

Taskforce for Innovative International Financing for Health Systems

Working Group 2: Raising and Channelling Funds

Progress report to Taskforce, 13 March 2009

SUMMARY

- The *financial crisis* presents a challenge, an opportunity, and a responsibility to ensure investments are made in the parts of the world where people are most vulnerable. Investments in a time of a financial crisis are happening across the world. Investments are needed for basic human development and survival. This is important for long term economic recovery.
- Remarkable *progress* has been made in global health over the past decade, including declines in child mortality, measles, tetanus, iodine deficiency, and malaria, as well as dramatic increases in access to antiretroviral treatment for AIDS.
- The *gap*, as estimated by Working Group 1, represents both a financial and a structural as well as managerial challenge. In tandem with mobilising additional resources, efforts are needed to ensure existing and new resources are deployed efficiently. This will require reform of local, national and international systems.
- Responsibility for financing and investing in health systems rests with *national governments*. Most low-income countries do not have enough resources to ensure universal access to health services and will not be able to reach the health-related Millennium Development Goals, even if they increase the share of total government spending devoted to health to 15% and development partners to commitments to spend 0.7% of Gross National Income on official development assistance.
- Increasing long-term predictable funding is of major importance and international financing – “traditional” ODA and *innovative financing* – can be an important part of the solution to fill the gap. There is no magic bullet. Resources will have to be mobilised from different sources. Working Group 2 is reviewing the potential of different initiatives and technical strengths but it is too early to make any explicit advice or recommendations.
- There is a case for selective *frontloading* investments in health systems with a focus on tackling the major bottlenecks and linking this very clearly to outcomes related to MDG 4, 5 and 6. Investments in solving some of the major constraints today will most likely have a major impact on a country’s general performance and economic growth in a 15-20 year perspective.
- International and domestic resources should support costed, validated, results-focussed *national health plans* and be as predictable, un-earmarked and efficient as possible.
- The existing global “*architecture*” for health – a multitude of disease-specific initiatives, partnerships and financing mechanisms and the overlapping functions and mandates of international institutions – needs reform. The transaction costs are too high when this landscape hits the ground in countries.

Questions to the Taskforce:

1. What are the Taskforce’s views on the different mechanisms as outlined in this report?
2. Should Working Group 2 further explore a) how to leverage private sector investment? b) debt relief and the link to health? c) buy downs?
3. How would the Taskforce like to address the pressing need to reform the global health architecture?

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Note to Taskforce: Our work is still in its infancy. A substantial amount of analysis and several consultations lie ahead in the next three months. We expect to address the potential relative value of the options presented in this progress report and to make more specific recommendations but we are not ready to do so yet. Your guidance and input at this point in our work will help ensure your satisfaction with the report we will deliver to you at the end of May.

Introduction

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. Health is a measure of social justice and equity and a driver of all sustainable development – economic, social, and cultural. Progress has been made on the health-related Millennium Development Goals (MDGs), but many low-income countries are lagging behind. Making progress in improving maternal, reproductive, newborn and child health requires robust and responsive health systems.

Today, most external funding for global health is targeted for specific and important purposes: antiretroviral treatment for AIDS, vaccinating children, supplying bed nets, and so forth. As positive as these efforts are, they are not enough. Much more needs to be done to raise more resources for health, to lower the cost of channelling international resources to countries, and to better balance spending of all resources for health according to a country's priority health needs. Those priorities include the health and nutritional needs of children, women and men, as well as other equally essential things like surveillance systems, laboratories, research capacity, information systems, human resources for health, and infrastructure.

Responsibility for financing health systems ultimately rests with national governments. But it is clear that many low-income countries will require substantial additional resources to strengthen health systems, even under the best-case scenario where domestic and present official development assistance (ODA) targets are met. For example, sub-Saharan African countries have committed to allocate at least 15% of their government's budget to health, and some development partners have committed to spend 0.7% of Gross National Income (GNI) on ODA.

Although innovative international financing can only be a complement to national governments' responsibilities for domestic financing and "traditional" ODA, it can mean improved living conditions and saving the lives of millions of people. No one single resource mobilising mechanism will be the answer. Moreover, the mechanisms discussed here are not restricted to international resources. Some could equally as well be adopted in countries to increase the availability of domestic funding for health.

