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CARLO MONTICELLI
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Ministry of Economics and Finance, Italy

CAROLINE KAYONGA
Permanent Secretary of Health
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Special Guest:
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P R O C E E D I N G S

MR. de FERRANTI: Good morning. I think we will get underway even as people continue to work through the registration and come in so that we get the full time possible from all of our speakers and questions, answers, and discussion.

First, my name is David de Ferranti and I welcome you to our Donor Perspectives on Innovative Financing for Global Health event A few words about our speakers. You have or can get on the table more extended biographies of them so I will be fairly brief.

First, we have Owen Barder, Director of Global Development Effectiveness at DFID**.**

Jurgen Zattler will speak on behalf of Germany on these issues and the Federal Ministry for Economic Cooperation and Development (BMZ).

Pierre Jacqué, Executive Director for Strategy at the Agence Francaise du Développement and who is here. The head of AFD, Jean Michel-Severino had planned to be here, but due to a family emergency, he was unable to come to Washington at this time.

I'll come back to Caroline. Next is Ruud Treffers from the Netherlands, Director General for International Cooperation at the Ministry of Foreign Affairs in the Netherlands. The Netherlands has been very engaged, including a 100 million EUR commitment to health insurance in Africa.

And at the far end Carlo Monticelli from Italy, the Director of the International Financial Relations Department at the Italian Ministry of Economics and Finance.

And in the middle representing and to keep the donors honest is Caroline Kayonga, the Permanent Secretary of Health from the Ministry of Health in Rwanda, and we're very pleased many of you will learn about the exciting developments in recent years in Rwanda that Caroline will be able to comment

after the other speakers have spoken about the perspective from the five-sixths of the world population who are in the South and the more than 50 percent who are women.

And I just want to mention briefly a few questions that we hope will come out in our comments by the panelists.

First, what role do innovative financing mechanisms play in overall health aid strategies? What can be done to maximize the impact and minimize noise or waste motion from financing efforts?

Second, how should we assess when a new innovative financing mechanism is a cost effective way to deliver aid and when not? How do the new mechanisms look vis-à-vis more traditional tools?

And third, finally, what additional thinking needs to be done and who could do what to help?

So with that, I'm going to turn the podium or speak from the seat, whichever you prefer, to Owen Barder. Owen.

MR. BARDER: Thanks, David.

MR. BARDER: So I've noticed that Americans tend to begin talks with a joke, and we British begin with an apology I've noticed.

(Laughter)

MR. BARDER: So I'm going to begin with an apology, which is that I'm losing my voice after not only several days of annual meetings and having to talk a lot, but also shouting at the English rugby team--

(Laughter)

MR. BARDER: --which apparently they didn't hear.

(Laughter)

MR. BARDER: So apologies and raise your hand if you can't hear me.

I'm going to try and use less than 10 minutes to protect my voice and to protect you. And I want to say a bit about answering this question about what is the role of innovative financing from our perspective, from the U.K.'s perspective.

Let me say something I think which may be controversial--it will be interesting to hear if the other speakers share this view -- about what innovative financing in health is not. And what I didn't think it is about is finding new money for global health. That's my controversial statement.

There is no doubt in my mind that we need to find more money for health needs. Estimates you're all familiar with the Microeconomic Commission on Health estimates somewhere between $30 billion and $70 billion a year needed. That's nothing actually in the grand scheme of things, but it's a lot by comparison with global aid flows. It would be about a 50 percent increase in aid just on health.

So we need to find more money for global health. And there are lots of advocates for innovative financing who see this as a way to get more money for global health.

My view is that if we can't get taxpayers and parliaments to vote for more money for health, then we need to redouble our efforts. We need to give them the evidence we need to persuade them.

But what we shouldn't be doing is trying to bypass budget processes, budget transparency, budget disciplines in order to get more money

into things that we think are important, but our taxpayers and parliaments haven't agreed with us on yet.

So I guess it's because I grew up in the British Treasury, you can take the man out of the Treasury, but you can't take the Treasury out of the man. As far as I'm concerned, budget processes are important to me and we should protect and preserve them.

So we shouldn't be trying to use innovative financing simply as a way to bypass those processes.

So if that isn't the point of innovative financing, why are we doing it? And it seems to me that the argument for innovative financing is that it makes spending much, much more effective; that we get more bang for the buck by doing things this way than doing it any other way.

And there are I think at least four reasons why that's true.

Three of them, which I'll run through very quickly, are to do with what we economists call inter-term proloptimization; that is, changing the way that you spend money over time to get a bigger impact.

And one of the striking things about the aid effectiveness literature is that we often talk as if there's no such thing as time. All our allocative models for aid should we spend money in this country or that country at a given time, and they don't attempt to optimize aid allocations across time.

So the performance-based framework that the World Bank uses that I'll be debating with my fellow (inaudible) tomorrow doesn't have time in it.

The DFID model for aid allocation, which is based on Collier and Dollar's work doesn't have time in it. And what the innovative financing mechanisms do is enable us to crack that problem.

So the first way it does that, and you see this in the International Finance Facility for Immunization (IFFIm) and UNITAID, which most of you know about, are excellent examples of ways to enable us, the donors, to enter into long-term contracts.

