

BACKGROUND NOTE

Workshop on Lessons for Development Finance from Innovative Financing in Health

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Part of the OECD Global Forum on Development
in collaboration with the Brookings Institution and IESE Business School,
which have contributed extensively to this background note

Ahead of the review of progress in implementing the 2002 Monterrey Consensus on Financing for Development (Doha, Qatar, 29 November - 2 December 2008), the search continues for new and innovative means to finance the achievement of globally agreed goals. But what do we mean by “innovative finance”? What are the strengths and weaknesses of the various innovative financing mechanisms? What progress has been made in developing new initiatives, and what have been the success factors and stumbling blocks in making them effective? What is the impact of innovative finance on the global aid architecture? And how can we work together to apply the lessons we have learned from innovative financing in the health sector?

This workshop aims to look at innovative finance through the lens of the health sector, in which a remarkable number and variety of new financing mechanisms have emerged since the turn of the Century. Through dialogue with government officials from OECD and partner countries, as well as experts from research institutions and the private sector, the Workshop will allow for a frank discussion on lessons learned for the future design and improvement of financing mechanisms, notably including the International Finance Facility. The Workshop is part of the OECD Global Forum on Development, a series of events which, since 2006, has been tackling the complexity of issues associated with financing for development (www.oecd.org/development/globalforum).

The background and key questions for each session are set out below.

Session 1: Overview of Innovative Financing for Health 2000 through 2007 – Purpose, Accomplishments, Issues, Extensions

Since the turn of the Century, a number of important phenomena have sparked the emergence of what are referred to as innovative financing mechanisms in the health sector:

- The establishment of new global partnerships for health – the GAVI Alliance in 2000; the Global Fund for AIDS, Tuberculosis, and Malaria in 2002; UNITAID in 2006 – and their development through reliable sources of funding.
- The collective commitments of the G8 and wider international community – as embodied in the Monterrey Consensus and the Gleneagles G8 Communiqué – to increase financing for the Millennium Development Goals and combat major global health problems.
- The realisation that financial vehicles could create incentives for the development of new products and technologies, could fill market gaps and could encourage behavioural change by users, especially to combat major communicable diseases.

- The establishment in 2000 of the Bill and Melinda Gates Foundation, which has used its grant funding to refocus and recharge international health efforts for the world's poorest. For example, it has supplied about a third of GAVI's funding to date.

Collectively, these events have led to the creation of new funding tools tied to specific global partnerships:

- GAVI is the beneficiary of the International Finance Facility for Immunisation (IFFIm), and, with the World Bank, is implementing the first Advance Market Commitment (AMC) for pneumococcal vaccines. These two initiatives total \$5.5 billion in commitments over 10 years.
- The Global Fund is the beneficiary of Product RED (USD 110 million to date) and Debt2Health (EUR 200 million pledged by the end of 2009, EUR 50 million disbursed so far). The Global Fund has been asked to host the Affordable Medicines Facility – malaria (AMFm), which is not yet funded.
- UNITAID receives revenue from the Solidarity Tax on Aircraft Tickets (USD 368 million in 2007).

Overall, disbursements of global aid for health increased from USD 4.6 billion in 2002 to USD 8.5 billion in 2005¹. Over this period, the Global Fund disbursements went from 0 to USD 1 billion annually² and GAVI increased from USD 100 million to USD 200 million annually³. By far, the largest increases came from bilateral donors, which increased from USD 3.5 to USD 7.2 billion between 2002 and 2005, and were the core contributors to other funds. On average, the World Bank disbursed about USD 1 billion per year for health projects over the same period⁴. HIV/AIDS treatment accounts for a large share of the increase of development assistance for health.⁵

As illustrated through the donor survey undertaken by IESE Business School, donor agencies identified three fundamental aims of innovative financing: i) generating new revenue to address global health problems through global taxes, ii) changing characteristics of existing funds through financial engineering like IFFIm or Debt2Health, and iii) increasing private sector contributions to health through programs like (PRODUCT) RED. This opening Session will bring together Panellists with four very different perspectives (analytical, donor, partner country and multilateral) on the impact of innovative financing in health. Large donor disbursements for health, often earmarked for specific interventions, can have important fiscal impacts on recipient countries, so we will also hear the perspective of the IMF on fiscal space and fungibility.

Discussions will touch on many of the new initiatives in health:

- Some health financing mechanisms, such as the Advance Market Commitment, are designed to spur new product development for unique developing-country needs. This is typically the case when

¹ The figures in this paragraph come from Christopher Lane and Amanda Glassman. "Bigger and better? Scaling up and innovation in development assistance for health". Health Affairs, July/August 2007.

