



**More money
for health,
and more health
for the money**

...to achieve the health MDGs,

**...to save the lives of millions
of women and children, and**

**...to help babies in low-income
settings have a safer start to life.**



**Taskforce on Innovative
International Financing
for Health Systems**



Members of the high-level Taskforce on Innovative International Financing for Health Systems meet in London, 13th March 2009.

Left to right: Josep Figueras, (on behalf of Graça Machel), Bob McMullan (International Development Assistance, Australia) on behalf of Stephen Smith, Christian Masset (Ministry of Foreign Affairs, France), on behalf of Bernard Kouchner, Tedros Adhanom Ghebreyesus (Minister of Health, Ethiopia), Giulio Tremonti (Minister of Economy and Finance, Italy), Gordon Brown (Prime Minister, United Kingdom), Robert B. Zoellick (President, World Bank), Margaret Chan (Director General, World Health Organization), Douglas Alexander (Secretary of State for International Development, United Kingdom), Tore Godal (Special Adviser of Prime Minister of Norway), on behalf of Jens Stoltenberg, Manfred Konukiewitz (Deputy Director General, Federal Ministry for Economic Cooperation and Development, Germany) on behalf of Heidemarie Wieczorek-Zeul, Philippe Douste-Blazy (United Nations Secretary General's Special Adviser for Innovative Financing for Development).



Mrs Graça Machel speaking at Taskforce consultation in Johannesburg



Margaret Chan attends the third Taskforce meeting held in Paris on 29th May



Chair Working Group 2, Anders Nordström, and co-chairs Working Group 1, Julio Frenk and Anne Mills, present to second Taskforce meeting hosted by Gordon Brown at No 10 Downing Street



Bernard Kouchner chairs third Taskforce meeting in Paris



Nicole Klinge, Taskforce Secretariat, speaking at Taskforce consultation event in Johannesburg



Robert Fryatt, Taskforce Secretariat, speaking at Taskforce consultation event in Johannesburg

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Summary and recommendations

The challenge

More and better resources are needed if the health Millennium Development Goals¹ are to be reached in 2015. The aim is to raise additional resources that are provided to countries in an effective way and linked to results.

Every human being is entitled to good health. Health is a measure of social justice and equity. Access for all people to safe, high-quality essential health-care services is vital, and is a key responsibility of governments. Investments in improving health play a crucial role in reducing poverty, achieving the Millennium Development Goals (MDGs) and promoting peace and stability.

Remarkable progress has been made during the past decade, with significant declines in child mortality, measles, tetanus, iodine deficiency and malaria, as well as dramatic increases in access to antiretroviral treatment for HIV – all of which have saved millions of lives and improved the quality of life of millions more.

Development assistance for health (DAH) has more than doubled since 2000 and has played a major role in making these gains. However, without more effort to build stronger national health systems in the 49 poorest countries, each year half a million women will continue to die from preventable complications in pregnancy, a quarter of a million adults will die from HIV and up to 11 million unplanned pregnancies will occur. And if the current financial crisis persists, these numbers will be even worse. The World Bank estimates between 200,000 and 400,000 additional children may die every year – between 1.4 and 2.8 million before 2015.

Progress is impeded by insufficient funding, poor use of resources, and fragmented and largely unpredictable financing flows. Low-income countries currently spend only US\$25 per capita on health; of this US\$10 comes from out-of-pocket payments and only US\$6 from DAH. More than 50% of DAH provided directly to countries is allocated to infectious diseases, while less than 20% is invested in basic health-care services, nutrition and infrastructure².

More money for health

Recommendation 1: The Taskforce highlights the critical need to raise up to an additional US\$10 billion per year to spend on health in poor countries.

Spending on health in low-income countries needs to be raised from an estimated US\$31 billion today to US\$67-76 billion per year by 2015. The innovative financing mechanisms presented in this report can raise up to US\$10 billion per year which, together with existing commitments, can help fill the financing gap to reach the health MDGs.

Meeting these ambitious goals will require that donors and partner governments honour the commitments they have made. But it will also require innovation and leverage in funding mechanisms and in the way that funds are used.

Innovative development finance involves non-traditional applications of official development assistance (ODA), joint public-private, or private mechanisms and flows that (i) support fund-raising by tapping new sources and engaging partners as investors and stakeholders, or (ii) deliver financial solutions to development problems on the ground. It can contribute to improved health outcomes by raising additional funds, and by supporting the more efficient and results-oriented use of resources.

Innovative finance is not a substitute for international and domestic commitments. This report shows that adhering to these commitments is now more important than ever.

The cost of not raising additional funding is dire – 4 million children dying each year, who otherwise would have been saved, and 780,000 avoidable deaths of adults, including 322,000 women dying as a result of giving birth³.

To mobilize these funds and to make better use of existing funds the Taskforce recommends the following set of innovative financing options that countries and other stakeholders can choose to support. These complementary options will be implemented through international coordination to strengthen health systems in low-income settings.

Recommendation 2: Expand the mandatory solidarity levy on airline tickets and explore the technical viability of other solidarity levies on tobacco and currency transactions.

Recommendation 3: Expand the use of the International Financing Facility for Immunization and other approaches to ensure predictability.

Recommendation 4: Provide public catalytic funding for large-scale private giving initiatives such as voluntary solidarity contributions and a proposed “De-Tax”.

Recommendation 5: Establish or expand existing funds for results-based “buy-down” funding.

Recommendation 6: Strengthen the capacity of governments to secure better performance and investment from private, faith-based, community, NGO and other non-state actors in the health sector.

Better health for the money

Recommendation 7: Make the allocation of existing and additional funds in countries more efficient, by filling gaps in costed and agreed national health strategies.

To make better use of funds, low-income countries need to strengthen health systems as part of a national health strategy to improve governance and finance the scaling up of services, ideally free at the point of delivery, required to reach the health MDGs.

The international community has a responsibility to assist in the implementation of these strategies in line with existing commitments^{4,5}. This includes recent work under the International Health Partnership and related initiatives (IHP+)⁶ on joint assessment of health strategies, common monitoring arrangements for outcomes and health systems performance, results-based financing, and more effective technical assistance and procurement arrangements

Allocations of all future funds should be linked to clear expectations of outcomes and results, and linked to a mutually agreed medium-term fiscal framework. A particular focus will be on using results-based financing to improve access to vital health services for women and vulnerable groups.

Recommendation 8: The Taskforce requests OECD/DAC with partners to undertake a review of all current technical assistance, with a view to focusing it on strengthening national and local institutional capacity in priority areas such as public administration and accountability, financing, service delivery arrangements and the non-state sectors.

A substantial proportion of international resources today is spent on technical assistance. It consisted of 42% of all DAH in 2002-2006. Technical assistance therefore represents an enormous opportunity for gains in efficiency and effectiveness.

Recommendation 9: Establish a health systems funding platform for the Global Fund, GAVI Alliance, the World Bank and others to coordinate, mobilize, streamline and channel the flow of existing and new international resources to support national health strategies.

¹ While all MDGs are related to health, for the purpose of this report the health MDGs refer to: MDG 1c (malnutrition), 4 (child mortality), 5 (maternal health), 6 (HIV, malaria and other diseases) and 8e (essential drugs).

² See Working Group 1 report.

³ See Working Group 1 report.

⁴ Gleneagles commitments and G8 updates.

⁵ Millennium Declaration.

⁶ International Health Partnership and related Initiatives: global compact.



Breakout session at Taskforce consultation, London

For pooling of resources at the global level the announced intention of the Global Fund, the GAVI Alliance (GAVI) and the World Bank to develop a coordinated, streamlined programming approach to support health systems strengthening provides an attractive way forward. The three agencies would receive funds from existing traditional DAH and innovative sources, but work under a new collaborative agreement for a health systems platform.