And that has a huge benefit in terms of being to drive down prices. It enables the private sector to invest, to build more productive capacity, to bring down unit costs, so they produce cheaper products. We get lower prices because you have the ability to enter into a contract not just for this year, but for next year and the year after and the year after that--hugely important benefit to bringing down prices.

The second benefit, which again you see in IFFIm, is it enables these services to be front loaded. You can do things sooner. You can do things today that you would otherwise have to wait for until tomorrow.

Now why does that matter? Surely, if you're going to deliver outputs, it doesn't matter much whether you deliver them today or whether you deliver them tomorrow. You're going to deliver the same amount of outputs.

Well, that's true of some things, and there are some things that front loading wouldn't be a good idea for. But for things like tackling infectious diseases, that is not true.

Clearly, the sooner you treat people or give people vaccines that reduce their risk of catching a disease, you have a herd immunity effect. Not only do you treat them, but you also reduce the risk to the rest of the population around them.

And the more you front load these things, by and large, the greater the overall benefit we're going to get.

And, of course, the limiting case of that is eradicating a disease. The eradication of smallpox. I see Ruth Levine sitting there from the Center for Global Development. Wonderful book, Millions Saved, documents the numbers.

Let me just read them to make sure I've got them right. Donors provided $98 million; $200 million came from the countries with smallpox. And, according to Millions Saved, the total spending by the U.S. is saved every 26 days from not having to treat people for smallpox.

So, clearly, if you can bring forward the expenditure, reduce the disease burden, eradicate the disease, you get a long-term benefit, much more effective than dealing with it year by year.

The third way that innovative financing can increase effectiveness is if it increases certainty about what donors are going to do in the future.

So the advanced market commitments, many of you here I see have been involved in that over past years, enables the private sector to predict with more certainty that there'll be a market for new products.

That enables them to invest for those to develop those products and bring them to market, and that means that those products will be available more quickly and more cheaply, and get to people more quickly.

So for a commitment by donors to do what they would do anyway, which is to buy a vaccine if it was available for pneumo or for malaria, by making a prior commitment that we will do that we engender a response in the private sector. They're able to scale up their work--their R&D -- bring those products to market more quickly.

So at the same amount of spending, the money we would spend anyway on vaccines does more work just by making it more credible earlier. Perhaps that's what we're going to do with it.

So there are three ways in which we're using time. Innovative financing has enabled us to change the time profile, entering into longer-term commitments, being clear about what donors will -- what decisions they will be making in the future when the time arrives, and being able to front load things and so do things sooner enables us to get much more bang for our buck.

The fourth thing is also related to innovative financing. We're seeing a lot of use of output-based aid mechanisms, of linking aid to results and changing incentives.

It's one of the attractive features of advanced market commitments that the money is only spent if somebody actually develops a vaccine that meets the criteria laid down by the donors.

And we're seeing in the Global Fund for AIDS, TB, and Malaria, we're seeing output-based funding and similarly in the GAVI Alliance's window.

And these are all good examples of how changing the incentives within delivery organizations can increase efficiency with which aid is used.

So to my mind, the important thing about innovative financing is not that it generates new funding streams, but that it uses the money much more efficiently.

And the money, the numbers can be quite big. I mean the IFFIm numbers we estimated were about a 25 percent increase in the effectiveness with which that money could be used. And that was a pretty conservative estimate,

including the extra costs of financing, so even after taking the expense into account.

And a 25 percent increase in the effectiveness of how money is spent is just as important as a 25 percent increase in the amount of money you're spending in terms of the number of lives you've saved.

So this is a huge benefit by increasing effectiveness.

And I'm worried that we sometimes present innovative finance as a "we"s . It's wrong in principle to do that. It's not attractive to some key donors, and the United States is surely one of them, who look at ideas to bypass budget processes.

And by "we," I mean, in this case, actually the U.K. I notice that we sold IFFIm as a way around budget processes. And the U.S. looked at this and said, nah, we're not interested in bypassing our budget process. Go away.

If we'd sold that as a way to increase the effectiveness of spending, I think there would have been a lot more interest in the U.S. And I think that was a mistake.

And there's a danger that if we take our eyes off the prize of increased effectiveness, we won't actually get the benefits of these long-term contracts, these long-term commitments, because we'll forget that that's the reason why we're actually doing these things. So we need to keep focused on how these innovative financing mechanisms enable us to do those transactions in a smarter way, and then make sure that we actually do use them to do those transactions smart.

So we're breaking new ground. I was at a meeting yesterday on climate change, and how the private sector could be incentivized to develop new

products for low carbon energy. And both IFFIm and advanced market commitments appeared in the paper as examples of what should be done in the climate change sector.

So the global health community is really pushing the boundaries of how to make development more effectively. So congratulations to all of you for that. It's an exciting time, but if we can make this aid more effective, that can have just as much impact as getting more aid into the system. Thanks.

(Applause)

MR. de FERRANTI: Thank you. Jurgen.

MR. ZATTLER: In Germany, we used to start our presentations with a joke and at the same time apologies--

(Laughter)

MR. ZATTLER: --because, as you know, Germans do not have a lot of humor, and the joke was bad and then we have to apologize for it.

(Laughter)

MR. ZATTLER: So, therefore, I go immediately into the subject.

I would like to present one specific innovative financing instrument, and I think it comes back to many points Owen outlined in his presentation.

