increasing resources available for health systems strengthening

To review different methods of increasing funding for HSS including:

- bringing new resources to the table: an expanded IFFIm
- efforts to leverage more aid for health to support health systems strengthening: UNITAID, GAVI, Global Fund, World Bank Trust Funds, bilateral donors
- efforts to leverage more non health development assistance to support health systems strengthening: EC MDG contracts and other general budget support
- efforts to leverage funding from other sources including domestic sources and the private sector

Identify approaches which can further increase the predictability of existing aid instruments

To assess potential approaches including, but not confined to, making bilateral aid flows legally binding and considering the case for some form of aid guarantee fund

Assess the case for frontloading support for health systems strengthening and examine the feasibility of expanding IFFIm to achieve this

To carry out a detailed review of the additional costs associated with the IFFIm mechanism drawing on existing work on the borrowing premium but also considering other costs involved. This will include sensitivity analyses to assess the robustness of the findings in different settings (e.g. different market conditions, size of an expanded IFFIm).

To consider possible management arrangements for any expanded IFFIm taking into account the strengths of the current approach and likely effects on the broader health architecture.

To further develop the arguments for and against an expanded IFFIm in terms of how it might usefully invest in health systems strengthening or other types of health investment (and, in the case of the latter, how these will contribute to HSS)

Develop working relationships with other relevant international initiatives

To consider how the Task Force can best complement other international efforts to mobilise resources and accelerate progress towards the health MDGs.

To consider how better linkages can be created between international efforts to support health systems strengthening with efforts

- to support domestic financing system strengthening agendas (Providing for Health)
- to develop innovative development financing mechanisms to increase ODA (UN Financing for Development, Initiative n Action against Hunger and Poverty, Leading Group on Solidarity Development Levies)

Consider how the private sector and actions in other sectors can contribute to HSS.

To examine the potential role for greater private sector involvement in both the financing and delivery of services to support efforts to scale up

To assess the importance of actions in other sectors which can support effective scaling up and suggest mechanisms to ensure that cross sectoral activities are developed in a coordinated fashion

Make recommendations on

- **the mix of financing mechanisms needed to help deliver the funds needed for health systems strengthening;**
- **how to secure international support for these recommendations to ensure they are implemented.**

ANNEX 1: ASSESSMENT OF REVENUE RAISING APPROACHES

	Scale (how big is it how big could it be?)	Additionality (does it result in additional external support?)	Potential for Front Loading	Predictability (in terms of raising and delivering resources) (discussed in further detail below)	Financing Cost (is it an efficient way of raising revenue?)	Transaction Costs (relevant to disbursements not revenue raising) (discussed in further detail below)	Broader Developmental Impact beyond health sector impact
IFFIm (revenue raising instrument)	Potentially V large (IFFM \$4bn – needs to be of a minimum size)	Overall: Slightly Less (given higher financing cost) More in short term – less than would otherwise be the case in the long term	Yes	Very high – legally binding commitment	Relatively high	Depends on how channelled. Typically proposal based. May change in IHP countries	No
MDTF (vehicle for channelling funds – not independent funding source)	Neutral Related to demand. Can be as large as donor interest and country demand Key supporters: UK, Netherlands, US, EC, Canada	No (but could be if it received funding from an additional source such as the UNITAID)	Yes, if country programme requires	High - for the period of the grant especially if funds from a number of donors are pooled	Same – uses traditional donor sources	May be higher initially at start- up but lowered over time as multiple donors use the same channel	Potential to strengthen links between health and finance ministries
MDTF – Health Results Innovation Trust fund	Related to Need	No (though potential to leverage additional resources for health from Government)	Yes	For the period of the grant (usually 3-5 years)	Same – uses traditional donor sources	May be higher initially at start- up but lowered over time as multiple donors use the same channel	Potential to strengthen links between health and finance ministries

GF HSS (vehicle for channelling funds from GF)	Small amount currently unknown	A little (given some funding comes from additional sources such as private sector and foundations)	Yes	5 year funding subject to performance review at 2 years Performance indicators required for fund disbursement known	Lower (as some additional funds)	Proposal based – cost passed on to in country development partners. Should reduce with shift to national strategy application	No
GAVI HSS (vehicle for channelling GAVI funds ~)	Modest (currently \$800m approved - \$500m committed for GAVI HSS and 45% from IFFIm)	Unknown, but intention is HSS resources are to be additional to other resources at country level such as private sector and foundations	Yes – proposals can be frontloaded (This did happen in earlier rounds – less so now)	Country entitlement known but disbursement rates are affecting predictability	Lower (as some additional funds)	Proposal based – cost passed on to in country development partners. Flexible grants available to cover costs. New approaches being considered in IHP countries	No
EC MDG Contract (vehicle for channelling EC aid)	Potentially Large	No	Some – variable component brought forward if good performance. MDG tranche is back loaded as it is not paid until after the mid term review	High – 70- 80% virtually guaranteed over 6 year time frame. Shift away from annual performance assessment Variable payment to be made in form of MDG tranche and annual performance tranche	Same – uses traditional donor sources	High (initially) then should be lower	Yes – broader impacts associated with provision of general budget support

