

# Taskforce on Innovative International Financing for Health Systems: showing the way forward

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When the high-level Taskforce on Innovative International Financing for Health Systems was launched in September 2008, with a 12-month timetable, it faced a vast array of challenges. A global financial crisis was gaining momentum, leading many to think that there was no chance of getting political support for raising additional funds for the United Nations Millennium Development Goals (MDGs) for low-income countries. Other challenges included differing views on how to define and handle international investments in "health systems", concerns by some donors on the value for money of much official development assistance, and a growing number of competing priorities such as the food crisis and climate change.

However, by the end of the 12-month period, a large number of world leaders met in New York to announce expanding support to several initiatives valued at more than 5 billion United States dollars (US\$) in low-income countries, with a particular focus on maternal and child health services. These announcements came at the end of a year of detailed analyses by some leading figures in international health and a series of lively consultations and debates that have brought much needed energy to previously ignored areas. This paper summarizes how the taskforce was conducted, its key achievements and progress made since the work was completed. A detailed description of the challenges the workforce faced has already been published.<sup>1</sup>

## The taskforce

The taskforce was an innovation itself in the way it was set up and run. Prime Ministers Gordon Brown (United Kingdom of Great Britain and Northern Ireland) and Jens Stoltenberg (Norway) were the original driving force, using their offices to bring in The World Bank president, Robert Zoellick, as co-chair and the Director-General of the World Health Organization (WHO), Margaret Chan. Japan and the

Netherlands joined later in 2009, drawn in by the process of consensus building. Final membership consisted of three heads of state (Liberia, Norway, United Kingdom), two heads of international institutions (The World Bank and WHO), six ministers (Australia, Ethiopia, France, Germany, Italy and the Netherlands), two special advisers (for Japan and the United Nations Secretary-General) and a representative of civil society (Graça Machel). The taskforce met four times: at the Conference on Financing for Development in Doha in December 2008, in Downing Street, London, before the G20 Summit in March 2009, in Paris during the French-led Leading Group on Innovative Financing for Development conference in May 2009, and in New York during the United Nations General Assembly in September 2009. Its secretariat was provided by the International Health Partnership Plus (IHP+) and the United Kingdom's Department for International Development.

## Key achievements

### Articulation of needs

When the taskforce started its work, different groups expressed the main constraints to scaling up health services in disparate ways. In many areas, important ideas were not being clearly articulated to national and international policy-makers. Through a large, widely representative working group, the final report from taskforce working group 1 successfully expressed the main constraints and policy responses to scaling up health services in low-income countries.<sup>2</sup>

### Unified costing

At the start of the taskforce's work, different international groups were promoting a plethora of costing tools and approaches to developing countries. The taskforce chose to publish two cost analyses based on quite different assumptions – one

focusing on high levels of early capital investment and the other on more gradual increases in capital.<sup>1,2</sup> The effort promoted close collaboration and allowed more detailed discussion on standards for future work. This will hopefully reduce the current confusion in countries and allow more efficient support by the United Nations and The World Bank. Given the limited time available, the intention was to produce plausible aggregate numbers rather than numbers that were robust at the country level. The country data used to produce the aggregates has not been made public. However the aim is to continue to develop country plans and related costs, as has already started under the IHP+ and related initiatives.

### Improved domestic finance

Although not in the terms of reference of the taskforce, the analysis clearly showed the fundamental importance of improving domestic health financing policy to meet the health MDGs in an equitable way. These conclusions were quickly highlighted by those advocating for more funds for health in developing countries. A landmark consultation between taskforce members and African parliamentarians in Addis Ababa, Ethiopia, focused on the potentially greater impact that a relatively small amount of international funds could have if used in conjunction with domestic finances. The final recommendations of the taskforce echo the sentiments of that meeting.<sup>3</sup>

### Innovative finance

The taskforce decided to recommend only those innovative financing mechanisms that had a clear sponsor for implementation. However, the analysis in the working group 2 report and the submissions made to the taskforce provide a rich array of ideas for countries to consider, both for health and other social sectors.<sup>4</sup> Some mechanisms clearly required further work before they could be put into action. The

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inclusion of the currency transaction levy in one of the recommendations, for example, was a key step in helping to promote it to a wider set of stakeholders, led by civil society activists and the Government of France.