The innovative financing instrument is the debt to health swap we launched only four weeks ago in Berlin. It was in the framework of the replenishment of the Global Fund.

There, Germany made a major effort to contribute to the replenishment. I think we mobilized some $850 million for three years, which is a lot. I think we tripled our contribution.

But additionally, we presented this innovative financing instrument, the debt to health swap.

This first debt to health swap has been prepared with Indonesia, and we prepared it together with the Global Fund. The Global Fund adopted the concept in April of this year. And, in fact, it has a two-year pilot phase, where we want to test this new instrument.

How does it work? Germany cancels the debt, the bilateral debt, with a specific country, in this case, this first case, with Indonesia. It is up to amount of 100 million EUR. And then Indonesia pays a part of the money, in this case it's 50 percent of the money, in local currency, in this case, to the Global Fund.

So we cancel the debt. A part of the counter value is paid into the Global Fund. And this goes for additional financing in the area of health and AIDS, malaria, tuberculosis. That's quite simple.

The advantage is that with this one instrument we reduce the debt, the bilateral debt, which comes from bilateral financial cooperation.

We increase the health spending, and also there's an element of front-loadedness in it, because at the moment the money is paid to the Global Fund. It can be immediately utilized. Before it was more complicated.

So we plan to contribute in the next three years to up to $300 million for these kinds of arrangements. And we plan to do the same kind of swap with three other countries: Pakistan, Peru, and with Kenya.

Perhaps a few words with regard to our debt swap instrument. I think that's a very old instrument, at least for us in Germany. It goes back to the

beginning of the '90s that we established this instrument. We committed so far some 930 million Euro, $1.43 billion, for debt swaps so far with 18 countries.

But about two years ago, we decided to reform this instrument. We wanted to make it more flexible. And also we wanted to utilize it in a broader way.

Usually, we can only, or we could only, utilize this instrument with a very limited number of countries.

In particular, we only could swap debt which went through the Paris Club. And as there are not so many countries rescheduling their debt in the Paris Club and many of them do it in the context of the HIPC debt relief, which then are not really interesting for the swap instrument. We really broadened the application of our instrument.

Now we can also swap debt which does not go through the Paris Club. We can swap all kinds of debt from bilateral financing corporations. So this makes the instrument more flexible and also we can use it, which many countries do now.

What are the challenges? I think there are at least two. The first one is to ensure additionality, because we tell the countries, we relieve your debt, but in exchange you have to make an effort and you have to mobilize some money in local currency for additional financing. So the problem is how to ensure this additionality and also how to measure it.

And there in the past we often looked at the project level, asking the countries to present some additional projects. This I think is a problem because I think it bears the risk that this kind of approach is not integrated into the

country policies, and also it bears the problem of fungibility, of course, because then ythe country presents projects which would have been undertaken anyway.

So I think in the future we will look more at the budget, but we'll discuss with the country their budgets, in this case the health budget, and we try to find a solution with the country how to increase the budget inscriptions in the respective areas.

This solves a little bit the problem of fungibility, and it also contributes to the alignment of this contribution, which is my second challenge.

We know that there are many problems also due to the fragmentation of donors' assistance in this specific sector, but there are many problems with alignment and I think we have to make sure that this new instrument doesn't contribute to non-alignment, but fosters alignment. Thank you.

(Applause)

MR. de FERRANTI: Thank you, Jurgen. Pierre.

MR. JACQUÉ: Good morning. Well, you know in France we prefer criticizing others to making jokes.

(Laughter)

MR. JACQUÉ: We never make apologies, and I apologize for that.

(Laughter)

MR. JACQUÉ: I have three points. I know the French always have three points.

My first point is that I think financial innovation in health is one aspect of a much broader trend of innovation that is very, very valuable in

development agencies. The traditional way we conduct our businesses has totally changed.

It's almost a revolution when you know the way in which development assistance was managed in the past, not only because there is now a focus on results, as Owen discussed, but also because instead of seeing development assistance as a government-to-government transaction now with the understanding, and I think it's a very valid understanding, that it's a global partnership in which you have many donors and many interested parties and many beneficiaries, not only the government and the government alone in the developing countries like in developed countries cannot do everything.

So what is fascinating about the health sector is that it has been the initiator of a very dramatic wave of innovations, not only in terms of sources of finance. Owen has discussed IFFIm.

Of course, in France we have pushed, as you know, the global taxation scheme, and, by the way, believes the two are very much complementary because if I agree with Owen that we need to front load some of the expenses, especially on health, the question when you have produced the goods and services is how to maintain them, and how to administer them.

And that requires a predictable recurrent source of finance and I think IFFIm is very much adequate for the first front loading need, but much less, of course, for the recurrent needs, and that's why schemes around taxation are very complementary to that and very useful.

But innovation has not only taken place in the sources of finance, it also has taken place in terms of the partnerships involved, and what is fascinating about the Global Funds or many of the initiatives and you have many of them

described in the handouts prepared here at Brookings, it's really the joint approaches between philanthropy, foundations, NGOs, both from the North and the South, research institutes, and donors. And I think that's a source of tremendous value added.

And there are again many, many examples. I couldn't focus more on the advanced market approach as agreement initiative, because I think it's an innovation that goes to the core of some of the market failures that we have in the health sector.