Air Ticket Levy/ UNITAID (revenue raising instrument)	High limited by external factors – scope for voluntary subscriptions to raise ~ \$2bn per annum	Yes – it is all additional	Limited by length of programme	Depends on arrangements with Partners	Lower borne by airlines	Low - transaction costs borne by existing partners (passed on to in country development partners?)	Yes Environmental benefits associated with small* reduction in air travel (*given low elasticity of demand)
GBS/SBS (vehicle for channelling donor support)	Modest and increasing	No (compared to donor support) Yes (should be additional to domestic support)	Yes (within project duration)	Mixed – reasonably short horizon	Low	High (initially) then should be lower	No
Project (vehicle for channelling donor support)	Large	No (in theory yes but often fungible)	Yes (within project duration)	Can be poor	Low	High	No

Additionality is used in the sense of bringing new resources to the table not just a reallocation of existing resources. The only true additional sources are the airline tax and private sources.

Annexes 1 to 3 analyse the role of the different mechanisms in relation to the key functions. Those sections shaded in green signify a relative strength - those in red a weakness. The counterfactual – project support and general/sector budget support - are included at the bottom of the tables for comparison. The table does not try and weight the different criteria – however, this is something individual donors might wish to do in considering how to spend their marginal dollars

ANNEX 2: ASSESSMENT OF REVENUE CHANNELING APPROACHES

	DISBURSEMENT CHANNEL	WHICH FUNDERS PROVIDE SUPPORT THROUGH THESE CHANNELS	TRANSACTIONS COSTS (DISCUSSED IN FURTHER DETAIL BELOW)	INCENTIVES FOR GOOD SECTOR PERFORMANCE (DISCUSSED IN FURTHER DETAIL BELOW)	FIDUCIARY RISKS
Outside Government systems	Pool managed outside Government systems e.g. through SWAp	Bilateral donors GAVI, Global Fund,	Common approach aimed at reducing transactions costs (but may be high in the negotiation stage)	Depends on conditions attached to support and quality of performance indicators	Donors can agree additional safeguards as required – tailored to local context
	Pooled: Multi Donor Trust Fund	Bilateral donors, World Bank, EC	Common approach aimed at reducing transactions costs (standard approach so tend to be low)	Depends on conditions attached to support and quality of performance indicators Health Results Innovation Trust Fund: Yes	Fiduciary safeguards mitigate risks
	Pooled: UN Trust Fund	Bilateral donors, World Bank, EC (in fragile state settings)	Tends to be high given typical project based approach	Low given low capacity	Typically high Major challenges given fragile state environment
	Unpooled	Bilateral, Multilateral donors UNITAID, Global Fund, GAVI	Very high	Low	Depends on design
Direct to Government	General Budget Support/ MDTF using Government systems	Bilateral donors, World Bank, EC GBS/ EC MDGc	High initially then low	Depends on conditions attached to support and quality of performance indicators	High – need to be rigorously appraised Only feasible if Government systems are sound

A detailed mapping exercise would be required to establish the full picture. In broad terms, however, EC MDG contracts will be delivered direct to governments, whilst UNITAID, GAVI and Global Fund support is primarily delivered through unpooled approaches outside government systems although the GAVI Alliance and the Global Fund are making efforts to participate in pooled swap arrangements. In terms of the other mechanisms reviewed World Bank MDTFs are a disbursement channel (the World Bank as an institution also channels resources through other channels – notably through general budget support)

ANNEX 3: ASSESSMENT OF USE OF FUNDS

	Resource Allocation: Who Benefits By Country Top Down or Bottom Up	Degree of Earmarking (specific activities or national/sector plans)	Primary Focus: Making New Things Happen or Supporting Good Things
IFFIm	Top down: GAVI spending is allocated through formula)	Indirect earmarking – must demonstrate impact on immunisation targets	Both
MDTF	Bottom Up	Depends on donor preferences/nature of programme	Supporting Good Things
MDTF Health Results Innovation TF	Bottom up	Linked to specific results. Flexible on how funds used	Both
GF HSS	Bottom Up	Yes/Indirect earmarking – Focus on interventions which support the 3 diseases. Must demonstrate impact on immunisation targets	Supporting Good Things
GAVI HSS	Top Down (formula based)	Yes/Indirect earmarking Focus on health workforce, supply logistics and local management. Plan to support national plans directly in countries with validated IHP plans	Supporting Good Things
EC MDG Contract	Top Down –confined to good performers	No –support for national programmes	Supporting Good Things
UNITAID	Proposals from partners	Funds specific items: products for the 3 diseases	Making New Things Happen
GBS/SBS	Bottom Up	No – support for national/sector programmes	Supporting Good Things
Project	Bottom Up	High	Supporting Good Things

