

Taskforce on Innovative Financing for Health Systems

Raising and Channeling Funds

Working Group 2 report

Final Draft

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Summary and main recommendations

In the past decade governments in many low-income countries have increased spending on health and, at the same time, development assistance for health (from governments, multinational agencies and private foundations) has more than doubled. These resources have saved millions of lives and improved the health, well-being and quality of life of millions more.

As positive as these efforts are, they are not enough. Far too many poor people still die prematurely and unnecessarily and far too many poor families continue to live in poverty because of ill health. Without the benefit of social safety nets, the poor must use a large portion of their household income to pay for health-care costs.

Working Group 1 has estimated that making rapid progress towards the health Millennium Development Goals (MDGs)¹ in 49 low-income countries requires more than doubling current annual health expenditures from an estimated US\$ 31 billion in 2008 to \$67-76 billion in 2015.

Depending on decisions taken by politicians and parliamentarians, a large part of the additional \$36-45 billion needed in 2015 could be available in an entirely predictable and sustained manner.

Most of the gap will need to be filled by domestic resources contributed by national governments and citizens. But even if governments in low-income countries give more priority to health, they will still, for the foreseeable future, be unable to meet the required costs of scaling up health systems and providing universal coverage, free at the point of delivery, of essential health services. This means that if low-income countries are to reach the health MDGs, international funding – from both governments and non-state sources – will have to complement domestic health resources.

Development partners are strongly urged to fulfil the commitments they have already made, such as those made at the 2002 International Conference on Financing for Development in Monterrey, Mexico.

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.

Innovative financing mechanisms and instruments (for example, the solidarity levy on air tickets and UNITAID) have demonstrated their potential for securing resources and distributing them to low-income countries. IFFIm and the Advance Market Commitment pilot have shown it is possible and feasible for donors to make long-term commitments to funding development programmes through non-traditional financing mechanisms.

Ultimately, the work of the Taskforce will be successful if development partners and sponsors agree on a complementary set of initiatives that will together provide new,

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).

predictable funding, when and as needed, from diverse sources. Working Group 2 suggests setting a specific target for raising funds through innovative mechanisms: \$10 billion per year by 2015, over and above the \$5 billion of development assistance for health that was spent in the 49 low-income countries in 2008. The Working Group also recommends that each recipient country select at least one of the options described in this report to increase their own domestic revenues for health.

International funding will have a catalytic role vis-à-vis domestic funding as the dominant source if part of the additional international financing is directed towards stimulating reform processes that will improve domestic modes of financing.

Health systems challenges need both more money and also “better” money, that is, more efficient and results-oriented use of resources.²

There is no one-size-fits-all approach to how best to strengthen health systems and attain the health MDGs. However, focusing on effective and equitable health systems and delivery of health services is consistent with a focus on specific health outcomes. The approach should be to connect the needed elements of an effective health system together in a more coherent and well-functioning health system.

The flow of all international resources for health to countries needs to be drastically streamlined. Three principles from the 2005 Paris Declaration on Aid Effectiveness must be applied to all international financing for health:

- respect and support for country ownership and country health priorities;
- harmonization and alignment of activities to country systems; and
- predictable, long-term funding flows.

The main recommendations of Working Group 2 to the Taskforce, which are listed below, fall into four areas: predictability of funds, effective timing of funds, channeling of funds, and mutual accountability. Implemented against the background established by Working Group 1, and with the co-operation of international, national, and bilateral and multilateral institutions, these measures will contribute significantly to the attainment of the health MDGs and to the global health, wealth and security they support.

Main recommendations to the Taskforce

More predictable funds

1. Development partners should ***increase the predictability of their development commitments*** under agreements that are legally binding or subject to legislative/parliamentary approval and commit to three to ten years of funding.

Additional funds at the right time

2. Set a target to raise an additional ***\$10 billion in international resources per year by 2015*** to spend on health in low-income countries.
3. Further explore the tax or levy options suggested in this report, including ***airline levies, currency transaction taxes and expanded tobacco taxes, among others.***

² The idea of "more money for health and more health for the money", which Working Group 2 is using as the report's organizing principle, was coined by the late Professor V Ramalingaswami of India.

4. Consider proposals that better match the timing of funding available and needs, including more use of *long-term commitments and guarantees, and the potential for mechanisms such as International Finance Facility for Immunization (IFFIm) to be expanded to strengthen health systems.*
5. Capitalize a fund that works in coordination with other facilities to purchase or provide guarantees to *private-sector investors* to absorb certain risks.
6. Provide public catalytic funding for the development of a range of large-scale private giving initiatives where market research indicates a material source of sustainable finance can be derived from them.
7. Consider establishing or expanding existing funds for *results-based “buy-down” funding and/or “Debt2Health”* to fill financing gaps for health systems development.

Streamlined channeling of funds

8. Facilitate the establishment of a *Health Systems Funding Platform* for the Global Fund, GAVI, the World Bank and others to coordinate, mobilize and channel both existing and new international resources.
9. Use the funds to fill critical gaps in costed *national health plans that cover the entire health system.* Couple the allocation of funds with clear expectations on outcomes and results and use a single disbursement channel to minimize transaction costs.
10. Make funds available, as and where required, to strengthen *capacity* in low-income countries to use resources for health system strengthening rapidly, efficiently and equitably, and to monitor the achievement of results.
11. Commission a review of the effectiveness of technical assistance aimed at improving long-term strengthening of national and local institutional capacity.
12. Explore the potential of further joint or *coordinated procurement* processes.

Mutual accountability

13. Build on the *IHP+ principles* and work to expand the numbers of countries that have signed compacts.
14. Actively engage with civil society, the corporate sector, and other relevant *stakeholders* when implementing new or expanded innovative financing mechanisms.
15. Continue well-prepared and structured *sector reviews in countries* involving all relevant stakeholders.
16. Establish a high-level review – a *Health and Development Forum* – that will report on health progress as well as the Taskforce’s target of raising US\$10 billion per year by 2015, and where policy makers can share lessons learnt about how to strengthen health systems and improve ways of working.

1. Responding to the crisis

“Health is not an expendable luxury item that can be dispensed with during a crisis. It is the very foundation for responding to the crisis. Health is the human capital for moving towards recovery. And health systems are the social institutions, the social capital, that make response and recovery possible.” Margaret Chan, Director-General, World Health Organization

A. Introduction

The enjoyment of the highest attainable standard of health is a basic *right* of every human being. Health is a measure of social justice and equity; access for all people to safe, high-quality, essential health-care services is a fundamental entitlement and a responsibility of governments. As argued by the Commission on Macroeconomics and Health in its landmark 2001 report, healthy citizens are a driver of all sustainable development – economic, social and cultural. Investments in improving health are crucial to reducing poverty, achieving the Millennium Development Goals (MDGs), and promoting peace and stability.

Remarkable *progress* has been made in global health financing during the past decade. Many governments in low- and middle-income countries have increased their commitments to health while development assistance for health (from governments, multinational agencies and private foundations) has more than doubled in recent years. There have been 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.

As positive as these efforts are, they are *not enough*. Far too many poor people still die prematurely and unnecessarily and far too many poor families continue to live in poverty because of ill health. Without the benefit of social safety nets, the poor must use a large portion of their household income to pay for health-care costs.

Most low-income countries are struggling to meet the *health MDGs* (Figure 1). Half of the 49 low-income countries have made insufficient progress in reducing child mortality, especially neonatal mortality, and many have made no progress at all. Nearly 11 million children under the age of five die every year globally. In 16 countries, 14 of which are in Africa, levels of under-five mortality are higher than in 1990. Almost all low-income countries have an unacceptably high incidence of maternal death. More than 500 000 women die in pregnancy and childbirth each year and maternal death rates are 1000 times higher in sub-Saharan Africa than in high-income countries. There have been successes in selected countries in which progress has been made on reducing or reversing the rate of HIV infection. However, the story is bleak in many countries. With three million deaths from HIV alone each year, the worsening global pandemic has reversed life expectancy and economic gains in several African countries.³

[TBA Figure 1 will be from the data in the annex in WG1’s report or from http://millenniumindicators.un.org/unsd/mdg/Resources/Static/Products/Progress2008/MDG_Report_2008_En.pdf page 20 for MDG 4 and map of maternal deaths page 24]

³ Add REF WHO

Investing in *health systems* that provide access to guaranteed health benefits would save millions of lives and also be an important and efficient mean to obtain and secure people's 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.

Because building strong health systems in low-income countries will require more resources from the international community, world leaders launched a *Taskforce on Innovative International Financing for Health Systems* (the Taskforce) in New York on 25 September 2008. Its objectives are to contribute to filling national financing gaps to reach the health MDGs through mobilizing additional resources for health systems; increasing the financial efficiency of health financing; and enhancing the effective use of funds.

The global economic and financial crisis makes the work of the Taskforce all the more relevant and all the more urgent. According to the World Bank, 45 million more people could fall into extreme poverty in 2009 and 400 000 children could die as a result.⁴ This comes on top of the food and energy crises, which pushed more than 130 million people into poverty in 2008. In 2009 it is expected that the number of people living in urban slums will triple. Half the world's population will remain below the poverty line of \$2 a day.

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 international or domestic – would threaten to halt nascent efforts underway in several countries to build health systems and accelerate progress towards the health MDGs. This would reverse some of the gains that have been achieved in global health and poverty alleviation, and that would be unacceptable.

Some countries have already taken steps to protect the health of their citizens. In April 2009, for example, the Thai government decided to increase the 2010 budget for its universal health insurance programme by almost 10% even though it also decided to reduce the overall public budget by 13%. This decision was taken mainly to protect the health of the poor and those who will be unemployed.

The financial crisis presents a challenge, an opportunity, and a responsibility to ensure that investments in health are made in the parts of the world where people are most vulnerable (Box 1). Such investments are needed for basic human development and survival, and for long-term economic recovery.

Box 1: Health and the financial crisis

A global crisis requires global solidarity and actions. Maintaining levels of health and other social expenditures is critical to protect life and livelihood and to boost productivity. Where countries do not have adequate resources, the shortfall will have to come from aid. It will need to be skilfully managed for maximum impact. But the critical point is that commitments to maintain levels of aid are not an additional extra to the recovery agenda, but an integral element for its success.

The impact of the crisis will vary country by country, but to sustain levels of health there is a growing consensus as to what needs to be done: We need good quality real-time information to guide the response; we need to be able to identify groups most at risk; to ensure that safety net programmes are well targeted so they reach the most needy; to seek efficiencies in spending, where possible; to recognize that crises often offer opportunities for reform; to sustain spending on prevention (which is often the first

⁴ Add REF World Bank

casualty of spending cuts); and where external aid is required to ensure it is as effective as possible.

People are the ultimate target of economic recovery: WHO's concern is people's health, but health is dependent on many factors: employment, shelter, nutrition, education. In some countries, economic stimulus packages target people's health directly (through reducing health insurance payments, or building clinics). But a well-planned infrastructure programme will have multiple benefits: rural roads increase access to markets, boost farmers' income, and reduce maternal mortality. Help to micro finance schemes helps keep children in schools, empowers women, and boosts the long-term health prospects of their families.

SOURCE: Excerpt of a statement by WHO Director-General Dr Margaret Chan, 1 April 2009

http://www.who.int/mediacentre/news/statements/2009/financial_crisis_20090401/en/index.html

Two technical *working groups* were established to present analyses and recommendations to the Taskforce. The focus of Working Group 1 has been on constraints to scaling up and costs, and the focus of Working Group 2 has been on raising and channeling funds (see Annex 1 for the terms of reference for Working Group 2).

The purpose of this report from *Working Group 2* is twofold:

1. to recommend innovative international financing mechanisms that could be implemented *to raise the required additional resources needed* to strengthen health systems in 49 low-income countries (listed in Annex 2) in order to achieve the health MDGs, especially those MDGs considered to be neglected, namely MDGs 4 and 5; and
2. to recommend how *to best achieve results, and how to best channel and use* international resources for health.

B. The importance of health systems

Working Group 1 has made a strong case that it will not be possible to scale up all the required activities to address all the health MDGs at the same time without strengthening health systems as a whole, and it has documented the major constraints to doing this in low-income countries. Working Group 1 has also described in detail how to achieve the health MDGs, how to provide guaranteed benefits, and what the costs of doing so would be.

As stated in Working Group 1's report:

The health system is made up not just of publicly financed and provided services, but also the activities of the private sector, whether in financing, service provision or supply of inputs such as pharmaceuticals and equipment. Most importantly, it encompasses not just the service delivery activities, but the supervisory, management, outreach and governance activities needed to ensure efficient, effective and equitable service delivery, the participatory and accountability mechanisms needed to ensure that services are responsive to population needs and demands, and the policies to promote healthy environments and lifestyles.

There is no-one-size-fits-all health system and no single approach to strengthening them in low-income countries. Health systems are clearly differentiated by national borders and vary greatly from country to country. Although each one is unique, almost all high-income countries have a national system that guarantees universal health-care coverage. Citizens, politicians, health-care practitioners and policy-makers tend to know them best by their proper name (such as, for example, Sécurité Sociale in France and the NHS or National

Health Service in the United Kingdom); they feature prominently in the daily press and in elections, and they are often subject to reform.

Several middle-income countries have achieved universal or near universal coverage, but almost all of *the 49 low-income countries* are nowhere near being able to ensure their citizens have universal access to quality care according to their needs, regardless of their income and socioeconomic status.

Working Group 1 has identified the major health system constraints by level, from communities through to the international arena, and by *four main building blocks – financing, health workforce, medicines and supplies, and information and evidence*. Because all parts of the health system influence each other, health system support has to have a broad, holistic view of the system instead of working with components in isolation.

As noted in its report: “Long-term solutions to inadequate coverage of health services demand efficient financing and action at all levels of the health system. The starting point is a technically sound national health strategy that sets out how health system governance, financing and service delivery will be improved”.

Although the degree of the severity of these constraints varies, all low-income countries experience multiple constraints in seeking to strengthen their health systems and increase coverage of the interventions required to achieve the health MDGs. Lack of money is a fundamental constraint, but unless other constraints are recognized and addressed, countries will find it difficult to absorb and use additional finance effectively.

Governance needs to be strengthened and, sometimes, modified to enable rapid scale up in a way that produces results. “Health governance includes setting strategic directions; designing how the health system is to be managed; arranging for stakeholder involvement; ensuring accountability and transparency; implementing regulation; gathering intelligence; and advocacy for intersectoral actions and policies that improve health”.

All these components need to be strengthened in a coherent and coordinated manner to enable health services to be scaled up. A health systems focus and understanding of the key elements of a well-functioning health system is consistent with ensuring that health outcomes (e.g. the health MDG targets) are achieved and health interventions delivered.

