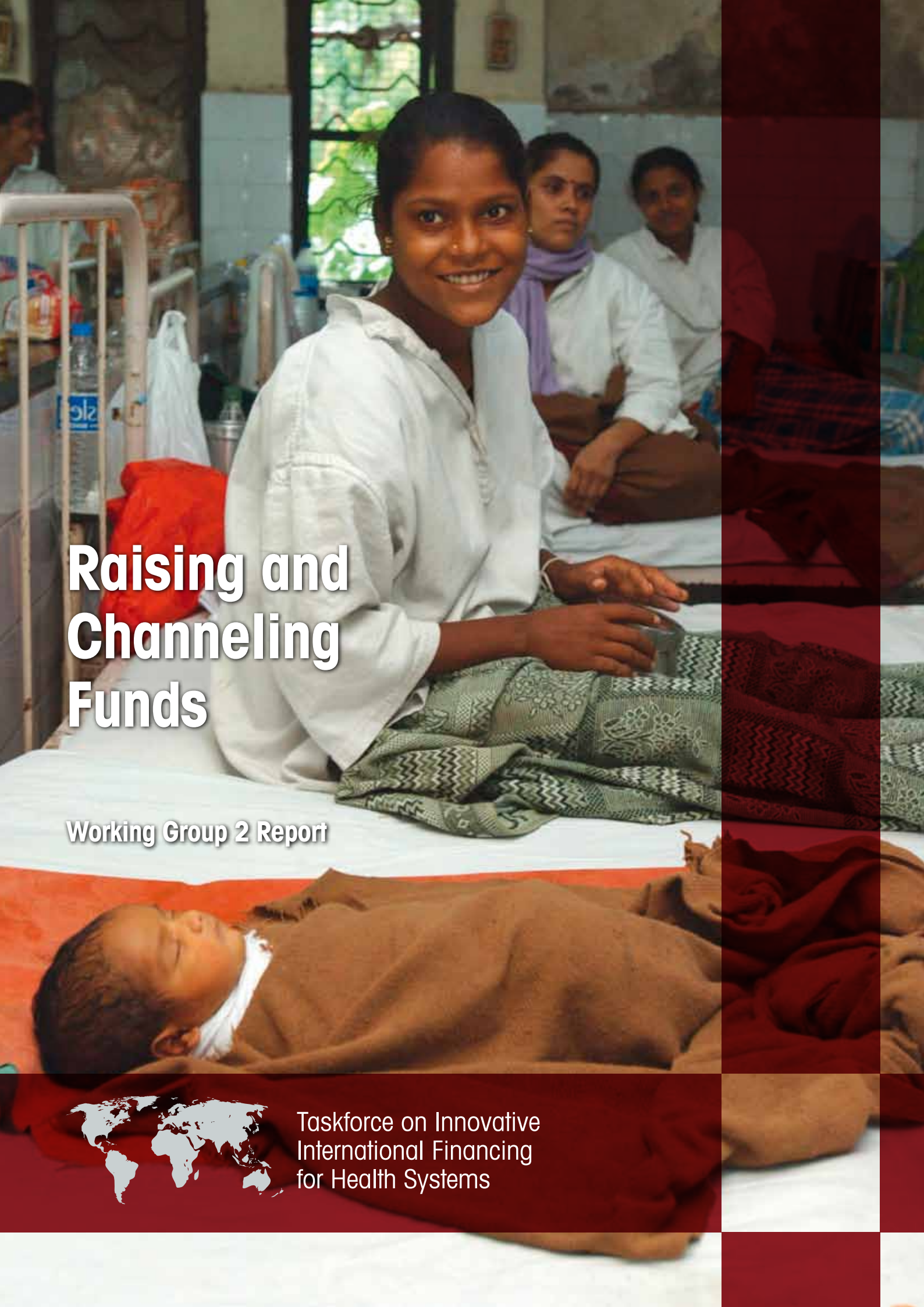

Raising and Channeling Funds

Working Group 2 Report

Taskforce on Innovative International Financing for Health Systems

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Preface

During the past decade we have seen impressive progress both in terms of improved health outcomes across the world as well as substantive increases in domestic and international funding for health. Despite this we still see major gaps and inequalities in health, especially in the poorest countries in the world. In many of these countries the health Millennium Development Goals are off track, in particular with regard to maternal and child mortality.

The Taskforce on Innovative International Financing for Health Systems was announced at the United Nations at a high-level event in New York on 25 September 2008. Its objective: to contribute to filling national financing gaps to reach the health MDGs through mobilizing additional resources, increasing the financial efficiency of health financing, and enhancing the effective use of funds. The Taskforce set up two working groups, one to analyse the constraints and costs to scaling up (Working Group 1), and one to make recommendations on raising and channeling funds (Working Group 2).

This report from Working Group 2 is the result of both a detailed technical review of options for innovative financing and an extensive consultative process with inputs from civil society, the private sector, donor countries, low-income countries, public-private partnerships and multilateral organizations.

The Working Group itself has been constituted of committed, experienced and highly skilled participants bringing expertise from a wide range of areas, including:

- Alice Albright (Chief Financial and Investment Officer, GAVI Alliance)
- Christopher Egerton-Warburton (Partner, Lion's Head Global Partners)
- David Evans (Director, Health Financing and Social Protection, World Health Organization)
- Rajat Gupta (Ex-Managing Director, McKinsey & Company)
- Susan McAdams (Director, Multilateral and Innovative Financing, World Bank)
- Jay Naidoo (Secretary General, Congress of South African Trade Unions)
- Kampeta Pitchette Sayingoza (Director of Macroeconomic Policy Unit, Ministry of Finance and Economic Planning, Government of Rwanda)
- Ismael Serageldin (Director, Alexandria Library)
- Christine Kirunga Tashobya (Public Health Advisor, Ministry of Health/DANIDA, Kampala, Uganda)

Susan McAdams provided invaluable leadership with her team at the World Bank producing the technical review section of our report.

Our work has been supported by Joanne McManus, Robert Fryatt, Anders Molin, Nicole Klingen, Laura Coronel, Justine Hsu and Jesper Sundewall.

Background papers were prepared by Mark Pearson and Andrew Rogerson.

Throughout the process we have also had a very close collaboration with Working Group 1 co-chairs Anne Mills and Julio Frenk.

I would like to express my deep gratitude to all for your dedicated and skilful contributions to this complex and extensive process leading up to the final report and its recommendations. Chairing the Working Group has been a truly rewarding experience.

Anders Nordstrom, Chair
Director-General
Swedish International Development Cooperation Agency

Summary and main recommendations

More money and better money

In the past decade governments in many low-income countries have increased spending on health. 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 people.

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 made 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. However, even if governments in low-income countries give more priority to health, they will still be unable for the foreseeable future 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 then international funding – from both governments and non-state sources – will have to complement domestic health resources.

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

The role of innovative financing

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. The International Finance Facility for Immunisation (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 together will provide new, predictable funding, as and when needed, from diverse sources. Working Group 2 suggests that the Taskforce set a specific target for raising funds through innovative mechanisms: US$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 as 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 funding is directed towards stimulating reform processes that will improve domestic modes of financing.

Health system challenges need both more money and "better" money, that is, more efficient and results-oriented use of resources.[2]

There is no one-size-fits-all approach to the best way to strengthen health systems and attain the health MDGs. However, a focus on health systems and delivering health services is consistent with a focus on specific health outcomes. The approach should be to connect all the required elements of a well-functioning and equitable health system in a more coherent manner and as efficiently and effectively as possible.

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

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.

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;
- predictable, long-term funding flows.

Main recommendations to the Taskforce

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 cooperation of international, regional, national, 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.

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.
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 the International Finance Facility for Immunisation (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.

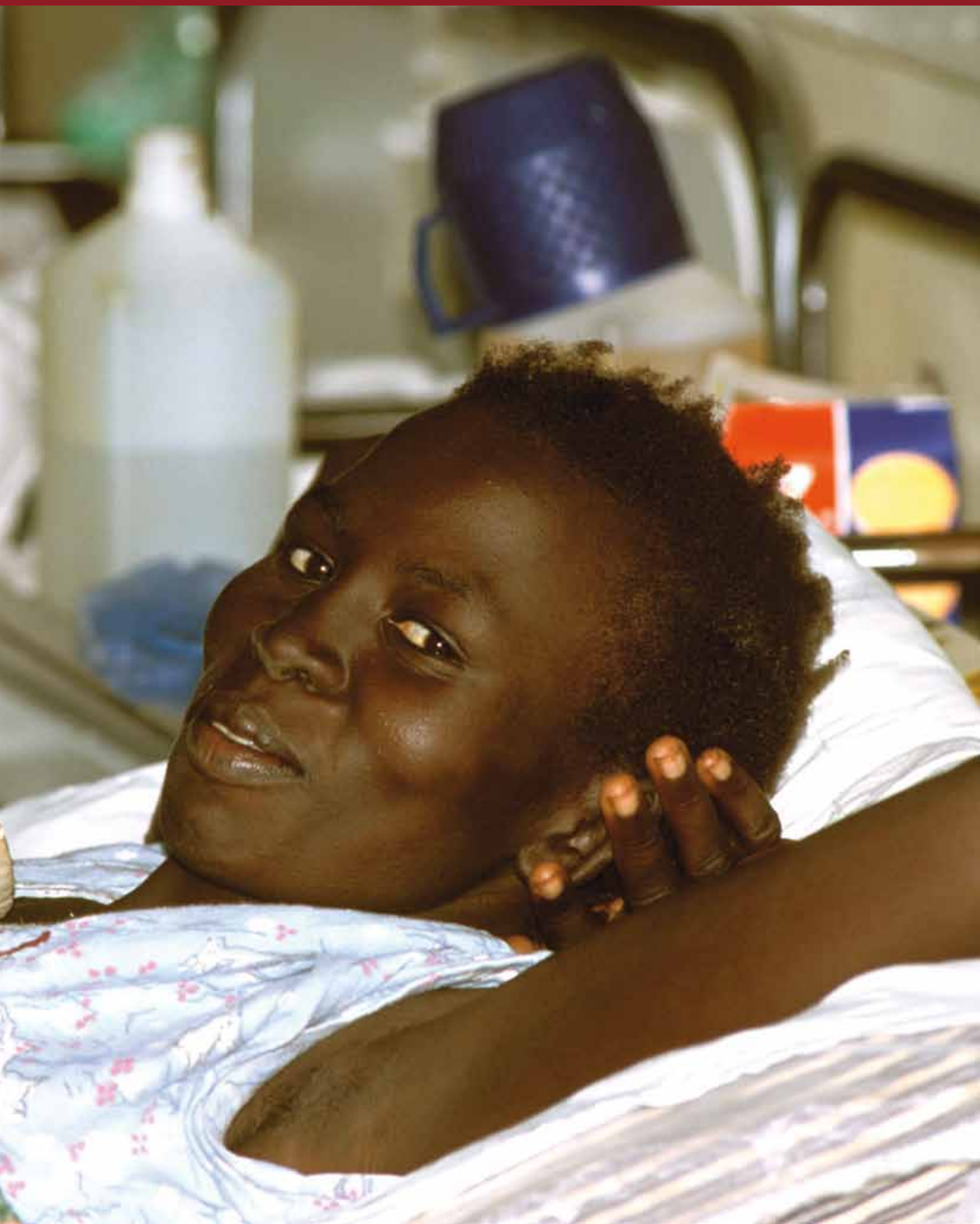
Streamlined channeling of funds

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 improve capacity in low-income countries to use resources for health systems 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 International Health Partnership and Related Initiatives (IHP+) principles and work to expand the number 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 "Health and Development Forum" to review progress on: health outcomes; financial resources, flows, and the Taskforce's target of raising $10 billion per year by 2015; and working in partnership. Focus on lessons learnt about how to strengthen health systems and on key actions that will improve the delivery of results.

Taskforce on Innovative
International Financing
for Health Systems



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 people.

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. 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). Often the countries making the least progress are those affected by high levels of HIV, economic hardship or conflict. The following key facts are from the most recent WHO progress report.[3]

- An estimated 112 million children are underweight.
- In 2007, some 9 million children died before their fifth birthday, including 3.8 million deaths from pneumonia and diarrhea, which are preventable and treatable.
- The global maternal mortality ratio of 400 maternal deaths per 100,000 live births in 2005 has barely changed since 1990. Every year an estimated 536,000 women die in pregnancy or childbirth. Most of these deaths occur in sub-Saharan Africa where the maternal mortality ratio is 900 per 100,000 births.
- There were an estimated 2.7 million new HIV infections during 2007, and deaths are increasing in parts of Africa, particularly eastern and southern Africa. Although the use of antiretroviral therapy has increased, in 2007 about two thirds of the estimated 9.7 million people in developing countries who needed the treatment were not receiving it.
- The availability of medicines at public health facilities is often poor. Surveys in about 30 developing countries show that availability of selected medicines at health facilities was only 35% in the public sector and 63% in the private sector. Lack of medicines in the public sector often means patients must either purchase them privately or do without treatment.

Investing in health systems that provide access to guaranteed health benefits would save millions of lives and also be an important and efficient means of obtaining and securing people's basic human rights. 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 to 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 meet the

3 http://www.who.int/mediacentre/factsheets/fs290/en/print.html

health MDGs through mobilizing additional resources for health systems; to increase the financial efficiency of health financing; and to enhance the effective use of funds.

The global economic and financial crisis makes the work of the Taskforce both more relevant and more urgent. According to World Bank forecasts, as many as 53 million more people could be trapped in poverty as economic growth slows around the world, and 200,000-400,000 more babies could die each year between now and 2015 if the crisis persists.[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, and that 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.

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 list of members and 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 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.

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 from country to country, but to sustain levels of health there is a growing consensus about 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 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 microfinance schemes helps keep children in schools, empowers women, and boosts the long-term health prospects of their families.

Source: Excerpt from 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

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 of publicly financed and provided services, and the activities of the private sector, whether in financing, service provision or the supply of inputs such as pharmaceuticals and equipment. Most important, it encompasses not only 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 mec hanisms needed to ensure that services are responsive to population needs and demands; and the policies needed to promote healthy environments and lifestyles."

4 http://go.worldbank.org/1FWPZ7KCJ0

There is no one-size-fits-all health system and no single approach to strengthening health systems 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.

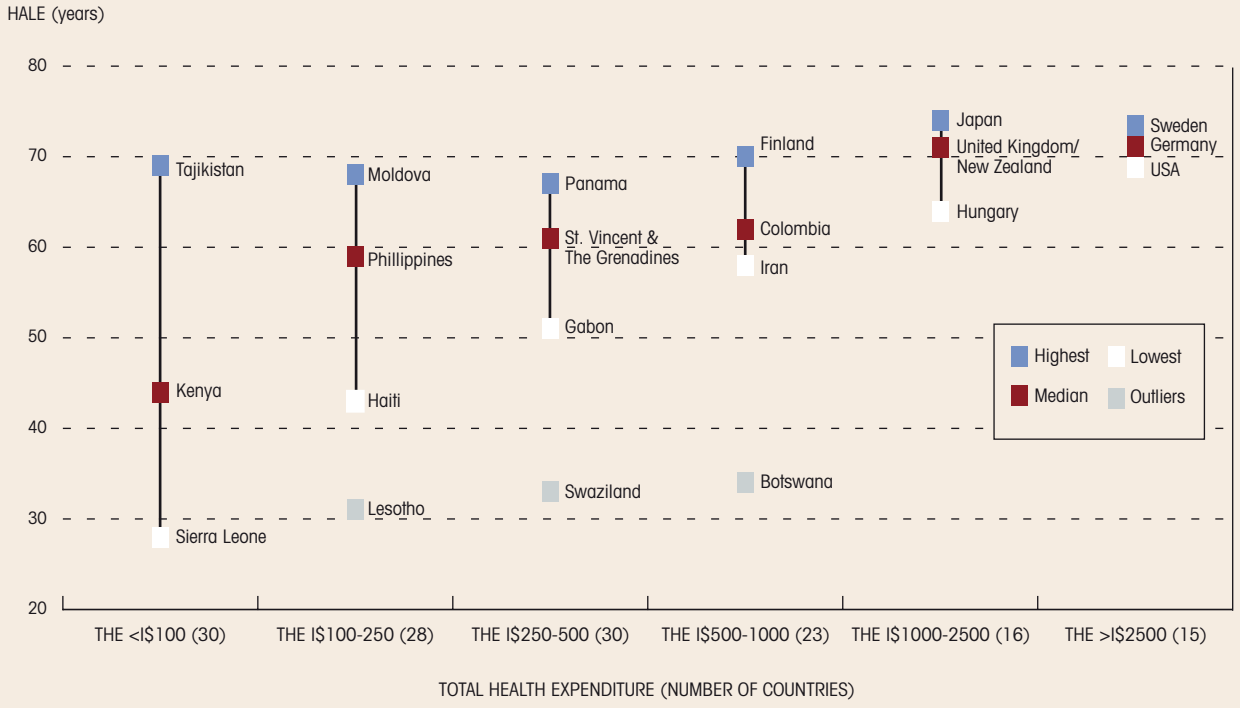
Several middle-income countries have achieved universal or near universal coverage, but almost all of the 49 low-income countries are far from being able to ensure their citizens have universal access to quality care according to their needs, regardless of their income and socioeconomic status.

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. Although the degree of 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 the other constraints are recognized and addressed, countries will find it difficult to absorb and use additional finance effectively.

For example, governance needs to be strengthened and sometimes modified to enable rapid scaling up in a way that produces results. Governance includes setting the strategic direction of the health system, designing how the system is managed, arranging for user and other stakeholder involvement, ensuring accountability and transparency, implementing regulatory arrangements, and gathering intelligence and information.[5]

Because all parts of the health system influence each other, health system support has to adopt a broad, holistic view instead of working with individual components in isolation. Focusing on health systems and the delivery of health services is consistent with focusing on specific health outcomes (e.g. the health MDG targets). The approach should be to connect all the required elements of a well-functioning and equitable health system in a more coherent manner and as efficiently and effectively as possible.

Figure 1: Higher spending on health is associated with better outcomes, but with large differences between countries*



* Countries grouped according to their total health expenditure in 2005 (international $)
HALE: Health-adjusted life expectancy

Source: World Health Report 2008.

5 Working Group 1 report.

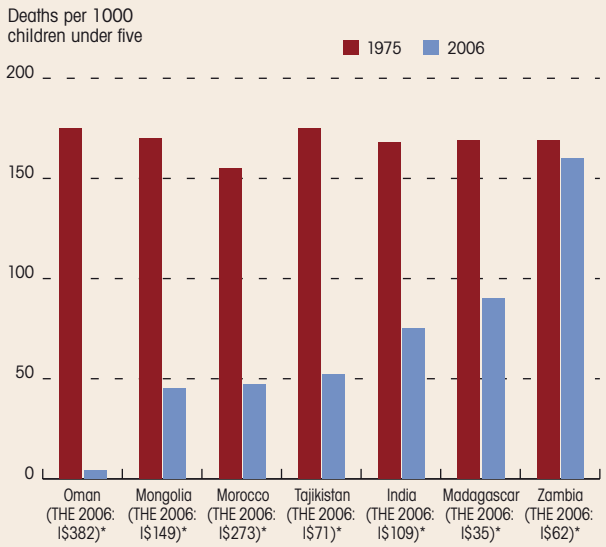
C. Financing health outcomes and effective health service delivery

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 the health services needed. 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, and $12 passed through government budgets. These figures for public and private expenditure include the contribution of international resources, which amounted to $6 per capita. Despite recent increases in development assistance for health, it is on average a relatively low proportion of total health expenditures (25%).[6]

Out-of-pocket spending, which is a much higher proportion of total health expenditure in low-income than in 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 to receive 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.

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



* Total health expenditure per capita in 2006 (international $)

Source: World Health Report 2008.

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 to 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%.[7]

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 figures 1 and 2.

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 governments in low-income country give more priority to health and, for example, meet the Abuja target, they would still be unable for the foreseeable future to meet the required costs of scaling up health systems and providing universal coverage of guaranteed health benefits. This means that if low-income countries are to reach the health MDGs then international resources – from both governments and non-state sources – will have to complement domestic health 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 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 scaling up of services.[8]

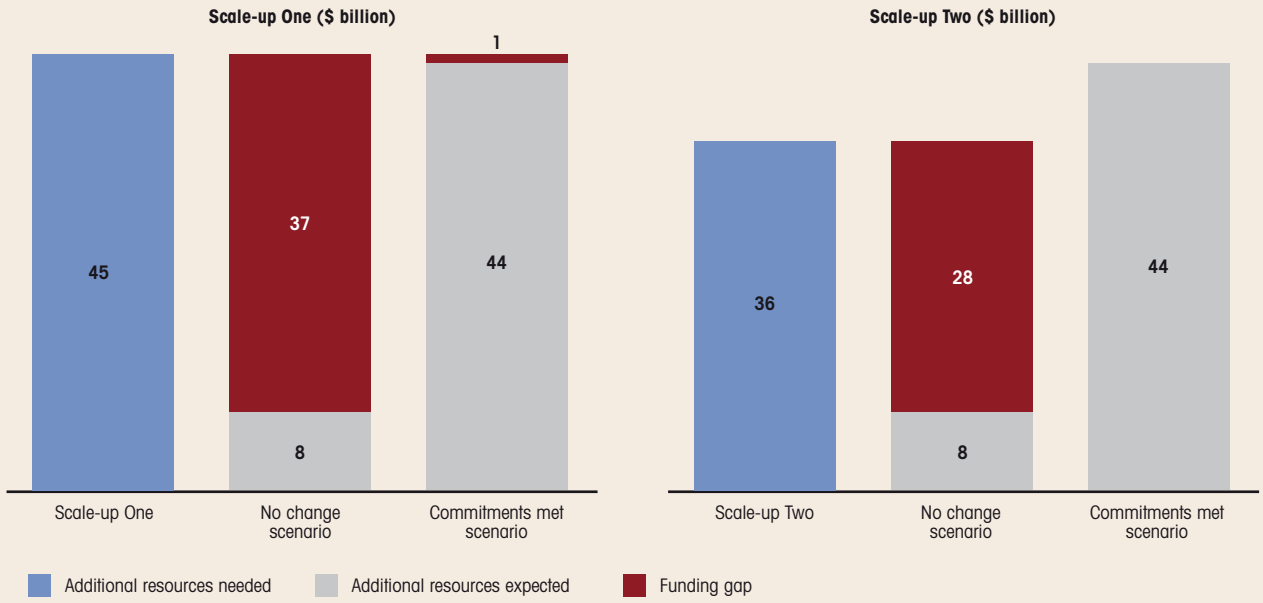
Making rapid progress towards the health MDGs in low-income countries requires more than doubling current annual health expenditures. It would cost by 2015 an additional US$ 36-45 billion per annum on top of the estimated $31 billion that is spent today in low-income countries (Figure 3). Two thirds or more of total costs need to be devoted to

6 Annex 4a, Working Group 1 report.

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

8 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, in US$ billions



Source: Based on data from Working Group 1.

general health system support, which includes multipurpose health workers and facilities, as well as the necessary investments in logistics, information systems, governance, financing systems, and so forth.

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). In order 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 made available in an entirely predictable and sustained manner.

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 would 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.

More development partners will need to meet their commitments and more resources will need 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 also essential to improve the quality of development assistance for health.

Table 1: Additional costs (in constant 2005 US$)

	Scale-up One	Scale-up Two
Total additional costs 2009-2015	251 bn	112 bn
Total additional costs in 2015	45 bn	36 bn
A. Resources available 2015 Assuming no-change scenario but same growth as past years	8 bn	
B. Resources available 2015 Assuming ODA and Abuja commitments met	44 bn	
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.

E. International development assistance for health today

Since the adoption of the Millennium Declaration, commitments to development assistance for health (DAH), including those from governments, multilateral agencies, private foundations and NGOs, have more than doubled: from $6.8 billion in 2000 to $16.7 billion in 2006.[9] 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 has current annual expenditure of around $3 billion.[10] However, as Figure 4 shows, most of the growth in DAH has come from bilateral agencies in high-income countries.

Official development assistance (ODA) for health, the largest component of DAH (see Box 2 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.

Figure 5 uses data from the United States which show that most of the increase in DAH has been allocated to the fight against HIV/AIDS.

Although this dramatic rise in DAH since 2000 has saved millions of lives, a number of challenges are presented by the way in which development assistance is organized and implemented. ODA is not organized in a way that is conducive to providing funds for overall health systems strengthening in low-income countries.

- Donor support for the health sector is extremely fragmented, reflected in the fact that only a small proportion of health ODA is channeled through direct budget support (the Paris Declaration target is 66%).[11]
- Low-income countries are the direct recipients of only one third of all health ODA, although 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.
- Between 2002 and 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.[12]

9 *Global monitoring report 2008*. Washington DC, World Bank and IMF, 2008. http://go.worldbank.org/J20HF0QLL0

10 McCoy D et al. The Bill & Melinda Gates Foundation's grant-making programme for global health. *Lancet*, 2009, 373:1645-1653.

11 Greco G et al. Countdown to 2015: assessment of donor assistance to maternal, newborn, and child health between 2003 and 2006. *Lancet*, 2008, 371:1268-1275.

12 *Effective aid, better health*. Report prepared for the Accra High Level Forum on Aid Effectiveness 2-4 September 2008. Geneva, World Health Organization, 2008.

Box 2: 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%.

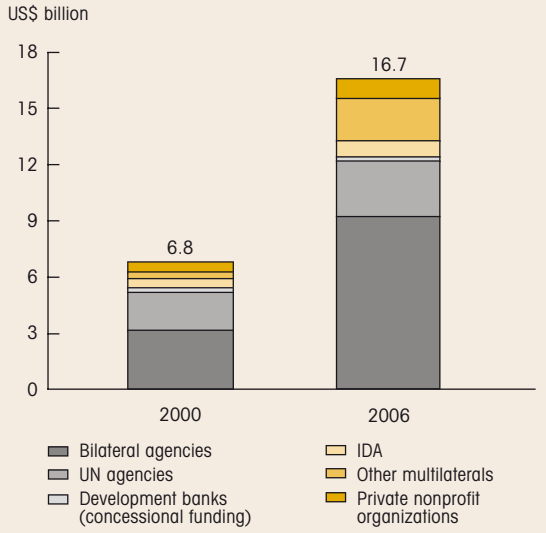
Development assistance for health (DAH) is broader than ODA. It includes nonconcessional loans provided by the World Bank and regional development banks to developing countries and funds from private foundations and NGOs (own funds) that contribute directly to the promotion of development and welfare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

Sources: Is it ODA? OECD Fact sheet November 2008. www.oecd.org/dataoecd/21/21/34086975.pdf
International Development Assistance and Health: The Report of Working Group 6 of the Commission on Macroeconomics and Health, WHO, 2002. http://whqlibdoc.who.int/publications/9241590140.pdf

- A substantial proportion (41% in 2006[13]) 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. For example, average annual health ODA per capita between 2002 and 2006 was $20 in Zambia and $1.6 in Chad.[12]
- The health systems windows offered by certain global health initiatives have been limited to activities related to specific diseases and do not address the need for all the health interventions identified by Working Group 1 to be scaled up at the same time.
- Commitments are sometimes not translated into disbursements and a proportion of disbursements do not reach countries. An IMF internal evaluation unit report recently found that in 29 sub-Saharan African countries between 1999 and 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.[14]

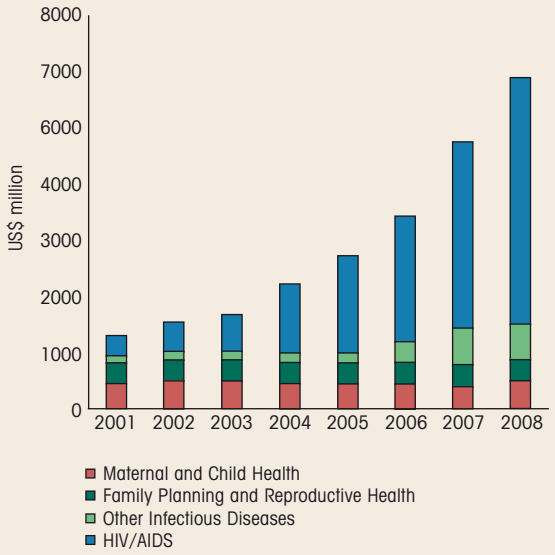
Despite the recent increases in DAH, the level of assistance remains insufficient. Many OECD countries have not yet met their international commitments. More aid will be required, and it is important to ensure that it reaches countries and that it is used to improve health outcomes. Figure 6 uses an example from Cambodia to illustrate the extreme disconnect between donor disbursements and national health priorities.

Figure 4: Growth in commitments to development assistance for health



Source: World Bank 2008

Figure 5: Spending on global health, USA (2001-2008)

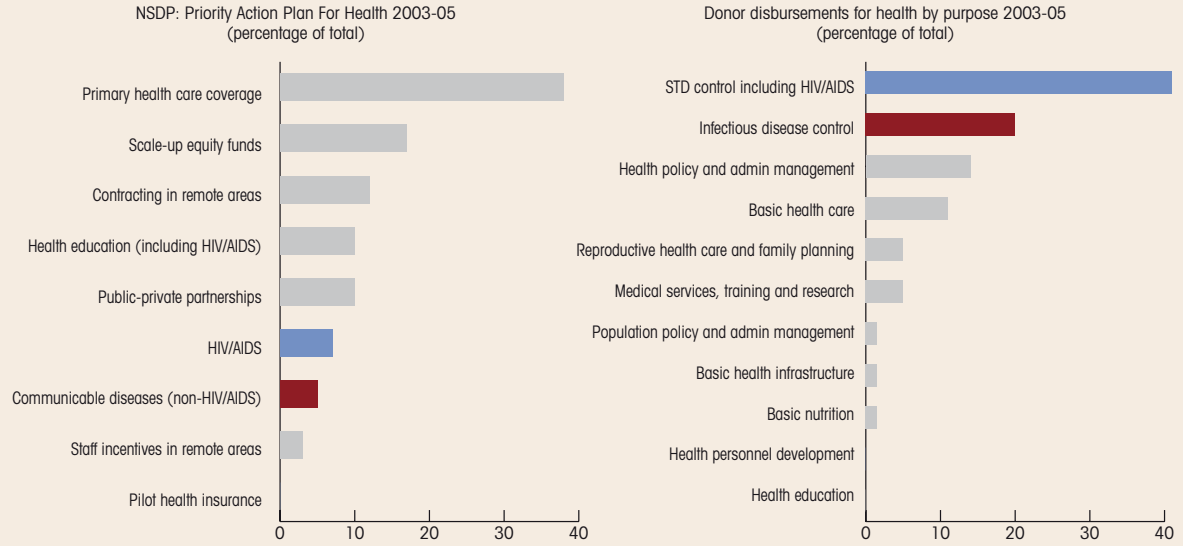


Source: US Congressional Research Service 2008

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

14 Rowden R. *The case for reconsidering IMF macroeconomic policies*. Background paper prepared for the Taskforce on Innovative International Financing for Health Systems, 2009.

Figure 6: Health plan priorities versus donor disbursements (2003-2005) Cambodia[15]



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

As noted by Working Group 1: "The problems of fragmentation, unpredictability and targeting of development assistance to the delivery of specific technologies have become so visible that they have resulted in a universal call for a coordinated effort to support the country health systems that all disease and programme-specific efforts must ultimately rely on". This problem was also highlighted at the Third High Level Forum on Aid Effectiveness in Accra in 2008.[16]

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 3).