ANNEX 4: AN OVERVIEW OF RESEARCH ON THE EFFECTS OF RESULTS-BASED FINANCING

Oxman A , Fretheim A 2008

Key messages

- The terms result-based financing and pay-for-performance (P4P) are used interchangeably. The Working Group on Performance-Based Incentives suggests the following working definition for P4P: “Transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target.”
- There are few rigorous studies of results-based financing (RBF) and overall the evidence of its effects is weak.
- Conditional cash transfers and other types of economic incentives targeting healthcare recipients can increase the use of preventive services.
- Financial incentives can also influence professional practice, such as increasing the delivery of immunisations or screening.
- RBF is typically part of a package of interventions and it is difficult, if not impossible to disentangle the effects of RBF from other components of the intervention packages, including increased funding, technical support, training, new management structures and monitoring systems.
- The flows of money required for RBF may be substantial, including the incentives themselves, administrative costs, and any additional service costs.
- There is almost no evidence of the cost-effectiveness of RBF.
- RBF can have unintended effects, including motivating unintended behaviours, distortions, gaming, corruption, cherry-picking, widening the resource gap between rich and poor, dependency on financial incentives, demoralisation, and bureaucratisation.
- RBF can only be cost-effective if the intervention or behaviour it is intended to motivate is cost-effective and worth encouraging and there is low compliance with the desired behaviour.
- Financial incentives should be designed to motivate desired behaviours based on an understanding of the underlying problem and the mechanism through which financial incentives could help.
- Financial incentives are more likely to influence discrete individual behaviours in the short run and less likely to influence sustained changes.
- The mechanisms through which financial incentives given to governments or organisations can improve performance are less clear.
- RBF schemes should be designed carefully, including the level at which they are targeted, the choice of targets and indicators, the type and magnitude of incentives, the proportion of financing that is paid based on results, and the ancillary components of the scheme.
- Stakeholders should be involved in the design of RBF.
- The focus should be on addressing important health system problems in order to achieve health goals – i.e. starting with the problem, not the solution.
- RBF should be used if it is an appropriate strategy to help address priority problems and goals.
- For RBF to be effective technical capacity or support must be available and it must be part of an appropriate package of interventions.
- RBF schemes should be monitored, among other things, for possible unintended effects, and evaluated, using as rigorous a design as possible to address important uncertainties.

ANNEX 5: STRATEGIC PLANS IN IHP COUNTRIES

Plans Reviewed

COUNTRY	PRSP	HEALTH PLAN
Burundi	Poverty Reduction Strategy Paper 2006 - 2009	National Health Development Plan 2006 - 2010
Cambodia	National Strategic Development Plan 2006-2010	Second Health Sector Strategic Plan (HSP2) 2008-2015
Ethiopia	Ethiopia: Building on Progress - A Plan for Accelerated and Sustained Development to End Poverty (PASDEP) 2005/06 - 2009/10	Health Sector Strategic Plan (HSDP III) 2005/2006 - 2009/2010
Kenya	The Economic Recovery Strategy for Wealth and Employment Creation (ERS) 2003-2007	Kenya's Health Policy Framework 2005-2010
Mali	Poverty Reduction and Growth Strategy Paper (PRGSP) 2007 – 2011	Health and Social Development programme (PRODESS II) 2005-2009
Mozambique	Action Plan for the Reduction of Absolute poverty (PARPA II) 2006-2009	Plano Estratégico Do Sector Saúde (PESS2) 2007 -2012
Nepal	The Tenth Plan (Poverty Reduction Strategy Paper) 2002–2007	Health Sector Programme Implementation Plan 2004-2009
Zambia	Fifth National Development Plan 2006-2010	National Health Strategic Plan 2006-2010

Analysis of Country Plans

Few plans break down spending into the various HSS components and the approach adopted is unlikely to be consistent. Having said this work to update the costing of the Ethiopia health plan which is incorporated into the recently signed compact does identify the HSS related components. It estimates that HSS investments account for 45 to 51% of total plan costs depending on the scenario chosen. However, it also points out that 60% of donor support is programmed for HIV/AIDS, TB and malaria and that much of the financing gap is concentrated on HSS (without apparently specifying how much).

Quick overviews of the country situations are followed by a general overview of the findings²⁵:

In **Ethiopia** although there is an MTEF much of the funding (especially from the Global Fund and other non Government funding sources) are not incorporated. Costing is based on an MDG Needs Assessment. Projected programme costs for health and HIV/AIDS were expected to increase from 4.7bn birr and 0.6bn birr respectively to 9.5bn and 2.0bn in 2009/10 (implying an increase in the share of total PASDEP (Plan for

²⁵ current exchange rates \$1= 9.91 Ethiopian birr, 70.1 Kenya Shs, 3,619 Zambia kwacha, 71 Nepali rupees, 24,130 Mozambican meticals, 4,187 Cambodia riels, 1,187 Burundi francs

Accelerated and Sustained Development to End Poverty) costs from 10.4% to 14.8% of the national budget²⁶). For expenditures *within* the MTEF health related spending costs for HIV/AIDS and health were projected to increase 1.29bn birr to 5.05bn birr