New commitments from donors and private entities to fund these agencies will need to be matched by commitments to demonstrate significant progress on improving ways of working and achieving results. WHO remains committed to facilitating this process.

The way forward

Recommendation 10: To monitor how well we are doing, a regular forum will be held for countries and partners, building on the IHP+ Ministerial Review.

This report is the start of a process. The Taskforce will report to the G8 in July 2009. Prior to the United Nations General Assembly in September 2009, the Taskforce will conduct further consultations and facilitate the preparation of implementation plans for the recommended innovative financing mechanisms with relevant stakeholders. A regular forum will be facilitated by WHO and the World Bank to allow countries and partners, including civil society, to monitor progress.

1. The challenge

A. The global squeeze on resources

The world is facing the most serious economic downturn since the 1930s. Earlier increases in the cost of food and fuel are estimated to have pushed more than 100 million people back into poverty. The challenge is to prevent an economic crisis from becoming a social and a health crisis. The poor in both high- and low-income countries will be hardest hit, and identifying vulnerable populations is as important as identifying vulnerable countries.

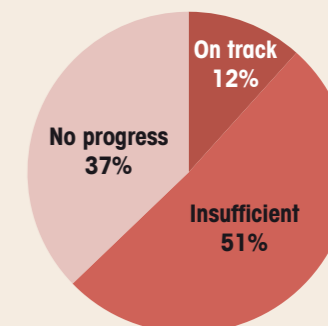
The effects of the crisis in many low- and middle-income countries are increasingly evident: net private financial flows have fallen (from US\$1 trillion in 2007 to less than US\$200 billion in 2009); foreign direct investment and remittances are decreasing; and exports from developing countries are down in terms of both price and volume. The consequences, such as unemployment and decreasing revenues, impact on household income, government spending and the capacity of other actors in the private and voluntary sectors to contribute to the health effort. All this is happening at a time when health needs are rising.

B. The need for essential health services

Every human being is entitled to good health. Health is a measure of social justice and equity; access for all people to safe, high-quality, essential health-care services is vital and a responsibility of all governments. Healthy citizens are a driver of all sustainable development – economic, social and cultural. Investments in improving health play a crucial role in reducing poverty, achieving the Millennium Development Goals (MDGs), and promoting peace and stability. Progress towards many health MDGs is poor (figures 1 and 2).

A country's health system should be capable of providing a minimum of essential services, especially for the poor and vulnerable, to achieve the health MDGs. Services should include: universal coverage of interventions proven to reduce mortality among mothers, newborns and children under five; childbirth care; reproductive health services; prevention and treatment of the main infectious diseases; diagnosis, information, referral, and relief of symptoms for those presenting at the primary care level; and health promotion. Effective service delivery requires a health system "platform" that can train and supervise the necessary health workers, provide essential drugs and supplies, channel money, and ensure accountability and transparency.

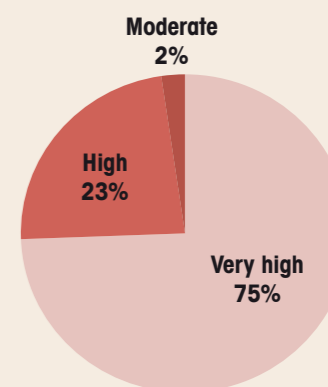
Figure 1: Poor progress towards MDG 4 (reduce child mortality)



Countries with under-five mortality rates of less than 40 per 1000 live births or an average annual reduction rate (in under-five mortality from 1990-2006) of at least 4.0% are considered "on track".

Source: UNICEF 2008.

Figure 2: Poor progress towards MDG 5 (improve maternal health)



Very high: maternal mortality ratio of 550 or greater; high: maternal mortality ratio of 300-549; moderate: maternal mortality ratio of 100-299; low: maternal mortality ratio of less than 100 per 100,000 live births.

Source: UNICEF 2008.



C. The need for more and “better” resources

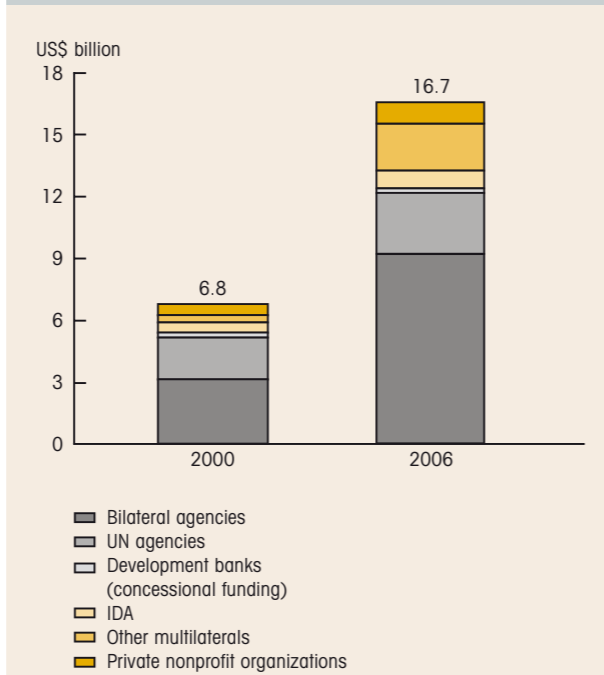
Investing in health systems that provide access to essential and vital services would save millions of lives. It is also an important and efficient means to obtain and secure basic human rights. In addition, as the recent appearance of H1N1 influenza illustrates, well-functioning national health systems are also necessary for countries to be able to address emerging global public health threats and meet their obligations under the International Health Regulations.

Since the Millennium Declaration in 2000, total development assistance for health has more than doubled (figure 3) and has saved the lives of millions of individuals and protected the livelihoods of their families. This money has not always been invested equally across the various programmes (figure 4). As shown above, most low-income countries are failing to make progress towards the child and maternal mortality MDG targets. The financial crisis threatens past achievements and may lead to an increase in infant deaths in developing countries by 200,000–400,000.

In times of uncertainty it is even more important to ensure a predictable flow of resources for health in poor countries. A drop in resources for health – either external or domestic – would threaten to halt nascent efforts underway in several countries to build health systems and accelerate progress towards the health MDGs.

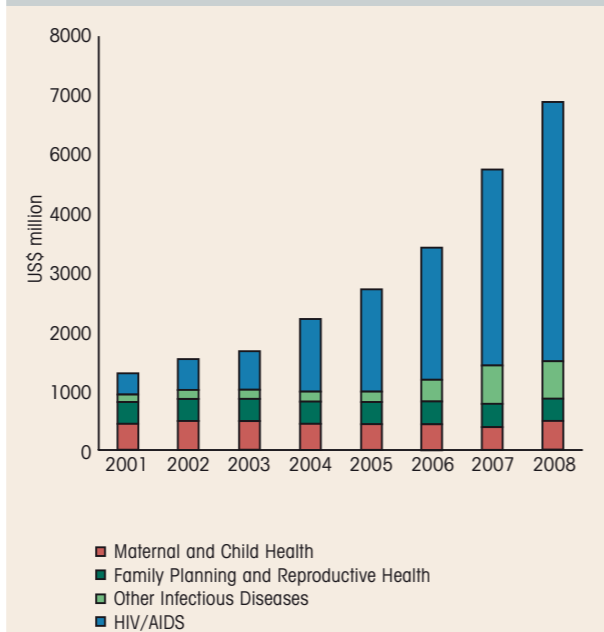
The cost of not raising additional funding is dire – 4 million children dying annually who otherwise would have been saved, and 780,000 adults dying each year, including 322,000 women as a result of childbirth. The loss of these mothers is particularly cruel when children with physical or learning disabilities are left behind. Addressing these challenges requires not only innovative finance, but also major political mobilization and rapid implementation⁷.

