

**“HEALTH FINANCING: EVOLVING CONTEXT,
EVOLVING METHODS”**
A REVIEW ON INNOVATIVE FINANCING FOR HEALTH

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EXECUTIVE SUMMARY

This report is the result of a 4-month work commissioned by the French Ministry of Foreign and European Affairs, in the framework of the Task Force on Innovative Financing for Health created by the Leading Group on Innovative Financing for Development in December 2010.

The report examines four existing innovative mechanisms, namely the International Solidarity Levy on Airline tickets, the International Finance Facility for Immunisation (IFFIm), the Advance Market Commitment (AMC) and Debt2Health, notably in the light of the criteria of predictability, sustainability, additionality and country ownership, and proposes recommendations that could help strengthen, adjust and/or expand these mechanisms. The report also aims at helping paving the way for new mechanisms. With respect to this, prospective mechanisms are suggested.

The study was done on the basis of a literature review as well as interviews – using a questionnaire - with more than 70 key professional actors, who kindly offered to share their views on existing and potential mechanisms.

1) Review and analysis of the mechanisms

Our review of the four mechanisms shows satisfactory performances, but there is room for improvement.

The International Solidarity Levy on Airline tickets, which collects an additional micro-tax on flight tickets, derives its strengths from its additionality and predictability. Another appealing feature is that implementation costs are relatively low, given that the air levy uses existing tax collection systems in participating countries. Recipient countries can also easily implement it. Yet, its limited donor basis – with only 9 countries having implemented the levy - can become detrimental to UNITAID -its main beneficiary.

IFFIm has proven to be a steady financial tool to fund GAVI's immunisation programmes, though better performance could be achieved with a larger funding basis. The frontloading of donors' future pledges has helped GAVI scale-up its immunization campaigns. For all, IFFIm's structure is complex. High transaction cost in terms of funding approval makes it difficult to expand and attract new donors. Moreover, IFFIm's "dependency" to donors' credit rating and donor concentration may imperil its future.

The pilot AMC has helped shape the pneumococcal vaccine market and deliver key health outcomes: incentives given to manufacturers using donors' pledges have helped reduce vaccine prices by 90% and accelerated the availability of these vaccines in developing countries. The long term market shaping impact has yet to be evaluated. During the original design and implementation stage, the pilot AMC required a significant investment of time and effort on the part of its donors and implementing partners and the 2012 AMC Process and Design Evaluation will inform the design of similar future instruments.

With respect to Debt2Health, which uses debt swaps between a bilateral creditor and a Global Fund recipient country to fund health budget outlays, the experience is attractive though limited. It stands for a great tool for donor and recipient countries. Donor countries can use it to contribute to the Global Fund. On the other hand, recipient countries contribute to the funding of their health programmes, which reinforces country ownership. However, it is a limited initiative. So far, only two donors, Australia and Germany have gone into Debt2Health agreements with recipient countries. Besides, there is little room for new debts – sovereign, multilateral or private - to be converted under Debt2Health.

2) Recommendations on existing mechanisms

The abovementioned points bring up the following recommendations regarding the four mechanisms.

There is room for improvement of the International Solidarity Levy on Airline tickets. First, its sustainability could be enhanced through multi-year agreements between donor countries and UNITAID. A broader tax base could also help make it more sustainable, e.g. a micro-tax on domestic flights – since not all participating countries have implemented the levy on their domestic flights -, a moderate increases in rates on international flights or a new “tax class” for intermediary travel classes. Finally, more communication and advocacy efforts is essential to win new donors over.

Several opportunities to strengthen and expand IFFIm have been identified. More communication and advocacy is needed from GAVI to attract new donors, notably ‘AAA’ donors that would help support IFFIm’s sustainability, and investors. GAVI should also consider the possibility to use IFFIm as a backload for graduating countries, regarding their future health expenditures. In terms of possible new applications for IFFIm, it could:

- help eradicate end-stage polio, which could trigger future cost savings
- could scale-up the introduction of a malaria vaccine, should the trials that are currently under way be positive
- be used either as catalyst of Health Systems and/or to support one-time investments in HSS.

Though the design and process of the pilot AMC are due to be evaluated in 2012, a few suggestions can already be made. Market shaping instruments such as the AMC warrant being analysed as part of specific medium and long term strategies to influence market dynamics towards healthy competition and adequate supply, including through the active participation of developing country manufacturers. Furthermore, a second AMC, if there is room and reason for it, would need to be built upon a clear understanding of the right moment to intervene in terms of development stage, and a strong political support from existing and future donors.

In spite of limited opportunities for new debt swaps, donor countries should consider the possibility to enter into debt swap agreements under Debt2Health. Besides, the establishment of a global framework for debt swap, including more coordinated action between donors, could strengthen the mechanism and help woo new donors.

3) Prospects for innovative financing for health

Lessons learned from the first experiences point to several areas. First and foremost, consolidating and streamlining the existing mechanisms is essential prior to thinking of a new mechanism. If we are to embark on a new mechanism, political championing is crucial for any new mechanisms. More visibility of innovative initiatives is also essential: communication and advocacy are two major pillars of any successful mechanism. Another challenge will be to have the emerging countries, notably the BRICS (Brazil, Russia, India, China and South Africa), sit at the negotiation table and become more involved in innovative financing. Finally, regular review, analysis and monitoring should be carried out on existing mechanisms prior to any new mechanisms.

Our study has shed light on a set of six potential new innovative mechanisms that could help raise substantial funds for global health:

- **A Financial TransactionTax:** high-level discussions are ongoing regarding this tax;

- **WHO Solidarity Tobacco Contribution:** a micro-tax would be levied on cigarettes pack to fund a wide range of health matters;
- **The French Cancer League proposal for a tobacco levy:** a tax would be levied on tobacco manufacturers' turnovers or profits, whose proceeds would be used to fund non-communicable diseases;
- **Malaria bonds:** social-impact bonds would be issued to fund malaria;
- **Diaspora bonds:** diasporas – in particular sub-Saharan migrants – would be called on to invest in bonds to fund health in their home country;
- **TBVI's proposal for a vaccine against Tuberculosis:** TBVI's multilateral funding scheme aims at developing two successful vaccines to fight tuberculosis.

A key element that must be taken into consideration in the discussion around innovative financing is the role of the private sector (for-profit) in the collective financing effort. It is necessary to tap the private sector, since donor countries will not be able to achieve set targets alone. Yet, it can bring more than just additional resources. Private actors can bring their skills and expertise. They can also be decisive relay of an organization's cause, in advocating in multiple directions, e.g. their consumer community, their business community or their financial community when dealing with the financial sector.

The discussion on new mechanisms should take a more comprehensive approach by looking at the broader context of health systems and the challenges countries have in comprehensively strengthen health systems to deliver quality health services. Therefore, the emphasis has to be put on:

- **Training top-level decision and strategic makers** at global and country level on global health challenges and responses to prepare the next generation to cope with very complex issues they are going to be confronted to, especially in Africa where the population is expected to double by 2050.
- **Infectious diseases:** emerging pandemics, HIV/AIDS, TB and Malaria as well as neglected diseases, and all other poverty-related diseases;
- **Malnutrition and food security**, with the double burden of undernutrition and obesity in many parts of developing countries, quite difficult to address policy-wise
- **Non-communicable diseases:** developing countries will face a high disease burden in the forthcoming years. Innovative financing should also help tackle it;
- **Health Systems Strengthening:** innovative financing should adopt a broader approach with respect to health systems.

4) Recommendations

International Solidarity Levy on Airline tickets

We recommend:

- UNITAID, WHO and donor countries to seek solutions, e.g. through multi-year pledges, to bring further sustainability
- to countries that have already implemented this mechanism, to consider a broader tax base with respect to the air levy applying progressive rate depending on destinations and travel classes
- to increase advocacy and communication to win new donors among developed, emerging and developing countries

IFFIm

We recommend:

- to pursue advocacy and communication efforts with a view to attract new donors, in particular 'AAA' donors, therefore making IFFIm more efficient
- to target "promising" capital markets, such as Japan, and make IFFIm and its purpose more visible to potential investors, in order to strengthen IFFIm's financing capacity
- to consider how can IFFIm help graduating countries meet their future health expenditures
- to analyze, as suggested by IFFIm's donors, to what extent could GAVI absorb a larger amount of resources generated through IFFIm
- to examine new applications potential for IFFIm: funding the eradication of a disease, e.g. end-stage polio, and/or boosting Health Systems Strengthening.

AMC

We recommend:

- to review in the AMC 2012 evaluation the efficiency and effectiveness of the AMC design
- to ensure that future AMC designs help secure broad competition, including the participation of developing country manufacturers, as well as adequate quality supply to meet the need of developing countries
- to explore the feasibility of a second AMC or other financial instruments for market dynamics in the broader context of mid-long term health commodity supply and procurement strategies, specific to the commodity's market characteristics

Debt2Health

We recommend:

- to establish a global framework for debt swaps
- to consider more coordinated actions between creditors
- to consider the feasibility of entering into debt swap agreements within Debt2Health. Major donors, like the US, "*could also explore the scope for its possible involvement in debt swaps for global health*"

Private Sector

We recommend:

- to mobilize substantially private resources to contribute to global health
- to consider a broader participation of the private sector in health financing, beyond mere additional financial resources: co-investments in recipient countries, expertise sharing, advocacy in multiple directions – with respect to this, we recommend to bring unconditional support to successful initiatives such as the Global Fund Red Initiative and Dow Jones Index, and the GAVI Matching Fund -

Overall recommendations

Considering the abovementioned elements, we recommend to:

- **adjust existing models to evolving environments**, e.g. IFFIm's structure with 'AAA' donors, future AMC and specific market dynamics, and a new air levy tax class for intermediate travel class
- **enhance advocacy and communication** for existing mechanisms and their allocation to health with a view to attract new partners/contributors, in particular emerging economy
- **explore flexible options** that could help gather new partners around existing tools: e.g. sharing proceeds of the air levy between UNITAID and a national health budget, loans/contributions from middle-income countries, allocating a portion of debt swaps to Debt2Health
- **set up adequate tools for private sector's commitment**: tools to match private funds, capital-market based mechanisms, cause marketing mechanisms, expertise sharing...
- **develop concrete action plans for new mechanisms**: malaria bonds, tobacco tax, TBVI's funding scheme for a tuberculosis vaccine. Valuable new mechanisms should:
 - ensure domestic resources in favor of health for resource limited countries that decide to implement the mechanism
 - follow aid effectiveness principles of country ownership in identifying health priorities within comprehensive national health strategies and plans
 - investigate on possibilities to support comprehensive national health strategies and plans through resources raised by innovative financing mechanisms, channeled through country systems where the conditions are in place (IHP+, Joint Assessments of National Strategies...)

LIST OF ABBREVIATIONS

ACP	Africa, Caribbean and Pacific States
AIDS	Acquired Immune Deficiency Syndrome
AMC	Advance Market Commitment
ARV	Antiretroviral
BCG	Bacille Calmette Guerin
CHAI	Clinton Health Access Initiative
DAH	Development Assistance for Health
DFID	Department for International Development UK
EC	European Commission
EIB	European Investment Bank
FTT	Financial Transaction Tax
GFATM	Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
GNP	Gross National Product
GSK	Glaxo-SmithKline
HIV	Human Immunodeficiency Virus
HLTF	High-Level Taskforce
HRH	Human Resources for Health
HSS	Health Systems Strengthening
IFFIm	International Finance Facility for Immunization
IHME	Institute for Health Metrics and Evaluation
LDC	Least Developed Country
MDG	Millennium Development Goal
NCD	Non-Communicable Disease
NGO	Non-Governmental Organization
ODA	Official Development Assistance
OECD	Organization for Economic Co-operation and Development
PCV	Pneumococcal Conjugate Vaccine
R&D	Research & Development
SIDA	Swedish International Development Cooperation Agency
TB	Tuberculosis
UN	United Nations
WHO	World Health Organization

INTRODUCTION

“While there are positive results across the continents, the magnitude of the challenges and the inequities are considerable, as well as the unacceptable burden of death caused by major diseases” says a lot on the contrasting picture of health indicators throughout the world (G8 Deauville Accountability Report on Commitments on Health and Food Security¹).

The adoption of the Millennium Development Goals in 2000 has increased the commitments of countries and the international community to respond to global health issues. Specific targets were set to address Child mortality (MDG 4), Maternal mortality (MDG 5) and the combat against HIV/AIDS, Malaria and other diseases (MDG 6) as well as access to essential drugs through Global public private partnerships (MDG 8). This international appeal was reflected in the substantial increase of Development Assistance for Health (DAH)²: DAH has more than trebled from 2001 to 2007, accounting for \$ 22.7 billion in 2007³.