We have been taking part in France to Drugs for Neglected Disease Initiative (DNDI), that is a very nice partnership between donors, some pharmaceutical companies, some research institute, like the Institut Pasteur, and I think again I would like to focus on the one of the value added of financial innovation there. That it's not only about new financial instruments, it's also about new processes and new ways to conceive development assistance.

That was my first point. The second point is that despite all what I've said, I think we haven't gone to the core of the global health challenges. It seems to me that the health challenge in developing countries is an integrated health challenge.

And what I mean by integrated is that it's not only about drugs, it's about how to deliver them efficiently. It's about how to use them and to administer them efficiently. It's about how to monitor results. It's about how to monitor new epidemics due to emerging viruses. And all this is an integrated chain that calls for more infrastructure, more trained personnel, and I have examples in mind of AIDS assistance given to some of the developing countries, notably Mozambique, in which the crucial obstacle is not the cost of drugs. It is

that there is not enough trained personnel to administer them and to explain how to use them, and to follow up on them, because one of the characteristics of the fight against AIDS is that it requires a constant, regular systematic use of drugs. And you cannot forget about them one day or two days in a row. You need really to be very constant in using them, and, for that, you need training. And you need a structure to explain that to the affected people.

So I think this global challenge escapes any focused approach on one aspect of the chain, and I'm worried that by focusing on one aspect of the chain, we may improve partial efficiency, but we may not work towards one global efficiency. And, of course, I've not mentioned water and water treatment and education about washing hands and so on. These are very, very basic things that I think our current approach is not providing adequate responses to.

My final point is that what is so fascinating about the health sector is that fighting global pandemics is a global public good. That's why we have also been able to mobilize much interest and much funding: that's because it is one area in which the interests of the North and the interests of the South meet. So it's a very promising interaction because that suggest that public policies in the North will take into account much more than the usual in the past, the interests of development.

And at the same time, it is what we call the weak link global public goods; that is, the provision of the global public good depends on the worst case scenario and depends on the worst governed country.

So again, I think we need absolutely to work in systematically on efficiency, but our task here is to target the poorly governed countries because this is where the source of the global problems also lies.

So that's -- and for me, that suggests that approaches focusing only on target a deficiency of a given instrument are not likely to meet the global challenge. So here we have a very interesting case of local and global interaction, and I think that a lot still needs to be done. Thank you very much.

(Applause)

MR. de FERRANTI: Thank you, Pierre. Ruud Treffers.

MR. TREFFERS: Thank you. We Dutch think there's no time for jokes or for apologies, because there's so much work has to be done. But, of course, we hold critical opinions on every subject you can imagine.

For me, it's very inspiring and thank you for inviting me here, because as a simple administrator, I'll have to see to it that our annual aid budget of about six and a half billion U.S. dollars is spent properly.

So I'm more confronted with competing claims between education, health, growth and you name it, and it's there because development is an issue which pertains of whole societal fabric. So it's very good for me to be here and as a learning experience.

Three out of the eight Millennium Development Goals refer to health and progress towards meeting the targets on child health and maternal health.

Funding for health has increased significantly over the last decade. And some impressive results have been achieved.

Polio is close to being eradicated. UNICEF recently reported decreasing child mortality and the increased access to anti-retrovirals.

However, more needs to be done if we want to accelerate progress, in particular in the fight against infectious diseases.

This requires a joint effort by countries, donors, international agencies as well as civil society organizations. And I see four areas where major action is required.

First, we must focus our efforts on developing the health systems that are needed to achieve and sustain improved health outcomes. Health systems have been largely neglected over the past decade, and it's encouraging to see that both WHO and the World Bank are now reemphasizing health systems strengthening at the center of their policies.

And moreover, global health partnerships, such as the Global Alliance for Vaccines and Immunization and the Global Fund to Fight AIDS, Tuberculosis, and Malaria, are more engaged in divesting system-wide barriers. They even claim that the 50 percent of their activities are geared to health systems. I still don't believe it, but Mr. (inaudible) will respond to it.

Secondly, more attention is needed to address those areas where progress has been most limited, and I refer especially to maternal health. Maternal mortality has hardly decreased over the last 20 years. Every minute one woman dies because of pregnancy-related causes. Poorly functioning health system. Politicization of the debate on sexual and reproductive health and rights and the low status of women are still major issues in many parts of the world negatively affecting the service delivery to prevent maternal mortality.

Accelerating actions to speed up progress towards the Millennium Development Goals three and five are a priority for the Netherlands in the coming years.

Third, we must make the best possible use of existing resources. This requires adjusting the fragmentation and overlap that has resulted from the

complex global health part aid architecture. We need more structure and a clear definition on the roles and responsibilities. The comparative advantage of the different players in the global health arena should be better defined. We should support countries to develop inclusive national health plans with clear accountability frameworks and a clear focus on result.

And then in doing this, we'll have to be aware of the perverse effects of brain drain from developing countries in the health sector and will have to look into the matter of decent salary levels in this sector as well.

And I think we will have to align our support for national plans and priorities.

The International Health Partnership, an initiative by Prime Minister Gordon Brown that was launched early this September in London, is an important step towards this end. We are proud that the Netherlands was among the signatories of this pact, and we are committed to support implementation at the country level.