Figure 3: Growth in development assistance for health



Source: World Bank 2008

Figure 4: US funding on global health (2001-2008)



Source: US Congressional Research Service 2008

⁷ A consensus is emerging for maternal and newborn health around five action points: 1) Political and operational leadership and community engagement and mobilization; “Leading by example: Protecting the most vulnerable during the economic crisis”; 2) Effective health systems delivering intervention packages for comprehensive family planning, safe abortion (where abortion is legal), antenatal care, quality care at birth including skilled birth attendance and emergency obstetric care, and postnatal care for mother and baby; 3) Removing barriers to access, with quality services for women and babies being free at the point of use where countries choose to provide it; 4) Skilled and motivated health workers; 5) Accountability for credible results. (To be published on 15 June 2009 in a report from The Global Campaign for the Health Millennium Development Goals: Leading by Example - Protecting the most vulnerable during the economic crisis.)



Civil Society representatives share their views on the Taskforce at the consultation in London

2. More money for health

A. The cost of scaling up essential services

The Taskforce highlights the critical need to raise up to an additional US\$10 billion per year to spend on health in poor countries.

The Taskforce has estimated the costs of the interventions and health-system support required to accelerate achievement of the health MDGs in low-income countries. There is no fixed or agreed-upon path that countries must follow to scale up services. Countries are very diverse, and follow diverse paths. To emphasize the differences that exist, two analyses (Scale up One and Two) were undertaken to provide a range of costs and impacts, based on different assumptions with regards to speed and approach to the scale-up of services.

Spending on health in low-income countries is an estimated US\$31 billion today (US\$25 per capita). The additional cost needed to achieve the health MDGs is an estimated US\$36-45 billion (US\$24-29 per capita) (table 1). Two thirds or more of total costs need to be devoted to general health system support, which includes multipurpose health workers and facilities, as well as the necessary investments for logistics, information systems, governance, financing systems, and so forth.

Capital expenditures are important for increasing system capacity to absorb more funding. They would take up 40-48% of the investment, with the remainder required for ongoing health system support including the health workforce, drugs and supplies. The numbers of health facilities would increase by 74,000-97,000, and health workers by 2.6-3.5 million.



	Scale-up One (US\$2005)	Scale-up Two (US\$2005)
Total additional costs 2009 - 2015		
Total	251 bn	112 bn
Capital	101 bn	54 bn
Recurrent	151 bn	58 bn
Total additional costs in 2015		
Total	45 bn	36 bn
Capital	2 bn	19 bn
Recurrent	43 bn	17 bn
Additional costs in 2015 per capita		
Total	29	24
Capital	1	13
Recurrent	28	11
Capital as % of total	40%	48%
Human resources as % of total	22%	12%
Drugs and commodities as % of total	13%	21%
Programme and disease as % of total*	26%	38%
Health systems platform as % of total	74%	62%
Sub-Saharan Africa as % of total	60%	80%

* Includes only programme or disease specific resources; multipurpose health workers and facilities are included within health systems. Details provided in Working Group 1 report.

B. What are the gains of this investment?

Four million children and babies would be saved annually, and up to 322,000 maternal deaths, 193,000 adult HIV deaths, and 265,000 tuberculosis deaths would be averted (table 2).

More than 30 million babies would be protected from stunting, and 11 million unwanted births would be avoided. Millions of children and adults would have their illnesses prevented or treated, averting a massive amount of morbidity. These figures may seem optimistic but rapid improvements have been shown to be possible if resources are mobilized and used effectively.

⁸ These figures are additional to the current estimated US\$31 billion spent on health today in the 49 low-income countries. Details in Working Group 1 Report.

	Scale-up One	Scale-up Two
Additional deaths averted in 2015		
Under-5 deaths averted (including newborn, infant and neonatal)	3.9m	4.3m
Maternal deaths averted	322,000	259,000
Adult HIV deaths averted	193,000	74,000
Tuberculosis deaths averted	265,000	235,000
Examples of other benefits		
Decrease in number of births due to increased use of family planning	11m	9m
Total stunting prevented	30m (12-59 months)	8.3m (12-23 months)
% progress towards MDGs 4 and 5 from 1990/95 baseline		
MDG 4: % of countries reaching target	80%	82%
MDG 5: % of countries reaching target	45%	39%
% progress towards MDG 6 from 2008 baseline		
% countries halving malaria incidence	likely to be reached	87%
% countries halving HIV incidence	not available	42%
% countries halving TB mortality	met at regional level	72%

*Details in Working Group 1 report

C. Options for innovative financing

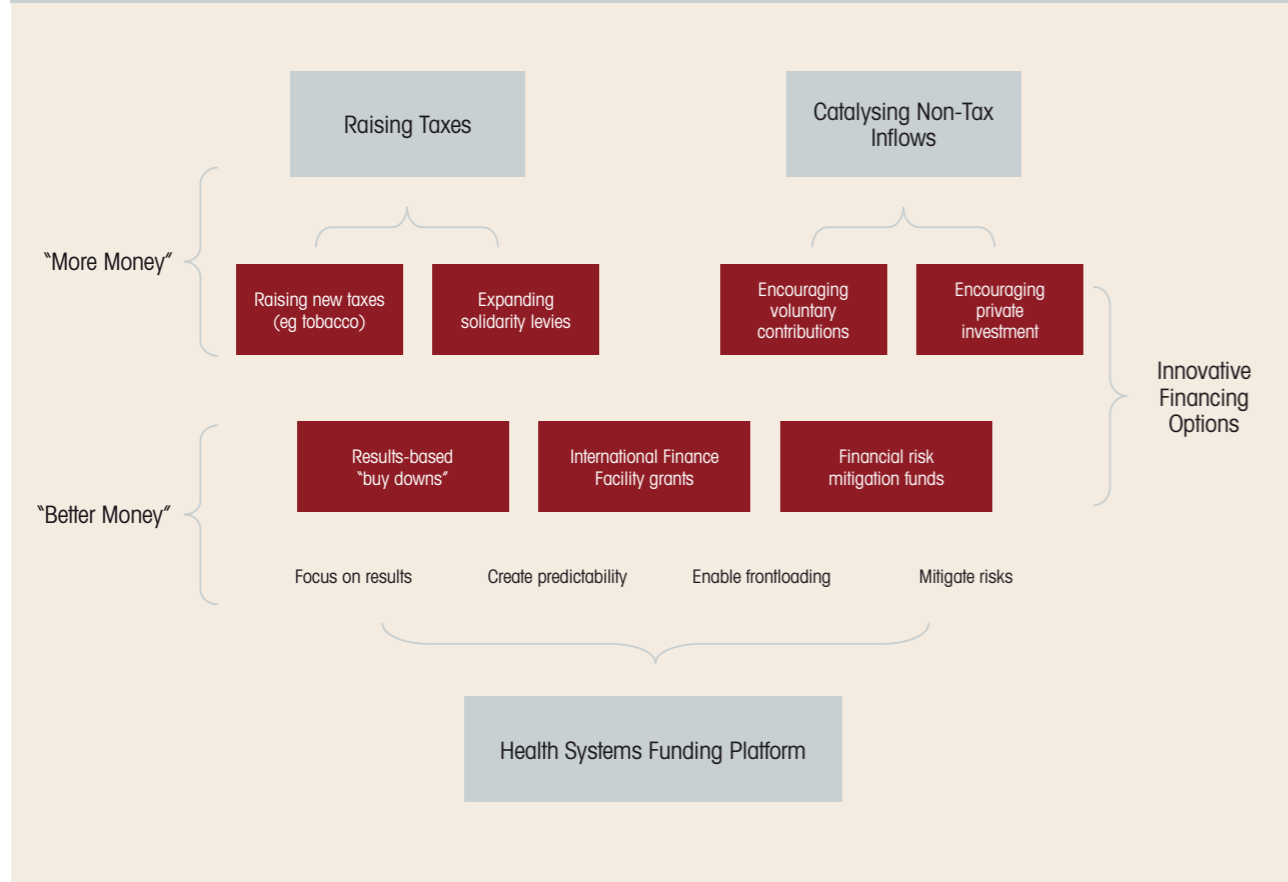
A detailed analysis of around 100 existing innovative financing mechanisms was carried out to assess their potential for use to strengthen health systems. From these 100 mechanisms a shortlist of 24 was developed⁹. To start with, the Taskforce recommends the following set of innovative financing options which countries and other stakeholders can choose to support:

- I. Expand the mandatory solidarity levy on airline tickets and explore the technical viability of other solidarity levies on tobacco and currency transactions;
- II. Expand the International Finance Facility for Immunization and other approaches to ensure predictability;
- III. Provide public catalytic funding for large-scale private giving initiatives such as voluntary solidarity contributions and De-Tax;
- IV. Establish or expand existing funds for results-based "buy-down" funding;
- V. Strengthen the capacity of governments to secure better performance and investment from private, faith-based, community, NGO, and other non-state actors in the health sector.

⁹ For a detailed analysis of the 24 mechanisms see Annex 3 of the Working Group 2 report.



Figure 5: Types of innovative financing mechanisms



The Taskforce also agrees that other options might well be considered in the future, including expansion of the sale of emission allowances. Figure 5 above illustrates how the types of mechanisms could fit together.

It is important to ensure that the different innovative mechanisms are complementary to avoid fragmenting financial flows. The red boxes above represent different approaches to innovative financing and their potential synergies. These activities provide the link between “more money” and “better money” discussed in further detail below.

While the Taskforce recognizes that financial resources for health systems have to come from a number of different sources, channeling of resources to countries must be done in line with the Accra Agenda for Action and the Paris Declaration on Aid Effectiveness. The IHP+ principles will be applied – one national strategy, one budget, one results framework and one reporting mechanism. Domestic and international resources will be used to ensure predictable financing is available to effectively plan and manage national strategies.

I) Expand the mandatory solidarity levy on airline tickets and explore the technical viability of other solidarity levies on tobacco and currency transactions.

Mandatory solidarity levies and taxes can generate clear benefits in terms of resource flows, low transaction costs (estimated to be 1-3% of revenues), and sustainability. At the same time, these mechanisms can be complex and difficult to implement, both technically and politically. This last consideration may be exacerbated during the current economic climate.

Levies or taxes may be implemented by a single country and, where appropriate, coordinated internationally. If backed by the necessary political support, levies may be implemented quickly in individual countries.

The precedent for this approach is the mandatory solidarity levy on airline tickets. This programme, introduced in 2006, now generates about €180 million per year in France. Additional revenues, about €22 million annually, come from domestic sources in other participating countries (Chile, Congo, Côte d’Ivoire, Madagascar, Mauritius, Niger and South Korea). UNITAID is the primary but not the only recipient of the proceeds of the tax.

The Taskforce recommends expanding the existing levy to countries beyond the current coalition. The levy would be mandatory for individuals buying airline tickets in participating countries. Proceeds could continue to be allocated to UNITAID, and/or other institutions. An expansion of the airline tax could potentially raise US\$200-400 million annually over the coming years. The feasibility of the mandatory solidarity levy on airline tickets has been proven and further roll-out might be quick, with a time frame for implementation of between two and 12 months. The value added of the mandatory solidarity levy on airline tickets is clearly to raise additional funds.

A number of other proposals for solidarity levies warrant further consideration. They include an expansion of tobacco levies and a currency transaction levy. There are potential challenges to these proposals and the Taskforce recommends a detailed exploration of their technical viability.

II) Expand the use of the International Financing Facility for Immunization and other approaches to ensure predictability.

Strong health systems require a package of interventions – which in turn require different forms of finance. The core health systems need is for predictable cash flows, particularly long-term finance commitments that enable ministries of health to plan for the long term. Examples of financing mechanisms that promote predictability with commitments of up to 20 years are the International Financing Facility of Immunization (IFFIm), the Advance Market Commitment for Vaccines (AMC) pilot and the recent eight-year pledge by the United Kingdom to the Global Fund.

In addition to the need for predictable funding, certain expenditures require frontloaded funds to finance one-time investments in services and delivery infrastructure. Frontloading is a way to move forward the timing of programme funding. With early availability of funds, they may be “invested” or used more quickly so that outputs/outcomes are realized sooner. Possible uses of frontloaded funds to strengthen health systems include investments to expand training capacity, expand and renovate physical infrastructure, and improve systems for financing, management and information. Frontloaded investments could make significantly more funding available in the near term, when funding gaps are urgent in the run up to 2015.

IFFIm has successfully demonstrated the effectiveness of frontloading. The Taskforce recommends a significant expansion of IFFIm for health systems. IFFIm is an international development financing mechanism that raises funds on the international capital markets to promote expanded immunization coverage and increase access to new vaccines. IFFIm is now an established borrower and could – with further donor support – raise substantially more than it does at present to be used toward other investments that would benefit from frontloading.

In support of IFFIm a number of development partners (France, Italy, Norway, Spain, Sweden, South Africa and the United Kingdom) have demonstrated ways to increase long-term predictability of funding commitments of up to 20 years. Since its inception in 2006, IFFIm has raised nearly US\$2 billion in the capital markets and distributed US\$1.25 billion for the GAVI Alliance’s programmes. At present, IFFIm is expected to raise approximately US\$3.3 billion for GAVI’s programmes through 2015. Taking into account the willingness of current partners to commit more resources and/or other partners to join IFFIm, substantially more money could be raised for health systems.

The value added of IFFIm lies in its ability to frontload future aid flows. The cost of expanding and maintaining this mechanism is estimated to be around 3.5-4.5% of the amount frontloaded (with start-up costs of below US\$3 million). The lack of sustainability of financing recurrent costs needs to be considered and mitigated when considering an expanded IFFIm for health systems. In addition, an analysis of the implications of an IFFIm expansion will be undertaken to resolve remaining technical issues.



III) Provide public catalytic funding for large-scale private giving initiatives such as voluntary solidarity contributions and a proposed "De-Tax".

Private giving has wide support, is relatively non-controversial, and can generate public awareness and support for health systems development. Generally, however, private giving has lower revenue-raising potential than taxes and potentially higher set-up and implementation costs. Initial investment would be required to conduct market surveys and focus groups, to assess the efficiency of a range of fund-raising tools, and to publicize programmes.

The Taskforce recommends to consider De-Tax:

a proposal, made by Italy, to earmark a share of VAT taxes generated by participating businesses in participating countries for health systems development, combined with a voluntary contribution from businesses. The participating government would waive 1% or more of VAT on any good or service sold by businesses associated with the initiative, while businesses themselves, on a voluntary basis, would waive a share of their profits on related transactions. Both government and business contributions would be collected into a national dedicated fund and used to strengthen health systems in poor countries through existing channels to support the health systems financing platform (chapter 3).

The value added of the De-Tax would lie in its potential to raise additional funds. Currently a feasibility study is underway to explore the costs and benefits of implementation. It is estimated that it would take about 12 months to set up this proposal. Potential revenues would be about US\$2 billion annually, if 26 countries participated with a 5% participation of businesses in these countries.

