Taskforce on Innovative International Financing for Health Systems: what next?

David McCoy[a] & Nouria Brikci[b]

Introduction

The high-level Taskforce on Innovative International Financing for Health Systems was set up in 2008 and chaired by Gordon Brown, Prime Minister of the United Kingdom of Great Britain and Northern Ireland, and Robert Zoellick, President of The World Bank. Its aim was to identify innovative and additional sources of funding for health systems strengthening in the 49 lowest-income countries of the world. The taskforce delivered its final recommendations in September 2009 together with two detailed working group papers.[1,2] Here we summarize the main outputs and recommendations of the taskforce according to three areas: (i) costing the financing gap; (ii) new and innovative sources of finance; and (iii) making development assistance for health work better (Box 1). We then examine their limitations and propose further actions for the international health community.

Gaps and challenges

Costing

Three issues stand out. The first relates to the models used for calculating the costs of scaling-up essential health services, including the assumptions on what is required to achieve that scale-up.[1] The different models used by the taskforce did not just produce alternative costings, but also reflected different approaches to health systems strengthening as well as different levels of ambition.

The World Health Organization (WHO)'s normative approach, for example, was bolder and advocated the simultaneous scaling-up of facility and community-based services, while The World Bank and the United Nations Children's Fund (UNICEF) were less ambitious and advocated expanding low-cost, community-based services before undertaking any strengthening or expansion of facility-based services. In addition to the confusion of having different costing models, the taskforce reveals fundamental differences in opinion about the minimum requirements to strengthen health systems and the best way to expand coverage of essential health services.

The second issue is that the individual country costings used to produce an aggregated "price tag" for all low-income countries are unavailable. And yet a full and proper discussion about the best way to fund and scale-up essential health services can ultimately only be conducted at the country level. In addition, the costings generated for health systems inputs such as "governance" are novel and need further empirical testing. A disaggregation of the data by country is therefore a vital next step.

Third, an implicit recommendation of the taskforce is that a significant proportion of funding should come from private expenditure, in spite of the need to reduce the burden of health expenditure on poor households. This suggests that the required future funding from governments and donors has been underestimated.

Innovative finance?

There are several problems with the recommended sources of new and innovative finance, namely; their lack of ambition, their orientation towards a voluntary and charitable approach (rather than one that is rights-based) and the largely consumption-based nature of the proposed levies.[2]

The opportunity to link revenue generation to a global redistributive and

Box 1. **Summary of recommendations by the high-level Taskforce on Innovative International Financing for Health Systems**[3]

New sources of finance:

- Extend the mandatory solidarity levy on airline tickets to more countries (currently in place in several countries and used primarily to finance paediatric AIDS treatment through UNITAID);
- Explore the viability of levies on tobacco and currency transactions;
- Encourage voluntary private giving through: (i) voluntary levies on the purchase of airline tickets and mobile phone minutes (expected to raise US$ 3.2 billion by 2015); and (ii) a scheme called a "de-tax" which would earmark a share of value added tax receipts when participating businesses agree to add a share of their profits (estimated potential of US$ 220 million in 2010);
- Secure more private investment in health systems through establishing capital/risk mitigation fund(s). Out-sourcing to non-government providers and encouraging greater use of advanced market commitments, such as for vaccine purchases, were also mentioned as ways of securing investment from private sector actors.

Making development assistance for health work better:

- More frontloading (i.e. concentrating payments at the beginning of an agreement) and predictability of aid, possibly by expanding the mandate of the International Financing Facility for Immunization.
- Expand the use of results-based "buy-down" (use of grant funding to reduce the cost of loans when specific performance targets are met) funding and more performance-based donor funding for the health sector.
- Establish a common health systems funding platform for the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and The World Bank.
- Undertake a review of technical assistance, in view of evidence that it consumes a large proportion of aid and appears to be poor value for money.

[a] Faculty of Public Health, University College London, London, England.
[b] Save the Children UK, 1 St John's Lane, London, EC1M, England.
Correspondence to Nouria Brikci (e-mail: n.brikci@savethechildren.org.uk).
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environmental agenda was ignored. The taskforce neither recommended carbon, luxury or capital flow taxes, reducing illicit capital outflows from low-income countries, nor did it recommend leveraging a higher domestic return on the natural resources and primary commodities of poor countries. Instead, the focus was mostly on low-value commercial transactions of ordinary consumers.

