



The Taskforce on Innovative International Financing for Health Systems

Civil Society Forum on the High Level Taskforce on Innovative International Financing for Health Systems

Johannesburg, 13-14 May 2009

Representatives of the High Level Taskforce on Innovative International Financing for Health Systems held a second consultation meeting with civil society actors in Johannesburg on 13-14 May 2009. The purpose of this meeting was to afford civil society representatives, principally from the South, who had been unable to attend the first consultation meeting a chance to air their views and share their experiences. The Taskforce was established in September 2008, in response to the call by world leaders at the UN High Level Event in New York, for an additional US\$30 billion to save 10 million lives – 3 million mothers and 7 million children. The Taskforce comprises a small number of leading international figures from both North and South, selected on the basis of perspectives they can offer on innovative financing, health systems, or the political plausibility of implementation. The Taskforce members include, among others, Prime Minister Gordon Brown (*United Kingdom, co-chair*), Robert Zoellick (*World Bank President, co-chair*), President Ellen Johnson-Sirleaf (*Liberia*) and Graca Machel (*President and Founder, Foundation for Community Development, Mozambique*), who attended the Johannesburg conference as a plenary member. The objectives of the Taskforce are to fill national financing gaps to reach the health MDGs through mobilizing additional resources; increasing the financial efficiency of health financing; and enhancing the effective use of funds.

The 13-14 May consultation brought together approximately 30 civil society actors from across the South, including NGOs, health sector workers, academics and AIDS activists.

The purpose of this meeting (and the first) was to develop analysis of the causes of the funding gaps and constraints to scaling-up health systems, and to identify potential innovative funding mechanisms and the effective use of donor aid, in addition to improving communication between the Taskforce and civil society. Within these purposes, specific objectives were to:



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- Determine the challenges at local and national level;
- Highlight key priorities for consideration by the Taskforce;
- Recommend the potential solutions – new and existing mechanisms that can be considered;
- Suggest urgent and feasible corrective measures; and
- Recommend ways for the Taskforce to continue to engage effectively

Both days of the consultation opened with plenary sessions. On Day 1, the plenary was followed by presentations by Secretariat members, and on both days by breakout sessions focusing on key issues, such as opportunities and challenges around health system strengthening, additional funding streams, and channelling funds/improving the effective use of resources.

Plenary Sessions

Following an introduction from facilitator Phil Hay, the delegates heard from Mrs. Graca Machel. Mrs. Machel's speech highlighted the reasons for setting up the Taskforce, and stressed that the consultation meeting was an opportunity to draw on delegates' expertise to guide the Taskforce's work. She highlighted three crises which have significant negative impact on the prospects of the world's poorest: the food crisis, the fuel crisis, and now the financial crisis. The impact of these crises can be seen in the 53 million additional people now living on less than US\$2 per day; their possible outcomes in the projections of another 200-400,000 deaths if the financial crisis continues. Mrs. Machel argued for a focus on the impact on children to generate a humane response, as well as concentrating on sustainability and cost-effectiveness of solutions. These efforts should be underpinned by strong social mobilisation and communication and advocacy campaigns with the support of civil society. Her suggestions for mobilising resources included a comprehensive approach to strengthening weak systems, moving away from an expectation of (external) donor partner contributions, slashing waste of resources and increasing co-ordination among CSOs. These particular goals were related to a wider purpose: a re-assessment of global priorities, to ensure saving lives is held in proper balance against maintaining economic systems.



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Mrs. Machel's speech was followed by a question-and-answer session with the panel. Broadly, these questions fell into four categories: HLTF reports, mechanisms/programmes, constraints and stakeholder involvement.

Presentations by Taskforce Secretariat

Nicole Klingen spoke on 'health financing and health systems strengthening – more and better resources to achieve the health MDGs', followed by Robert Fryatt addressing the issue of 'raising funds through innovative financing mechanisms and channelling those funds – more money and better health for the money.'

Breakout Sessions

See below a brief summary of key points and proposals raised in the breakout sessions. These points by no means represent the consensus view of all participants but rather a compilation of the different proposals made and ideas discussed.

Breakout Session Group 1: Financing health systems and attainment of the health MDGs – responding to the gaps and making better use of resources

The group argued for a holistic approach to the challenges ahead, making the point that one person's needs can cut across several MDGs. Equally; financial support can have different targets, but still reaches the same people. Vertical programmes have enjoyed success in keeping people alive and healthy.

The group argued for moving away from expensive services towards essential basic medication. There was a sense that good models had failed to be replicated, and that solutions had not been implemented with long-term sustainability in mind. It was felt that community priorities had not been reflected in planning and budgeting, and that basic health information was often unavailable (public health). There exists an imbalance in infrastructure between rural and urban regions.



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These issues were linked to, and compounded by, a lack of trust in public health systems, leading to opt-out by the wealthy.