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.

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

- International Finance Facility for Immunisation (IFFIm)
- Solidarity Contribution on Air Tickets
- 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.

15 Pearson M. *Expanding predictable finance for health systems strengthening and delivering results.* Background paper prepared for the Taskforce on Innovative International Financing for Health Systems, HLSP, 2008.

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

Box 3: 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.

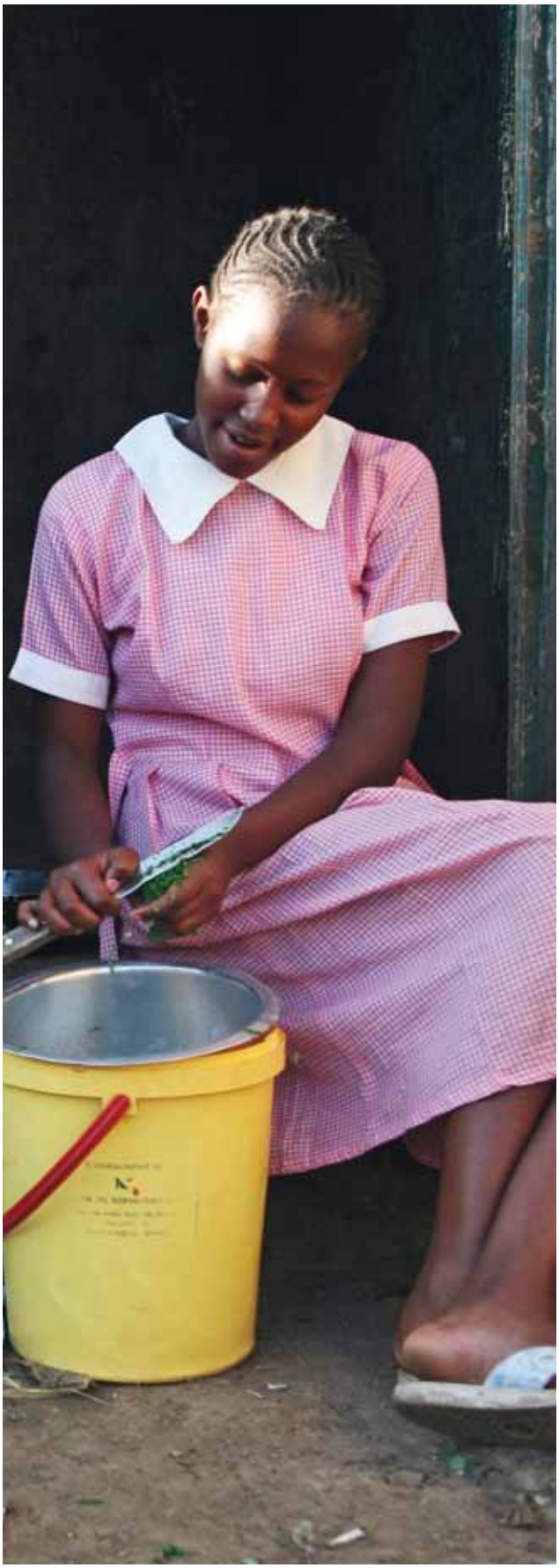
…We recognize the considerable progress made since the Monterrey Conference in voluntary innovative sources of finance and innovative programmes linked to them. We acknowledge that a number of the initiatives of the Technical Group created by the Global Action Initiative against Hunger and Poverty and 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

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

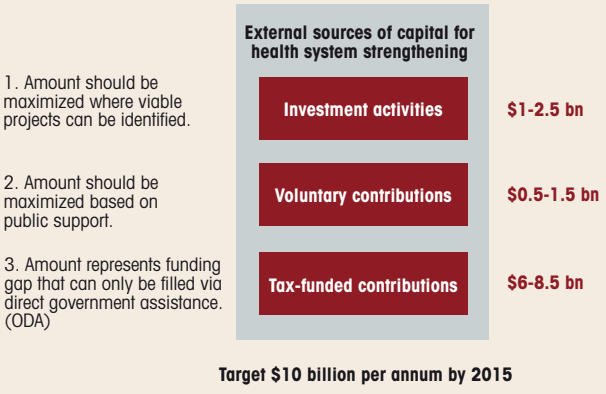
A. The role of innovative financing

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. However, as described in Chapter 1, there is a clear and substantial international annual funding gap. This chapter seeks to review how additional international resources could be mobilized so as to contribute to filling that gap, recognizing that any such programme would need to be coordinated 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 Taskforce:

• Set a target to raise an additional $10 billion in international resources per year by 2015 to spend on health in low-income countries.

Figure 7: 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, an essential 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.

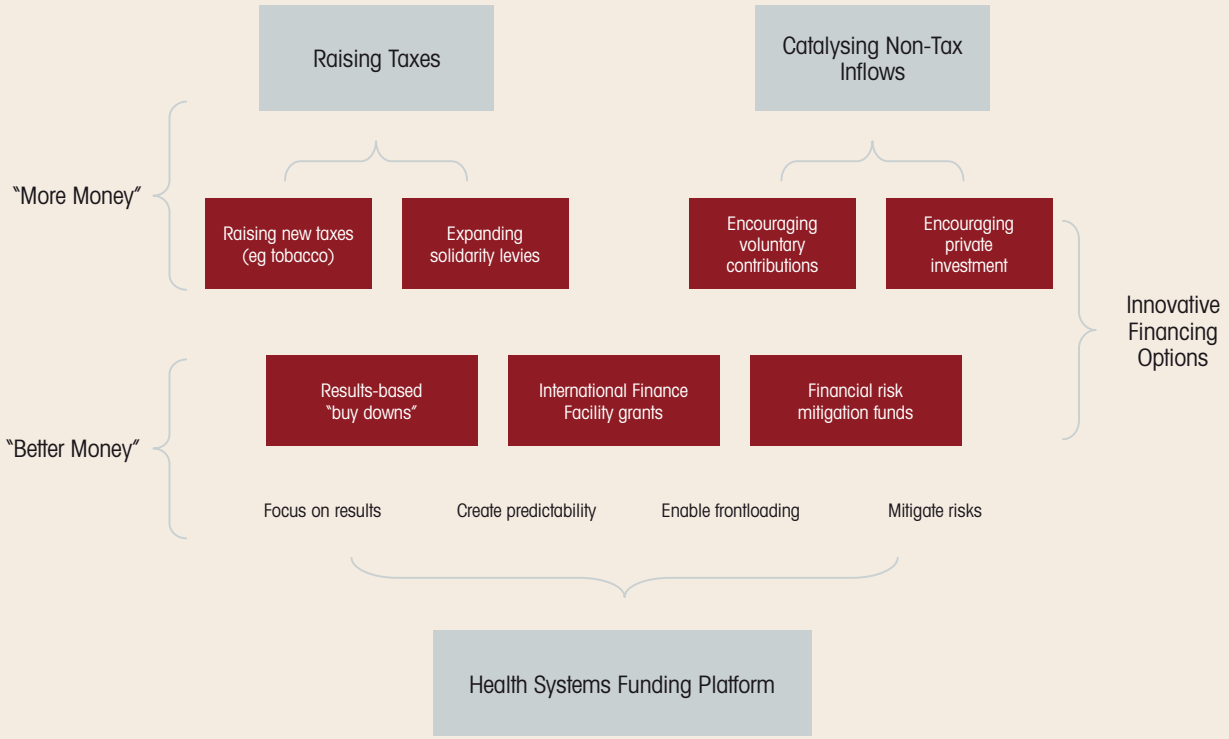
Innovative development finance involves non-traditional applications of ODA, joint public-private, or private mechanisms and flows[17] that (i) support fund-raising by tapping new sources and engaging partners as investors and stakeholders, or (ii) deliver financial solutions to development problems 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, whether 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 in both donor and 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 there are interesting experiences in this area from innovative financing mechanisms.

17 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.

Figure 8: Types of 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.** This 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 sector 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.

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. Figure 8 illustrates how the types of mechanisms could fit together. The red boxes represent different approaches to innovative financing. These activities represent the link between "more money" and "better money" discussed in further detail below.

Working Group 2 recommends the Taskforce:

• Actively explore the links and possibilities for leveraging in the design, rethinking or establishment of different instruments, recognizing that innovative financing mechanisms are complementary.

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 plan and manage their development programmes effectively. It is also a precondition for desired strengthening of country ownership. IFFIm and the Advance Market Commitment pilot have shown that 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.

Working Group 2 recommends the Taskforce:

• Increase the predictability of development partners' 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 Box 4.

Box 4: 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 (setup 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 the predictability and 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 transaction costs (estimated to be 1-3% of revenues) and sustainability. At the same time, these mechanisms can be complex and difficult to implement both technically and politically. This last consideration may be exacerbated by 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, Côte

d'Ivoire, Madagascar, Mauritius, Niger and South Korea). UNITAID is the primary but not the 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.** This is 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.[18]

iii. Raising the tax rate on specific products, particularly those harmful to health, such as a **tobacco products tax** (152 countries already have such taxes) – a nationally implemented, internationally coordinated proposal that could, like the air ticket levy, be implemented in both developing and developed countries (Box 5).

Box 5: 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 Thailand's 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 transaction 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 the usage of funds in countries.

Source: Tobacco Free Initiative, World Health Organization. *Innovative health financing: earmarking tobacco taxes.* Background paper prepared for Working Group 2.

These levies and taxes vary with respect to the 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 rapid.
- 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. (Sponsors may want to explore other taxes with positive externalities, such as taxes on alcohol, fast food or drinks high in sugar and salt.)

Working Group 2 recommends the Taskforce:

• Further explore the necessary implementation steps for taxes or levies that enjoy strong government sponsorship, including airline levies, currency transaction taxes and expanded tobacco taxes.

2. Innovative approaches that improve the predictability and 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 system 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 been shown to be feasible with IFFIm (Box 6) and the AMC pilot. The European Union's MDG contract is a longer-term, more predictable form of general budget

18 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 that of transaction fees, and was 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 considered carefully.

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 sufficient funds are available subsequently to meet the necessary 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 in health systems 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 funds raised through it.

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 channeled 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 leveragability in the capital markets. This combination of ideas could improve predictability and enhance the amount of funds available on a frontloaded basis.

Box 6: International Financing Facility for Immunisation (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 are used to 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 to the health system challenges facing its country partners. It is particularly effective for immunization because it allows the 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 that which the underlying governments would incur had they borrowed sums of similar sizes annually and forwarded proceeds to GAVI.

Working Group 2 recommends the Taskforce:

• Consider proposals that better match the timing of funding available and needs, including more use of long-term commitments and guarantees, and assess the potential for mechanisms such as IFFIm to 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, although there is some scope for not-for-profit insurance especially as part of a 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 of both public and private subsectors, in many combinations. In many low-income countries, the non-state subsector (meaning anything that is not public, 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 and the level of cost for poor people are not always optimal. There are 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 government's role 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 (Box 7).

Box 7: Examples of private sector investment in low-income 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 US-headquartered non-profit organization, 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.

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 are 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.

There is a particular desire to ensure an ongoing focus on the poorest countries and the poorest people in those countries, and to ensure alignment with the overall planning and priority setting activities within each country's health sector. Risk appetite towards incremental private investment is another challenge that needs to be considered. One of the factors constraining larger-scale 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.

Table 2: Examples of different types of mechanisms

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

A number of examples illustrate the potential of private sector investment, at scale, in health-care delivery in the poorest countries (Table 2). Capital-pooling mechanisms increase at-risk and debt capital to the private sector (including both 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.

Working Group 2 recommends the Taskforce:

- **Capitalize a fund[19] that works in coordination with other facilities to purchase or provide guarantees to private sector investors to absorb certain risks, and develop strongly defined eligibility criteria for accessing the funds.**
- **Ensure the fund facilitates local currency lending capability through local banks and co-invests where targets are focused 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, and regulatory and other requirements to better manage 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 transaction 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.

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 funds for health systems. 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 transaction 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.

19 This 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.

Several mechanisms focusing on charitable contributions have been considered:

i. **Private Giving Campaign:** This 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 donate voluntarily 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 governments 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 phones to donate voluntarily 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. Proposals 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 entail higher set-up costs but could also result in significant benefits.

iii. **De-Tax:** This is 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:** This is a proposal to 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.

These mechanisms are complementary, and implementing a range of them would maximize both 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.

Working Group 2 recommends the Taskforce:

• Provide public catalytic funding for the development of a range of large-scale private giving initiatives where market research indicates that a material source of sustainable finance can be derived from them.

Box 8: 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 burgeoned. The Chinese Red Cross now receives significant contributions for disaster relief outside China. Overall, donations climbed from $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 $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 health care in the states of Andhra Pradesh and Bihar.

Sources: *The China Daily*, April 3 and December 5, 2008.
Walsh B. Learning the art of giving. *Time Magazine* September 4, 2006.
Asia Pacific Philanthropy Consortium

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. Buy-downs have supported IDA projects worth about $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 by the 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 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).

Working Group 2 recommends the Taskforce:

• Consider establishing or expanding existing funds for results-based "buy-down" funding and/ or "Debt2Health" to fill financing gaps for health systems development.

Table 3: Innovative mechanisms: potential benefits and costs

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

Revenue potential
Assuming that a broad range of countries would participate in mechanism
$$$$ double digit billions of US dollars annually
$$$ single digit billions of US dollars annually
$$ hundreds of millions of US dollars annually
$ less than hundreds of millions US dollars annually

Costs
+ less than 5% of revenues
++ 5-20% of revenues
+++ 20% of revenues and more

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. Table 3 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 together will provide new, predictable funding, when and as needed, from different sources.

3. More health for the money

The success of any innovative financing mechanism adopted by the Taskforce will be measured not only 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 channeling 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

It is a widely recognized problem that the present health aid "architecture" is not efficient enough and that transaction costs are too high both for countries that benefit and for 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 of Working Group 1's report: "How innovative financing is raised is of less concern to low-income countries than how funds are 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 ministry of health budgets, 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:[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 funding channels 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.

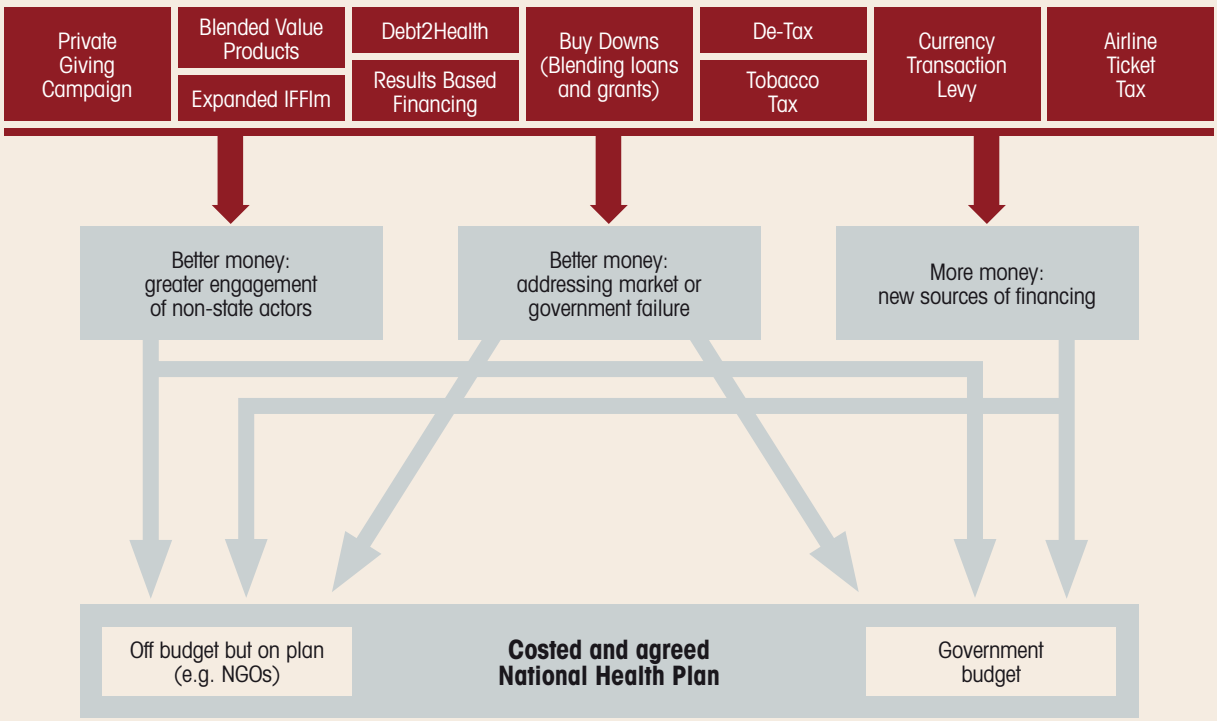
Figure 9 shows the major innovative mechanisms identified in Chapter 2. From a channeling perspective the challenge is to ensure that funds support quality assured health plans based on the principles of the International Health Partnership and the Paris Declaration on Aid Effectiveness.

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 Figure 9, all innovative financing should support health plans and budgets. It could be allocated through government budgets as general, sector or earmarked

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

Figure 9: Channeling funds from innovative mechanisms to countries[21]



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.

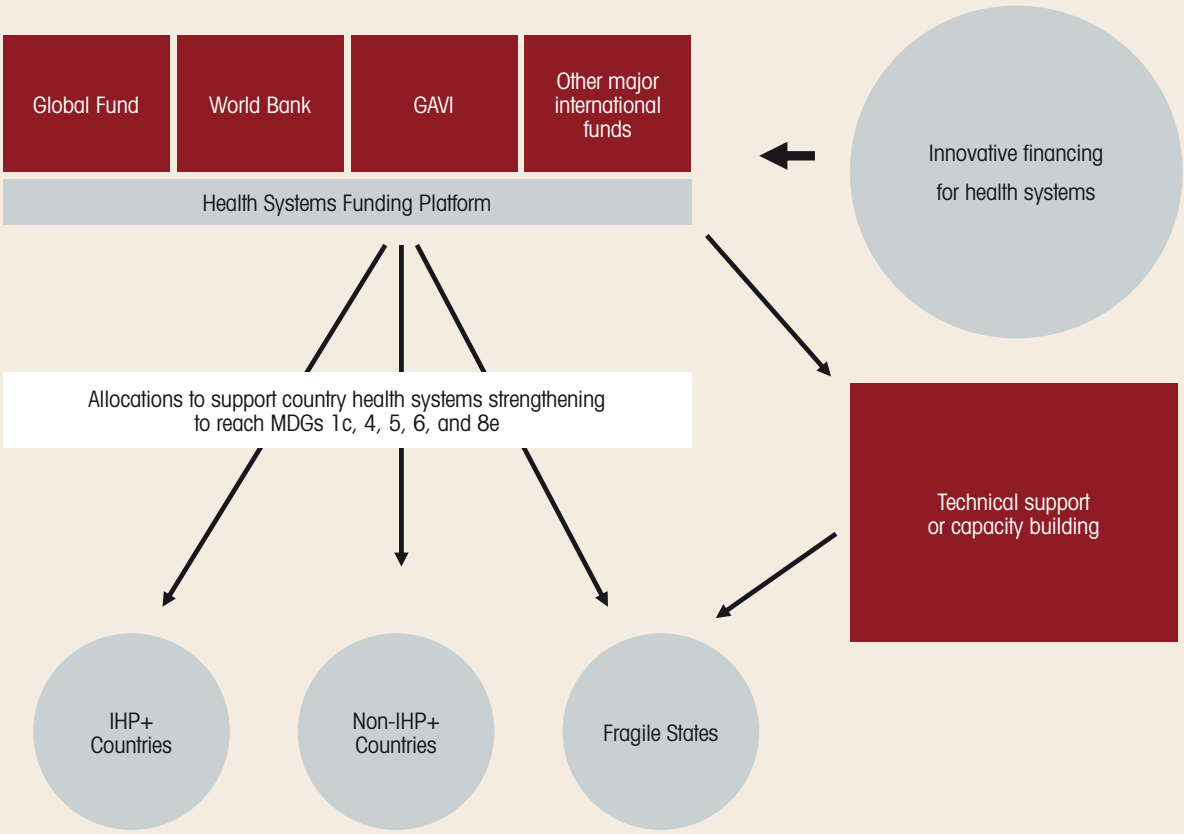
Innovative financing raised for health systems strengthening should be used to fund costed and agreed national health plans that address the entire health system. At the global level, Working Group 2 suggests the Taskforce makes a strong recommendation for pooled approaches and takes action towards realizing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

21 Pearson M. *Expanding predictable finance for health systems strengthening and delivering results.* Background paper prepared for the Taskforce on Innovative International Financing for Health Systems, 2008.

Figure 10: Proposed health systems funding platform for low-income countries[22]



As far as 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 the 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.

Figure 10 represents 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 transaction 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, and others) or to the Health Systems Funding Platform itself.

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 national development plans that aim to achieve all the MDGs.

22 Pearson M. *Expanding predictable finance for health systems strengthening and delivering results*. Background paper prepared for the Taskforce on Innovative International Financing for Health Systems, HLSP, 2008.

Working Group 2 recommends the Taskforce:

• Facilitate the establishment of a Health Systems Funding Platform for the GAVI Alliance, the Global Fund, the World Bank and others to coordinate, mobilize and channel 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.

• Make funds available, as and where required, to improve capacity in low-income countries to use resources for health systems strengthening 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 identifying the key health systems constraints and bottlenecks that need special attention. The IHP+ provides one possible framework with its country compacts[23] based on the principles of 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 to be a useful umbrella for responding 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, the financing of national health systems and services should be based on prepayment (with subsequent risk pooling and risk sharing) either through general taxes or insurance or a 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 another but recognizes that the needs of the country should dictate which model to apply. It also recognizes the need for flows of international funds to complement, rather than handicap, the move towards prepayment and pooling of the country's own domestic funds for health (Box 9).

Box 9: 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 health insurance schemes and public subsidies for the poor has 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" – 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. Sharing the burden of sickness: mutual health insurance in Rwanda. *Bulletin of the World Health Organization 2008*, 86:823-824.

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

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

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.[24]

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.[25]

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 providing services to countries. 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 significant scope for: investing more in national capacity to manage procurements of commodities; and 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 extends 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 $500,000 and $1 million, AccessRH is expected to save $3-11 million in its first three years of operation.[26]

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 strategies is of great importance, especially civil society and the private sector. Major steps have been taken at the global and country levels in order to better coordinate partners (for example, the H8,[27] national sector mechanisms, the Global Fund Country Coordinating Mechanism 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 (Box 10). 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.

Fifth, a substantive share of international resources today is spent on technical assistance. However, it has 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 obtain the greatest possible 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 of addressing problems of leadership and managerial capacity, and of building long-term sustainable capacity.

The United Nations has a special role to play in enhancing the efficiency of technical assistance, but needs greater understanding of 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 and national health finance policies and schemes).

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

25 de Savigny D. *Fixing health systems (second edition)*. Ottawa, International Development Research Centre, 2008.

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

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

Box 10: 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

Improved capacity is needed, not only for public actors such as ministries of health, but also for 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.

Working Group 2 recommends the Taskforce:

- **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 engage strategically and actively with civil society, the corporate sector and other relevant stakeholders, based on their specific roles and mandates.**
- **Commission a review of the effectiveness of technical assistance aimed 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 of 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 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 policies. 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 (Box 11). These experiences have shown that well-designed and implemented CCT programmes can have a wide range of good outcomes, e.g. efficient targeting, increased food consumption and improved school enrolment.

Resources from the World Bank's International Development Association (IDA) and from the other multilateral development banks are already allocated on the basis of performance (Box 12). The Global Fund and GAVI have built innovative financing instruments on the concept of RBF.

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. Mechanisms are also in place for reviewing performance and progress.

Box 11: 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 on 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 A, Schady N. *Conditional cash transfers: Reducing present and future poverty*. Washington DC, World Bank, 2009.

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

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 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 must be agreed and clearly communicated from the start.

Box 12: Performance-based incentives

The World Bank is currently managing a total of $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 responsibilities to meet donor demands and can be operated at global, regional and country levels.

One example is 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 in eight to ten pilot countries to establish incentive systems that reward good performance. Technical support is being provided and implementation will be closely monitored. The 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 Medicine*, 2007, 4(8).

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

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

Working Group 2 recommends the Taskforce:

• 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 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.[28] 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 are different from those in countries with well-developed national health plans. Often the United Nations and NGOs play significant roles (Box 13).

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, ad hoc and 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%.[29] As public finance for health declines, private spending on health increases, and unpaid health workers move into 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.

Working Group 2 recommends the Taskforce:

- **Design responses so that humanitarian assistance forms a bridge with more long-term development engagement.**
- **Ensure long-term national institutional and health systems development is supported when setting up mechanisms for channeling humanitarian assistance, including situations in which the multilateral system plays an important role.**

Box 13: 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, both as an end in its own right and as 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. However, building effective institutions takes time, energy and patience.

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

Eldon J, Waddington C. *Health system reconstruction: Can it contribute to state building?* HLSP Institute, Health and Fragile States Network, London, 2008.

Rural expansion of Afghanistan's community-based health care program (REACH). *Transforming a fragile health system. Management Sciences for Health*, USAID Mission to Afghanistan, 2006.

28 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.

29 Castillo G. *Rebuilding war-torn states: the challenge of post-conflict economic reconstruction.* Oxford University Press, 2008.

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4. From political commitment to accountability

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.

A. Political support and public engagement

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,[30] 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.

B. Information, monitoring and evaluation

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 must be accompanied by visible investments in country systems that increase the availability of reliable information. Otherwise 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. There are several efforts underway that merit the Taskforce's support.

- Since its foundation in 2005, the Health Metrics Network's framework[31] 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.
- The 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.[32] For example, 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 health system "dashboard" tools 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.

30 http://norad.no/en/Thematic+areas/Health+and+aids/Maternal%2C+child+and+women%27s+health/Media+advisory

31 http://www.who.int/healthmetrics/documents/hmn_framework200803.pdf

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

- 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.[33]

C. Mutual accountability and reviewing progress

In addition to engaging all stakeholders and to having access to information and assessment tools, accountability also requires 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.

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 the following actions.

- Regular reviews of progress that take place first and foremost 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. Over time it should involve all 49 low-income countries, the major international health actors, civil society, the private corporate sector and the governments that provide substantive international development resources for health.
- WHO and the World Bank produce a yearly report on progress related to: health outcomes, financial resources and flows, and partner ways of working (this together with the OECD/DAC secretariat).

Working Group 2 recommends the Taskforce:

• 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.

• Build on the IHP+ principles and work to expand the number of countries that have signed compacts.

• Actively engage with civil society, the corporate sector and other relevant stakeholders when implementing new or expanded innovative financing mechanisms.

• Continue well-prepared and structured sector reviews in countries involving all relevant stakeholders.

• Establish a high-level "Health and Development Forum" to review progress on: health outcomes; financial resources, flows, and the Taskforce's target of raising $10 billion per year by 2015; and working in partnership. Focus on lessons learnt about how to strengthen health systems and on key actions that will improve the delivery of results.

33 http://network.human-scale.net/community/ihp The first external review of IHP+ is available at http://www.internationalhealthpartnership.net/pdf/IHP_External_review_2008_EN.pdf

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ANNEXES

Annex 1: Working Group 2 Members and Terms of Reference

Working Group 2 Members

Anders Nordstrom (Director-General, Swedish International Development Agency), Chair

Alice Albright (Chief Financial and Investment Officer, GAVI Alliance)

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David Evans (Director, Health Financing and Social Protection, World Health Organization)

Rajat Gupta (Ex-Managing Director, McKinsey & Company)

Susan McAdams (Director, Multilateral and Innovative Financing, World Bank)

Jay Naidoo (Secretary General, Congress of South African Trade Unions)

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Ismael Serageldin (Director, Alexandria Library)

Christine Kirunga Tashobya (Public Health Advisor, Ministry of Health/DANIDA, Kampala, Uganda)

Terms of Reference

Working Group 2 will focus on the international financing aspects of the work of the Taskforce. The objective 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 2 will work in close cooperation with Working Group 1. Working Group 2 will need substantial input from Working Group 1 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 1. Working from a mutually agreed foundation, Working Group 2 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 2 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 fund 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 and 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, and how to establish the right incentives for private sector actors;
  - how voluntary and philanthropic contributions can best be captured and integrated effectively and efficiently into existing financial flows;
  - how the expected additional financial flows should be linked to existing channels and aligned with domestic policy agendas.

The feasibility of different options should be mainly technical, with political aspects being left for politicians to consider. However, the Working Group should prepare recommendations that can be supported, even if final decisions are for the politicians. It is also important to consider what is feasible within the 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 monitor and evaluate** the impact of existing and additional resources for health systems. Monitoring impact should involve the use of existing mechanisms and country systems, as already agreed as part of the IHP+, the Paris Declaration, and the Accra Agenda for Action.

From the perspective of Working Group 2, information on key quantitative and qualitative aspects of health systems and health systems strengthening is needed from Working Group 1 and other sources to assess and design innovative financing instruments. This includes, for example: the volume and time period 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.

Annex 2: List of low-income countries, July 2008

Country	Region[34]		
Afghanistan	South Asia	IDA[35]	HIPC[36]
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 Principe	Sub-Saharan Africa	IDA	HIPC
Senegal	Sub-Saharan Africa	IDA	HIPC
Sierra Leone	Sub-Saharan Africa	IDA	HIPC
Solomon Islands	East Asia & Pacific	IDA	
Somalia	Sub-Saharan Africa	IDA	HIPC
Tajikistan	Europe & Central Asia	IDA	
Tanzania	Sub-Saharan Africa	IDA	HIPC
Togo	Sub-Saharan Africa	IDA	HIPC
Uganda	Sub-Saharan Africa	IDA	HIPC
Uzbekistan	Europe & Central Asia	Blend	
Vietnam	East Asia & Pacific	IDA	
Yemen, Rep.	Middle East & North Africa	IDA	
Zambia	Sub-Saharan Africa	IDA	HIPC
Zimbabwe	Sub-Saharan Africa	Blend	

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

34 World Bank Regional Code.

35 IDA: International Development Association.

36 HIPC: Heavily Indebted Poor Country.

Annex 3: Review of shortlist of innovative financing mechanisms (in alphabetical order)

Introduction

Working Group 2 examined a long list of about 100 potential innovative financing mechanisms to support health systems, and identified and reviewed 24 shortlisted mechanisms. The focus has been on three broad categories, seeking (i) more money; (ii) better channels; and/or (iii) "better" money – that is, initiatives and approaches that can increase the health impact for the same amount of money.

The following points are worth emphasizing. First, to succeed in the Taskforce's goals – delivering more money for health systems strengthening, and achieving better results for every dollar spent – will require moving forward with more than one mechanism. Ways to combine approaches that are complementary and efficient need to be explored further. Second, in the context of the financial crisis, a strong emphasis must be placed on mechanisms that can assure effective impact. Success both in attracting funds and in ensuring health impact will depend on country level choices, on effective disbursement channels, and on the strength of local governance and institutions. Capacity building, systems development, and an approach working toward long-term sustainable health systems are key needs. Third, new initiatives need a clear link between the financing mechanism and ultimate health benefits. For many of the mechanisms considered, funds could be put to any use. The link between source, channel and use of funds is critical. The governance arrangements and resource allocation approaches need to ensure that resources flow to uses that contribute to the needs set out by Working Group 1.