² The Global Fund reached USD 1.3 billion in 2006 and USD 1.7 billion in 2007. See http://www.theglobalfund.org/documents/publications/annualreports/2007/09_FinancialStatements.pdf.

³ With a boost from IFFIm, GAVI disbursed USD 400 million in 2006 and an estimated USD 900 million in 2007. See <http://www.gavialliance.org/performance/disbursements/index.php>.

⁴ These figures come from Christopher Lane and Amanda Glassman. "Bigger and better? Scaling up and innovation in development assistance for health." Health Affairs, July/August 2007.

⁵ In 2002-2006, aid for HIV accounted for almost one third of health ODA ("Effective Aid – better aid", WHO, World Bank, OECD, August 2008)

product development costs are high relative to production costs, as in the case of intellectual property like drugs and vaccines.

- Other mechanisms, such as the Affordable Medicines Facility for malaria (AMFm), provide price subsidies for a drug, making them more accessible to the poor and driving ineffective treatments out of the market.
- Product RED and Debt2Health are designed to tap new sources of funding for the Global Fund: consumers and long outstanding debt respectively.
- The Airline Solidarity Tax is an attempt to find a solution to the difficulty of assessing global taxes to finance global public goods.
- The International Finance Facility for Immunisation, which will be discussed in detail during Session 2, is a pilot initiative: the original proposal was for a global IFF to frontload financing of projects, not exclusively in the health sector.

Key questions for Panellists will include:

- What, if any, are the costs associated with various new financing mechanisms? To what extent do their benefits outweigh the costs?
- To what extent do mechanisms leverage additional funds? With the exception of private and voluntary mechanisms, the abovementioned initiatives still depend heavily on contributions by bilateral donors. Is a relatively static volume of aid simply being moved to different sectors and different mechanisms?
- Innovative financing mechanisms add complexity to the international aid system, with new sources of funding often financing new organisations and, thus, additional donors for partner countries to deal with. Furthermore, these new organisations often come with specific objectives and earmarked funds. How can this complexity be reconciled with international discussions on aid effectiveness, which call for donors to harmonise actions and align within partner countries' priorities and systems?
- What are the fiscal impacts on recipient countries of large financial disbursements in the health sector and how do they relate to the issues of fiscal space and fungibility?
- What are the positive and negative lessons that can be drawn from health initiatives for other areas of development finance?

Session 2: Learning from the International Facility for Immunisation (IFFIm)

This session will use the case study method to discuss the International Finance Facility for Immunisation and what can be learnt from its experience.

The case study method

The case-study method is a tool used in management education to discuss complex decision-making processes. Case discussions do not aim to provide one right answer to a problem, but to stimulate analysis and discussion. Used in previous workshops and conferences, it has proven an excellent tool for the exchange of experiences among participants. In order to allow for a good case discussion, we strongly encourage participants to read the case and identify critical issues prior to the session. The *general case discussion*, led by a facilitator, will draw on inputs from all participants to foster an open discussion, for which preparation is essential.

The IFFIm Case Study

The Innovative Finance Facility for Immunization is a pilot project of a financing mechanism intended to raise funds for the achievement of the Millennium Development Goals (MDGs). Two years into its existence, IFFIm is proving successful in delivering on its initial promise: providing timely, reliable, long-term and stable financing for the vaccination of children in developing countries, through the Global Alliance for Vaccination (GAVI), by raising funds in capital markets. IFFIm raises funds by issuing bonds on international capital markets, backed by donor countries. It allows frontloading of assistance—the funds are available to GAVI immediately, but the countries financing the bonds are to repay them over a longer period. Several rounds of bonds have already been issued and IFFIm’s contribution has about doubled GAVI’s available resources in its first year of existence. The case study describes the history of IFFIm and looks into which lessons can be drawn from the IFFIm experience, albeit early in its lifespan and with limited data or monitoring and evaluation studies available to examine the details of this success.

The following questions may be useful for participants in reading the case study and preparing for the discussion:

- What are the three main lessons we can draw from experience with IFFIm? How can the additional impact of IFFIm be measured?
- Would competition among development agencies for IFF funds provide an incentive to improve their performance? How can other donors be drawn to participate in IFFIm or similar IFF initiatives?
- Middle income countries could make a small but important symbolic contribution to IFFIm – would this impact on past and future bond issues?
- Which of the potential drawbacks of IFFIm (effect on other development aid, impact on GAVI, IFFIm cost-benefit, etc.) should its managers worry about and how should they address these issues?
- What is/should be the role of partner countries in implementing the IFFIm? What do they have to gain from IFFIm? What could be their recommendations on the effective use of IFFIm and potential other IFFs?
- How can the preliminary lessons of IFFIm be used in light of the possible emergence of IFF vehicles for other purposes?