Working Group 1 (WG1) has estimated that providing universal access to good quality, safe and essential health interventions in 49 low-income countries would cost an additional US\$49 billion in 2015, out of which \$41 billion could, in an optimistic scenario, be provided if domestic financing and ODA commitments are met. International innovative financing mechanisms can potentially contribute to filling the estimated \$8 billion annual gap. For this to be successful, the additional funds should:

- be large enough to make a significant contribution to cover the gap
- be linked to results
- strengthen the entire health system
- reach the entire population.

The mechanisms can have one of three impacts. The first is the type of investment that shows an almost immediate result (providing a drug to save a life, for example). The second is a set of investments that yields results in the longer term (building research capacity, for example). The third type gives a country an external push and spurs innovation in health financing domestically, moving from out-of-pocket spending on health to a more structured type of financing health that pools risks and protects families from catastrophic expenditures.

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On the face of it, innovative financing for health systems doesn't seem plausible in the midst of the current global financial crisis. Although the impact of the crisis is already being felt across the world, it is the poor who are most vulnerable. Some of their suffering can be mitigated if decision makers are prepared to think in ways they were not prepared to think about before and this will create opportunities for real change and collaborative action.

The starting point must be three principles from the Paris Declaration that need to be applied to all external financing for health: respect and support for country ownership and country health priorities; harmonized and aligned activities to country systems; and predictable, long-term funding flows.

Scaling up existing international financing mechanisms for health systems

As part of its work to date, Working Group 2 (WG2) has carried out a preliminary analysis of around 100 existing innovative financing mechanisms for their potential to be expanded or adapted for use to strengthen health systems. The mechanisms are different in nature and have been assessed according to what they have delivered, or have potential to achieve in terms of:

- a) additionality
- b) front loading and predictability
- c) enhancing the market.

The "short list" of options below is a tentative and early one. Some mechanisms such as debt relief for health, buy downs, and the potential link to financing for climate change or global public goods have not yet been possible to review. The importance of aid effectiveness as well as technical feasibility at reasonable cost will be further assessed.

In the following list of options there are a few "global mechanisms" that have the potential to raise billions of dollars and others with the potential to raise relatively smaller amounts of resources, which are available to countries that wish to do more. The final report will provide more specific estimates of the financial potential of each mechanism.

A. True additionality

Solidarity levies – globally coordinated and nationally implemented – have many elements of a global tax, but are based on voluntary participation by member countries. The solidarity levy on airline tickets (with the incremental cost included in the cost of the ticket) is an example, and there could be others. Since mid-2006, 24 countries have implemented the tax or are in the process of doing so. The funds are currently used to finance UNITAID, an international purchase facility for drugs and treatments for HIV/AIDS, malaria and tuberculosis, although they could be used in other ways if UNITAID board members and funders so wished, including supporting other components of health system development. *A specific proposal might be to further link solidarity levies to the IFFIm whereby the levy flows are provided to a sovereign donor who then subsequently uses these flows to finance additional grants to the IFFIm.*

Global taxes – globally coordinated and nationally implemented – require national legislation, strong inter-country coordination, and the establishment of structures to implement the tax and to collect and transfer the funds. Negotiations can be lengthy and broad political support difficult to secure, but it has been estimated that a currency transfer tax of 0.005% would have the potential to generate revenues of US\$33-60 billion per year. Another option might be taxes on negative externalities such as tobacco or alcohol. *A specific proposal might be for a country or a region to launch a financial transaction tax for the health-related MDGs with a focus on health systems.*

Guarantees are mature financial instruments: in 2006, between US\$225 and \$439 billion foreign direct investment was covered by some type of political risk mitigation instrument; and about a third of loans to developing countries were guaranteed in 2005. Guarantees could facilitate expansion and adaptation to the requirements of health systems strengthening by complementing private sector investments and reducing the level of direct outlay required from development partners. However, they only indirectly trigger investments, take up and success are hard to predict, and the level of

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additional funds leveraged by guarantees is unclear. Differing treatment of guarantees in different countries may reduce transparency around the fiscal impact of issuing guarantees. *A specific proposal might be to set up a guarantee facility covering risks, such as regulatory risk or local currency exposure, associated with private sector investments (including impact investments) into health systems.*

The options listed below have the potential to raise millions as opposed to billions of dollars for health system strengthening. The mechanisms do not have to be global; they can be adopted and implemented by any country wishing to do so.

