

Terms of Reference

Working Group I: Constraints to Scaling Up and Costs

High Level Taskforce on International Innovative Financing for Health Systems

A. Background

1. At the UN High Level Event in New York on 25 September 2008, world leaders announced a High Level Taskforce on Innovative International Financing for Health Systems (the Taskforce). The objective of the Taskforce is to contribute to filling national financing gaps to reach the health related Millennium Development Goals by providing recommendations on how best to mobilize additional resources, increase the efficiency of health systems, and enhance the effective use of raised funds.¹

2. In a first phase, from November 2008 to June 2009, the Taskforce will be supported by two technical working groups that focus on health systems and innovative financing respectively.

Working Group I will: (i) foster a better understanding of key determinants of well functioning health systems; (ii) analyze existing financing gaps including volume and types of funding required; and (iii) identify the main constraints to scaling up interventions in support of the health Millennium Development Goals at the country level and suggest ways in which to address those constraints.

Working Group II will analyze the range of existing innovative financing instruments to respond to the health systems constraints identified in Working Group 1. It will make recommendations on instruments that are ready for expansion as well as examine possible new or complementary approaches. As innovative international funding can only supplement domestic resources, the Working Group will take into account the broader discussion and emerging consensus among development partners on how to increase domestic revenue mobilization for health financing. The working group will also review the efficiency of the present channeling of international funds for health and what changes might be required for.

3. Both Working Groups will provide recommendations for consideration by the High Level Taskforce that will be used to compile a first Taskforce report in time for the G8 in July 2009; this is expected to focus on a few mechanisms, existing and new, that will attract the necessary political support for implementation. In a second phase, from May to October 2009, a group of “champions” will secure support for the final recommendations of the Taskforce through a broad based consultation and

¹ Financing gaps are being clarified in country compacts developed as part of the IHP+ and other initiatives to strengthen health sector commitments by national and international stakeholders. Health Millennium Development Goals refer to 1c, 4, 5 & 6.

communications campaign. A final Taskforce Report will then be made in time for the UNGA in September 2009.

4. This paper outlines the Terms of Reference of Working Group I: Constraints to Scaling Up and Costs.

B. Terms of Reference

5. Working Group I will focus on defining the need and clarifying understanding of health systems.

6. The Working Group will look into the total amount and distribution of additional funds required to fill the financing gaps (existing and projected) and to deliver results in low income countries², as identified in national health plans and strategies. This will take into account funds expected to come from domestic sources, from existing international donor commitments, and from new sources of international finance.

7. The Working Group will look into the types of funding that are required (long-term, predictable, sustainable, frontloaded, etc) for what needs.

8. In understanding the opportunities for resolving constraints to scaling up to reach the health MDGs at the country level, the Working Group will summarize:

- Current understanding on the priority constraints that prevent scaling up, including health financing and social protection policies;
- Ways to maximize the contributions of other sectors to strengthening health systems;
- How to ensure absorption and effective spending of additional external funds.

9. Working Group I shall:

- (a) Define (i) the health system platform which is needed to support achievement of the health MDGs and (ii) particularly the package of guaranteed benefits or interventions that is needed to achieve those MDGs where least progress is being made, namely MDGs 4, 5 and 1c, in the light of the Task Force definition of a health system³ that ‘*Within the political and institutional framework for each country, a health system is the ensemble of all organizations, institutions, and resources mandated to improve, maintain or restore health. They encompass both personal and population services and activities to influence policies and actions of other sectors to address the environmental and economic determinants of health*’. Key sub components of health systems include: delivering health

² There are 49 Low Income Countries using the WB categorization, see: <http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS>

³ Taskforce Focal Points have agreed that this definition will be reviewed and possibly amended by Working Group 1

services through a primary health care approach; financing and social protection; health workforce; logistics and supply chains; information and knowledge; and governance'⁴.

(b) In the light of (a), review evidence on the main constraints that hamper scaling up, efficient and equitable delivery of services, and achievement of health outcomes, including:

- constraints operating at the various levels of a health system, from community to the whole system
- constraints with respect to health system components such as the availability and productivity of the health workforce, and patterns and volumes of domestic financing
- constraints that especially relate to fiscal space and absorptive capacity
- constraints that result from modes of external funding and mechanisms for transferring them to countries and within countries
- constraints that concern intersectoral action to strengthen health systems

(c) Identify specific policies and approaches which can strengthen the overall health system, its various elements and address constraints to scaling up; with respect to each policy/approach, review:

- whether there is consensus on the preferred policy
- whether there is controversy
- whether no promising solutions are available and therefore more evidence generation is required.