Causes of health system inefficiency included:

- Lack of alignment of priority amongst donors and governments to realities in the communities (“universal access”)
- Lack of involvement of communities in decisions about finance
- Lack of intersectoral coordination
- Low government expenditure on health
- Lack of monitoring and accountability of donors and governments on commitments made
- Lack of linkages of health reform with national reform
- Poor governance leading to limited resource flows and access to resources at local level e.g. Zimbabwe
- HR-brain-drain, lack of training, incentives/rewards- e.g. rural areas

These problems lead to inadequate task-shifting and resource absorption at national level to meet health needs, which in turn makes health care inaccessible. Solving such problems will require, among other elements, strengthening information and surveillance systems to ensure transparency, ensuring accurate transmission of information on health needs, investing in IT infrastructure, and political leadership.

Proposals to strengthen health systems

On Day 2, the group called on the Taskforce to:

- Conduct a situational analysis of available HR & identify gaps
- To consider the development of sustainable financial incentives, the implementation of international codes of conduct on the ‘poaching’ of HR from the public sector



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- Well-defined training needs, and clear outcomes from the training
- Health Information Systems (HIS): Identify low-cost and appropriate options, ensure transparency/accessibility, set up partnerships to strengthen IMS, integrate and streamline HIS and IMS, train HR to use HIS and IMS, greater investment in such systems is needed.
- Innovative funding: dedicate resources to rare diseases, ensure careful mapping and budgeting for infrastructure to ensure equitable distribution
- Policy implementation: campaign for 15% allocation of budget to health Legislative framework to be in place to support policies; ensure that policies are costed, time-bound and have clear outcomes
- Revision of funding gap estimates transparently to ensure they meet adequate human resources
- Resources need to be tailored to complex, high-cost diseases

The group affirmed that for these recommendations to be met, the following pre-conditions must be in place

- Government: Integration and coordination; strengthen national health coordinating mechanisms and HSS through disease-specific resources; greater 'social safety nets' ensuring wider access to health care
- Financing context: removal of donor conditionalities, review of legislative barriers, push global consensus on accessing EDLs, better regulation of pharmaceuticals-TRIPS, coordinated supply chain management systems (explore bulk procurement and regional pooling), resources for research & HIV-AIDS Treatment; improved harmonisation



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Breakout Session Group 2: Mobilising more resources for health – the use of existing and innovative financing mechanisms

This group discussed various forms of additional financing, including international levies and taxes, auctioning/sales of emission permits, voluntary and philanthropic contributions, and domestic sources. The group stated that integration and flexibility of financial solutions will be crucial to address the major challenges to reach the health MDGs and especially of funding long-life ART, improving diagnostic tools, TB treatment, and 2nd ARVs.

The success of these solutions will depend on innovative advocacy at the highest level, on voluntary contributions (by increasing communication with donors), and the creation of 'demand' for health.

Potential innovative financing mechanisms and solutions suggested by the group to the Taskforce included:

- Sharing of information on and replication of best-practice mechanisms.
- Funding including funding from vertical funds and donors must strengthen country systems and domestic services (harmonization, alignment, and country ownership).
- Utilisation of funding to supplement or pay HR.
- Promotion of social responsibility especially by multinationals active in countries.
- Need for and support of predictable source of funding.
- A perceived need to revisit MDG8 & focus on PPPs.
- The economic costs of doing nothing or missing set targets should be documented and shared.
- Governments should support to NGO's, FBOs, and other not for profit providers of health services and Ministries of Health should be encouraged to collaborate with private sector including NGO's, communities, and donors.
- Exploring how private foundations can do more.
- Ensuring political accountability of health issues.

Proposals for equitable funding

On Day 2, the group called on the Taskforce to:

- Strengthen funding mechanism to support all HSS components
- Harmonise funding at all levels (local, country and donor levels)



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- CSO participation in health priority setting, costing, allocation of resources, implementation and M&E
- Institute joint planning –all stakeholders
- Strengthen & scale-up resource mobilisation initiatives
- Encourage donor funding to complement country initiatives
- Encourage co-operates to invest in social programmes (MDG 4,5 & 6)
- Encourage provision of incentives e.g. tax relief/awards etc.
- Develop marketing strategies to encourage support of social programme by the private sector with related M&E
- Encourage expansion of existing medical insurance packages to cover the poor & provide incentives
- Ensure that governments adhere to 15% as a minimum contribution for the health budget
- Encourage CSOs to monitor the budget allocated for health
- Ensure community involvement & empowerment for prevention, care and support
- Establish CSOs to share best practices & lessons learned
- Develop a tracking system for donor assistance & commitments and allocations
- Develop systems to track in-country training programmes

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Breakout Session Group 3: Channelling funds for health and making a difference – the global health architecture and national health plans

The group felt that national health policy environments were increasingly receptive and supportive towards streamlining resources, and that service delivery can be improved as a result. The financial crisis has brought a new impetus to these efforts.



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Current challenges include the lack of harmonisation around funding, the question of integrated versus vertical programmes, HR capacity, lack of transference of skills to local individuals, unavailability of supplies to weak supply chain management, poor health planning, and lack of M&E and accountability.

Potential solutions include the integration of funding to create synergies to fund health systems vs. diseases, the promotion of PPPs, improving efficiency and removing the invisible conditionalities of donor funding.