In the end, the key to success may be working to combine different ideas/initiatives that can together support an effective, predictable and well-aligned flow of funds from initial sources through the health aid architecture to high-impact uses on the ground.

While the major purpose of the Taskforce's work is to raise more external funds for health in poor countries, many of these mechanisms could be applied within low- and middle-income countries as ways of increasing domestic funding for health. As such, the Working Group hopes that the menu approach will be of general assistance, so that each country can explore the mechanisms that suit it best.

The review provides broad, preliminary estimates and is intended to help choose promising mechanisms. Implementation would need detailed studies. Broadly, three categories of criteria were used:

1. general criteria covering value added, past experience, technical feasibility, political sponsors, and timeframe needed for implementation;
2. financial criteria that include revenue potential, additionality and costs;
3. aid effectiveness criteria based on the Paris agenda.

Most of the criteria are self-explanatory, and are discussed in more detail under the "Approach" section below. A few criteria may benefit from a short explanation. "Value added" describes the kind of value a mechanism is designed to deliver, for example additional funds, more predictable funds, or incentives for more effective implementation. "Additionality" is the net additional financing a mechanism delivers, taking into account its level of concessionality and potential crowding out of existing financing. "Timeframe for implementation" estimates the time needed to make the political decisions and complete the preparations/negotiations to implement a mechanism. "Technical feasibility" focuses on what technical and practical actions are needed for implementation.

Advance Market Commitments (AMCs)

Description

AMCs are meant to tackle a long-standing development problem: persistent failures of the private sector to develop and manufacture products needed in developing countries, due to market uncertainties or perceptions of insufficient demand.

The AMC is a funding commitment, made in advance, designed to spur the creation of a market that does not yet exist or functions poorly. Generically, an AMC works as follows: Donors first commit to fund an AMC of a specified market size and price for a product with specifications targeting effectiveness and development impact in developing countries. As and when candidate products become available, a credible independent body determines if new products meet the target specifications. The manufacturer is then entitled to enter into a supply agreement under which AMC funds subsidize purchase of the target product. When AMC subsidy funding is depleted, the manufacturer is required under the supply agreement to provide the product at an established retail price for a specified period to meet continuing demand.

General criteria

Value added: AMCs leverage private sector expertise, R&D, investment, and engagement. AMCs resolve market failures to provide goods or services needed in developing countries, and provide an incentive and legal framework for the long-term provision of needed products.

Experience: A pilot AMC for pneumococcal vaccines for low-income countries is currently underway. Vaccines are a product for which research, development, and manufacture of products specific to the needs of the poorest countries are limited by the small number of manufacturers, high cost of product development and scale-up of production capacity, and uncertainty about demand.[i]

Technical feasibility: AMCs may be technically complex, particularly in terms of pricing; distinctive legal issues; and possible reputation risk if they are perceived as contributing to the profits of large, well-resourced private companies. Each AMC would be designed for a specific purpose, e.g. targeting commodities or commoditized services such as birthing kits or a solar-powered cold chain.

Political sponsors: The pilot AMC, targeting a pneumococcal vaccine, is sponsored by Italy, the United Kingdom, Canada, Russia, Norway, and the Bill & Melinda Gates Foundation.

Timeframe for implementation: The timeframe for setting up a new AMC is considered to be one to two years.[ii] Achieving initial results will take even longer, and will vary depending on the project; once an AMC has triggered investment in a new good or service, research, development, and production still need to be carried out. Implementation of the pilot is expected to be four to five years. Scaling up further AMCs could be faster, because they could draw on the experience of the pilot.

Financial criteria

Realized flows: Grants totalling US$1.5 billion for the pneumococcal pilot.

Potential flows: Depends on donors' willingness to support future AMCs. Most flows are expected to come from international sources.

Costs (set-up and recurring costs): Costs would be substantial, and would include start-up costs (conservatively estimated at more than US$5 million), capital charges (US$25 million for the pilot), and recurring costs (US$2-3 million).[iii]

Additionality: An AMC does not generate new funds, but rather relies on additional financing. Funds would come from conventional ODA and foundations.

Sustainability: If successful, high. AMCs are designed to have a sustainable long-term impact through long-term supply commitments and market creation, although the length of the AMC subsidy period is limited. Under the terms of the pneumococcal pilot, when AMC funding is depleted, the manufacturer will continue to provide the vaccine at an established retail price for a specified period of time.

ODA: Long-term grants qualify as ODA when and as grant payments are made.

Aid effectiveness criteria

Country ownership: Does not depend on mechanisms but on channel. In the case of the pilot, country co-payments will be channeled through GAVI and will follow GAVI policies and its country application process.

Predictability: High, for a limited time: financing for industries and countries is predictable until the AMC funding is depleted.

Alignment: Does not depend on mechanisms but on channel. In the case of the pilot, co-payment will be channeled through GAVI and will follow GAVI criteria.

Synergies and externalities: Potentially some, in the form of positive reputational spillover to industry.

Impact on aid architecture for health and harmonization: The pilot was established within an existing institutional framework, and thus did not create additional complexity.

Results: Expected to be high, because financing is directly linked to results. An AMC creates incentives for the private sector to develop and deliver the agreed-on goods and services. It includes quality-assurance mechanisms. The pilot's expected results are saving an estimated 7.7 million lives by 2030 with a much lower estimated cost per DALY (Disability-Adjusted Life Year) saved (around $33) than the $100 benchmark cost for efficient health interventions in developing countries.

Accountability: Does not depend on mechanisms but on channel. In case of the pilot, co-payments will be channeled through GAVI and follow GAVI criteria.

Pro poor: If successfully implemented, AMCs will be pro poor. The pilot is pro-poor, with eligibility limited to low-income countries. However, the mechanism's future potential to deliver health goods, commodities, and services to the poor is not known.

Summary and overall evaluation

The value added of AMCs is to create a market for products and services needed in low-income countries. An AMC can engage the private sector in researching, developing, manufacturing, and distributing those products and services.

Funding for an AMC would come from conventional ODA or one of the financing mechanisms discussed elsewhere in this report. AMCs focus on specific markets, product and service needs; further exploration is needed to identify the specific market failures within the health sector that might be successfully addressed through an AMC.

Further information

Information: http://www.vaccineamc.org
http://www.worldbank.org/amc

Reading: (Kremer 2000; Kremer and Glennerster 2004; Kremer and Zwane 2005; Tremonti and Ministero dell'Economia e delle Finanze 2005b; Tremonti and Ministero dell'Economia e delle Finanze 2005a; Batson, Meheus et al. 2006; Ridker 2006; World Bank and GAVI 2006; Berndt 2007)

Airline Ticket Voluntary Solidarity Contribution

Description

The proposed Airline Ticket Voluntary Solidarity Contribution (VSC) gives individuals and corporations the option of making a micro-contribution to a charitable cause (for example 2 $, €, or £) when buying an airplane ticket. The consumer can exercise this option in a simple, convenient manner – e.g. by checking a box while making an online booking.

The Millennium Foundation for Innovative Finance for Health is developing a pilot programme, whose proceeds are expected to go to UNITAID.

General criteria

Value added: Additional funds from a new source.

Experience: Under implementation. The first results are expected in January 2010.

Technical feasibility: Implementation appears feasible. Some 65% of airline ticket reservations go through global distribution systems. The largest three (Amadeus, Sabre, and Travelport) have already indicated their interest in participating. Technically, payments would be collected based on the partner's IT architecture. Discussions with legal experts have so far revealed no major legal or regulatory barriers.

Political sponsors: The Millennium Foundation for Innovative Finance for Health, along with its supporters (UNITAID and its funders: the Gates Foundation, Brazil, Chile, France, Norway, Korea and the United Kingdom).

Timeframe for implementation: The planning phase for the pilot programme will be about 18 months from the first feasibility study to the launch, which is scheduled for January 2010. Complete roll-out is expected to take three years from launch.[iv]

Financial criteria

Realized flows: The Millennium Foundation expects to begin generating flows in January 2010.

Potential flows: An early assessment by a leading consulting firm suggests that the Airline Ticket VSC has the potential to raise up to US$980 million a year by 2011.[v] Revenues are expected to come from worldwide contributions.

Costs (set-up and running costs): According to the Millennium Foundation, operating costs are estimated to be 1 to 3% of revenue as soon as the mechanism is fully up and running. No reliable estimates of the start-up-costs are available.

Additionality: Likely to be additional. The funds would be

concessional. There are few blended value products to date that fund development, and in particular health, so crowding out from competition is likely to be low. However, because small contributions might make some donors think they have fulfilled their duty to charity, the Airline Ticket VSC might crowd out some conventional donations. (No quantitative study or hard evidence on this is available.)

Sustainability: Expected to be sustainable as long as the airline ticket global distribution systems make a long-term commitment.[vi]

ODA: Private voluntary contributions do not qualify as ODA.

Aid effectiveness criteria

Country ownership: Some earmarking of funds might be needed to motivate ticket-buyers to make donations. This might limit country ownership and flexibility for targeting funds. However, contributors to these micro-donations are less likely to be well informed about the cause than contributors to a private giving campaign, so the Airline Ticket VSC's effect on country ownership should be smaller.

Predictability: The Airline Ticket VSC is expected to be somewhat more volatile than the Solidarity Levy on Airline Tickets. The underlying source, air travel, is the same, and would have the same moderate volatility: air travel tends to increase from year to year, but it is subject to some fluctuation, especially from events like the 9/11 attacks. Additional volatility compared to the Solidarity Levy could stem from the voluntary nature of the contribution, which might add to the pro-cyclicality of the source.[vii]

Alignment: As discussed under country ownership, the potential need to earmark funds might limit alignment with country systems and priorities. However, this effect should be somewhat smaller than the limiting effect from earmarking in a private giving campaign.

Synergies and externalities: The Airline Ticket VSC could raise awareness for the importance of health systems.[viii]

Impact on aid architecture for health and harmonization: Does not depend on mechanism but on channel. If the Airline Ticket VSC is implemented by a new organization, such as the Millennium Foundation, the complexity of the aid architecture for health would increase. Close cooperation between the new player, UNITAID, and WHO would mitigate the added complexity.

Results: Does not depend on mechanism but on channel.

Accountability: Does not depend on mechanism but on channel

Pro poor: A pro-poor effect may result from the partial charitable character of VSCs. Compared with other charitable mechanisms such as private giving campaigns, the Airline Ticket VSC is expected to have a moderate additional pro-poor effect. Contributors are generally expected to be less engaged in the cause than people who give to charities via private campaigns, but more engaged than contributors who give through the purchase of blended value products, who often have no choice but to give.

Summary and overall evaluation

The value added of an Airline Ticket VSC is to raise additional funds. It would potentially generate revenues of up to US$980 million a year by 2011. The funds are expected to be additional. According to the Millennium Foundation, the sponsor of a pilot programme, transaction and administrative costs should be low (about 1 to 3% of revenues). Even so, costs are higher than for blended value product instruments, where costs can be transferred to corporate partners.

The Airline Ticket VSC would raise visibility and create greater awareness of the importance of health systems, but not to the same extent as a private giving campaign, which is focused solely on philanthropy and has no commercial component.

Technical feasibility has not been proven but looks promising. Early assessment by a leading consulting firm (October 2007–April 2008) suggests that the VSC could be successfully implemented in the air-travel industry.

Further information

Information: Presentations by UNITAID:
www.oecd.orgdataoecd/7/57/41466538.pdf
www.who.int/phi/UNITAID_Jan09.ppt

Reading: For literature on cause related marketing see blended value products.

Auction and/or Sale of Greenhouse Gas Emissions Permits

Description

A potential source of financing is the auction or sale of greenhouse-gas emissions permits under a cap-and-trade mechanism. For example, under the European Union's Emissions Trading Scheme (EU ETS), EU Allowances (EUAs) may be auctioned or otherwise sold to emitters rather than distributed for free. The proceeds could be directed to international development, including health systems. As with solidarity levies, programmes could be nationally implemented and internationally coordinated.

Last year, Germany piloted the sales of emissions permits, earmarking some of the proceeds for its development budget. The EU is working to create a similar mechanism throughout the Union. Under the EU ETS for the first years, most emissions permits were allocated for free. The latest EU Commission proposal recommends a system of full auctioning in the power sector starting in 2013, and phasing out free allocations to industry between 2013 and 2020.[ix] According to an EU Directive, at least half the revenue should be used to fight and adapt to climate change, mainly within the EU but also in developing countries.[x] Although there may be a strong political logic to use all revenues toward climate change, up to half could be used for other purposes including health systems.

General criteria

Value added: Additional funds from a new source.

Experience: In 2008, Germany has sold EUAs and has allocated a share of proceeds to development through its general development budget.[xi] Austria and the United Kingdom have auctioned emissions permits but have not earmarked proceeds for development.[xii]

Technical feasibility: Austria, Germany, and the United Kingdom have all proven the technical feasibility of auctioning emissions permits; Germany has also proven the technical feasibility of earmarking the revenues for development. Technical feasibility elsewhere requires the existence of a functioning emissions trading/cap-and-trade mechanism like the EU ETS.

Political sponsors: Germany.

Timeframe for technical implementation: Information is not available.

Financial criteria

Realized flows: Between 1 January 2008 and 14 November 2008, Germany sold 40 million EUAs for a total of €933 million.[xiii] It decided that a share of the income, €120 million in 2008, will be invested in international climate protection measures in developing

countries. According to Germany, this share will be and must be increased in subsequent years.[xiv]

Potential flows: Germany's 2009 budget allocates €225 million from EUA sales for development assistance.[xv] Extrapolation from the German experience suggests that auctions and sales of greenhouse-gas emissions permits could raise between several hundred millions and some billions annually, depending on how many countries joined the initiative. Flows would also depend on countries' willingness to earmark proceeds for health systems in developing countries.

Costs (set-up and running costs): Information is not available.

Additionality: Auctions and sales of greenhouse-gas emissions permits are likely to generate additionality. They generate funds that would not have to be repaid. The source is distinct from traditional ODA flows and additional to existing development assistance, but could crowd out some future ODA giving participating countries an excuse not to increase their general aid budgets.

Sustainability: Sustainability depends on many variables that are not necessarily under the control of a single government: the continued existence of emissions trading mechanisms such as the ETS and the Kyoto Protocol; the long-term willingness to auction or sell permits; and the long-term willingness to earmark proceeds for development. Sustainability is hard to assess; it could be fragile or robust depending on these factors.

ODA: Expected to qualify as ODA. The German proceeds from emissions permits sales that are earmarked for development are accounted as ODA.

Aid effectiveness criteria

Country ownership: Does not depend on mechanism but on channel and use.

Predictability: Proceeds from auctions and sales may be volatile, given past history of prices for greenhouse-gas emissions permits.[xvi] Prices peaked at over €27 per ton in June 2008 and bottomed at less than €10 per ton in February 2009. During 2008, daily fluctuations of more than 5% were not uncommon. Prices tend to be pro-cyclical and to correlate closely with prices for electricity, gas, and coal.

Alignment: Does not depend on mechanism but on channel and use.

Synergies and externalities: The auction and sale of greenhouse-gas emissions permits creates double dividends by generating revenues and setting a price on a negative externality, greenhouse-gas emissions, thereby potentially reducing them.

Impact on aid architecture for health and harmonization: Does not depend on mechanism but on channel and use. Germany's current channeling through the general aid budget does not add to the complexity of the aid architecture or require extra harmonization efforts.

Results: Does not depend on mechanism but on channel and use.

Accountability: Does not depend on mechanism but on channel and use.

Pro poor: As with other additional funds, the mechanism is potentially pro poor since it could lower user fees.

Summary and overall evaluation

The auction and sale of emissions permits score relatively high on financial criteria. Extrapolation of proceeds in Germany suggests that between several hundred millions and some billions might be raised annually, depending on how many countries implemented such a mechanism and on those countries' willingness to earmark funds for health systems. There might be considerable competition for funds from other sectors, especially adaptation to and mitigation of climate change. Potential revenues are higher than many other mechanisms. Additionality is likely to be high.

The auction and sale of emissions permits are technically feasible. Scaling up this mechanism might be faster and less complex than instituting a new one. Sales/auctions have little impact on aid effectiveness criteria and would require an appropriate channeling entity, such as one of the existing IHP+ players in health systems.

Emissions auctions and sales are part of a larger emissions trading system and generate a double dividend by reducing greenhouse-gas emissions as they raise funds.

Further information

Information: http://www.bmz.de/en/approaches/bilateral_development_cooperation/approaches/joint-financing/innovative_funding_instruments/index.html

http://ec.europa.eu/environment/climat/emission/auctioning_en.htm

Reading: (Cramton and Kerr 2002; Sandmo 2005; Hepburn, Grubb et al. 2006; Capoor and Ambrosi 2008; Konukiewitz forthcoming)

Blended Value Product Line for Health Systems

Description

Blended value products stimulate voluntary contributions from individuals by combining consumption with charity. When a purchase is made, a charitable contribution is added to the bill. This can be done either through focusing on specific products (as in the case of the Global Fund's (PRODUCT) RED[xvii], for example) or through "affinity" credit cards. This mechanism would initiate a dedicated blended value product line for health systems. It could include several consumer products as well as an affinity credit card offered in multiple countries.

Blended value products and VSCs are similar in that they combine a commercial transaction with a charitable contribution. With a blended value product, the charitable contribution is inextricably linked to the purchase of the product; in other words, once a consumer has chosen to buy a product identified with the programme or to use an affinity credit card, the charitable contribution automatically follows. In contrast, VSC consumers choose whether they want a charitable contribution to be tied to their purchase.[xviii]

General criteria

Value added: Additional funds.

Experience: Blended value products are a well-developed fundraising tool. The best-known example in the health sector is (PRODUCT) RED. Affinity credit cards have been widely tested and employed. Examples include credit cards linked with the World Wildlife Fund and the Green Credit Cards issued by banks worldwide, through which a share of revenues is channeled to environmental causes.

Technical feasibility: The technical feasibility has been proven specifically in the health sector by (PRODUCT) RED, and more broadly by a variety of affinity credit cards in many countries. A blended value product requires a specific platform and leadership, a compelling PR story, and substantial investments in marketing and building a brand. Campaigns can involve one company, a few, or many. Important necessary support includes legal agreements with each participating company detailing how contributions are

collected, managed, and disbursed.

Political sponsors: No specific sponsor for health systems.

Timeframe for implementation: A typical lead-time for implementation is one to two years, with another one to two years before significant revenues are generated.[xix]

Financial criteria

Realized flows: A successful blended value product line can generate annual revenues of US$50 to 150 million. (PRODUCT) RED, for example, raised US$25 million during the first three and a half months. By the end of March 2009, after about two and a half years, it had raised about US$130 million. In the United States, it is estimated that an affinity credit card could generate about US$12.5 to 25 million during its first year and up to US$50-100 million annually after four or five years.[xx]

Potential flows: Annual revenues for a successful blended product line can reach about US$50 to 150 million. Most revenues typically come from international sources.

Costs (set-up and running costs): No explicit cost estimates exist for (PRODUCT) RED; the programme's administrative costs are covered by its corporate partners.[xxi] When evaluating (PRODUCT) RED in view of this blended product line mechanism, care should be taken not to assume that administrative costs are therefore nil. Set-up costs for an affinity credit card are typically US$100,000 to 1 million, depending on the size of the market and the required marketing campaign. Annual administration costs are about 10% of contributions.

Additionality: Funds generated are likely to be additional. They would also be concessional. Crowding out is expected to be low to medium. Because few blended value products to date support development finance, particularly for health, competition for health funds is likely to be low, although there may be competition for development funds for other areas such as climate change. Making small contributions through a blended value product might lead contributors to think they have fulfilled their duty to charity, resulting in some crowding out of conventional charitable donations. (Quantitative evidence of this effect is not available.)

Sustainability: Depends on the sustainability of associated products' sales. No quantitative evidence exists, but expected to be relatively high.

ODA: Private voluntary contributions do not qualify as ODA.

Aid effectiveness criteria

Country ownership: Blended value products require some earmarking of funds to attract consumers. This might limit country ownership. The limiting effect is expected to be comparable to or perhaps slightly less than the limiting effect of VSCs. (Contributions raised by blended value products are slightly less "voluntary" than those raised by VSCs.)

Predictability: Depends on the volatility of associated products' sales. No quantitative evidence exists.

Alignment: Does not depend on mechanism but on channel.

Synergies and externalities: A blended value products campaign would raise awareness of the importance of health systems.[xxii]

Impact on aid architecture for health and harmonization: Does not depend on mechanism but rather on the charitable organization implementing the blended value product and on the channel.

Results: Does not depend on mechanism but on channel.

Accountability: Does not depend on mechanism but on channel.

Pro poor: A pro-poor effect may result from the partial charitable character of blended value products. Most purchasers of blended value products care about the cause the product supports. Therefore, proceeds are likely to be used pro-poor in order to increase fundraising results.

Summary and overall evaluation

The value added of a blended value product line is to raise additional funds. However, fundraising potential is estimated to be low (about US$50 to 150 million annually). Revenues are expected to be additional but may crowd out some funds from private giving campaigns and from the existing blended value product line, (PRODUCT) RED, which funds Global Fund HIV/AIDS programmes in Africa. The costs of implementing blended value product lines are relatively low; the mechanism can be set up so that corporate partners cover most administrative and transaction costs.

Associated products tend to have high visibility and can help create awareness of the importance of health systems. This benefit could be smaller than that of a private giving campaign (because the primary reason for giving is not charity but consumption) or higher (because of the high visibility attached to consumer goods). Further experience is needed to assess this effect.

Funds raised through blended value products require a channeling mechanism. As in a private giving campaign, not all channels are suitable, because of consumer preferences. However, it is expected that the proceeds from a blended value product line would be less restricted with respect to channeling than the proceeds from a private giving campaign, because donors' primary motivation is not charity but consumption.

Further information

Information: (PRODUCT) RED: www.joinred.com
http://www.theglobalfund.org/en/partners/private/red/
Affinity credit card: https://www.visagreencard.nl/

Reading: (O'Manique and Labonte ; Smith and Alcorn 1991; Schlegelmilch and Woodruffe 1995; File and Prince 1998; Polonsky and Wood 2001; Worthington 2001; Earle 2002; Berglind and Nakata 2005; Dyer 2006; Asongu 2007; Nelson, Kanso et al. 2007; Jungar and Salo 2008; Stole 2008; Nickel and Eikenberry 2009)

Buy-Downs

Description

A buy-down (also called "credit buy-down" and "loan buy-down") is the use of grant funding to reduce the amount of or interest level of a loan or to pay it down completely, increasing the level of concessionality. The buy-down is triggered by the achievement of defined results/targets. Buy-downs could be used to buy down concessional loans, including IDA credits, in order to fill financing gaps in health systems development. The developing country receives funding for a specific project up front, along with insurance that, if the project is successfully implemented, a donor will cancel or reduce the debt.

In general, buy-downs have been considered for three reasons: to support countries under debt distress; to support countries producing cross-national public goods; and to link concessionality levels to results in targeted sectors. In the case of health systems, the third reason applies. This mechanism would create additional buy-downs for health systems.

General criteria

Value added: Increasing the concessionality for regional and global public goods, and leveraging money from new donors. With well-designed results-based targets, increasing the effectiveness of the delivery and use of funds, and creating incentives to achieve results.

Experience: Results-based IDA buy-downs have been implemented in Pakistan and Nigeria. Two more IDA buy-downs in those countries are in the late negotiation/preparation phase.[xxiii]

Technical feasibility: Has been proven by the existing IDA buy-downs. However, so far the mechanism has not been scaled up.

Political sponsors: Previous buy-downs have been supported by the World Bank (providing the loan or credit to be bought down), UK DFID, the United Nations Foundation (UNF), the Bill & Melinda Gates Foundation, and Rotary International (providing grant funding).

Timeframe for implementation: On an individual basis, a new IDA buy-down for health systems would take eight to 16 months from project identification to the start of implementation. Buy-downs for existing types of projects are expected to take three to six months less. Actual implementation is expected to take two to four years.[xxiv] Establishment of a multi-donor fund to support results-based buy-downs would help create a generic platform for buy-downs and potentially reduce preparation time.

Financial criteria

Realized flows: Donors have provided a total of more than US$100 million for buy-downs, facilitating IDA projects of about US$190 million.

Potential flows: These depend on donor and recipient interest. In theory, a substantial part of development aid could be channeled through buy-downs. However, in reality buy-downs may make sense only in certain circumstances – for example, to promote a health systems reform project. Potential flows are therefore country-specific.

Costs (set-up and running costs): Estimated to be comparable or slightly higher than those for conventional World Bank operations. Additional costs might come from designing more complex results agreements and implementing more complex monitoring and evaluation systems to guard against misreporting.

Additionality: No additional funds raised, but grant funding can leverage higher flows via loans.

Sustainability: Comparable to conventional grants. Buy-downs operate on a project-by-project basis.

ODA: Previous IDA buy-downs were financed by foundations and the buy-down funding did not qualify as ODA. It is expected that buy-downs for health systems would qualify for ODA if the financing source was public (for example, funds from a country's general development budget or from a solidarity levy).

Aid effectiveness criteria

Country ownership: Depends on programme design. If countries have a say in setting priorities and performance indicators, country ownership can be high. If the mechanism is designed as a donor tool to control countries' performance, country ownership would be low.

Predictability: Financing depends on results. Therefore, predictability is lower than for conventional loans and grants.

Alignment: Depends on the concrete implementation process. The performance indicators needed to trigger the buy-down could be aligned with country systems.

Synergies and externalities: The built-in evaluation scheme and motivation to report results should provide a positive externality.

Impact on aid architecture for health and harmonization: The buy-down proposal relies on existing channels and therefore would not increase the complexity of the aid architecture for health systems.

Results: The mechanism is designed to reward results. No hard evidence exists to date, but anecdotal evidence is promising. One example is a buy-down programme in Rwanda (see Working Group 1 report).

Accountability: Increases countries' accountability.

Pro poor: Buy-downs connected to results can be targeted toward pro-poor interventions. Because financing is linked to results, it can be linked to results that especially benefit the poor. Ultimately, the pro-poor extent of a buy-down depends on what factors are chosen to indicate results.

Summary and overall evaluation

The value added of a buy-down is to increase the level of concessionality of loan financing where appropriate, and to create incentives for governments to achieve results, thereby increasing the effectiveness of funding. Buy-downs for health systems might be a good tool to incentivize senior government officials to allocate resources to health systems and to invest resources to achieve certain results.

Buy-downs can increase aid effectiveness if designed properly, and can increase the degree to which development aid is focused on results. They can also be designed to use country systems.

Buy-downs may not be the best solution for all health system needs. However, their ability to incentivize and align governments and senior officials behind common goals might make them a good tool for large-scale reform projects.

Further information

Reading: (Development Committee 2004; Hecht and Shah 2006)

Currency Transaction Levy (CTL)[xxv]

Description

The proposed CTL is a nationally implemented solidarity levy on all currency transactions undertaken in all foreign exchange markets, traditional and non-traditional, and applied to all foreign exchange instruments. Counties could coordinate their efforts to implement the tax, as they have done with the Solidarity Levy on Airline Tickets. This would create additional leverage and would close potential routes for tax evasion. Countries would adopt the levy on a voluntary basis. It would then apply on a mandatory basis to all trades in that country's currency worldwide.[xxvi] Under the proposal, the levy would be collected by large-scale foreign-exchange settlement systems such as the Continuous Linked Settlement (CLS) Bank and SWIFT (Society for Worldwide Interbank Financial Telecommunication). As proposed, each participating country would impose the tax on all transactions involving its currency, through settlement system transactions overseen and regulated by central banks.

General criteria

Value added: Additional funds from a new source.

Experience: No experience with a currency transactions tax to date. However, financial transaction taxes with similar characteristics

have been successfully implemented at the national level in several countries.[xxvii] Taxes on financial transactions have been in decline for various reasons.[xxviii]

Technical feasibility: As proposed, the CTL would be collected by large-scale foreign-exchange settlement systems.[xxix] Several studies contain detailed recommendations about how it could be implemented.[xxx] The market has continued to evolve since this proposal was first drafted. Pre-market crisis, bid-offer spreads had reportedly narrowed, which could imply a lower tax rate and reduced revenues compared to original estimates. In addition, many currencies do not trade directly with one another but instead engage in double-legged trades through USD, a currency unlikely to be included under this proposal. Because of these factors, the feasibility and externalities of the CTL proposal would need to be further explored.

Political sponsors: The CTL is sponsored by developed country NGOs, including the Stamp Out Poverty coalition. Political support will depend on how the tax would be implemented. As proposed, the CTL could first be implemented in a coalition of supporters, including single countries with respect to their own currency. (By contrast, a tax obligatory to all countries would need wide-ranging support by all major economies; a tax on the Euro would presumably need support from all Eurozone members.)

Timeframe for technical implementation: Estimates based on financial transaction taxes suggest that it could take anywhere from about two months to two years to introduce the CTL, depending on the country context and approval processes.[xxxi]

Financial criteria

Realized flows: None to date.

Potential flows: The mechanism uses a tax rate of 0.5 basis points on transactions among four major currencies (US$, €, JPY, GBP) and estimates that from transactions between these and all other currencies, the tax would generate US$33 billion in annual revenues. (Transactions between the US$and all other currencies would generate US$28 billion; € with all other currencies – US$12 billion; JPY with all other currencies – US$6 billion; GBP with all other currencies – US$5 billion.) However, the tax rate proposed may be ambitious. Evasion possibilities would depend on which currencies were covered by the tax.

Costs (set-up and running costs): Based on experience with tax administration in general, the cost of administering the CTL would be in the range of 1 to 2% of revenues. CTL proponents estimated that compliance costs would be low since the tax could be administered electronically.[xxxii]

Additionality: The CTL is likely to generate additionality. It does not itself require any repayments/reflows. The source is distinct from traditional ODA flows and additional to existing development assistance. At the same time, tax revenues might substitute for other ODA flows, giving participating countries an excuse not to increase their general aid budgets.

Sustainability: The underlying source for the CTL is sustainable.[xxxiii] Total daily currency transaction volumes worldwide increased from US$820 billion in 1992 to US$3,210 billion in 2007.[xxxiv] However, sustainability also depends on countries' long-term willingness to collect the levy and to allocate CTL revenues to health systems.

ODA: Spending CTL revenues on health systems would be expected to qualify as ODA since it would effectively be a national tax earmarked for development uses in low-income countries.

Aid effectiveness criteria

Country ownership: Does not depend on mechanism but on channel.

Predictability: Predictability is estimated to be relatively high.

Alignment: Does not depend on mechanism but on channel.

Synergies and externalities: There is debate over whether the levy would pose significant externalities on currency transaction markets. Proponents of the tax argue, based on a 2007 study, that (unlike with earlier Tobin and currency transaction tax proposals) because the proposed tax rate, 0.5 basis points, is designed to be smaller than bid-offer spreads and roughly of the same magnitude as transaction fees, the CTL would not significantly affect markets.[xxxv] This needs to be rechecked against current markets. Critics argue that margins and profits in currency trade (as percentages of turnover) are very small, and that a levy as large as the transaction fees themselves would, by doubling trading costs, affect markets and the behaviour of traders.