Private giving generates substantial resources for development, with estimates ranging from US\$17 billion from Development Assistance Committee (DAC) donors in 2001 to \$34 billion by the US only (including faith-based organizations and education at universities within the US) in 2007. Flows for specific purposes, however, rarely top \$1 billion annually. Fundraising campaigns require sponsors with organizational and strategic capacity, an effective communications strategy, and start-up funding (e.g. the polio campaign). The Millennium Foundation is an interesting initiative that also connects to another mechanism (UNITAID). *A specific proposal might be a campaign for contributions and engagement by major foundations, and/or governments introducing tax exemptions for charitable deductions when not already existing.*

A **global lottery** or a **global premium bond** requires government commitment to participate, to implement internally, and to earmark revenues. They need to be structured to minimize possible gambling, regressivity and other ethical issues. Potential flows depend on the issuance volume and proportion allocated. In the UK, the average spread over the past year on premium bonds as compared to regular sovereign bonds was 1.7%, generating revenues of over £600 million on outstanding premium bonds. *A specific proposal might be a nationally implemented, globally coordinated premium bond with a share of the proceeds directed towards the health-related MDGs.*

Blended value products stimulate voluntary contributions from individuals by combining consumption with charity. The (PRODUCT)RED campaign and “affinity” credit cards are two examples. A blended value product requires a specific platform and leadership, a compelling public relations story, and substantial investments into marketing and building a brand. It may be done with one, a few, or many companies, and requires supporting legal agreements detailing how the contribution is collected, managed and disbursed. *A specific proposal might be for sponsors to launch a blended value health campaign.*

Public-private partnerships (PPPs) draw on private sector involvement (commercial, faith-based or NGO); funding is of a catalytic nature, leveraging flows from other sources; and commercial risk is transferred to a private entity. They can be structured to address public concerns, and to produce positive externalities or reduce negative ones. PPPs require strong regulatory and oversight capacity that is often lacking in low-income countries. *A specific proposal might be to establish a fund that invests in or provides technical assistance and advice to governments on health PPPs and on strengthening regulation, supervision and quality control of non-state actors in health care and medicine delivery.*

B. Frontloading

1. Frontloading long-term assets through capital markets includes the pilot **International Finance Facility for Immunisation (IFFIm)**, global development bonds, securitization of future flow receivables, and credit card receivables to back the issuance of securities on the capital markets. Current IFFIm contributions through a GAVI affiliate of US\$5.3 billion support \$3-4 billion in frontloaded disbursements. Frontloading would help to address some of the health system constraints identified by WG1 by providing up-front investments and predictability, at relatively low incremental cost, but it might be less appropriate for other constraints. *A specific proposal would be to expand the current IFFIm to fund broader health system uses, provided that it was recapitalized to do so.*

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C. Enhancing the market

1. An **advance market commitment** (AMC) is a new mechanism being piloted where donors commit specified funding in advance to accelerate the availability and reduce the price of needed products. AMCs are technically complex particularly with respect to pricing, have distinctive legal issues, and have reputational risk with respect to contributing to profits of often large and well-resourced private companies. Pilot AMCs will provide lessons for more streamlined development processes in the future, but each AMC will be market-specific so scale-up can take place only one initiative at a time. *A specific proposal might be to look at commodity or commoditized services, such as the development of a solar-powered cold chain.*

2. **Procurement mechanisms** rely on predictability of demand and economies of scale in purchasing, pooling demand, building up procurement expertise, and reducing administrative costs in order to secure the lowest possible price. Examples include UNICEF, UNITAID, AccessRH (formerly Minimum Volume Guarantee), GAVI's pooled procurement of vaccines contracted to UNICEF, and the Global Fund's voluntary pooled procurement system. Concrete outcomes and often quantifiable efficiency gains make these types of interventions marketable at a political level and to the general public. They are, however, applicable only to certain inputs, and monitoring and incentive systems are required to ensure quantities purchased correspond to actual need. *A specific proposal might be to expand the mandate of an existing procurement mechanism to finance broader health commodities.*

Financing for results: improving health outcomes and health equity

The measure of success of whatever innovative financing mechanism is adopted by the Taskforce will not be how much money it raises per se, but whether it saves lives and improves, protects and promotes the health and well-being of the poor and marginalized. As such, the collection of international funds cannot be considered in isolation of how the funds will be channelled to countries and what they will be used to finance.

From a country's perspective, there are three major challenges and problems in many countries with external financing for health (irrespective of the size of the envelope):

1. funds are largely *earmarked* for specific purposes before they reach the country, which leaves parts of the health system chronically under-funded and undermines national ownership and priorities;
2. the *ever-growing number* of donors, agencies, programmes and initiatives, each with different application and reporting formats, performance indicators, and mechanisms for fund disbursement, has led to unacceptably high transaction costs, wasted resources, and drained absorptive capacity;
3. the flow of external funds is *unpredictable* in terms of amount and time, which makes it impossible to implement the medium to long-term plans that are necessary to strengthen health systems.