Yet, there is a long way off. Indeed, in 2008, the World Health Organization estimated adequate funds to an additional \$ 250 billion to achieve the MDG goals in the 49 poorest countries⁴. Besides, the financial crisis has shaken the world’s economies and put a lot of pressure on national budgets.

Finding complementary sources of funding for global health is therefore crucial. In this context, the use and the development of innovative mechanisms come to the fore in the years 2000s.

This study sets out to review existing mechanisms of innovative financing for health, in order to identify strengths and weaknesses, as well as discuss the potential mechanisms that may help generate more resources to be allocated to health matters in the world.

1. The recognition of the importance of innovative financing

Over the years, the issue of innovative financing has become increasingly preponderant in various fora, both within health and development arena.

a. The early stages of innovative financing

In the aftermath of the Millennium Summit, the Monterrey Conference, in 2002, marked a real turning point in the international community’s efforts to mobilize resources for development: the importance of innovative sources of financing for development was officially recognized. In the field of health, the 2001 Macroeconomics and Health report by Jeffrey Sachs, commissioned by the WHO DG, is a turning point in showing that investing in health helps economic development, and that much more funding is needed to improve health and combat poverty-related diseases⁵. In France few years later, the Landau report⁶,

¹ http://www.g20-g8.com/g8-g20/root/bank_objects/Rapport_G8_GB.pdf

² *Innovative financing for Global Health, A moment for expanded US engagement*, CSIS, March 2010

³ N. Ravishankar et al., “Financing of global health: tracking development assistance for health from 1990 to 2007,” *The Lancet* 373, issue 9681 (June 2009).

⁴ World Health Organization (WHO) and partners, “Reaching the Health-Related MDGs in 49 Low Income Countries: Estimates of Cost, Financing Gap and Health Impact,” Technical Summary for Working Group 1 of the High-Level Task Force (HLTF) on Innovative Finance for Health Systems, http://www.internationalhealthpartnership.net/CMS_files/documents/wg1_-_cost_impact_technical_summary_EN.pdf.

⁵ WHO Commission on Macroeconomics and Health. (J Sachs). Investing in Health for Economic Development. December 2001. <http://www.cid.harvard.edu/archive/cmh/cmhrefport.pdf>

⁶ Landau report on new international financial contributions, 2004

commissioned by the French President himself, then advocated in 2004 for new sources of financial contributions to fund development.

In 2006 at global level, two innovative mechanisms for health were introduced: the **International Solidarity Levy on Airline Tickets** and the **International Finance Facility for Immunisation (IFFIm)**.

Since 2006, the **Leading Group on Innovative Financing for Development**, formerly known as the Leading Group on Solidarity Levies to fund Development, embraced the cause of innovative financing and became an essential forum for leaders to meet and discuss the future of innovative financing. It found its climax at the plenary meeting in Conakry⁷.

b. The work of the High-Level Taskforce on Innovative Financing

Against the backdrop of the 2015 milestone, the High-Level Taskforce on Innovative Financing for Health Systems, co-chaired by UK former Prime Minister Gordon Brown and World Bank President Robert Zoellick, was launched at the UN Millennium Development Summit in September 2008. The mandate of the High-Level Taskforce, supported by two working groups, was to **identify the funding gap on health, assess over a hundred mechanisms of innovative financing**; it draws recommendations organized around two key headings: more money for health, and more health for the money⁸. The final report outlined the principles surrounding innovative financing for health: it should be **additional to existing ODA**, and should contribute to **aid effectiveness**, in line with the 2008 Accra Agenda for Action and the 2005 Paris Declaration on Aid Effectiveness and Harmonisation⁹.

Working group 1¹⁰ of the High-Level Taskforce on Innovative Financing for Health Systems (HLTF) has estimated that *“an additional \$36-45 billion (\$24-29 per capita) per annum, on top of the estimated \$31 billion that is spent today in low-income countries”*, of which up to **10 billion could be raised through innovative mechanisms** (supported by the HLTF), would be needed on health funding to make steady and significant progress towards the Health MDGs.

c. Challenges

Until now, the various initiatives of innovative financing have emerged separately on the international agenda. Donor country governments became involved on the mechanism(s) of their choice according to their **“own agenda”**. Although some countries have contributed to different mechanisms (notably France, Italy, Norway and the UK), the international community does not speak with one voice when it comes to innovative financing.

Yet, and as previously said, innovative financing is of **ever-greater interest** for countries, witness the work of the Leading group on innovative financing for development and the continuing support of participating countries, among which emerging, in particular Brazil and Chile, and developing countries are increasingly getting involved. The 9th plenary meeting of the Leading group in Bamako (during Mali’s rotating Presidency in the first half of 2011) was another concrete evidence: the Leading group called on developed countries to fulfill their commitments, while trying to tap new innovative resources.

⁷ “the urgency of the action against poverty forces us to consider innovative financing mechanisms, with a view to increasing and supplementing traditional sources of finance”, Conakry Declaration, 2008

⁸ High-Level Taskforce on Innovative Financing for Health Systems report: “More money for health, more health for the money”, 2009

⁹ http://www.oecd.org/document/15/0,3746,en_2649_3236398_35401554_1_1_1_1,00.html

¹⁰ High-Level Taskforce Working group 1 report: « Constraints to scaling up and costs »

2. A Review on Innovative Financing for Health

Given the growing interest for innovative financing and the purported benefits of these mechanisms, it is important to take stock of the innovative landscape and test existing and new mechanisms' ability to bridge the health funding gap.

Within the framework of the Leading Group on Innovative Financing for Development and its recently launched Taskforce on Innovative Financing for Health¹¹, France offered to spearhead a review on these mechanisms. The final report, including a few targeted recommendations, will then be proposed to **feed the debate of the next Leading Group Meeting to be held**.

a. Objectives and terms of reference of our study

The review will focus on four major innovative mechanisms for health:

- AMC,
- Debt2Health,
- IFFIm,
- and the International Solidarity Levy on Airline tickets

The review will first consist in drawing a **panorama of existing mechanisms** of innovative financing for health: their history, objectives as well as description of the mechanism and achieved results.

These mechanisms will then be reviewed to **highlight their strengths and weaknesses**. This will be done from **four perspectives**: the **recipient countries**, the « **financers** » (donor countries), the managing structure (international organizations such as UNITAID, Global Fund and GAVI) and the external **partners** (notably the civil society).

This evaluation will also include a **quantitative assessment** of funds raised for health as well as a **qualitative review** of the extent to which funds raised are **additional, sustainable, predictable**, and the extent to which they conform to the **Paris/Accra principles of aid effectiveness**.

The last part of the study will focus on:

- **addressing the development priorities** as for the four studied mechanisms: to what extent shall we change, adjust or resize the existing mechanisms? Shall we widespread or narrow the application to other diseases or health-related sectors?
- **discussing new** (innovative) **mechanisms** likely to help bridge the health funding gap as well as **new funding policies** (connection between source of funding and health and cooperation policies, funded sectors,...).
- **In that section we will also make recommendations in relation to the use of further funding**

b. Definition

With a view to clarification, we will adopt OECD's categorization¹² of innovative mechanisms:

- **New public revenue streams** : the International Solidarity Levy on Airline tickets
- **Debt-based instruments and frontloading** : Debt2Health and IFFIm
- **Public-private partnerships**: AMC

¹¹ <http://www.leadinggroup.org/rubrique266.html>

¹² Mapping of some important Innovative Finance for Development Mechanisms, OECD/DAC, 2011

We will be using the following « definition » of innovative financing. Innovative financing mechanisms are supposed to enable raise additional resources to traditional ODA provided to countries in an effective way¹³ (in compliance with the principles of the Paris Declaration and Accra Agenda for Action) and linked to results¹⁴, “*by explicitly linking funding flows to measurable performance on the ground*”¹⁵. Innovative mechanisms are meant to generate predictable and stable funds by tapping new resources¹⁶ or “*deliver financial solutions to development problems on the ground*”¹⁷.

c. Methodology

Panorama of existing mechanisms

The inventory was carried out on the basis of a **detailed literature review**. In addition, **questions** were asked to key people within international organizations such as GAVI (AMC and IFFIm), the Global Fund and UNITAID so as to supplement the literature review.

Analysis and Discussion

The analysis of the four abovementioned mechanisms was done through **interviews** as well as using **data collected** (document and on-the-spot checks).

There was no Southern country visit for this study. Trip visits were conducted in Brussels, Geneva, Paris and London. Stakeholders were interviewed¹⁸ (in-person, conference call or email). A **specific questionnaire** was used to conduct the interviews, on the basis of the terms of reference of the Task Force and the literature review. To extract the necessary information to meet the study objectives, our analysis was framed across the three following items:

- **Evaluation of the four mechanisms**
- **Recommendations on existing mechanisms**
- **Lessons learned and prospective mechanisms**

¹³ Cf. Supra 8

¹⁴ Ibidem

¹⁵ Innovative Financing for Development Solutions, World Bank, <http://siteresources.worldbank.org/CFPEXT/Resources/IF-for-Development-Solutions.pdf>

¹⁶ High-Level Taskforce Working group 2 report: « Raising and Channelling Funds »

¹⁷ Ibidem

¹⁸ See list of people interview in Appendix 1

1. International Solidarity Levy on Airline tickets

1.1. Objectives

With a view to contribute to a new shaping of the world, where the globalization of the economic growth would also benefit the globalization of solidarity, the International Solidarity Levy on Airline tickets was launched in 2006. It aims at raising secure and sustainable resources, earmarked for health products purchase, by collecting at national level an extra micro-tax on airline tickets.

It is the funding backbone of the International Drug Purchase Facility (UNITAID), an international organization established in 2006, whose purpose is to improve **access to life-saving and appropriate drugs and diagnostics for HIV/AIDS, malaria and tuberculosis** in countries facing high burdens for the three diseases.

1.2. Overall mechanism

The International Solidarity Levy on Airline tickets is a two-fold mechanism.

First, national governments, where the levy is being implemented, impose the tax to all flights departing from their country. Therefore, passengers pay an additional amount corresponding to the cost of the tax when they purchase their tickets. Countries are free to decide which amounts to be charged on the tickets, depending on the travel class. The table below shows the rates applied, as of 1st of November 2010, in seven countries, for each type of flight, either domestic or international, and travel class, i.e. economy/business/first class:

Country	Domestic flights	International flights
Chile	No tax	2/2/2 (US \$)
Republic of Korea	No tax	US \$ 1/1/1 (US \$)
France	1/10/10 (€)	4/40/40 (€)
Madagascar	0/2/2 (€)	0/2/2 (€)
Mali	From 0.76 (€)	To 10.67 (€)
Mauritius	No tax	1/2/2 (€)
Niger	0.76/3/3 (€)	3.8/15/15 (€)

Source: French Ministry of Foreign and European Affairs, UNITAID and Cour des Comptes

Airline companies are responsible for declaring and collecting the tax.

Then, participating countries allocate all or part of the proceeds of the air tax to UNITAID. The proceeds are used by UNITAID, in addition to direct contributions from other countries, to fund its activities.

1.3. Donors

To date, **14 countries**¹⁹ have passed a parliamentary law to implement the airline tax²⁰, of which 9 are already contributing to UNITAID (**Cameroon, Chile, Congo, France, Madagascar, Mali, Mauritius, Niger, Republic of Korea**).

1.4. Partners

UNITAID partners with **implementing agencies**, including the Global Fund to Fight Aids, TB and Malaria, the World Health Organization (notably through the StopTB partnership) and the Clinton Health Access Initiative (CHAI)²¹.

1.5. Results

1.5.1. Financial contributions

As of December 2010, around US \$ 900 million²² have been raised through the airline tax, accounting for 67% of contributions to UNITAID. France is the main contributor, with US \$ 852 million.

1.5.2. Health benefits

UNITAID's support covers **94 countries** worldwide: HIV/AIDS in 51 countries; malaria in 29 countries; and tuberculosis in 72 countries²³.