The session will have two parts – an interactive discussion on the case study and reflections from the Panel at the end of the session.

Case study discussion (50 min)

The first part of the session will consist of the facilitated case discussion. The facilitator (Jaume Ribera, IESE business school) will play an active role in organising the analytical discussions, pointing out where disagreements may persist in the case study and even playing “devil’s advocate” where contrary opinions may not have been raised. What participants gain from the discussion will depend on what they put in (mainly from their individual case preparation and their willingness to present and defend their views during the session). It is important to remember that the object of case learning is not to come up with solutions, but to learn from the session discussion with the facilitator and the rest of participants.

Panel Discussion 35 min

The expert panellists in this session will share their insights and views on the issues which arose in the case discussion.

REMINDER: Please read the case study before the session.

Session 3: Prospects for Other Recently Developed Innovative Financing Mechanisms

Whilst IFFIm has developed a track record and channels substantial resources, other mechanisms are young, but have enormous potential. Panellists in this session will update participants on the latest developments in these mechanisms. More generally, participants will discuss criteria under which new initiatives are worth launching: do the potential benefits outweigh the administrative costs of donors being involved, for example through participation in financial management or administrative decision-making.

The Airline Solidarity Tax, which is still a recent mechanism, has enabled France to contribute 75% of UNITAID's resources (2007) . It has several unique characteristics:

- It is not simply a Northern-driven initiative since it is supported by some developing countries, which also levy the tax and make financial contributions.
- Its administrative costs are relatively low, given that it generally comes in the form of an earmarked rate increase on an existing tax.
- The recipient of the funds – UNITAID – is of a size that enables it to negotiate substantial discounts when purchasing drugs, thus leveraging the funds still further.

Questions on the Airline Solidarity Tax will include:

- What are the prospects of expanding the revenue base?
- How is UNITAID using its niche to improve the global health architecture?
- How to measure the additional impact or value of UNITAID relative to existing funding sources for access to drugs?
- Is it the intention that revenues from the Airline Solidarity Tax become available for needs outside of the health sector?
- Is there potential for expansion of this tax more generally for global public goods?

Product RED's funding has exceeded expectations. In two years, it has begun making a substantial contribution to the Global Fund – USD 110 million – exceeding the contribution of many official donors. Moreover, Product Red is additional to donor funding, as it comes from private parties either purchasing Product Red merchandise or participating in Product Red events.

Questions on Product RED will include:

- In light of the initiative's personality-driven nature, to what extent can Product Red be institutionalised?
- Almost half of the money raised so far came from one publicity event. What are the implications of this for sustainable funding?

- Is there room for Product Red to diversify its recipient agencies beyond the Global Fund?
- With most donations coming from governments and philanthropists, can Product Red serve as a model for other instruments to assemble funds at low cost from individual purchasing decisions?

Debt2Health relies on successful debt negotiations between donors and debtors, and may imply heavy administrative costs. However, the large volume of remaining debt is not to be neglected, with some experts pointing to the debt owed to high-income country export credit agencies. The challenge in realising this potential would be to reduce administrative costs to donors and recipients associated with debt forgiveness and increase the confidence that debt relief will be directed to achieving development results. Debt2Health attempts to address both of these challenges.

Questions on Debt2Health will include:

- Given the complex and context-specific nature of international debt negotiations, there are many risks and benefits associated with the Debt2Health initiative. Does the Global Fund's experience so far suggest that this initiative could succeed on a broader scale?
- How manageable is this initiative for donor and debtor countries and how does it fit within their plans and budget for these activities?
- Could this mechanism generate funds for other development needs?

The first Advanced Market Commitment (AMC) was launched in February 2007, aiming to support the adaptation of pneumococcal vaccines for use in developing countries. With USD 1.5 billion in donor funding, and up to another USD 7 billion from GAVI, the financial undertaking is substantial and AMCs are inherently complex scientific and economic undertakings. However, risks are distributed across all market participants and across time, since payout only occurs if the vaccine is produced and there is demand for it. The pilot will be a useful test for the AMC concept: the greatest challenge will be to create a larger-scale AMC with a longer time horizon, for example in the development of a malaria vaccine.