Capital flight and competition between trading centres pose another controversial issue. Proponents of the CTL argue that collecting the tax through a worldwide settlement system would solve this problem (although they estimate that the CTL would reduce currency transactions by 14%[xxxvi]). The low tax rate would limit incentives to build costly alternative settlement systems or to increase settling positions internally within banks in order to avoid the levy. Conversely, critics argue that market participants would avoid the tax by settling transactions internally within banks or through multiple legs. Negative externalities might stem from costs of evading the tax (as well as costs of preventing tax evasion) and from less efficient markets. International coordination efforts might limit these effects.

Impact on aid architecture for health and harmonization: Does not depend on mechanism but on channel and use.

Results: Does not depend on mechanism but on channel and use.

Accountability: Does not depend on mechanism but on channel and use.

Pro poor: Does not depend on the source but on channel and use.

Summary and overall evaluation

The CTL as proposed scores high on financial criteria. If widely supported, it could generate significant revenues at transaction costs as low as 1 to 2% of revenues. The additionality of funds raised is expected to be high. Sustainability and predictability are also expected to be high. The CTL proposal is a relatively recent development, and it has not been tested. Various forms of currency transaction taxes have been discussed for decades, but to date, none has had the political support required for implementation. Note that the CTL differs from previous currency tax proposals, such as the Tobin Tax, in that it is designed to minimize direct impact on trading behaviour.

The CTL itself would have little impact on aid effectiveness criteria. Impact would depend on the use of funds and require an appropriate channeling entity, such as one of the existing IHP+ players in health systems, a new fund for health systems, or a multi-donor trust fund with one or more implementing entities.

Further information

Information: http://www.stampoutpoverty.org/?lid=10556 http://www.cttforffd.net/docs/

Reading: (Tobin 1996; Schmidt 1999; Spahn 2002; Nissanke 2005; Hillman, Kapoor et al. 2006; Spratt 2006b; Spratt 2006a; Schmidt 2007; Schulmeister, Schratzenstaller-Altzinger et al. 2008)

Debt2Health

Description

The proposed mechanism would apply Debt2Health, a recently developed finance mechanism, to additional countries and/or organizations. Debt2Health involves a three-way partnership between creditors, grant-recipient countries, and a multilateral institution – currently, the Global Fund to Fight AIDS, Tuberculosis, and Malaria. Under an agreement facilitated by the Global Fund, creditors forgo repayment of a portion of their loan to a developing country on the condition that that country invests an agreed-upon counterpart amount in health. The investment is made through the Global Fund according to the systems and principles it regularly uses to disburse grants.

Debt2Health could be scaled up by the Global Fund to support its health systems strengthening programmes. It could also be extended to other IHP+ multilateral institutions.

General criteria

Value added: Additional funds targeted to health systems through debt relief. Also, some of the funds might be considered frontloaded: instead of repaying debt owed in the future, countries would be investing in health systems in the present.

Experience: The first pilot programme is underway and involves Germany, Indonesia, and the Global Fund. Germany is writing off bilateral Indonesian debt of €50 million, Indonesia is paying €25 million to the Global Fund, and the Global Fund is spending the contribution on health projects in Indonesia. An agreement for a second programme, involving Germany, Pakistan, and the Global Fund, has been signed. The Global Fund and Germany are also planning Debt2Health initiatives with Ecuador, Egypt, and the Kyrgyz Republic. In total, Germany intends to make up to €200 million in debt conversions available from 2008 to 2010.

Technical feasibility: The feasibility has been proven by the pilot. Implementation is technically somewhat different from conventional debt conversion, in that three rather than two parties are involved.

Political sponsors: Currently, the Global Fund and Germany.

Timeframe: Fairly short: about one year to develop a new swap, and six to 12 months to implement a swap.[xxxvii]

Financial criteria

Realized flows: Germany is canceling €50 million and €40 million of bilateral debt with Indonesia and Pakistan respectively. These amounts represent a 50% discount in repayments to the German government, and are generating payments to the Global Fund of €25 million and €20 million (amounts that will then be disbursed to health systems in Indonesia and Pakistan).

Potential flows: Depends on donors' willingness to cancel some portion of debt; and depends on the availability of debt for cancellation. A Global Fund study has identified several areas for further swaps, including additional bilateral claims, non-performing commercial claims, and multilateral claims remaining on Heavily Indebted Poor Countries (HIPCs). Quantitative information on potential debt available for Debt2Health swaps has not been published.

Costs (set-up and running): No quantitative estimates for administrative costs available. To date, costs have been borne by the administrative budgets of the three partners.[xxxviii]

Additionality: Some limited additionality is possible, depending on the original ODA treatment of the debt being cancelled.

Sustainability: Comparable to that of conventional bilateral aid, and dependent on the countries and any possible new institutions involved.

ODA: Debt conversion through Debt2Health may qualify as ODA, again depending on the original ODA treatment of the debt being cancelled.[xxxix]

Aid effectiveness criteria

Country ownership: The grant-recipient country's counterpart payments make it a donor to and partner of the Global Fund, potentially strengthening country ownership and local participation.

Predictability: Comparable to that of conventional bilateral aid.

Alignment: Does not depend on mechanism but on channel. For the current Debt2Health grants, alignment depends on the Global Fund's use of country systems.

Synergies and externalities: None.

Impact on aid architecture for health and harmonization: Positive. Debt2Health uses the existing aid architecture. Because agreements are trilateral, they could potentially enhance aid harmonization.

Results: Does not depend on mechanism but on channel – for existing debt swaps, depends on the Global Fund's programmes.

Accountability: Positive. Trilateral arrangements assign a clear role to all parties including the recipient country.

Pro poor: Does not depend on mechanism but on the source and the channel (currently, the Global Fund).

Summary and overall evaluation

The value added of Debt2Health is to target additional funds to health systems through debt conversion. Debt2Health has generated €45 million to date. Its potential depends on donors' willingness to cancel debt and the stock of debt available to be cancelled. There is disagreement over the mechanism's additionality, since Debt2Health is connected to creditors' conventional aid budgets.

Debt2Health is similar to conventional bilateral and multilateral aid with respect to such criteria as sustainability, timeframe, and costs. It makes use of existing multilateral channels to target financing for health. Through its trilateral structure, it could have a potentially positive impact on the effectiveness of aid. The design transforms recipients into donor/partners, thereby potentially increasing their ownership and accountability.

Further information

Information: http://www.theglobalfund.org/en/funds_raised/innovative_financing/initiatives/debt2health/

Reading: (Cassimon, Renard et al. 2008); (Edwards 1992; Kaiser, Lambert et al. 1996)

De-Tax

Description

The De-Tax is a proposed mechanism to earmark a share of VAT revenue, based on consumer and business choices, for the development of health systems; these funds would be topped by a voluntary contribution by businesses. The De-Tax would thus combine two elements.

- Governments would waive 1 percentage point or more of VAT rates on goods or services sold by businesses associated with the initiative, based on the customer's choice.
- Businesses would, on a voluntary basis, waive a share of their profit on associated transactions if they wish to co-finance development projects.

All revenues would be channeled into a national dedicated fund supporting health systems.

The De-Tax would be implemented nationally but could be coordinated internationally, thereby raising more funds and providing support for additional governments to establish it.

General criteria

Value added: Additional funds.

Experience: No experience to date.

Technical feasibility: Italy is conducting a feasibility study, in particular to determine the simplest way to collect consumer agreements. The idea is to earmark the goods at the production level – creating a special De-Tax mark – or to make use of customer-loyalty schemes.

Political sponsors: Italy

Timeframe for implementation: Italy estimates that the initiative may take about 12 months to be set up, more or less the same time needed to implement national taxes. This time would include VAT earmarking based on businesses' association with the initiative, the preparation of a detailed feasibility study, and other administrative issues. However, implementation of the mechanism might take longer than implementation of a new national tax. Basing VAT earmarking on sellers' association with the initiative is apt to extend the timeframe. In some countries, the tax would need to be implemented at a state/province level rather than federally, adding an extra level of complexity to implementation.

Financial criteria

Realized flows: None to date.

Potential flows: Assuming a reasonably high level of business and consumer participation, Italy estimates that its annual revenues from waived VATs would be between €100-150 million. This estimate does not include revenue flows from voluntary contributions by businesses.

International revenues from the "tax reduction" are estimated to be about US$2 billion annually if 26 countries (see page VAT calculations, page 71) participate and if 5% of the businesses in each country join the initiative.[xl] Under these assumptions, if the De-Tax had been implemented in 2008, that year it could have collected revenues amounting to US$628 million in Japan, US$344 million in Germany, US$233 million in France, and US$138 million in Italy (this figure is in line with Italy's own estimate).

Estimates of voluntary contributions by businesses are lower. If, out of the 5% of businesses assumed to join the initiative in each participating country, 10% donated 1% of their associated sales, the mechanism would create an additional 10% of revenues. In 2008, this would have amounted to a total of about US$200 million from the 26 countries designated, including US$63 million in Japan, US$34 million in Germany, US$23 million in France, and US$14 million in Italy.

Costs (set-up and running costs): Costs for tax reduction part of the proposal should be comparable to the administrative costs of general tax collection – about 1 to 2% of revenues. Compliance costs are estimated to be low, since the tax could be collected with VAT and participation by businesses would be voluntary. These costs would depend on the level of development of each country's public-administration information system. The transaction costs of convincing businesses to participate may be significant.

Additionality: Likely to provide some additionality. The funds generated would be paid into a fund that is independent from governments' aid budgets. But because proceeds from the De-Tax would be based in large part on governments "forgiving" income from VAT, government revenues would fall by the amount forgiven, making it possible that ODA would be reduced to some extent.

Sustainability: The underlying source, VAT income, is highly sustainable assuming continued support by participating governments. Business participation might be less sustainable. Overall, sustainability of the De-Tax is considered to be medium to high, though not as high as for other taxes with a sustainable base, because of its reliance on voluntarily participation by businesses.

ODA: Not enough information is available for a conclusive assessment. The first part of revenues, the VAT deduction, would qualify as ODA if it were treated as tax revenue earmarked for development. The second part of revenues, the voluntary contributions by businesses, would be a form of philanthropic giving and as such would not qualify as ODA.

Aid effectiveness criteria

Country ownership: Does not depend on mechanism but on channel – specifically, on the design of the fund to which the De-Tax is directed.

Predictability: Predictability is estimated to be fairly high, since VAT income is relatively stable.[xli] The total VAT revenue of all countries with existing data has risen each year since 1990. However, some individual countries, including France, Germany, Mexico, Norway, Sweden, and the United Kingdom, saw decreasing VAT revenues in the mid-1990s. The voluntary nature of businesses' participation adds uncertainty and thus may slightly reduce predictability.

Alignment: Does not depend on mechanism but on channel – specifically, on the design of the fund to which the De-Tax is directed.

Synergies and externalities: The De-Tax could raise awareness of the importance of health systems if businesses used it as a tool to demonstrate to consumers their support for the cause. A country's total VAT proceeds would not be affected (only part of VAT revenues would be earmarked for development). However, the negative effect on donor countries' budgets due to decreasing discretionary tax income has to be considered.

Impact on aid architecture for health and harmonization: The De-Tax can be implemented unilaterally on a national level. Its sponsor states that it will not add complexity to the aid architecture for health, "as it implies the establishment of a national dedicated fund where VAT revenues and business' contributions will be collected. The resources so mobilized will be transferred through existing channels." The impact of new national funds on aid architecture and coordination among donors will need to be an area of focus.

Results: Does not depend on mechanism but on channel.

Accountability: Does not depend on mechanism but on channel.

Pro poor: Does not depend on the source but on the channel and use.

Summary and overall evaluation

The De-Tax has the capacity to raise substantial additional revenues in participating countries.

The De-Tax would also help raise awareness of the importance of health systems. This benefit is estimated to be similar to that of blended value products or Voluntary Solidarity Contributions. The De-Tax is a relatively new proposal; Italy is carrying out a feasibility study of technical and administrative issues.

Further information

Information: Presentation by Giulio Tremonti, DE-TAX: A new approach to development finance, for the Taskforce on Innovative International Financing for Health Systems, London, 13 March 2009.

Global Lottery

Description

A global lottery would direct the proceeds from nationally executed and regionally or internationally coordinated lotteries towards international development. Participation by countries would be voluntary. Lotteries can generate funds for governments and/or charities by paying out prizes that are significantly lower than total sales. (An alternative approach, not considered here, would be a globally executed lottery organized by an international body.)

General criteria

Value added: Additional funds from a new source.

Experience: National lotteries are an established source of income mainly for governments and charities. Existing lotteries mostly support national causes but sometimes give a share to international causes. For example, World Bank (2009) estimates that Belgian and U.K. lotteries transferred US$66 million to developing countries in 2007.

Technical feasibility: The feasibility of national lotteries has been proven in virtually every country. The mechanism's only new requirement would be that participating countries either give a share of their proceeds to health systems in developing countries or start a new national lottery whose proceeds would be channeled to health systems in developing countries.

Political sponsors: None.

Timeframe for implementation: Estimated to be one to two years after the political commitment has been made.[xlii]

Financial criteria

Realized flows: It is estimated that, in 2003, lotteries worldwide generated government income of about US$50 billion in total. Of this amount, about US$25 billion was generated in Europe and US$15 billion in North America. It is also estimated that during the same year, 41 national lotteries each generated government income of more than US$300 million, and two lotteries generated government income of about US$3 billion. Net income from U.S. lotteries that year was US$13.3 billion.[xliii]

Potential flows: If a global lottery could gain 0.5 to 1% of worldwide market share – an optimistic assumption – it would generate US$250 to US$500 million in the first year of operation and US$750 million to 1.5 billion in the third year. Extrapolation from the size of existing lotteries suggests that ten countries would each have to create a lottery with sales equal to those of the world's top 40 lotteries in order for the global lottery to generate US$3 billion annually.

The lottery's cost structure would be similar to that of existing national lotteries: about 50 to 60% of sales are paid out in prizes, about 30 to 40% is transferred to governments and charities, and about 10% covers administrative and operational costs.

Most revenues are expected to come from international sources. In 2003, total lottery sales in Africa were only US$1 billion; in Central and South America and the Caribbean they were only US$3.6 billion. In contrast, in Europe they were US$75.8 billion and in North America they were US$49.1 billion.

Costs (set-up and running costs): It is estimated that costs, including commissions, would be about 10% of sales.[xliv]

Additionality: Revenues from a global lottery are likely to be additional. Revenues are concessional and do not have to be paid back. Crowding out is expected to be low because national lotteries do not currently provide significant funds to development and health systems. However, a global lottery could compete with national lotteries and crowd out funds for charitable causes.

Sustainability: Proceeds from lotteries are considered to be sustainable. Sustainability also depends on countries' long-term willingness to earmark proceeds for health systems.

ODA: The mechanism could be structured so that revenues count as ODA. For example, Belgium counts the revenues from its national lottery that are channeled to developing countries as ODA.

Aid effectiveness criteria

Country ownership: Does not depend on mechanism but on channel.

Predictability: Information is not available.

Alignment: Does not depend on mechanism but on channel.

Synergies and externalities: A lottery raises particular issues, including addiction and other gambling issues. Some positive externalities may arise in the form of greater awareness of health systems if the lottery is connected to an awareness campaign.

Impact on aid architecture for health and harmonization: Does not depend on mechanism but on channel.

Results: Does not depend on mechanism but on channel.

Accountability: Does not depend on mechanism but on channel.

Pro poor: Lotteries are regressive: in the country where a lottery is played, it has a negative effect especially on the poor, who are the ones most apt to play.[xlv] In the countries where the proceeds are spent, targeting funds to the poor does not depend on the source but on the channel and use.

Summary and overall evaluation

The value added of a global lottery is to raise additional funds. It would potentially generate moderately high annual revenues – very rough estimates indicate several hundred million dollars in the first years of operation, scaling up to US$1 to 3 billion if highly successful. Costs are expected to be around 10%, moderate compared to a private giving campaign, but high compared to levies. Additionality, predictability, and sustainability are expected to be high.

Like other mechanisms, a global lottery might create some additional benefit through visibility and increased awareness for the importance of health systems. However, this benefit may be limited

(perhaps comparable to that of a global premium bond) compared to other mechanisms, because lottery players typically do not have a high degree of awareness of the philanthropic element of the lotteries they enter.

One aspect of the mechanism that warrants special consideration is the regressive effect of a lottery in the country where it is held. Ample evidence shows that it is mainly the poorer segment of society that plays. The ethical aspects of promoting gambling should also be taken into consideration.

Further information

Reading: (Moore 1996; Hu, Xu et al. 1998; Jha and Chaloupka 1999; Chaloupka, Hu et al. 2000; Gruber and Koszegi 2002; van Walbeek 2003; Remler 2004; WHO Tobacco Free Initiative 2004; Cnossen 2005; Jha, Chaloupka et al. 2006; World Health Organization 2008)

Global Premium Bond

Description

This mechanism would direct the "premium" proceeds from national bonds to the development of health systems. A Global Premium Bond is a debt instrument whereby people buy savings bonds whose interest proceeds are not disbursed. A share of the interest is paid into a lottery and ultimately goes to the winners of that lottery. The remaining proceeds are directed towards development, with some portion covering the bond's administrative costs.

This mechanism involves creating national, sovereign savings bonds like those in, for example, the United Kingdom. It would require national governments to commit to participation, to implement the bonds in their country, and to earmark revenues for health systems.

The programme would be coordinated globally. (A variation on this mechanism, not discussed here, would involve the sale of premium bonds from developing countries to those in other countries. Effectively, people would take on developing countries' credit and political risk. This version would be a slightly concessional, frontloading instrument.)

General criteria

Value added: Additional funds from a new source.

Experience: National premiums bonds (also called lottery bonds) have been implemented in several countries including France, Germany, Sweden, and the United Kingdom.

Developing countries have no experience to date with premium bonds. It is expected that most revenues would come from international sources.

Technical feasibility: The technical feasibility of national premium bonds has been proven in several countries.

The mechanism would require participating countries to give a share of the proceeds from their national premium bonds to health systems in developing countries or to issue new national premium bonds that transfer proceeds to health systems.

Political sponsors: No specific sponsor.

Timeframe for implementation: No estimates are available.

Financial criteria

Realized flows: It is estimated that in the past year, outstanding premium bonds in the United Kingdom generated over £600 million. It is also estimated that the average spread over the past year on premium bonds as compared to regular sovereign savings bonds was 1.7%, and that £37 billion in premium bonds are outstanding.[xlvi]

Potential flows: Investment decisions by individuals, especially through small savings accounts, are relatively stable. Premium bonds in the United Kingdom have a market share of 10 to 20%. If this range could be achieved in five countries with comparably sized economies, the revenue from a Global Premium Bond would be about US$450 to 900 million a year.

Costs (set-up and running costs): No estimates are available.

Additionality: Revenues from a global premium bond are very likely to be additional. Revenues are concessional and do not have to be paid back (on the basis of the net revenue estimates in this review). Crowding out is expected to be low, because premium bond revenues do not currently support development efforts.

Sustainability: Experience in the United Kingdom suggests that premium bonds can be a sustainable source of development funding. The amount invested in premium bonds there has risen continuously from £15.4 billion in 2001 to £36.9 billion in 2008.[xlvii]

ODA: It is expected that if the mechanism is implemented by national governments and structured appropriately, funds would qualify as ODA. However, no experience is available.

Aid effectiveness criteria

Country ownership: Does not depend on mechanism but on channel.

Predictability: Expected to be high, based on experience in the UK, where the amount invested in premium bonds has risen continuously since 2001.

Alignment: Does not depend on mechanisms but on channel.

Synergies and externalities: Small positive externalities are possible. A global premium bond might raise some awareness for health systems if connected to an awareness campaign. However, such awareness is expected to be lower than for private donations (it would probably be comparable to the awareness raised by a global lottery), because the primary reason people buy premium bonds is not philanthropy.

Impact on aid architecture for health and harmonization: Does not depend on mechanism but on channel.

Results: Does not depend on mechanism but on channel.

Accountability: Does not depend on mechanism but on channel.

Pro poor: The regressivity/progressivity of a premium bond in the country where it is issued is mixed. On one hand, lower-income families tend to invest in premium bonds. Assuming that these bonds pay lower average returns than other investments, the bonds would therefore be regressive. However, the regressivity is expected to be lower than for lotteries, since premium bonds require higher levels of investment. On the other hand, premium bonds are considered a good incentive for lower-income households to save money.[xlviii]

In the countries where proceeds are spent, targeting funds to the poor does not depend on the source but on the channel and use. Funds are potentially pro poor, since they could lower out-of-pocket payments.

Summary and overall evaluation

The value added of a global premium bond is to raise additional funds. Potential revenues are estimated to range between US$450 and US$900 million annually – slightly lower than revenues generated by a global lottery. Additionality, predictability, and sustainability are expected to be high.

It is expected that a global premium bond would be a flexible fundraising instrument, comparable to a global lottery and solidarity levies.

Like a global lottery, a global premium bond might create an additional (albeit small) benefit by raising awareness of the importance of health systems.

Also like a global lottery, a global premium bond could have potentially regressive effects in the country that generates funds.

There are no detailed studies of implementation, including timeframe. However, premium bonds have proven successful on a national level.

Further information

Information: UK: www.nsandi.com
Sweden: https://www.riksgalden.se/templates/RGK_Templates/TwoColumnPage____1875.aspx
Germany: http://www.gsv.de/inhalte/index.php
http://www.postbank.de/privatkunden/pk_gewinnsparen.html

Reading: (Guillén and Tschoegl 2002; George Chacko 2003; Addison and Chowdhury 2005; Tufano 2008)

Health Systems Funding Platform (Multi-Donor Trust Fund)

Description

The proposed Health Systems (HS) Funding Platform would be a long-term mechanism for coordinating, combining, and channeling multiple streams of new and existing funds to developing countries.

As a disbursement mechanism, it could draw on the IHP+ framework. It could fund programmes of IHP+ member institutions, finance national health plans directly, and provide short-term bridge financing or credit as needed to speed up disbursements for drugs and other supplies.

The HS Funding Platform could be structured in a number of ways – along the lines of existing mechanisms like the Norwegian Health Results Innovation Fund and IFFIm, or like a private sector bank that is active worldwide. It could accept flows from levies, private contributions, private sector investment and guarantees, and other sources.

Long-term commitments could be made conditional on adherence to results-based financing rules, in order to limit fiscal impact to current payments. Funds could be allocated under existing, expanded, or adapted governance arrangements, or by a trust committee.

General criteria

Value added: Coordinating financing sources and channeling funds to countries; improved harmonization of HS flows.

Experience: Several elements of the proposed HS Funding Platform could draw on the experience of existing mechanisms. Coordination functions could be based on IHP+ experience, financial management could be based on the experience of Multi-Donor Trust Funds, and channeling and allocation could be based on the experience of organizations like the World Bank, Global Fund, and GAVI.

Technical feasibility: Technical feasibility has been proven for several elements of the proposed HS Funding Platform because several successful existing organizations have comparable elements, as noted above. The biggest challenge of implementation would involve combining the different functions and designing the mechanisms needed to support aid effectiveness, i.e., ensuring harmonization and alignment.

Political sponsors: No sponsor.

Timeframe for technical implementation: Based on experience from existing complex Multi-Donor Trust Funds, some 12 to 18 months would be needed to set up the mechanism's basic functions. More complicated functions, such as frontloading, would take more time.

Financial criteria

Realized flows: None to date.

Potential flows: Would depend on overall financing to health systems. Could be several billion USD annually.

Costs (set-up and running costs): Estimated to be US$1 to 3 million, based on the costs of setting up Multi-Donor Trust funds and new vertical funds.[xlix]

Additionality: No financial additionality. The HS Funding Platform would simply channel and coordinate sources.

Sustainability: Would depend on the sustainability of sources.

ODA: It is expected that concessional funds from public donors channeled through a HS Funding Platform and used to strengthen health systems would qualify as ODA.

Aid effectiveness criteria

Country ownership: The HS Funding Platform would be a good tool for delivering funds according to countries' needs. Its governance structure could give countries broad representation.

Predictability: The HS Funding Platform, by coordinating sources, is expected to increase the predictability of funding. If modeled on Results-Based Financing (RBF), the predictability of inputs to countries might be slightly lower.

Alignment: If built on IHP+ principles, as proposed, the HS Funding Platform would have a high degree of alignment with country systems.

Synergies and externalities: No synergies or externalities.

Impact on aid architecture for health and harmonization: If set up carefully, the HS Funding Platform could help harmonize donors and decrease the complexity of the aid architecture. However, it could increase the complexity of the aid architecture if it caused the evolution of a new kind of aid structure.

Results: If built on IHP+ and RBF principles, would support results.

Accountability: Would provide the opportunity to institute best practices in accountability.

Pro poor: Depends on the disbursements principles established. If based on RBF, funding could be targeted to benefit the poor.

Summary and overall evaluation

This is a new proposal that needs fleshing out. Its value added would be coordinating financing sources and channeling funds to developing countries. It would respond to one of the main challenges of the Taskforce: finding an efficient, effective disbursement channel that connects the various sources of health systems financing and coordinates the aid architecture for health.

Impact Investment Fund for Health Systems

Description

The proposed mechanisms would be an impact investment fund for developing country health systems.[I] Impact investing generates social value along with financial returns. Investors get a "proper" return on their money, which is invested specifically to drive positive social change. In this case, funds would be invested in companies and organizations engaged in "best-practice" work in health care in developing countries. Impact investment can include both private equity and debt investments. Funds would come from private investors who want a reasonable return on their investments, and believe the instruments they are choosing could also contribute to long-term, sustainable improvement in developing countries' health systems. Typically, impact investors are looking to support entrepreneurs trying to build viable enterprises that would have social benefits in high-risk environments.

Investment impact funds can be set up by a private entity or a multilateral development bank. The funds would be invested in private organizations involved in high risk, pro-poor health systems projects. The fund would operate according to IHP+ guidelines and principles.

Investment funds can have different funding sources, including private for-profit investors, socially responsible investors (that is, investors who are not actively seeking new instruments that support social causes but instead are screening the existing landscape in order to avoid instruments with negative social impacts), and public investors such as national banks and multilateral development banks. Investment funds can also differ in the social element they support and in the financial return investors seek. Some investors expect no financial return except for preservation of the principal (see Kiva.org), some expect a certain amount of financial return but also put a high premium on social impact (typical impact investing), and some seek to maximize financial return (conventional foreign direct investment). Impact investment funds are targeted to achieving a combination of both social and financial returns, with the funding coming from private investors.

General criteria

Value added: Impact investments would potentially generate additional private investment in health systems. They might bring investors into development environments whose high degree of risk can be tolerated only by those with an active commitment to the social values promoted.

Experience: Impact investments have been piloted and scaled up mostly in three sectors: clean technology, microfinance, and, to a somewhat lesser extent, community investing in the United States; there are a number of small and/or new funds.

Technical feasibility: The technical feasibility of impact investments has been proven for microfinance, clean technology, and community development in the United States. Feasibility with regard to health systems in developing countries will depend on identifying good investment opportunities. Recent trends indicate growing and sufficient interest in new impact investment opportunities in health systems on the part of both private investors and foundations. In addition, some impact investors currently engaged in one of the three existing sectors might be ready to diversify into a new sector.

Political sponsors: No specific sponsor, although impact investing is promoted by the Rockefeller Foundation.

Timeframe for implementation: No estimates are available.

Financial criteria

Realized flows: No figures for impact investments in health systems are available. Recent figures for impact investments in microfinance include a portfolio of loans totalling US$87 million issued by Blue Orchard, and more than US$600 million channeled by a Zurich-based advisory firm. Figures for impact funds in clean technology include a US$638 million Climate Solutions Fund established in 2008 by the Generation Investment Management Fund and a US$335 million fund established by Mission Point Capital Partners.

Potential flows: A useful pilot approach might be to start an impact investment fund in commercially viable health systems projects on the order of US$100 to US$200 million, which could be scaled up later. It is estimated that the total market for impact investing of all sorts could reach US$500 billion within the next decade.[II] If impact investing in health systems could capture 1 to 2% of this market, annual impact investments in health systems could be as much as US$500 million to US$1 billion. These estimates are based on the assumption that impact investing in health systems would enjoy success comparable to impact investing in microfinance, and those investors could find sufficient investment opportunities. Most funds are expected to come from international sources.

Costs (set-up and running costs): No cost estimates are available.

Additionality: Impact investing in health systems is considered to be additional to some degree. Funds are not expected to crowd out existing ODA, but might crowd out some foreign direct investment that otherwise would have gone to developing countries. The grant element of debt investments and the foregoing of return on equity would be comparatively low by development aid standards.

Sustainability: Expected to be medium to high. Invested capital might be difficult to withdraw. Also, impact investors might be less inclined than conventional investors to withdraw money in times of crisis.

ODA: Impact investments are private investments and therefore do not qualify as ODA.

Aid effectiveness criteria

Country ownership: Impact investing would be channeled to the for-profit sector (and potentially to some non-profit and low-profit organizations), not to government systems. Therefore, there would be no country ownership; ownership would be by health businesses within countries.

Predictability: Little experience to draw on.

Alignment: If combined with a properly designed non-state-sector mechanism, impact investing could be closely aligned with country systems.

Synergies and externalities: Potential heightened visibility or public awareness effects.

Impact on aid architecture for health and harmonization: Impact investing has earmarking issues and would require some degree of harmonization with existing aid architecture.

Results: Impact investors by definition focus on projects that have a positive social impact, and equity investments are strongly results-driven because they provide incentives to entrepreneurs. (However, unless carefully structured, results-focused, incentive-based investments can create distortions such as over-servicing that can conflict with the intention to create social change. The results orientation of any specific impact investment fund will depend on the concrete implementation of the fund.)

Accountability: The mechanism is based on the concept that

investors are willing to take responsibility for social change and hence would be accountable for their investments. Also, the mechanism makes entrepreneurs accountable in terms of delivering results for health systems as well as building sustainable, profitable businesses.

Pro poor: The mechanism contains some ambiguities in this regard. (i) On one hand, it could be pro poor by stimulating direct investment in companies that serve the poor and by helping to foster strong local industries that create sustainable jobs and growth. On the other hand, its for-profit component could bias it toward investments with strong returns that might favour the rich. (ii) Impact investing might have some indirect pro-poor effects: funds from international impact investors might relieve a developing country's government of the need to make certain investments, potentially freeing up government funds for other pro-poor uses. However, there is no hard evidence to support this scenario, especially the assumption that freed-up capital would be used for health systems.

Summary and overall evaluation

The value added of impact investing is to raise additional funds that would be invested in private health systems ventures (for-profit, non-profit, and social enterprises). A useful pilot approach might be to start an impact investment fund on the order of US$100 to US$200 million, which could be scaled up later.

The success of impact investing for health systems will depend on the quality of investment opportunities. The general concept of impact investing is technically feasible, as has been proven in other sectors.

Funds would not be channeled through one of the conventional bilateral or multilateral channels, such as multi-donor-trust funds and vertical funds. Funds would have to be channeled through a dedicated investment fund or directly from investors to businesses.

This mechanism has many similarities to a mechanism explored later in this report, an investment fund for private health-service delivery. The chief difference is that the impact investment fund would rely on private investors and the fund discussed later would (at least initially) rely on development banks and public sources.