The fourth element. We plead for more financial flows to health as current flows are not nearly sufficient to make a real difference. The Netherlands complies with the international target of 0.7 percent of gross national income, and we are pleased to see that a large number of donor countries have adopted clear and benchmarked timelines to reach this target as well.

However, regular ODA may not come in time to meet the level of funding that is needed to accelerate progress.

Innovative financing mechanisms can act as an additional source of funding. I agree, of course, with Owen Barder that improving the effectiveness

to have more bang for the buck is of utmost importance and that we'll have to give due account to the budget processes.

But if I look from the Dutch perspective, where we have annually 0.8 percent of our GDP devoted to development corporation, in conformity with the ODA definition as the donors in the Development System Committee of the OECD defined, then we have a problem in a sense that we can't guarantee additionality. So innovative for us, in our definition, is also to attract other sources of funding in addition to the traditional ODA funding.

And indeed interesting examples to that are the international financing facility for immunization and the advanced market commitments as well. Owen and Mr. Jacqué spoke on that.

I think a final word on what we are doing and we regard it as somewhat innovative. Your research fellow, Professor Jacques van de Gaag, is working on indeed the voluntary private health insurance systems as an option to make things better, and the Netherlands is financing a new initiative, the so-called health insurance fund, and the objective of this program is to increase access to good health care through the extensioning of private health insurance systems in Africa.

The idea is that a health insurance branch in Africa develops basic health insurance for low-income groups, like farmers, micro credit groups, women's groups, et cetera. This program has been initiated by representatives from the Dutch insurance branch and by a Dutch NGO, Pharm-Access.

One of the anticipated effects is that once there is an efficient health sector in place, this will attract private investors to invest in health infrastructure and the supply chain distribution of medicines, equipment, et cetera.

Due to this initiative, the private sector has now established the Investment Fund for Health in Africa. Shell, Panaca, S&S Real, a Dutch bank, AEGON and ACMEA, two large insurance companies from the Netherlands, have already contributed to the health insurance fund. And negotiations are ongoing with our development finance institute, EVERMOR , and IFC to also support this fund, and other private investors are interested. And this health insurance fund is on its way to trigger a new way of financing and attracting additional private sector flows as an additional input for the needed resources for the health sector. Thank you.

(Applause)

MR. de FERRANTI: Thank you, Ruud. Carlo.

MR. MONTICELLI: Thank you. Italians start their presentation thanking to be invited and then making flattering contribution with no comment on the host.

Sometimes, to comply with that is not so easy. It requires imagination. Luckily, today it is not too difficult for me, because as an economist I know the Brookings Institution well. Brookings' papers on economic activity have been really important points of reference for me during my youth, as an economist.

You can tell from this short introduction that my background is not in health or in health economics, and indeed, cooperation and health is not my main line of business. For me, the event coming to Washington is the IMF Committee. I'm involved in the monetary macroeconomic cooperation and this I think gives me the disadvantage of having less background on the specific issue,

but, possibly the advantage of bringing in the debate the perspective of the other actors in this effort against poverty that are finance ministers.

I would like to make comments on the political economy role that innovative finance can play and then put forward three areas for the work avenues to go forward.

The first area where innovative financing can help is to reduce donors' fatigue. Both governments and parliaments are tired of being asked for money. All of us here in this room are all convinced that resources are not enough with respect to the challenges. However, we have to make an effort to convince the parliaments and finance ministers about that, and this is not easy. And this is where innovative finance can help in terms of finding new bases that can become sort of revenue, and here I have in mind the airline tax as an example. One can think of other ideas to increase the resources without playing tricks with democracy, of course. And this is the point that we don't have to forget.

But, at the same time innovation helps.

The second area where innovative finance can be very helpful is in increasing the efficiency and here I have in my notes a few points, but they have been mostly covered by Owen, so I don't need to repeat them. And these are the points in terms of increasing efficiency that have to do with the economics argument.

But then there is an important political economic argument, namely the notion that aid, development aid, development aid in the health sector can benefit greatly from working together with markets. And this is something that is a bit alien from the tradition of aid as perceived in financing circles in the

sense that the efficiency is typically thought in terms of getting an efficient procurement.

Whereas, innovation with IFFIm, with AMC is working together with markets in reaching effectiveness through market mechanisms at the very outset of the initiative. And this is really an argument that is very attractive for obvious reasons to finance ministers and gives a sense to efficiency really from the very beginning of the initiative.

Now let me briefly turn to three avenues that I see to make progress. The first one is to extend the mechanisms that have already been devised, mainly two: the IFFIm and the AMC in terms of working with markets. One, with IFFIm, we front load and avoid the difference to try to overcome the difference between social rate of return and market return. With the advanced market commitment, we avoid a market failure creating a market where there is not one. Both add an application on vaccines, but first there are more vaccines out there that could benefit from these initiatives.

But then we have other areas in health and not only in health where these mechanisms could be applied.

The second area for improvement going forward is to devise other mechanisms, and David –asked to give comments on who should do what. You know, in this creative effort to devise other mechanisms there is no allocation of work. Whoever has a good idea is really welcomed, and indeed the process that we've seen for AMC shows that good ideas have a strength of their own. You know, this is an idea in the academia and the World Bank that was taken up by think tanks and eventually was implemented. So we need to get other good ideas, and if they are good, they do get implemented, and this is important.