The idea of a currency transaction levy was barely supported despite its potential to raise as much as US$ 33 billion every year (even at a rate as small as 0.005%).[4] The timidity of the taskforce is now more apparent in light of the current political momentum within the G-20 (Group of 20 industrialized and emerging-market countries) in favour of a higher rate currency transaction levy and additional financial transaction taxes that could also be used to regulate the global financial system.[5]

The suggestion to expand private (profit-seeking) investment through the use of public funds to mitigate risk was alarming. Low-income countries suffer from a lack of investment in public services combined with an unregulated commercially-driven health system. This recommendation would therefore make the problem worse.

Finally, the taskforce ignored the agenda of expanding the domestic resource base of low-income countries. Many of these countries could increase their volume of domestic public finance by reducing capital flight, promoting more effective tax policy and improving their tax collecting systems. Such an agenda would have the added benefit of placing greater attention on the broader challenges of economic development, and improving democratic and accountable governance. The reason why the taskforce excluded domestic finance from its remit is unclear.

More effective assistance

The recommendations for making development assistance more effective and efficient were undermined by inconsistencies and contradictions. One of the working group reports included an assessment of the evidence on several "controversies" about health systems development including: (i) the desirable mix of public and private financing; (ii) the desirability of expanding the for-profit sector; (iii) the appropriateness of scaling-up community-based health insurance; and (iv) whether and how vertical, disease-based programmes should be embedded into comprehensive health systems development.[1]

Despite commissioning this analysis, the taskforce appears to have disregarded the evidence by recommending the expansion of private (for-profit) investment finance. Similarly, the enthusiastic promotion of results-based funding does not tally with the more equivocal evidence on the effectiveness and efficiency of performance-based finance.[6]

However, the recommendation to create a common funding platform for health systems strengthening across the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and The World Bank must be welcomed, given the current fragmentation and disorganization of development assistance for health. However, these agencies have, at best, a mixed track record on health systems strengthening.[7] The lack of clarity about the way that this common funding platform would work in practice is therefore a limitation that requires further attention.

What next?

Given the scale of the world's health challenges, it seems hard to escape the conclusion that the taskforce has turned out to be a major disappointment. It has not met its primary objective of raising significant new and more predictable finance for global health. Meanwhile, in the background, high-income countries continue to fall short of their responsibility to allocate 0.7% of their gross national income to development assistance.

In this context, innovative finance is a potential smokescreen for reneging on donor commitments (certainly the case with Italy), as well as a distraction from the need to create a new global agreement for a more systematic transfer of resources to low-income countries. Disappointingly, the taskforce chose not to build on the work of the WHO Commission on the Social Determinants of Health and to make an important contribution on the underlying structural determinants of under-resourced health systems.

The international health community, including WHO, should ignore many of the financing recommendations of the taskforce (with the exception of the half-hearted mention of a currency transaction levy) and focus instead on other actions that will provide a better political and economic environment for health systems in low-income countries. These include expanding the domestic finance base for development, reducing the loss of capital and resources from low-income countries and establishing principles and mechanisms for a more systematic transfer of resources from high-income to low-income countries.

The costing work of the taskforce was, however, more valuable and now needs to be developed. Specifically, country-specific data should be made available and should be used to support country-specific discussions about health systems and financing policy. WHO's normative costing model would be a good starting point.

Finally, although the taskforce has helpfully pushed The World Bank, the Global Fund and GAVI to work in a more integrated manner, there is still a need to establish clearer principles and positions on health systems policy. The disjuncture between the evidence and the pro-market recommendations of the taskforce needs to be challenged, while a clearer normative vision on the key ingredients of an equitable, comprehensive, efficient and accountable health system is expressed. ■

Competing interests: None declared.