With reference to resource utilisation efficiency, the group suggested the following:

- Domestic: joint planning with M&E process including all stakeholders, involvement of private sector in training of health workers, involvement of a range of stakeholders in national policy development, provision of tax incentives for private health providers, leveraging of matching grants through incentives which ensure a 15% health allocation, capitalisation on national health insurance affordability
- External (Donors): pool funding to a common basket, include performance-based funding to common criteria, set spending thresholds

The group stated that progress towards these ambitions of higher efficiency could be accomplished by strengthening advocacy by involving media in raising awareness, developing clear criteria for M&E, Ministries of Health taking leading roles in resource allocation and priority setting, and placing a firm emphasis on results.

Proposals for improving the effectiveness of resource channelling and use

On Day 2, the group called on the Taskforce to:

- Pool resources to identify best practice-cost-benefit analysis; evidence-based advocacy and lobby of donors to buy-in
- Strengthen alignment, coordination and harmonisation (Global Donor Forum - G20-led by WHO)



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- Formalise broad policy framework on health
- Ensure that neglected diseases are earmarked for resources
- Involve global health alliance in supporting and training HR- integrate curriculum for better use of resources and ensure multi-skilling of HR
- Invest in Health workforce
- Ensure good IMS & in-country functional M&E with infrastructure

Appendices

1. Delegates
2. Q&A Day 1
3. Breakout groups reports (Days 1 and 2)
4. Summary of recommendations
5. Working Group 1 update
6. Working Group 2 update
7. General information on the Taskforce

1. Delegates

NAME	ORGANISATION	COUNTRY
Albert Kalonji	SANRU	Democratic Republic of Congo
Ana Luisa Libombo	Hope World Wide Mozambique	Mozambique
André Viljoen	Oxfam	South Africa
Antonina (Nina) O'Farrell	VSO Malawi	Malawi
Arvind Betigeri	PATH (Program for Appropriate Technology)	India



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	in Health)	
Bona Chitah	EQUINET / University of Zambia	Zambia
César Mufanequiço	Mozambican Treatment Access Movement (MATRAM)	Mozambique
Dackson Kampira	Malawi Aids Counselling & Resource Organisation (MACRO)	Malawi
Dorothy Juma Okemo	Health Action International Africa	Kenya
Dr Jean Kaseya	SANRU	Democratic Republic of Congo
Dr Ratna Tamsary Caya	White Ribbon Alliance Indonesia	Indonesia
Dr. Ahmed Makuwani	White Ribbon Alliance RA Tanzania & National Blood Transfusion Service	Tanzania
Dr. Srihartati Pandi	White Ribbon Alliance Indonesia	Indonesia
Friday Nkhoma	White Ribbon Alliance Zambia	Zambia
Hattas Yumnah	AMREF SA	South Africa
Karen Hofman	Fogarty International Center	South Africa
Luisa Mariaque Banze	FORCOM	Mozambique
Cherif Rahimy	International Pediatric Association	Benin
Maziko Hisbon Matemba	Health and Rights Education Programme (HREP)	Malawi
Michael Mwiinga Gwaba	Community Initiative for HIV/AIDS, TB and Malaria, Zambia	Zambia
Ngoni Chibukire	Southern African Aids Dissemination Service- SAFAIDS (Southern Africa)	South Africa
Paula Akugizibwe	AIDS and Rights Alliance for Southern Africa (ARASA)	South Africa
Peter Cooper	Former President of the Union of African Pediatric Societies and Associations	South Africa
Peter Kamau	KANCO	Kenya
Prof. Chok-Wan Chan	International Pediatric Association	Hong Kong
Robin Gorna	DfID South Africa	South Africa
Robina Biteyi	White Ribbon Alliance Uganda	Uganda
Rose Wongani Kumwenda-Ng'oma	Christian Health Association of Malawi	Malawi
Sharonann Lynch	MSF South Africa and Lesotho	South Africa
Vuyiseka Dubula Majola	TAC	South Africa



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2. Q&A Day 1

Appendix 4: Questions and Observations

A number of questions and observations were raised by the delegates during the first plenary session. The questions and responses have been grouped into themes.

Questions and observations were raised by the delegates during 1st plenary sessions on Day 1.

Themes	Questions	Responses or Answers from the Panel
<i>HLTF Reports</i>	<ul style="list-style-type: none"> • Was the auditing of current funding done by the working groups? • What are the timelines of deliverables of the reports and accountability? • How does the international innovation for finance system will bring about innovative programmes, and assist in the reduction of corruption of government? • How do we 	<ul style="list-style-type: none"> • The outputs will be recorded, the summary will be available to working groups, website and taskforce and wider audience. • A report feedback will be given to politicians via the representatives of politicians and taskforce secretariats. • The documentation of CSO consultations will be available by end of May 2009. • The taskforce report will include clear plans on how to operationalise the recommendations.