Costing of HSDP III was carried out using the Marginal Budgeting for Bottlenecks (MBB) approach. Three scenarios were considered²⁷. Costs varied from a total of 19.3bn birr over the period 2005/6 to 2009/10 to 27bn birr to 37.5bn birr under the different scenarios (and imply per capita spending of \$6.1, \$8.7 and \$12.3 per head by 2009/10²⁸). Capital costs were heavily frontloaded in the different scenarios accounting for around half of total spend over the period (declining from 79% of costs in 2005/6 to 30% in 2009/10 – though HSDP recognizes that such costs may well be too high given poor execution rates for capital investment. Costs are broken down by component²⁹ (**Annex 6**)

Ethiopia: Health Plan – Funding Scenarios

		2005/6	2006/7	2007/8	2008/9	2009/10
Scenario 1	Government + GBS	945	1023	1152	1306	1520
	Global Funds	701	851	1040	1232	1402
	Bilaterals, UN	660	699	767	842	925
	NGO Private	35	43	53	63	73
	Out of Pocket	96	183	275	370	474
Scenario 2		4071	4638	5433	6290	7217
Scenario 3		5078	6101	7385	8740	10180

The shortfall between scenario 1, which was expected to be fully funded, and scenarios 2 and 3 was estimated to amount to \$1.11 and \$2.11bn respectively

Update of Ethiopia Figures

Recent revisions (November 2007) have increased the estimated funding gap to \$1.56bn, \$2.34bn and \$2.84bn (according to scenarios 1, 2, and 3) for the period 2007/8 to 2009/10 (the original Plan estimated a gap of around \$1.5bn over the same period)

In the case of **Nepal** the cost of delivering the Essential Health Care Services (EHCS) set out in the Nepal Health Sector Program Implementation Plan (NHSP-IP) does “not reflect true costs because it was balanced against known resource availability” At \$2.1 per head it is well below what a World Bank costing study (\$5.1 per head) and MDG costing study (\$12 per head) which the Plan seems to concede is insufficient to achieve HSP-IP targets (though there is no suggestion that the targets are subsequently revised down). The estimated shortfall even against this limited target is of the order of \$35 – 50m³⁰ per annum depending upon the outcome of the proposed HSPSP support. In

²⁶ spending of ~ \$100 per annum on population and development is also included here

²⁷ The first included full implementation of the Health Service Extension Programme, the second added the Accelerated Expansion of PHC and the third, was not constrained by resource availability and reflected figures from the MDG Needs Assessment

²⁸ Authors estimates – HSDP figures suggest figures a range from \$47.4 to \$93.8 per head which appear to be a mistaken (table 4.3 p126)

²⁹ Table 4.4 p127

³⁰ figure 4.7.1 p42

short, it seems to be saying there is not enough funding to deliver a range of services which would still be far less than are needed to achieve the targets – but let's keep the targets anyway. This raises the question of what constitutes good performance if Nepal's progress is measured against such unrealistic targets. (Check)

In **Zambia** the cost of the Basic Health Care Package (BHCP) all levels is put at around \$162m (or \$14 per head) increasing to \$209m (\$18 per head) when other requirements are included³¹. The total financing requirement by strategic area increased from 1,071bn ZMK in 2006 to 2,381bn ZMK in 2010. The financing gap increases from 176bn ZMK in 2006 to 430bn ZMK (best case) 1397 bn ZMK (worst case) by 2010. Although, the needs are broken down in a way which is helpful in terms of the HSS components it is not clear which areas have a funding gap. It would be useful to follow up at the country level to understand how the definitions were derived and whether they can be used more generally

In **Mozambique** the PESS (health sector strategic plan) costing suggests expenditure requirements increasing from \$437m in 2007 to 661m in 2012 (\$29 per head). Available financing is expected to increase from \$340m to \$496m over the period leaving a financing gap of \$97m in 2007 increasing to \$165m by 2012. In terms of breakdown recurrent expenditure is expected to increase by 72% over the period. Needs related directly to service provision were expected to increase by 80% whilst those devoted to the support system are only expected to increase by 22% (suggesting that systems strengthening is not being prioritised. \$41m is earmarked for support systems and \$30m for the network of training institutions) The share allocated to capital investment – which could presumably be frontloaded to some extent - is expected to decline from over 22% to less than 12%.

In **Kenya** the cost of implementing NHSSP 2 was projected to increase from 92.7bn KSh in 2005/06 to 142.4bn by 2009/10 (some \$50.2 per head). Around 70% of this was allocated to the KEPH in 2005/6 declining to around 65% in 2009/10. Two scenarios are presented for the financing gaps – one based on the Kenya Medium Term Budget Strategy Paper the second a more optimistic case incorporating additional donor support. The actual gaps are presented in figures so cannot be gauged exactly but are of the order of 50-60bn KShs each year – although off budget items such as Global Fund are PEPFAR are not included in the figures.