UNITAID reports the following achievements:

- **UNITAID action has driven prices down.** Since 2006, prices of **children's HIV/AIDS medicines** have fallen by **64%** and prices of **paediatric TB medicines** have dropped by **10-30%**.
- UNITAID has delivered more than **45 million high-quality malaria treatments** and **20 million preventive bednets**.
- Around **1.5 million first- and second-line TB treatments** have been supplied by UNITAID and its partners to patients

2. IFFIm

2.1. Objectives

Against the backdrop of over 2 million children dying every year from easily-preventable diseases due to a lack of predictable funding in developing countries, IFFIm (International Finance Facility for Immunisation) was launched in 2006, by **the UK, France, Italy, Sweden, Spain and Norway**, to help provide stable and predictable cash flows for immunization

¹⁹ Benin, Burkina Faso, Cameroon, Chile, Congo, France, Guinea, Ivory Coast, Madagascar, Mali, Mauritius, Niger, Norway, Republic of Korea

²⁰ UNITAID Annual report 2010: http://www.unitaid.eu/images/NewWeb/documents/AR10/unitaid_ar2010_web.pdf

²¹ UNITAID in 2011, http://www.unitaid.eu/images/NewWeb/documents/UNITAID_in_2011/UNITAID_in_2011_EN_June13.pdf

²² Ibidem

²³ UNITAID financial report 2010

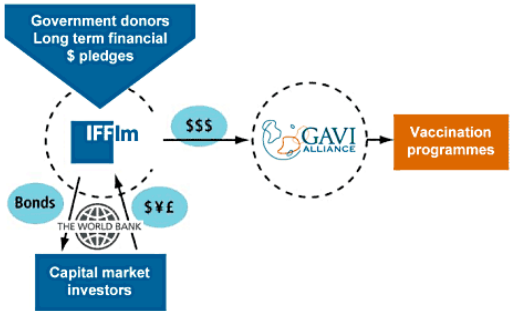
purposes over a long period of time. The funds raised through IFFIm are used by the GAVI Alliance, a public-private partnership, to finance its immunization campaigns. GAVI partners with UNICEF supply division to procure its new and underused vaccines and devices for recipient countries.

2.2. Overall mechanism

IFFIm frontloads future development assistance, by converting donors' future aid flows into immediate resources available for immunization purposes. Donors commit to long-term pledges (from 8 to 23 years) signing legally-binding agreements.

2.3. Financial design

IFFIm enables to raise upfront large volumes of funds by issuing bonds secured by long-term legally-binding donor pledges. Bonds are issued by IFFIm's treasury manager, the World Bank, on the capital markets at very low rates, close or better to sovereign donors' rate. The government pledges are then used to repay IFFIm bonds.



Source: GAVI

IFFIm can shift its bond issuances to coincide with GAVI's funding requirements.

IFFIm feature
 IFFIm's capacity to raise cash at relatively low rates relies on its ability to maintain its credit rating of 'AAA'. Indeed, to make it efficient and attractive both to donors and investors, IFFIm was designed to enjoy a "supranational" status, benefiting from its sovereign donors high credit ratings, therefore enabling it to raise bonds at highly competitive costs.

2.4. Donor countries

As of June 2011, **US \$ 6.3 billion** have been pledged over **23 years** by **9 donor countries**:

Country	Amount committed	Commitment period
UK	US \$ 2,980 million	23 years
France	US \$ 1,719 million	20 years
Italy	US \$ 638 million	20 years
Norway	US \$ 264 million	15 years
Australia	US \$ 256 million	20 years
Spain	US \$ 240 million	20 years

The Netherlands	US \$ 114 million	8 years
Sweden	US \$ 38 million	15 years
South Africa	US \$ 20 million	20 years

Source: IFFIm

Brazil has just made a **US \$ 20 million pledge** to IFFIm over **20 years**.

2.5. Results

US \$ 3.6 billion have been raised to date (2006-2011) through IFFIm. As of November 2010, **US \$ 1.349 billion raised on Japanese capital markets**, i.e. 42% of total bonds issued at the end of the year 2010.

2.5.1. Programmatic disbursements

As of June 2011, GAVI has disbursed **US\$ 1.8 billion of IFFIm funds** (over the US \$ 2.9 billion overall disbursement by GAVI from 2000 to 2011) to support **vaccine purchase** and delivery to 70 developing countries, of which:

- **US \$ 538 million** were used for **investment cases**²⁴ (polio eradication, measles mortality reduction, yellow fever stockpiles, meningitis eradication, maternal and neonatal tetanus)
- **US \$ 1 billion** for **new and underused vaccine**, in particular the scale-up of **pentavalent vaccine**
- **US \$ 231 million to Health Systems Strengthening**.

As of now, GAVI had two windows of support for Health Systems Strengthening, immunization specific and HSS in general. GAVI board decided in July 2011 that all the cash grants given before would be allocated to a “single HSS window” to be channeled through the Health Systems Funding Platform toward 2014.

2.5.2. Health benefits

The IFFIm 2011 evaluation estimates that, thanks to IFFIm funding, at least 250,000 deaths were averted on investment cases and 2.5 million deaths were averted on GAVI core programmes.

Large-scale immunization campaigns also benefit non-immunized persons, who come in contact with immunized persons: this effect is known as “**Herd immunity**”.

²⁴ Investment cases are tactical purchase for special disease areas

3. AMC– Advance Market Commitment for pneumococcal vaccines

3.1. Objectives

With developing countries facing **difficulties to access affordable life-saving vaccines** on the one hand, and pharmaceutical companies reluctant to bear the risk to enter these markets or to scale up production capacity without visibility on demand, an Advance Market Commitment (AMC) was conceived in 2005 to stimulate the development and manufacture of new vaccines for developing countries.

The AMC therefore addresses both the vaccine gap for developing countries, by making the vaccines available early on and affordable, and the funding gap required for pharmaceutical companies to end or finish the development by incentivizing them to invest in late stages R&D and manufacturing.

With the support of six donors, the first AMC was launched in June 2009 by the GAVI Alliance to bring forward the availability of effective pneumococcal vaccines for developing countries and ensure predictable vaccine pricing for countries and manufacturers. It also aimed to pilot the effectiveness of the AMC mechanism by incentivizing the creation of a market for needed vaccines and to learn lessons for possible future AMCs.

The pneumococcal AMC addresses the vaccine gap for developing countries by making the pneumococcal vaccine available shortly after the same vaccines became available in affluent countries and more affordable for children in poor countries now whereas without the pneumococcal AMC, they would have been waiting until after 2015. It also secured a 90% price reduction and the availability of pneumococcal vaccines that meet developing country specific vaccine profile requirements.

3.2. Overall mechanism

3.2.1. AMC process

Donors commit to co-pay, contingent on vaccine demand from countries, the future pneumococcal vaccines at a **fixed price** once they have been developed. Therefore, pharmaceutical companies are **incentivized** to invest in **research, development and production** of the pneumococcal vaccine, while recipient countries (GAVI-eligible countries²⁵) have **access to appropriate and affordable vaccines**, and have the ability to plan their long-term immunization campaigns. The AMC also requires **recipient countries** to **co-finance** the vaccine purchase and as for all GAVI supported vaccines GAVI's co-financing policy is applied.

The **World Bank** holds donor payments onto its balance sheet, which means that it **assumes the financial risks of future donor payments**. Besides, the **World Bank commits to pay AMC funds** to GAVI even if donors have not paid on schedule their contribution. The funds are then disbursed to GAVI when needed.

GAVI partners with UNICEF for supply agreement and vaccine procurement. UNICEF assesses all supplier offers, and enters into supply agreement with manufacturers whose

²⁵ Current GAVI-eligible countries are countries, whose GNI per capita does not exceed US \$ 1520 (2011 GNI data). In addition, countries must achieve a minimum DTP3 coverage of 70% to be eligible for new vaccines support from GAVI. Countries graduating from GAVI support that were eligible at the time of signature of the AMC legal agreements - in June 2009 - are still able to access pneumococcal vaccines through GAVI at the AMC terms and conditions.

products are AMC eligible, i.e. meet WHO criteria²⁶ as well as a set of criteria for the pneumococcal vaccine, known as the Target Product Profile. The pharmaceutical companies must sign a legally binding agreement to provide their vaccine at a **price no higher than US \$3.5 per dose for a period of 10 years.**

3.2.2. AMC pricing structure

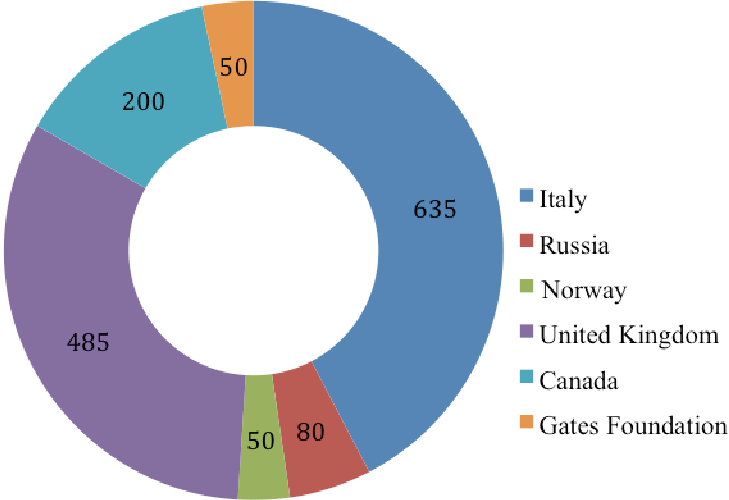
AMC has a **two-stage pricing structure.** On the one hand, suppliers are bound to supply vaccines at a price not higher than US \$ 3.5. This will be paid by the GAVI funding and the country co-financing, and is known as the **tail price.** The country co-financing is relatively small in the beginning, starting at US \$0.20 per dose and ramps up over the years in line with countries’ per capita income levels.

On the other hand, suppliers will receive **an extra US \$ 3.50 for approximately 20% of the doses,** known as the **top-up price.** The AMC funds (donor commitments) will be used to pay these 20%.

3.3. Donors

3.3.1. Commitments

To date, **six donors,** namely **Italy, the UK, Canada, Russia, Norway and the Gates Foundation,** have committed to a \$1.5 billion grant as follows:



Donors' contribution in US \$ million (Source: GAVI)

3.3.2. Types of donors

Within these six donors, there are two categories:

- the **“fixed payment donors”** (Italy, Russia and the Gates Foundation), accounting for **765 million dollars** of the total pledges, who make annual payments to the World Bank as scheduled in their individual grant agreements.

²⁶ The WHO prequalification programme aims to ensure unified standards of quality, safety and efficacy of medicines that can be produced through the United Nations system, national governments and agencies.

- The “**on-demand donors**” (the UK, Norway and Canada), accounting for **735 million dollars of the total pledges**, who make payments when requested by the World Bank to meet GAVI specific funding needs.

3.4. Results

3.4.1. Supply agreements

As of December 2011, UNICEF Supply Division had entered into supply agreements with two manufacturers, Glaxo Smith-Kline (GSK) and Pfizer. The first supply agreements under the AMC were signed in March 2010. Both agreed to supply **30 million doses** annually from January 2012 (GSK) and January 2013 (Pfizer). The 30 million doses represent 15% of the total demand forecast at peak of 200 million doses annually. Therefore, **15% of AMC funds** (donor commitments) were allocated to each manufacturer, i.e. **US \$ 225 million for each supplier** under this first procurement round. In light of the new demand from GAVI countries, new supply agreements with those two manufacturers were signed in December 2011 to contract additional doses. Each manufacturer was awarded 18 million doses annually, i.e. US\$ 165 million each, from January 2014. 52% of the AMC funds remain available for future tenders.

3.4.2. Health benefits

The global roll out of pneumococcal vaccines in developing countries began in December 2010 when Nicaragua introduced the vaccine into its routine programme with GAVI's support. Another 15 countries introduced pneumococcal vaccines in 2011 and an additional 12 countries are expected to roll out these life saving vaccines in 2012. GAVI estimates that the pneumococcal AMC will help save approximately 900,000 lives by 2015 and up to 7 million children's lives by 2030²⁷.

²⁷ World Bank, UNICEF and World Health Organization, *State of the world's vaccines and immunization*, Third edition, 2009

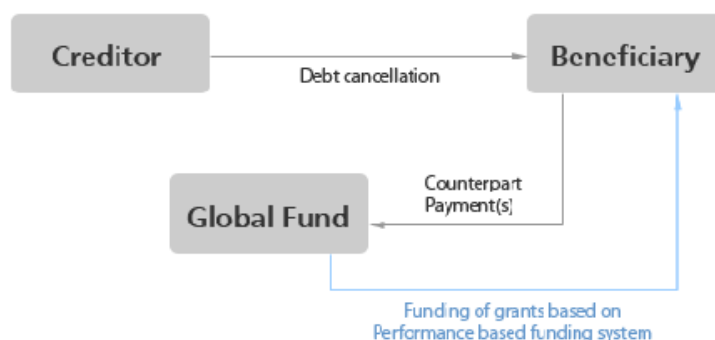
4. Debt2Health

4.1. Objectives

The Global Fund to fight HIV/AIDS, TB and Malaria (thereafter GFATM), noting that many countries being funded by its grants were directing a substantial part of their export revenues to repay their external debt while facing a high disease burden (notably AIDS, tuberculosis and Malaria), conceived a mechanism that would help countries **channel these resources away from debt repayments towards life-saving investments in health**. These resources would then be channeled to the country via the GFATM. Germany was the first country to support and commit its participation to Debt2Health.