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	<p>monitor political leader management of resources?</p> <ul style="list-style-type: none"> • How is the money used to achieve efficiency? • How have the development countries been involved in the work of the taskforce? • To what extent have local governments engage CSO in resource mobilisation? • What other innovative financing approaches that are available but requires less funds- to be implemented to save lives? • How do we mobilise resources to monitor impact and outcomes? • How much of effort has been put to towards achieving MDG 4, 	<ul style="list-style-type: none"> • The CSO are expected to give recommendation on where the taskforce should put their efforts, at country levels. • The private sector is also involved, in fact there are two members involved in the working groups. • The working group documents are not yet ready to be accessible through public domain. • Recommend that meetings be organised to discuss the management of health systems.
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	5, 6, what does it cost to save mother's life?	
Theme	Observations	Responses to observations from the Panel
<i>HLTF Reports</i>	<ul style="list-style-type: none"> • Focus on policy issues: bilateral, tri-lateral • African countries are similar to Asia- can we focus more on prevention, review what has not worked well and focus on preventive approaches. • My concern is that it is 2 weeks before the report is finalised and there is limited time for wide consultation with CSOs, therefore, a collective views of local people are not properly reflected. • It is important to take back this information and share with local people to get their 	<ul style="list-style-type: none"> • Monitor the resource gaps and assess how the government is addressing the gaps. • There is a need for an integrated view of investment. • The agenda for the meeting is to determine funding gaps and what need to be done to cover these. Therefore, focus on costing of delivery services needed.



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	<p>views.</p> <ul style="list-style-type: none"> • Focus on commitment already made by world leaders-e.g. Global Fund. • Focus on private sector e.g. pharmaceuticals and include private sector consultations in the report to obtain buy-in and reduce resistant during regional consultations. 	
<i>Mechanisms/ Programmes</i>	<ul style="list-style-type: none"> • Support, capacity building to ensure that the workers reach people in a village to save lives, through prevention • Focus on best practices and documentation of best practices. • Identify innovative ways of raising finances from the communities. • Lost direction of 	<ul style="list-style-type: none"> • Country ownership is critical to implementation and adherence to innovative health finance options and these options have to be linked to national plans and policies. • Accountability is required at international, national and local levels (CSO). • Prevention makes sense as many of diseases are preventable. Therefore it is necessary to increase invest in prevention. Good prevention programme will require funding, time, strategies and technology.



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	<p>priorities, the Alma Alta the Primary Health Care (PHC) has been overlooked and opportunities available not utilised effectively.</p> <ul style="list-style-type: none"> • Less focus on health promotion programmes • H1N1 will help countries to refocus on PHC. • Focus on CSO and MDGs 4, 5, 6 that are related to children and integrate maternal and child programmes. • In terms of innovative financing mechanisms, the CSOs “need more of everything”. 	<ul style="list-style-type: none"> • Be clear that although prevention is important, other components of the Health systems are also important, therefore, strive to achieve balance.
Constraints	<ul style="list-style-type: none"> • Development partners do not fund infrastructure. • Impact and outcomes- lack of commitment to tie down process 	<ul style="list-style-type: none"> • Corruption is a global phenomenon- not only in Africa. • There is a need to monitor the health budget at country level.



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	<p>issues, communication, highlighting resolution and causes for mobilisation resources.</p> <ul style="list-style-type: none"> • Countries are not using available technology to pass information on health prevention, promotion. • Paediatricians need to be involved to ensure child survival and child development. • There is money for election, but, we ignore the exploitation of health workers, brain drain and poor working conditions. • There is a need for the availability of diagnostic and technology. 	<ul style="list-style-type: none"> • Monitor and change the systems and policies for aid effectiveness. • Hold donors and government to account in implementing Paris Declaration in terms of donor funding and processes. • Ensure that there is a need for qualified staff and for expanding the health network. • Health and education impact on health outcomes. Hence, health outcomes are not solely owned by the health sector; hence, wider consultation is essential with the business sector, other government departments and CSOs. • The focus is in all MDGs not only on 4, 5, and 6. The MDGs are mutually dependent and mutually reinforcing each other. • It is possible to make dramatically effort with a little bit of resources to change and save the lives of children and mothers
Stakeholder Involvement	<ul style="list-style-type: none"> • Community participation and involvement in 	<ul style="list-style-type: none"> • Strengthen the capacity of the Ministry of Health (MoH) to discuss with Finance Ministries and



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	<p>identification of needs, addressing problems and creating low cost solutions to community problems is critical.</p> <ul style="list-style-type: none"> • Community ownership of health is also important. • Identify community resources that can be mobilised to finance health care. • Working with the media to highlight the issues in health. • Transparency of the health budget-where the districts and local plans & budget are shared widely and community has access to them. • Small NGOs in small communities usually have a strong voice but are excluded from funding due to lack of capacity. 	<p>advocate for health investment in health.</p> <ul style="list-style-type: none"> • Strengthen national CSOs to support the small organisations and international CSOs need to complement in-country CSOs. • Make government accountable to invest in human resources, medical products, technology, and infrastructure. • Challenge corruption and monitor aid effectiveness from local to global level
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	<ul style="list-style-type: none">• Accessibility of information from government in terms of budgets and formal engagement of government with CSO is recommended.	
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A number of questions and observations were raised by the participants during the second plenary session on Day 1, following the presentation on the working group 1 feedback reports presented by Nicole Klingen on ***Constraints to Scaling Up and Costs and*** working group 2 feedback reports presented by Robert Fryatt, on ***Raising and Channelling Funds***, taskforce secretariats. These together with responses have been grouped into themes.