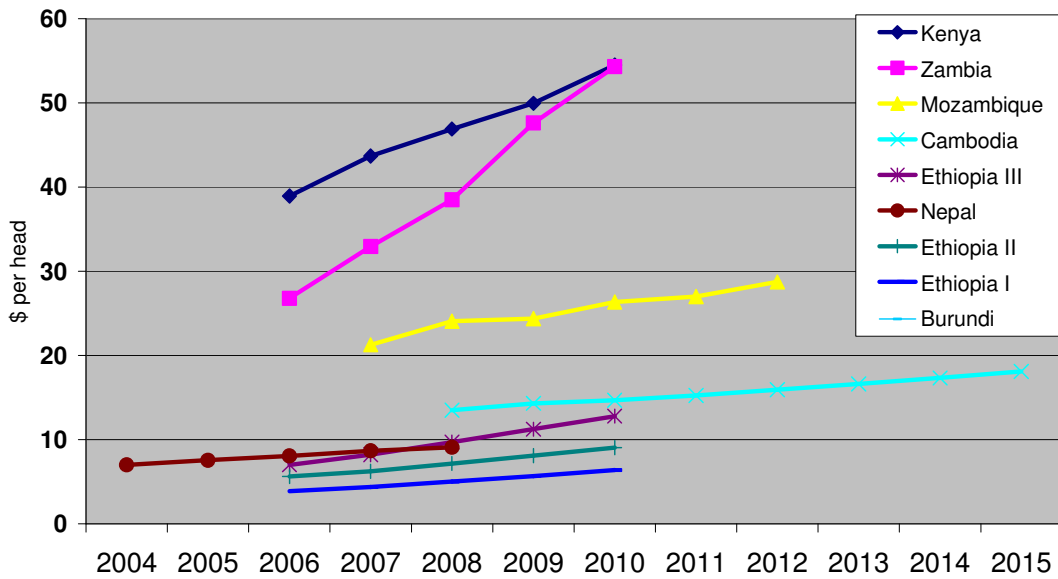
What does this tell us?

- There are major uncertainties in assessing financing gaps but **the gaps are large**. Costings are often approximations based on the best available information at the time. As a result it is not possible to get a clear picture of the true financing gap – the issue will need constant review

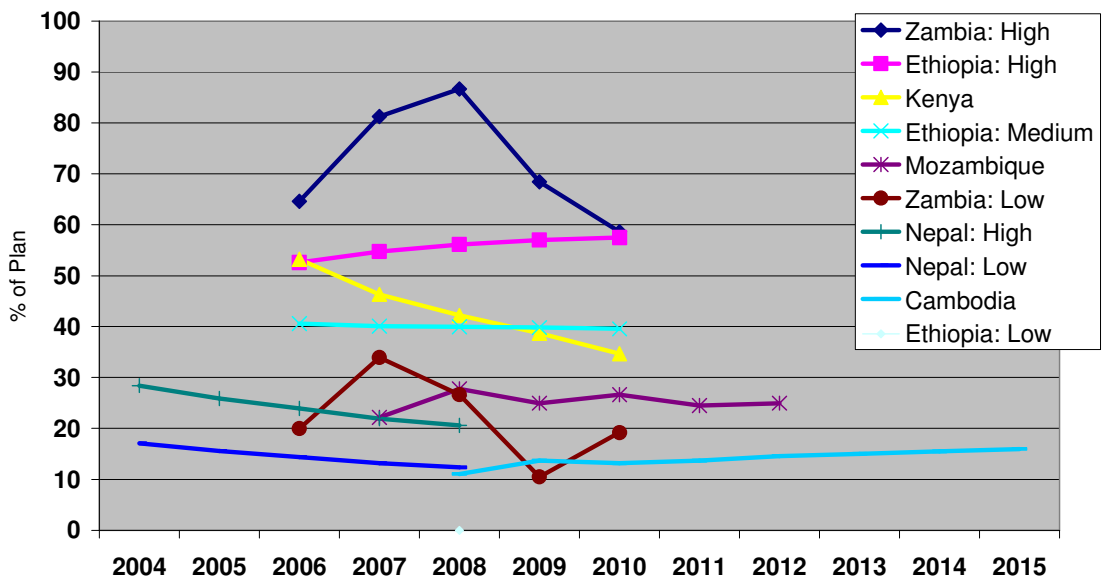
³¹ The cost of sending patients for specialized treatment abroad; the Cost of ART and extensive use of nevirapine to control mother-to-child transmission of HIV/AIDS, estimated to cost US\$36 Million per year; the cost implications of the recent policy change to adopt Coartem as the first line of treatment for malaria, estimated to cost US\$ 5 Million per year; the re-introduction of residual indoor spraying for malaria; the introduction of DPT+ Hib vaccine in January 2004, with a view to switching to pentavalent vaccine in 2005, estimated to cost around US\$6 Million per year; and the cost of the human resource complement needed to carry out the approved Global Fund proposals, PEPFAR and related activities.