The Taskforce recommends to consider voluntary solidarity contributions, which are "high volume and low ticket" in nature and seek small contributions from purchasers of services - such as airline tickets or mobile phone minutes. Once embedded and operational, solicitations could be made to a large number of customers (and transactions), with the potential to deliver significant funding. Start-up costs, principally for marketing and implementation, could be substantial. The Millennium Foundation for Innovative Finance for Health is pursuing two initiatives that merit support from the Taskforce. Under current arrangements, all revenue raised would in the first instance be directed to UNITAID. UNITAID could potentially contribute to the health systems funding platform (chapter 3).

- **The voluntary solidarity contribution tied to travel products** is a proposal already under development (with seed funding committed by UNITAID) to raise funds by providing individuals and corporations who purchase airline tickets or other travel products such as hotel rooms, rail tickets and car rentals, with the opportunity to voluntarily donate a small sum for each purchase. The value added would be to generate additional funds. It could potentially generate revenues of up to US\$1 billion annually with low administrative costs.
- **The voluntary solidarity contribution linked to the use of mobile phones** is a similar proposal, at an early stage of conception, based on small contributions added to individuals' monthly mobile phone bills. This proposal has the potential to raise up to US\$1 billion additional funds.

These voluntary mechanisms provide potential contributors the option to donate to health systems; they have a medium-high revenue potential but with relatively high start-up costs. They could conceivably be developed to raise money on health sector transactions in the richer countries, such as paying premiums on health insurance and buying other health services and products. However, not much experience exists to date. Feasibility studies and market research are underway to further the understanding of the costs and benefits.

IV) Establish or expand existing funds for results-based "buy-down" funding.

Some innovative financing mechanisms are linked to the result of specific programmes. **The Taskforce recommends Debt2Health and buy-downs** as a means to target concessionality.

- **Debt2Health** is a partnership between creditors, grant recipient countries and multilateral institutions, in which the latter facilitate a tripartite agreement. Under these agreements, creditors forgo repayment of a portion of their claim on the condition that the beneficiary country invests an agreed-upon counterpart amount in health through a multilateral institution. The multilateral institution disburses the counterpart funds through the same systems and on the same principles as it does for regular grants. Germany has cancelled €50 million and €40 million, respectively, of Indonesia's and Pakistan's debt through this mechanism. These agreements represent payments of €25 million and €20 million, respectively, to the Global Fund (both countries received a 50% discount from the German government). More recently, Australia has joined this initiative to cancel AU\$75 million of Indonesia's debt. The potential revenue depends on donor willingness to cancel debt through the mechanism, and on the amount of debt that is available to cancel. A Global Fund study has identified several areas for further swaps including bilateral claims, non-performing commercial claims, and multilateral claims that remain on the Heavily Indebted Poor Countries Initiative (HIPCs). This mechanism could raise about US\$100 million per year.

- **Results-based credits and buy-downs** reduce the cost of borrowing if specific performance targets are achieved. Buy-downs serve multiple purposes. Grant (or guarantee) funding is used to increase the concessionality of loan financing so that it is appropriate to recipient needs. For low-income countries it could mean turning a loan for specific health MDG results through health systems strengthening into a grant. In this way, grant funds effectively leverage larger flows of loan financing.

Results-based credits are being expanded through a multi-donor trust fund with support from Norway. These credits and buy-downs add value by creating incentives for recipients of funds to achieve specific results, with the intent of increasing the effectiveness of funding. The buy-down itself – payment of grant funding to reduce or discharge the developing country's obligation – is triggered upon achievement or performance of specified goals. Results-based buy-downs have been implemented for polio eradication. Potential flows depend on donor and recipient interest in the concept of results-based buy-downs and targeted concessionality.

V) Strengthen the capacity of governments to secure better performance and investment from private, faith-based, community, NGO and other non-state actors in the health sector.

Whether as a function of access, preference or economics, non-state actors play a critical role in the provision of health-care delivery in low- and middle-income countries¹⁰. Improving the health of the world's poor will often involve managing, harnessing, mobilizing and raising the performance of the non-state sector – in addition to strengthening the role of the government in governance, regulation, contracting and quality enhancement – a neglected area over the past decades.

¹⁰ Non-state actors include community organizations, NGOs, faith-based organizations, small-scale vendors and commercial companies.



The high-level Taskforce at its inaugural meeting in Doha at the UN Financing for Development Conference

A key characteristic of this sector is its fragmentation, driven in part by a lack of access to capital to invest in expansion or renewal. Innovative mechanisms can play a significant role in providing capital for investment to this sector in low-income countries. Investment opportunities in health care in the poorest countries include service delivery and supply chain logistics, cost and risk reduction through insurance and other risk-pooling arrangements, information services, laboratory and diagnostic services, administration, production of medicines and other vital health care goods, and staffing.

The small- and medium-sized enterprises that make up the majority of health-care businesses in low-income countries face many challenges towards effective scale-up. These include lack of access to sufficient capital and the right type of capital, insufficient knowledge of investment opportunities, and lack of knowledge about how to engage with non-state actors in countries.

The Taskforce recommends the following:

- **Consider capital/risk mitigation fund(s)**¹¹ to demonstrate the viability of investments in the non-state sector and to purchase or provide guarantees to non-state investors to absorb certain risks. For this to work, strongly defined eligibility criteria for accessing the guarantee facility are required. The fund could work in coordination with other guarantee facilities (such as the Overseas Private Investment Corporation and Multilateral Investment Guaranteed Agency) to ensure that it facilitates local currency lending capability through local banks, for example by providing back-to-back loans or swaps-based solutions at competitive rates, and to co-invest where economic and social targets are acceptable.

- **Develop approaches that help put together viable investment propositions.** Governments wishing to use non-state actors as contracted service deliverers or in financing public health-care facilities, and commercial investors considering investment in the health sector, are often thwarted by a lack of appropriately structured propositions. A number of approaches could be developed to address these issues and facilitate more and better investment.
- **Consider one or more new advance market commitment(s) and patent pooling.** Advance market commitments aim to strengthen the incentives for pharmaceutical companies to develop and manufacture vaccines (and potentially other products) for the developing world. Patent pooling allows more efficient delivery of health-care technology in areas such as drug therapy.

Governments in many low-income countries face substantial challenges in managing the non-state actors effectively. Many governments have little accurate knowledge about their activities, and little capacity to assess challenges and better manage the sector.

- **Consider an advisory facility,** based on existing structures, to support governments to develop strategies for engaging non-state actors and better integrating them into their overall health systems. This would lead to improved stewardship by governments, more coherent health systems, more equitable application of scarce governmental resources, improved regulation, and the introduction of private resources into the creation of much-needed health infrastructure – and ultimately better health for the poorest parts of the population.

¹¹ One such instrument could be positioned in the market as an **Impact Investment Fund** supporting health systems. Impact investing generates both social value and financial returns, and can include private equity or debt investments. A private entity or multilateral development bank would set up an impact investment fund. The funds would be invested in non-state organizations that operate in high-risk environments and invest in high-risk pro-poor health systems projects. The fund would operate according to guidelines and invest in a manner that is aligned with IHP+ principles.