4.2. Overall mechanism

Debt2Health is a **tripartite agreement** under which a creditor country (either bilateral, multilateral or commercial) agrees to cancel a portion of its claims, with or without discount, of a debtor country, on condition that the latter invests an agreed counterpart of the cancelled debt into its national health programmes, via grants approved by the GFATM (performance-based funding). The **counterpart payment** by the recipient country to the GFATM can be a **one-time payment** or **installments** that correspond to the debt service payments.



Source: The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria

The counterpart payments cannot come from health-related budgets or health ministries expenditures.

4.3. Participating countries

As of July 2011, **Germany** and **Australia** have entered into Debt2Health agreements. Overall, **five debt swap agreements** have been signed. Among these agreements, **four concessional debts**²⁸ agreements have been converted by Germany and **one non-concessional debt** converted by Australia.

Discussions with additional creditors and beneficiary countries are on-going.

²⁸ Concessional debts are defined as loans including a grant element of at least 25%

4.4. Results

To date, the signed agreements have enabled to free up over **85.1 million euros** for the GFATM to be channelled to the recipient countries.

The table below details the different debt swap agreements as of today, and the corresponding amounts:

Creditor/Debtor	Date	Debt swap agreement	Total amount available to the Global Fund	Amount paid to the GF ATM	Amount disbursed by the GF
Germany/Indonesia	Sept. 2007	EUR 50 million with 50% discount	EUR 25 million	EUR 20 million	US \$ 21.5 million
Germany/Pakistan	Nov. 2008	EUR 40 million with 50% discount	EUR 20 million	EUR 15 million	US \$ 13 million
Australia/Indonesia	Jul.2010	EUR 54.6 million with 50% discount	EUR 27.7 million	US \$ 3.8 million	No disbursement yet
Germany/Côte d'Ivoire	Sept.2010	EUR 19 million with 50% discount	EUR 9.5 million	EUR 0.47 million	No disbursement yet
Germany/Egypt	Jun.2011	EUR 6.65 million with 50% discount	EUR 3.325 million	EUR 3.325 million	No disbursement yet

The **last agreement signed between Germany and Egypt** differs from the other agreements, since the **funds provided by Egypt** in regard to the debt cancellation will be used by the **Global Fund to fight malaria in Ethiopia**.

1. Common criteria

As set in the terms of reference, we first conducted an analysis of the four mechanisms using the criteria of additionality, sustainability, predictability and country ownership.

The purpose of this part is not to compare the four mechanisms. We do not intend to produce an exhaustive analysis of the mechanisms given those criteria. Indeed, we have not had access to any quantitative assessments of the mechanisms (no available OECD DAC statistics on innovative financing as of now) that may help us corroborate our arguments. Yet, the report of the second working group of the taskforce on Innovative International Financing for Health greatly helped us structure and complete our findings.

The table below shows the results of our analysis. The green-shaded cells highlights, for each mechanism, their strengths with respect to the four criteria:

	Additionality	Sustainability	Country ownership	Predictability
International Solidarity Levy on Airline tickets	Theoretically, fully additional. Though, additionality may be altered should the levy be counted as ODA: donors may use it to achieve their 0.7% GNI target.	Sustainability could be limited by the absence of multi-year agreements between donors and UNITAID.	The mechanism itself does not support country ownership directly. Actually, funds are channeled through UNITAID and its partners. Worth noting that some traditional recipient countries, notably in sub-Saharan Africa, have implemented an ISL, which part of the resources collected are directly allocated to their national health budget, while also "receiving" funds from UNITAID.	Strongly predictable in terms of resources collected. Predictability on allocation of resources could be limited by the memorandum of understanding between WHO and donors countries, which requires the latter to confirm their commitments at the latest at Year -1.
IFFIm	IFFIm mainly modifies the timing of funds available. Worth noting that IFFIm funding is additional to GAVI funding (IFFIm 2011 evaluation) as per donor countries.	Not really sustainable. Funds are spent upfront over the frontloading period, making it difficult for recipient countries to plan beyond received funds. Besides, GAVI will even face high challenges when funds start declining (IFFIm 2011 evaluation). Yet, IFFIm's flexibility, which allows bonds time-shifting to coincide with GAVI funding needs, may bring some sustainability.	See comments for AMC. Worth noting that GAVI partners with recipient countries, to plan immunization campaigns for new and underused vaccines (in addition to partnering with UNICEF for procurement and delivery).	Long-term and stable commitments. Highly predictable and flexible funding throughout the grant period
AMC	No additional fund generated. The mechanism has attracted new donors like Russia.	High if it reaches its price reduction targets, through long-term legally-binding supply commitments and market creation.	Does not depend on the mechanism, but on the channel (GAVI and its partners). GAVI's co-financing policy encourages countries to mobilize and plan	Very high, for a limited period of time (until AMC funds are depleted).

			funds for their immunization campaigns.	
Debt2Health	Limited additionality, depending on the ODA treatment of the cancelled debt.	Funds are not sustainable on the long run, since country counterparts are time limited following the debt service schedule. The number of donor countries participating as of now also limits sustainability.	Country ownership is fostered: the counterpart payment turns a recipient country into a donor and a partner of the GF. In addition, the country-coordinating mechanisms encourage recipient countries towards ownership.	Fairly predictable (if recipient countries meet their commitments), for a limited period of time (following the debt service schedule).

2. Mechanism-specific analysis

Based on the interviews and the relevant readings, this part seeks to bring to the fore the main pluses and the minuses of each mechanism. Once more, we do not intend to provide an exhaustive analysis of each mechanism: the idea is to highlight the main points that may help decision-makers draw recommendations as for each mechanism.

To date, only IFFIm has been officially and independently evaluated (evaluation released in 2011) from a broader perspective. We abundantly used it in our IFFIm analysis. An evaluation of the AMC is to be done in 2012.

2.1. International Solidarity Levy on Airline tickets

2.1.1. User-friendliness

2.1.1.1. Low costs

An interesting and appealing feature of the airline levy is that implementation costs are very low for governments and airlines. Airport tax systems already exist, and companies just have to make few modifications in their pricing system. The French “Cour des Comptes”, in its 2011 Audit Report on the airline levy, demonstrates the evidence that incurred costs tend to be very low for airlines: in France, they accounted for 0.5% of the total proceeds. Furthermore, the first years of implementation have also shown no negative impact on air traffic.

The costs are nil in terms of fiscal sovereignty for countries implementing the levy: they decide the amounts to be levied on air tickets.

2.1.1.2. A “universal” tool

The International Solidarity Levy on Airline ticket can be easily implemented in recipient countries as well as in donor countries. Therefore, it can help recipient countries raise more domestic resources either for UNITAID, for their own health budget or both.

The experience of sub-Saharan countries, namely Cameroon, Congo, Mali and Niger, having recently implemented the levy shows that it is feasible and promising.

2.1.2. Donor basis

Though it has succeeded in mobilizing substantial funds, the International Solidarity Levy on airline tickets may require minor adjustments. Indeed, it still relies on a limited number of donor countries. France even accounts for more than 90% of the revenues. This situation can become detrimental to UNITAID. One can also regret the limited appeal²⁹ of the levy.

It might be needed to better explain and demonstrate the logic under the concept. The link between the funding mechanism and its allocation to “access to treatments for pandemics” may be still unfamiliar for a large audience.

2.1.3. UNITAID and innovation

Though recent, UNITAID has made a significant breakthrough in achieving its goals: hundreds of thousands of patients benefit treatments for HIV/AIDS, TB and malaria thanks to UNITAID’s action and its partners.

UNITAID is also innovative in its stakeholder approach. Indeed, it has a global approach in terms of ownership and accountability. All stakeholders, including the civil society, sit at the table to discuss and decide.

2.1.4. Market impact

As described in the panorama, UNITAID continually seeks to bring prices down. The figures clearly show that UNITAID has achieved outstanding results in terms of price reduction: children’s HIV/AIDS medicines are now 64% cheaper than in 2006 for instance.

Against the backdrop of its mission to bring drug prices down, UNITAID look for new innovative approaches to further influence the markets. The patent pool, spawned by UNITAID, is another way to shape drug markets.

2.2. IFFIm

2.2.1. IFFIm’s structure

2.2.1.1. Legal framework

Though well in place now, the legal framework of IFFIm is a recurring topic of discussion for the different stakeholders. The design of the IFFIm’s legal framework is depicted as something that was burdensome and costly. The negotiations were cost-intensive to reach a “*legal framework acceptable to all the parties involved*”³⁰.

Now, the robust and complete framework poses new problems. First, the legally-binding multi-year pledges that donors are to commit have yet brought to IFFIm predictability, which is a good thing for GAVI and recipient countries, but also additional complexity at the same time. Indeed, since it is difficult to make legally-binding commitments from future government budgets (for obvious budgetary and legal reasons), the transaction costs are high in terms of funding approval.

²⁹ “Rapport d’information sur la taxe sur les billets d’avion et l’utilisation de ses recettes, par Mr le Député Henri Emmanuelli”, 2011

³⁰ IFFIm evaluation 2011

Besides, IFFIm's sovereign credit rating may be jeopardized by the possible credit rating downgrading of one or more of its country donors. The French Cour des Comptes³¹ warns that it could affect negatively IFFIm's financial expenses.

2.2.1.2. Donor basis

IFFIm is continually seeking to extend its donor basis (refer to GAVI's last pledging conference in June 2011). To date, 10 sovereign donors have committed to long-term pledges to IFFIm. Yet, if we look at the breakdown of pledges, we see that IFFIm funding relies on two major donors, the UK and France, accounting for more than 70% of total pledges. The UK accounts for nearly half of the pledges. This situation is highlighted in the IFFIm 2011 evaluation as "donor concentration". This concentration could also affect IFFIm credit rating since it is directly linked on its two majors donors credit rating³².

Winning new donor countries over to pledge funds for IFFIm is not straightforward given the complex and binding agreements that donor countries have to face. Potential donors might fear that their internal legal and budgetary processes hamper the agreement or they just do not wish, on principle, to be legally bound.

2.2.2. Sound financial performance

IFFIm has achieved steady and efficient financial performances according to the IFFIm 2011 evaluation. Funds have been raised, on average, at lower costs compared to sovereign donors rates. IFFIm has benefited from a "World Bank halo" in the words of the evaluators. This sound financial management has enabled IFFIm to offset its running costs thanks to cost savings.

In the words of the IFFIm 2011 evaluation, IFFIm's mission is a good selling argument to investors, with its capacity to attract social investors not expecting high returns, notably Japan.

IFFIm has been able to meet funding requests from GAVI in a timely and adequate manner. On the other hand, GAVI's investments have proven to be cost-effective: IFFIm's health benefits already outweigh IFFIm total costs³³.

Yet, the IFFIm evaluation underscores the insufficient funding basis of IFFIm: "*IFFIm has paid the upfront costs of gaining access to important funding markets but has been unable to fully utilise those markets because it does not have a sufficiently large funding programme*".

2.2.3. Promising market impacts

IFFIm has had an effective market impact on:

- Polio stockpile investment case
- Measles vaccine investment case, in particular on the second dose market
- Pentavalent vaccine support: four companies are now producing the vaccine when there was just one in 2001

IFFIm has also had a catalytic impact beyond GAVI core beneficiaries. For instance, many middle-income countries will be more likely to adopt the pentavalent vaccine since the price has dropped below US \$ 3 per dose for the poorest countries³⁴.

³¹ French National Audit report on the International Solidarity Levy on Airline tickets, 2011

³² IFFIm evaluation 2011, <http://www.iffim.org/library/documents/evaluations/iffim-evaluation--full-report/>

³³ Ibidem

³⁴ Ibidem

2.2.4. The power of frontloading

The frontloading of funds have enabled GAVI to scale-up its immunization campaigns. More people get vaccinated, and receive vaccines in an “optimal time frame”. The 2011 evaluation gives estimation of health benefits: at least, 250,000 deaths averted on investment cases and 2.5 million deaths averted for GAVI core programmes.

Large-scale immunization campaigns have also certainly helped reduce risks for un-immunized people: *“IFFIm funding has helped increase access in many countries to coverage levels at which one might expect herd immunity to have an effect”* (IFFIm 2011 evaluation).

Yet, attention should be paid to the future of IFFIm. Indeed, IFFIm benefits *“today’s population but what about tomorrow’s population³⁵”*. As pointed out by Dr. Ranjana Kumar (GAVI), *“if IFFIm was to fade out, countries would be in big trouble”*.