Further information

Information: http://www.rockfound.org/efforts/impact_investing/impact_investing.shtml
http://www.blendedvalue.org/
http://www.globalimpactinvestingnetwork.org/
http://www.rootcapital.org/
http://www.acumenfund.org/

Reading: (Global Foundation Leaders Advisory Group 2005; World Economic Forum 2006; Monitor Institute 2009)

Investment Fund for Private Delivery of Health Services[lii]

Description

The proposed mechanism would provide access to capital to for-profit, non-profit, and faith-based private and social enterprises by:

- Creating targeted private-equity vehicles to provide private health companies with capital and with expertise. Fund managers would be given incentives to invest in companies that provide services to the poor.
- Providing lines of credit and credit enhancements to local banks in order to encourage them to lend to the private sector at reasonable rates. The banks and the health care companies they fund should receive technical assistance in building the capacity for these mechanisms.
- Creating a targeted venture-capital fund to provide capital and expertise to start-up health care companies in order to encourage entrepreneurship and risk-taking in the health sector, particularly in providing services to the poor.

Financing is expected to come foremost from bilateral and multilateral development banks. If the concept proves viable in the long run, private investors might contribute to the fund.

General criteria

Value added: Increasing flows and engaging the private sector in the delivery of health services. An investment fund would increase the flow of at-risk and debt capital to the private sector (including for-profit and non-profit actors). Equity could be used to drive greater efficiencies through consolidation in health care sub-sectors, and to replicate business models proven in other countries or regions. Debt financing might also contribute to expansion capital.[liii]

Experience: *Private-equity vehicles:* IFC, AfDB, the Gates Foundation, and DEG have together established a US$100 million fund to support private health companies in Africa. FMO and Goldman Sachs have together established a similar fund.

Lines of credit and credit enhancements: Institutions such as IFC, USAID, and AfDB have products that provide such support to local banks.

Venture-capital funds: Experience exists in other sectors.

Technical feasibility: The proposed instruments have been proven through several pilots, which could be scaled-up if given financial and political support. Technical feasibility depends on countries' readiness for private sector participation in health, including whether they have the regulatory systems and legislative and stewardship functions needed for the successful functioning of private health insurers, private hospitals, and so on. An advisory platform is proposed as a complementary mechanism that could help assure these instruments' success.

Political sponsors: World Bank Group.

Timeframe for implementation: *Private equity vehicles*: According to IFC, a fund for health systems could be established in 12 to 18 months.

Lines of credit and credit enhancements: Immediately.

Venture-capital fund: Could be established in 18 to 24 months.[liv]

Financial criteria

Realized flows: None to date.

Potential flows: *Private equity vehicles:* US$5 million of seed money. US$500 million to US$1 billion of investment funds to be provided by private sector DFIs and private investors over three to five years. US$30 to US$50 million of technical-assistance funds.

Lines of credit and credit enhancements: US$1 billion of credit facilities funded through a combination of the balance sheets of local banks and DFIs over three to five years. US$50 million of technical-assistance funds.

Venture-capital fund: US$1 million of seed money. US$50 million of investment funds for the initial pilot. US$10 million of technical-assistance funds for the initial pilot.[lv] Most funds are expected to come from international sources. They could come from governments and also private investors, including impact investors.

Costs (set-up and running costs): Estimates are not available, but

costs are expected to be comparable to costs for World Bank Group private sector operations.

Additionality: Limited additionality expected. The mechanism would use ODA or one the fundraising mechanisms discussed above. However, initiatives targeting funds to the private sector might attract donors who might not contribute to other mechanisms proposed by the Taskforce.

Sustainability: The sustainability of financing the mechanism depends on the source. Long-term sustainability is ambiguous. On one hand, private sector operations are considered sustainable, because no donor financing is required over the long run. On the other hand, for-profit private providers might leave the sector if it does not become profitable within a short time.

ODA: Not expected to qualify as ODA. Funds would be provided on non-concessional term to private sector actors. Could potentially be designed to qualify as ODA if returns on investments remained in multilateral institutions, such as development banks.

Aid effectiveness criteria

Country ownership: The mechanisms would support private sector providers operating independently of country control but within the limits of country regulations.

Predictability: Predictability of financing of the mechanism depends on the source. Predictability of activities and delivery of services depends on various elements, including business opportunities, regulation, and long-term access to financing.

Alignment: It is expected that private actors would be well aligned with existing country systems. Countries would provide the framework for alignment through regulation.

Synergies and externalities: Some synergies with and externalities for private sector operations in other sectors is expected.

Impact on aid architecture for health and harmonization: None. Implementation would be within the existing institutional framework.

Results: Private sector operations and investments tend to focus on results. Investments tend to have a results focus since private sectors' capital is at stake as long a private sector income depends on results.

Accountability: Accountability in the private sector is considered to be high, assuming sufficient oversight and transparency of operations.

Pro poor: The mechanisms could be pro poor (i) directly, by investing in companies that serve the poor. However, private sector operations have an inherent bias toward providing services to those who can pay. Pro-poorness would have to be guaranteed through appropriate implementation. (ii) Indirectly, by removing the financing burden from governments. However, this effect is not proven and is controversial (see Impact Investing).

Summary and overall evaluation

The primary role of an investment fund would be to provide equity and debt financing to the private enterprises. This could increase the efficiency and effectiveness of the health sector.

The mechanism is expected to provide results in many of the aid effectiveness criteria, particularly because the delivery of funds would not rely on the aid industry but on the private sector. If successful, the mechanism could create sustainable institutions in the health sector and would not rely on aid in the long run. However, success requires countries' readiness to engage the private sector in health, and especially to apply effective regulation.

The mechanism involves a trade-off with respect to the use of public funds. On one hand, supporting the private sector could increase efficiency and effectiveness in the delivery of health care. On the other hand, the funds would support for-profit activities.

This trade-off is intensified by the fact that for the mechanism to be considered successful, increases in efficiency and effectiveness would have to be large and demonstrable, in which case the profits of the private actors involved would also tend to be large.

Further information

Reading: (Preker and Harding 2000; Harding and Preker 2003; Marek, Eichler et al. 2004; Preker and Langenbruner 2004; International Finance Corporation 2007; Preker, Baris et al. 2007)

Long-Term Grants

Description

Donors could commit to providing long-term, legally binding financing for health systems as a regular practice.

General criteria

Value added: Predictability of financing. (Unpredictability and volatility of donor contributions creates significant costs for developing countries.[lvi])

Experience: Grants and contributions to IDA and the soft-loan windows of regional development banks, the Global Environmental Facility, and other multilateral funds are made over three or four years and paid over eight to ten years. Experience with IFFIm and the Advance Market Commitments (AMC) pilot demonstrates the feasibility of commitments from some donors of up to 20 years. The EU expects to launch a Millennium Development Goals (MDG) contract in a number of countries in order to create a long-term, more predictable form of general budget support. The MDG contract would guarantee a six-year commitment of funds.[lvii]

Technical feasibility: On the donor side, long-term grants to IFFIm have been proven to be feasible, as a number of countries have made legally binding commitments. On the recipient side, the effects of commitments of 10 to 20 years have not been truly tested, since the terms have not yet ended. Technical feasibility depends mainly on donors' will and on any legal or budgetary constraints on long-term commitments. The legislative process in several major donor countries limits or discourages entering into legally binding commitments of more than three years.

Political sponsors: No specific sponsor. Donors agree generally about the usefulness of long-term contributions.

Timeframe for implementation: IFFIm's experience suggests that some long-term grant pilots could be implemented within one to three years. Scaling up the mechanisms would take longer. Many of the operating procedures used for conventional development aid would have to be changed.

Financial criteria

Realized flows: Long-term commitments (up to 20 years) to IFFIm total US$5.3 billion, and to the pilot AMC total $1.5 billion.

Potential flows: These depend on donors; might involve a substantial part of total ODA. Most funds are expected to come from international sources.

Costs (set-up and running costs): No substantive cost estimates are available. Developing new long-term financial mechanisms could involve substantial costs. The ongoing costs of providing long-term grants to countries are expected to be comparable to the costs of running conventional grants.

Additionality: No additionality is expected. The mechanism would not tap a new source of funding; rather, it would change the modalities of existing ODA. (One could argue that long-term commitments might generate some additionality nonetheless, because donors who found themselves facing unexpected budget constraints after the fact could not reduce their ODA, or could reduce it only by a small amount. One could also argue a contrary position, that donors might be more reluctant to commit large annual amounts if they had to commit for many years in the future, and that funds donated might decrease if long-term commitments were not simply one option for ODA but were the norm.)

Sustainability: High. Long-term commitments are sustainable by definition.

ODA: It is expected that long-term grants would qualify as ODA as payments are made.

Aid effectiveness criteria

Country ownership: Strengthens country ownership. Long-term commitments would transfer responsibility to recipient countries because micro-management by donors would be more difficult over the long term.

Predictability: High, by definition.

Alignment: Does not depend on mechanisms but on channel.

Synergies and externalities: Does not depend on mechanisms but on channel.

Impact on aid architecture for health and harmonization: Does not depend on mechanisms but on channel.

Results: Does not depend on mechanisms but on channel.

Accountability: Long-term grants will not in themselves increase accountability, but they will make accountability even more important. Long-term grants require greater trust on the part of donors that funds will be used responsibly. Therefore, accountability and transparency need to be built into any new mechanisms.

Pro poor: Does not depend on mechanisms but on the source and the channel.

Summary and overall evaluation

The value added of long-term grants is to provide predictable and sustainable long-term financing for the development of health systems. Long-term grants are proposed not only for a single financing mechanism such as IFFIm; they might also be used to implement many of the other mechanisms described in this paper, such as Results-Based Financing (RBF).

Experience with IFFIm and the AMC pilot has proven legally binding long-term commitments to be feasible for several donor countries. However, several countries cannot provide long-term grants due to legal reasons and budgetary processes.

Long-term grants score high on aid effectiveness criteria for providing predictable funding and strengthening country ownership. From a donor perspective, they require trust in countries' long-term and stable capacity to implement programmes.

Further information

Information: www.theglobalfund.org/en/innovativefinancing/debt2health/
www.bmz.de/en/zentrales_downloadarchiv/Presse/GFATM/09_Debt2Health_Factsheet_en.pdf

Reading: (Hansen 1989; Kaiser, Lambert et al. 1996; Cassimon and Vaessen 2007; Global Fund to Fight Aids Tuberculosis and Malaria 2007; Cassimon, Renard et al. 2008)

Mobile Phone Voluntary Solidarity Contribution[lviii]

Description

The proposed Mobile Phone Voluntary Solidarity Contribution (VSC) would allow individuals and corporations to make voluntary donations via their monthly mobile phone bill. Mobile phone users who opted into the programme would pay a fixed additional amount, ranging from the equivalent of €1.5 (China) and €6.5 (Ireland), with their monthly bill.[lix] This VSC is tied to mobile phones rather than to landline or internet services for several reasons, including the high number of mobile phone users worldwide (3.5 billion), the high worldwide revenues from postpaid mobile phone service (US$750 billion in 2008), the continuing growth of the industry, and its concentrated market structure, containing a limited number of providers. The mechanism is currently under development by the Millennium Foundation for Innovative Finance for Health. Initially, all revenues would go to UNITAID.

General criteria

Value added: Additional funds from a new source.

Experience: None to date. The most comparable existing mechanisms are other blended value products, such as (PRODUCT) RED.

Technical feasibility: Currently being explored by the Millennium Foundation. Implementation appears to be feasible but complex. Mobile phone services are a highly concentrated area of business: the top six operators have almost 80% of the market share for postpaid subscriptions. Implementation of a Mobile Phone VSC would, however, be complicated by the number and variety of costs for operators (adaptation of information systems, including charging, order taking, billing, and settlement), by potential effects on customer relationships, and by the need for marketing.

Political sponsors: The Millennium Foundation for Innovative Finance for Health, along with its supporters (UNITAID and its funders: the Gates Foundation, Brazil, Chile, France, Norway, Korea and the United Kingdom).

Timeframe for implementation: Assuming comparability to the timeframe for the Airline Ticket VSC, the planning phase, from the first feasibility study of the launch of a pilot programme, is expected to take one to two years. Full rollout is likely to take another three years.

Financial criteria

Realized flows: None existing.

Potential flows: The Millennium Foundation estimates potential revenues of between €200 million (under a minimum scenario), €650 million (realistic scenario), and €1.3 billion (optimistic scenario) annually, starting four years after the launch.[lx] Most revenues are expected to come from Japan (40%) and the United States (31%), but a significant amount is expected from middle-income countries, including China (9%).[lxi] The Foundation

estimates that an additional €215 million could be generated in China if the government provided nationwide incentives for consumers to participate.[lxii]

Costs (set-up and running costs): If comparable to Airline Ticket VSC, estimated to be 1 to 3% of revenues.

Additionality: Likely to be additional for the same reason as other VSCs.

Sustainability: Expected to be relatively high. Contributions would be recurrent since they would be linked to recurrent mobile phone bills. In addition, the industry's number of customers and revenues are expected to grow.

ODA: Private voluntary contributions do not qualify as ODA.

Aid effectiveness criteria

Country ownership: Some degree of earmarking of funds might be needed in order to motivate consumers to give. This might limit country ownership and flexibility to target funds. But since contributors making micro-donations of this sort are less informed about the cause than contributors to a private giving campaign, the effect of the Mobile Phone VSC on country ownership should be less than that of private campaigns.

Predictability: Expected to be relatively high because contributions would be linked to recurrent mobile phone bills, and because the size of contributions would be fixed: funds raised would depend only on the number of participating mobile phone subscribers, not on phone companies' revenues.

Alignment: As discussed under country ownership, the potential need to earmark funds might limit alignment with country systems and priorities somewhat. However, this effect should be smaller than the limiting effect from earmarking in a private giving campaign.

Synergies and externalities: Would raise awareness of the importance of health systems.[lxiii]

Impact on aid architecture for health and harmonization: Does not depend on mechanism but on channel. If implemented by a new organization, such as the Millennium Foundation, the complexity of the aid architecture for health would increase. Close cooperation between the new player, UNITAID, and WHO would mitigate the added complexity.

Results: Does not depend on mechanism but on channel.

Accountability: Does not depend on mechanism but on channel.

Pro poor: As with other VSCs, likely to have a positive effect for its additional funds and charitable character. (See Airline Ticket Voluntary Solidarity Contribution.)

Summary and overall evaluation

Overall, the benefits and drawbacks of the proposed Mobile Phone Voluntary Solidarity Contribution are almost identical to those for the Airline Ticket VSC. Revenue estimates are similar (about US$1 billion annually), funds are expected to be highly additional, and collection costs should be comparable.

So far the Mobile Phone VSC is less concrete and detailed than the Airline Ticket VSC. Therefore, it is expected that it would take longer to work out a pilot and implement the mechanism. Also, the market for mobile phone services is slightly less concentrated than the market for airline ticket purchases, making large-scale implementation somewhat more challenging.

Further information

Information: No detailed information is available.

Output-Based Aid

Description

Output-Based Aid (OBA) uses explicit performance-based subsidies to support the delivery of basic services in instances where policy concerns justify using public funding to reduce high out-of-pocket payments.

The core of the OBA approach involves contracting out the delivery of services, commonly but not exclusively to a private sector actor, and linking the payment of public funds to the actual delivery of those services. This transfers risk from the government to private providers. In the health sector, OBA fosters government contracts with private sector health care providers, covering the delivery of health services and possibly also health insurance for the poor. It can increase the output of health workers, particularly nurses and community workers.

OBA is a form of Results-Based Financing, and the two terms overlap somewhat. The critical distinction is that OBA focuses on contracts with private sector providers, whereas other forms of RBF typically have a public-sector focus.

General criteria

Value added: Increasing the efficiency and effectiveness of expenditures to the health system.

Experience: The mechanism draws on the World Bank Group's experience with numerous existing OBA projects.

Technical feasibility: Has been proven with a range of output-based aid programmes, including in post-conflict environments. Some 120 OBA programmes are currently in various stages of implementation by the World Bank Group. Other institutions are also engaging in OBA projects.

Political sponsors: This mechanism draws on the experience of the Global Partnership for Output Based Aid (GPOBA), an initiative administered by the World Bank that involves multiple bilateral and multilateral donor agencies: the Australian Agency for International Development (AusAID), the International Finance Corporation (IFC), the Dutch Ministry of Foreign Affairs (DGIS), the Swedish International Development Cooperation Agency (SIDA), and the United Kingdom's Department for International Development (DFID).

Timeframe for implementation: No start-up time would be required. IFC's Performance Based Grant Initiative, for example, has been operating since 2006, in close coordination with the GPOBA. Other institutions have also successfully piloted voucher schemes.

Financial criteria

Realized flows: Funding for World Bank OBA projects under implementation to date totals about US$3.7 billion. US$2.6 billion of this comes directly from donor funding; the other US$1.1 billion comes from government co-financing.

Potential flows: The near term demand and capacity for ODA for health systems is expected to be US$200 million, with most funds coming from international donors.

Costs (set-up and running costs): Set-up and running costs should be comparable to those of conventional World Bank Group non-state-sector operations.

Additionality: No additionality from new financing sources, since funds would come from ODA or one of the other mechanisms proposed in this report. Some additionality is expected from increased co-payments if services are provided to the non-poor. Also, the mechanism would trigger upfront private sector investments to upgrade health-care capabilities.

Sustainability: Depends on the long-term commitment of donors.

ODA: It is expected that ODA interventions to strengthen health systems in low-income countries would qualify as ODA if financing comes from public sources (for example, a country's general development budget or a Solidarity Levy).

Aid effectiveness criteria

Country ownership: OBA can be designed in a country-driven process. Country ownership would be high if projects are country-driven in practice.

Predictability: The predictability of funds depends on long-term commitment by donors. Actual disbursements are likely to vary according to the results delivered and the degree of success achieved by health-care providers.

Accountability: The mechanism provides a framework for accountability, since the disbursement of funds is tied to results.

Synergies and externalities: Possible improvements in data collected, and in monitoring and evaluation; also, an increased motivation to report. However, if systems are poorly designed, the incentive to misreport could increase.

Impact on aid architecture for health and harmonization: None. The mechanism could be implemented within the existing institutional framework and would require no new facilities.

Results: The mechanism is specifically designed to reward results. First evidence (for example, from programmes in Rwanda and Uganda, described in Working Group 1 report) is promising.

Alignment: Positive, again to the degree that projects and grants are country-driven, and depending on the design of trust fund, the benchmarks used to measure results, and health service activities in country.

Pro poor: OBA provides opportunities for targeting groups who are particularly poor or particularly at risk, but incorporating pro-poor requirements in output indicators. However, OBA programmes aimed at expanding training for health-care workers are less likely to be explicitly pro poor focus.

Summary and overall evaluation

The value-added of OBA is to create incentives within country systems, mainly in the private sector (including for- profit, non-profit, faith-based, and social enterprises), to deliver tangible results. OBA is a Results-Based Financing mechanism geared toward the private sector.

Its advantages and disadvantages are similar to those of other forms of RBF: It is expected to be strong in supporting results and providing opportunities to target goods and services toward the needs of the poor. More than government-oriented RBF, it tries to introduce transparent competition among private sector providers and to transfer risk from the government to private sector providers. OBA also triggers upfront private sector investment. However, it will work only in circumstances where results can be clearly defined. Shifting to OBA might decrease the predictability of financing for countries whose health care providers are under- or non-performers.

OBA's design may not make it effective for delivering all health system goods and services. It might be best used as one of several financing mechanisms in an overall funding package, complementing financing tools that focus less explicitly on results.

Further information

Information: http://www.gpoba.org

Reading: (Brook, Smith et al. 2001)

Private Giving Campaign

Description

A private giving campaign would raise funds for health systems from individuals (retail fundraising) and major foundations. It would require sponsors with organizational and strategic capacity, strong communications, and startup funding. The campaign could focus on one aspect of health systems – for example, reducing maternal mortality – that could be presented to potential givers in a straightforward, clear-cut manner. (An alternative approach would involve enlisting a group of major charities to launch a joint campaign to strengthen health systems.)

General criteria

Value added: Additional funds from an existing source.

Experience: Broad experience by UN organizations and by NGOs in all sectors. Private giving is a substantial source of revenue for several organizations.

Technical feasibility: Proven by numerous successful fundraising campaigns. However, the organization running the campaign would have to create fundraising capacity.

Political sponsors: No specific sponsor.

Timeframe for implementation: A major fundraising campaign can be started within weeks, as several emergency-relief campaigns have proven. However, this requires unusually high media exposure and momentum for the cause. Fundraising campaigns more typically require 6 to 18 months of lead time.

Financial criteria

Realized flows: Private giving generates substantial funds for development. Estimates range from US$17 billion from OECD DAC donors in 2001 to US$34 billion from donors in the United States (including faith-based organizations and universities) in 2007.[lxiv] Flows for any one purpose or organization rarely top US$1 billion a year.

Potential flows: Depends on the specific cause, campaign, and supporters. It would be optimistic to expect that a private fundraising campaign could generate several hundred millions of dollars annually in its early years. A "marketable" cause, such as a natural disaster, significantly increases fundraising results. Most revenues are expected to come from international sources.

Costs (set-up and running costs): Costs for retail fundraising vary widely. Good, comprehensive information is not available; many organizations under-report their fundraising costs because high reported costs tend to deter giving. It is expected that a well-run campaign would have "real" costs of 20 to 30% once it was fully up and running, and that costs would be higher during the first few years. Sponsors could reduce their costs by forming partnerships with other groups.[lxv]

Additionality: A private giving campaign is expected to be additional to a large degree:

- Retail funding is likely to be additional. A fundraising campaign would generate grants. There might be a moderate amount of crowding out of existing private giving to development and health.
- Contributions from foundations are less likely to be additional. Particular foundations might already be funding health in general or health systems in particular. Crowding out is expected to be medium or even high.

Sustainability: According to OECD DAC statistics, private giving to developing countries has been sustainable.[lxvi]

ODA: Private donations and donations from foundations do not qualify as ODA.

Aid effectiveness criteria

Country ownership: For giving by foundations, country ownership could be high, depending on foundation policies. For retail fundraising, country ownership is expected to be somewhat lower, because in order to attract contributors, retail fundraising generally is structured to earmark funds to a high degree.

Predictability: Private giving is considered to be volatile and cyclical to varying degrees, depending on the source. Contributions from individuals are the most volatile, since they depend on household income.[lxvii] Contributions from foundations (and from sources like remittances) are considered less volatile. According to OECD DAC statistics, private giving to developing countries has been fairly predictable (these statistics include some government contributions to NGOs).

Alignment: Effective fundraising might conflict with alignment. Private donations are easier to raise if proceeds are earmarked to highly visible causes. This earmarking might deter alignment with country systems and programmes.

Synergies and externalities: A private campaign would raise awareness for the importance of health systems.

Impact on aid architecture for health and harmonization: Depends on the organization implementing the campaign. Individuals might prefer to channel contributions through NGOs, which could increase the complexity of aid architecture and affect harmonization.

Results: Does not depend on mechanism but on channel.

Accountability: Does not depend on mechanism but on channel.

Pro poor: Compared with other mechanisms (blended value products, VSCs), private giving campaigns are expected to have the highest pro-poor effect because contributors are interested only in supporting the charitable cause. Funds generated are also potentially pro poor, since they could lower out-of-pocket payments.

Summary and overall evaluation

The value added of a private giving campaign is to raise additional funds. It could potentially generate revenues of up to US$1 billion annually, but more likely would raise less. Transaction costs are expected to be very high, especially in the start-up phase, when costs might be as much as 40% of revenues.

A considerable benefit of a private giving campaign is high visibility and a high degree of awareness of the importance of health systems.

A private giving campaign would require a channeling mechanism. Not all channels might be suitable. Individuals might prefer to give funds through NGOs and faith-based organizations rather than through national governments or "big" channels like the World Bank or WHO. This might increase the complexity of the aid architecture for health and affect alignment and harmonization.

Private giving campaigns are a mature fundraising tool and thus technically feasible, although they can be costly to implement.

Further information

Information: (Development Assistance Committee 2003; Scott 2003; Conceição and Merlen 2005; Micklewright and Wright 2005; CAF 2006; Roodman and Standley 2006; NCVO and CAF 2007; Brainard and Chollet 2008; Hudson's Center for Global Prosperity 2008; Koch 2008)

Procurement Mechanism

Description

The procurement facility would pool purchases of health goods, commodities, and services. Its purpose would be to secure the lowest possible prices by utilizing economies of scale. Successful implementation would require pooling sufficient demand, building up procurement expertise, and reducing administrative expenses. Pooled procurement could be implemented by scaling up an existing procurement facility, such as UNITAID. Alternatively, an existing multilateral organization could pool procurements for governments, bilateral and multilateral organizations, and other buyers. It either could procure on behalf of other organizations or could make its favourable terms available to them (as Access RH, discussed below, has done).

The proposed Procurement Mechanism could be modeled on AccessRH (formerly Minimum Volume Guarantee), a pilot reproductive-health procurement mechanism that "helps countries and other buyers get the lowest possible price for supplies by allowing them to buy through a master framework agreement with suppliers."[lxviii] AccessRH "contracts with manufacturers for specific products, guaranteeing a minimum volume, the magnitude of which will depend on the mechanism's appetite for risk and the forecasts provided by the buyers. In exchange for this guaranteed minimum volume, the manufacturer would extend favourable terms to buyers making purchases through the master contract."[lxix] AccessRH is managed by the United Nations Population Fund (UNFPA).

General criteria

Value added: Efficiency of procurement, and reductions in the costs of goods and services.

Experience: UNITAID reports achieving price reductions of 20 to 50% (excluding administrative costs) through centralized procurement. AccessRH projects a total return of 0.6 to 2.4% on investment in its first three years of operations.[lxx, lxxi]

Technical feasibility: The feasibility of centralized procurement has been proven in various areas of health services – for example, by UNITAID and the Global Fund to Fight AIDS, Tuberculosis and Malaria. A key factor for success will be the ability to coordinate the procurement activities of several implementing entities.

Political sponsors: No particular sponsor for health systems.[lxxii]

Timeframe for implementation: The experience of the AccessRH pilot that is comparable because the mechanism is set up within an existing multilateral organization suggests that a new procurement mechanism could be established in one to two years. [lxxiii]

Financial criteria

Realized flows: UNITAID provides procurement funding of more than US$100 million annually. Information not yet available for AccessRH.

Potential flows: A procurement mechanism can be flexibly scaled to the size needed. UNITAID's procurement funding of more than US$100 million annually could be scaled up. AccessRH is designed to carry out procurements of about US$35 to 80 million annually.[lxxiv]

Costs (set-up and running costs): Costs depend on the size of the operation and associated economies of scale. The estimated operating cost for AccessRH is US$6 million in total for the first three years, or about 7 to 17% of planned procurements. UNITAID's

operating cost for November 2006 through December 2007 was 6.5 million, or about 4.2% of disbursements.

Additionality: The Procurement Mechanism would not generate new funding. The source of funding would be conventional ODA and/or other mechanisms discussed in this paper.

Sustainability: Depends on the source of funding and on donor commitments.

ODA: It is expected that concessional funds from the public sector used for pooled procurement of health goods and services for low-income countries would qualify as ODA.

Aid effectiveness criteria

Country ownership: The mechanism would limit country choice in procurement and therefore limit country ownership.

Predictability: The mechanism should increase the predictability of costs.

Alignment: Centralized procurement could limit the use of country systems.

Synergies and externalities: Because the mechanism would potentially limit local procurement, it could reduce positive spillovers to the local economy.

Impact on aid architecture for health and harmonization: Scaling up an existing procurement facility such as UNITAID or setting up pooled procurement within an existing organization would not impact the aid architecture.

Results: Procurement is an input intervention and is not necessarily linked to results.

Accountability: Depends on the mechanism's design and implementation.

Pro poor: Although the mechanism does not specifically target poor people, more affordable drugs, vaccines, and other health goods and services would benefit the poor.

Summary and overall evaluation

The value added of a procurement facility is to save money on goods and services. Savings can be substantial – as much as 20 to 50%. Administrative costs would depend on the volume of procurements and are estimated to be between 4% and 20% of the total procurements made by the facility.

A major drawback to the proposed Procurement Mechanism is that it could potentially limit country choices in procurement, and therefore decreases country ownership.

Further information

Information: http://www.rhsupplies.org/
http://www.unitaid.eu/

Reading: (Schwanenflügel 2005; McKinsey & Company 2006; Reproductive Health Supplies Coalition and Dalberg Global Development Advisors 2008)

Public-Private Health Advisory Platform

Description

The public-private health advisory platform would advise governments on policies, regulations, institutions, supervision, and quality control in the for-profit and non-profit private sectors of health systems. The platform would help governments identify, develop, and implement Public-Private Partnership (PPP) transactions and other mechanisms to engage the private sector, such as vouchers, franchising, and pay-for-performance contracting. It could be a multi-donor institution providing on-demand technical and implementation advice.

The platform could be modeled on elements taken, variously, from two existing structures: (i) The Private Infrastructure Development Group (PIDG) and specifically the affiliated DEVCO facility.[lxxv] PIDG was established in 2002 with the aim of increasing private sector investment in the infrastructure of developing countries. DEVCO was established in 2003 specifically to address the major obstacle to increasing sustainable private sector investment in public health, which continues to be the thin pipeline of well articulated, "bankable" PPP projects contracted out by governments in a transparent fashion.[lxxvi] A facility modeled after DEVCO would, as one part of the proposed platform, advise governments about implementing PPPs. (ii) The Public-Private Infrastructure Advisory Facility (PPIAF), launched in 1999. A facility modeled after PPIAF would, as another part of the proposed platform, advise governments about upstream policy and regulatory issues.[lxxvii]

The platform could provide assistance with preparing and structuring PPP projects, promoting opportunities to potential investors, drafting PPP contracts and tender documents, carrying out the tender process, and negotiating with winning bidders and their lenders up until financial close. It could help governments enhance the business environment within the health sector, improve health-services contracting, and incentivize and regulate health insurance through strategies such as risk pooling.

General criteria

Value added: Increasing the efficiency and effectiveness of health expenditures by (i) strengthening the interface between state and non-state sectors;[lxxviii] (ii) mobilizing private investment; and (iii) increasing investment flows to the private sector.

Experience: The proposed mechanism draws on experience from DEVCO and PPIAF. Using donor funding totalling about US$20 million, DEVCO projects to date are expected to leverage private investment of about US$1.675 billion, yield US$713 million in fiscal benefits for client governments,[lxxix] and expand access or improve services for about 7.23 million people. DEVCO's pilot projects in the health sector indicate higher success rates. Since its inception, PPIAF has implemented 379 activities. Positive impact of 286 of these – three-quarters of the total, which together account for about 87% of funding – has been documented.[lxxx]

Technical feasibility: IFC mandates have led to health-oriented PPPs in several countries and have proven their technical feasibility. PPIAF experience has proven the feasibility of an advisory facility, although PPIAF does not specifically target the health sector.

Political sponsors: The Center for Global Development; the World Bank Group.

Timeframe for implementation: Setting up new facilities to provide upstream policy and regulatory advice and to support transaction mandates is expected to take six to 15 months. The World Bank and IFC could implement an advisory platform immediately, through two existing mechanisms. A joint Bank-IFC advisory unit already operates in Africa and could be easily expanded to other regions. And the IFC already provides transaction advisory services for health PPPs in several countries. Because the IFC has several potential projects in IDA/IHP+ countries already in preparation, IFC advisory services could be expanded swiftly if additional funds became available.