Table 3: Questions and observations were raised by the participants during 2nd plenary sessions in Day 1.



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Themes	Questions/Observations	Responses or Answers from the Panel
<p>HLTF Reports</p>	<ul style="list-style-type: none"> • The interventions do not work in general due to environmental circumstances but work is fragmented and mobilisation of resources is also fragmented. When do you set feasible timelines so that group can work towards these? • Did the taskforce focus on health system (HS) sub-component, were these prioritised? • What is the progress towards ensuring the development of innovative finance mechanism to address malaria? • A call to limit resource ceiling, on last consultation meeting with CSOs was made, can you revisit the issue and comment on progress? • What items are included based on the tools that are being used? • It is good that the report has integrated programmes e.g. ART and PHC. 	<ul style="list-style-type: none"> • Develop system that quantifies social returns. The working group 2 is working on how to do this. • All these mechanism are being analysed to assess how they can be accessed, aligned, harmonised and be coordinated at country level. • Demand side is also included in the report. • Integration with previous work is included to highlight lessons learned to date. • The report include some case studies and situations e.g. Tanzania case of budget ceilings. • The report addresses the lack of evidence. • Reproductive health and family planning programmes are included in the report as



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	<ul style="list-style-type: none"> • Separate the issues of Health System from the issue of global development. • Include the upstream issues needs to be considered to full assess the impact on health and the cost of health care. • Alternative treatment in Africa-how have you included alternative medicine in your work and reports? • Conduct a technical assessment of pros and cons for each financing mechanism option and include in the report. 	<p>sexual and reproductive rights.</p> <ul style="list-style-type: none"> • The taskforce can recommend sound M&E systems to monitor aid effectiveness at country level. • The impact of the yo-yo effect, caused by drastic and unreasonable policy changes at country level may affect the benefits of innovative funding mechanisms. Te taskforce need to consider this issue in detail. • The taskforce, in the report, will advocate for the implementation of financing options or scenarios that require or effect change and not those that do not call for action.
<p><i>Mechanisms/ Programmes</i></p>	<ul style="list-style-type: none"> • Which of the options are priorities? What is the process of prioritisation? 	<ul style="list-style-type: none"> • Priorities for countries need to be at national level rather than be made by the taskforce, depending on



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	<ul style="list-style-type: none"> • Who is making decision as to what are health priorities? • How are the options going to be used in high disease burden countries? • There is a need to start in a small scale, even if you have to start with sub-standard regimen e.g. HIV treatment, but we need to move forward to make investments for longevity by using good regimen e.g. in HIV matching those used in developed countries. • Clarity: Pool resource proposals-is this a new mechanisms or strengthening the existing systems, if it is new, how are these mechanisms going to facilitate CSO involvement and engagement with govt to reflect community needs? • Good suggestion on frontloading: donor and in-country priorities, e.g. India, HIV-AIDS strategy- there is now more donor funding for HIV-AIDS but this does not match the 	<p>country strategies.</p> <ul style="list-style-type: none"> • Pooling is the way to go to spread the risk and increase the efficiency. Local level impact is important thus, M&E and transparency is critical. • Capital pool proposal: investment fund for public and private sector. • There are two types of return- social and financial return and impact investment, balance both of these returns to stimulate interest on this approach. • Domestic and international financing: airline ticket-most money is coming from developed countries but there are contributions from developing countries. All countries are included in decision-making on how the money is used and have their voices heard at global level. This money can be channelled through Global
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	<p>community needs . How can this be managed?</p> <ul style="list-style-type: none"> • Integration of programmes for efficiency is necessary. • What mechanisms that are more feasible than others—how do you prioritise these mechanisms? 	<p>Fund or through multilateral organisations.</p> <ul style="list-style-type: none"> • It is important that these be linked to national strategies to be implemented and not be parallel. • Make strong cases for examples that have worked and advocate for scale-up at global level. • Choose M&E and micro-finance options to channel money to local, by focusing on social returns. • Obtain advisory services to engage private sector and develop legislature that guide the partnerships and pooling of capital. • Identify countries ready to scale-up and consider sustainability where best practices mentioned can be implemented.
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		<ul style="list-style-type: none"> • Cash transfers need to be evaluated every 6-12 months.
Constraints	<ul style="list-style-type: none"> • At country level we lack funding and political support affecting the scale up of health campaigns. • Limited funding supporting on reproductive health-family planning and maternal mortality programmes • Issues of quality of care, in Malawi there are volunteers in all clinics the quality is compromised as the systems are being strengthened. The SWAP approaches may b also limiting some of the innovative work. As they do not support anything that falls outside the SWAP. • There is money for stimulus packages to bail out banks etc, but health is a global public good and need to ensure that it stays a priority. 	<ul style="list-style-type: none"> • There was policy change that removed conditionality. • Develop a cohesive framework of Public Finance Management to look at the health workforce. • Health must be integrated into the development strategies. • Many development partners focus on and claim results. • Focus on multi-sectoral approaches. • Audit M&E system to identify what works and what does not work at country level. • Invest in operational research at country level.