For the AMC, questions will include:

- Would an AMC be an appropriate mechanism to take on major unsolved problems like malaria vaccines and other sectors/cases where market failure results in underinvestments in research, development, production of products needed in the poorest countries?
- To what degree is the IFFIm a substitute for the AMC? How do both mechanisms address the needs for product development and sustainable funding for specific purposes like the adaptation of vaccines?
- Are there products for which the AMC is uniquely suited as a solution for developing countries?
- For the IFFIm and other recently developed innovative financing mechanisms: beyond "more money", how have innovative finance mechanisms contributed to the mission of their hosts? And what has been the experience in incorporating developing country voices in the design and implementation of these different mechanisms?

Session 4: Leveraging private sector engagement

Much debate about innovative finance concerns its ability to engage the private sector more than traditional ODA has been able to do. Both global health partnerships and the financing mechanisms that underpin them have seen a high degree of public-private collaboration. This session will review the main

aspects of current developments and look at future potential developments for leveraging private sector engagement.

Most new global partnerships for health are organised as independent charitable organisations whose boards include representatives of disease advocates, patient advocates, civil society organisations, and private businesses that have a proprietary interest and technical capacity in the area of concern. All have an equal voice on the boards. Most of their funding comes either directly or indirectly from high-income country governments, yet donors have no greater voice than others in principle.

As will be illustrated during the day's discussions, all of the innovative financing mechanisms used in health have been tied to these organisations. The funding mechanisms are also "hybrids". They are supported by public and private charitable giving, and they either require buy-in by capital markets (IFFIm), are intended to change incentives of private suppliers (AMC), or are intended to affect incentives in the entire supply chain and for consumers (the AMFm). As a marketing device with a charitable purpose, Product Red is completely independent, but as a vehicle for branding and selling merchandise with a charitable purpose, it needs buy-in from firms and customers, a complex task.

A further set of initiatives – Product Development Partnerships (PDPs) – have emerged recently, aiming to bridge the gap between science and product manufacturing to accelerate development and access to new health technologies. PDPs (we count at least 14 of them and they are on average 8 years old⁶), bringing together basic researchers, pharmaceutical companies, vaccine firms and others involved in bringing new technologies to the market, have transformed science into profitable health products to address developing-country health problems. Until early 2006, PDPs had raised around USD 2 billion from a range of public and private donors (66% of the funding came from the Bill and Melinda Gates Foundation). Some PDPs are now bringing products to Phase 1, 2 and 3 trials for safety and efficacy, with the need for substantial additional investments to move through these phases and into the market. There is considerable scope and need for innovative financing tools in this transition from laboratory to market. In addition, significant additional resources are needed to ensure the absorption of new products into the market and increase purchasing power among those who need them.

When it comes to health-service delivery in developing countries, the role of the private sector is widely recognized, but also raises important questions. Health services are delivered by a mix of public, private for-profit and charitable services, but because a significant share of donor funding is funnelled only through public-sector providers, people who continue to use private providers need to contribute heavily and the level of out-of-pocket contributions remains too high to promote access. Private sector providers tend to face limited opportunities in capital markets and have to compete with free public sector services (which don't always function well). One might ask how markets for medical services in developing countries might be expanded so that the most efficient and innovative drugs are made available to patients, and whether there is a role for innovative financing in achieving this.

To develop options to improve the financing of health services, a Dutch-supported PharmAccess/Health Insurance Fund (HIF) program was started in Nigeria in early 2007 under the name of Hygeia Community Health Plan (HCHP). The program targets a potential of 115,000 individuals from Lagos and rural areas for subsidized health insurance coverage. In the first year, members contribute 5-10% of their annual

⁶ There are at least 14 PDPs: Dengue Vaccines, Diagnostics, HIV Vaccines, Meningitis Vaccines, Microbicides, Neglected Diseases, TB Drugs, TB Vaccines, Vaccines for Neglected Diseases and Pneumococcal Vaccines. The oldest PDP – the Infectious Disease research Institute – started in 1993 and the youngest – PATH Vaccine Solutions – started in 2004

premiums themselves (whilst the rest is subsidized by HIF) for coverage of the most common medical problems (including HIV/AIDS treatment). The local executing partner of the program is Hygeia, a 20 year-old Health Maintenance Organization (HMO) in Nigeria. Hygeia plans to increase the number of enrolled persons in the Plan and is working with PharmAccess to upgrade health facilities and the level of care.

Panelists in this session will have the opportunity to reflect on the incentives, opportunities and potential contributions created by health partnerships from the perspective of private businesses, charitable organisations and private providers of services in developing countries. Discussions will build on these experiences and explore prospects for further partnerships in health, and extensions beyond health .