Financial criteria

Realized flows: DEVCO has utilized donor funding totalling about US$20 million since its inception. Since its inception, PPIAF has implemented 379 activities, whose expenditures total about US$80 million in total funding.

Potential flows: Based on sponsor experience and projections, the demand for contributions to facilities that implement policy and transaction projects is expected to be about US$70 to 150 million for three to five years.

Costs (set-up and running costs): Set-up and running costs are estimated to be comparable to those of conventional World Bank Group multi-donor partnership arrangements.

Additionality: PPPs and private-health-sector policy improvements exhibit moderate additionality, depending on which part of the private sector is involved. IFC expects that PPP advisory services costing US$20 million could trigger up to US$500 million in private sector investments. However, new investments in PPPs might crowd out some foreign direct investment that would have gone to health systems in any case.

Sustainability: The sustainability of financing depends on the source. The IFC reports that the sustainability of PPPs in emerging markets is high, even in difficult financial times. The number of PPP deals cancelled has been consistently low across countries and sectors, including the health sector. The sustainability of advisory services is enhanced when governments receiving these services themselves make significant contributions to the Platform's cost, as some governments participating in DEVCO advisory programmes have done.

ODA: It is expected that concessional funds used for the proposed Platform will qualify as ODA.

Aid effectiveness criteria

Country ownership: Positive. The Advisory Platform would (i) operate on an on-demand basis, and (ii) support countries in the context of their own health systems and policy priorities. Contributions to programme costs by recipient governments can enhance country ownership, as experience has proven.

Predictability: The predictability of financing depends on the source of funds and on donors' long-term commitment.

Impact on aid architecture for health and harmonization: The Platform could be designed within the existing aid architecture for health – for example, it could be established within an existing multilateral entity.[lxxxi] If established as an independent new entity, it might add to the complexity of the aid architecture.

Alignment: An Advisory Platform would help a government align the private sector with country systems.

Synergies and externalities: An Advisory Platform could potentially generate substantial synergies with existing aid flows and public health expenditures.

Results: An Advisory Platform would not directly link financing to results but impact has been documented in the past (see "experience").

Accountability: Does not directly depend on the financing mechanism. An Advisory Platform could increase the accountability of the private sector.

Pro poor: Does not depend on financing but on the mechanism's policies and programmes. Delineating pro-poor from broader benefits may be difficult in policy-advisory work. An Advisory Platform could support the pro-poorness of the private sector and public-private partnerships by helping governments identify and implement pro-poor engagement strategies, such as issuing vouchers to poor woman for attended deliveries, and contracting for delivery of health services in underserved areas. Advice about structuring PPPs can focus on expanding services to the poor.

Summary and overall evaluation

The main value added of a Public-Private Health Advisory Platform would be to create an interface between state and non-state sectors, mobilize private investment, and enable PPPs to strengthen health systems and achieve specific health goals. Support would be provided to governments on demand. The Platform would support other private sector mechanisms discussed in this report. It is expected that it could effect change at a relatively modest cost.

A recent survey of policymakers in developing countries (conducted by the Center for Global Development) indicates that a low technical capacity to engage the private health sector is seen as a serious constraint on meeting priority health goals and increasing the effectiveness of health spending.

Further information

Information: www.ppiaf.org/
www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/psaf
www.pidg.org
www.ifc.org/HealthinAfrica
www.ifc.org/advisory
www.ifc.org/ifcext/psa.nsf/Content/DevCo

Reading: (Preker and Harding 2000; Harding and Preker 2003; Marek, Eichler et al. 2004; Preker and Langenbruner 2004; International Finance Corporation 2007; Preker, Baris et al. 2007)

Results-Based Financing (RBF)

Description

This mechanism would scale up the use of Results-Based Financing (RBF) in health systems. RBF is an umbrella term embracing several mechanisms designed to increase the quality of services provided. It includes output-based aid, provider-payment incentives, performance-based inter-fiscal transfers, conditional cash transfers, and incentives for households to adopt health-promoting behaviours. Payment is made in cash or goods in response to measurable actions taken or performance targets achieved. Depending on country objectives and challenges, RBF can be designed as supply-side mechanisms, such as output-based aid and pay-for-performance, that provide subsidies or incentives to health workers, or as demand-side mechanisms targeting communities and consumers and aimed at reducing or eliminating hidden costs that constrain the use of services.

A multi-donor trust fund could be established to fund new RBF interventions in health systems. Alternatively, the existing Health Results Innovation Trust Fund, currently financed by Norway, could be expanded to include other donors, while IHP+ institutions could access the fund and channel resources according to RBF principles.

General criteria

Value added: Increasing effectiveness of the delivery and use of funds because of high incentives to achieve results.

Experience: New RBF mechanisms could build on the experience of the Health Results Innovation Trust Fund. This provides financing to support national plans; build learning and evidence based on innovative mechanisms to strengthen health systems and build

national capacity. For further description of existing experience, see Working Group 1's report.

Technical feasibility: The Health Results Innovative Trust Fund is implementing pilot RBF programmes in several countries. Past experience with RBF and RBF-like mechanisms includes successful and unsuccessful examples. Unsuccessful programmes have shown that feasibility depends on concrete implementation and on countries' readiness. Prior to implementation, countries must have or build the capacity to detect and prevent gaming, misreporting, and leakage of benefits, including conditional cash transfers. They also need the means of avoiding unintended effects – for example, providers doing only what is measured and dropping other activities. And they must have accounting systems capable of paying out the incentives.

Political sponsors: The pilot – the Health Results Innovation Trust Fund – is supported by the World Bank and Norway.

Timeframe for implementation: An expanded RBF Multi-Donor Trust Fund could be set up relatively quickly (in nine to 12 months) assuming there is political support and funding. It could be used for new pilots and/or for scaled up RBF.

Financial criteria

Realized flows: US$100 million in the Health Results Innovation Trust Fund.

Potential flows: RBF support to health systems could potentially reach several billion USD a year. The World Bank estimates that it could channel up to US$2 billion a year in grants to governments through a scaled-up Health Results Innovation Trust Fund. Both international and domestic funds could be channeled through RBF.

Costs (set-up and running costs): Costs of providing financing: Estimated to be in the range of conventional concessional loans and grants to developing countries. Costs to the World Bank are estimated to be comparable to those of its conventional operations.

Cost within countries of establishing necessary support systems: Estimates are not available. It is expected that RBF is more costly to implement than traditional input-focused financing mechanisms. It requires more detailed specification of the goods and services to be provided, of performance indicators, and in general of the duties of those involved. It also requires more sophisticated monitoring and evaluation, including systems that prevent gaming.

Additionality: RBF does not raise additional funds.

Sustainability: Depends on ongoing donor commitment and funding. Successful RBF programmes may over time exhibit more sustainability than conventional programmes, since donors are rewarding proven results.

ODA: It is expected that RBF interventions for strengthening health systems in low-income countries would qualify as ODA if financing comes from public sources (for example, a country's general development budget or a Solidarity Levy).

Aid effectiveness criteria

Country ownership: RBF is designed to strengthen country systems and channel funds through them. Country ownership would be high as long as projects are country-driven in practice.

Predictability: Predictability can be viewed as potentially low, and thus a disadvantage, in that flows depend on results. It can also be viewed as potentially high, in that recipients can to some degree control the flow of funds by their own actions.

Alignment: Varies by countries. Ultimately, depends on whether country systems can accommodate the monitoring and evaluation systems RBF requires.

Synergies and externalities: Possible improvements in data collected and in monitoring and evaluation; also an increased motivation to report. However, if systems are poorly designed, incentives for misreporting and gaming could increase.

Impact on aid architecture for health and harmonization: None. No new organization would have to be created. Existing players could implement the mechanism, and processes could be aligned with and coordinated by IHP+.

Results: One of the most important potential benefits of RBF as compared with other funding mechanisms is its orientation toward measurable, verified results (rather than inputs and processes). Anecdotal evidence of RBF's ability to achieve positive results (for example, from the Health Results Innovative Trust Fund pilot programme in Rwanda) is promising. For a more detailed discussion, see Working Group 1's paper.

Accountability: Provides a framework for accountability, since disbursement of funds is tied to specified results. RBF necessarily focuses on improved governance (changing the relationship between public and private stakeholders and increasing accountability and transparency) in order to prevent misreporting and gaming. However, accountability depends on successful implementation.

Pro poor: RBF can be targeted toward pro-poor interventions by linking financing to results that especially benefit the poor. Ultimately depends on the chosen results indicators.

Summary and overall evaluation

The value added of RBF is to create incentives within recipient countries to deliver results. RBF is a relatively flexible approach that could be supported though a multi-donor trust fund, as suggested here. Several billion dollars annually could be channeled through RBF. Potential disadvantages include upfront costs, including the need for carefully designed programmes to avoid the creation of inappropriate incentives, and the fact that funding would have to come from conventional ODA or from one or more of the other financing mechanisms in this paper. Ultimately, RBF's success would depend on well-designed programmes that take into consideration country systems and capacity for implementation.

If properly implemented, RBF could score high on aid effectiveness criteria. It is designed to support strong results and could be used to target funding to the poor. Since RBF channels funds through country systems, funding is expected to be well aligned with country priorities. Positive externalities could arise from the additional data collected, the high motivation to report, and monitoring and evaluation requirements.

Predictability may be viewed either as a disadvantage (in that flows depend on results) or as an advantage (in that recipients can to some degree control the flow of funds by their own actions).

Further information

Information: http://go.worldbank.org/04UNXY1MS0
http://www.norad.no/default.asp?V_ITEM_ID=11711

Reading: (Loevinsohn and Harding ; Barder and Birdsall 2006; Ivanova 2006; Oxman and Fretheim 2008; Fiszbein, Schady et al. 2009)

Scaling up the International Finance Facility for Immunisation (IFFIm)

Description

This mechanism would frontload future ODA and/or revenues from other sources by expanding IFFIm into a funding channel used for broader health system purposes and by all IHP+ institutions.

IFFIm relies on legally binding long-term ODA grants to underpin bonds issued in the international capital markets for the purpose of leveraging immediate resources for development assistance. The long-term pledges are used to repay the bonds. The result is the frontloading of future development assistance. This instrument was first proposed in 2003, to help close the gap in the financing of the Millennium Development Goals and also in response to near-term fiscal constraints faced by many donors. IFFIm was established as a new supranational in 2006, with some US$5 billion in assets to be paid over 20 years from sovereign donors (the United Kingdom, France, Italy, Spain, Sweden, Norway, and South Africa). Proceeds from its bond issuances fund programmes of the Global Alliance for Vaccines and Immunization (GAVI). IFFIm's Treasury Manager is the World Bank.

This mechanism concentrates on IFFIm's core element: the frontloading of future aid flows through leveraging of funds in capital markets. Although frontloading depends on long-term grants, these are discussed separately in this report, for two reasons: First, the function and value added of long-term grants per se (predictable financing) is distinct from frontloading through capital markets. Second, long-term commitments are an element of other instruments, such as Advance Market Commitments, and could be applied more generally to provide predictability without necessarily frontloading funds.

General criteria

Value added: Frontloading of future aid flows. For immunization projects, the value added by frontloading has been an estimated increase in the impact of funds of roughly 11%.[lxxxii] The value added by predictability has been an estimated increase in the impact of funds of roughly 10%. Working Group 1's report estimates that between 38 and 58% of funds necessary (US$26 billion to US$132 billion) are for capital costs between 2009 and 2015. It articulates the impact of increased health systems spending as a whole, but does not disaggregate the relative impact of funding front-loaded vs. recurrent expenditure.

Experience: The successful implementation of IFFIm – the pilot IFF – proves that the instrument can be successful within this particular set of circumstances.[lxxxiii]

Technical feasibility: Technically, IFFIm could be expanded. However, expansion would have some complications, which warrant further exploration: (i) An expanded IFFIm would require either additional donor contributions or financing from one of the other mechanisms discussed in this report. The added risk of volatility could be managed by guarantees from donor governments to cover potential shortfalls, but this would increase the complexity of the mechanism. (ii) If some funds were channeled through organizations other than GAVI, IFFIm's structure and governance may have to be amended to accommodate them, as they might involve different allocation needs and decision processes. Alternatively, funds could continue to be directed to GAVI, which could then allocate some of the funds to other organizations for eventual disbursement.

Political sponsors: The original IFFIm proposal was sponsored by the United Kingdom and is financially supported by the United Kingdom, France, Italy, Spain, Sweden, Norway, and South Africa, while other donors have expressed interest in contributing.

Timeframe: The implementation period for IFFIm was about three years from concrete proposal to the issuance of the first bond. Expanding IFFIm would also take time for the identification of new donors/sources and documentation thereof, though probably less than three years.[lxxxiv] The timeframe for new bond issuance is two or three months, depending on the type of issuance.

Financial criteria

Realized flows: IFFIm has commitments for long-term, legally binding grants totalling US$5.3 billion over 20 years. These future flows will allow it to issue up to US$3 billion in bonds in the capital markets. As of March 2009, IFFIm has issued US$2 billion in triple-A rated bonds. Over this time period, IFFIm's donors have paid in US$323.4 million.

Potential flows: These depend on donors' willingness to commit additional grants to an expanded IFFIm. They also depend on the continued ability to raise funds in capital markets – although it may be noted that, even under current conditions, capital markets are not expected to be a bottleneck.

Costs (set-up and running costs): Absolute costs: Frontloading has costs of capital. IFFIm has more than US$1 billion in outstanding debt from funds disbursed to developing countries, and as a result faced annual costs of capital US$30 to 40 million in 2007 and 2008. IFFIm's startup-costs were at least US$3.6 million. Costs of expanding the mechanism are estimated to be lower. Ongoing administrative costs are US$3 to 5 million annually.[lxxxv] These figures indicate that the total cost of frontloading US$1 by one year have ranged from 3.5 to 4.5 cents.

Relative costs: These absolute costs should be seen in the context of costs of capital from other sources: (i) It can be argued that countries with budget deficits finance their ODA by borrowing capital at similar rates to IFFIm, therefore facing similar costs of capital. Under this assumption, the relative costs can be considered insignificant. (ii) Alternatively, it can be argued that countries with budget deficits finance their ODA by borrowing capital proportionally to their budget deficits. Since budget deficits are in the range of a few percent, relative costs would be considered to be almost equal to absolute costs. (iii) Finally, it can be argued that countries finance their investments but not their expenditures by borrowing. In this case, relative costs would be considered equal to absolute costs.

Additionality: No additionality. IFFIm does not generate additional grants, but rather changes the timing of availability of grants. More financing is available earlier, less later. Donors have to repay the bonds' principal and interest. IFFIm's value added lies in frontloading and predictability.

Sustainability: Not sustainable. Spending funds upfront necessarily means that they are not available over a long period. Therefore, frontloading is recommended for one-time capital investments and expenditures but not for recurring costs. Frontloading also might be justified in times of crisis, as a form of bridge financing when it is expected that other funds will later become available and will ensure sustainability.

ODA: Long-term grants to IFFIm qualify as ODA as and when grant contributions are made.

Aid effectiveness criteria

Country ownership: Does not depend on mechanisms but on channel (so currently depends on GAVI's policies and practices).

Predictability: High predictability during the frontloading period. The overall envelope for funding is known. Funds can be made available relatively quickly. The time needed for a new bond issuance is about two or three months.

Alignment: Does not depend on mechanism but on channel (so again, currently depends on GAVI's policies and practices).

Synergies and externalities: Does not create specific synergies and externalities.

Impact on aid architecture for health and harmonization: Depends on concrete implementation of expansion (see also "technical feasibility"). Neutral, if the current IFFIm structure is used and all funds were channeled through GAVI. Increasing complexity, if (i) the expansion is financed by one of the proposed innovative sources that would have to be backed up by a guarantee mechanism of some sort, or if (ii) funds were allocated by GAVI to other channels/institutions. The creation of IFFIm in its current form has increased the complexity of arrangements for donors and added new institutions to the aid architecture.

Results: Does not depend on mechanism but on channel (currently GAVI).

Accountability: Does not depend on mechanism but on channel (currently GAVI).

Pro poor: Does not depend on mechanism but on the source (currently ODA) and the channel (currently GAVI).

Summary and overall evaluation

The value added of IFFIm is to frontload future development aid. (For the predictability element, see Long-Term Grants.) Frontloading has absolute costs of capital and some administrative costs, in the range of 3.5 to 4.5 cents for each US$1 that can be invested a year earlier. Depending on the source of finance, it can be argued that these costs are much lower. Funds are predictable due to long-term donor commitments and relatively fast and flexible bond issuances. In the short-term, donor grant payments can be leveraged to allow frontloading of funds invested towards health systems.

An expanded IFFIm would require additional donor contributions and/or revenues from other sources. Resources mobilized through one or more of the mechanisms discussed earlier in this report (for example, CTL, Solidarity Levy on Airline Tickets, or De-Tax) could potentially be channeled to IFFIm. One way to address the volatility risks of these revenue streams would be for donor governments to guarantee potential shortfalls.

IFFIm uses aid funds as a means of accessing capital markets in order to bring forward expenditures in key areas. Sustainability, by definition, is low, since funds that are potentially required in the future are spent upfront. Therefore, IFFIm is better suited to providing financing for capital expenditures than for recurring costs.

The Working Group 1 costing estimates suggest that between 38 and 58% of the total estimated costs necessary to develop health systems is capital expenditure. It is expected that strengthening health systems will require a balanced approach that includes both frontloading and sustainability.

Expanding IFFIm would also require amending the IFFIm structure to accommodate multiple channels, as well as making governance changes in order to handle different funding needs and decision processes.

Further information

Information: http://www.hm-treasury.gov.uk/press_21_03.htm www.iff-immunisation.org/

Reading: (Lob-Levyt and Affolder 2006; Development Committee 2004; Global Alliance for Vaccines and Immunization (GAVI) 2004; HM Treasury 2004; Moore 2004; Conceição, Rajan et al. 2005; Mavrotas 2005; Barder and Yeh 2006; Tang and Yeoh 2007; World Business Council for Sustainable Development and World Economic Forum 2007)

Seed Mechanism

Description

This mechanism would support large, complex infrastructure projects that are beyond the capacity of local companies funded by other mechanisms proposed in this report. This mechanism would seed such projects and bring them to the point of viability, with other financiers taking them to completion as the risk of the project is reduced.

According to the sponsor, large, complex infrastructure, particularly in the form of tertiary/teaching hospitals and complicated supply chains, is an important part of any complete health system. However, developing such infrastructure usually involves significant commercial risk, and the non-state sector is usually reluctant to undertake it. As a result, developing this type of infrastructure typically falls to the state. However, the governments of low-income countries are often ill-equipped and lacking the resources to invest in large infrastructure development.

General criteria

Value added: Increasing the efficiency and effectiveness of health system expenditures. The creation of larger and more efficient infrastructure may improve the delivery of health care goods and services.

Experience: The mechanism draws on the World Bank Group's experience and on the successful Private Infrastructure Development Group (PIDG; see www.pidg.org).

Technical feasibility: Has been proven with several infrastructure mechanisms. A mechanism of this sort is expected to have a fairly high hit-miss ratio for a seed mechanism, about 1:3 or 1:4.

Political sponsors: World Bank Group.

Timeframe for implementation: The mechanism could be established quickly through InfraCo, an existing entity focused on developing infrastructure, which is already considering expanding into the health sector.

Financial criteria

Realized flows: None to date.

Potential flows: US$1 million of seed money to test the idea and develop a pipeline of projects. US$50 million of investment funds for a pilot. Initial flows are expected to come from international, mostly public, sources. Later financing is expected to come from international private sources and could also come from domestic investors.

Costs (set-up and running costs): Estimated to be comparable to costs of conventional World Bank Group non-state-sector operations.

Additionality: No additionality expected. The mechanism would use ODA or funds from one the fundraising mechanisms discussed earlier in this report.

Sustainability: If the mechanism is successfully implemented, sustainability is expected to be high. However, successful implementation is not guaranteed: the mechanism would be expected to have a fairly high hit-miss ratio, about 1:3 or 1:4.

ODA: Not expected to qualify as ODA. Funds would be provided on non-concessional term to private sector actors. Could potentially be designed to qualify as ODA if returns on investments went to multilateral institutions, such as development banks.

Aid effectiveness criteria

Country ownership: The mechanism would support private sector actors operating independently of country control but within the limits of country regulation.

Predictability: Predictability of financing depends on the source. Predictability of activities and delivery of services is expected to be high as long as the seed mechanism is successfully implemented.

Alignment: It is expected that non-state actors would be well aligned with existing country systems. Countries would provide the framework for alignment through regulation.

Synergies and externalities: Some synergies with and positive externalities for private sector operations in other sectors is expected.

Impact on aid architecture for health and harmonization: None. Implementation would be within the existing institutional framework.

Results: In the start-up phase, a high focus on results so that projects could become independent of the seed mechanism. In later stages, funding would come from private sources, which tend to focus on results.

Accountability: Accountability in the private sector is considered to be high as long as there is sufficient oversight and transparency of operations.

Pro poor: In the first phase, when the mechanism is set up, it would be controlled by the sponsors/donors; pro-poorness would depend on their policies and services (but these could be targeted pro poor). Later, when the financing is assumed by private actors, the projects supported face the inherent tendency of private sector operations to provide services to those who can pay. Pro-poorness would have to be guaranteed through appropriate implementation. The mechanism could have an indirect pro-poor effect by removing the financing burden from governments. However, this effect is not proven and is controversial (see Impact Investing).

Summary and overall evaluation

The proposed seed mechanism could increase the efficiency of the private for-profit and non-profit health sectors by creating larger, more complex infrastructure. It would be a comparatively risky venture, however, expected to be successful only in perhaps one out of three or four cases. However, when it is successful, its positive impact is expected to be high.

Further information

Reading: (Preker and Harding 2000; Harding and Preker 2003; Marek, Eichler et al. 2004; Preker and Langenbruner 2004; International Finance Corporation 2007; Preker, Baris et al. 2007)

Solidarity Levy on Airline Tickets

Description

The existing Solidarity Levy on Airline Tickets – a nationally implemented levy adopted by countries on a voluntary basis and coordinated by a coalition of countries – could be expanded and implemented in more countries.

The Levy is mandatory for individuals buying airline tickets in participating countries; it is imposed on international departures, but not on transfer passengers. It is progressive, since a higher tax rate is applied to business class than to economy class tickets, and the Levy is borne only by those who can afford air travel.

Most of the proceeds from the Levy in countries that already participate are transferred to UNITAID, an international drug-purchasing facility that fights HIV/AIDS, tuberculosis, and malaria. Alternatively, countries could channel proceeds through different multilateral or bilateral institutions.

General criteria

Value added: Additional funds from a new source. Because of the international solidarity characteristic, the Levy may provide a convincing political rationale for developing countries interested in establishing it.

Experience: Currently, the Levy is applied to all airlines departing from eight of UNITAID's 29 member countries: Chile, Congo, Côte d'Ivoire, France, Republic of Korea, Madagascar, Mauritius, and Niger. It is paid by passengers (although not transit passengers) when buying their tickets, normally as an addition to existing airport taxes. Airlines are responsible for declaring and collecting the Levy. The Levy respects countries' tax sovereignty.[lxxxvi]

Technical feasibility: Has been proven to work in the countries that have established it.

Political sponsors: In addition to the countries already implementing the Levy, sponsors include nations that plan to introduce it: Benin, Brazil, Burkina Faso, Cameroon, Central African Republic, Gabon, Guinea, Liberia, Mali, Morocco, Namibia, Senegal, São Tomé and Principe, and Togo.

Timeframe for technical implementation: Implementation of the Levy (July 2006) took about two years from the publication of the Landau Report recommending it (September 2004).[lxxxvi] Technical implementation in new countries is expected to be faster with the benefit of experience in countries that have already adopted it.

Financial criteria

Realized flows: Most of the revenues have been generated in France, where the Levy raised €414.3 million from July 2006 to April 9, 2009.[lxxxviii] 90% of the proceeds from France are disbursed to UNITAID and up to 10% are designated to fund France's first tranche of payments to IFFIm. About €22 million annually is generated by all other participating countries combined. These revenues are channeled through UNITAID.

Potential flows: France forecasts that in its country the Levy will raise between €157 million and €163 million in 2009.[lxxxix] Extrapolation of this estimate suggests that the Levy could generate annual revenues between several hundred millions and the low billions if it were implemented in a number of countries with high volumes of international departures.[xc] Most of the funds would be expected to come from Europe, Asia Pacific, and North America.[xci]

Costs (set-up and running costs): Similar to CTL, as long as no new distribution channels are created.[xcii]

Additionality: A Solidarity Levy on Airline Tickets is likely to generate additionality. The Levy does not require any reflows. The source is not the general budget. Since it is already implemented in several countries, and already used to support the health sector in developing countries, there may be some competition for funds for health. In addition, it might crowd out some potential future ODA giving participating countries an excuse not to increase their general aid budgets.

Sustainability: Sustainability depends on air travel and also on countries' long-term willingness to collect the Levy and to grant it to health systems. Although detailed data on air traffic were not examined, it is expected that, in general, air travel is a sustainable source of funding.

ODA: Expected to qualify as ODA since it is a national tax earmarked for health systems in low-income countries. The French Levy is accounted as ODA.[xciii]

Aid effectiveness criteria

Country ownership: Does not depend on mechanism but on channel.

Predictability: Global and regional data on passenger volume suggest some volatility in the tax base. The International Air Transport Association reports that the number of passengers carried worldwide increased from 1.29 billion in 1998 to 1.63 billion in 2007. However, the increase has not been entirely steady. For example, in 2008 the number of international passengers dropped to 824 million.[xciv] Volatility may be expected from events like the terrorist attacks of 9/11/2001, the wars in Afghanistan and the Arabian Gulf, and diseases like SARS, all of which caused air travel to drop.

Alignment: Does not depend on mechanism but on channel.

Synergies and externalities: The effect on the airline industry is not clear. According to UNITAID, in France the Levy has had no impact on air traffic and caused no harm to the airline industry. The national carrier, Air France, experienced a nearly 5% increase in traffic in September 2007 compared to September 2006.[xcv] However, more in-depth analysis, comparing countries that have implemented the Levy with countries that have not, would be required to assess the impact.

Impact on aid architecture for health and harmonization: Does not depend on mechanism but on channel.

Results: Does not depend on mechanism but on channel.

Accountability: Does not depend on mechanism but on channel.

Pro poor: The Levy is not specifically targeted to support the poor. This would depend on the channel. However, actual implementation of the Levy has been pro poor and progressive. Business-class passengers pay a higher tax than economy-class passengers, and the rich tend to fly more than the poor.

Summary and overall evaluation

The Levy scores relatively high on financial criteria. Its value added is to raise additional funds. If implemented in a number of countries with high volumes of international departures, annual amounts between several hundred millions and the low billions might be raised. However, these potential revenues are smaller than those expected from a CTL. Transaction costs are expected to be low, similar to those of the CTL (some 1 to 2% of revenues), as long as funds are channeled through existing mechanisms.

Additionality is expected to be high. Of prime importance, the Levy has already been implemented. Its technical feasibility has been proven, and because there is experience to draw on, scaling it up might be faster and less complex than instituting a new programme such as the CTL.

Like other fundraising mechanisms, the Levy has little impact on aid effectiveness criteria and would require an appropriate channeling entity, such as one of the existing IHP+ players in health systems, a HS financing platform, or a multi-donor trust fund with one or more implementing entities.

Further information

Information: UNITAID – http://www.unitaid.eu/index.php/en/The-air-ticket-levy.html
UNITAID – http://www.unitaid.eu/images/stories/unitaiden.pdf

Reading: (Kerr 2006; Müller and Hepburn 2006; Segerstad 2006; Keen and Strand 2007)

Tobacco Taxes

Description

Introducing and expanding an earmarked tobacco tax would institute a tobacco tax in the few countries without one and to raise the rate in countries with one. The proposed mechanism intends to generate proceeds from tobacco taxes in developing and developed countries. The tax could be implemented nationally and coordinated internationally. The additional revenues could be channeled to developing countries and earmarked for health systems.

General criteria

Value added: Additional funds from a new source or an existing source, depending on the country.

Experience: Tobacco taxes in one form or another are already in place in 152 countries, and in many instances are earmarked. For example, several U.S. states (notably Arizona, California, Massachusetts, and Oregon) and several countries (Ecuador, Egypt, Estonia, Finland, Iceland, India, Korea, Nepal, and Thailand) earmark part or all of their tobacco tax revenues for various purposes. When the earmarks are for health programmes, the funds are spent mainly on tobacco control and health promotion.[xcvi]

Technical feasibility: The feasibility of tobacco taxes has been proven in 152 countries.[xcvii] In about 20 of these countries, including two low-income countries, tobacco taxes are earmarked, proving the feasibility of this part of the proposal.

Increasing the tax rate would be feasible for some countries. It might be limited for others by the fact that they have already implemented a tobacco tax.[xcviii] Among the 152 countries with tobacco taxes, "one quarter of countries report tax rates less than 25% of the tobacco retail price. Only four countries, representing 2% of the world's population, have tax rates greater than 75% of retail price."[xcix] Considering the wide range of tax rates worldwide, some room for further proceeds should remain.

Further, tobacco taxes are accepted by the public and political leadership. Allocating tax revenues for health programmes may further increase their popularity.[c]

Political sponsors: Tobacco Free Initiative, World Health Organization.

Timeframe for technical implementation: Expected to be fairly quick in countries with an existing tobacco tax. In many countries, tax increase of such a tax does not require legislation but may be effected by executive order. In countries without an existing tobacco tax, the time needed to institute a tax is expected to be comparable to the time needed to institute the CTL (six to 24 months).

Financial criteria

Realized flows: 1. Domestic tax: Low-income countries for which information is available together collect the equivalent of US$13.8 billion in tobacco tax revenues. Their combined population is two billion, so this amounts to about US$7 per capita. Middle-income countries for which information is available together collect US$52.7 billion; with their combined population at 1.9 billion, this amounts to about US$28.40 per capita.[ci]

2. International tax in developed countries: High-income countries together collect US$110 billion in tobacco tax revenues, or in average about US$205 per capita.[cii]

Potential flows: 1. Domestic tax: Based on current tax proceeds, a 5 to 10% increase in tobacco taxes could raise a total of about US$700 million to US$1.4 billion a year in low-income countries for which information is available, and about US$2.5 to US$5 billion a year in middle-income countries for which information is available. A 50% increase in the 12 selected low-income countries named above could generate about US$900 million a year, which would cover 10 to 45% of those countries' health expenditures. [ciii]

2. International tax in developed countries: A 5 to 10% increase in tobacco taxes in high-income countries could generate additional revenues of US$5.5 to US$11 billion, which could be earmarked for health systems in developing countries.

Costs (set-up and running costs): Same as CTL for administering the tax.

Additionality: Likely to be additional for the same reasons as for CTL.

Sustainability: The tax base, tobacco consumption, is relatively sustainable. Sustainability would also depend on currency transactions as well as countries' long-term willingness to collect the tax and to grant it to health systems in developing countries.

ODA: Contributions from developed countries would be expected to qualify as ODA, since they would basically be national taxes earmarked for health systems in low-income countries.

Aid effectiveness criteria

Country ownership: High for domestic tax in developing countries: countries would have complete ownership of taxes. The tax would be a flexible source that is not necessarily tied to the use of funds. Ownership ultimately depends on the policies of countries that collect the tax and on any conditions attached to the use of the funds.