C. Financing health outcomes and effective health service delivery

The set of low-income countries that are the focus of the Taskforce do not yet have adequate financial resources to strengthen their health systems in ways that will ensure universal access to needed health services. *In 2006*, annual per capita expenditure on health in these countries was a mere **US\$ 25** (compared with \$4012 per person spent on health services in high-income countries).

Out of this total amount, \$13 was from private expenditure on health, 80% of which came from out-of-pocket payments by patients. The outstanding \$12 of the total expenditure passed through the government budget. These figures for public and private expenditure include the contribution of international resources, which amounted to \$6 per capita. Despite the recent scale up in development assistance for health, it is on average a relatively

low proportion of total health expenditures (25%).⁵

Out-of-pocket spending, which is a much higher proportion of total health expenditure in low-income than high-income countries, is the most inequitable way to fund health systems because it disproportionately hurts the poor, vulnerable and marginalized. It prevents many from seeking or continuing care, and results in severe financial problems and even impoverishment for those who use services. This is why health systems need structured, predictable, sustainable financing mechanisms that pool risk and provide social protection.

Although on the rise, many of the governments of low-income countries still spend relatively low proportions of their overall budgets on health. For example, in *the 2001 Abuja Declaration*, sub-Saharan African countries committed to allocate at least 15% of their budgets on health, but as of 2006 few had reached this target. Of the 49 low-income countries, only five governments were spending more than 15% on health in 2006, and this figure includes international resources. Twelve countries were spending between 10% and 15%, 21 countries were spending between 5% and 10% and 10 countries were spending less than 5%.⁶

Although higher levels of per capita expenditure are important for improving health outcomes, it is also essential to consider the efficiency and effectiveness of health expenditures: countries can achieve radically different health outcomes with roughly the same per capita total health expenditure, as shown in the box and figure below.

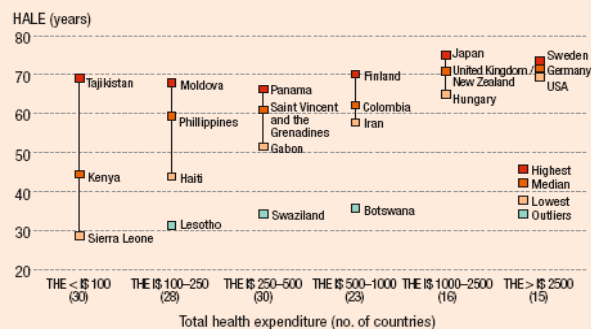
Box 2: Higher spending on health is associated with better outcomes, but with large differences between countries

In many countries, the total amount spent on health is insufficient to finance access for all to even a very limited package of essential health care³⁹. This is bound to make a difference to health and survival. Figure 1.6 shows that Kenya has a health-adjusted life expectancy (HALE) of 44.4 years, the median for countries that currently spend less than \$ 100 per capita on health. This is 27 years less than Germany, the median for countries that spend more than \$ 2500 per capita. Every \$ 100 per capita spent on health corresponds to a 1.1-year gain in HALE.

However, this masks large differences in outcomes at comparable levels of spending. There are up to five years difference in HALE between countries that spend more than \$ 2500 per capita per year on health. The spread is wider at lower expenditure levels, even within rather narrow spending bands. Inhabitants of Moldova, for example, enjoy 24 more HALE years than those of Haiti, yet they are both among the 28 countries that spend \$ 250–500 per capita on health. These gaps can even be wider if one also considers countries that are heavily affected by HIV/AIDS. Lesotho spends more on health than Jamaica, yet its people have a HALE that is 34 years shorter. In contrast, the differences in HALE between the countries with the best outcomes in each

spending band are comparatively small. Tajikistan, for example, has a HALE that is 4.3 years less than that of Sweden – less than the difference between Sweden and the United States. These differences suggest that how, for what and for whom money is spent matters considerably. Particularly in countries where the envelope for health is very small, every dollar that is allocated sub-optimally seems to make a disproportionate difference.

Figure 1.6 Countries grouped according to their total health expenditure in 2005 (international \$)^{38,40}

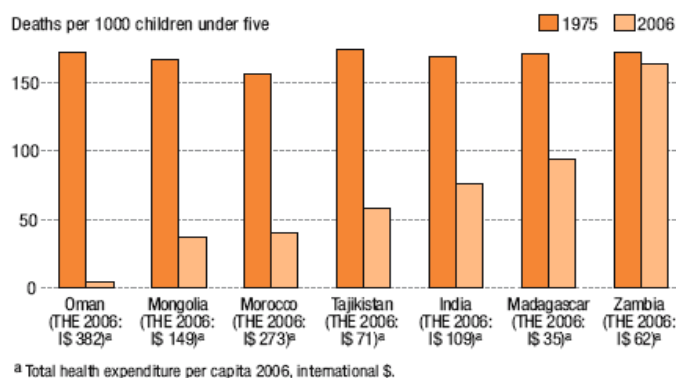


Source: World Health Report 2008

⁵ Annex 4a Working Group 1 report

⁶ There is no data for one country. Annex 4b Working Group 1 report

Figure 2: Variable progress in reducing under-five mortality, 1975 and 2006, in selected countries with similar rates in 1975^a



Source: World Health Report 2008

Issues related to the ways in which higher efficiencies and productivity rates can be achieved are taken up in Chapter 3.

D. *The estimated cost and projected financial gap*

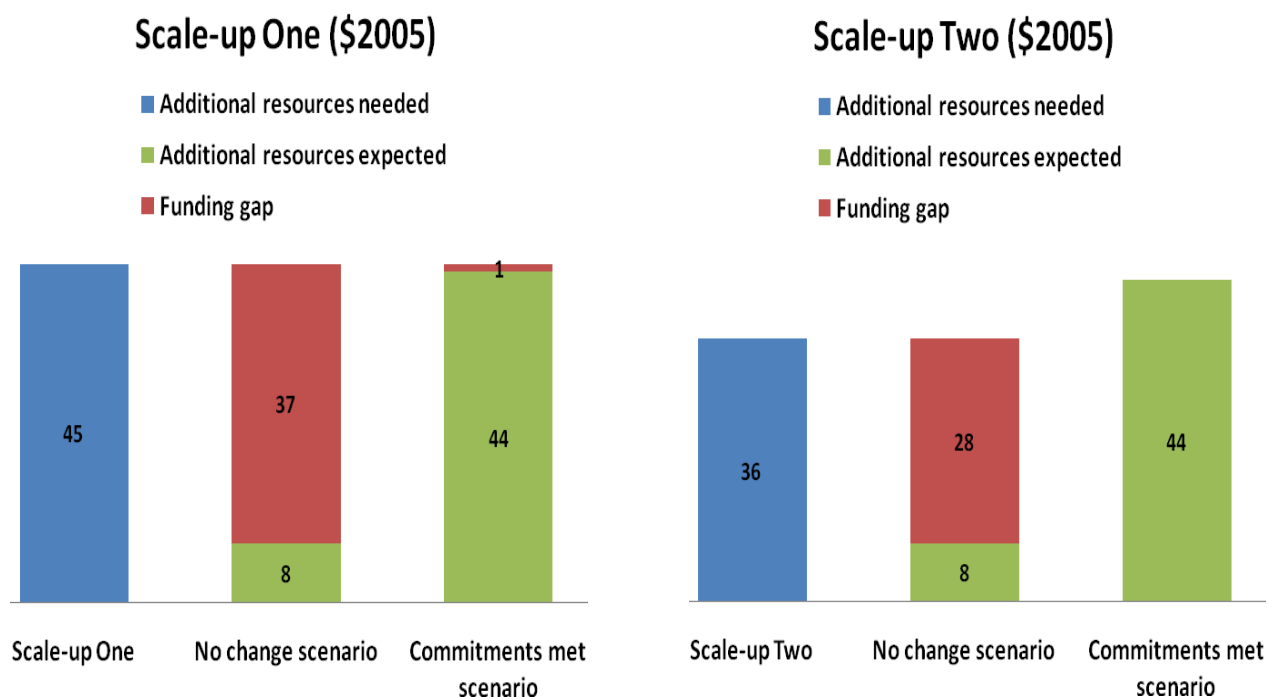
Even if low-income country governments gave more priority to health and, for example, met the Abuja target, they would still be unable to meet the required costs of scaling up their health systems and providing universal coverage of guaranteed health benefits from domestic sources for the foreseeable future. That means that if low-income countries are to reach the health MDGs, international resources – from both governments and non-state sources – will have to complement domestic resources.

Working Group 1 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.⁷

Making rapid progress towards the health MDGs in low-income countries *requires more than doubling current health expenditures* from an estimated US\$ 31 billion in 2008 to \$67-76 billion in 2015. The additional cost to achieve the health MDGs is an estimated US\$36-45 million (US\$24-29 per capita) (Figure 3). 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.

⁷ For more details see Working Group 1 report

Figure 3: Additional resources needed per year by 2015 to attain the health MDGs in 49 low-income countries



Source: Working Group 1

To have an impact on improving health and attaining the health MDGs the funds must be spent in the 49 low-income countries on high priority services and the necessary systems platform described by Working Group 1.

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 and drugs and supplies. The numbers of health facilities would increase by 74,000 - 97,000, and health workers by 2.6-3.5 million (Table 1). For additional funds to be used as intended to expand health spending, governments must agree to prioritize health within national budgets, and devote the additional resources to high impact interventions and the necessary systems support.

Depending on decisions taken by politicians and parliamentarians, on economic growth, and on a number of other difficult-to-predict factors, a large part of the additional \$36-45 billion needed in 2015 could be available in an entirely predictable and sustained manner.

Table 1: Additional costs

		Scale-up One	Scale-up Two
Total additional costs 2009-2015	Total	251 bn	112 bn
Total additional costs in 2015	Total	45 bn	36 bn
A. Resources available 2015			8 bn
<i>Assuming no change scenario but same growth as past years</i>			
B. Resources available 2015			44 bn
<i>Assuming ODA and Abuja commitments met</i>			
A. Estimated funding gap 2015 no change		37 bn	28 bn
B. Estimated funding gap 2015 commitments met		1 bn	-8 bn
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.

In fact, according to Working Group 1, if low-income country governments increase the share of government expenditure going to health to at least 12-15%, if OECD member states honour the commitments they have made to increase development assistance, and if the current share of ODA spent on health remains the same, there could be no financial shortfall (Figure 3). On the other hand, under the “no-change scenario”, the financing gap in 2015 will be **\$28-37 billion**.

The gap will need to be filled by domestic resources contributed by national governments and citizens and by international funds. Increases in total health expenditure must be accompanied by reduced out-of-pocket payments and the implementation of domestic financing policies that can capture such spending and pool risk, through insurance arrangements or increased domestic taxation.

Working Group 2 recommends the Taskforce should set a target to raise an additional \$ 10 billion per year by 2015 for health systems strengthening in low-income countries.

Reaching this target will require more donors to meet their commitments and more resources to be raised that are additional to ODA. Innovative financing mechanisms can help to do both (see Chapter 2).

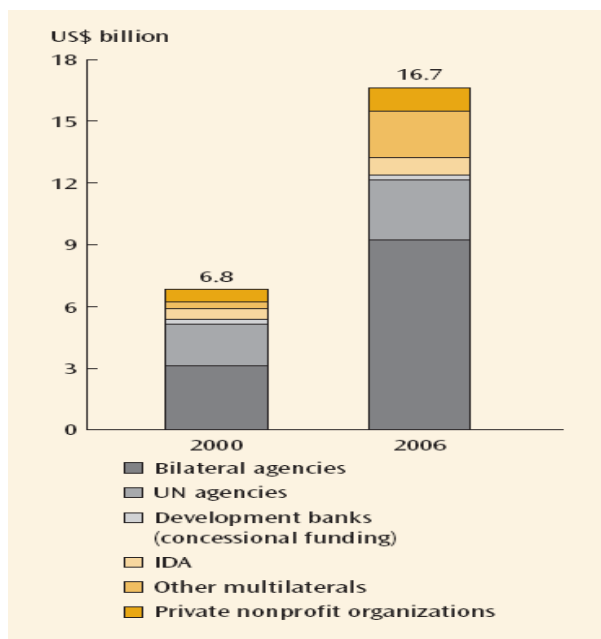
This section has highlighted the need for more money; the next section elaborates on why it is essential to also improve the quality of development assistance for health.

E. International development assistance for health today

Since the adoption of the Millennium Declaration, commitments to development assistance for health (DAH), including from governments, multilateral agencies, private foundations and NGOs, has more than doubled, from \$6.8 billion in 2000 to \$16.7 billion in 2006.⁸ Figures 4 and 5 show that most of this growth has come from bilateral agencies in DAC countries.

Global partnerships and private philanthropic organizations have risen in prominence in recent years. The Bill & Melinda Gates Foundation, for example, has contributed billions of dollars towards global health since its inception in 1994, and its current annual expenditure of around \$3 billion.⁹

Figure 4: Growth in commitments to development assistance for health

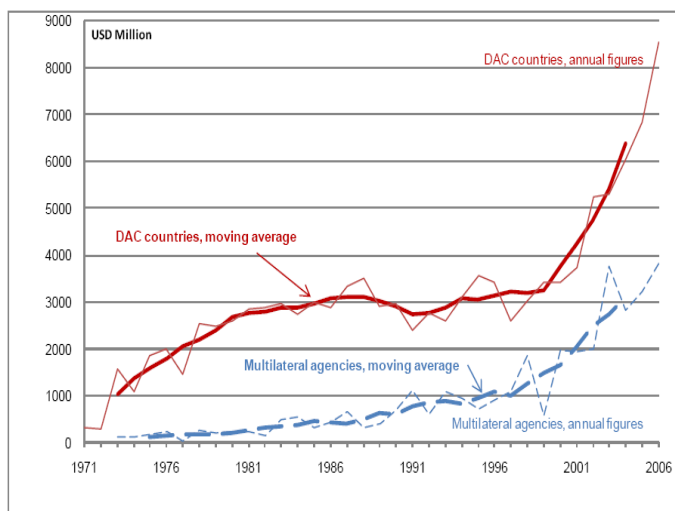


Source: World Bank 2008 global monitoring report.

⁸ Add ref World Bank

⁹ Add ref to Lancet article

Figure 5: Trends in aid to health
1973-2006, 5-year moving averages and annual figures, constant 2006 prices



Source: Measuring aid to health, OECD <http://www.oecd.org/dataoecd/18/35/42242018.pdf>

Official development assistance (ODA) for health, the largest component of DAH (see Box 3 for definitions), increased from \$5.5 billion in 2001 to \$13.4 billion in 2006-07. This is equivalent to 8% of all ODA commitments.