### Making better use of funds

The taskforce recommended expansion of support to the IHP+, which aims to better link international financial aid to results in countries. Central to these efforts are more robust country-level planning, costing, budgeting and monitoring. IHP+ was closely involved in the work of the taskforce and its momentum continues to grow. In addition, the United States of America is also aligning its support more closely with national policies and plans of developing countries with proactive governments.

### Health systems strengthening platform

One of the key outcomes of the taskforce was the recommendation of a more efficient approach to health investments by the three main multilateral health sector donors – The World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance. Some countries are now piloting a closer collaboration across agencies on result-driven investments within their national health plans and strategies. But it is an area where there is still a lot to be learnt. However, this could be key to unblocking many constraints to expanding health services and improving efficiency of the international health architecture.

### Monitoring commitments

Another key success of the taskforce was the agreement to a regular Health and Development Forum where global and country commitments can be more openly monitored. This started under the IHP+, but will now be a broader group of coun-

tries given that the previous IHP+ ministerial meeting was criticized for missing out many of the poorer countries which have not had as much international support.

### Challenges

A paper recently published<sup>1</sup> outlines the many problems the taskforce faced, including the short timeframe for completing technical work and mobilizing political support for the recommendations, limitations in the evidence base and areas of disagreement – particularly over the role of non-state actors and public-private partnerships. On the other hand, the tight timeline may have actually contributed to its success, reducing opportunities for confusion and delays. An extended reporting period may have encountered more problems due to political changes in donor countries.

Concerns have been expressed that the “innovative finance” proposals may detract public and government support in some donor countries for the United Nations target of 0.7% of gross national income for official development assistance. However, some members of the taskforce argued forcefully that more innovative mechanisms could lead to greater public engagement and support. Examples include the International Finance Facility for Immunisation (IFFIm) bonds, and joint government and business initiatives such as the “D-Tax” (announced by Italy), which aim to encourage the general public to support and be engaged in international health aid in low-income settings.<sup>4</sup>

### Progress

Progress on many of the final announcements is already well underway in 2010. This includes US\$ 1 billion to expand health system investments through IFFIm and US\$ 400 million to expand the Health Results Innovation Trust Fund held by The World Bank. Some of the

announcements reaffirm support for ongoing work, such as for Advance Market Commitments for vaccines and the Debt-2Health initiative by the Global Fund. Some areas were completely new and have yet to prove they can deliver, such as the D-Tax and the “Massive Good” initiative managed by the Millennium Foundation for Innovative Finance for Health. An independent assessment of this initiative by The World Bank suggested that US\$ 3.2 billion could be raised before 2015 through a coordinated effort within the travel industry. As with the airline tax used to fund UNITAID, those who initially scoffed at these innovations may well be proven wrong.

### Conclusion

The taskforce delivered on its terms of reference and produced recommendations, despite the dire global financial circumstances. Perhaps its most important outcome was driving the momentum for health aid in developing countries – not an easy task given that donors and ministers of finance have many other competing interests. Political engagement at the highest level was critical to this. The consultations with civil society, particular those hosted by Graça Machel in Africa, and with African parliamentarians in the Economic Commission for Africa in Addis Ababa, showed the growing importance of engaging with regional and national lobbies in low-income settings. Of course, not all will be content with the taskforce findings and many will, no doubt, be concerned that they were not adequately consulted. However, the taskforce has started on the right track by linking international, regional and national efforts to mobilize resources for health in the poorest countries more effectively, in a way that aims at giving value for money. ■

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