Predictability: The proceeds from tobacco taxes are considered to be relatively predictable, but some volatility is expected. 76 out of 123 countries reported a decrease in total cigarette consumption between 1990 and 2007.[civ] In 33 of those countries, the decrease was over 25%.

Alignment: High for domestic tax: funds would be part of country systems. For international tax, does not depend on mechanism but on channel.

Synergies and externalities: A tobacco tax earmarked for health systems might have positive and negative externalities.

High positive externalities in countries raising the tax, in the form of reduced tobacco consumption. Increasing the price of tobacco by raising taxes is considered to be the single most effective way to decrease consumption and encourage users to quit.[cv] It has been estimated that a 70% increase in the price of tobacco could prevent up to a quarter of all smoking-related deaths worldwide, and that tax increases that would raise cigarette prices by 10% would prevent at least 10 million tobacco related deaths.[cvi]

Negative externalities might include:

- distortionary effects from earmarking taxes nationally;
- increased smuggling from neighbouring countries that do not increase taxes (it should be noted that the WHO argues that higher taxes do not increase smuggling[cvii]); and
- the counterpart to decreased consumption: losses to national tobacco industries due to decreased revenues from taxes.

Impact on aid architecture for health and harmonization: Positive for domestic tax proceeds in developing countries: Would not be development aid and therefore would not impact aid architecture. For international tax proceeds, does not depend on mechanism but on channel.

Results: Does not depend on mechanism but on channel.

Accountability: High for domestic tax: countries would be accountable to their citizens. For international tax, does not depend on mechanism but on channel.

Pro poor: Proponents of the tax argue that that higher taxes are especially important for deterring tobacco use among the young and the poor, who will benefit most from a decrease in consumption. People in these socioeconomic groups are much more sensitive to the price of goods.[cviii] Opponents, including the tobacco industry, argue that higher tobacco taxes would disproportionately hurt the poor because excise taxes are regressive.[cix]

Summary and overall evaluation

The tobacco tax scores high on financial and some aid-effectiveness criteria. The value added is to raise funds for health systems while, by decreasing tobacco consumption, directly improving people's health. The tax could generate significant new funds – several billion dollars in low- and middle-income countries and up to US$10 billion in high-income countries. Transaction costs are expected to be similar to those for the other tax and levy proposals discussed (as low as 1 to 2% of revenues).

The tax has been implemented and proven to be technically feasible in numerous countries, including countries where revenues are earmarked for health systems. Scaling it up might be faster and less complex than implementing other taxes and levies. But precisely because a tobacco tax already exists in most countries, the degree to which it could be scaled up is limited.

The tax would require one of the channeling mechanisms discussed for the CTL, such as one or more IHP+ institutions, a multi-donor trust fund, or one of the channels discussed in this review.

The tobacco tax has several compelling advantages: (i) Raising funds in low-, middle-, and high-income countries would demonstrate a joint effort and new burden-sharing agreement among countries and increase the accountability of developing countries. It would pose responsibility for financing to all, according to their ability to pay. (ii) A tobacco tax would generate a double dividend: while raising funds, it would also reduce tobacco consumption and tobacco-related disease and death. (iii) Tobacco taxes enjoy broad public support, especially when the proceeds are earmarked for health.

Further information

Information: http://www.who.int/tobacco
http://www1.worldbank.org/tobacco/

Reading: (Moore 1996; Hu, Xu et al. 1998; Jha and Chaloupka 1999; Chaloupka, Hu et al. 2000; Gruber and Koszegi 2002; van Walbeek 2003; Remler 2004; WHO Tobacco Free Initiative 2004; Cnossen 2005; Jha, Chaloupka et al. 2006; World Health Organization 2008)

Approach[37]

Description

Includes key features of the proposed mechanism, its purpose, and the responsibilities and interactions of key actors.

General criteria

Value added: Describes the financial function of and the value created by the mechanism. Factors considered include additional funds, leveraging funds, targeting concessionality toward health systems, channeling funds efficiently, creating predictability, frontloading, creating incentives, enhancing markets, and engaging the private sector.

Experience: Describes past experience, if any, with the mechanism. When the mechanism proposed is entirely new, provides information on any structurally similar financing mechanisms that do exist.

Technical feasibility: Identifies the main technical obstacles to implementation and, where possible, assesses the complexity of implementation. Does not consider the time potentially needed for political processes and consensus-building.

Sponsorship: Lists stakeholders, such as governments, civil society, and multilateral organizations that have officially expressed support for the mechanism.

Timeframe for implementation: Gives estimates (minimum and/or realistic average) of how long implementing and scaling up of the mechanism would require. Takes into consideration the time needed for technical implementation. Does not take into consideration the time potentially needed for consensus building and political implementation.

Financial criteria

Realized flows: Mechanisms that create financial additionality: Gives figures, if available, for funds generated in the past. Includes estimates, if possible, of domestic and international shares of funding sources.

Mechanisms that channel or disburse funds: Gives figures, if available for disbursements and spending in the past.

Potential flows: Mechanisms that create financial additionality: Gives figures, if available, for potential or expected funds that might be generated in the future. Includes estimates, if possible, of domestic and international shares of funding sources.

Mechanisms that channel or disburse funds: Gives figures, if available for potential or expected disbursements and spending in the future.

Costs (set-up and running costs): Gives quantitative estimates of set-up costs and running costs, if available. Puts costs in the context of resulting value added – for example, for a mechanism that generates additional funds, estimates the cost of raising one dollar; for a mechanism that targets concessionality, estimates the cost of redirecting one dollar to health systems; and for a mechanism that frontloads aid, estimates the cost of providing one dollar X years earlier. Costs are compared to those of similar mechanisms and, where possible, are based on past experience.

Additionality: Gives a qualitative assessment of the financial additionality of funds. (The qualitative additionality of value added is assessed earlier.) Criteria for assessing additionality include (cumulative) whether the mechanism crowds out or is likely to crowd out existing financing, and what types of funds (how concessional are they and do they require reflows in the future?) it generates or is likely to generate. The assessment is based on the following matrix:

Crowding out					
	Low	Not additional	Some limited additionality	Likely to be additional	Very likely to be additional
	Medium	Not additional	Unlikely to be additional	Some limited additionality	Likely to be additional
	High	Not additional	Very unlikely to be additional	Unlikely to be additional	Some limited additionality
		Zero	Low	Medium	High
		Concessionality			

The baseline for additionality is the amount of funding that would exist if the new mechanism is not implemented. (Other possible baselines, such as ODA, 0.7% of GDP target, and past flows, are not considered.)

Assessments of crowding out relate to the degree to which the mechanism is estimated to compete with conventional mechanisms for funds. For example, new or additional grants and loans are evaluated with respect to their likely competition with conventional ODA; new philanthropic funds with respect to their likely competition with existing philanthropy to health; and new forms of investment, such as impact investing, with their likely competition with foreign direct investments.

Sustainability: Considers whether the mechanism can be maintained financially over the long run. Sustainability may depend on the nature of the mechanism (for example, the sustainability of a mechanism that involves tax increases will require a stable tax base), and/or on political factors (such as the likely impact of changing priorities in the event of a financial crisis).

ODA: Discusses whether the proceeds from the mechanism could be accounted as Official Development Assistance, or ODA. A definitive assessment would have to be based on the detailed design of any given mechanism. The assessments offered here are preliminary and are based on OECD-DAC criteria for ODA: "Flows of official financing administered with the promotion of the economic development and welfare of developing countries as the main objective, and which are concessional in character with a grant element of at least 25% (using a fixed 10% rate of discount). By

37 Annex 3 was prepared by Johannes Kiess, World Bank, with information and inputs provided by proposal and initiative sponsors, consultation participants, Taskforce Focal Points and Working Group members.

convention, ODA flows comprise contributions of donor government agencies, at all levels, to developing countries ('bilateral ODA') and to multilat eral institutions. ODA receipts comprise disbursements by bilateral donors and multilateral institutions. Lending by export credit agencies – with the pure purpose of export promotion – is excluded."[cx]

The purpose of financing (to strengthen health systems) and the types of countries receiving the aid (low-income countries) are the same for all the mechanisms proposed in this review, and in all cases these factors are assumed to meet the criteria for ODA. Whether the mechanisms under consideration here qualify as ODA depends mostly on their concessionality and the source (public or private) of funding.

Aid effectiveness criteria

Country ownership: Assesses whether the mechanism supports developing countries' own efforts to set development policies and strategies and manage development work. Accordingly, considers whether the mechanism provides space for developing countries to take the lead in determining their development goals and priorities and setting the agenda for how they are achieved.

Predictability: Assesses the stability or volatility of the funding the proposed mechanism would provide.

Alignment: Assesses the degree to which the mechanism would allow for the utilization of developing countries' own structures for managing public finances, accounting, auditing, procurement, and monitoring, on national, sub-national, and local levels. Also takes into consideration whether the mechanism strengthens countries' capacity to implement, monitor, and evaluate projects and programmes.

Synergies and externalities: Describes potential side effects, ranging from positive externalities such as double dividends to negative externalities such as distorted markets. The synergies and externalities taken into account could potentially appear in developing countries, in the country or countries where funds are raised, or globally.

Impact on aid architecture for health and harmonization: Assesses whether the mechanism would increase, decrease, or have no effect on the complexity of the existing overall aid architecture – whether it would tend to fragment the existing architecture and/or cause the proliferation of new components; help or hinder the coordination of donors' development work; harmonize or disrupt systems for delivering aid; and allow for reliance on programme-based approaches.

Results: Evaluates whether the mechanism's design incorporates incentives to achieve results. The main focus here is on whether financing is directly linked to performance and will evoke the specific outcomes intended. A secondary focus is on the successful use or creation of systems for monitoring and evaluating results.

Accountability: Assesses whether the mechanism fosters transparency on the part of donors and aid-receiving countries: for example, does it assign clearly defined roles and responsibilities to all parties involved and provide for a means of monitoring achievements? This measure includes discussion of whether the mechanism strengthens global accountability (that between donors and developing countries) and national accountability (that between a government and its citizens). It also looks at other stakeholders, such as the for profit and non-profit private sector including NGOs, faith-based organizations and social enterprises.

Pro poor: Discusses whether the mechanism's funds particularly help the poor. A mechanism is considered pro-poor primarily if it permits funds to be targeted directly toward the poor. If applicable, includes an assessment of the progressivity or regressivity of the mechanism in the country where funds are generated. (Also, all additional funds can be considered pro-poor because they are likely to reduce out-of-pocket payments and other user fees in low-income countries. This fact is not mentioned separately.)

Summary and overall evaluation

Describes the mechanism's overall contributions to health systems, including contributions to funding needs, timing needs, and greater efficiency; gives an overview of the mechanism's pros and cons.

Further information

Cites resources to consult for a broader picture of the mechanism, including any similar proposals. These include:

- links to other sources, if available
- a list of relevant literature, if available.

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	1990	1992	1994	1996	1998	2000	2001	2002	2003	2004	2005	2006	2007	2008
Australia	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Austria	318	284	275	286	294	295	413	517	549	547	680	701	787	757
Belgium	463	391	320	298	276	285	384	489	536	536	669	682	734	705
Canada	..	..	..	..	..	..	..	..	1828	2144	2065	2176	2405	3654
Czech Republic	..	..	..	..	..	..	..	..	..	..	..	..	..	139
Denmark	304	237	222	220	214	228	325	399	408	386	463	459	555	526
Finland	..	..	150	145	167	182	248	340	420	464	531	479	397	308
France	3112	2742	2667	2260	2120	2222	3142	3867	4162	4074	4915	4718	4978	4667
Germany	3672	3091	2685	2764	2426	2332	3199	4131	4387	4371	5709	6767	6663	6886
Greece	..	..	..	..	..	..	..	205	235	244	337	349	399	357
Hungary	..	..	..	..	..	..	..	..	..	..	..	100	111	156
Iceland	..	..	..	..	..	..	..	..	..	..	23	27	28	24
Ireland	42	47	64	71	71	70	98	113	133	131	155	154	177	159
Italy	1123	1012	1025	1125	1086	1063	1591	2004	2336	2318	3147	3269	3410	2763
Japan	..	..	..	..	..	..	..	..	..	5925	7982	9235	10345	12560
Korea	242	265	286	330	335	333	371	444	575	788	984	1125	1291	1456
Luxembourg	19	13	12	12	13	13	18	23	26	28	36	36	42	47
Mexico	348	649	385	296	375	354	250	285	373	461	631	719	656	709
Netherlands	664	571	537	527	503	523	693	888	957	882	1097	1124	1216	1133
New Zealand	..	..	..	..	..	..	51	180	227	272	294	289	283	320
Norway	246	221	219	202	194	217	282	345	362	328	362	351	391	378
Poland	..	..	..	..	..	..	..	..	..	..	..	..	..	129
Portugal	..	..	..	..	..	..	97	142	153	168	215	221	310	250
Slovak Republic	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Spain	..	..	..	..	..	..	652	954	1159	1340	1663	1789	2094	1532
Sweden	349	313	263	252	257	281	375	480	533	579	760	841	787	629
Switzerland	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Turkey	..	..	..	..	..	136	173	208	199	206	307	355	389	475
United Kingdom	1843	1499	1428	1405	1401	1557	1903	2337	2934	2967	3464	3782	4115	3579
Total	12,745	11,336	10,538	10,193	9,732	10,090	14,265	18,351	22,493	29,159	36,488	39,748	42,563	44,297

VAT calculations – Total flows from 1% reduction of national value added tax rate, in million US$ (calculated from tax rates and VAT tax income). Source: OECD

VAT calculations – Flows under the assumption that 5% of businesses would participate in De-Tax, in million US$

	1990	1992	1994	1996	1998	2000	2001	2002	2003	2004	2005	2006	2007	2008
Australia	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Austria	16	14	14	14	15	15	21	26	27	27	34	35	39	38
Belgium	23	20	16	15	14	14	19	24	27	27	33	34	37	35
Canada	..	..	..	..	..	..	..	..	91	107	103	109	120	183
Czech Republic	..	..	..	..	..	..	..	..	..	..	..	..	..	7
Denmark	15	12	11	11	11	11	16	20	20	19	23	23	28	26
Finland	..	..	7	7	8	9	12	17	21	23	27	24	20	15
France	156	137	133	113	106	111	157	193	208	204	246	236	249	233
Germany	184	155	134	138	121	117	160	207	219	219	285	338	333	344
Greece	..	..	..	..	..	..	..	10	12	12	17	17	20	18
Hungary	..	..	..	..	..	..	..	..	..	..	..	5	6	8
Iceland	..	..	..	..	..	..	..	..	..	..	1	1	1	1
Ireland	2	2	3	4	4	4	5	6	7	7	8	8	9	8
Italy	56	51	51	56	54	53	80	100	117	116	157	163	171	138
Japan	..	..	..	..	..	..	..	..	..	296	399	462	517	628
Korea	12	13	14	16	17	17	19	22	29	39	49	56	65	73
Luxembourg	1	1	1	1	1	1	1	1	1	1	2	2	2	2
Mexico	17	32	19	15	19	18	12	14	19	23	32	36	33	35
Netherlands	33	29	27	26	25	26	35	44	48	44	55	56	61	57
New Zealand	..	..	..	..	..	..	3	9	11	14	15	14	14	16
Norway	12	11	11	10	10	11	14	17	18	16	18	18	20	19
Poland	..	..	..	..	..	..	..	..	..	..	..	..	..	6
Portugal	..	..	..	..	..	..	5	7	8	8	11	11	15	12
Slovak Republic	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Spain	..	..	..	..	..	..	33	48	58	67	83	89	105	77
Sweden	17	16	13	13	13	14	19	24	27	29	38	42	39	31
Switzerland	..	..	..	..	..	..	..	..	..	..	..	..	..	..
Turkey	..	..	..	..	..	7	9	10	10	10	15	18	19	24
United Kingdom	92	75	71	70	70	78	95	117	147	148	173	189	206	179
Total	637	567	527	510	487	505	713	918	1125	1458	1824	1987	2128	2215

Notes

[i] Official and private donors – Italy, United Kingdom, Canada, Russia, Norway, and the Bill & Melinda Gates Foundation – have committed US$ 1.5 billion for a pilot AMC for vaccines against pneumococcal diseases. GAVI will provide operational support and the World Bank will provide the financial platform. The pilot AMC offers a subsidy to manufacturers to purchase eligible vaccines against pneumococcal diseases, in exchange for a ten-year commitment by manufacturers to supply the vaccine at a low price subject to a price cap.

[ii] New AMCs should benefit from lessons learnt as well as the legal structure created by the pilot. The timeframe for the AMC pneumococcal pilot was four years:

- April 2005: The report *Making markets for vaccines* was published (Levine, Kremer and Albright (2005).
- December 2005: The Tremonti Report was presented to the G8 (Tremonti and Ministero dell'Economia e delle Finanze (2005a).
- September 2006: The first Technical Working Group was formed.
- November 2006: The AMC framework document was drawn up by GAVI and the World Bank.
- February 2007: Donors pledged US$ 1.5 billion to fund the pilot AMC.
- December 2008: The Target Product Profile was endorsed.
- June 2009: The AMC agreements became effective.

[iii] Start-up costs: Full cost recovery of the costs of the World Bank is estimated to be US$ 1.9 million. GAVI estimated start-up costs of US$ 2.7 million to US$ 3 million for 2007, to cover expert group and consultation meetings, a serotype study, legal costs, Independent Assessment Committee meetings, and evaluation. Actual costs are not available.

Capital charge: The capital charge for the AMC commitment will be based on IBRD loan terms. A 30 basis point balance sheet commitment fee would apply annually to IBRD's outstanding exposure on grant payments owed by AMC donors. The fee is estimated to total US$ 25.5 million over the life of the AMC.

Recurrent costs: The World Bank currently estimates recurring annual costs of about US$ 800,000-900,000 on a full cost-recovery basis. Estimates from GAVI are not available.

[iv] Planning phase

- October 2007 to April 2008: Early assessment undertaken by a leading consulting firm.

Implementation phase

- 2009: pilot with three global distribution systems, two to five travel agencies and one to two e-brokers.
- 2010: launch of rollout with priority on main players.
- 2011: finalization of rollout.

[v] Estimated revenues of US$ 980 million annually are based on several assumptions.

- People would make a voluntary solidarity contribution 27% of the time.
- As proposed, the VSC would be offered on 848 million out of 2,200 million worldwide air tickets (for technical reasons, in 125 countries it could be applied only to tickets bought with credit cards; these represent an estimated 63% of the total tickets described above).
- The VSC could also be offered on 77 million other "easy to capture" travel-related purchases, including car rentals, hotel bookings, train tickets, and cruises.
- Each traveller's donation from each purchase would amount, on average, to US$ 4.30.

[vi] "As the mechanism creates minimal economic distortions it should be highly sustainable, in line with a small tax. The will of the public to keep contributing must be maintained through a sustained communications effort, but if this can be achieved and the mechanism can enter people's travel habits, it may be highly sustainable." (Millennium Foundation)

[vii] The Millennium Foundation assumes that "the share of people donating can be sustained, the predictability should be high as number of flights varies only marginally, in line with economic fluctuations."

[viii] (PRODUCT) RED achieved a high level of consumer awareness in the United States in a short period of time. Prior to launch, fewer than 1% of consumers were aware of the (PRODUCT) RED brands. By January 2007, just three months later, 17% were aware of (PRODUCT) RED and knew that it supported AIDS programmes in Africa – a significant increase in awareness and engagement, which was particularly strong among the young.

[ix] http://ec.europa.eu/environment/climat/emission/auctioning_en.htm

[x] http://ec.europa.eu/environment/climat/emission/auctioning_en.htm

[xi] http://www.bmz.de/en/approaches/bilateral_development_cooperation/approaches/joint-financing/innovative_funding_instruments/index.html

[xii] http://ec.europa.eu/environment/climat/emission/auctioning_en.htm

http://www.defra.gov.uk/environment/climatechange/trading/eu/operators/auctioning.htm

[xiii] http://www.bmu.de/files/pdfs/allgemein/application/pdf/jahresbericht_kwf_08_en.pdf

[xiv] http://www.bmz.de/en/approaches/bilateral_development_cooperation/approaches/joint-financing/innovative_funding_instruments/index.html

[xv] Bundesministrium für Umwelt Naturschutz und Reaktorsicherheit (2009)

[xvi] Experience with German sales programme in 2008:

Table 1: Volume of sales, revenues and average prices in the months January – November 2008

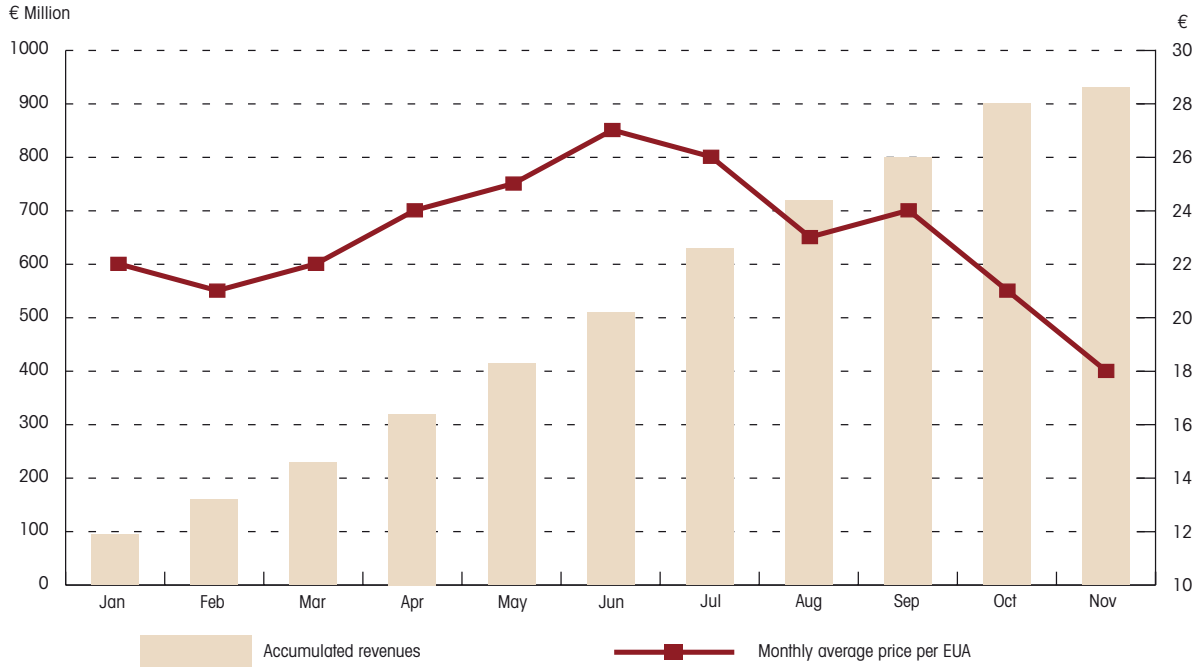
Month	Volume of sales	Revenues price/allowance	Average monthly revenues	Accumulated
January	3,960,000	€87,053,660.00	€21.98	€87,053,660.00
February	3,780,000	€77,909,110.00	€20.61	€164,962,770.00
March	3,431,000	€74,595,980.00	€21.74	€239,558,750.00
April	3,949,000	€95,748,000.00	€24.25	€335,306,750.00
May	3,425,000	€86,915,660.00	€25.38	€422,222,410.00
June	3,770,000	€103,189,980.00	€27.37	€525,412,390.00
July	4,118,000	€106,658,020.00	€25.90	€632,070,410.00
August	3,859,000	€90,587,910.00	€23.47	€722,658,320.00
September	3,953,000	€94,795,180.00	€23.98	€817,453,500.00
October	3,934,000	€82,624,980.00	€21.00	€900,078,480.00
November	1,821,000	€33,250,770.00	€18.26	€933,329,250.00
2008	40,000,000	€933,329,250.00	€23.33	

Source: Bundesministrium für Umwelt Naturschutz und Reaktorsicherheit (2009)

Month	Contract	Volume sold	Average price	Difference from ECX/CFI	Revenues
January	Future	3,647,000	€13.14	0.11%	€47,936,650.00
	Spot	-	-	-	-
February	Future	3,692,000	€9.72	0.22%	€35,895,360.00
	Spot	-	-	-	-
March	Future	3,781,000	€11.49	0.10%	€43,456,840.00
	Spot	241,000	€10.93	-	€2,633,874.40
Total		11,361,000	€11.44	0.14%	€129,922,724.40
Still to be sold in 2009		28,639,000			

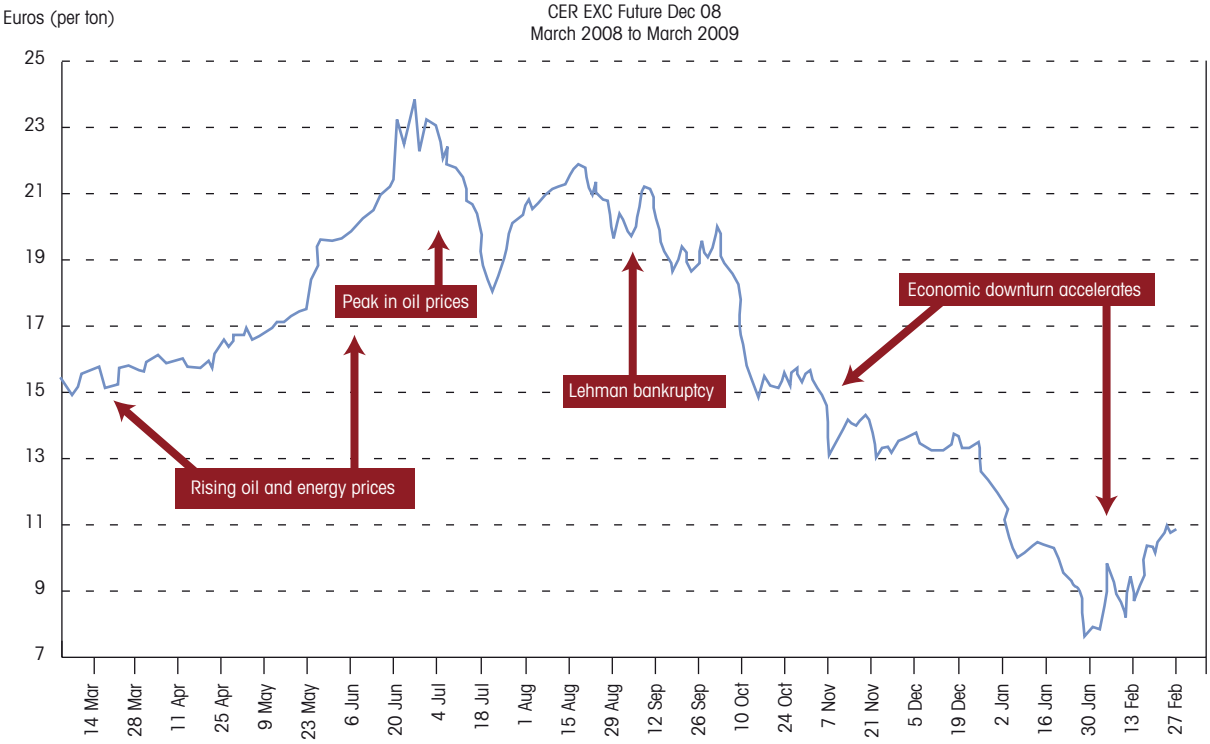
Source: Bundesministrium fuer Umwelt Naturschutz und Reaktorsicherheit (2009)

Table 2: Realised average price in the months January – November 2008



Source: Bundesministrium für Umwelt Naturschutz und Reaktorsicherheit (2009)

Prices for CERs



Source: Barclays, Bloomberg

[xvii] (PRODUCT) RED was launched in 2006 and raises funds for HIV/AIDS programmes in Africa through the Global Fund to Fight AIDS, Tuberculosis and Malaria. Corporate partners include American Express, Apple, Converse, Dell, Emporio Armani, GAP, Hallmark, and Microsoft. They design and sell (RED) products and make corresponding contributions.

[xviii] Definitions for VSC, blended value products, and other versions of social marketing activities are still evolving, and can differ according to author and context.

[xix] The first meeting between the Global Fund and a potential (PRODUCT) RED partner (American Express) took place in the fall of 2004. The initiative was announced by the Global Fund, (PRODUCT) RED and its launch partners (American Express, Converse, Emporio Armani, and Gap) at the World Economic Forum in Davos, Switzerland, in January 2006. A "soft launch" was completed within a few months, involving a limited number of products in the United Kingdom, including a (PRODUCT) RED American Express card. The official launch in the United States followed in October 2006, involving products from Apple, Converse, Emporio Armani, Gap, and Motorola; additional partners joined later. Funds began flowing to Global Fund-financed HIV and AIDS grants in May 2006, with a US$ 760,000 contribution to an HIV/AIDS grant in Rwanda made as part of the Global Fund's regular disbursement cycle.

[xx] Based on expert interviews. It is estimated that the U.S. market for affinity credit cards would include about 50 million cards, and that each card, on average, would generate annual sales of US$ 5000. The contribution to health systems is estimated to be about 1% of sales, less transaction costs. Estimates assume a market share of 0.5 to 1% in the first year and gains in market share of about 0.5 to 1% in each of the following four or five years.

[xxi] None of the contributions to (PRODUCT) RED are used to cover the administrative costs incurred by the project, its corporate partners, or the Global Fund. (PRODUCT) RED is a for-profit organization funded by a licensing fee paid by each partner company for the use of the (PRODUCT) RED mark. Current (PRODUCT) RED partners include American Express (United Kingdom only), Apple, Converse, Dell, Emporio Armani, Gap, Hallmark, Microsoft, (RED) Wire, and Starbucks. Each partner contributes up to 50% of the profits from the sales of (RED)-branded products directly to the Global Fund; 100% of these contributions are invested in existing Global Fund-financed HIV and AIDS grants in Africa.

[xxii] See endnote viii.

[xxiii] Implemented IDA buy-downs to date:

- The first Pakistan project for US$ 20 million, with a supplementary credit of US$ 21.51 million, funded by the Gates Foundation, closed on June 30, 2006. Following an independent performance audit, the buy-down was successfully triggered on December 16, 2006.
- The second Pakistan project, for US$ 46.7 million, funded largely by the United Nations Foundation (UNF) with a small contribution from the Gates Foundation, is still being implemented. A supplementary credit of US$ 21.14 million, funded by UNF, was approved in June 2007.
- An IDA buy-down project in Nigeria, funded by UNF for US$ 28.7 million, with a supplementary credit of US$ 51.7 million, is still being implemented.
- Two further buy-downs are under preparation. One, in Nigeria, involves a credit of US$ 50 million and a buy-down amount of US$ 25.61 million. The other, in Pakistan, involves a credit of about US$ 78 million and a buy-down amount of about US$ 38.88 million.

The use of buy-downs was piloted by a 2003 IBRD buy-down for a tuberculosis project in China. The objective was to increase loan concessionality in response to China's graduation from IDA and because China refused to borrow on IBRD terms for the health sector. DFID grant funds were combined with IBRD funds into a single stream, which reduced the cost of borrowing to roughly 2%. Two additional buy-down arrangements in China followed, one for education and one for rural development. The difference between these buy-downs and the ones discussed in this review is that the buy-downs in China were not linked to results; their only aim was to increase the grant element of financing.