Box 3: The difference between ODA and DAH

Official development assistance (ODA) is defined as those flows to countries and territories on the DAC List of ODA Recipients and to multilateral development institutions that are:

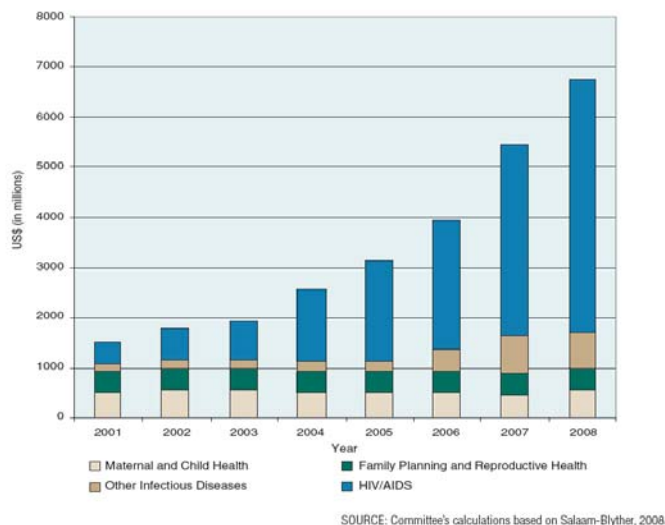
- i. provided by official agencies, including state and local governments, or by their executive agencies; and
- ii. each transaction of which:
 - a) is administered with the promotion of the economic development and welfare of developing countries as its main objective; and
 - b) is concessional in character and conveys a grant element of at least 25%.

Development assistance for health (DAH) is broader than ODA. It includes nonconcessional loans provided by the World Bank and regional development banks to developing countries and funds from private foundations and NGOs (own funds) that contribute directly to the promotion of development and welfare in the health sector in developing countries.

Sources: Is it ODA? OECD Fact sheet November 2008. www.oecd.org/dataoecd/21/21/34086975.pdf
CMH report from Working group 6 paper <http://whqlibdoc.who.int/publications/9241590140.pdf>

Figure 6 uses data from the United States to show that most of the increase in DAH has been allocated to the fight against HIV/AIDS.

Figure 6: Spending on global health, USA (2001-2008)



Although this dramatic rise in DAH since 2000 has saved millions of lives, there are a number of *challenges* with the way development assistance is organized and implemented.

- The health sector suffers more than most other sectors from a fragmentation of donor support with different interests and funding of specific activities and projects. This is reflected in the fact that only a small proportion of health ODA is channelled through direct budget support (the Paris Declaration target is 66%).¹⁰
- Low-income countries are the direct recipients of only one third of all health ODA, even though these are the countries with the worst health outcomes, where the health MDGs are least likely to be met, and that are most likely to be affected by or recovering from conflict.
- ODA is not organized in a way that is conducive to providing funds for overall health system strengthening in low-income countries. In 2006 more than 50% of all health aid provided directly to countries was absorbed by commitments relating to MDG 6, leaving only \$2.25 per capita per year for MDGs 4 and 5.¹¹
- A substantial proportion (41% in 2006)¹² of health ODA is spent on technical cooperation and there are a large number of small projects and activities, resulting in a high level of fragmentation and adding to transaction costs at country level.
- Not all low-income countries have benefited equally from the increase in ODA. Health ODA per capita between 2002 and 2006 ranged from \$20 in Zambia to, for example, \$1.6 in Chad.¹⁰
- While certain global health initiatives offer health systems windows, this has been limited in scope to activities related to specific diseases. None of the global initiatives

¹⁰ Greco G. et al. Countdown to 2015: assessment of donor assistance to maternal, newborn, and child health between 2003 and 2006. The Lancet, 2008. 371(9620): p. 1268-75.

¹¹ WHO, Effective Aid Better Health, Report prepared for the Accra High Level Forum on Aid Effectiveness 2-4 September 2008, World Health Organization: Geneva.

¹² WHO, The World Health Report 2008: Primary health care, now more than ever. 2008, World Health Organization: Geneva.

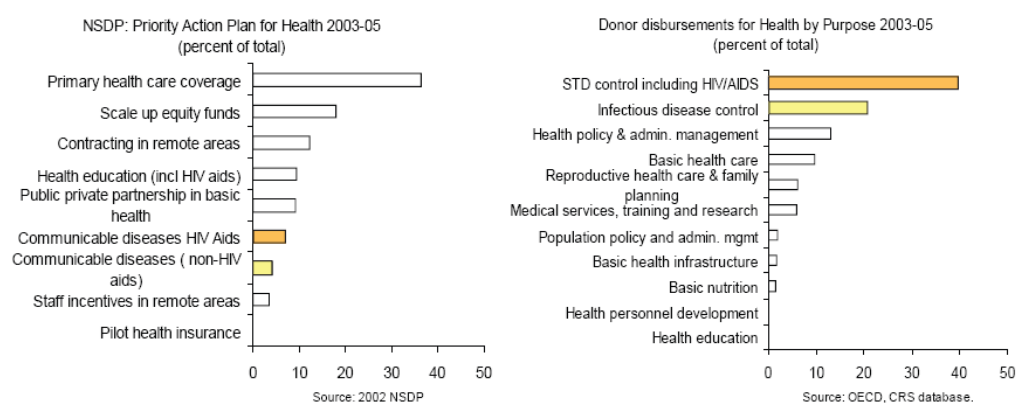
has a fully scaled and coherent health systems programme that can tackle the need to strengthen health systems to allow the entire array of health interventions identified by Working Group 1 to be scaled up at the same time.

- Finally, commitments are sometimes not translated into disbursements. A proportion of disbursements do not reach countries, taken partly by technical assistance. An IMF internal evaluation unit report recently found that in 29 sub-Saharan African countries between 1999-2005, only about \$3 of every \$10 in annual aid (all types of aid) increases had actually been programmed to be spent in the recipient countries either because they were used to build up the foreign exchange reserves, or because there were concerns about macroeconomic stability and inflation related to large increases in domestic spending.¹³

Despite the recent increases in DAH, it remains insufficient. Many developed countries have not yet met their international commitments. More aid will be required, and it is important to ensure that it reaches countries and that it is used to improve health outcomes.

The figure below uses an example from Cambodia to illustrate the extreme disconnect between donor disbursements and national health priorities.

Figure 7: Health plan priorities versus donor disbursements (2003-2005) Cambodia



Source: National Strategic Development Plan, Cambodia, and OECD/CRS

As noted by Working Group 1: “the problems of fragmentation and targeting of support have become so visible that they have resulted in a universal call for a coordinated effort to support the strengthening of country health systems that all disease- and programme-specific efforts ultimately need to rely on”. This problem was also highlighted at the Third High Level Forum on Aid Effectiveness in Accra in 2008.¹⁴

¹³ Rowden R. The case for reconsidering IMF macroeconomic policies. Background paper prepared for the Taskforce

¹⁴ The Third High Level Forum on Aid Effectiveness. *Accra Agenda for Action*. 2008 September 2008. Available from: <http://www.oecd.org/dataoecd/58/16/41202012.pdf>

F. Experiences of innovative financing for health and development

The necessity of exploring innovative sources to finance the achievement of the MDGs was first acknowledged in the Monterrey Consensus, which was the outcome of the 2002 International Conference on Financing for Development in Monterrey, Mexico. Six years later, innovation featured prominently in the 2008 Doha Declaration on Financing for Development (Box 4).

In a relatively short period of time innovative financing mechanisms and instruments have demonstrated their potential for mobilizing resources and distributing them to low-income countries, and innovative financing for development is now a permanent fixture on the agendas of the United Nations, the World Bank, the International Monetary Fund, the European Union and the G8.

In 2005, 79 countries endorsed a Declaration on Innovative Sources of Financing for Development, which was adopted at the United Nations in September 2005.

In 2006, the Leading Group on Solidarity Levies was launched. Comprising 55 member countries, three observer countries, and a number of major international organizations, the Leading Group has helped to identify and initiate a number of effective mechanisms, particularly in the field of health.

Box 4: Innovation and the 2008 Doha Declaration on Financing for Development

Excerpts from the declaration:

...Official development assistance (ODA) and other mechanisms, such as, inter alia, guarantees and public-private partnerships, can play a catalytic role in mobilizing private flows. At the same time, multilateral and regional development banks should continue to explore innovative modalities with developing countries, including low- and middle-income countries and countries with economies in transition, so as to facilitate additional private flows to such countries.

...We recognize the considerable progress made since the Monterrey Conference in voluntary innovative sources of finance and innovative programmes linked to them. We acknowledge that a number of the initiatives of the Technical Group created by the Global Action Initiative against Hunger and Poverty and the Leading Group on Solidarity Levies to Fund Development have become a reality or are in an advanced stage towards implementation.

..We encourage the scaling up and the implementation, where appropriate, of innovative sources of finance initiatives. We acknowledge that these funds should supplement and not be a substitute for traditional sources of finance, and should be disbursed in accordance with the priorities of developing countries and not unduly burden them. We call on the international community to consider strengthening current initiatives and explore new proposals, while recognizing their voluntary and complementary nature. We request the Secretary-General of the United Nations to continue to address the issue of innovative sources of development finance, public and private, and to produce a progress report by the sixty-fourth session of the General Assembly, taking into account all existing initiatives.

For full text of declaration see: <http://daccessdds.un.org/doc/UNDOC/LTD/N08/630/55/PDF/N0863055.pdf?OpenElement>

To date the international community has focused on four major multilateral innovative financing mechanisms:

- International Finance Facility for Immunization (IFFIm)
- Solidarity Contribution on Air Tickets/UNITAID
- Advance Market Commitments for Vaccines (AMC)
- Affordable Medicines Facility for Malaria (AMFm).

Various other initiatives have been proposed and are at different stages of development. Given the urgency, new ideas or the expansion of current mechanisms will need to be implemented quickly and successfully. The Taskforce will need to coordinate its work with other related initiatives exploring innovative financing for the broader development agenda.

In addition to raising more money than is available today, which is the topic of Chapter 2, innovative financing mechanisms can also be used to introduce new ways to coordinate the channeling of funds and the use of resources in low-income countries in order to achieve maximum impact on the ground. These important topics are covered in Chapter 3.

The idea of "more money for health and more health for the money", which Working Group 2 is using as the report's organizing principle, was coined by the late Professor V Ramalingaswami of India.

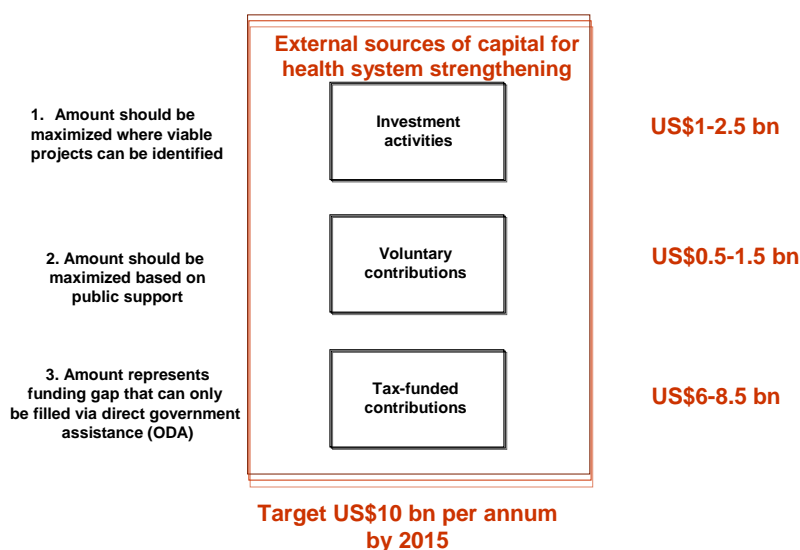
2. More money for health systems

A. *The role of innovative financing*

Health systems in low-income countries are financed by a variety of domestic and international sources. Domestic funding sources, public and private, provide the majority share – a share that increases as countries move toward sustainable systems. As described in Chapter 1, however, there is a clear and substantial international annual funding gap. This chapter seeks to review how additional international resources could be mobilized and contribute to filling that gap, recognizing that any such programme would need to be co-ordinated with mechanisms to increase domestic resources. Optimally, new international resources would help catalyse increased domestic resource creation, including domestic public expenditures as well as domestic and international private investment.

Working Group 2 recommends the target the Taskforce should aim to raise by 2015 is US\$10 billion per year.

Figure 8: Meeting the \$10 billion per year target



In general, such gaps are addressed using ODA flows, and indeed most innovative financing initiatives rely on or involve ODA flows. However, in a fundamental sense, new ODA requires new tax-based government funding, a difficult proposition in the current market environment. Thus, a first question is whether non-ODA flows can help meet the funding gap. Once non-ODA sources have been optimized, new ODA funds can be used to fill the remaining gap, and may also help in leveraging the non-ODA flows.

Innovative financing mechanisms can play an important role in filling funding gaps and catalysing private sector funding flows towards the same goal. What makes financing mechanisms “innovative” is not necessarily their intrinsic financial novelty. Rather,

innovative financing departs from traditional approaches to *mobilizing* or *delivering* development finance – that is, traditional mobilization via budget outlays from established sovereign donors, or bonds issued by multilateral and national development banks, and traditional delivery of development finance through grants and loans.

Innovative development finance involves non-traditional applications of ODA, joint public-private, or private mechanisms and flows¹⁵ 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.