Table 3: Innovative mechanisms: costs, projected revenue¹², implementation summary, and health system outcomes

Mechanism	Revenue	Costs	Implementation	ODA credit	Examples of health system results
Solidarity levy					
Airline ticket	\$\$	+	Expansion underway	Yes	Commodities for health MDGs
Tobacco	\$\$\$\$	+	Expansion	Yes	Broad health system results
Currency transaction	\$\$\$	+	New	Yes	Broad health system results
Align funding time with needs					
IFFIm (frontloading)	\$\$\$	++	Expansion	Yes, as grants paid	Frontloaded health system investments e.g. health worker training capacity, infrastructure renovation, catalytic funds to improve domestic financing, management, information systems, and evaluation
Public resources for private giving					
De-Tax	\$\$\$	+	New	Partial	Private giving requires "results" that the public is willing to contribute to e.g. safe delivery of babies, emergency obstetric care, and treatment of illness in children
Airline tickets	\$\$	+	New, underway	No	
Mobile phones	\$\$	+	New	No	
Leveraging lending instruments					
Buy downs	\$\$	+	Some experience	Yes	Broad health system results
Debt2Health	\$\$	+	Expansion underway	Yes	
Non-state sector					
Capital-pooling	\$	+	New	?	Accreditation programmes, supply-chain management, training schools, low-cost clinic chains for the poor in urban areas, low-cost pharmacy chains and diagnostic labs
Seed capital	\$	+	New	?	Global public goods where market fails (drugs, vaccines and other commodities)
Advance Market Commitments and patent pooling	\$	++	Expansion	?	
Revenue potential				Costs	
Assuming that a broad range of countries would participate in mechanism				+ less than 5% of revenues	
\$\$\$\$ double digit billions of US dollars annually				++ 5-20% of revenues	
\$\$\$ single digit billions of US dollars annually				+++ 20% of revenues and more	
\$\$ hundreds of millions of US dollars annually					
\$ less than hundreds of millions US dollars annually					

¹² Revenue and costs estimates depend on significant assumptions about participation levels.



3. More health for the money

Make allocation of existing and additional funds in countries more efficient, by filling gaps in costed and agreed national health strategies.

A. Health systems and achieving the health MDGs¹³

There is strong agreement on the interventions necessary for achieving the health MDGs¹⁴. They include measures to reduce mortality among mothers, newborns and children under five, and to improve childbirth care, reproductive health services, and prevention and treatment of the main infectious diseases. A strong health system is needed to ensure that interventions are combined to provide efficient, effective and equitable services. Certain areas require targeted support to ensure essential capacities are in place for the health system to function properly.

- **Public administration and accountability (or governance):** This includes setting the strategic direction for the health system, designing how it is managed, arranging for stakeholder involvement, ensuring accountability and transparency, implementing regulatory arrangements, and gathering intelligence and information. Effective health systems also need strong leadership to influence policies across government that will help to promote health. Competence in public financial management, management and leadership are all essential. However, major reforms of low-income country health systems generally fall short of expectations. In low-income countries, governance reform is best promoted through incremental, small-scale and flexible responses to domestically driven reform agendas based on long-term visions for public administration and accountability arrangements rather than complex structural reforms.

- **Financing:** Financing includes raising money, pooling risk across individuals, and purchasing services. A financial strategy needs to be part of the national health strategy, and external assistance and domestic financing should ideally be pooled together to spread risk, reduce volatility of income, and allow for predictable finance. Out-of-pocket payment is the least desirable form of revenue raising. Pooled funds allow purchasers of health-care services to implement their priorities and to put in place incentives to encourage the efficient, equitable and responsive provision of care. This includes paying the public sector health workforce in a way that removes inefficiencies, improves lines of accountability, and brings human resources management practices more in line with stated policies.
- **Service delivery arrangements:** Service delivery arrangements need to be laid out in the national strategy and follow from the interventions required to reach the health MDGs. They encompass the types of provider needed (e.g., self-care, public and private providers), integration of services, numerous issues concerning the workforce, quality of care, provision of drugs, and information systems. The delivery goal is to improve health outcomes by providing services that are accessible, technically effective and responsive to users, efficient and equitable.
- **Results-based financing:** Results-based financing refers to a range of mechanisms including output-based aid, results-based loan “buy-downs”, provider payment incentives, and conditional cash transfers. The conditions for successful implementation of results-based financing include independent evaluation and “verification” of services provided, and effective arrangements for quality assurance. Finding the right approaches varies with country context. Exchanges of experience by practitioners in different countries continue to be promoted.

B. Mobilizing the non-state sector

The capabilities and potential of the private sector, both profit and not-for-profit, are often overlooked when designing national health strategies in low-income countries. This means opportunities are missed to improve quality of care among non-state providers, and to contract them to fill gaps in services in certain situations. The Taskforce recognizes the enormous potential of the private sector contribution to health in low-income countries. Areas that merit more exploration and testing include private sector involvement in supply-chain management for the public sector, private training schools, low-cost clinic chains for the low-income employed in urban areas, low-cost pharmacy chains and diagnostic labs.

While experience is growing in this area, understanding is still very limited and agencies will need to continue to provide advice to governments and non-state actors in low-income countries on how best to approach non-state involvement in health systems. Given limited knowledge at present, rigorous evaluations will be required to show where investment in the non-state sector will reap the greatest benefits for the poorest people.

C. Technical assistance

The Taskforce requests OECD/DAC with partners to undertake a review of all current technical assistance, with a view to focusing it on strengthening national and local institutional capacity in priority areas such as public administration and accountability, financing, service delivery arrangements and the non-state sectors.

A substantial proportion of international resources today is spent on technical assistance. It consisted of 42% of all DAH in 2002-2006. Technical assistance represents an enormous opportunity for efficiency gains. The current inefficient approaches to supplying technical assistance should be replaced by strategies that promote long-term institutional capacity development and skills.

D. More efficient international support in countries

There is a growing acceptance by international and national stakeholders of the need to adhere to the Paris Declaration on Aid Effectiveness, focusing on national ownership, alignment with national priorities, harmonization of behaviors, managing for results and mutual accountability. To put these principles into action a technically sound national health strategy is required in low-income settings as a focus for domestic and international financing. International actors have agreed measures to improve the efficiency of development assistance for health, including in the following areas.

- **Joint assessment of national health strategies (JANS being developed in IHP+):** Based on a commonly agreed set of “attributes” as to what constitutes a sound fundable national strategy, the joint assessment provides a streamlined way of providing assurance to different agencies to proceed with financing the strategy. The joint assessment is being piloted in 2009.
- **Country health systems surveillance (CHeSS)¹⁵:** All countries should have one system for monitoring health and health systems that all stakeholders use. CHeSS, now being adopted by many developing countries, improves the availability, quality and use of the data needed to inform country reviews of the national health strategy.
- **Procurement:** Innovative methods of improving procurement need to be built upon. Services provided for low-income countries should be more in line with country needs, and linked to strengthening of country supply chains and distributions systems.

¹³ The Taskforce’s definition of a health system is based on the Tallinn Charter, as “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 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. <http://www.euro.who.int/document/E91438.pdf>.

¹⁴ Detailed in Working Group 1 Report.

¹⁵ Developed by the IHP+ inter-agency working group on monitoring and evaluation.