- Needs can be as large as we want to them to be – there are **huge variations in the projected per capita cost of the plans reflecting huge variations in the degree of ambition** with major differences in the size of the funding gap as a share of the plan (very high in the case of Zambia and Ethiopia modest in the cases of Nepal and Cambodia (see figures below) This raises questions about the relevance of the global needs estimates which encourage overly planning based on spending which *should* but ultimately *will not* be available. The Health Financing Task Force should consider steps to establish more realistic intermediate financing targets e.g. \$20 per head in all countries by 2015 (see below) as well as the case for (and against) proposing new global spending targets.
- The plans are not presented consistently. Some incorporate private spending (e.g. Zambia) - most don't. Some present multiple scenarios based on the scope of the Plan (e.g. Ethiopia) or based on assumptions about resource availability (Nepal, Zambia). Different approaches are taken in terms of meeting demands for existing services, Ethiopia assumes zero change – Cambodia has factored in ongoing increases in demand. Many of the plans are resource constrained rather than needs based (i.e. they assume that scaling up will not occur). The Ethiopian plan explicitly states this – assuming that donor support will be in line with past trends.
- Current aid mechanisms are undermining country's ability to develop sound, costed plans. Attempts are made to link Plans to MTEFs where they exist but a number of countries specifically refer to the problems of incorporating off budget spending from the global funds into the analysis (Ethiopia). In Cambodia well resourced vertical programmes have made little input to the recent Strategic Health Plan which raises questions about the extent to which Plans are truly country owned. Until countries believe scale up will happen they are unlikely to plan for it.
- There is a mismatch between resource and targets: There seems to be pressure to maintain targets even if it is well recognised that the resources are not there to achieve them. This raises the question of how we measure performance and on the reliance of performance based funding in such settings