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Letters

Please visit http://www.who.int/bulletin/volumes/88/6 to read the following letters received in response to *Bulletin* papers:
Further research required to determine link between khat consumption and driver impairment, by Anita Feigin, Peter Higgs, Margaret Hellard & Paul Dietze
responding to:
Eckersley W, Salmon R, Gebru M. Khat. Driver impairment and road traffic injuries: a view from Ethiopia. *Bull World Health Organ* 2010;88:235-6 doi:10.2471/BLT.09.067512. PMID:20428394

Further research required to determine link between khat consumption and driver impairment

We read with interest the recent paper by Eckersley et al. on khat use and driver impairment in Ethiopia.[1] The paper highlighted the increasing concern about the association between khat use and traffic accidents with drivers using khat to stay awake and alert. However, much of the information provided was anecdotal and, as yet, there is no clear evidence of a causal relationship between the use of khat and traffic accidents.

Recent research we have undertaken in Melbourne, the capital city of Victoria, Australia, suggests that east African migrants have brought with them the habit of consuming khat while working to stay awake and alert. Through our observations and discussions we identified that east African taxi drivers in Melbourne currently use khat for this purpose.

The increase in migration to Australia from east Africa over the past two decades, together with improved transport facilities, have led to the importation and use of khat in Australia, predominantly by east African community members.[2] In Victoria, individuals with a licence and permit can import up to five kilograms of khat per month for personal use. Within east African migrant communities in Melbourne there is a community divide on the issue of khat use and its effects on khat users and their communities. Concerns have been raised by some east African community members that khat use has increased substantially and that it is leading to family breakdowns, economic hardship and health problems.[3] To understand these issues further, we conducted an exploratory qualitative study with 29 members of Melbourne's east African communities; some of whom reported chewing khat and some of whom were opposed to khat use.[4]

Most of our khat-chewing participants reported that one of the main reasons for using the drug was to improve concentration while studying or working. Several participants worked as taxi drivers or had friends who drive taxis and admitted that they themselves or their friends chewed khat on the job to help them stay awake during their shift. However, in our open-ended interviews there was no mention, positive or negative, of the effect of khat consumption on an individual's ability to drive. Our research did not produce any evidence to suggest a causal relationship between the use of khat and driver impairment.

While some east Africans in Melbourne have reported concerns that khat consumption leads to health and social problems, data from our study suggest that the most significant negative effect of khat use was that it takes individuals, usually men, away from their families. Non-users, 77% of whom were female, spoke extensively of male chewers spending long periods away from the home to chew khat with their friends. Indeed, women (mostly wives and daughters of khat users) were the main groups of people critical of khat use. Some of our participants reported relationship breakdowns that they attributed to khat, but this was most directly linked to the male being away from the home for extended periods, rather than any specific drug effects.

Driving under the influence of drugs is thought to be a major contributor to road fatalities in Victoria. Currently in Melbourne, police conduct random drug tests on motor vehicle drivers as one way of reducing traffic-related accidents and harm. A recent study of driver fatalities in several states in Australia found that drugs other than alcohol were present in over a quarter of the 3398 fatalities.[5] Saliva screening can be used to detect for the active components of cannabis, ecstasy, amphetamines and methamphetamines with some precision. However, to the best of our knowledge, there is no testing specifically for khat undertaken anywhere in the world.

We believe more robust evidence is needed about the health and social effects of khat use in general to inform decisions regarding the legal status of khat. Specifically, in the light of the recent work of Eckersley et al., more work is required to establish whether or not khat consumption actually impairs driving ability. If it does cause driver impairment as suggested by Eckersley et al., a new testing regime may need to be developed, especially in relation to commercial drivers such as taxi drivers. Anecdotal reports to suggest that khat use is associated with impaired driving ability do not establish a causal relationship. Further research is thus required to determine whether khat consumption is at all related to motor vehicle accidents outside settings where the use of khat is commonplace. ■

Competing interests: None declared.

Anita Feigin,[a] Peter Higgs,[b] Margaret Hellard,[a] & Paul Dietze[a]

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[a] Centre for Population Health, Burnet Institute, 85 Commercial Road, Melbourne, Vic., 3004, Australia.
[b] National Centre in HIV Epidemiology and Clinical Research, University of NSW, Darlinghurst, Australia.
Correspondence to Anita Feigin (e-mail: afeigin@burnet.edu.au).