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	<ul style="list-style-type: none"> • Funding of health programmes in Tanzania, during 1980's received tied funding such as retrenchment of health workers. As a result, this weakened the health care system. The health facilities are expected to have skilled health workers but now, these facilities are now staffed by health aid workers. Some of the training institutions were closed as a result of less demand in training. • Some policies contradict the commitments made. How do we monitor and correct the contradictions? • M&E, documentation of best practices and adherence of commitment made remain as challenge. • There is limited and weak M&E approaches that are effective. 	<ul style="list-style-type: none"> • The SWAP and principles of International Health Partnerships are the same. • International Health Partnerships initiative met with the IMF to discuss effective use of funding for achieving results in countries. The IMF has removed harmful funding conditionality.
<p>Stakeholder Involvement</p>	<ul style="list-style-type: none"> • In Indonesia, community participation is very important, from highly informed to less informed. 	<ul style="list-style-type: none"> • Country ownership and honouring of Paris Declaration is critical and through this taskforce it is

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	<ul style="list-style-type: none"> • Collaborating efforts of WHO with UNAIDS • How to obtain buy-in of governments to the international recommended mechanisms? • How can we increase involvement of the private sector? It is difficult to get money from the private sector? How can it be involved? • Issue of bottom-up approach as the communities are influencing the health system is critical. With improved education amongst communities we have seen increased uptake of health services. The community have increased understanding and knowledge of health and health services. • How can these multinational cooperations (automobile, oil and petrol companies e.g. General Motors, Shell, and BP etc) be involved in global partnerships to achieve MDG 8? 	<p>important that these are promoted and monitored at country level.</p> <ul style="list-style-type: none"> • WHO worked with UNFPA, UNICEF and UNAIDS using the tools. Agencies involved will be included in the table in annex including assumptions made for costing using different tools. • Efforts are underway to bring about all developed countries to work together in exploring these issues of financing for health system. This is a start, it is envisaged that more developed countries will join in but requires political diplomacy. • Link international and domestic financing and ensure policy dialogue and involvement of government to identify mechanisms— including, finance and other agencies at national and global level. • CSO can contribute and be drawn upon to delivery their
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	<ul style="list-style-type: none">• How to you involve development partners at country level to support these mechanisms?	<p>services.</p> <ul style="list-style-type: none">• Multi-national companies-in Nigeria, they have clinics and hospitals, but, these are outside of the country health system. Hence is important that when impact assessments are conducted, this need to be taken into account against national priorities.
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3. Breakout groups reports (Days 1 and 2)

Civil Society Forum on the High Level Taskforce on Innovative International Financing for Health Systems

Day 1: Group Discussion



Financing health systems and
attainment of the health MDGs –
responding to the gaps and making
better use of resources

Workgroup 1

Feedback

- Key Messages
- 1) Same person but different MDGs.
 - 2) Finance support different focus areas but reach same people
 - 3) Vertical programmes have kept people alive and healthy



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Challenges

More Money

- Move away from services that cost more
- Essential medication-affordability-generics & logistics and SCM
- Failure to replicate good models
- Sustainability
- Community priorities not reflected in planning and budgeting
- Inaccessibility of health information
- Lack of trust in public system- poor quality of care-lead to out of pocket-payment for health care
- Distribution of infrastructure (balance between rural and urban areas)

Efficiency

- Lack of alignment of priority amongst donors, govt, to realities on the communities (universal access")
- Lack of involvement of communities in decision about finance
- Lack of intersectoral coordination
- Low government expenditure on health
- Lack of monitoring and accountability of donors and govt on commitments made
- Lack of linkages of health reform with national reform
- Poor governance limiting resource flows and access to resources at local level e.g. Zimbabwe

Constraints-cross cutting

- HR-brain-drain, lack of training, incentives/rewards- e.g. rural areas
- As a result:
 - Task-shifting is inadequate to meet health needs
 - Inaccessibility of health care
 - Lack of absorption of resources-at national level due to lack of skills e.g. financial management and HR
- Information systems need to be strengthened, independent & transparent
- Surveillance systems
- Accurate & reliable information on need and gaps reflecting community priorities
- Money for IT infrastructure
- Political leadership



Mobilising more resources for health – the use of existing and innovative financing mechanisms

Group 2

Mobilisation Resources for Health

- Integration is important-flexibility to address funding for life-long ART, better diagnostic tools, TB treatment & 2nd line ARV
- Innovative advocacy at the highest level
- Voluntary solidarity contribution-increase communication to donors calling upon honouring commitments made
- Create demand for health



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Innovative financing mechanisms