The third avenue is to continue the advocacy with civil society and NGOs; of collaboration between the private and the public sector.

Again, in this room I suspect that most people are already convinced about that, but I think that in the civil society there is what I would regard as a minority, but a very vocal minority, that basically believes that when you do aid, you basically have to do either a philanthropic or a government intervention. You know, whenever you mix with profit making agents, you are blurring the waters. You are giving it in presents to these profit-making institutions. The AMC is a big gift to the pharma industry. IFFIm is a big gift to investors because of the spreads, which is, of course, not true from my point of view, but there is a fight out there to be carried forward in getting accepted.

When I made a similar comment in another forum, I was bashed basically because first I was patronizing, saying you have some people that don't see the truth, and we have to eliminate them. But this is not politically correct, as we know at this time.

On the other hand, I think that I stand in between on these issues. And also on the fact that it might be tactically correct to move forward. But I think that the importers of the relationship between aid effectiveness and markets is too important for us not to refrain from this intellectual battle at any opportunity. Thank you.

(Applause)

MR. de FERRANTI: Thank you. Just before we continue. In addition to Caroline, we're delighted that the Deputy Minister of Health for Liberia, Mr.Tornorlah Varpilah is here. Following Caroline, he will make a few comments. And then because our speakers have been so disciplined on time,

which in this room has to be considered innovative, we will have some time for discussion, so I wanted everybody to start thinking about the following question. A lot of the work in this field focuses a lot of time spent on the solution. What about the problems the solutions are meant to solve? We heard some discussion of that.

My question for all of us is are there some particular problems now going forward that need more attention? Some problems have been well treated, and the solutions we have before us. But are there any problems? I had some clues but an invitation more of a doubt, but now Caroline.

MS. KAYONGA: Thank you. I would love to start with a joke, but I have only five minutes, so it wouldn't be wise.

Thank you to the previous speakers. It was the perspective of the donor, and I would like to bring the perspective of the other side, the recipient or the developing countries. We have a bigger part of the problem that you are referring to when we talked about the global public good is.

What we all share really is the need to improve the health status of the world by providing accessible quality and health services to better contribute to economic development and poverty reductions so that would address at least the donor fatigue if it could go that way.

And this has been the health or the way to do it or the goals have been very nicely elaborated in the Millennium Development Goals, which we all agree to and which we're all trying to see how we can achieve them.

And countries, like ours, have really developed the questions that we are asking ourselves, which are where do we want to be 10 years, 2015, but

also three years from now, five years from now, and since and in the medium-term, short-term, and long.

And of course, as we are thinking of where we want to be, we are thinking of how do we do it and what are the strategies for doing it. And then comes the question what will it cost for us to do it, to achieve these targets.

And that is where the health financing comes in because we usually have a beautiful house which is the strategy, but the door that opens it is the finance. And then the questions that we are trying to address here, as we are talking about innovation is--do we do what we want to do with what we have and do it better-- as David has just said.

Do we need more or can we first try to use what we have better? And, of course, yes, that's the big innovation, but even as we are thinking of what it needs or what it costs to get us there, it may need more as the targets that we've all given ourselves. I'll quickly get into that.

So where do we want to be? We have, as we're thinking of the goals, we have the reduction of infant mortality goals that we've given ourselves. I can't go into it, as each country has its own targets. We have reducing infant mortality from 86 to 37 out of a thousand live births for child mortality targets. We have the maternal mortality targets. We have a big problem of population growth in our countries where whatever we are doing; we cannot do because the population is really growing so fast. So we have our fertility targets, our population targets, and then we have the big diseases of HIV, targets and all.

Then we also have even a bigger problem, nutrition and we have those targets. We have anemia and we have those targets.

So then we ask ourselves how are we going to handle this, and we developed these very good strategies. For example when you were talking about private-public partnerships. We have the strategies that have been developed within country, country with the public, the private, with development partners.

Recently, we've had the poverty reduction strategies. We've had economic development and poverty reduction strategies that we've developed, and the health aspects of it, which are holistic. It's a whole chain. We can't just talk about one first. They're all interconnected.

So we have the human resources aspect of it. We have the drugs and vaccines and consumables aspect. We have the institutional capacity, which is very important. We have the infrastructure, equipment and laboratory networks.

We have the research, the referral facilities and treatment and research centers and then the financing aspects, which have to really be innovative to get to where we want to go.

And how do we do it? The issue that is of paramount importance is how to ensure that all people have access to health care when they need it, and so the question is how do we achieve the universal coverage of health care?

So then we come to what will it cost? There are so many in the World Health Organization macroeconomic targets that come up, but we have come up with what we consider an unconstrained scenario, where we see that it's an ambitious scenario that aims at maximum targets and full health intervention packages, and that would mean that it's (inaudible) of the newest donors per capita in health.

And the financing (inaudible), going by the budgets that we have today, we'd need to invest 2.9 or three times more than the current spending to get there.

Then there's a medium scenario, which has lower coverage targets and key lower cost interventions, and that will be about $18, about $19 per capita. And when then constraint scenario, which we have today, which is $12 or 0.8-- $12.8 per capita.

And then we're asking ourselves how are we going to do this? We've seen what it costs. Now the part, the how, may mean better innovation and more investments. For us, we are looking at it in terms of improved efficiency in utilization of the public funds by selecting the most cost effective health activities and strengthening the health system.