Health systems challenges need both more money and also “better” money, i.e. more efficient and results-oriented use of resources. Innovative financing mechanisms can contribute to meeting these goals through:

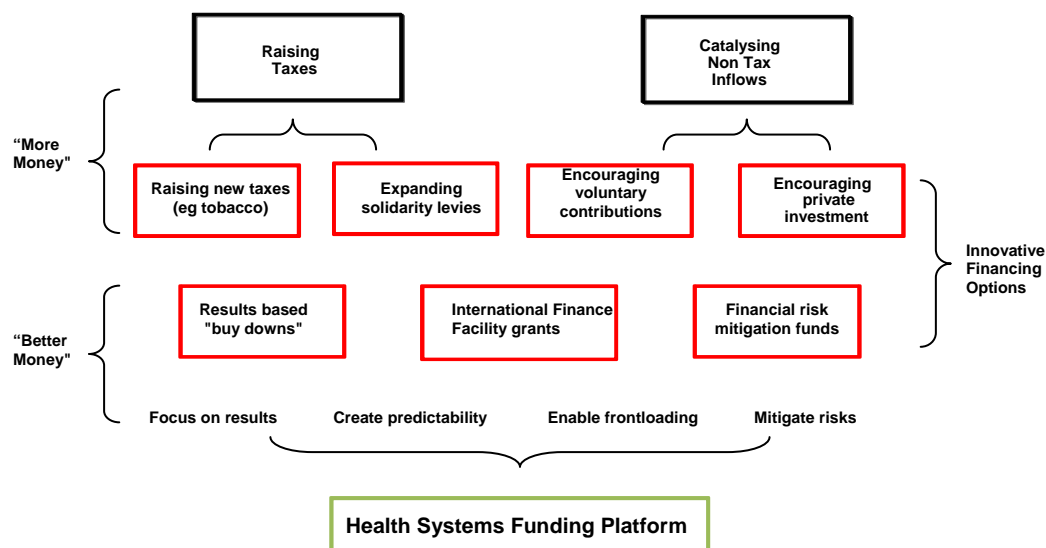
- **Focusing on results** – this is central to all health financing, domestic or international, and there are many lessons that can be learnt from innovative financing mechanisms.
- **Mobilizing voluntary and philanthropic contributions** at both the global and the country level. Voluntary and philanthropic contributions depend on broader public knowledge and commitment to better health outcomes, which will encourage governments to live up to their commitments both in donor and in recipient countries. This is particularly important in light of the present financial crisis.
- **Catalysing engagement with the private sector** to raise more funds and to improve management, efficiency and equity in national health systems.
- **Increasing predictability.** Predictability of funding is central to health systems development, and this is an area where there are interesting experiences from innovative financing mechanisms.
- **Mobilizing domestic resources.** Innovative international financing mechanisms are often scaleable and adaptable, and can be used in low-income countries to increase domestic resources for health systems.
- **Frontloading of resources**, which can help remove bottlenecks in health systems development and complement mechanisms that need a longer time to provide resources.

From a finance perspective, the challenges in the health sectors in the poorest countries are multifaceted. There is a critical need for more funding, more predictable funding, more long-term commitments, a variety of sources that can finance up-front investments in scaled up service delivery, steady ongoing funding to meet annual operating expenditures, and risk capital to finance new businesses serving the public sector at competitive prices. Relative to the current situation, chief among the requirements are predictable, long-term funding sources that are free from traditional vulnerability to annual budget cycles.

¹⁵ *Solidarity mechanisms* support sovereign-to-sovereign transfers and form the backbone of multilateral and bilateral ODA and other official flows. *Public-private partnership mechanisms* leverage or mobilize private finance in support of public service delivery and other public functions such as sovereign risk management. *Public-private catalytic mechanisms* involve public support for creating and developing private markets (*inter alia* by reducing risks of private entry). *Private mechanisms* (which are not covered in the referenced paper) involve private-to-private flows into the market and in civil society. Three of these mechanisms (solidarity, partnership and catalytic) depend on official flows, which they either mobilize or deploy in support of country and global efforts. Source: N Girishankar. *Innovating Development Finance: From Financing Sources to Financial Solutions*. World Bank Group Working Group on Innovative Finance, May 2009.

Rather than examine each mechanism on a stand-alone basis, the focus should be on how, when used together, they can address the finance challenges in the health sector. The diagram below illustrates how the types of mechanisms could fit together.

Figure 9: Types of innovative financing mechanisms



The red boxes above represent different approaches to innovative financing. These activities represent the link between “more money” and “better money” discussed in further detail below.

Recommendation:

- **Innovative financing mechanisms are complementary. Working Group 2 recommends that in the design, rethinking or establishment of different instruments the links and possibilities for leveraging should be actively explored.**

Specific innovative finance mechanisms may achieve some of the objectives cited above. However, as a whole, this group of mechanisms needs to be considered in a broader context. While recognizing 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, based on IHP+ principles of one national plan, one budget, one results framework and one reporting mechanism, and linked with national efforts at raising necessary domestic and international resources.

Development partners should commit to providing long-term financing for health systems as a regular practice. *Increased predictability is essential to enable low-income countries to effectively plan and manage their development programmes.* It is also a precondition for desired strengthening of country ownership. IFFIm and the Advance Market Commitment pilot have shown it is possible and feasible for donors to make more long-term commitments to funding development programmes. Recent pledges, for example the United Kingdom’s 2007 pledge of £1 billion to the Global Fund for the coming eight years, illustrate that some donors are both willing and able to move in the direction of making longer-term commitments.

Recommendation:

- **Development partners should increase the predictability of their development commitments under agreements that are legally binding or subject to legislative/parliamentary approval and commit to three to ten years of funding.**

B. *Main options for innovative financing*

Working Group 2 looked at approximately 100 existing innovative financing mechanisms for their relevance to financing strengthened health systems. The group then focused on the most promising, which were reviewed in more detail (Annex 3). The mechanisms are different in nature and were assessed according to what they have delivered, or have potential to achieve. The criteria used are described in the box below.

Box 5: The criteria used for assessing the options

1. **General criteria**

Value added, experience, technical feasibility, sponsorship, time frame for implementation

2. **Financial criteria**

Realized revenues, potential flows, costs (set-up and running costs), additionality, sustainability, ODA credit

3. **Aid effectiveness criteria**

Country ownership, predictability, alignment, synergies and externalities, impact on aid architecture for health and harmonization, results (including performance, outputs and outcomes), accountability, pro poor

4. **Linkages, fit and overall evaluation**

Linkage of the mechanism to the needs and challenges identified by Working Group 1. This is relevant not just in terms of contributing toward the required levels of funding according to timing needs, but also should look at purposes (to accomplish X, mechanisms A, B and C are relevant). Overall discussion of pros and cons, comparison across mechanisms including a discussion of complementarities.

The review has shown (i) a first group of mechanisms that may generate or leverage more funds and perform on the financial criteria – these include levies and taxes, sale/auction of emissions permits, global lottery and premium bonds, philanthropic sources, an expanded IFFIm, and debt buy-downs; and (ii) a second group of mechanisms that may contribute to aid effectiveness and more efficient channeling, disbursement and use of funds (these are discussed in Chapter 3). The first group of mechanisms breaks down into five broad categories.

1. Raise more money through *internationally coordinated and nationally implemented levies and taxes*. These mechanisms have the greatest potential to raise substantial amounts of additional resources.

2. Explore *innovative approaches that improve predictability* and the duration of financial commitments that are available to countries.

3. Catalyse *private sector engagement* in more efficient health systems.

4. Catalyse *private voluntary contributions*.

5. Leverage lending instruments by using grant funding to “buy down” IDA credits or other concessional loans and through an expansion of the debt to health swaps to fill financing gaps in health systems development.

The following sections list recommendations in each of the five areas noted above (levies and taxes, mechanisms that improve predictability, private sector engagement, private voluntary contributions, and leveraging lending instruments). Recognizing that it is unlikely that all interested countries will agree unanimously on a single solution, all countries should be able to support at least one of the meritorious proposals considered by Working Group 2. An approach of combining mechanisms can also capitalize on their complementary characteristics.

1. Internationally coordinated and nationally implemented levies and taxes

Levies and taxes can generate clear benefits in terms of resource flows, low transactions 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. Coordination among countries can create additional leverage, including political support for introducing “solidarity” levies in other countries, including developing countries.

The precedent for this approach is the 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, Cote d’Ivoire, Madagascar, Mauritius, Niger and South Korea). UNITAID is the primary but not only recipient of the proceeds of the tax.

Levy and tax proposals that were reviewed include:

- i. The **solidarity levy on airline tickets** – The proposal is to expand 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 to other institutions.
- ii. **Financial transaction levy** – a proposal to introduce a regionally coordinated, nationally implemented solidarity levy on, for example, all foreign exchange transactions; the levy would be mandatory for individuals trading a covered currency in participating countries.¹⁶

¹⁶ Currency transaction tax proposals have been put forward, in different forms, for decades. A specific currency transaction levy has been proposed for this work [by Stamp Out Poverty/AIDS Alliance] of a tax rate of 0.5 basis points, designed to be narrower than the usual bid-offer spread. This tax rate was roughly the same magnitude as transaction fees and intended to have very limited market impact) on transactions among major currencies (USD, EUR, JPY, GBP). As proposed, it was estimated that a currency transaction tax could generate up to US\$33 billion in annual revenues. The market has continued to evolve since the proposal was made. Bid-offer spreads have narrowed further, which would mean a lower tax rate and reduced revenues compared to the estimate. In addition, many currencies do not trade directly with each other but instead in double-legged trade through USD, the currency unlikely to be covered under this proposal. Taking these changes into account, the feasibility and externalities of the currency transaction tax proposal would need to be carefully considered.

- iii. Raising the tax rate on specific products, particularly those harmful to health such as a **tobacco products tax** (152 countries have existing taxes) – a nationally implemented, internationally coordinated proposal that could, like the air ticket levy, be implemented in both developing and developed countries.

Box 6: Earmarked Tobacco Taxes

In 2001, the Government of Thailand set up the ThaiHealth Promotion Foundation, which receives 2% of total national tax revenue on alcohol and tobacco products, generating about US\$35 million per year. ThaiHealth acts as a catalyst and supports groups and organizations that are already working on public health issues. It reports directly to the cabinet and parliament. It has inspired neighbouring countries, including Mongolia, to adopt or contemplate setting up, the same structure.

Earmarking can be a mixed blessing, however. The key challenge is downstream, when donors are keen to track the use of their contributions to specific projects, which increases administrative and transactions costs, creates distortions within countries and undermines a country's ability to articulate its own funding priorities. If the Taskforce decides to adopt earmarked taxes, care will need to be taken to avoid earmarking usage of funds in countries.

These levies and taxes vary with respect to evaluation criteria considered.

- The currency transaction tax has the highest revenue potential, but its feasibility and likelihood of adoption are unproven.
- The feasibility of the levy on airline tickets has been proven and further roll-out might be quick.
- The tobacco tax, based on a wide base of existing taxes, might provide the widest participation platform by developing countries, including beneficial effects on accountability and burden sharing. It benefits from a positive externality by reducing tobacco consumption and potentially saving lives. However, given the high number of countries that have implemented the tax already, the potential for expansion in high-income countries as a source of ODA is unclear. (It may be noted that sponsors may want to explore other taxes with positive externalities, such as taxes on alcohol or fast food and drinks high in sugar and salt.)

Recommendation:

- **Taxes and levies, where feasible, can provide long-term, sustainable funding and solidarity approaches. If a tax or levy option enjoys strong government sponsorship, the Taskforce should further explore the necessary implementation steps.**

2. Innovative approaches that improve predictability and the duration of cash flows

As noted by Working Group 1, strong health-care 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.

Whether looking at ODA flows or those from private voluntary contributions, cash flows to health systems tend to exhibit some volatility – that is, a lack of predictability. This volatility can stem from a variety of reasons, such as overall economic conditions, political preferences, donor preferences, competing interests, or earmarking (funding a defined subset of projects). From a Ministry of Health’s perspective, these potential sources of unpredictability represent fundamental challenges to long-term effective programme planning.

In their support of recent innovative financing initiatives, a number of development partners have demonstrated ways to increase long-term predictability of funding commitments. Long-term commitments of up to 20 years have shown to be feasible with *IFFIm* and the *AMC pilot*. The European Union’s *MDG contract* is a longer term, more predictable form of general budget support which the European Commission expects to launch in a number of countries. It would provide six-year commitment of funds. Where the key funding need is for certain funding over a lengthy period, long-term commitments could be a constructive answer. Nonetheless, these commitments have not been simple to structure; a downside is increased complexity in the process of entering into such arrangements, which must be conditional to avoid immediate and substantial fiscal impact.

Guarantees can also provide predictability. Different sources of cash can be made more predictable by “wrapping” them with guarantees from sovereign entities. Generally speaking, guarantees support long-term government planning by providing the necessary assurance that funds will flow. From a development partner perspective, guarantees can be particularly attractive because provisioning required for issuing guarantees is less than the face value of the guarantee, reflecting the likelihood that the guarantee will be utilized. The short-term fiscal impact of a long-term commitment is therefore reduced.

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 include investments that would 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. To balance this, it is important to ensure that there are sufficient funds available subsequently to meet the needed recurrent costs of the system and to meet future needs.

IFFIm is an international development financing mechanism that raises funds in 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 investments that would benefit from frontloading. Such an expansion would require an examination and potential alteration of IFFIm’s governance arrangements, amendment of

the legal agreements establishing it, and consideration of how best to allocate health systems funds raised through it.

Box 7: International Financing Facility for Immunization (IFFIm)

IFFIm raises finance in the international capital markets by issuing bonds. Its financial base comprises long-term (15-20 years), legally-binding, conditional commitments provided to it by seven sovereign donors: France, Italy, Norway, South Africa, Spain, Sweden and the United Kingdom. Based on its sovereign assets and financial management policies, IFFIm has been classified as a multilateral development organization and is rated a triple-A by the three leading credit rating agencies. This has enabled IFFIm to borrow funds at highly competitive rates even during the current market turmoil. Since it was launched in November 2006, IFFIm has raised US\$2 billion in the capital markets and distributed \$1.25 billion for GAVI's programmes; donors have contributed \$323 million in cash. Over its current life, IFFIm is expected to raise approximately \$3.3 billion through 2015.

Proceeds from bonds issued by IFFIm finance GAVI programmes including vaccine procurement, health systems finance, routine and catch-up immunization campaigns, and vaccine stockpiles. IFFIm's ability to generate frontloaded and predictable funding is beneficial to immunization and health systems challenges facing its country partners. It is particularly effective for immunization because it allows rapid increases in uptake that are necessary to attain required levels of coverage.

Using IFFIm funds, GAVI can enter into long-term supply agreements with vaccine producers, which ensures a sustainable supply of essential vaccines at a lower cost. It can also use remaining IFFIm funds to address other health challenges. The International Health Partnership believes IFFIm "is best suited to interventions which are highly cost effective in terms of health impact but also ones which have no long-term recurrent costs, significantly reduce long-term funding requirements, or bring about large efficiency gains".

IFFIm's ability to frontload funds does entail costs over and above traditional ODA. These include principally the interest expense on the outstanding bonds and annual administrative costs. The level of interest expense is comparable to what the underlying governments would incur had they borrowed sums of similar sizes annually and forwarded proceeds to GAVI.

As noted above, certain innovative finance mechanisms can be used together. In this case, cash flows from traditional ODA could be combined with those from private voluntary sources and together channelled into IFFIm to expand its current resource base for further investments in health systems. The IFFIm structure could be used to provide sovereign guarantees around the incoming cash flows (a wrap structure) to improve predictability and leverageability in the capital markets. This combination of ideas could improve predictability and enhance the amount of funds available on a frontloaded basis.