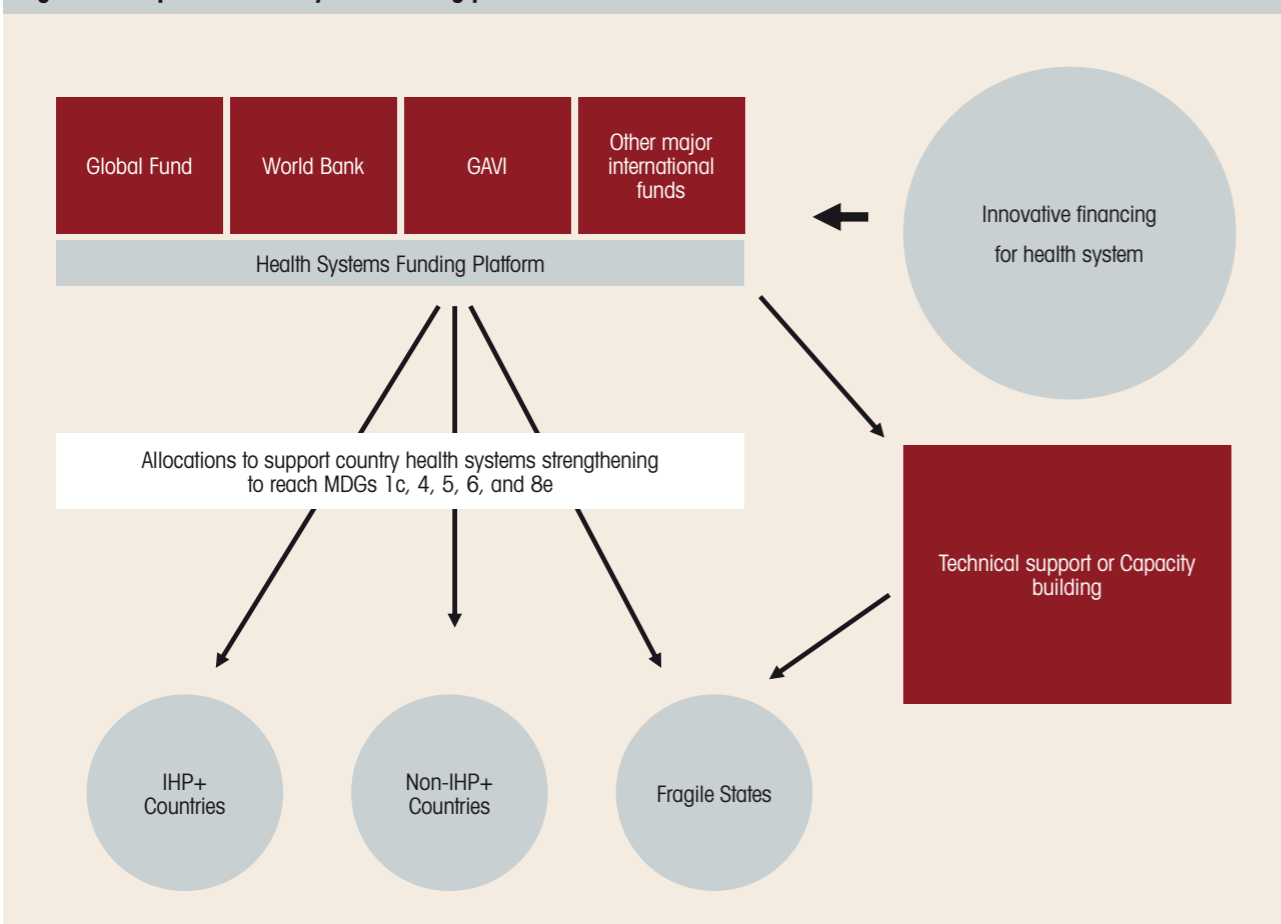
E. More efficient channeling of resources

Establish a health systems funding platform for the Global Fund, GAVI Alliance, the World Bank and others to coordinate, mobilize, streamline and channel the flow of existing and new international resources to support national health strategies.

The highly fragmented nature of external support has led to calls for better coordination of resources: all external funds should support one national health strategy. In some cases, innovative mechanisms can be pooled and made available for allocation to any country – in other cases support is tied to particular countries. Innovative financing raised for health systems strengthening should be used to fund costed and agreed national health strategies that address the entire health system.

In March 2009 the executive directors of GAVI¹⁶ and the Global Fund¹⁷ signaled their intent to strengthen coordination with the World Bank and others to make the health “architecture” more effective both globally and at the country level. This coordination is critical to sustain accelerated scale-up of interventions to achieve the health MDGs by 2015, particularly in the area of maternal and child health to which both organizations and the World Bank contribute significantly (e.g. by funding platforms to deliver immunization services, prevention of mother-to-child transmission of HIV, sexual and reproductive health, and protection of pregnant women and small children from malaria).

Figure 6: Proposed health system funding platform for low-income countries



¹⁶ The mandate of GAVI is “to increase access to immunization in poor countries”.

¹⁷ The mandate of the Global Fund is “to dramatically increase resources to fight three of the world’s most devastating diseases” - AIDS, tuberculosis and malaria.

The GAVI Alliance, Global Fund and World Bank will outline a joint mechanism for investment in health systems. WHO will continue to help facilitate this process. The joint programming will mean: unified guidance to countries in areas covered; common appraisal; agreed monitoring using shared indicators and country-level processes; and harmonized approaches to technical support provision. Pilots will be considered in 2009, including a fragile state. Pending approval by the respective boards, this process could become fully operational during 2010.

The three agencies would continue to receive funds from existing traditional DAH and innovative sources as now, but would work under a new collaborative agreement. New commitments from donors and private entities to fund these agencies will need to be matched by significant progress on improving ways of working and achieving results.

F. Special considerations for fragile states

In fragile states the scope and potential for innovative financing is different from those countries with well-developed national health plans. Often the UN and NGOs play significant roles. Of the 49 low-income countries, 26 are included on the list of fragile states¹⁸. Conflict-affected fragile states have some of the worst health indicators in the world and are farthest from meeting the MDGs. Consequently, they must benefit more from the additional resources raised from the Taskforce recommendations.

Channeling international resources to fragile states offers the potential to raise more money and ensure resources are channeled to areas of greatest need. Public interest is often high for humanitarian needs and can be an opportunity to include a long-term health systems response and health outcome focus. The response by the international community should help in such a way that humanitarian assistance bridges into more long-term development engagement. This should ensure a long-term national institutional and health systems perspective when setting up mechanisms for channeling funds.

G. Improving accountability

To monitor how well we are doing, a regular forum will be held for countries and partners, building on the IHP+ Ministerial Review.

Accountability in countries. Each low-income country’s national health strategy provides the basis for accountability of all national and international stakeholders. In Ethiopia, for example, the “health compact” outlines specific commitments and obligations on the part of both government and development partners, including targets for the minimum level of total aid for health, and for the management of external assistance (including increasing the use of government systems to procure, disburse, implement, report, monitor, account and audit). In Tanzania, the health Sector Wide Approach has been used in a similar way since 1999 with well-documented success.

Building government capacity to carry out these functions and hold themselves and external financiers to account is critically important to building trust and increasing investment. Regular reviews of progress should first and foremost take place at the country level. Joint and coordinated efforts for this should be used, building on what already exists in many countries today, with a strong focus on monitoring results and independent evaluations.

A global informal health and development forum will take place each year building on experiences from the IHP+ high-level ministerial meeting. This will involve all 49 countries (both IHP+ and non-IHP+), the key international health actors, the “Health 8”¹⁹, civil society, the private corporate sector and countries providing substantive international development resources for health. The aim will be to allow countries and development partners, including civil society, to monitor progress of existing commitments, including the Taskforce recommendations²⁰. WHO and the World Bank would generate – together with the OECD/DAC secretariat – a yearly report on progress of health results, flows and financial resources, and partner ways of working.

¹⁸ The World Bank’s definition of fragile states covers low-income countries scoring 3.2 and below on the Country Policy and Institutional Assessment (CPIA). They are classified into four groups: (1) prolonged crisis or impasse (e.g. Myanmar, Somalia, Zimbabwe); (2) post-conflict or political transition (e.g. Democratic Republic of the Congo, Liberia, Southern Sudan); (3) gradual improvement (e.g. Burundi, Cambodia); and (4) deteriorating governance (e.g. Côte d’Ivoire). Each year the lists are revised, so fragility is a status, not a permanent classification.