And then we are talking about increasing government spending. All of us (inaudible) have talked about the 15 percent government -- three percent of the government budget. And then we have tried to mobilize also the community funds through the decentralized system by developing a suitable cost recovery system through health insurance systems, which have tried to develop -- at some later time, we can go in deeper into that.

And then promoting the sector-wide approach mechanism, strengthening donor support towards national health interventions. We're happy to say at least -- I was just telling Amanda -- that we have finally gone a step further in the swap process. Recently, just Wednesday, the swap memorandum of understanding was signed by eight partners, including the U.S. government, so we are really happy and we'll take it from there.

And then there are opportunities of bypassing the budget processes. The Paris Declaration on Harmonization and Alignments is the best opportunity that is there, and that's where the swap comes in, the swap process. And then really bypassing budget, experience has shown that budget support is the most effective, but when it's not possible at least sector budget support.

And basically, because I don't have so much time to go much deeper into that, but why is budget funding better? There's more information on what we need to do and what resources are available. There's ability to implement policies, efficiency and equity, better targeting of resources, integration of vertical programs, lower transaction costs, improved management capacity -- all that comes in.

But what I'd like just to end by saying is that really the opportunities we've seen with the Paris Declaration and the swap process, but also we have tested the water. The performance-based aid has been seen to work with Global Fund and GAVI. The main thing that I see is to deal with the donor fatigue issues by documenting and going with what works. Go for it and really let it be country specific. The one-size-fits-all solution would just only increase the donor fatigue. It's better to go with the country by country approach. It's said that it's country-specific, but the solutions are usually one-size-fits-all. But I think it will be better to go with the country-specific issues and deal with them that way. That will be more effective. Thank you.

(Applause)

VARPILAH: Well, in Liberia, we start by either apologizing or thanking. We apologize usually for being late. And I'm happy I'm not late.

And I will thank for being invited to talk. So I will thank you for giving me the opportunity to just share my insights with you.

Well, I sort of agree with a lot of issues that have been already stated. But I want to add my voice to two main issues, and then take up two problems that I think we need to focus on. The first issue has to do with improving the global and regional coordination. It's very important. While we do this, we also need to look at it at a national or country level, because without robust donor coordination, we will not be able to enhance what we want to achieve.

When I talk about donor coordination, I also mean that this coordination should be based on evidence. In other words, what has worked globally? What are the practices globally that have worked that could be used at the regional level? Regionally, the donor coordination regionally also has some big gaps. Regionally, I'm talking about say, for instance, let's look at Africa.

What mechanism is there to ensure that there is sustained coordination among African countries, because we have the worst health outcomes in the world. And we have a large continent. And we are receiving a lot of support to make sure that the disease burden of our continent is reduced.

But in doing that, we also have to ensure that the coordination in Africa and with other developing countries is strengthened so that the monies that come into the system doesn't (sic.) leak out, but that it is coordinated in a way that it makes the maximum output. That is very key.

Nationally, some of our African countries or even developing countries are also receiving a lot of monies, but with very weak donor coordination. I can speak for Liberia.

We have a national plan. After 14 years of war, the first time to have a national plan 30 years. In that plan, we were projecting around $54.4 million for health in this fiscal year. What we have been able to do is to capture an inflow of around $70 million, but the question is how do we ensure that this amount of money makes the maximum impact -- produces the maximum results, with very weak donor coordination mechanisms?

And I think the big challenge is that without a good mechanism in place, whether it is a swap you want to put in place or just lose money coming into the system, from each of the areas, from each donor country or from Global Fund or from GAVI , you stand a chance of not making the targeted results you want to achieve, because you don't have the way of knowing where the monies are going to make the maximum outcome.

So we need to strengthen globally the coordination, whether it's between Global Fund or GAVI or whether it's just the different donor countries, we need to do that. And also think regionally. Say let's come again to Africa. Look at my region. In Africa, we also have our region, the (inaudible) region. How do we make sure that Sierra Leone, Liberia, Ghana in that region the people in West Africa, for instance, will work together and coordinate the donor support in a way that let's take a classic example of malaria.

Malaria is a common illness in these countries and it is the leading cause of morbidity and mortality. How do we ensure that there's coordination among West African countries so that the monies that come in there are targeted in a way that to make the maximum output, not only coordinating the funds, the resources, but also coordinating the programs. We have to look into that area.

The second point I want to make is to add my voice to the issue of advocacy. We should and we must advocate for a very good integration based on programming. Programming and integration is key. If we don't integrate the programs and we think malaria, we think HIV/AIDS, we think TB, we will not achieve our results, because in some of the areas what has happened is that when we get funding, say, for malaria, the danger is people at the program level start to think malaria. They don't think HIV/AIDS. They don't think TB.

So what you're doing now is -- to create parallel structures for program delivery, and we create specialists to think and deliver special services. I think this is not the way to go. We need to think systemic so that we plan and look at the picture in the horizontal way instead of looking at it vertically.

And you know in many of the places where we have serious high disease burden, the question has to do with two issues. The two key problems that I have seen as a newcomer into the health field are human resources -- there's a serious gap. And this gap is created in most developing countries by the huge migration of health workers to developed countries. So there has to be a way to cut that; otherwise, you're going to have a cycle. As you increase, as we increase funding to health, we will not be able to achieve the results. Why? Because there's a serious shortage of manpower and of human resources. I can also speak about my country.