2.3. AMC

2.3.1. The early impacts

2.3.1.1. Price reduction target

Overall, the pilot AMC can be considered as fairly successful. It has achieved its vaccine price reduction target. Indeed, the pneumococcal vaccine ended up 90% cheaper than the price paid by developed countries for the same vaccine.

Therefore, we can consider that the incentives given by the AMC to pharmaceutical manufacturers to enter underserved pneumococcal vaccine markets for developing countries have had success, given that the price reduction target was reached.

2.3.1.2. Countries’ participation

The AMC pilot experience has shown that there is appetite, among recipient countries, to accelerate the introduction of a life saving vaccine and benefit from a lower price. The year 2011 has seen a record number of applications – a 60% increase compared to 2010 - due to the fact that the process was also open to countries graduating from GAVI.

2.3.2. The political factor

Another lesson drawn from the AMC pilot is that the political factor is the major hurdle – and trigger – to its design and development. Italy championed the pilot AMC, which is certainly a reason of success. Multiple parties including donors, GAVI, the World Bank, accountants – spent a great amount of time and effort during the design stage of the mechanism. Once agreement was reached, a certain time elapsed before the AMC was implemented. Interviewees responding to the question on the AMC downsides confirmed that the political will to implement such a structure must be sustained and vigorous..

2.3.3. Unclear market impacts

Though the objective of driving prices down was attained (see section 2.3.1), there are questions as to whether the pilot AMC could have done more.

³⁵ Innovative financing for global health: tools for analyzing the options, David de Ferranti, Charles Griffin, Maria-Luisa Escobar, Amanda Glassman and Gina Lagomarsino, August 2008

There is a lot of uncertainty surrounding the vaccine price. Many interviewees asked whether the vaccine price was really competitive and/or not too high. The overall purpose of the mechanism is questioned: does the AMC incentivize manufacturers to maintain the AMC ceiling price? Is the best mechanism for market shaping?

We note that only two suppliers (GSK and Pfizer) have entered into supply agreements with UNICEF (GAVI's procurement partner for the pneumococcal vaccine). Four manufacturers have publicly disclosed their registration to the AMC: Pfizer, GSK, Serum Institute of India and Panacea. However, as per the AMC terms and conditions, UNICEF can only enter into supply agreements with those manufacturers whose products are WHO prequalified and deemed AMC eligible by an Independent Assessment Committee - UNICEF can also enter into provisional supply agreements with the suppliers whose vaccine has been accepted for review by WHO prequalification team. As of December 2011, only 2 products have received WHO prequalification and been deemed AMC eligible (PCV10 and PCV13 produced respectively by GSK and Pfizer). Emerging market manufacturers have signaled their interest in the AMC through their registration. New vaccines are currently under development and are expected to enter the market by 2016. It is regrettable that more suppliers did not participate. We can notice the absence of producers from emerging countries, whose participation could have had a positive impact on price reduction. One can also question whether or not the AMC did not push enough for R&D, as the vaccines produced by the two manufacturers were almost "ready", i.e. end-stage products. The AMC might have therefore ended-up with weak R&D stimulation.

Among the interviewees, civil society representatives voiced this concern and raised question of whether or not the AMC should have included provisions on intellectual property.

2.4. Debt2Health

2.4.1. A tool for donor countries

Debt2Health first incentivizes bilateral donors and recipient countries to participate, since it can really reduce time and efforts to agree on the amount and use of the swapped funds, because the Global Fund does it. It is worth noting that transaction times and costs have been substantially reduced since the first swaps.

The Debt2Health mechanism can be a way for some donors to increase their contribution to the Global Fund. They might not have been able to do it otherwise. If successful, it can have a real catalyst effect on other potential donors.

2.4.2. Value for recipient countries

Debt2Health is of great value for recipient countries. It helps them reduce their debt burden and brings strong programmatic benefits, by contributing to the development of their health sector.

Recipient countries, so far, acknowledge the important role that Debt2Health swaps can play in their national development strategy. The feedback from the Indonesian Ministry of Finance illustrates it:

"Health sector is among the most fundamental development sector in the current Indonesia's development strategy document. The fact that there is only 5% allocation of fund in this year state budget planning for health sector has somewhat halted our commitment to make it as a crucial fundament of the development. Then we see the significant role might be played by foreign financing in the form of debt which then may fill this development funding gap. Innovative financing scheme such as Debt2Health facility that may help to reach

development goals and at the same time help to manage our debt burden is highly regarded as an instrument breaking through further to the lack of development funding. “

2.4.3. Diversification of funding

Only two donors – Australia and Germany – have so far joined the Debt2Health initiative, with Germany accounting for the majority of debt swaps. The donor basis is therefore very limited.

In terms of new debts likely to be converted into programmatic funds within Debt2Health, the possibilities are not many. Our interviews suggest that there is:

- a limited number of sovereign debt to be swapped
- little room for maneuver with regional development banks,
- little room for private claims conversion (private creditors debts are also often guaranteed by state export agencies).

1. International Solidarity Levy on Airline tickets

The majority of interviewees view the International Solidarity Levy on Airline tickets as a valuable and expandable tool to fund global health.

1.1. Sustainability

Air traffic growth is likely to bring sustainability over the long run. However, the airline levy heavily relies on governments' decision to allocate the proceeds of the tax to UNITAID, since there is no binding commitment from participating countries. Should there be implemented multi-year agreements between donor countries and UNITAID – actually WHO -, the levy would be further sustainable.

1.2. Tax engineering

With respect to countries where the tax is already in place, there is certainly room for a broader tax base:

- **levying domestic flights.** Some countries have chosen to implement the tax on international flights in the first place. They could consider now starting implementing it on domestic flights, in particular for business and first class passengers.
- **Increasing moderately rates on international flights**
- **Setting a new “tax class” for intermediate travel classes**, such as “economy plus” classes. The amount could be slightly superior to the economy class.
- **Adjusting the tax** to reflect the inflation rate increase since the implementation

1.3. Advocacy efforts

To date, the air levy relies on few donors. France is far the biggest one. UNITAID could have a bigger impact should there be “*more countries in the basket*”, as backed by Carlos Passarelli (Fiocruz).

Yet, the political factor is the biggest constraint – as well as the overriding element – for the development of the air levy. As stated by David de Ferranti (Results for Development), « *if there is political acceptance, this tax is a good idea* ». Should the political barrier be lifted, the levy could be worthwhile for the whole community:

- Donor countries raise additional resources
- UNITAID gets even more funding for its programmes
- Recipient countries get more money in the end for their health.

To achieve this, there should be more communication and demonstration efforts to convince of the interest of the levy to contribute to global health issues.

Advocacy efforts should also be made towards attracting more developing countries to join the initiative. The International Solidarity Levy on Airline tickets can be a powerful tool for recipient countries to run and plan their health expenditures: a portion of the proceeds could be allocated to UNITAID and the rest to their domestic health budget.

International Solidarity Levy on Airline tickets

We recommend:

- UNITAID, WHO and donor countries to seek solutions, e.g. through multi-year pledges, to bring further sustainability
- to countries that have already implemented this mechanism, to consider a broader tax base with respect to the air levy applying progressive rate depending on destinations and travel classes
- to increase advocacy and communication to win new donors among developed, emerging and developing countries

2. IFFIm

2.1. Sustainability of IFFIm

2.1.1. Donors

IFFIm would need an increased number of donors over the long run in order to consolidate its funding basis and avoid donor concentration, as mentioned in the analysis. Yet, IFFIm's financial model requires top donors – currently France and the UK – to have the highest credit rating, so as to guarantee IFFIm supranational triple-A borrower status. Therefore, a sound and steady strategy would consist in both:

- Attracting new 'AAA' donors to prevent any concentration – solution suggested by the IFFIm 2011 evaluation – and credit rating risk as well as broaden IFFIm's funding basis
- Continuing to convince smaller donors to contribute. IFFIm can be a medium-term solution for new donors with limited financial capacities, especially from emerging countries. GAVI has already done it with South Africa and grant agreements are in process with Brazil.

To achieve this objective, GAVI needs to fine-tune its funding strategy in terms of communication and advocacy. The IFFIm 2011 evaluation recommends *“more focus and investment in these areas to maintain and build donor support and to broaden the investor supporter base”*. Advocacy and communication are to be at the center of GAVI's strategy. We fully back this recommendation. GAVI's mission is a good selling argument for donors and investors. As pointed out by Christopher Egerton-Warburton (Lion's Head Global Partners), *“you can't have innovation just for the purpose of innovation. You need innovation to solve a problem. That is what GAVI does”*.

2.1.2. Investors

As mentioned in the introduction of section 1.4.1, IFFIm's sustainability also depends on its financing capacity. Our interviews confirm that IFFIm is an appropriate financial tool to raise funds. In terms of strategy towards bond markets and investors, the World Bank and IFFIm Board should:

- Consider the issuance of more bonds on markets such as Japan, accounting for over 40% of total bonds issued as of now. GAVI agrees that Japan is a promising market for IFFIm, since Japanese investors are keen on social bonds, and especially “vaccine bonds”

- Involve “debt people” in the discussion around IFFIm, to benefit their expertise, as suggested by Leone Gianturco (Italian Treasury)
- Pursue and reinforce, following the IFFIm 2011 evaluation, its advocacy and communication strategy, with a view to make its action more visible and appealing.

2.1.3. Recipient countries

The question of sustainability is critical from a recipient country perspective. GAVI’s funds for immunization campaigns are yet milestone resources for GAVI-eligible countries, but graduating countries still face uncertainty regarding their future health expenditures. To further investigate this, we recommend GAVI and its partners to:

- Look at the question of how will graduating countries cope with their health expenditures once graduated
- Think of how could IFFIm be a “backload” for graduating countries.

2.2. Scalability of IFFIm?

IFFIm’s frontloading is a promising mechanism. Unsurprisingly, some interviewees suggest that a lot more money could be put into IFFIm. The IFFIm 2011 evaluation confirms it: *“Should a greater degree of frontloading be needed in future, the model is fully scaleable”*.

The evaluation also suggests that a larger funding basis would be less costly for IFFIm: *“IFFIm has paid the upfront costs of gaining access to important funding markets but has been unable to fully utilise those markets because it does not have a sufficiently large funding programme. IFFIm could be scaled up significantly in size without paying much more in marketing costs and still be able to access spreads which are attractive.”*

Yet, the donors, in response to IFFIm evaluation’s concern that IFFIm may be overpowered for GAVI, recommend that *“there should be strategic discussions to analyze whether there is room to further improve GAVI’s utilizations of IFFIm’s frontloading opportunities”*.

2.3. New applications for IFFIm

Our interviewees suggest that there is room and reason for expanding IFFIm. According to Leone Gianturco (Italian Treasury), IFFIm could be used in a broader context, in line with countries’ national health strategy: recipient countries should be therefore involved. In their response to the IFFIm 2011 evaluation, donor countries acknowledge that expanding IFFIm to other uses could also make it attractive to new donors.

2.3.1. IFFIm to fund the eradication of a disease?

There is obviously a strong case for frontloaded funds to help eradicate a disease. The IFFIm 2011 evaluation concluded that *“investing in global public goods – such as eradication of a disease is [...] a perfect fit for frontloaded funds (you buy now so you don’t have to pay later) provided there is a strong developmental case for the investment”*.

IFFIm could therefore be useful in helping eradicate end-stage diseases. The support for end-stage polio eradication is a case in point. Daniel Kress (Bill & Melinda Gates Foundation) holds the view that an IFFIm would be likely to help “finish off the work”. If funding is unstable, polio eradication could be jeopardized as we can observe in African countries where the polio disease still spreads. A new IFFIm could help secure these funding.

Polio eradication could also trigger future cost savings. The IFFIm 2011 evaluation estimate that, if achieved in GAVI-eligible countries, between US \$ 1.1 billion and US \$ 1.6 billion per year would be saved thanks to polio eradication. This would mean potential additional core funding for GAVI, given that “*polio is externally funded*”.

2.3.2. Support for the introduction of a malaria vaccine?

Either GAVI or some donor countries to GAVI agree that IFFIm could scale up the introduction of a malaria vaccine. Donor countries, responding to the IFFIm 2011 evaluation, argued that IFFIm could be useful to introduce massively a challenging brand new vaccine, such as for malaria.

GAVI is very enthusiastic about delivering a malaria vaccine on the field. The developers will be releasing early trial results in the coming months. Pricing and efficacy is of great importance. GAVI is in discussion with GSK and MMV, a product development partnership that invested in the vaccine. If the trial results are positive, the next steps will be to explore pricing with the company and implementation planning with the GFATM, WHO and others.