- Micro-finance initiatives
- National Health Insurance
- Document best practices-replicated
- Involve CSOs to determine funding priorities
- Health must be a political issue-make political leaders accountable
- Global Fund and Donor funding must strengthen domestic services
- Utilisation of funding to supplement or pay HR

Involvement of the private sector

- Promote social responsibility and predictable source of funding
- Need to revisit MDG8 & focus on PPPs
- Regional bodies (SADC)-to mobilise regional finance sources e.g. wealthy people within developing countries
- Document and share economic costs of doing little or nothing or missing set targets
- Develop clear marketing strategy on innovative finance approaches to reach the private sector
- Increase govt support to FBOs-role in fund-raising and providing services
- Encourage MoH-to collaborate with private sector and donors.
- Explore how private foundations-e.g. Bill Gate-can do more



Channelling funds for health and making a difference – the global health architecture and national health plans

Group 3

Global Opportunities & NHP

- Yes-there are opportunities to channelling funds for health and make a difference to improve policies & health architecture
- National H. Policy Environment-receptive & supportive towards streamlining of resources
- Service delivery-can be improved by pooling of resources.
- Financial crisis-has forced govt to re-prioritise



Challenges-

- Lack of harmonisation of funding for health programmes (govt, CSOs, donors)
- Integration versus vertical programmes & lack of collaboration
- HR capacity-TA is provided but there is lack of capacity to build local people
- Lack of transference of skills from foreign TA to local HR.
- Inavailability of drugs, supplies and medical commodities due to weak supply chain management systems
- Poor planning and prioritisation for health
- Lack of M&E & accountability mechanism

Solutions

- Integrate funding-create synergies to fund health systems versus diseases.
- Promote PPPs
- Holistic approach to HS strengthening
- Improve efficiency: by reducing competition amongst donors & channel more funds to programmes-more outcomes
- Remove invisible conditionalities of donor funding
- Prioritise resource allocation



Efficiency in resource utilisation

Domestic

- Have joint planning with M&E process including all stakeholders
- Involve private sector in training of health workers-transfer capacity and skills
- Involve-different stakeholders in national policy development
- Provide tax incentives for private care providers-increase invest in HS-for sustainability
- Leveraging of matching grants through incentives to ensure that 15% is allocated to health.
- Capatalisation on national health insurance-affordability

External (Donors)

- Pool funding-to a common basket with 1 plan & 1 M&E
- Include performance based financing of programme that produce results
- Set threshold of spending (e.g. Reduce admin-costs % versus programme activities).

National strategies

- India-has an inclusive process-CSO, govt, when developing national health policies & strategies
- Zambia & Malawi-have similar processes but needing improvement
- CSO-must be active and govt-need to allow greater engagement of CSOs.



Recommendations:

- Strengthen advocacy by involving media in raising awareness
- Develop clear criteria for M&E framework
- MoH-to take a lead in sharing national health plan and be transparent on resource allocation and setting of priorities
- Focus on health outcomes & results-versus-process or admin. overheard

4. Summary of recommendations

Breakout Groups Recommendations

Group 1

Health systems strengthening –
opportunities and challenges



Human Resources (HR)

- Conduct situational analysis of available HR & identify gaps

Requires:

- Structured training planning
 - More skilled HR –trained, retained and equitable distributed (quality and quantity)
 - Address task-shifting; quality control, incentive
 - Improve working conditions

Cost vs. Efficiency

Cost Implication

- Training – career development
- Performance based Incentives e.g. top-up salaries
- Mentoring, supervision and support

Efficiency:

Challenges:

- HR migration (in-country, between countries)
- Allowance culture

Require:

- Sustainable incentives
- Implementation of international code of conducts-poaching HR from public sector
- Well-defined training needs
- Training-clear outcomes



Health Information System (HIS)

- Identify low cost and appropriate options of HIS
- Ensure transparency of HIS (accessibility)
- Establish partnerships for strengthening of IMS
- Integrate and streamline HIS & IMS: to ensure integration when capturing data: commodities, disease burden, finance-allocation, projections-expenditure
- Train HR to use HIS & IMS

Innovative Funding

Dedicated Resource to rare disease

- Include rare diseases
- Map and budget for infrastructure to ensure equitable distribution

Requires:

- Integration and coordination
- Strengthen national health coordinating mechanisms
- Strengthen HSS through disease-specific resources

Policy Implementation

- Campaign for 15% allocation of budget to health Legislative framework to be in place to support policies
- Ensure that policies are costed, time-bound and have clear outcomes



Context of Financing-Requires

- Removal of donor conditionalities
- Review of legislative barriers
- Push global consensus on accessing EDLs
- Better regulation of pharmaceuticals-TRIPS
- Coordinated supply chain management systems (explore bulk procurement and regional pooling)
- Resources for research & HIV-AIDS Treatment

Safety nets

- National health insurance- community distribution?
- Specific country approaches
- Tie to broader-approaches-nutrition



Recommendations

Group 2

Additional and predictable funding for health systems

Equitable Financing

- Strengthen funding mechanism to support all HSS components
- Harmonise funding at all levels-from local, country and donor levels
- CSO participation in health priority setting, costing, allocation of resources, implementation and M&E
- Joint planning –all stakeholders
- Strengthen & scale-up resource mobilisation initiatives-.g. microfinance; National Health Insurance systems, tax
- Donors funding to complement country initiatives



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Rec-contd (2)

“Health is also important for recovery from the financial crises!”