Recommendation:

- **Working Group 2 recommends that the Taskforce consider specific proposals that better match the timing of funding provision and needs, including expanded use of long-term commitments and guarantees and exploration of how IFFIm could be expanded to strengthen health systems.**

3. Catalyse private sector engagement in more efficient health systems

What is the role of the private sector in health systems? One way to think about this complex question is by referring to the four essential functions of health systems: stewardship, financing, service provision, and resource generation. The private sector becomes increasingly more prominent as one moves down this list of functions.

Stewardship is eminently a public function, and it is crucial in order to avoid the pitfalls of private participation in the other functions. In what is only an apparent contradiction, one essential ingredient for effective private participation is to strengthen public sector capacity for stewardship.

One objective of the financing function is to avoid out-of-pocket expenditures, which is the dominant form of private financing in low-income countries. All countries need to adopt and implement policies to reduce out-of-pocket expenditures and improve financial protection. The role of the private sector in insurance in low-income countries is likely to be limited with respect to for-profit insurance, though there is some scope for not-for-profit insurance especially as part of mix of financing arrangements.

If strong stewardship and financial protection are in place, then subject to national decisions there is room for private-sector innovations in service delivery and resource generation (including workforce training, drug procurement, and investment in infrastructure development).

Health systems the world over are plural. They consist, in many combinations, of both public and private subsectors. In many low-income countries, the non-state subsector (meaning anything that is not public and including both for-profit and not-for-profit, and both formal providers and the retail drug market) tends to play a prominent role. The quality of care provided as well as the level of cost for poor people is not always optimal but there are also examples where the private sector delivers good quality health services for poor people, but rarely for the very poorest.

Thus, whether as a function of access, preference or economics, the private sector plays a critical role in the provision of health-care delivery in low-income countries. To improve the health of the world's poor means managing, harnessing and mobilizing an effective, high-quality private sector – in addition to strengthening the role of the government in governance, regulation, contracting and quality enhancement.

Scaling up health services in the poorest countries will require investment in service delivery and logistics, cost and risk reduction through risk-pooling arrangements, information services, laboratory and diagnostic services, administration, production of medicines and other vital health-care goods, and staffing. There are a number of promising cases of successful private sector involvement in the poorest countries in some of these areas.

Governments in many low-income countries face substantial challenges in managing effective private sector engagement. Many governments have little accurate knowledge about private sector activities, reporting requirements are often not complied with by the private sector, and capacity to assess challenges and opportunities for better private sector management is limited. Expert assessment and advice on the specifics of private sector activities is needed to develop strategies for engaging the private health sector and better

integrating it into their overall health systems. Properly done, this could lead over time to increased 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. Ultimately non-state engagement could lead to better health for the poorest parts of the population.

Box 8: Examples of private sector investment in developing country health systems

The marketplace for dedicated investment funds for health care is beginning to grow. The examples below are capitalized with philanthropic dollars and seek returns in two dimensions: traditional financial returns commensurate with each project, and social returns in the form of increased access to health care for the poorest parts of society.

The **Investment Fund for Health in Africa (IFHA)** was established in Holland under the sponsorship of the Netherlands Development Finance Company (FMO), a Dutch Foundation and an American investment bank to invest in small- and medium-sized health-care companies in Africa.

The purpose of **The Acumen Fund**, a USA-headquartered non-profit, is to build transformative businesses that alleviate poverty. Since its establishment in 2001, the fund has invested over \$35 million in 26 enterprises, in four portfolios – health, energy, housing and water, of which the largest portfolio is health.

The **Ignia Fund** invests in scaleable businesses in sectors such as health care that specifically benefit the "bottom of the pyramid" (i.e., the poorest parts of society).

The International Finance Corporation, and the Bill & Melinda Gates Foundation are also in the process of establishing a new fund to invest in small- and medium-sized health-care companies in Africa and to provide managerial advice and support. Over its lifetime, the fund will seek to raise up to \$ 1 billion.

There is a particular desire to assure an ongoing focus on the poorest countries and the poorest people in those countries, and to assure alignment with the overall planning and priority setting activities within each country's health sector. Risk appetite towards incremental private investment is a challenge that too needs to be considered. One of the constraining factors towards a larger scale of private investment is the assumption of political risk in the poorest countries, a risk that can be shifted to official organizations better placed to absorb the capital consequences of investing in the poorest country settings.

A number of examples illustrate the potential of private sector investment, at scale, in health-care delivery in the poorest countries. Capital-pooling mechanisms increase at-risk and debt capital to the private sector (including for-profit and non-profit actors), particularly those that are focused on servicing the poor. Using equity, there is significant opportunity to drive greater efficiencies in the health-care industry through consolidation in health-care subsectors, as well the opportunity to replicate business models proven in one country in other countries and regions. Simultaneously, there is substantial demand for debt financing for expansion capital.

Type	Nature	Purpose
Venture	Commercial	To finance start-up companies and entrepreneurs
Private equity	Commercial	At risk capital employed to grow reasonably well established, profitable companies
	Sub-commercial	At risk capital employed to grow reasonably well established companies that are sustainable but not profitable or profit-maximizing
Debt	Commercial	Loans that are issued on a commercial basis to finance health-related projects. Such loans can vary in size
	Sub-commercial	Subsidized loans that are issued to finance health-related projects. Such loans can vary in size

Recommendations:

- **A capital fund:¹⁷ to purchase or provide guarantees to private sector investors to absorb certain risks. For this to work, strongly defined eligibility criteria for accessing the guarantee facility would need to be developed. 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 targets are focusing on pro-poor health improvements.**
- **Increase information and advice to ministries of health about the types and level of existing private sector engagement in their countries, and ways to improve effectiveness (such as how to establish effective pro-poor private sector policies, regulatory and other requirements to better manage increased private sector investment in health systems).**

4. Catalyse private voluntary contributions

Private giving has wide support and can generate very important public awareness and support for health systems development. Generally, however, due to the advocacy work required to generate a large number of individual contributions, and the relatively small average contribution size, private giving initiatives have a lower revenue raising potential than sovereign grant or tax programmes, as well as potentially higher transactions costs related to setting up and implementation. These costs include initial investment in market surveys and focus groups to understand how to create market appetite and a niche for a health systems-dedicated giving opportunity, as well as substantial ongoing fundraising and publicity costs.

¹⁷This fund 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.

The internet provides a powerful channel through which to reach potential contributors, and by which to facilitate fundraising. There are many ways to promote causes on the web, however, and comparative analysis is necessary to determine the most efficient option for raising health system funds. In addition, the internet is only one of many media through which fundraising campaigns can be conducted, and its effectiveness may be complemented by other modes and mechanisms.

Private giving tends to invite earmarking, which is the practice of some donors to make their contribution conditional on its application to a particular project. Earmarking should be discouraged because it adds to administrative and transactions costs: it introduces inefficiencies. Moreover, earmarking impedes a country's flexibility to plan resources according to its specific health system needs, and can thereby have a negative impact on health outcomes.

Several mechanisms focusing on charitable contributions have been considered:

- i. *Private Giving Campaign* is a proposal to organize a fundraising campaign in support of health systems, with contributions/engagement by individuals (retail fundraising) and by major foundations.
- ii. *Voluntary Solidarity Contributions*: These programmes 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. As noted above, start-up costs, principally for marketing and implementation, could be substantial.

Several proposals are under discussion. The Millennium Foundation for Innovative Finance for Health is pursuing two initiatives that merit support from the Taskforce. A voluntary solidarity contribution tied to airline tickets would raise funds by providing individuals and corporations who purchase airline tickets with the opportunity to voluntarily donate a small sum for every ticket purchased; the levy would not be mandatory for consumers. Revenue flows are uncertain, but the Millennium Foundation estimates significant potential revenues, and relatively low transaction and administrative costs for government to run the initiative.

A second proposal to establish a voluntary solidarity levy on the use of mobile phones would enable individuals who use mobile phone to voluntarily donate a small sum in connection with their monthly mobile phone bills.

Other options include voluntary contributions related to financial transactions, such as e-banking or credit card purchases, or in connection with payment of utility bills. Proposal with a clear health link (such as donations attached to the purchase of health insurance or health-related consumer goods) are also under consideration. Many of these options depend on sponsorship, which may have higher set-up costs but significant benefits.

- iii. *De-Tax* - a proposal 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 divert 1% or more of VAT on any good or service sold by businesses

associated with the initiative to a designated fund for health systems development, while businesses, on a voluntary basis, would commit a share of their profits on related transactions to the same fund.

De-Tax is aimed at fostering private solidarity. Its success depends on the number of participating businesses and the level of consumers' support. Revenues would depend, in part, on the level and quality of publicity, and the administrative and transaction costs imposed on businesses.

- iv. ***Blended Value Products*** solicit contributions from individuals, by combining consumption with charity. This can be done with a focus on the product or service purchased (for example, (PRODUCT) RED) or with the purchase itself (for example, via an "affinity" credit card). Proposals such as the De-Tax could encourage greater consumer participation in blended value products. De-Tax and blended value products could be particularly strong fundraisers when tied in with internet-based purchasing by individuals.

Each of these approaches has different benefits. Private giving campaigns, for instance, would be more effective in raising awareness about health system challenges, while blended value products give the purchaser the chance to show his or her commitment to the cause. Voluntary solidarity contributions allow consumers to make choices, while De-Tax focuses on businesses and governments.

Together these mechanisms are complementary, and implementation of a range of them would maximize revenues and public-awareness. The implementation must be planned and coordinated so as to minimize duplication, maximize synergy, and offer flexibility and choice to participant governments. Coordination will also help prevent earmarking, and ensure that generated funds are channeled efficiently and do not further fragment health funding flows.

All countries, even the poorest, have middle-class and wealthy individuals, and private giving initiatives have the potential to raise significant funds and highlight the importance of health systems in achieving critical health goals. Further exploration of the range of mechanisms outlined here, and their relative merits and complementarity, is needed, as is research to establish the size and preferences of the pool of potential donors.

Recommendation:

- **Working Group 2 recommends the Taskforce to provide public catalytic funding for the development of a range of large-scale private giving initiatives where market research indicates a material source of sustainable finance can be derived from them.**

Box 9: Philanthropy in China and India

Since market reforms in **China** gave the green light to private enterprise in the late 1970s, individual and corporate donations have taken off. The Chinese Red Cross now receives significant contributions for disaster relief outside China. Overall, donations climbed from US\$1.2 billion in 2005 to \$4.5 billion in 2007 and \$14.7 billion in 2008 – the last driven by a record outpouring of support after the devastating earthquake in Sichuan province. It represented about 0.4% of China's GDP. The emerging Chinese philanthropic sector also includes some significant single contributors. Since 2003, the country's top 100 individual philanthropists have given away about \$1.8 billion toward education, social welfare, health, and poverty reduction.

India has a long tradition of philanthropy, and traditional faith-based giving is beginning to expand in a number of ways. Some charitable institutions have started to extend their reach into areas such as rural development, environment, income generation and women's empowerment. Corporate wealth is beginning to be channeled into broader philanthropic work, and wealthy and well-educated Indians are looking globally for models of charitable giving. The government has established the Public Health Foundation of India, in part with US\$20 million from Indian philanthropists, as a public-private partnership to address public health education and research. Diaspora philanthropy is substantial, and manifests itself in different ways. The American Association of Physicians of Indian Origin, for instance, is doing valuable work in rural healthcare in the states of Andhra Pradesh and Bihar.

5. Leveraging lending instruments

Buy-downs (also called “credit buy-downs”, or “loan buy-downs”) are a combination of a loan to a developing country and donor commitment to pay off part of the loan. The developing country receives funds up-front and has the assurance that, with successful implementation and after results have been proven, a donor will cancel the debt. Results-based IDA buy-downs have been implemented in Pakistan and Nigeria, and more than US\$100 million has been provided by two foundations to buy down IDA credits for polio eradication once vaccination targets are attained, thereby effectively turning the loans into grants. This supported IDA projects of about US\$190 million.

Buy-downs serve multiple purposes. Grant (or guarantee) funding can lower the cost of borrowing to recipients because it lowers the risk to the provider. For a middle-income country, this could mean reducing the applicable interest rate on a multilateral development bank loan to support health system loans. For low-income countries, highly concessional loans can be bought down to grant terms. As a result, grant funds effectively leverage larger flows of loan financing.

Buy-downs also 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.

A health systems buy-down fund, which could be combined with a results-based financing fund or be one characteristic of the Health Systems Funding Platform proposed in Chapter 3, could be used to channel ODA and funds from one or more of the mechanisms discussed in this chapter. (Channeling issues are discussed in detail in Chapter 3.) Potential flows depend on donor and recipient interest in the concept of results-based buy-downs and targeted 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 AUS\$75 million of Indonesia's debt. The potential revenue depends on donor willingness to cancel debt through the mechanisms, 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).

Recommendation:

- **Working Group 2 recommends that development partners consider establishing or expanding existing funds for results-based "buy-down" funding and/or "Debt2Health" to fill financing gaps for health systems development.**

C. Additional options

Other mechanisms reviewed by Working Group 2 will be of interest to specific donors. Details about all mechanisms analysed by the Working Group are presented in Annex 3. Selected examples of other instruments reviewed there include:

- *Global lotteries* (already established for social funding purposes in many countries);
- *Advance Market Commitments* (building on the pilot AMC for pneumococcal diseases to target other needed vaccines or drugs where there are market failure issues);
- *The sale or auction of greenhouse gas emission permits* (EU Allowances under the European Unions European Trading System may be auctioned or otherwise sold and the proceeds used to finance health systems).

Each innovative funding mechanism has different revenue potential, set up costs, and relationship to ODA. The table below gives a rough picture of the relative qualities of selected mechanisms.

There is a great variety of options for securing additional financing for health systems and thereby supporting the ability of countries and the global community to reach the MDGs. Individual options and combinations of complementary options can be developed to suit a

wide range of local, regional, national, multilateral, and international prerogatives. Ultimately, the work of the Taskforce will be successful if development partners and sponsors can agree on a complementary set of initiatives that will together provide new, predictable funding, when and as needed, from different sources.