2.3.3. IFFIm to jump-start Health Systems Strengthening?

IFFIm has proven to be a key player in the immunization landscape. GAVI is also seeking to adopt a broader approach with respect to Health Systems Strengthening. Up until now, GAVI health system programs have been specific to immunization delivery and support, which is in line with IFFIm's principle objective of supporting immunization, some interviewees suggest that IFFIm could be used for broader HSS support.

We are not so sure that everyone would agree on this even if the idea is appealing. The implementation may not be so straightforward. Indeed, “investments” in HSS are not so capital-intensive or upfront-intensive, they are rather year after year investments. That's the reason why the European Commission and the World Bank bilateral financial mechanisms are more relevant to funding systems and strengthening systems strategies. The European Court of Auditors' report on EC support to health in Africa is quite clear on that EC funding and mechanisms are clearly relevant to supporting systems as a whole and systems strengthening³⁶. For instance, if one builds a new hospital, one has to make sure that qualified medical and non-medical staff get hired to run the hospital, and get decently and regularly paid. Therefore, spending massively upfront will certainly not be enough. There must be additional and regular funding to make the whole system work. However, we do agree with the conclusions of the High-Level Taskforce, that frontloaded funds, say IFFIm, could be useful “to finance one-time investments in services and delivery infrastructure”, such as “expand training capacity, expand and renovate physical infrastructure, and improve systems for financing, management and information”.

The other concern is to wonder whether we play with initial mandates and end up mixing roles between various players in the international health architecture. It belongs to countries, with technical support from WHO, a funding from bilateral donors to fund Health systems and contribute to improving Health Systems capacity at country level.

We would recommend IFFIm to be used:

³⁶ ECA. EC Development assistance to health services in Sub-Saharan Africa. Special report 10/2008. <http://eca.europa.eu/portal/pls/portal/docs/1/8428812.PDF>

- Either as catalyst of Health Systems Strengthening if bridged with other funding programmes that would ensure regular and appropriate funding for recurring needs (notably human resources for health). Anders Molin (SIDA)'s suggestion to use IFFIm as a catalyst of the Health Systems Funding Platform is worth considering.
- And/Or to support one-time investments, such as training or physical infrastructure renovation in Health Systems Strengthening, under certain conditions.

IFFIm

We recommend:

- to pursue advocacy and communication efforts with a view to attract new donors, in particular 'AAA' donors, therefore making IFFIm more efficient
- to target "promising" capital markets, such as Japan, and make IFFIm and its purpose more visible to potential investors, in order to strengthen IFFIm's financing capacity
- to consider how can IFFIm help graduating countries meet their future health expenditures
- to analyze, as suggested by IFFIm's donors, to what extent could GAVI absorb a larger amount of resources generated through IFFIm
- to examine new applications potential for IFFIm: funding the eradication of a disease, e.g. end-stage polio, and/or boosting Health Systems Strengthening.

3. AMC

3.1. The influence of the AMC on the vaccine prices

3.1.1. Lessons from the pilot AMC

During the interviews, many questions were raised on the genuine effect of the AMC on vaccine markets. The pilot experience is a real opportunity to draw the lessons learned from this experience.

The AMC 2012 evaluation will focus specifically on the Process and Design of the AMC and will not provide an assessment of the AMC's impact. It will evaluate the extent to which AMC implementation is as planned and whether the complementary activities to support the introduction and demand of conjugate vaccines are occurring. Impact studies will be conducted every 4 years after the signature of the first supply agreements which means that the first one will be conducted in 2014. It will focus on the achievement of AMC outcomes and will assess causality between the AMC intervention and its results through the comparisons with the counterfactual.

We would recommend that the AMC analyze as earlier as it is possible to what extent the first AMC was actually instrumental in shaping vaccine markets. This analysis should be done in light with of GAVI's procurement strategy.

We also recommend GAVI to work closely, along with private manufacturers, with public research institutes to develop new cheaper and quality vaccines.

3.1.2. Intellectual property

Our interviews suggested also that the AMC was not addressing sufficiently the intellectual property issue. This is critical: prices could be driven further down. Of course, there is not a “one size fits all” approach. The intellectual property in global health, though the importance of setting flexibility windows for global health³⁷ has been recognized, is a tricky question. Pharmaceutical manufacturers may be reluctant to enter supply agreements to provide vaccines for neglected diseases, should they be required to turn over intellectual property to third-parties. We deem relevant to consider this aspect in the forthcoming evaluation and recommend to:

- look at the feasibility of including a clause in the AMC stating that the manufacturers transfer intellectual property to GAVI
- look at the feasibility of including a clause in the AMC stating that the manufacturers grant non-exclusive license in the end, either to a licensing pool or to qualified third-parties³⁸

3.2. A second AMC?

The interviews confirm that there is appetite for a guarantee mechanism that would help develop cheaper quality vaccines for underserved markets in developing countries. An AMC-type mechanism is appealing, if successful in its market shaping objectives. Therefore, and under these conditions, a second AMC could make sense.

3.2.1. AMC's timing

Yet, if we are to think of a possible second AMC, it is worth discussing its scope first. Indeed, as for the pneumococcal AMC, the focus was on an end-stage product. NGOs, notably Oxfam UK and Oxfam France, blamed the AMC for being unnecessarily too expensive and therefore serving as a non-cost-effective procurement mechanism for a vaccine that would have been produced anyway. David de Ferranti (Results for Development), in its co-written paper “Innovative financing for global health: tools for analyzing the options³⁹”, agrees that there may be uncertainty about the effects of an AMC at end-stages. In this paper, he also doubts that an AMC can make a real difference at earlier stages of development. For early-stages development, there may be too much uncertainty for too much money at stake. If the bar is set too high, research and development groups would not respond. If the bar is set too low, the funders would pay “*for some work that would have happened anyway*⁴⁰”. Therefore, an AMC at mid-stages might be an acceptable trade-off.

3.2.2. The political championing

According to James Droop (DFID), a second AMC should be considered, but it is important to remember that a key ingredient in getting the first AMC in place was strong, high-level political leadership. Robert Hecht (Results for Development) thinks that there is a lack of political support for a second AMC at the moment, in addition to strong financial commitments: the AMC is a relatively expensive tool for donors and they do not seem ready to embark on a new AMC.

Thus, if there are reasons to push for a second AMC, provided that the lessons would be learned from the pilot experience, there should be a steady political support from existing and

³⁷ Flexibilities under the TRIPS agreement, WIPO, http://www.wipo.int/ip-development/en/legislative_assistance/advice_trips.html

³⁸ *Prizes for Global Health Technology*, Paul Wilson and Amrita Palriwala, Results for Development Institute, 2011

³⁹ Cf. Supra 36

⁴⁰ Ibidem

future donors, and GAVI should work with its partners – the World Bank, UNICEF and the donors – to shorten time between the agreement and the pilot next time.

AMC

We recommend:

- to review in the AMC 2012 evaluation the efficiency and effectiveness of the AMC design
- to ensure that future AMC designs help secure broad competition, including the participation of developing country manufacturers, as well as adequate quality supply to meet the need of developing countries
- to explore the feasibility of a second AMC or other financial instruments for market dynamics in the broader context of mid-long term health commodity supply and procurement strategies, specific to the commodity's market characteristics

4. Debt2Health

Though our interviews and findings suggest that there may be few opportunities for new debt swaps under Debt2Health, the mechanism deserves further attention.

As of now, some donor countries use their own debt swap mechanism at national level. As a consequence, it may be interesting that creditors coordinate their actions to further boost the impact on recipient countries' programmes.

Likewise, bilateral creditors, whether they already contribute to the Global Fund or not, could join the initiative. Robert Filipp (Innovative Financing Foundation) expressed the view that the donor countries within the Leading Group "*should look more favorably at longer-term participation and at new debt swaps including using old commercial debt held by their investment guarantee agencies in Debt2Health*". Yet, the absence of a global framework for debt swaps under Debt2Health – the first swaps result from case by case agreements – is likely to hinder the visibility and attractiveness of Debt2Health.

Debt2Health

We recommend:

- to establish a global framework for debt swaps
- to consider more coordinated actions between creditors.
- to consider the feasibility of entering into debt swap agreements within Debt2Health. Major donors, like the US, "*could also explore the scope for its possible involvement in debt swaps for global health*"⁴¹.

⁴¹ Cf. Supra 2

1. Ready for new mechanisms?

1.1. Lessons from the first experiences

Our interviews confirmed that there is a room and momentum for new innovative mechanisms. Though, strong suggestions are that lessons should be drawn from the previous and present experiences for any new mechanism:

- A **political champion** is decisive to any new mechanisms. Interviews revealed the importance of a political buy-in from donor countries.
- Leone Gianturco (Italian Treasury) recommend that **the design of a new mechanism be crafted in advance**, so that the rules cannot be changed. However, other partners think that choices should be made independently of governments and that a fixed design would reduce the buy-in and political advocacy and leadership which has been essential in getting existing mechanisms off the ground.
- Another key lesson is that, in the words of David de Ferranti (Results for Development), « **there is not that much appetite for lengthy negotiations** » to have many donors sitting at a table to agree on a mechanism.
- **More visibility of innovative initiatives** is essential: more communication should be done to the international community about innovative financing including towards the countries
- More transparency on the use of funds
- One of the challenges will be to have the emerging countries, in particular the BRICS (Brazil, Russia, India, China and South Africa), become larger players of innovative financing, though some of these countries like Russia and South Africa – and more recently Brazil with IFFIm – have already engaged in innovative financing.
- **Multi-sector** – donors, the civil society and recipient country – **ownership and accountability** is necessary
- **Better demonstrate the logic between funding mechanisms and health for enhanced ownership and legitimacy**

Overall, interviewees have highlighted the importance of sharing experiences on innovative financing prior to and in order to think of new mechanisms. With respect to this, we follow the suggestion of Elisabeth Sandor (OECD) that **regular review, analysis and monitoring** of mechanisms be carried out. We would add evaluation as well, to measure, not only whether objectives are met with respect to mobilizing additional funding to development and improve country mobilization of this funding, but also whether this funding has contributed to disease reduction and mortality reduction. Has additional funding had any impact on the implementation of health MDGs? To which extent, and at what cost? Aid effectiveness principles should be reviewed to include thorough thinking on what means ownership and how countries can improve strategic design based on evidence from quantitative and qualitative studies and research. Equity of access to funding and quality technical expertise should definitely be part of aid effectiveness's concept. There are major dimensions of aid effectiveness that have to be thought through if new mechanisms are to be designed and even larger funding mobilized. Governance in the international aid architecture is part of it with institutions sticking to their respective mandates.

1.2. Consolidation and streamlining

Most interviewees agree that existing mechanisms should be strengthened while also thinking of new mechanisms.

1.2.1. Meeting initial commitments first

Prior to any new mechanisms, we must ensure that the existing mechanisms are fully and properly funded. As said by Carlos Passarelli (Fiocruz), **initial commitments must be first fulfilled by countries**. We agree with that and also warn that new mechanisms should not be used to offset declining traditional aid.

1.2.2. Streamlining the funding channels

While there seems to be appetite for new financing mechanisms, some interviewees fear that it come along with new channels. Among the answers, key people in cooperation ministries and agencies expressed this view. Notably the Spanish Cooperation Agency. Jose Luis Solano Gadea stated that, though Spain is really supportive of any new financing mechanism, they are not in favor of new channels.

Others warned that new mechanisms should not create “huge animals”, where end-users receive few.

We therefore recommend:

- To get the best of existing mechanisms: for instance, by creating different funding channels within existing structures
- To work closely with end-users

Focus on a donor country: Norway

Norway is really **supportive of any new innovative mechanisms** to fund health, though they have achieved the 0.7% target (1% of GNP). Yet, Norway wants to participate (Norway has recently doubled its pledge to GAVI from 500 million to 1 billion dollars, including an increased contribution to IFFIm), to **show other countries that committing for these mechanisms is a good thing**.

Norway believes that there is a good potential for better tax collection in developing countries.

2. Key elements for success

2.1. Health funding “priorities”

An overall thinking on global health funding needs is proposed in appendix 2. We insist on the huge needs to train top-level policy and strategic makers in the area of global health challenges and responses at country and global level.

2.1.1. Infectious diseases

The emphasis has to be put on:

- Emerging pandemics
- HIV/AIDS, TB and Malaria
- Neglected diseases

With respect to the question of the introduction of new vaccines, it is worth meditating the suggestion made by Aka Kakou, a hospital infectious diseases specialist in Ivory Coast, advocating for a malaria vaccine: *“Apart from that, there are a lot of vaccines for other diseases, and may be too many vaccines: it’s now time to make them affordable”*.

2.1.1.1. Funding Tuberculosis

Interview with key informants on Tuberculosis raised concern that it is high time we thought of how to fund TB vaccines for the poorest countries.