Questions for participants might include:

- On PDPs:
 - Would this type of vehicle be applicable to problems in other sectors, where product development globally has not been responsive to developing country problems?
 - How can the financing issues raised by the success of PDPs – primarily costs associated with moving products to market and their uptake – be resolved in innovative ways? Have there been instances from other sectors where this goal has been achieved? How can PDPs ensure a fair distribution of risks in negotiating agreement/deals?
- On incentive issues:
 - Why have capital markets responded positively to the innovative financing mechanisms pioneered in health, particularly IFFIm, that have raised additional funds? What can we learn from this experience in order to raise additional funding to move products to low-income clients?
 - Why are pharmaceutical companies willing to engage with the new global health partnerships? Do AMCs make more transparent the investment that is needed for pharmaceutical companies to develop new products?
 - Hygeia faces poorly developed capital markets domestically, limited access to international capital markets and serious challenges in convincing clients with limited confidence and experience in prepaid health services. What innovations has Hygeia experimented with to make sure it can finance its expansion? Do the global forms of innovative financing affect Hygeia's business plan or behaviour with its client base? Are there suggestions from its experience about mechanisms to improve new product take-up and getting services to the poorest?
- On thinking ahead:
 - There is a growing body of knowledge about what works and doesn't work in public-private partnership (including bringing together different cultures and languages). What other issues need to be considered in order to engage the private sector successfully in achieving social goals?
 - Much attention has been devoted to the idea of "business at the bottom of the pyramid" (i.e. for the poorest). How well are organizations equipped, and where are the most been creative models to reach that market segment? What are the barriers to doing more? What are the pros and cons of seeing the bottom of the pyramid as a "business" versus corporate social responsibility or philanthropy?
 - What is next in innovative finance? What problems are private organizations gathered today working to solve, and what recommendations might they have for other participants?

Session 5: Innovative Financing: wave of the future?

In Japan in July 2008, G8 Leaders confirmed the importance of “innovative approaches to leverage private investments in connection with domestic public financing and official development assistance”. At the Doha conference on financing for development in November, governments are likely to welcome the progress made in developing innovative sources of finance. They will call on new funds to be truly additional to ODA and to avoid burdening developing-country administrations. This gives rise to important discussions about how further innovations can be developed and how the international consensus around innovative finance can be broadened.

A further crucial question concerns the application of lessons on innovative finance from health to other sectors that may lend themselves to public-private partnership. In particular, this concerns the provision of global public goods with important externalities. These goods cannot be covered through traditional ODA, but require long-term and predictable financing.

Since 2004, the “Leading Group on solidarity levies”, currently chaired by Guinea, has brought together more than 50 countries that are committed to promote and implement additional and sustainable resources for development. This group has played a key role in the development of innovative financing mechanisms in health and is also looking at potential development of innovative financing in other areas.

Some countries have also been pioneering the design and implementation of new approaches for funding development activities, with the support of development agencies. One example of innovative finance over recent decades has emerged in the area of environment. Payments for Environmental Services (PES) have mobilised sustainable financing for watershed management and forest conservation, benefiting local communities, protecting large scale investments and generally contributing to environmental protection. In Costa Rica, for example, PES schemes in forest and ecosystem conservation have mobilised voluntary and sustainable contributions from private and public sources for the provision of environmental services.

In this final session, representatives of both Costa Rica and Guinea will be asked to comment on innovations in their countries and on the conditions under which innovative finance can have measurable and sustainable development impacts.

In the discussion, participants will discuss the tools required to improve understanding of various financing schemes and maximise their positive impact for development.

The main questions will include:

- What are the lessons from implementing innovative financing in sectors other than health? How has innovative financing been useful for addressing environmental challenges? How were new approaches designed and what has been their impact in this sector?
- Do different sectors and challenges require different types of innovative financing mechanisms? Are there common features across innovative approaches in health and environment?
- What respective roles have donors – multilateral and bilateral – and partner countries played in the design and implementation of new financing mechanisms?

- What have been the transaction costs incurred by developing countries in engaging with these different financing mechanisms and how to ensure they play a key role in the design and implementation of these mechanisms?
- What are the problems that innovative approaches need to address to financing development issues (in health, environment, or other areas)?
- How can one ensure the complementarity and additionality of innovative financing to traditional forms of finance? Should innovative finance trigger traditional development assistance and be streamlined?
- Is there a limit to innovative financing? Is “innovative finance” always the answer ?
- Do we accept the “think twice” principle in innovative finance, whereby new institutions and administrations are only set up if absolutely necessary? How can we minimise the contribution of innovative finance to the fragmentation of the global aid architecture?