Table 2: Innovative mechanisms: costs, projected revenue¹⁸, implementation summary, and health system outcomes

Mechanism	Revenue	Costs	Implementation	ODA credit	Examples of Health System Results
<i>Solidarity levy</i>					
Airline ticket	\$\$	+	Expansion	Yes	Commodities for health MDGs
<i>Align funding time with needs</i>					
IFFIm (frontloading)	\$\$\$	++	Expansion underway	Yes	Frontloaded health system investments e.g. health worker training capacity, infrastructure renovation, catalytic funds to improve domestic financing, management, information systems, and evaluation
<i>Public resources for private giving</i>					
De-Tax	\$\$\$	+	New	Partial	Private giving requires ‘results’ that public are willing to contribute to e.g. safe delivery of babies, emergency obstetric care, and treatment of illness in children.
VSC: airline tickets	\$\$	+	New, underway	No	
VSC: mobile phones	\$\$	+	New	No	
<i>Leveraging lending instruments</i>					
Buy downs	\$\$	+	Some experience	Yes	Broad Health System Results
Debt2Health	\$\$	+	Expansion	Yes	
<i>Non-state sector</i>					
Capital-pooling	\$	+	New	?	Accreditation programs, supply-chain management, training schools, low cost clinic chains for the low-income in urban Global public goods where market fails (drugs, vaccines & other commodities)
Seed capital	\$	+	New	?	
AMC & patent pooling	\$	++	Expansion	?	

Revenue potential

Based on assumption that a broad range of countries would participate in mechanism
 \$\$\$\$ double digit billions of dollars annually.
 \$\$\$ single digit billions of dollars annually
 \$\$ hundreds of millions of dollars annually
 \$ less than hundreds of millions dollars annually

Costs

+ less than 5 percent of revenues
 ++ 5-20 percent of revenues
 +++ 20 percent of revenues and more

¹⁸ Revenue and costs estimates depend on significant assumptions about participation levels

3. More health for the money

The success of any innovative financing mechanism adopted by the Taskforce will not only be measured by how much money it raises, but also by the results it achieves in terms of improved health outcomes and health equity in low-income countries. The funds raised through the implementation of the recommendations in Chapter 2 need to be used in the most equitable and cost-effective way, and to flow as efficiently as possible.

This chapter focuses on making recommendations in four important areas:

- How to *improve the channelling* of international funds to low-income countries;
- How to *maximize the efficiency, equity and effectiveness* of funds for national health systems;
- How to *better link financing to health outcomes* and tangible results at country level;
- What special arrangements are required in *fragile states*.

A. Streamline the flow of resources to low-income countries

It is a widely recognized problem that the present health aid “architecture” is not efficient enough and that *transaction costs are too high* both to countries that benefit and to partners that provide the funding.

It is critical to give due attention to better coordinating how funds are channeled to countries and how they are spent. As stated in the concluding remarks in the report from Working Group 1: “How innovative financing is raised is of less concern to low-income countries than how it is channeled. Additional sources of finance should not give rise to additional channels of funding, and should enhance predictability and help reduce fragmentation. Of special significance to health system strengthening is the long-term recurrent support needed to ensure continuing access to health services...”

In health there are more than 40 bilateral development partners, 90 global initiatives and a large number of international NGOs. In effect, these compete for attention and scarce country resources, especially human resources. This skews country priorities, increases transaction costs, and encourages piecemeal solutions to problems of service delivery.

Development partners channel resources in a variety of ways: as direct budget support through ministries of finance, as sector support through ministries of health, as earmarked support for specific projects or activities, or as in-kind donations of various goods or services. Some international funds flow through the Ministry of Health budget, some to other ministries linked to health, some are off-budget flows to different parts of government, and some flow directly to the non-state sector, particularly to NGOs.

The problems this causes have long been known. In 2001 the report from Working Group 6 of the Commission on Macroeconomics and Health stated:¹⁹

¹⁹ See <http://whqlibdoc.who.int/publications/9241590140.pdf> page 19-20

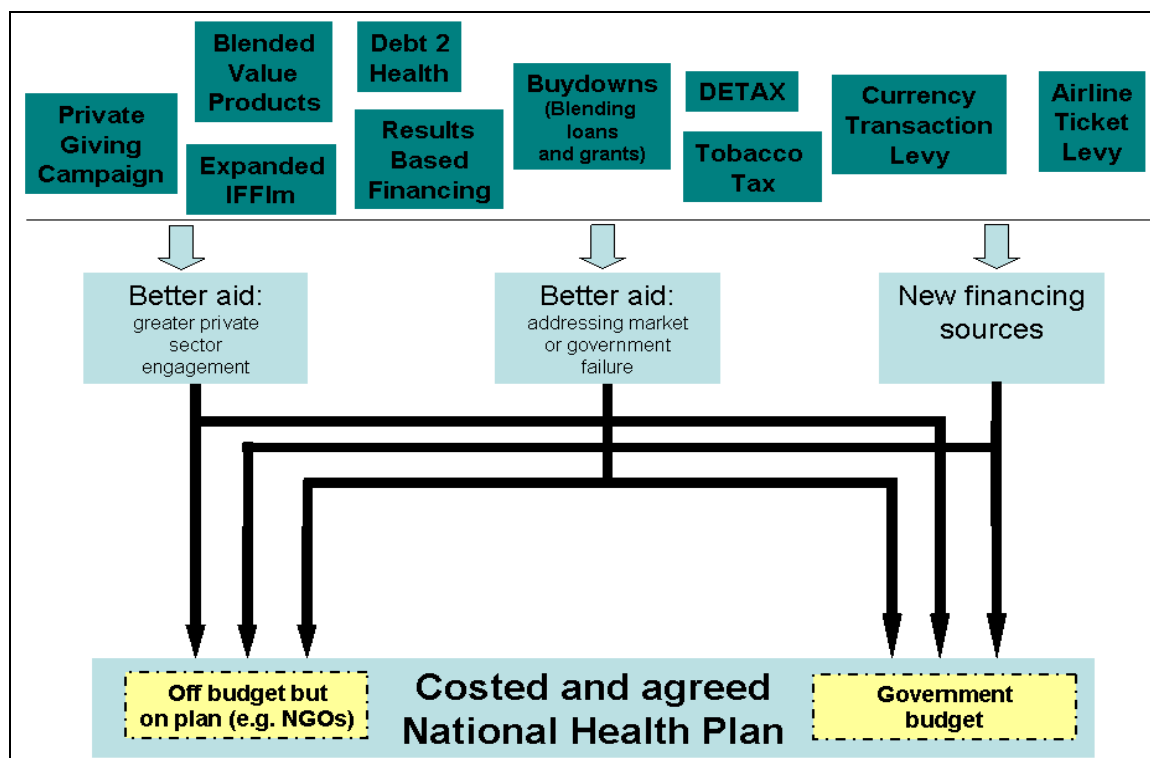
This proliferation of channels of funds may have increased the accompanying administrative costs for managing development assistance for health. For example, the cost of channeling funds from donor governments through national agencies to the multilateral system is estimated to reduce the funds available for direct health interventions by some 17%, excluding any additional overhead arising from the use of funds by the multilateral organizations. Likewise, the average donor-funded health project leaves less than 50% of available funds for what are normally termed project costs – capital costs of infrastructure and equipment and recurrent costs for drugs and materials, but excluding technical assistance.

In the years since this passage was written, the situation has gotten worse rather than better; despite knowledge of the problem, the proliferation of channels of funds to countries has continued.

The highly fragmented nature of international support has led to calls for better coordination of resources and for all international funds to support one national health plan, which would also require better coordination between various parts of government and with civil society at the country level. Follow-up and monitoring of donor resources should also be harmonized with country procedures.

The figure below shows the major innovative mechanisms identified in Chapter 2. From a channeling perspective the challenge is to ensure that funds support quality assured health plans based on the principles of the International Health Partnership and the Paris Declaration on Aid Effectiveness.

Figure 10: Channeling funds from innovative mechanisms to countries



Ideally, relying on a small number of channeling mechanisms would be preferable given the existing complexity of the health aid architecture. However, from a country perspective it is more important that all mechanisms for channeling funds can be effectively aligned and harmonized with priorities and procedures at the country level.

As shown in the figure above, all innovative financing should support *health plans and budgets*. It could be allocated through government budgets as general-, sector- or earmarked budget support. Development partners could also provide funds that are off budget, i.e. provided through parallel channels, as long as those resources are in line with the overall health plan and reported on. This includes, for example, support to the non-state sector, which is likely to be provided off budget – but should ideally be on plan. The aim is that over time, the principles of the Paris Declaration should be gradually achieved where more and more funds are reported in government systems and fewer parallel implementation mechanisms exist.

In some cases, revenues from innovative mechanisms can be pooled and made available for allocation to any country. In other cases support will be tied to particular countries. Global pooling offers the major advantage of allowing resources to be allocated strategically where they are most needed. Some mechanisms, such as the suggested currency transaction levy, lend themselves particularly well to global pooling. For others there is likely to be little scope for pooling at global level.

Innovative financing raised for health systems strengthening should be used to fund costed and agreed national health plans that address the entire health system. At the global level, Working Group 2 suggests the Taskforce makes a strong recommendation for pooled approaches and takes action towards the realization of a single disbursement channel – *a single account* – to countries in order to both minimize transaction costs and achieve better results.

Working Group 2's recommendation in this regard is in line with the ongoing work between GAVI, the Global Fund and the World Bank, which are collaborating to produce a framework in which a single funding arrangement (alongside a single plan and a single apparatus for monitoring and evaluation) will be used to support the health system strengthening activities that are needed to accelerate progress towards the MDGs. Implementation of this framework is expected to commence towards the end of 2009.

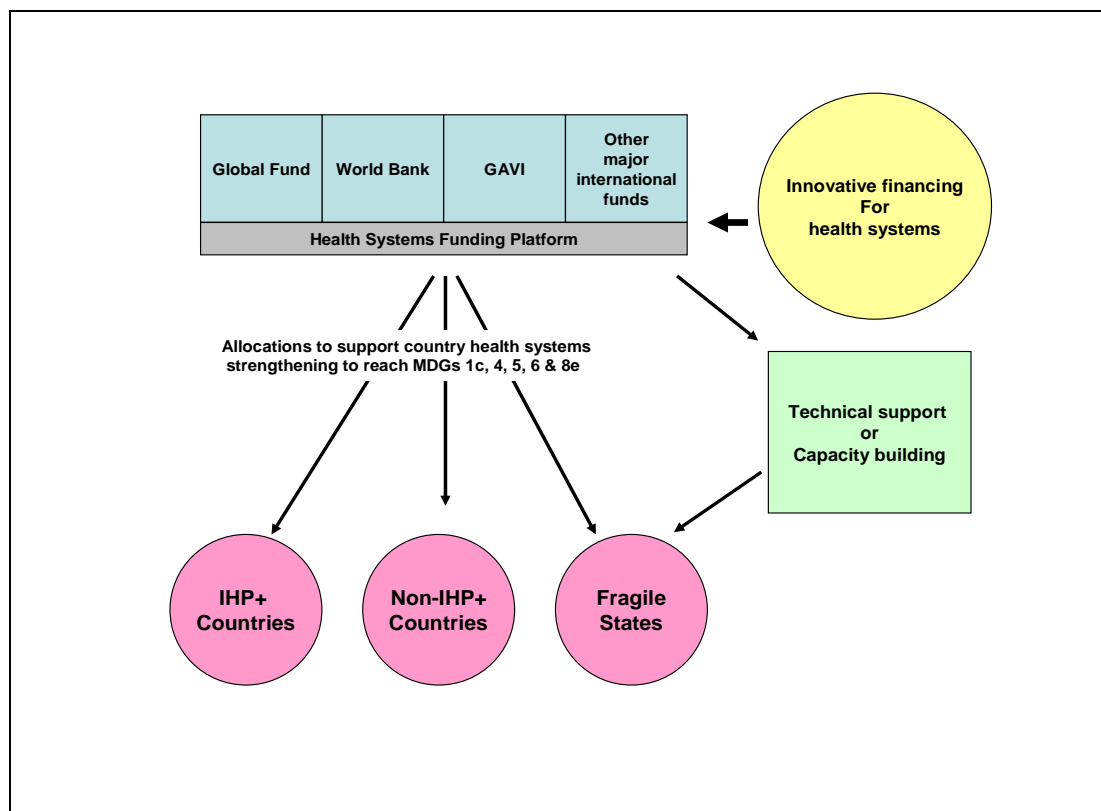
A coordinated, streamlined programming approach to support health systems strengthening provides an attractive way forward and can be a key part of the investment case to attract new funds. GAVI and the Global Fund use slightly different business model but are becoming more aligned. All three institutions have committed to work more efficiently and effectively at country level and align with national plans. Such an approach, however, must be linked to a strong focus on results in country level health plans to ensure that funds are used in an efficient manner and have the greatest possible impact.

To the extent possible, funds raised from innovative financing mechanisms should not be subject to earmarking, but should be available to support the strengthening of health systems. In cases where earmarking of funds is unavoidable, such earmarking must be consistent with the guaranteed benefits that provide the basis for the cost estimates. A general principle is that the choice of funding mechanism should be guided by country needs and not by funds available.

The figure below provides a conceptual framework of how a proposed Health Systems Funding Platform organized jointly by GAVI, the Global Fund and the World Bank could be designed. The core features of the model are:

1. The Health Systems Funding Platform uses a coordinated and aligned business model for programming between GAVI, the Global Fund and the World Bank. Resources are allocated through one model and one process, improving efficiency at the international level and reducing transactions costs for countries.
2. Resources are pooled through a joint mechanism to provide support to national health plans focusing on strengthening health systems to reach the health MDGs in 49 low-income countries.
3. The platform is not exclusive to these three institutions; it can also channel other international funds. Resources mobilized through innovative mechanisms could contribute to any of the participating organizations (GAVI, Global Fund, World Bank, others) or to the Health System Funding Platform itself.

Figure 11: Proposed health system funding platform for low-income countries



Such a framework would mainly be a platform for raising and distributing funds. Priority setting, implementation, and monitoring and evaluation would all be country level undertakings. Funding from the Health Systems Funding Platform should be aligned with existing country systems for planning, coordination, delivery and management of the health sector. The health sector should in turn be guided by the national development plans and achieving the all the MDGs.

Recommendations:

- **Establish a Health Systems Funding Platform for the GAVI Alliance, the Global Fund, the World Bank and others to coordinate and mobilize both existing and new funds.**
- **Use the funds to fill critical gaps in costed and agreed national health plans that cover the entire health system.**
- **Couple the allocation of funds with clear expectations on outcomes and results and use a single disbursement channel to minimize transaction costs.**
- **Strengthen capacity in low-income countries to use the funds rapidly, efficiently and equitably, and to monitor the achievement of results.**

B. Accelerate efforts already underway to improve ways of working

Especially in countries where international resources constitute a substantial part of the health budget, the complexities of the global health “architecture” make the effective use of resources very difficult.