National ownership, manifested by costed and validated country health plans with a clear results focus, should constitute the basis for all financing from both internal and external sources. The International Health Partnership (IHP) provides the framework for this in some countries. In other situations similar approaches are already well advanced.

Domestic financing of health systems is the first choice, and should be based on risk-pooling, tax or be insurance based. ODA will continue to play an important complementary role, especially in low-income countries. International funding should respect national priorities within an agreed national plan and budget, and aim to minimize transaction costs and maximize effective health outcomes.

A shift from international financing mechanisms that build on project applications approved in a

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development partner's global headquarters or capital, to agreed financial contributions to national health plans, where reporting and follow up of results take place at the national level is desired.

Experience has shown that the engagement of relevant stakeholders in different stages of the process is of great importance, especially civil society and the private sector. Major steps have been taken at the global as well as country level in order to better coordinate partners (for example, the H8, national sector mechanisms, and IHP+, among others).

Results-based funding (RBF) flows

The focus on results should be the basis for all financing of national health plans or sector programmes for international as well as domestic financing. RBF refers to a range of mechanisms (output-based aid, results-based loan buy downs, conditional cash transfers, provider payment incentives, vouchers, performance-based inter-fiscal transfers, etc.)

RBF is politically attractive to demonstrate concrete outcomes (achieving measurable results, changing behaviour, promoting efficiency, reducing transaction costs, etc.) and can be structured to increase mutual accountability via contractual relationships. RBF requires an information system that is capable of tracking outcomes, and a method of "verification". Because most low-income countries have weak information systems, this provides an opportunity. ***A specific proposal might be to create, or build on an existing instrument, a funding mechanism that distributes funds to countries based on proven results and supports countries to establish results-based financing systems.***

The Global Fund and GAVI have built innovative financing instruments on the concept of RBF. Already two of the largest international funders of health systems in low-income countries, both are expanding their role in this area. Their moves towards national strategy applications and implementing gender strategies provide an opportunity to expand their role even further. ***A proposal could be to consider the Global Fund and GAVI as a conduit for additional resources for health systems and achieving MDG 4, 5 and 6 while maintaining a focus on results.***

More predictable, long-term funding flows

In order to be able to make more long-term commitments, an increasing number of development partners are finding ways to structure contribution arrangements beyond their traditional annual ODA commitments. One example is the European Union MDG Contracts, which provide flexible, performance-based budget support over six years. Some development partners do not like tailored financing because it puts limits on donor flexibility, "mortgages" future aid budgets, can make it harder to establish conditionality, and is not always consistent with budgetary processes and rules. But in the Accra Agenda for Action, OECD-DAC donors committed to three- to five-year funding cycles. ***A specific proposal might be for development partners to commit to provide more long-term financing for health systems as a regular practice.***

Simplifying the landscape for global health

The strong international response for health and HIV/AIDS has been impressive in recent years, resulting in more financial resources, but it has also led to an architecture for health that is very complex. The mix of global funding modalities, partnerships and international initiatives does not provide the best and optimal arrangement for countries to interact with. ***A specific proposal might be a radical simplification of the overall funding landscape – including partnerships, international agencies, and others in combination with a harmonization of business models and coordination of global funding modalities.***

Next steps

In the next three months, WG2 will:

- continue to assess the benefits, costs, inherent risk and likely support for existing innovative

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financing mechanisms and select a few that are best suited to respond to the health system needs and constraints identified by WG1;

- study different financing needs in the health sector – recurrent, one time, capital – and how the different finance mechanisms can meet those needs;
- give further consideration to where the “new” money will come from (wealthy individuals, private foundations, private corporations, and governments, including emerging markets) and analyse the enabling environments that would encourage them or make it possible for them to donate money to or invest in health systems;
- make recommendations on instruments to increase the efficiency of external funding flows to countries, including traditional ODA, and link these delivery modalities to the challenges identified in WG1;
- develop case studies of countries (Cuba, Ethiopia, Mexico, Thailand, for example) that have taken bold action to strengthen health systems in times of crisis in order to illustrate how it can be done and what can be achieved;
- make recommendations on monitoring and evaluation, building the evidence base, and actively sharing what is learned.

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