Projected Per Capita Expenditure in Health Plan

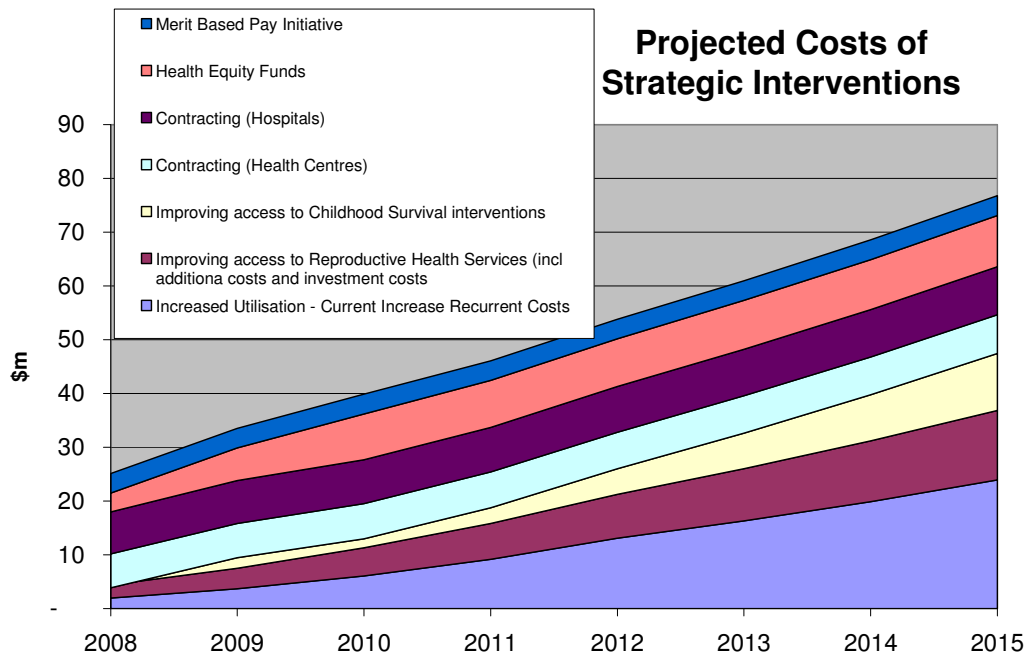


Financing Shortfall as % of Plan



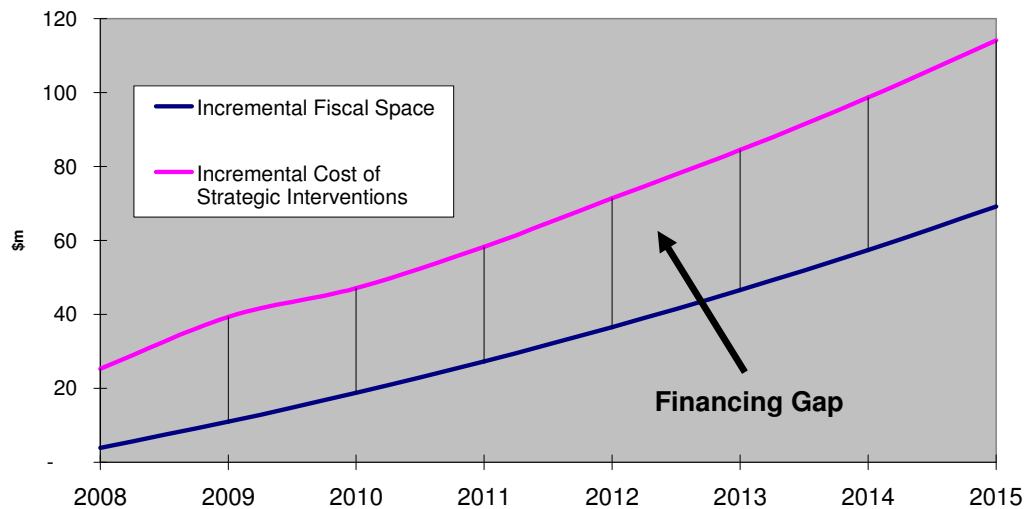
ANNEX 6: CAMBODIA CASE STUDY

Strategic Interventions Costed



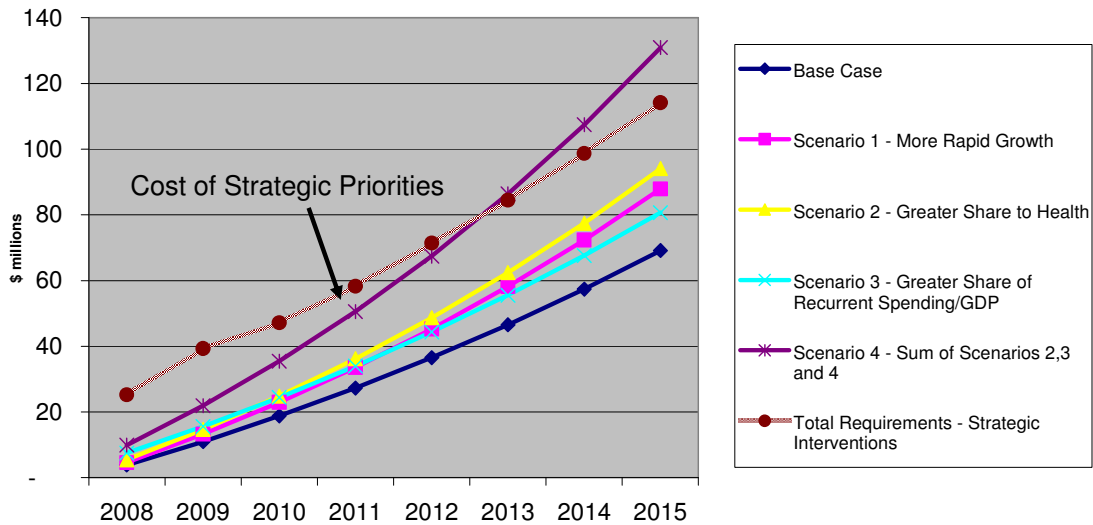
Compared to Fiscal Space –more than enough if donor support were aligned ... but it isn't and isn't likely to be

Affordability of Strategic Interventions Incremental Costs of Key Interventions Compared to Likely Resource Availability



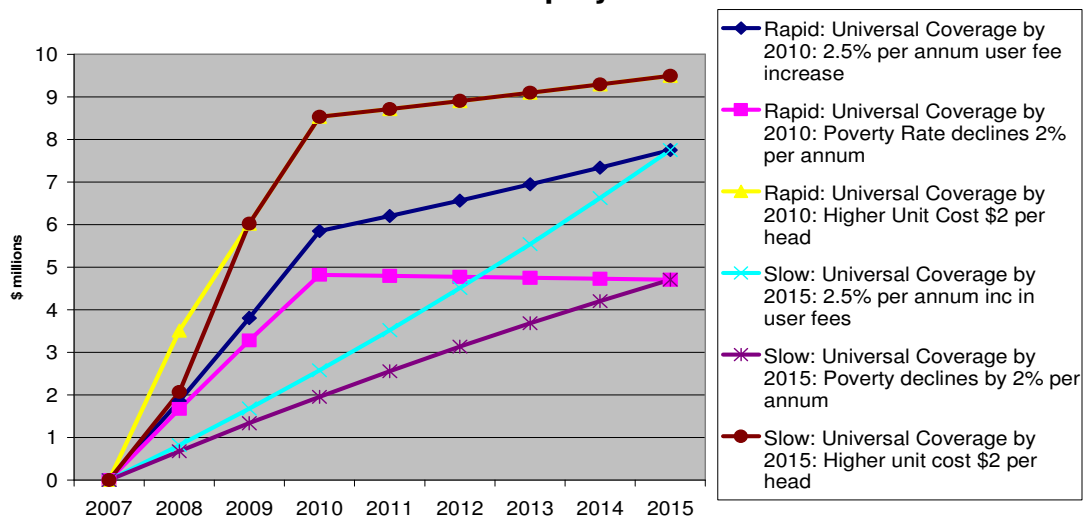
But it is extremely uncertain..... so the situation would need to be closely monitored