- Encourage cooperates-to invest in social programmes (MDG 4,5 & 6)
- Provide incentives e.g. tax relief/awards etc.
- Develop marketing strategy to encourage support of social programme by the private sector with related M&E
- Expand existing medical insurance packages to cover the poor & provide incentives
- Ensure that governments adhere to 15% as a minimum contribution for the health budget
- CSO to monitor the budget allocated for health
- Ensure community involvement & empowerment for prevention, care and support
- Establish CSOs fora to share best practices & lessons learned
- Despite the financial crises, the funding for health must not be compromised.
- Develop a tracking system for donor assistance & commitments and allocations
- Develop systems to track in country training programmes

Recommendations

Group 3

Channelling funds and improving the effective use of resources



Channelling Resources

- Pool Resources
Require: identify best practice-cost-benefit analysis;
evidence-based advocacy and lobby of donors to buy-in
- Strengthen alignment, coordination and harmonisation
(Global Donor Forum -G20-led by WHO)
- Formalise of broad policy framework on health
- Ensure that the neglected diseases are earmarked for
resources
- Involve global health alliance in supporting and training
HR-integrate curriculum for better use of resources and
ensure multi-skilling of HR
- Invest in Health workforce
Require: succession planning- transference of skills; work-
rotation system t fill in the gaps

Recomm (cntd)

- Good Info Management Systems (IMS)& in-country
functional M&E with infrastructure
Requires:
 - Evidence-based practices: planning tools,
programmes for scaling-up
 - Multi-sectoral joint planning at country-level:
govt, donor, CSO
 - Strengthen planning & management bodies- to
allow for accountability, synergy and results
orientated outcomes
 - Leverage funding by matching funding with govt-
spending and tracking funding



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5. Summary of Recommendations

“Health is part of the recovery from the financial crisis.” (Group 2 Participants)

Recorded below is a summary of recommendations given by the three groups during the breakout session on Day 2.

Table 4: Summary of Recommendations

	Group 1	Group 2	Group 3
Topic	Health systems strengthening – opportunities and challenges	Additional and predictable funding for health systems	Channelling funds and improving the effective use of resources
Themes			
Human Resources	Conduct a situational analysis of available human resources and	Develop a system to track health worker in-country	Invest in Health Workforce



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	<p>gaps</p> <p>Introduce performance based incentives e.g. top-up salaries</p> <p>Establish mentoring, supervision and support systems</p>	<p>training programmes</p>	
<p>Health Information System (HIS)</p>	<p>Identify low cost and appropriate options of HIS</p> <p>Ensure transparency of HIS (accessibility of information)</p> <p>Build partnerships to strengthen information management system(IMS)</p> <p>Integrate and streamline HIS & IMS</p> <p>Train health workforce to use HIS and IMS</p>		<p>Establish good Information Management Systems including infrastructure & functional M&ER mechanisms</p>



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Innovative Finance Mechanisms-Focus Areas	<p>Strengthen funding mechanism to include all sub- components (governance, leadership, finance, service delivery, human resources, technology, infrastructure, medical products, IS) of health system strengthening (HSS)</p> <p>Strengthen & scale-up resource mobilisation- .g. microfinance; NHI systems, tax</p> <p>Earmark funding to support rare disease programmes, HIV- AIDS treatment & research</p>	<p>Hold government accountable to allocate 15% as minimum allocation of the health budget</p> <p>Expand existing medical insurance packages to cover the poor & provide incentives</p> <p>Ensure performance based funding</p> <p>Strengthen planning & management bodies- to allow for accountability, synergy and results orientated outcomes</p>	<p>Pool resources</p> <p>Leverage funding and track the management funds</p> <p>Ensure that accountability and synergy mechanisms are developed</p>
Private Sector	<p>Encourage cooperates-to invest in social programmes (MDG 4,5 & 6)</p>		



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	<p>Provide incentives e.g. tax relief and rewards etc. for supporting social programmes</p> <p>Develop a marketing strategy with related M&E to track social programme support by the private sector</p>		
Stakeholder Involvement	<p>Advocate for joint planning –all stakeholders</p> <p>Ensure that policies are costed, time-bound and have clear outcomes</p> <p>Better regulation of pharmaceuticals- TRIPS</p> <p>Coordinated supply chain management systems</p>	<p>CSO participation in health priority setting, costing, allocation of resources, implementation and M&E</p> <p>CSO to regularly monitor and advocate for 15% budget allocation</p> <p>Involve and empower communities in prevention, care and support</p>	<p>Advocate for multi-sectoral joint planning of the government, donors, CSOs</p>



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Behaviour of Development Partners	Strengthen in country donor coordinating mechanisms	Develop a tracking system to track and monitor donor funding and flows	Strengthen alignment, coordination and harmonisation (Global Donor Forum -G20-led by WHO)