Lucica Ditiu (Stop TB partnership) agrees with that and thinks that it would be a good idea to have a mechanism that would help fund TB second-line drugs. Currently, there is not much competition, the market is very fragmented and prices are really high. Besides, she encourages common financing initiatives for HIV and TB, which could help fund diagnostic kits for instance.

2.1.1.2. Fighting Malaria

The fight against malaria has benefited from existing innovative mechanisms (Debt2Health, UNITAID notably), but given the still considerable funding needs, as estimated in the “Global Malaria Action Plan”, there is a need to find new resources and new fundraising mechanisms, says Silvia Ferrazzi (Rollback Malaria partnership).

According to Aka Kakou, a clinician in Ivory Coast, a malaria vaccine would be the most obvious and needed vaccine.

2.1.2. Non communicable diseases

Health problems in developing countries are increasingly related to non-communicable diseases. By 2030, the burden of non-communicable diseases for low-income and middle-income countries will rise to 54%⁴². That is why we cannot afford to miss the “non-communicable diseases train”, as urged by the French Cancer League (“Ligue Contre le Cancer”).

Currently, the non-communicable diseases are not sufficiently funded, notes Agnès Leclerc, from the French Ministry of Health. Aka Kakou confirms that too few funds are allocated to prevent and care for non-communicable diseases.

Though the 66th UN General Assembly has seen UN Member States ratify a Political Declaration calling for global, national and local actions to fight the growing epidemic of non-communicable diseases, with emphasis on cardiovascular diseases, diabetes, cancer and chronic lung diseases, we deem important to have a broader operational focus on:

- a. Prevention of NCDs
- b. Alcohol, tobacco control
- c. Care and treatment for NCDs
- d. Psychosocial support for people living with NCDs
- e. Regulation, laws and alcohol and tobacco control

2.1.3. Health Systems Strengthening

In line with the recommendations of the High-Level Taskforce on Innovative financing for Health Systems, interviews with key informants confirmed that any new mechanisms should

⁴² Global burden of disease and risk factors, Alan D Lopez, Colin D Mathers, Majid Ezzati, Dean T Jamison, and Christopher JL Murray, The World Bank, 2006

adopt a broader approach with respect to health systems: the way patients are treated, the availability of drugs, the human resources...

Our interviews with medical staff in recipient countries also insist on the fact health services should be strengthened from a **community-based** perspective. Makan Coulibaly, a Senior Adviser at UNICEF in Ivory Coast, thinks that problems have to be addressed at the community level. For instance, over 800 000 pregnant women every year, only 600 000 have access to a pre-natal diagnostics. Therefore, this gap must be filled. Similar is the problem in the access to the distribution of bednets. In a nutshell, the issue of access to services at the community level must be addressed and could be addressed through innovative financing, to help countries expand and scale up their activities from regions to districts and local communities. More broadly, women's health, sexual and reproductive health as well as the prevention and care of women who suffered rape and sexual violence have to be part of women's health national strategies.

2.2. The role of WHO

We cannot talk about addressing global health issues without mentioning the role of the World Health Organization (WHO). It is also important to clarify and reinforce the role of WHO, as the health governance body at the international level, and technical assistance coordinator at the country level. Many countries and international institutions, despite acknowledging that WHO's position and authority is being challenged by other players, trust that this organization should remain the technical leader in the field of health. Some countries, like Brazil, consider that the role of WHO should not be undermined. WHO could be the coordinator of all the initiatives in place as well as new initiatives. Agnès Leclerc, from the French Ministry of Health, agrees on the importance of WHO within the debate: *"this is the only organization that has a global vision of all health issues over all the continents"*.

2.3. Link between the source of funding and the funded sector

Since the question of innovative financing is also – and sometimes unfortunately only – about finding additional resources to fund health, there is a debate over the need to link a source of funding to its funded object.

While we think that it is uneasy and can rather sound artificial to find a link between what you raise money for and what you intend to use that money for – the tobacco tax is maybe one of the few examples where there is a direct link between the source, the levy on tobacco, and the destination, the non-communicable diseases –, we consider appealing, for campaigning purposes notably, to link a mechanism to a specific cause (specific disease for example). This is a view shared by many interviewees though, from an end-user perspective, it is not necessarily relevant to have earmarked funds.

We deem also important to demonstrate, *a fortiori* given the current agenda around "value for money". Therefore, we recommend to link any new mechanisms to health outcomes.

2.4. The voice of recipient countries

2.4.1. Reaffirming a national health strategy

“Unless it is built in the country, money will be dropped”, says Lucica Ditiu (Stop TB partnership).

Recipient countries are to be leading the strategy. The Paris Declaration on Aid Effectiveness and Harmonization, and the Accra Agenda for Action, foster country ownership and alignment. Innovative financing mechanisms fall within the framework of aid effectiveness. This is not just a new tool for donor countries: we should keep in mind that raised resources should aim at helping recipient countries plan and implement their own strategies. Therefore, the priority must be given to discussions at country level, and to a national health strategy. And further money should fund research to improve country leaders' understanding of their national health and social situations and needs. That's also part of ownership.

Our interviews confirm that priorities must be decided with recipient countries, especially for HSS.

Yet, not all recipient countries decide that health issues are on the top of the agenda, either because there is no political will in that area, or because they lack sound health policy-making capacities. Even those deciding to tackle health matters may also lack proper policy-making capacities. Therefore, recipient countries should be sensitized and trained on how build a sound national health strategy. The International Health Partnership (IHP+) was created to better harmonize donor funding commitments, and improve the way international agencies, donors and developing countries work together to develop and implement national health plans. IHP+ can support countries in developing sound national health strategies.

2.4.2. Raising more domestic resources

In its 2010 report⁴³ on health systems financing, the World Health Organization (WHO) recognizes that, in the short-term, substantial financial support from the international community will be needed to meet the MDGs and help achieve universal coverage, but emphasizes on expanding domestic efforts to raise more funds by notably developing innovative financing, following the HLTF recommendations regarding solidarity levies (tax on airline tickets, foreign exchange transactions and tobacco).

As a consequence, we deem necessary to consider innovative financing as a way to raise more domestic resources that could be allocated to health matters in particular. The European Commission is supportive of innovative financing in general and believes necessary that recipient countries raise more domestic resources.

We will discuss the possibilities in the section “New mechanisms”.

Focus on a recipient country: Mali

Mali thinks that **innovative financing should be promoted**, though set targets have not been achieved. Mali is supportive of innovative financing. In 2008, Mali has passed a bill to allow the levy of an air tax. Up to now, some 140 million CFA francs have been raised and channeled to UNITAID. Mali thinks that **innovative financing can be a good solution for recipient countries to substitute to foreign aid decline**, especially in the actual context, where northern governments face high debt burden.

As of now, there are **enough mechanisms**. The **next step** is to **make these mechanisms workable**.

Mali's funding targets are AIDS and malaria.

⁴³ WHO 2010 report, *The world health report - Health systems financing: the path to universal coverage*

3. The private sector

The question of the role of the private sector in developmental issues has gained importance over the last years.

Involving the private sector is first necessary, since sovereign donors alone will not be able to make it to achieve the 0.7% target towards development and the MDGs. Against the backdrop of slow progress towards the UN's sovereign donor targets, the private sector is a good way to supplement donors' money. As said by Indra de Lanerolle (Consultant), the private sector *"may be not the next frontier, but it is hard to believe we can rely on donors' money alone to achieve these targets"*.

As voiced by many interviewed stakeholders, the private sector must be taken into account in the collective financing effort.

The term "private sector" will refer in this section to for-profit actors.

3.1. Leveraging to contribute to global health

Involving the private sector in innovative financing is nothing new. For instance, public-private partnerships, such as GAVI and the Global Fund, have already been implemented. The contribution of the private sector to the fight against HIV/AIDS is a longstanding example of public private partnerships worldwide, including at country level.

Yet, the whole thinking is now on how private sector, notably for-profit resources can help leverage "investments" in global health and how can public funds help leverage private resources. A relevant suggestion was made by some interviewees to be able to measure the leverage of innovative financing, in order to attract private investors notably.

It is worth noting that DFID deems important to involve non-state actors in health, witness the GAVI Matching Fund initiative along with the Bill&Melinda Gates Foundation. Furthermore, DFID has recently launched an initiative, inviting the different cooperation agencies to join to think of the different ways that could help correct market failures, in other words how could non-state and private actors contribute to build better health (Research for Development initiative -R4D). Within this framework, DFID and its partners notably think of how we could enhance the capacity of informal health providers.

3.2. More than just additional resources

Private sector involvement in health aid should not be restricted to giving money. These actors should be taken to the strategic thinking table too, not only because their contribution should also be aligned and coordinated, but because they have innovative decision-making and management skills to share with the public sector.

3.2.1. A tool for recipient countries

The private actors can bring a lot to recipient countries, beyond additional funds. The private sector can become an important actor in the local health community. The in-country co-investments partnerships with the Private Sector forged by the Global Fund are a case in point. Co-investments stand for a powerful tool to the Global Fund's programmatic and funding strategy.

Co-investments are joint investments by private and public sector to provide and facilitate access to prevention, treatment and care at the workplace and in the surrounding community. These co-investments contribute to the Global Fund through different channels, in particular:

- Company actions
- Core competence and Technical expertise

Co-investments benefit the whole community:

- they bring financial sustainability to the private companies participating
- they help institutions achieve their objectives on finding sustainable and local solutions to development issues
- they help populations access health services equitably as well as economic development
- they are positive to countries' governance and finance

3.2.2. A tool for advocacy

When engaged with a government or an international organization, the private sector can play a powerful role as an advocate towards multiple directions. It extends the community of donors and relays the action of a government or an international organization to the whole community, therefore bringing more visibility to their action and more public acceptance. It can leverage:

- The consumer community: cause branding enables to unite a brand and its consumers on a social cause. A compelling example is the **Global Fund Red Initiative**⁴⁴.
- The financial community: the **Dow Jones Global Fund 50 index**⁴⁵ intends to bring together the financial community and a health-related international organization
- The whole business community, i.e. business relations, employees, customers and suppliers. The GAVI **Matching Fund**⁴⁶ is a perfect example.

3.2.2.1. The Global Fund Red Initiative

(RED) was launched in 2006 by the Global Fund to Fight AIDS, Tuberculosis and Malaria, with a view to raise sustainable funds for HIV/AIDS through cause-related partnerships with the private sector. (RED) intends to engage the private sector in the fight against HIV/AIDS and raise public awareness on HIV and AIDS in Africa.

Under (RED), the Global Fund to Fight AIDS, Tuberculosis and Malaria receives a portion – up to 50% of the gross profits on (RED) products are directed to the Global Fund - of profits from the sale of (RED) branded products. Partner companies design, market and sell (RED) branded products.

As of June 2011, over US \$ 170 million have been raised thanks to (RED). The resources generated are allocated to programs in six African countries – Rwanda, Swaziland, Ghana, Lesotho, Zambia and South Africa.

⁴⁴ <http://www.theglobalfund.org/en/privatesector/red/>

⁴⁵ <http://www.theglobalfund.org/fr/about/donors/innovativefinancing/>

⁴⁶ GAVI Matching Fund for Immunization

(RED) has proven to be successful, by bringing together some of the major corporate companies in a joint effort to fund the fight against AIDS in Africa and by building a large aware-consumer network on a social-related brand.

3.2.2.2. The Dow Jones Global Fund 50 index

The Global Fund to Fight Aids, Tuberculosis and Malaria is collaborating along with the Dow Jones Indexes have launched in December 2010 a market index – the Dow Jones Global Fund 50 index, which will help contributing to the funding of the Global Fund's programmes.

The Dow Jones Global Fund 50 index is a financial product that measures the performance of the largest companies that support the mission of the Global Fund. Funds are raised through the licensing of the index, by allocating a portion of the revenues generated from the licensing.

As of October 2011, there is no available estimation of potential future flows that could be generated by the index.

The Dow Jones Global Fund 50 index is one of the first initiatives that offer to bridge the financial world and a developmental cause. As declared by Michael A. Petronella, president of Dow Jones Indexes, the *“collaboration between Dow Jones Indexes and the Global Fund enables Dow Jones Indexes to create a new socially conscious measure”*.

3.2.2.3. The GAVI Matching Fund

The GAVI Matching Fund is a recently branded mechanism where donors (as of now the Bill & Melinda Gates Foundation and DFID) make conditional pledges to GAVI to be matched with private sector pledges. For every million pounds given by a private company for example, DFID matches it with an extra million pounds, therefore making it a two million pound contribution that goes to GAVI.

To date, DFID and the Bill & Melinda Gates Foundation have both pledged a certain amount (50 million pounds for the UK and US \$ 50 million for the Bill & Melinda Gates Foundation) to be matched with private funding (with specific conditions for each regarding the type of private companies to be involved in). Other donor countries have shown interest in the GAVI Matching Fund initiative.