Comparison of Costs of Strategic Interventions with Likely Government Fiscal Space



So the plans were scaled back to fit

Sensitivity Analyses - Incremental Costs of Expanding of Health Equity Funds



Scaling Back Implies

- initial priority is given to meeting existing increased in demand
- the roll out of HEFs is as set out in the base case (with the exception that funding in 2008 is halved)
- the roll out of contracting is delayed until 2010 and then only rolled out to 1/3 of the currently uncovered population
- Introduction of MBPI is delayed until 2012
- Implementation of the reproductive health strategy is delayed until 2012 and the rate of introduction halved
- implementation of childhood scorecard intervention strategies is delayed until 2010

Frontloading would mean:

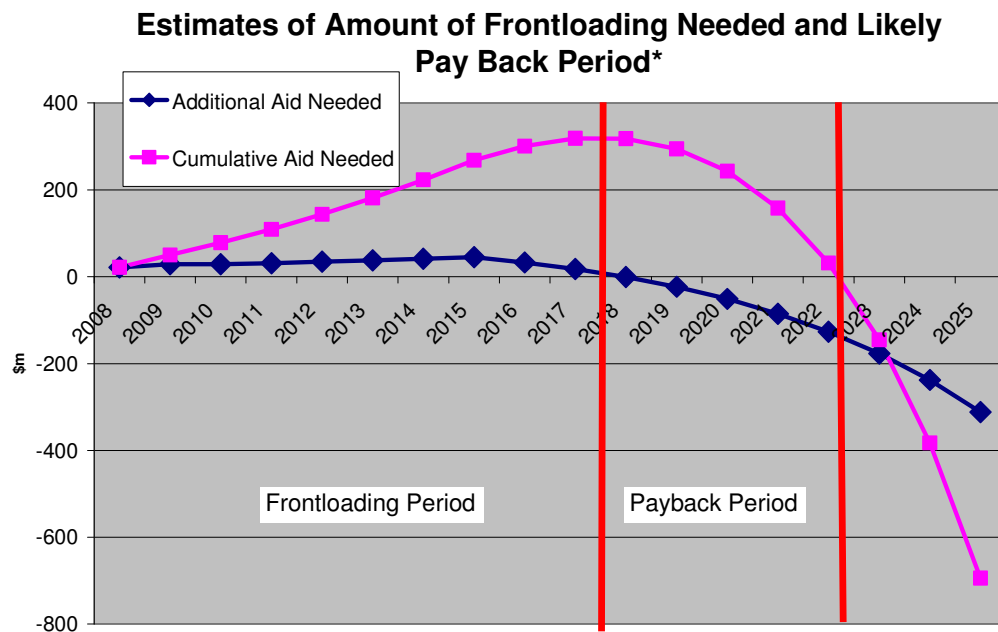
- more good things happening earlier
- efficiency gains materialising earlier (MBPI)

... and could meet more besides ... could be more ambitious

How much frontloading?

Maximum needed ~ \$300m – Cambodia likely to get twice this in aid for health over the period – so may not be needed

Payback period is minimised if all additional fiscal space is used to sustain IHP funded activities – raises the question of which countries will face the burden of the reduced support in the long term



ANNEX 7: ASSUMPTIONS UNDERLYING FINANCING GAP ESTIMATES

Overview of Assumptions and Scenarios Tested

	BASE CASE	OPTIMISTIC (HIGH)	PESSIMISTIC (LOW)
Growth in Per Capita Income	World Bank Long Term Development Indicators	Base Case +50%	Base Case – 50%
Population	UN Population Division medium estimates	UN Population Division medium estimates	UN Population Division medium estimates
Share of GDP to Public Expenditure	Increase of 0.25% of GDP per annum to a maximum of 50%	Increase of 0.5% of GDP per annum to a maximum of 50%	Constant
Share of Public Expenditure to Health	Increase of 0.25% per annum to maximum of 20%	At least 15% of public expenditure by 2010 (Abuja)	Constant
Overall Aid Flows	Consistent with spending commitments made by different donors as the 2005 Gleneagles G8 meeting ³²		
Allocation of Aid Flows	4 approaches: business as usual; additional funds population based; additional funds equity based (the base case scenario); radical equity allocation		
Share of Development Assistance to Health	Assumed to increase by 10% from 2003 levels by 2010	Assumed to increase 10% from 2003 levels 2010	Assumed to increase 10% from 2003 levels 2010
Private Expenditure	Income elasticity ³³ of 1	Income elasticity of 1	Income elasticity of 1

³² http://www.fco.gov.uk/Files/kfile/PostG8_Gleneagles_Communique_0.pdf annex II

³³ income elasticity is the extent to which private spending on health increases as income rises. A figure of 1.1 indicates a 10% increase in income results in a 11% increase in private spending on health

ANNEX 8: ESTIMATED FUNDING GAPS BY REGION

Projected Financing Shortfall against \$35 per head target
by Region