Possible topics include: the roles that international development assistance can play in supporting improved health system performance, sources of domestic financing, modes of payment eg P4P, demand-side financing, contracting NGOs and commercial players, franchising, specific ways of reaching poorest and most vulnerable, task-shifting, decentralization, improving information systems, regulation, promoting good governance.

(d) Identify, based on existing evidence including global costings and national health plans and strategies, the total amount and distribution of additional funds required to fill the financing gaps (existing and projected for all health MDGs) and to deliver results in low income countries⁵. This will take into account funds expected to come from domestic sources, from existing international donor commitments, and from new sources of international finance. It will also need to take into consideration issues such as scope for productivity gains, potential for crowding out or stimulating domestic financing, and the need to fund adequately higher level system functions above the service delivery level.

⁴ TOR of Taskforce

⁵ There are 49 Low Income Countries using the WB categorization, see: <http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS>

- (e) Recommend to Working Group II the specific types of flows needed (eg capital, upfront investments, recurrent flows, funding predictability) to support the needs and levels of flows identified in (d).

C. Composition

9. The Working Group “will be a virtual network of global experts chaired by a member of the international community. The Working Group participants will consist of individual experts that represent a balance of global views; able to commit dedicated time to the work of the Taskforce. They will be serving the Taskforce in their individual capacity and not as representatives of their government or agency.”⁶

10. The members of Working Group I are:

Julio Frenk (Dean, Harvard School of Public Health), Co-Chair
Anne Mills (Head, Public Health and Policy, the London School of Hygiene and Tropical Medicine), Co-Chair
Edward Addai (Head of Evaluation, The Global Fund)
Flavia Bustreo (Deputy Director, Partnership for Maternal and Newborn Child Health, WHO)
Helga Fogstad (Coordinator, MNCH, Global Health and AIDS Dept, NORAD)
Elliot Harris (Special Representative to the UN, IMF)
Brenda Killen (Head, Aid Effectiveness, OECD)
Jacqueline Mahon (Senior Policy Adviser, Health Systems, UNFPA)
Martina Metz (Head of Section, Health, Population Policy, BMZ)
Chris Murray (Director, Institute of Health Metrics & Evaluation)
Kampeta Pitchette Sayinzoga (Director of Macroeconomic Policy Unit, Ministry of Finance and Economic Planning, Govt of Rwanda)
Srinath Reddy (Head, Public Health Foundation of India)
Keizo Takemi (Research Fellow, Harvard School of Public Health)
Christine Kirunga Tashobya (Public Health Advisor, Ministry of Health/DANIDA, Kampala, Uganda)
Rajeev Venkayya (Director, Global Health Delivery, The Bill and Melinda Gates Foundation)

11. The Working Group will be supported by a virtual secretariat consisting of the IHP+ core team⁷ and a small network of full-time staff based in development partners.

D. Collaboration between the Working Groups in Phase One

12. There should be a strong link between any innovative financing instrument with the financial needs (as concerns both size and financial characteristics) to strengthen

⁶ See Terms of Reference and Management Arrangements of the Taskforce

⁷ The IHP+ core team works out of Geneva, Washington and Brazzaville, led by WHO and World Bank

health systems. This will, as outlined above, require close collaboration and regular information exchange between the two working groups of the first phase.

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

14. From the perspective of Working Group I, continuing input will be required from Working Group II on their evolving thinking on specific types of innovative financing, how they might be transferred to countries, and what performance or results criteria might be attached and their implications.

E. Draft timeline

December 18, 2008. First Meeting of Working Group 1 (virtual).

January 14, 2009. TBC. Virtual meeting between Taskforce Focal Points and Working Group 1.

January 29-30, 2009. Second Meeting of WG 1 in Boston (face-to-face). To discuss the draft paper being prepared by Anne Mills.

TBD. Third Meeting of WG 1 to discuss draft report.

Week of February 16. First draft report of WG1 submitted to WG2.

March 2, 2009. Draft first report ready for presentation to Taskforce

March 12 2009, second meeting of the Taskforce at the G20 Meeting. First report of Working Group 1 (by co-chairs) to the Taskforce and guidance for final report.

April. TBC. Venue TBC. Fourth and Final Meeting of Working Groups 1 to complete the final report (face-to-face)

Week of May 11: Deadline for final report of WG1.

F. Other Consultations and interactions. To be determined during first WG1 teleconferences.