[xxiv] The estimated timeframe for a new IDA buy-down for health systems after projects have been identified:

- Appraisal/negotiation: six to 12 months (three to six months for polio buy-downs where the World Bank has experience).
- World Bank Board approval: one to two months.
- Evaluating the effectiveness: one to two months.
- Operational implementation of buy-down: two to four years, depending on project time frame; alternatively, could structure buy-down to pay out in two, e.g., at year two and year four).

[xxv] This review of the CTL is based on the proposal presented at the Follow-up International Conference on Financing for Development to Review the Implementation of the Monterrey Consensus in Doha in November 2008. See http://www.internationalhealthpartnership.net/pdf/IHP%20Update%2013/

Taskforce/Stamp%20Out%20Poverty%20presentation%20-%20Doha%20Side%20Event.pdf

[xxvi] The CTL would apply to all foreign-exchange dealers trading in the inter-bank or wholesale foreign exchange markets, and would be imposed on all trades involving the currency of the taxing country. This level of comprehensiveness is expected to be possible because the tax would be collected during settlement of accounts, rather than dealing or trading.

[xxvii] Financial-transaction taxes with similar characteristics have been implemented nationally in several countries. (Schulmeister, Schratzenstaller-Altzinger and Picek (2008) Examples include taxes on: transfers of shares, bonds, and other securities in Belgium (tax rate 0.5 to 1.7%, 2005 revenues €147 million); Over-the-counter (OTC) transactions in Finland (tax rate 1.6%, 2005 revenues €554 million); securities trades in France (tax rate 0.15 to 0.3%, 2005 revenues €215 million); securities transfers in Germany (tax rate 0.01 to 0.25%, tax abolished in 1991); transfers of shares registered in Ireland and transfers in Ireland of shares and securities of foreign-registered companies (tax rate 0.5 to 1%, 2005 revenues €2.585 billion); trades of stocks and bonds in Italy (tax rate 0.009 to 0.14%, tax abolished in 2000); transactions involving some shares and securities in the United Kingdom (tax rate 0.5%, 2005 revenues 9.9 billion pounds); and securities trades in Switzerland (tax rate 0.15 to 0.3%, 2005 revenues CHF 1.6 billion).

[xxviii] According to Rodney Schmidt of the North-South Institute, taxes on financial transactions have been in decline primarily because transactions can be moved to other, non-taxed, trading sites. As proposed, the CTL would be levied via worldwide settlements, not trading sites, to avoid this method of evasion. Schulmeister, Schratzenstaller-Altzinger, et al. (2008) identify other factors for the decline, including changes in political power and taxation

objectives, EU legislation, possible competition from other financial centres, efforts to foster local stock exchanges, and disadvantages from market distortions.

[xxix] According to Schmidt, countries could implement the tax even though settlement systems are privately owned and in many cases located offshore.

[xxx] Spahn (2002)

[xxxi] Implementation of the Solidarity Levy on Airline Tickets took about two years. In general, technical implementation of new taxes is relatively fast. Some data on implementation in specific countries are provided below.

- United States: The legislative process required to institute a new tax takes about a year on average. The tax typically goes into effect immediately or at the beginning of the next year.
- United Kingdom: The legislative process takes up to four months. Generally, taxes are implemented as soon as they become law. Some bills may stipulate a different time frame.
- France: Absent constitutional challenges, the legislative process takes about three or four months. Implementation begins immediately unless the law stipulates otherwise.
- Japan: The majority party in the Diet controls all legislative enactments, primarily through cabinet oversight. A bill becomes law if it is approved by a majority in each house. A bill voted down in the upper house can be passed into law if two-thirds of the lower house approves it on a second vote. If the upper and lower houses disagree over approval of a bill, the decision of the lower house becomes law after 30 days, without a second vote. Complicated bills can take years to become law. Implementation depends on the type of tax, with some but not all new taxes being implemented as soon as they are passed.
- Germany: The passage of new tax laws is complex, and the legislative process takes up to four months. Once a tax bill has been passed into law, it is published in the Law Gazette on the 28th of December for scrutiny, and takes effect on January 1st.

[xxxii] Administrative costs. These are estimated to be comparable to the administrative costs of general tax collection. For OECD countries, the 2007 administrative costs of collecting taxes, expressed as a percentage of tax revenues, (the cost-collection ratio), ranged from a low of 0.28% in Switzerland to a high of 2.41% in the Slovak republic. The 2007 average for all OECD countries was 0.96%. Among 13 selected non-OECD countries, the 2007 cost-collection ratio ranged from 0.63% (Chile) to 5.8% (Cyprus), and the average for all non-OECD countries included in the study was 1.46%. This indicator is influenced by many factors, including tax rates and types, changes to tax rates and scope, unusual expenditures by the revenue-collecting authority, the scope of services the administration provides, and macroeconomic changes.

Administrative costs for the proposed CTL were estimated to be in the lower end of the overall range, because the tax would be collected electronically. Past experience indicates that the mechanism would have start-up costs as well.

Compliance costs. For traders: Low to negligible, since the proposed CTL would be collected automatically through an electronic trading system. For currency exchanges: No estimates are available for initially adapting their electronic trading systems or for the ongoing reporting of collections. The process should be similar to the existing collection of transaction fees, so implementation should be relatively straightforward and economical.

[xxxiii] Bank for International Settlements (2007)

[xxxiv] Global foreign exchange market turnover in April, 1989-2007

Daily averages in April, in billions of US dollars						
	1992	1995	1998	2001	2004	2007
Total	820	1,190	1,490	1,200	1,900	3,210

Source: Bank for International Settlements (2007)

[xxxv] According to Rodney Schmidt (2007), a half basis point tax rate will affect markets, widening spreads and reducing volume by about 14%. However, both changes would be well within the range of historical movements of spreads and volumes, and so would not affect fundamental trading behaviour or normal market operations or efficiency.

[xxxvi] Schmidt (2007)

[xxxvii] Implementation of programme: About one year.

- November 2006: The Global Fund presented the concept to Germany.
- April 2007: The concept was approved by the Board of the Global Fund.
- September 2007: The first swap was signed.

Implementation of swap: The time needed for technical implementation, from donor decision to signing of the debt-swap agreement, is expected to be six to 12 months. In Pakistan, for example, technical implementation took eight months. The time needed for political decisions is expected to vary according to the donor and the developing country involved.

[xxxviii] According to the Global Fund, Debt2Health incurs no administrative costs: "D2H funds are disbursed through the same Global Fund performance-based systems. No new governance structure or administration is required for D2H (no transaction costs); therefore 100% of the funds generated through this initiative are allocated to the GF approved projects in the recipient country." However, this assessment does not take into account administrative costs of running the programme, identifying donors and recipient countries, and signing debt-swap agreements. Also, Germany has no estimates for its administrative costs. Parts of these are borne by KfW, which receives the remainder of servicing fees for the cancelled debt in exchange for the services it provides, such as conducting country feasibility studies.

[xxxix] http://www.theglobalfund.org/en/innovativefinancing/debt2health/incentives/

[xl] See VAT Calculations Table.

[xli] See VAT Calculations Table.

[xlii] In the United Kingdom, implementing the national lottery took about a year: the Office of the National Lottery was established in October 1993, and the first National Lottery draw was held in November 1994 (http://www.natlotcomm.gov.uk/CLIENT/content.ASP?ContentId=23).

[xliii] Total government transfers from state lotteries in the United States (net income) were US$13.3 billion in 2003. This has been on average 31.8% of total sales in 2003; the figure in most states was between 20 and 50%. Prizes awarded accounted for 57% of total sales on average; the figure in most states was between 50 and 65%. The cost structure is similar in the United Kingdom: 50% of total sales is paid out in prizes, 28% is given to charitable causes, and 12% is transferred to the Government in lottery duty.

Based on the average cost structure in the United States, it is estimated that 41 national lotteries each generated government

transfers of more than US$ 300 million in 2003, and that two generated government transfers of more than US$3 billion. 41 lotteries had sales of more than US$1billion, and two had sales of more than US$10 billion (La Fleur (2004).

Based on the figures of footnote xliii, it is estimated that lotteries worldwide together generated about US$ 50 billion in transfers to governments in 2003. About US$ 25 billion of this amount was generated in Europe, and about US$ 15 billion in North America. That year lottery sales worldwide totalled more than US$ 159 billion (US$ 1 billion in Africa, US$ 3.2 billion in Australasia, US$ 26.8 billion in Asia and the Middle East, US$ 75.8 billion in Europe, US$ 3.6 billion in Central and South America and the Caribbean, and US$ 49.1 billion in North America). (La Fleur (2004)

[xliv] Average statewide expenses in the United States, including commissions, were about 11.2% in 2003. Commissions in most states were between 5 and 8%, and administrative and operational expenses were between 5 and 15%. In the United Kingdom, a commission of 5% is paid to National Lottery retailers for all tickets sold, and 5% is retained by the operator to cover costs and returns to shareholders.

[xlv] Tufano (2008)

[xlvi] In the past year, the interest rate on premium bonds has ranged from 3.8% (February 7, 2008; the rate on that date for a comparable sovereign savings bond was 5.8%) and 1.8% (February 6, 2009; the rate on that date for a comparable sovereign savings bond was 3.3%). The average spread between February 7, 2008 and February 6, 2009 was 1.7% (http://www.nsandi.com).

[xlvii] Premium bonds in the United Kingdom (Annual reports of National Savings and Investments).

Year (as of March 31)	2001	2002	2003	2004	2005	2006	2007	2008
Invested, £ billion	15.4	17.3	19.7	24.3	26.5	31.1	35.3	36,9

Source: http://www.nsandi.com

[xlviii] Tufano (2008)

[xlix] Large and complex Multi-Donor Trust Funds: US$ 1-2 million. Vertical funds with their own legal structure: up to US$ 5-10 million. Given the requirements for the Health System Funding Platform, slightly higher costs than for a Multi-Donor Trust Fund but considerably lower than for a vertical fund are expected.

[l] For definitions of and explanations of the differences between similar terms such as impact investing, socially responsible investing, and blended value investing, see Monitor Institute (2009).

[li] Monitor Institute (2009)

[lii] Based on a proposal to the Taskforce on Innovative International Financing for Health Systems by the World Bank Group, "Encouraging non-state actors to contribute to equitable access to health care."

[liii] The value added, according to the sponsor, of:

Private equity vehicles: At-risk capital at a reasonable price for qualifying private health companies. Better managed, more efficient, and larger companies that are consequently better able to provide high-quality, low-cost goods and services. Increased access to goods and services for the poor.

Lines of credit and credit enhancements: Reasonably-priced loans for qualifying private health companies. Mobilization of domestic savings to provide health-related goods and services. Increased access to goods and services for the poor.

Venture capital fund: Entrepreneurship and risk-taking in health areas, resulting in new products and services.

[liv] Based on World Bank estimates.

[lv] Based on World Bank estimates.

[lvi] For example Celasun and Walliser (2008) find that "aid shortfalls lead to debt accumulation and cuts in investment spending, whereas aid windfalls help reduce debt but also lead to additional government consumption." Further reading: Eifert and Gelb (2005), Fielding and Mavrotas (2005), Leurs (2005), Barder and Yeh (2006), Bulir and Hamann (2006).

[lvii] http://ec.europa.eu/development/how/aid/mdg-contract_en.cfm

[lviii] Based on the presentation "*Opportunities in the telecom environment for voluntary recurring contributions to finance the Millennium Development Goals*" by the Millennium Foundation for Innovative Finance for Health, April 2009.

[lix] These figures were arrived at by calculating the average postpaid monthly mobile phone bills in several countries and assigning a contribution amounting to 7% of those averages. However, the contribution proposed would be a fixed amount, not a figure that fluctuated according to the size of each monthly bill.

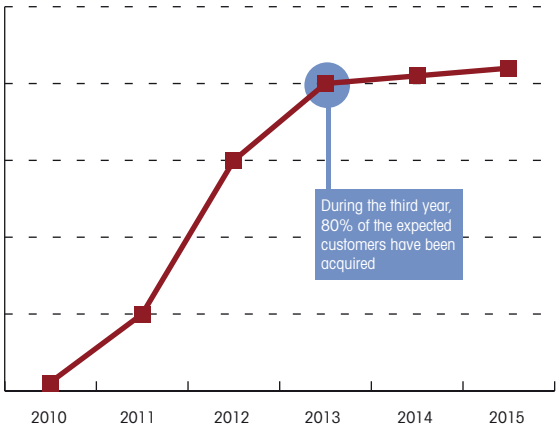
[lx] Estimates are based on the following assumptions.

- 15 target countries: Austria, China, Czech Republic, France, Germany, Greece, Hungary, Ireland, Italy, Japan, Netherlands, Portugal, Spain, United Kingdom, United States.
- Seven target operators: AT&T, China Mobile, NTT DoCoMo, T-Mobile, Orange, Telefonica, and Vodafone.
- A target of 3.9 billion postpaid invoices annually.
- 330 million customers.
- A fixed monthly donation per user ranging from the equivalent of €1.5 (China) to €6.5 (Ireland). See previous footnote for an explanation of how these amounts were arrived at.
- Penetration rates as estimated below.

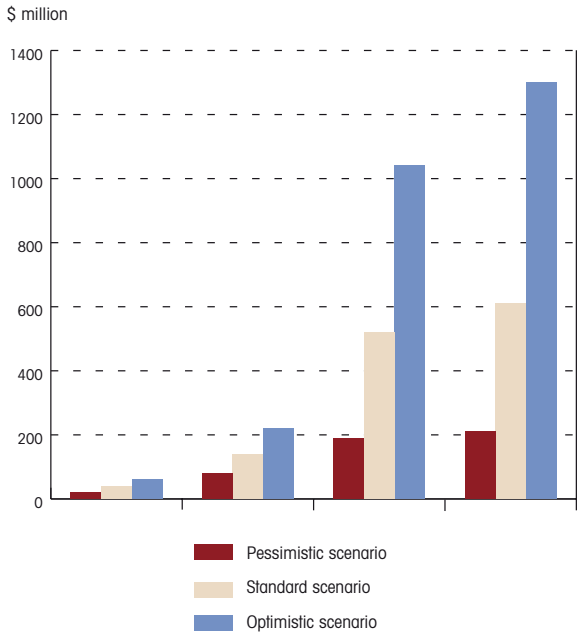
Penetration rate (%)	Pessimistic	Realistic	Optimistic
Japan	4%	10%	20%
USA	2%	5%	10%
Western Europe	1.2%	3%	6%
Eastern Europe & China	0.5%	1.25%	2.5%

Source for table above and the following three figures is the presentation *"Opportunities in the telecom environment for voluntary recurring contributions to finance the Millennium Development Goals"* by the Millennium Foundation for Innovative Finance for Health, April 2009.

S curve: Customer acquisition over time



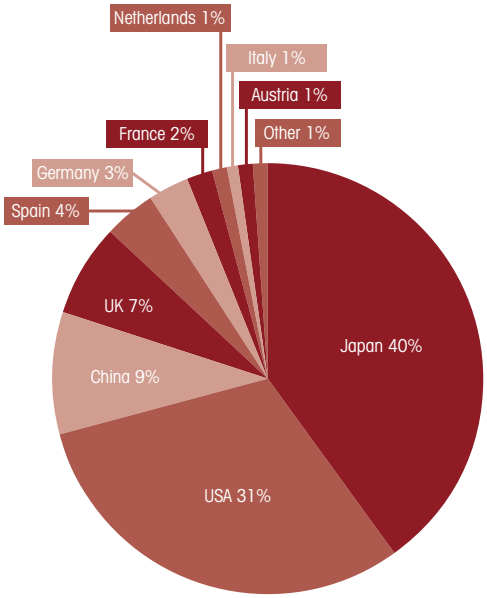
Scenarios for revenue generation by mobile phone VSC:



Estimates are based on the following figures:

- more than 50% of the world's population use mobile phones
- more than 1 billion mobile phones are sold worldwide every year
- the total turnover for mobile services was US$ 740 billion in 2008
- the average monthly revenue per user is US$ 17.50.

[lxi] Revenue generation per country:



[lxii] This estimate is based on the following assumptions:

- a Chinese mobile-phone customer base of 675 million
- a penetration rate of 40% because of a government incentive to participate
- an average annual donation of €1 per user.

[lxiii] See endnote viii

[lxiv]

Campaign/Event	Year	Funds
Live Aid (multi-venue rock music concert)	1985	£150 m
Tsunami	2005	
Donations to NGOs		$3214 m
Donations to UN (mostly UNICEF)		$494 m
Donations to Red Cross		$1783 m
Private Sector Contributions to UNICEF	2007	
National Committees		$800 m
NGOs		$150 m
Private contributions to UNHCR	2008	$48 m
World Vision International	2008	
Private Cash		$468 m
Gifts in kind		$336 m
Save the Children Alliance	2007	
Private		$342 m
Corporate		$51 m
Child sponsorship		$51 m
Foundations		$31 m
Corporate in kind		$10 m

[lxv] For example, a study carried out by McKinsey & Company for the World Bank, based on interviews and document analysis, found costs of 30 to 50% of funds raised among UN agencies that rely heavily on private fundraising.

[lxvi]

DAC1 Official and Private Flows, Net Private Grants, US$ million								
1990	1991	1992	1993	1994	1995	1996	1997	1998
5,076	5,402	6,004	5,692	6,046	5,973	5,768	5,191	5,609
1999	2000	2001	2002	2003	2004	2005	2006	2007
6,715	6,933	7,289	8,768	10,239	11,320	14,711	14,647	18,508

Source: OECD

[lxvii] Hughes P & Luksetich W (2008); Hudson (2007)

[lxviii] http://www.rhsupplies.org/

[lxix] See Reproductive Health Supplies Coalition and Dalberg Global Development Advisors (2008). PG4Health (formerly Pledge Guarantee) is a financing mechanisms complementary to AccessRH that will allow recipients of "international donor assistance to obtain short-term commercial credit by essentially using their pending donor 'pledges' as collateral. ... When disbursements do finally come through, the loan amount and associated costs are then simply deducted at the source, with the donor, in effect, paying off the loan."

[lxx] AccessRH: Leverages the scale of reproductive health commodities currently purchased by donors and developing country governments, to provide access to the best products at optimal pricing. The benefits are both qualitative and quantitative. Qualitative benefits include reducing the cost of emergency shipments, wastage, and storage, reducing the complexity of supply chains, and providing quality products from pre-approved and inspected suppliers to end-users upon need. Quantitative benefits are driven by savings on existing sub-scale orders that do not receive volume discounts, as well as on sub-optimal orders which do not receive manufacturer-guarantee discounts. The quantifiable benefits are expected to equal US$ 3 million to US$ 11 million during the first three years of operations, with an expected return on investment of 0.6 to 2.4%. Although the return on investment is initially modest, the benefits would grow disproportionately with respect to costs over time, leading to a larger return on investment as customer uptake and usage increases.

[lxxi] So far, UNITAID has achieved price reductions of 23 to 49%. It estimates that a price reduction of 20% could save US$ 600 million of spending on antiretrovirals between 2008 and 2020. It is aiming to achieve savings of up to 25% for certain tuberculosis medicines by 2010.

[lxxii] The general concept is sponsored by the supporters of UNITAID and AccessRH, described below.

- UNITAID: In 2006, France, Brazil, Chile, Norway, and the United Kingdom decided to create the organization.
- AccessRH: Sponsored by the United Nations Foundation (UNF) and UNFPA. The study leading to AccessRH's development was commissioned by the World Bank on behalf of DfID, KfW, the Netherlands Ministry of Foreign Affairs, and the Gates Foundation.

[lxxiii] UNITAID: The creation of this organization took about three years (start of discussion to initial funds disbursed). UNITAID was operational within a year of the final donor commitment.

- 2004: France and Brazil, along with other countries and international organizations, opened the discussion that led to the creation of UNITAID.
- 2006: Donors decided to create UNITAID.
- September 2006: UNITAID was officially launched in New York.
- November 2006: First funds were committed.

AccessRH: Creation of this organization took three to four years (first conceptual reports in 2005/2006; implementation in 2009).

[lxxiv] AccessRH: It is expected that about US$ 37 million in commitments to suppliers will be needed to scale up the pilot and achieve optimal benefits. The expected volume of uptake is estimated to be US$ 37 million in the first year of operations and to grow to about US$ 60 to 80 million by the fifth year, representing 23-30% of the in-scope reproductive health market, which is expected to be about US$ 257 million a year.

[lxxv] http://www.pidg.org

[lxxvi] http://www.ifc.org/ifcext/psa.nsf/content/Devco

[lxxvii] http://www.ppiaf.org

[lxxviii] Example 1. Reducing maternal mortality through the use of vouchers. The state government of Gujarat, in India, dramatically increased coverage of pre-natal and delivery services for poor women by accrediting doctors to be reimbursed for a pre-approved service package. Any doctor who provided services to women who were "below the poverty line" (this is a formal category, and people are issued cards that indicate their status) was reimbursed. This increased coverage of services for poor women, relieved them of the burden of paying, and allowed them to choose among qualified providers. Maternal mortality rates in the pilot districts fell. Support to other countries with high maternal mortality rates due to low access to services could enable some to adapt the Gujarat model to their own circumstances.

Example 2. Controlling malaria by expanding the use of insecticide-treated bednets (ITNs). In 2006, approximately 247 million episodes of malaria occurred, causing an estimated 881,000 deaths – most in Africa, and most involving children and the poor. The use of ITNs reduces malaria prevalence and transmission. Although most donor-supported programmes rely on imported ITNs, the A to Z Company in Tanzania now produces three to four million high-quality nets each year. Investments from the IFC and the Acumen Fund helped the company re-tool and produce nets of sufficient quality. If more donor subsidies for nets took the form of vouchers to increase production capabilities, rather than free give-aways of nets, other companies would have increased incentives to enter the market. A voucher approach would not only encourage local investment and production; it would also encourage the development of distribution and retail markets, rather than crowding them out, as give-away programmes often do. This sort of shift in policy could thus help shift malaria-control programmes toward these more-inclusive and sustainable solutions.

Source: April Harding, Center for Global Development.

[lxxix] According to DEVCO fiscal benefits would come from upfront license fees obtained by governments and efficiency gains that should allow governments to reduce subsidies paid out to support inefficient public sector operations. "The tangible development impact of DEVCO mandates has been confirmed by independent reviews: mandates to date will leverage private investment in the order of US$ 1.675 billion, yield US$ 713 million in fiscal benefits for client governments (from upfront license fees obtained by governments and efficiency gains that should allow governments to reduce subsidies paid out to support inefficient public sector

Outcomes acheived by PPIAF activities by region through fiscal 2008

	Activities completed			Activities achieving at least one measurable outcome		
Region	Total	With no measurable outcome	With measurable outcome	Total	Share of total (%)	Outcomes achieved
Sub-Saharan Africa	112	33	79	63	80	125
Central Asia and Europe	59	7	52	47	90	67
Latin America & The Caribbean	58	11	47	36	77	63
East Asia & Pacific	76	19	57	44	77	50
South Asia	52	18	34	33	97	37
Middle East & North Africa	22	5	17	14	82	22
Total	379	93	286	237	83	364

operations) and expand access or improve services for about 7.23 million people – for a donor investment of roughly US$ 20 million over the last few years. Initial mandates in the health sector show indicate even higher success rates of transaction mandates and comparatively high levels of leverage."

[lxxx] 237 activities, or about 83%, achieved at least one outcome: a law passed, a strategy adopted, an institution established, or a transaction facilitated. 93 activities, or about 25%, accounting for about 13% of funding, targeted outputs such as training programmes, stakeholder consultation activities, or global or regional knowledge management studies. These activities typically have diffuse, hard-to-quantify impacts and thus did not have measurable outcomes. Nine of the projects that aimed for measurable outcomes could not be evaluated because of a lack of historical data. The 237 activities together achieved 364 outcomes, an average of more than 1.5 distinct outcomes per activity.

PPIAF has reported that its activities to date have facilitated 82 transactions, supported 51 laws and regulations, created or strengthened 74 institutions, and assisted in the formulation of 146 strategies (see above table). In addition, 338 PPIAF-funded conferences and training activities, with a total of 24,274 participants, were held through fiscal 2008. According to PPIAF, it achieved this level of results by focusing on initial reviews of project proposals and because it has a strong network of field-based staff and task managers, who work with client countries during the design of an activity and the implementation of technical assistance. In addition, its Program Management Unit conducts semiannual portfolio reviews of all ongoing activities and annual reviews of the outcomes of all closed activities.

Source: PPFIAF Annual Report 2008 (http://www.ppiaf.org/documents/Reports/PPIAF_Annual-Report-FY08_FINAL.pdf)

[lxxxi] A Working Group of the Center for Global Development is currently considering a proposal to locate a global advisory facility for health systems within the existing "Health in Africa" initiative in the IFC/ World Bank (see www.ifc.org/HealthinAfrica). The mandate of the proposed facility is similar to that of Health in Africa; therefore, this option could provide a "quick start" for the proposed new facility and minimizes its overhead costs. The new facility could also realized advantages from linking to the business knowledge and private-sector financing capacity of the IFC, and from the on-going policy dialogue among World Bank operational staff. Source: Briefing by April Harding, Center for Global Development.

[lxxxii] Barder and Yeh (2006)

[lxxxiii] IFFIm is a multilateral development institution. It was created in 2006 to accelerate the availability of predictable, long-term funds for health and immunization programmes supported by GAVI in 70 of the world's poorest countries. IFFIm is supported by long-term, legally binding grants from sovereign donors (the United Kingdom, France, Italy, Spain, Sweden, Norway, and South Africa) totalling approximately US$ 5.3 billion. It issues bonds in capital markets, thereby converting long-term government pledges into immediately available cash resources. The long-term government pledges are used to repay the bonds. As of March 2009, approximately US$ 1.6 billion in triple-A rated bonds have been issued for GAVI immunization programmes. IFFIm's Treasury Manager is the World Bank.

[lxxxiv] Timeframe:

- January 2003: HM Treasury and the Department for International Development (DFID) launched a proposal for a Finance Facility for Immunization
- January 2005: The first donor pledge was received
- September 2005: IFFIm was officially announced
- February 2006: IFFIm board members were selected
- November 2006: The first bond issuance took place.

[lxxxv] Costs of capital: The cost of frontloading funds is substantial. In 2007, IFFIm's capital costs (total borrowing costs, including debt-service payments, less investment income) were about US$ 38.7 million; in 2008, they were about US$ 32.6 million.

Start-up costs: Compared with those for a comparable commercial transaction or a multi-donor trust fund, IFFIm's start-up costs were high. Particularly noteworthy was the cost of using three different law firms over the course of two years. IFFIm's start-up costs, as reported in IFFIm's 2006 financial statements, totalled about US$ 3.6 million. These costs related to (among other things): legally establishing the IFFIm entities and arranging for IFFIm management functions within the World Bank and GAVI; negotiating and drafting a comprehensive suite of supporting legal agreements; obtaining IFFIm's special capital-markets status and preparing its first bond issuance; and determining accounting arrangements under a variety of accounting standards. This figure includes only those costs paid directly by IFFIm; it does not include substantial external and internal costs paid directly by GAVI or internal World Bank costs incurred prior to IFFIm's legal establishment.

Costs of potential modifications: Because any modification to IFFIm would entail changes to its numerous legal and financial documents, the costs involved would be significant, including costs related to:

- modification of IFFIm and GFA Articles of Association – UK Charities Commission
- amendment of prospectus
- amendment of other legal documents.

The level of annual running costs of an expanded IFFIm would also need to be considered:

- legal fees
- accounting fees
- treasury manager's fees (including fund management, donor relations and internal accounting costs)
- rating agency fees
- other/PR costs.

Administrative costs: These cover such things as legal services, the trustee, ratings agencies, auditing, risk management, investor relations and communications, and board meetings. They totalled US$ 3 million in 2007 and US$ 4.6 million in 2008.

[lxxxvi] For passengers, the cost of the tax is low compared with the cost of a ticket; the tax would range from US$ 1 for economy tickets to US$ 40 for business and first-class tickets. Different rates can be set according to countries' level of development; the charge can vary according to the distance travelled. Some countries in Africa have imposed the levy only on international flights or business and first-class tickets.

[lxxxvii] Working Group on New International Contributions to Finance Development and Landau (2004)

[lxxxviii] Source: French Ministry of Economy, Industry and Employment, Treasury and Economic Policy Directorate General.

[lxxxix] Forecast for 2009 revenues as of February 2009. Source: French Ministry of Economy, Industry and Employment, Treasury and Economic Policy Directorate General.

[xc] Information on countries' international departures was not obtainable in the time allotted for producing this paper. Further estimations of the Levy's revenue-raising potential are suggested.

[xci] IATA Airlines Air Transportation Operations by Region, 2007:

Region	Africa	Asia Pacific	Europe	Latin America	Middle East	North America
Passengers carried	22.1m	185.6m	314.1m	32.6m	61.6m	83.4m

[xcii] According to the French Ministry of Economy, Industry and Employment, Treasury and Economic Policy Directorate General, no figures are available for start-up and compliance costs; Agence Française de Développement is paid €80,000 a year to run the Levy; and indirect costs for other administrative activities involved in managing the Levy, which are not included, are "probably marginal".

[xciii] According to the French Ministry of Economy, Industry and Employment, Treasury and Economic Policy Directorate General, "the Levy is additional to ODA but is accounted as ODA, as it perfectly fits the DAC ODA statistics definition".

[xciv] See: http://www.unitaid.eu/index.php/en/The-air-ticket-levy.html. The biggest decrease over the last ten years was about 4% (2001), and the biggest increase was about 11% (2004).

Year	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Passengers carried	1.29m	1.34m	1.41m	1.35m	1.34m	1.31m	1.46m	1.52m	1.58m	1.63m
Percentage change	-	3.88%	5.22%	-4.26%	-0.74%	-2.24%	11.45%	4.11%	3.95%	3.16%

Source: IATA Airlines Air Transportation Operations by Region, 2007

[xcv] http://www.unitaid.eu/index.php/en/The-air-ticket-levy.html

[xcvi] World Health Organization (2008)

[xcvii] World Health Organization (2008)

[xcviii] World Health Organization (2008)

[xcix] Also, "while more than four fifths of high-income countries tax tobacco at more than 50% of retail price, less than a quarter of low- and middle-income countries tax tobacco at 50% or more of retail price". (World Health Organization (2008)

[c] Jha, Chaloupka, Moore, Gajalakshmi, Gupta, Peck, Asma and Zatonski (2006)

[ci] World Health Organization (2008)

[cii] World Health Organization (2008)

[ciii] Source: Briefing note by Tobacco Free Initiative, World Health Organization

[civ] Based on WHO and ERC data. Over the ten years from 1998-2007, 82 out of 132 countries saw decreasing total cigarette consumption.

[cv] World Health Organization (2008)

[cvi] World Health Organization (2008)

[cvii] World Health Organization (2008)

[cviii] World Health Organization (2008). In South Africa, for example, tobacco tax rates were increased by 250% during the 1990s, eventually reaching slightly less than 50% of the retail price. Cigarette consumption fell by 5 to 7% for every 10% increase in price, resulting in a sharp cumulative decline in consumption. The largest decreases were among the young and the poor (van Walbeek (2003).

[cix] For a comprehensive discussion, see Remler (2004).

[cx] OECD Glossary of statistical terms, Official Development Assistance (ODA) (http://stats.oecd.org/glossary/detail.asp?ID=6043). For more information see: http://www.oecd.org/dataoecd/21/21/34086975.pdf.

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