Experience has shown that applying the principles of the Paris Declaration on Aid Effectiveness can lead to improved health outcomes. Lessons so far show that more effort is needed in five areas.

First, national ownership, manifested by costed, quality-assured and *agreed health plans* with a clear results focus, should constitute the basis for all financing from both domestic and international sources.

National health plans should prioritize the strengthening of health systems to improve the provision of essential services and achieve clear health outcomes, as well as identify the key health systems constraints and bottlenecks that need special attention. The IHP+ provides one possible framework with its country compacts²⁰ based on the “one's” principles: one country health strategy, one single results framework, one budget process, and one monitoring and evaluation framework.

More and more low-income countries are adopting a sector-wide approach (SWAp) model in the health sector. The SWAp model has proven itself as a useful umbrella to respond to commitments made in the Paris Declaration and for countries that have signed the IHP. In particular the SWAp model has enabled a more coordinated approach in the health sector, bringing together all stakeholders in planning and priority setting. However, many donors involved in SWAps and similar coordination efforts still choose to channel and implement their funds through separate project implementation units, which tend to be off budget but on plan. For full country ownership to be achieved, development partners should become better at fully harmonizing and aligning their efforts with national plans.

Second, national health systems and services should be *financed* based on prepayment (with subsequent risk-pooling and risk-sharing) either through general taxes or insurance or a

²⁰ IHP+ Country Compact Guidance Note available at:
<http://www.internationalhealthpartnership.net/pdf/IHP%20Guidance%20CC.pdf>

combination. Risk-pooling is central to the health systems of all high- and middle-income countries. It is only low-income countries where widespread risk-pooling is notably absent. Working Group 2 does not recommend one mechanism over the other but recognizes that the needs of the country should dictate which model can be applied. It also recognizes the need for the flows of international funds to complement, rather than handicap, the move to prepayment and pooling of the country's own domestic funds for health.

Box 10: Health insurance in Rwanda

Rwanda is an example of effective risk pooling. A key pillar in the Rwandan health strategy is community-based health insurance called Mutuelle. The insurance scheme was kick-started by a Global Fund grant. The Global Fund is still partly involved in the insurance, financing the premiums for 1.5 million vulnerable people. The aim is to strengthen the health system so as to improve the quality of care and access, especially for the poor, the very poor, people living with HIV/AIDS, orphans and other vulnerable groups. The now mandatory participation in mutual health insurance schemes and public subsidies for the poor have led to considerable improvement in public health and health care in Rwanda, but even at US\$ 2 a year, the price for some members of the population remains prohibitively high and the "depth of coverage" – or the proportion of total health expenditures covered by the insurance – is still relatively low.

Sources: Ministry of Health Rwanda Brochure, <http://www.moh.gov.rw/docs/Brochure.pdf>

Global Fund website http://www.theglobalfund.org/en/announcements/?an=an_071221a

Twahirwa A. 2008. Sharing the burden of sickness: mutual health insurance in Rwanda. Bull World Health Org. November 2008 (86)11: 823-824

Whatever risk-pooling model is used, low-income countries will require a significant level of international support and both ODA and innovative financing will have important complementary roles to play. Success will depend on a shift from international financing mechanisms that build on project applications approved in a development partner's global headquarters or capital, to agreed financial contributions to national health plans.

In Ethiopia for example, the Health Compact on scaling up for reaching the health MDGs 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 future practice for managing international assistance including increasing use of government systems to procure, disburse, implement, report, monitor and account, and audit.²¹

In Tanzania, the health SWAp implemented in 1999 has supported a government-led health sector development programme to improve access, delivery and quality of health services. An external evaluation found that it has delivered real improvements in outcomes, including reductions in infant and child mortality, greater drug provision, and improved services.²²

Third, joint and coordinated *procurement* of health system inputs has the potential to lower prices and deliver more value for money by drawing on economies of scale. The purpose would be to pool demand, build up procurement expertise, and reduce administrative costs in order to secure the lowest possible price for health systems inputs such as medicines, diagnostics and vaccines.

Mechanisms for coordinated procurement already exist, such as the Global Drug Facility and UNICEF, as well as other multilateral organizations are providing services to countries.

²¹ http://www.internationalhealthpartnership.net/pdf/04_Ethiopia_IHP_Compact_August_2008_FINAL.pdf

²² ADD ref

The Global Fund and UNITAID focus on more efficient procurement and lowering the prices of commodities.

Major progress has been achieved in terms of prices and quality in recent years; for example coordinated procurement has greatly facilitated the distribution of antiretroviral drugs and vaccines. However, there is major scope for:

1. investing more in national capacity to manage procurements of commodities; and
2. more coordinated international efforts to consolidate and better coordinate some of the existing mechanisms.

An interesting example of global coordinated procurement is AccessRH. AccessRH is a global procurement mechanism that helps countries get the lowest possible price for reproductive health supplies by allowing them to buy through a master framework agreement with suppliers. The master framework agreement is a contract with manufacturers that guarantees a minimum volume order. In exchange for this guaranteed minimum volume, the manufacturer will extend favourable terms to buyers. These agreements help poorer countries to get better prices and purchasing terms on essential supplies. With annual operating costs of between \$.5 and 1 million, Access RH is expected to save between \$3 and \$11 million in its first three years of operation.²³

Savings on procurement costs are estimated to be substantial, up to 20-50% depending on the procured products and services.

Fourth, experience has shown that the engagement of relevant *stakeholders* in different stages of the process of coordinating, planning and implementing national health-sector strategies 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 H8,²⁴ national sector mechanisms, the Global Fund Country Coordinating Mechanisms and IHP+, among others).

The Global Fund Country Coordinating Mechanism has recognized that several stakeholder groups, including government, private sector, civil society and communities must be engaged to optimize the delivery of health interventions. The Global Fund experience has, in particular, shown that involvement of civil society is a key to success.

It is worth noting that civil society today is playing a more prominent and effective role both in countries and globally. However, the private corporate sector is still not engaged in such a way that its inputs and contributions are benefiting work in the best possible way.

Several low-income countries have improved the involvement of stakeholder groups in planning and follow-up of the health sector. In Zambia and Uganda for example, the regular follow-up and planning meetings in the health SWAp are normally attended by representatives of civil society groups, professional organizations and NGOs.

²³ www.rhsuppliesorg/work_groups/systems_strengthening/global_financing_and_procurement.html

²⁴ H8 or Health 8 are: Bill & Melinda Gates Foundation, GAVI Alliance, Global Fund, UNAIDs, UNFPA, UNICEF, WHO, World Bank

Box 11: NGO Code of Conduct for Health Systems Strengthening

The NGO Code of Conduct for Health Systems Strengthening is a response to the recent growth in the number of international NGOs associated with the increase in aid flows to the health sector. This Code is intended as a tool for service organizations — and eventually, funders and host governments. The Code serves as a guide to encourage NGO practices that contribute to building public health systems and discourage those that are harmful. The document was drafted by a group of activist and service delivery organizations including ActionAid International USA, African Medical and Research Foundation (AMREF), Health Alliance International, Health GAP, Partners in Health and Physicians for Human Rights. The content was further refined in a series of consultations held in the United States and Africa.

Articles of the NGO Code of Conduct for Health Systems Strengthening

- I. NGOs will engage in hiring practices that ensure long-term health system sustainability.
- II. NGOs will enact employee compensation practices that strengthen the public sector.
- III. NGOs pledge to create and maintain human resources training and support systems that are good for the countries where they work.
- IV. NGOs will minimize the NGO management burden for ministries.
- V. NGOs will support Ministries of Health as they engage with communities.
- VI. NGOs will advocate for policies that promote and support the public sector.

Full text of each article available at <http://www.ngocodeofconduct.org/pdf/ngocodeofconduct.pdf>

Fifth, a substantive share of international resources today is spent on technical assistance. It has, however, been shown that the effectiveness of this support is not optimal and that there are enormous opportunities for efficiency gains.

The perspectives are often short and frequently bypass rather than strengthen national systems. Technical support and advice are needed in order to best benefit from additional resources but the focus needs to be on strengthening *national and local institutional capacity*.

Technical assistance also ought to be a means to address problems of leadership and managerial capacity, and to build long-term sustainable capacity.

The United Nations has a special role to play in enhancing the efficiency of technical assistance, but needs to better understand technical matters and institutional development. Special efforts are needed to strengthen technical skills and policies relating to specific health outcomes and to address the core elements of a well-functioning health system (e.g. strategic planning for and management of human resources, well integrated health management information system, national health finance policies and schemes).

Improved capacity is not only needed for public actors such as ministries of health but also the private sector and civil society. Where recipient governments choose to scale up with increased involvement of non-state actors, the ability to set the rules of the game, monitor, legislate and generally give the appropriate incentives for good practice in the private sector is particularly important.

Recommendations:

- **Use costed, quality assured and agreed health plans with a clear results focus as the basis for all financing from both internal and international sources.**
- **Explore the potential of further joint or coordinated procurement processes.**
- **Encourage global and national innovative financing mechanisms to strategically and actively engage with civil society, the corporate sector and other relevant stakeholders, based on their specific roles and mandates.**
- **Initiate a process to review the effectiveness of technical assistance aiming at improving long-term strengthening of national and local institutional capacity.**

C. Link financing to results at the country level

A stronger focus on effective health systems and addressing the key bottlenecks would greatly improve the prospects for tangible results and improved health outcomes.

There exist today a number of different models for linking financing to actual achievements and results. Results-based 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, and so forth).

RBF is important in order to demonstrate concrete outcomes (achieving measurable results, changing behaviour, promoting efficiency, reducing transaction costs, among others) 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” of reported results.

There are different approaches to the assessment and management of results. All traditional development projects have defined results and a desire to monitor both outputs (e.g. number of vaccinations performed) and outcomes (e.g. changes in vaccination coverage). Financing is often linked to the cost of specific inputs. What is common among all the different RBF mechanisms is that financing is linked to the outcomes that are actually achieved. Very often successful outcomes are linked to a performance bonus, such as buy downs (see Chapter 2).

Conditional cash transfer (CCT) programmes are a fast growing part of safety-net policy. CCT programmes provide cash payments to poor households that meet certain behavioural requirements, generally related to children’s health care and education. The first generation of conditional cash transfers (mostly in middle-income countries in Latin America) has been marked by good implementation with respect to targeting, general administration and impact evaluation.²⁵ These experiences have shown that well-designed and implemented

²⁵ ADD ref

CCT programmes can have a wide range of good outcomes, e.g. efficient targeting, increased food consumption and improved school enrolment.

Box 12: The Nicaraguan Social Safety Net

The Nicaraguan *Red de Protección Social* (RPS), or “Social Safety Net”, is designed to address both current and future poverty via cash transfers targeted to households living in poverty in rural Nicaragua. By targeting the transfers to poor households, the programme alleviates short-term poverty. By linking the transfers to investments in human capital, the programme addresses long-term poverty. The transfers are conditional, and households are monitored to ensure that they undertake prescribed actions intended to improve their children’s health and education levels. RPS’s specific objectives include supplementing household income for up to three years to increase expenditures on food, reducing school dropout during the first four years of primary school, and increasing the health care and nutritional status of children under five. In its pilot phase, RPS had positive and significant effects on a broad range of indicators and outcomes. Household expenditure on food increased by 18%, school enrolment was up by 13% and vaccination rates climbed by 30 percentage points.

Sources: Fiszbein and Schady. Conditional cash transfers: Reducing present and future poverty. World Bank, 2009.

Maluccio and Flores. Impact evaluation of a conditional cash transfer programme: The Nicaraguan Red de Protección Social. International Food Policy Research Institute, 2005.

Allocation of resources from the World Bank’s International Development Association (IDA) and resources from the other multilateral development banks is already today done on the basis of performance. The Global Fund and GAVI have built innovative financing instruments on the concept of RBF.

Box 13: Performance-based incentives

The World Bank is currently managing a total of US\$ 21.4 billion in trust funds – this represents an increasing share of World Bank allocations to IDA eligible countries. Trust funds have rigorous fiduciary oversight and reporting to meet donor demands and can be operated at global, regional and country levels.

The World Bank also manages the Health Result Innovation Trust Fund (HRITF). It was established in November 2007 with a \$105 million grant from the Norwegian Government. It focuses specifically on strengthening health systems by working with governments to establish incentive systems that reward good performance in 8-10 pilot countries. Technical support is being provided and implementation will be closely monitored. Pilot countries include Afghanistan, Eritrea, Rwanda and Zambia.

Access to the HRITF depends on the presence of an ongoing IDA health credit. The Rwandan government used part of its IDA allocation for health so it could benefit from the HRITF. Unlike results-based aid that focuses on the performance of governments at national level, the HRITF supports governments in designing results based financing mechanisms at the sub national level that suit the local context and meet country needs.

Experiences from USAID projects in Haiti have shown encouraging results. The project began by reimbursing contracted NGOs for documented expenditures or inputs. In 1999, payment was changed to being based partly on attaining performance targets or outputs. The project also provided technical assistance to the NGOs, along with opportunities to participate in an NGO network and other cross-fertilization activities. Remarkable improvements in key health indicators have been achieved in the six years since payment for performance was phased in. Although it is difficult to isolate the effects of performance-based payment on these improved indicators from the efforts aimed at strengthening NGOs and other factors, results suggest that the new payment incentives were responsible for considerable improvements in both immunization coverage and attended deliveries.

Sources: www.internationalhealthpartnership.net/pdf/TF_Core_Script_-_MDTF_Handout.pdf

Low-Beer D et al. Making performance-based funding work for health. PLoS Med. August 4(8), 2007.

Eichler R et al. Performance-based incentives for health: Six years of results from supply-side programs in Haiti. Center for Global Development, 2007.

Focusing on results and linking financing to actual outcomes is just as relevant for the organization and management of projects as it is to broader programmes. Most sector programmes in place today across the world have clear overall objectives as well as measurable results over time. And mechanisms are in place reviewing performance and progress.

The situation is the same for General Budget Support as an instrument for providing resources in an effective manner clearly linked to results and mutual accountability. For example, the United States government's contributions to the Zambian health SWAp are based on the achievement of jointly agreed milestones and general budget support from the European Commission is released against reported satisfactory progress towards agreed outcome indicators.

Regardless of which mechanism or umbrella is used for cooperation, a guiding principle should be that all financing of national health plans or sector programmes for international as well as domestic financing should have a focus on results. Thus it is imperative that national health plans must have well developed and carefully thought through indicators and mechanisms for monitoring progress.