¹⁹ Bill & Melinda Gates Foundation, GAVI Alliance, Global Fund, UNAIDs, UNFPA, UNICEF, WHO, World Bank.

²⁰ This would include the G8 monitoring process for health.



4. The way forward

Start mobilizing the finance: Experience in the use of innovative finance for development has taught us important lessons regarding implementation. Strong political backing for each of the initiatives recommended is critically important. Each initiative will be sponsored by a lead country to take the work forward and put together a coalition of partners that can help with the expansion. Successful implementation of these recommendations requires purposeful engagement with civil society, in both donor countries and recipient countries.

The economic case for implementation: Previous analysis of the cost-per-death averted for an essential package was US\$ 9,000²¹. This can be compared with the US\$ 8,000-\$10,000 cost-per-death-averted implied by the calculations presented here. While very high-impact and low-cost interventions (such as immunization) can have cost-effectiveness ratios that look very much more attractive, the estimates here look plausible for a broad set of interventions that address the main causes of burden of disease. Moreover, averted deaths are only one element of the broad health gains that would be created by scaling up interventions and the health system platform.

Dissemination of knowledge on innovative financing:

The individuals, communities, corporations and governments that want to get behind these efforts need access to the latest knowledge on innovative financing for strengthening health systems in low-income countries. Existing efforts to spread knowledge of innovative financing for development, led by the United Nations²², the Government of France²³, and the World Bank should continue.

As discussed above, technical viability studies will now be undertaken by expert groups on areas such as the currency transaction levy and an expansion of tobacco levies, as well as the implications of an expanded IFFIm.



Delegate reports outcome of breakout session, consultation in Johannesburg

Engagement of new development partners: Mobilizing more resources also means engaging with more countries, foundations and wealthy individuals. Members of the G8 will undertake to engage the G20 group of nations, especially those with larger economies.

Keeping up the momentum: This report is the start of a process. The Taskforce will report to the G8 in July 2009. Prior to the UN General Assembly in September 2009, the Taskforce will conduct further consultations and facilitate the preparation of implementation plans for the recommended innovative financing mechanisms with relevant stakeholders. The regular health and development forum will be used to monitor progress.

Annex 1: List of low-income countries, July 2008

Country	Region ²⁴	IDA ²⁵	HIPC ²⁶
Afghanistan	South Asia	IDA ²⁵	HIPC ²⁶
Bangladesh	South Asia	IDA	
Benin	Sub-Saharan Africa	IDA	HIPC
Burkina Faso	Sub-Saharan Africa	IDA	HIPC
Burundi	Sub-Saharan Africa	IDA	HIPC
Cambodia	East Asia & Pacific	IDA	
Central African Republic	Sub-Saharan Africa	IDA	HIPC
Chad	Sub-Saharan Africa	IDA	HIPC
Comoros	Sub-Saharan Africa	IDA	HIPC
Congo, Dem. Rep	Sub-Saharan Africa	IDA	HIPC
Cote d'Ivoire	Sub-Saharan Africa	IDA	HIPC
Eritrea	Sub-Saharan Africa	IDA	HIPC
Ethiopia	Sub-Saharan Africa	IDA	HIPC
Gambia	Sub-Saharan Africa	IDA	HIPC
Ghan	Sub-Saharan Africa	IDA	HIPC
Guinea	Sub-Saharan Africa	IDA	HIPC
Guinea-Bissau	Sub-Saharan Africa	IDA	HIPC
Haiti	Latin American & Caribbean	IDA	HIPC
Kenya	Sub-Saharan Africa	IDA	
Korea, Dem, Rep	East Asia & Pacific	..	
Kyrgyz Republic	Europe and Central Asia	IDA	HIPC
Lao PDR	East Asia & Pacific	IDA	
Liberia	Sub-Saharan Africa	IDA	HIPC
Madagascar	Sub-Saharan Africa	IDA	HIPC
Malawi	Sub-Saharan Africa	IDA	HIPC
Mali	Sub-Saharan Africa	IDA	HIPC
Mauritania	Sub-Saharan Africa	IDA	HIPC
Mozambique	Sub-Saharan Africa	IDA	HIPC
Myanmar	East Asia & Pacific	IDA	
Nepal	South Asia	IDA	HIPC
Niger	Sub-Saharan Africa	IDA	HIPC
Nigeria	Sub-Saharan Africa	IDA	
Pakistan	South Asia	Blend	
Papua New Guinea	East Asia & Pacific	Blend	
Rwanda	Sub-Saharan Africa	IDA	HIPC
Sao Tome and Principe	Sub-Saharan Africa	IDA	HIPC
Senegal	Sub-Saharan Africa	IDA	HIPC
Sierra Leone	Sub-Saharan Africa	IDA	HIPC
Solomon Islands	East Asia & Pacific	IDA	
Somalia	Sub-Saharan Africa	IDA	HIPC
Tajikistan	Europe & central Asia	IDA	
Tanzania	Sub-Saharan Africa	IDA	HIPC
Togo	Sub-Saharan Africa	IDA	HIPC
Uganda	Sub-Saharan Africa	IDA	HIPC
Uzbekistan	Europe & central Asia	Blend	
Vietnam	East Asia & Pacific	IDA	
Yemen, Rep.	Middle East & North Africa	IDA	
Zambia	Sub-Saharan Africa	IDA	HIPC
Zimbabwe	Sub-Saharan Africa	Blend	

²¹ 1993 World Development Report (WDR).

²² Led by Special Adviser to the UN Secretary-General on Innovative Financing for Development.

²³ Leading Group: <http://www.leadinggroup.org/rubrique20.html>.

²⁴ World Bank Regional Code.

²⁵ IDA: International Development Association.

²⁶ HIPC: Heavily Indebted Poor Country.

Annex 2: List of Taskforce and Working Group Members

Taskforce Members

Prime Minister Gordon Brown (United Kingdom) (co-chair)
Robert Zoellick (President of the World Bank) (co-chair)
President Ellen Johnson-Sirleaf (Liberia)
Prime Minister Jens Stoltenberg (Norway)
Tedros Adhanom Ghebreyesus (Health Minister, Ethiopia)
Bernard Kouchner (Foreign Minister, France)
Giulio Tremonti (Finance Minister, Italy)
Heidemarie Wieczorek-Zeul (Development Minister, Germany)
Stephen Smith (Foreign Affairs Minister, Australia)
Margaret Chan (Director-General, World Health Organization)
Graça Machel (President and Founder, Foundation for Community Development, Mozambique)
Shigeru Omi (Special Adviser to the Minister of Foreign Affairs, Japan)
Bert Koenders (Development Cooperation Minister, Netherlands)
Philippe Douste-Blazy (United Nations Secretary General's Special Adviser for Innovative Financing for Development) Special Adviser to the Taskforce

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Helga Fogstad Coordinator, Maternal and Newborn Child Health, Global Health and AIDS Department, NORAD
Elliot Harris Special Representative to the United Nations, International Monetary Fund
Brenda Killen Head, Aid Effectiveness, Organisation for Economic Cooperation and Development
Jacqueline Mahon Senior Policy Adviser, Health Systems, United Nations Population Fund
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David Evans Director, Health Financing and Social Protection, World Health Organization
Rajat Gupta Ex-Managing Director, McKinsey & Company
Susan McAdams Director, Multilateral and Innovative Financing, World Bank
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Manfred Konukiewicz	Germany
Murray Proctor/Andrew Laing	Australia
Ian Smith	World Health Organization
Josep Figueras	Representing Graça Machel
Shinichi Asazuma	Japan
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Nicole Kligen, Laura Coronel	World Bank
Rob Ward, Julia Watson, Sarah Beeching & Helena Lindborg	UK
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