I know, for instance, in Ghana, Ghana exports around 3,000 health workers. So Africa has a high number, and Nigeria also is in lead. In my country, Liberia, our doctor to patient ratio is 0.03 nationally. But as we go in regions, the case is worse. We had over 500 doctors providing services to a

population, a pre-war population, of about 2.5 million people. Today, we have 122 doctors. So there's a huge migration of the workers.

We have to plan globally to tackle that problem by investing and making sure that -- and I agree with the last speaker. One of the speakers said providing incentives to keep the health workers in their countries, especially in countries with a high disease burden.

The next problem we have as a challenge is the area of health systems. Many of our developing countries have a very weak health system, very weak.

And so we should try to support and develop innovative ways to finance health, we should also look at innovative ways to try to strengthen the health system. In my country, for instance, there's no way I can predict or know when there's going to be a blackout or a shortage of drugs from one point to another because our system is weak.

There's no way I can be able to tell you nationally that this is the -- the case load of this illness is this amount, even in a year's time, because the system is weak.

So as we plan, we have to be able to address these key issues to enable us to achieve the global health outcome that is most desired.

And to conclude, what does this mean? It means that we have to think, act, and do globally as well as nationally. Thank you.

(Applause)

MR. de FERRANTI: We have eight minutes. That's not time for questions, and it's not time for our panelists all to have something to say.

However, if there are one or two -- one liners that anyone in the audience would like to say, now would be a great time. There's one right there. And excuse me if I interrupt for time.

SPEAKER: Chow Chen, freelance correspondent. If you say short sentence -- I think it is cooperation. I think among the donors should do that. And second, an outreach program, because health is not just money. There's manpower and like we just heard and also material, the medicine, equipment, and also that health system; and that integration problem.

So I think there needs to be cooperation among yourselves and also have outreach program to other sectors. Thank you.

MR. de FERRANTI: Thank you, and yes, very briefly.

MR. CAROL: Tony Carol.

No mention has been made of potential savings within the supply chain itself. Last week, I was with the director of one of the regional economic organizations of Africa --

MR. de FERRANTI: Very quickly.

SPEAKER: --who said that we're thinking of reducing from 40 percent to 20 percent tariffs on medicines and vaccines. I find this preposterous because there's no local production to protect in essence, and this money does not get translated into the health system for savings and use elsewhere. So we've not mentioned the areas where we can immediately seize opportunities for savings and reducing tariffs on vaccines and medicines and supplies pertaining to malaria are an area in which we could work right away.

MR. de FERRANTI: Now let me turn to the panel, and again, we don't have time for everyone to say anything, is there anything that any of the panelists would like to comment? Yes, Carlo.

MR. MONTICELLI: You're asking for one liner, and I have one, which is the importance of coordination of coordinating actors.

(Laughter)

MR. MONTICELLI: And this is not a joke. I mean, I totally agree with the importance of coordination of donors for effectiveness of the aid. This has been understood by sometime by the international community, but you have parallel exercises in the World Bank, in the OECD, and so it's important to coordinate the coordinators.

MR. de FERRANTI: All right. One more one liner. Pierre?

MS. JACQUÉ: Yeah, just on this. We have, you know, this alignment, harmonization recommendation of the Paris Conference. It's a commitment taken by donors.

I would suggest that the most important aspect of this (inaudible) is not harmonization. It is alignment. What we need to really focus on in the developing countries is policies, health policies, and I think we need to focus on swaps, as you mentioned. And that will coordinate donors. I think that we need to keep the dynamics of innovation and (inaudible) harmonization will not necessarily help innovation. But what matters in the end is that all our actions contribute to the policy in certain developing countries. And that's something that we are not -- and so I would suggest that we need to -- that the current innovation has reached its limit because it has been too vertical. (inaudible) It

has been very useful, but now the time has come to move it to what a more (inaudible) or holistic point.

MR. de FERRANTI: Ruud?

MR. TREFFERS: I think I fully agree. We as donors have to stop practices which are untenable if a meeting in the health sector in Zambia is called for, 65 representatives of donor institutions are around the table. This is madness. This is idiocy. So we have indeed to have our act better together at the country level work with the local systems, local governments, et cetera, and I fully agree with the words Mr. -- from Liberia has said and what our Rwanda colleague said. The action has to be at the local scene, and we must stop with this indeed coordinating the coordinators to coordinate, et cetera. These discussions in Paris are unwieldy.

MR. JACQUÉ: Nothing to do with Paris.

(Laughter)

MR. TREFFERS: Apologies within the OECD. But so let's put our money where our mouth is and do it at the country level best practices and work there in a constructive way together.

MR. de FERRANTI: As we close, I want to first thank Yamilett Fuentes. Would you stand up Yami? Who did all the organizing here. Thank you very much, Yami.

(Applause)

MR. de FERRANTI: And apologies, but no jokes, to you and to our audience for not giving more time for your comments. But please find a way and there are web addresses and so on to send in any of your comments that you'd like to see followed up in some way. Those of us who are working here at

Brookings and other colleagues who are in the room and other places I'm sure should be delighted to continue this dialogue discussion. And many thanks also to our distinguished panelists. Thank you.

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