There are also risks associated with RBF that must be acknowledged and considered. Further expansion of RBF in low-income countries should include recommendations on how to avoid repeating the problems of performance-related pay/fee-for-service that have been experienced with RBF in high-income countries. Results should be measured against the targets of national health plans.

Another challenge with RBF is how to manage – in a transparent and mutually accountable manner – situations with weak results or failure. Weak performers need further support, but at the same time, non-performance should not generate a positive financial result. How these different situations will be handled needs to be agreed upon and clearly communicated from the start.

Results are likely to be poorest in the countries that have the greatest needs. The need for resources and continuous capacity development must therefore be balanced with short-term performance indicators.

Recommendations:

- **Clearly link financing for health to defined outcomes and to measurable results in broader programmes as well as in projects, building on the specific experiences from performance-based funding and SWAps.**
- **Further develop and scale up systems that effectively manage development results and provide the incentives for achieving health outcomes.**

D. What special considerations are required in fragile states

According to Working Group 1, of the 49 low-income countries, 26 are included on the list of fragile states.²⁶ About 80% of fragile states have been or are still engaged in conflict. Conflict-affected fragile states have some of the worst health indicators in the world and are farthest from meeting the MDGs. In fragile states the scope and potential for innovative financing is different than in countries with well-developed national health plans. Often the United Nations and NGOs play significant roles.

Moreover, their characteristics make it especially challenging to accelerate progress towards the MDGs. Often there is no effective state; if there is a functioning government the capacity of the Ministry of Health is severely limited. Fragile states have very low and often declining economic growth, and high rates of relapse into conflict.

In fragile states, particularly those that have experienced extended periods of conflict, health systems have typically been seriously eroded and damaged. Health infrastructure has been destroyed, or is not functional. Services are fragmented and ad hoc, differentially available depending upon where conflict-affected areas are located. Financial resources become scarce; for example, during El Salvador's civil war, per capita health spending dropped by 50%.²⁷ As public finance for health declines, private spending on health increases, and unpaid health workers shift to private practice. Better-off citizens may still be able to purchase care, but the poor and marginalized have fewer options, obtaining care wherever they can, and increasing their use of informal health-care providers.

A complicating factor is that there is sometimes no clear divide, or even tension, between humanitarian and development goals in fragile states. Humanitarian aid is aimed at saving lives in emergencies and conflicts and providing aid to refugees. It has a very short-term focus. Development aid on the other hand aims at reducing poverty and promoting sustainable development. Development goals are achieved through a long-term focus on interventions in health, democracy, education, infrastructure, and so forth.

For development efforts in fragile states, public-private partnership may be of particular interest. For example, contracting for service delivery has proved a viable option in countries where the public health services are not able to meet the demands of their population. Another reason for looking into options for how funds should be spent is that financial management systems are often weak, which raises significant fiduciary risks and concerns about providing funds through the government budget. In fragile states civil society has a particularly important role to play as government institutions and social safety nets are often lacking. Civil society organizations and NGOs should therefore be engaged to reflect on how funds can best be channeled to and spent in countries.

²⁶ 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); or (4) deteriorating governance (e.g. Côte d'Ivoire). Each year the lists are revised, so fragility is a status, not a permanent classification.

²⁷ Add ref

Box 14: Examples of health systems strengthening in fragile states

In Timor Leste a transition strategy was applied that moves from bypass to partnership with an increasing emphasis on systems issues. This case illustrates how international NGOs, donors, and government officials worked together to restore the health system after the breakdown in public institutions and services. At an early phase the approach relied on international NGOs but during latter stages, as capacity was developed, the government took on more and more responsibilities.

A similar approach was implemented in Afghanistan where a strong partnership was built between the Afghanistan government, international donors and local and international NGOs. Through the REACH programme, one third of the population could be reached with health services and significant investments were made in the health system. The government developed plans and policies for the health sector at national and local level. Information systems were also developed and strengthened to enable managers to monitor and evaluate activities.

Building stable systems for governance is essential as an end in its own right and a major contribution to overall state-building. Without oversight capacity in the health system, key institutions will remain weak and outcomes will not be delivered equitably. At the same time, building effective institutions takes time, energy and patience.

Sources: USAID. From humanitarian and post-conflict assistance to health system strengthening in fragile states: Clarifying the transition and the role of NGOs, 2008.

Eldon, Waddington and Hadi. Health system reconstruction: Can it contribute to state building? 2008.

High level forum on the health MDGs. Health in fragile states: An overview note, 2005.

USAID. Transforming a fragile health system. USAID Afghanistan, 2006.

Recommendations:

- **Design responses so that humanitarian assistance bridges into more long-term development engagement.**
- **Ensure long-term national institutional and health systems development is supported when setting up mechanisms for channelling of funds, including situations in which the multilateral system plays an important role.**

4. From political commitment to accountability for health outcomes and effective ways of working

Strong and clear accountability and means of monitoring progress are essential to meeting the pressing needs to accelerate health results, to raise more financial resources, and to find more efficient ways of working.

The recommendations in this report require further development in terms of operationalization, turning the proposals for innovative financing into more elaborated business cases and finding practical solutions for connecting and leveraging different options and components.

Working Group 2 further emphasizes that alongside the concerted effort to mobilize resources at the global level, low-income countries should be encouraged to consider and implement at least one of the innovative mechanisms presented in this report in order to raise domestic funds for health systems strengthening. Successful examples from individual countries could be scaled up by development partners and other governments.

Sustained and visible high-level *political support and engagement* for global and local health are almost as important as additional financial resources. More global and national champions need to become front figures for the importance of achieving tangible health outcomes.

Involving *the public* is important – not only to encourage private giving but also to maintain and increase public support and opinion for the goals and objectives of the Taskforce. Working Group 2 suggests the Taskforce build momentum for global solidarity by launching a new phase of the Global Campaign for the Health MDGs, including a multilingual website that would:

- track progress towards reaching the \$10 billion per year target;
- serve as a platform for raising funds from citizens and corporations;
- profile successful efforts to strengthen health systems and reach the health MDGs in low-income countries;
- encourage the participation of civil society and community groups;
- communicate timely, accurate and relevant information and evidence;
- foster regional networks and institution building.

There is a specific need for timely, accurate and relevant *information*. A strong health information system is fundamental to a robust health system, and can drive reform across the health sector.

Monitoring financial flows is important for national governments as well as for development partners and governments. The Accra Agenda for Action states that monitoring should be based on information generated by country-owned systems.

As has been highlighted throughout this report, building support for innovative financing

for health requires a strong focus on achieving results. As such, the work of the Taskforce has to be accompanied by visible investments in country systems that increase the availability of reliable information. There is a clear danger that, as so often in the past, more donor-led systems will consequently be imposed in order to help deliver the necessary information. Since its foundation in 2005, the Health Metrics Network's framework has been used by some 80 countries to assess their own health information systems in a standard fashion, and its use is formally endorsed by the Global Fund for access to its funds for health systems strengthening.

IHP+ inter-agency working group on monitoring and evaluation is developing tools and analytic approaches to enhance country capacities to critically evaluate and analyse available information, fill data gaps, and share and present data.²⁸

- The country health systems surveillance (CHeSS) is a tool to realize the principle that 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.
- Country "dashboards" are being designed to provide a regular assessment of health systems performance at national and district levels. The focus is on the national health sector strategic planning and monitoring and evaluation related processes.
- Monitoring and evaluation efforts including a global framework to monitor country compacts, now to be taken forward and operationalized country-by-country; the country health system dashboard tool to assess health systems performance;

The IHP+ Results Consortium is an independent "north-south consortium" of civil society researchers and advocacy organizations that assesses progress and maintains accountability of the IHP+ in supporting implementation of national health plans and strategies from funding inputs to health outcomes.²⁹

Accountability requires also proper and transparent *financial management*. In the broad sense, public financial management includes planning, budgeting and implementation, financial transfers to and from public bodies, accounting and reporting. Shouldering this requires capacity within public institutions, in particular ministries of finance, along with well-organized, independent auditing of public finances.

The formal and ultimate accountability for results at country level lies with national governments and elected parliamentarians. For development partners providing resources, accountability is an issue for their tax payers. For international organizations or foundations it is mainly a concern for their boards.

Given the strong political and financial engagement for the health MDGs combined with a very fragmented landscape and response there is a need for regular monitoring of overall progress in terms of results, financial flows and ways of working.

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<http://www.internationalhealthpartnership.net/pdf/IAWG/IHP+%20CHeSS%20scope%20of%20work%20for%20Update.pdf>

²⁹ The first external review of IHP+ is available at

http://www.internationalhealthpartnership.net/pdf/IHP_External_review_2008_EN.pdf

Initiatives have been taken during the past few years to enable mutual accountability as well as learning among key stakeholders at a high political level. The IHP+ Ministerial Review in February 2009 provided such an opportunity.

Working Group 2 recognizes the need to regularly *monitor and review progress* and suggests:

- Regular reviews of progress that 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.
- At the global level, convening a yearly informal *Health and Development Forum* with the purpose of joint reviews and learning – not decision making – that:
 - builds on the experiences from the IHP+ high-level ministerial meetings; and
 - involves over time all 49 low-income countries, the major international health actors, civil society, the private cooperate sector and the governments that provide substantive international development resources for health.
- WHO and the World Bank produce a yearly report on progress on health outcomes, financial resources and flows, and partner ways of working (this together with the OECD/DAC secretariat).

Recommendations:

- **Endorse existing international, standards-based approaches to building competent, locally-owned health information systems, including the framework developed by the Health Metrics Network, and call for international support for diversifying the tool-kit of such approaches.**
- **Undertake yearly well-prepared and structured sector reviews in countries involving all relevant stakeholders.**
- **Convene a yearly high-level “Health and Development Forum” to review progress on health outcomes, financial resources and flows, and partner ways of working, focusing on lessons learnt and key actions that will improve the delivery of results.**

Working Group 2 Members and Terms of Reference

Working Group 2 Members

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Terms of Reference

Working Group II will focus on the international financing aspects of the work of the Taskforce. The objective of WG II will be to recommend international innovative financing mechanisms that can assist in meeting the identified financial gaps and that by their design can tackle some of the constraints to scaling up country health systems. It will consider a range of approaches including raising additional funds by focusing on previously untapped sources, financial engineering, and financial solutions for effective implementation.

The Working Group will analyse costs and benefits of existing and potential public and private sector financing approaches. While the analysis will be focused on health systems it will take into account experience with innovative financing approaches in other domains.

The Working Group will consider the implications of different approaches on the wider aid architecture. Any recommendations of the Working Group should seek to ensure that the architecture in the health sector serves to reinforce the commitments made by development partners in the Paris Declaration and Accra Agenda for Action. Examining how funding flows come together at the country level in support of national health priorities will be important in this regard.

Working Group II will work in close cooperation with Working Group I. Working Group II will need substantial input from Working Group I on the specific types of flows needed (e.g. capital, upfront investments, recurrent flows, funding predictability) to support the needs and levels of flows identified by Working Group I. Working from a mutually agreed foundation, Working Group II will review and assess a range of innovative approaches, as

discussed at the first Taskforce meeting in Doha, to raising and delivering additional funding for strengthening health systems.

The work needs to capture the ambition and urgency expressed in the First Taskforce meeting in Doha.

Working Group II shall:

1. Report on the range of feasible approaches that:

- *provide additionality* in revenue raising and in securing long-term predictable funds, including, for example, innovative taxation, voluntary financing, and domestic sources of financing.
- *increase efficiency* in transferring funds through appropriate types of financing and possible financial intermediaries, financial markets, and by the use of financial engineering, for example matching the timing of funds flows with financing needs (i.e. frontloading or flexible flows) and managing the financial risks of the financing process in order to solve the key financial challenges linked to health systems strengthening ensuring predictability as well as sustainability.
- *increase effectiveness* in the delivery of funds and aid, by explicitly linking flows to achievement of concrete performance criteria or expected results.

2. Based on the above review, an analysis of the political feasibility of wider support make recommendations on:

- *Which instruments might be suitable in which contexts* based on
 - the costs and benefits of different approaches, including an understanding of the levels of financial risk;
 - how to involve the private sector and private sector approaches in raising resources and channeling them to countries considering, and how to establish the right incentives for private sector actors;
 - how voluntary and philanthropic contributions can be captured best and integrated effectively and efficiently into existing financial flows;
 - how the additional financial flows expected should be linked to existing channels and aligned with domestic policy agendas.

The feasibility of different options should mainly be technical, with political aspects being left to politicians to consider. However, the working group should prepare recommendations that can be supported, even if final decisions are for the politicians. Important also to consider what is feasible within current economic climate.

- *What adaptations of the existing international health architecture* are required in order for the Taskforce recommendations to be implemented in line with the recent Accra declaration on aid effectiveness. Major changes in the global health architecture are beyond the scope of the Taskforce, although new initiatives are likely to have some implications on existing architecture, and this should be considered in the Working Group recommendations, particularly if there is evidence that it would lead to greater effectiveness.
- *How to monitoring and evaluate* the impact of existing and additional resources for health systems. Monitoring impact should use existing mechanisms and country systems, as has

already been agreed as part of the IHP+ and the Paris Declaration and Accra Agenda for Action.

From the perspective of Working Group II, information on key quantitative and qualitative aspects of health systems and health systems strengthening is needed from Working Group I and other sources to assess and design innovative financing instruments. This includes, for example: Volume and period of time of funds needed; a detailed description of spending objectives; expected patterns of funding needs (e.g. frontloading or recurring costs); risks to the financing process including potential risks from unforeseen funding needs, country risks, and operational risks; entities involved and their incentives to deliver results; and market and government failures that need to be solved.

List of low-income countries, July 2008

Country	Region ³⁰		
Afghanistan	South Asia	IDA	HIPC ³¹
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
Côte d'Ivoire	Sub-Saharan Africa	IDA	HIPC
Eritrea	Sub-Saharan Africa	IDA	HIPC
Ethiopia	Sub-Saharan Africa	IDA	HIPC
Gambia, The	Sub-Saharan Africa	IDA	HIPC
Ghana	Sub-Saharan Africa	IDA	HIPC
Guinea	Sub-Saharan Africa	IDA	HIPC
Guinea-Bissau	Sub-Saharan Africa	IDA	HIPC
Haiti	Latin America & Caribbean	IDA	HIPC
Kenya	Sub-Saharan Africa	IDA	
Korea, Dem. Rep.	East Asia & Pacific	..	
Kyrgyz Republic	Europe & 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
São Tomé and Príncipe	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	

Source: <http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS>

³⁰ World Bank Regional Code

³¹ HIPC: Heavily Indebted Poor Country

Technical review report