It works as follows. A private sector partner makes a pledge to GAVI. Then, the partner engages with employees or customers to raise additional funds. Finally, donors match all funds raised by the private partner and their outreach programme.

Therefore, the GAVI Matching Fund leverages the whole private community. Indeed, the private sector can attract others, to a far greater extent than what GAVI could do alone, by reaching their employees, suppliers, customers, business partners. The GAVI Matching Fund enables raising both money and awareness on behalf of GAVI's mission. As said by Christopher Egerton-Warburton (Lion's Head Global Partners), *“GAVI feels strongly that it should broaden the net of donors, not just from a money perspective, but from an advocacy perspective”*.

3.2.3. Sharing expertise: a concrete example

An area of partnership between the private sector and the governments could be health monitoring. For example, telecommunication companies could give their support to mobile health projects, since they already work on such projects. In other words, private companies

could bring in their expertise, and they are prone to do it according to Indra de Lanerolle (Consultant): *“they like to see that they can give not only their money but their skills and effort”*.

Private Sector

We recommend:

- to mobilize substantially private resources to contribute to global health
- to consider a broader participation of the private sector in health financing, beyond mere additional financial resources: co-investments in recipient countries, expertise sharing, advocacy in multiple directions – with respect to this, we recommend to bring unconditional support to successful initiatives such as the Global Fund Red Initiative and Dow Jones Index, and the GAVI Matching Fund -

4. New mechanisms

The following section intends to cover mechanisms that could help bridge the health funding gap. In the light of the criteria set in the introduction with respect to innovative financing mechanism, we will try to see to what extent these mechanisms fit within these criteria. In addition, potential limits to each mechanism will be highlighted.

4.1. Financial Transaction Tax

The idea of a financial transaction tax (FTT) is not new. Yet, it has recently been the center of renewed interest, due notably to the effects of the financial crisis on the world's economy. France and Germany are strong supporters of this tax.

Given the different views on the subject, the tax is currently being discussed at the highest levels (European Commission, G8, G20, dedicated taskforce of the leading group). Besides, the civil society has always endorsed the idea of a tax on financial transactions and is working with political leaders to discuss its feasibility and implementation.

In a recently released report (Sept 2011) by UNITAID, it recommends implementing an FTT design similar to the UK Stamp Duty and applying it to bonds and derivatives transactions. At low rates such a tax is estimated to generate more than EUR 12 billion annually in a country like France and more than EUR 265 billion in G20 countries without having significant negative impact on domestic financial markets. The tax is based on the principle that primary beneficiaries of globalization (financial markets) are able to contribute towards globalizing solidarity. Based on sound economic rationale of enhancing the efficiency and reducing the volatility of financial markets, the tax is unlikely to lead to flight of capital or relocation of financial activities to other destinations.

The report of the Committee of Experts to the Taskforce on International Financial Transactions and Development "Globalizing solidarity: The Case for Financial Levies" brings further information on the feasibility of this mechanism.

What is now required is the political will to remain faithful to the use of the funds from FTT for development including health priorities and to use the existing mechanisms and channels to achieve the results.

4.2. WHO Solidarity Tobacco Contribution

4.2.1. Context and Concept

With a view to curb tobacco use – every 10% increase in tobacco taxes yields to – 4% decrease in consumption in developed countries or 8% in developing countries according to the World Bank - and support non-communicable and tobacco-related diseases, the World Health Organization advocates for a Solidarity Tobacco Contribution that could generate between US \$ 5.47 billion and US \$ 16 billion a year – WHO assessed three scenarios with different rates for each scenario - if all G20+⁴⁷ countries would apply it.

The contribution would consist in a small amount levied on each pack of cigarette. A first "low" scenario could consist in:

- An additional US \$ 0.05 per pack applied in high-income G20+ countries would raise

⁴⁷ The Solidarity Tobacco Contribution: A new international health financing concept prepared by the World Health Organization, WHO, 2011

US \$ 3.1 billion

- An additional US \$ 0.03 per pack applied in upper-middle income G20+countries would raise US \$ 1.2 billion
- An additional US \$ 0.01 per pack applied in the G20+ lower-middle income countries would raise US \$1.2 billion

WHO has assessed two additional scenarios, where applied rates are respectively doubled and trebled for each category of country, which could respectively generate US \$ 11 billion and US \$ 16 billion a year.

The member states voluntarily decide to participate in and contribute to the Solidarity Tobacco Contribution. The decisions – countries can also decide to levy higher amounts - and implementation would be under full national authority. Countries would then decide to use the proceeds for national or international purposes.

WHO supports key investments in health as for the use of funds generated, which is subject to member-state decisions. As recommended by WHO, countries will *“need to consider whether to invest some of the funds for tobacco control and for tobacco-related diseases”*.

WHO has also reviewed different possibilities as for the administration and the disbursements of the proceeds, ranging from existing structures, such as the World Bank or UNITAID, to the creation of new funds.

4.2.2. What's innovative?

The levy would be:

- Theoretically additional to health ODA;
- Sustainable and predictable, up to a certain limit where tobacco consumption starts decreasing significantly, which is the purpose of the tax;
- A good opportunity for countries with low excise duties on tobacco to implement it and fund health, therefore fostering country ownership;
- A worthwhile initiative to fund non-communicable diseases and reduce tobacco effects on people's lives;
- Easy to implement, since it would use existing national tax systems (161 of the WHO 182 member states have tobacco excise duties).

4.2.3. Limits

Though promising, this mechanism is limited by:

- The fact that it needs strong political support;
- The fact that it requires a certain number of participating countries to have a real impact;
- The fact that many countries have already in place a Tobacco Levy at a high rate;
- The voluntary aspect of the mechanism can be detrimental to its stability.

4.3. The French Cancer League mechanism for a tobacco levy

4.3.1. Context and concept

The tobacco levy supported by the French Cancer League aims, similarly to the WHO mechanism, at supporting tobacco-related diseases. This levy could raise between US \$ 13 billion and US \$ 15 billion a year.

Conversely to the Global Tobacco Solidarity Levy, the levy proposed by the French Cancer League would target the tobacco manufacturers. A percentage – to be decided – would be levied either on their revenues or profits: the objective is to levy a fixed amount each year that would worth between US \$ 13 billion and US \$ 15 billion. The proceeds would then be channeled to a solidarity fund, without any connection to government budgets. The idea is to sanctuarize the funds raised, in order to avoid situations where governments would use them as an adjustment variable to their national budget. Yet, the governments would be responsible for implementing the levy.

There has to be a broad reflection on the feasibility – it could require the creation of a new managing structure for administration and disbursements - and implementation of such a levy. The French Cancer League suggests that the Global Fund, with budget lines separate from infectious diseases, could host the fund.

4.3.2. What's innovative?

The levy would be:

- fully additional to health ODA, since funds are not channeled through governments' budgets
- Sustainable and predictable, since the amounts levied each year are fixed.
- A milestone for non-communicable and tobacco-related diseases. Indeed, beyond substantial resources raised, it could have real positive effects on tobacco consumption. Should the tobacco manufacturers decide to increase their price in response to the levy, it would lead also to a consumption decrease.

4.3.3. Limits

There are limits to this mechanism:

- All countries should implement the levy ideally. Otherwise, there is the risk of tobacco-related disease exportation.
- The creation of a new dedicated structure might be burdensome
- Countries could have to face legislative issues if they would decide to implement the levy

4.4. Malaria bonds

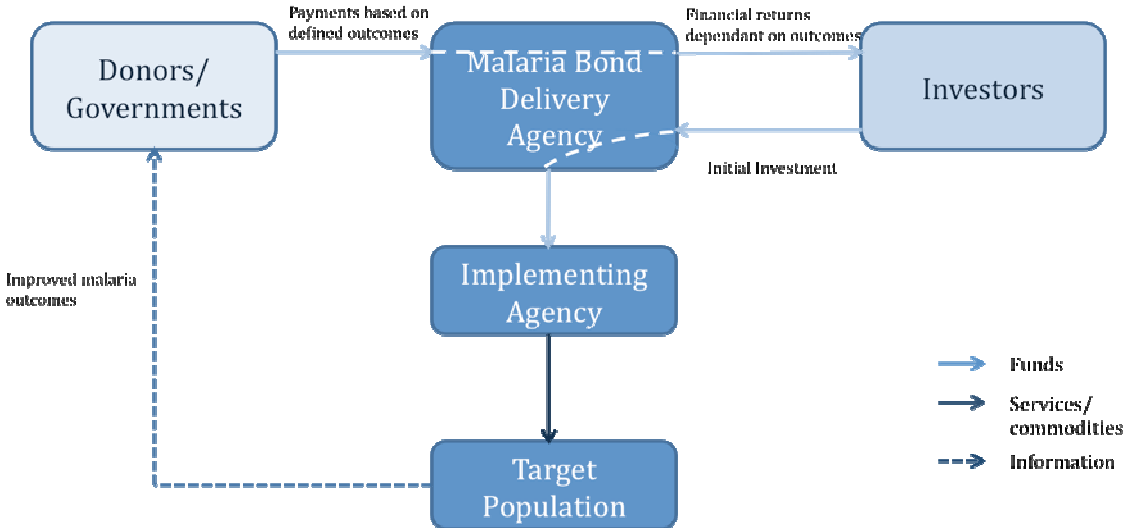
4.4.1. Context and concept

With a view to map and assess the potential of innovative mechanisms that could apply to malaria, Rollback Malaria's Resource Mobilization Sub-Committee set up a taskforce on Innovative Financing for Malaria in March 2011. The work of the taskforce would support the implementation of the Global Malaria Action Plan towards 2015.

After an extensive mapping of some 150 mechanisms, the taskforce ended up with a 4 mechanisms' shortlist: malaria bonds, Rounding up credit & debit card spending, ATM donations, cause related marketing. Rollback Malaria board then decided to endorse the development of a specific business plan for the malaria bond.

The malaria bonds are based on social impact mechanisms. Social impact bonds are outcomes-based contracts in which public commissioners commit to pay against the improvement of social outcomes⁴⁸. The UK have issues their first social impact bond in 2010 – run by a UK charity organization – intended to provide support to prisoners – not all the prisoners could benefit it – in prison and in the community. Funds would be repaid to the investors on condition that no more than 7.5% of prisoners would reoffend.

In the case of the malaria bonds, this would work similarly except that the public commissioners would be donors and the investors would be get repaid provided that tangible improvements in malaria outcomes would be measurable. The mechanism is represented below:



Source: RollBack Malaria partnership

4.4.2. What’s innovative?

In terms of innovative financing criteria, the mechanisms would be:

- Additional if donors would not count as ODA;
- Limitedly sustainable over the bond issuance period;
- Fairly Predictable, but on a limited period of time (bond issuance period).

4.4.3. Limits

The business plan is still under construction. Yet, we can point out some obvious limits:

- The bonds are another debt for donors, at least for donor countries;
- If the bonds are issued on a IFFIm-type scheme, it might be difficult, certainly impossible, to get budgetary and legal approvals from potentially participating governments;

⁴⁸ <http://www.socialfinance.org.uk/about/vision>

- Should IFFIm be used for malaria support, the malaria bonds could lose visibility among social investors. IFFIm is a reputed borrower;
- It may not be straightforward to find interested investors other than in countries where the resources generated by the bonds could be used;
- The monitoring metrics may not be so easy to define. In addition, there should not be confusion between outputs and outcomes.

4.5. Diaspora bonds

4.5.1. Context and concept

Given the number of migrants throughout the world – around 200 million – and their tendency to send money back home either for household or community purposes, funding key investments in their home country, such as health or education, would make sense. Therefore, diaspora bonds can stand for an appropriate solution.

Diaspora bonds work similarly to “normal” bonds on international markets, but would be issued by governments and/or regional institutions, such as regional development banks. The bonds could be sold in small denominations – in local currency - to individual investors or in larger denominations to institutional or corporate investors.

Few developing countries have resorted to this possibility, either because they lack information on the availability of such a mechanism or “*have little concrete appreciation of the capabilities and resources of their respective diaspora*”⁴⁹. Among the few countries having issued so-called diaspora bonds, India is a pioneer. Since 1991, more than US \$ 35 million have been raised through these bonds. Yet, the rationale behind the Indian authorities was to support its balance of payment, at times when they felt uneasy to access international capital markets.

Diaspora bonds work and would work well for various reasons. From a diaspora investor’s perspective, they may have a “home bias” and be willing to buy diaspora bonds⁵⁰. Besides, diaspora bonds provide a good opportunity for risk management. Indeed, diaspora investors may not fear, unlike “traditional investors”, that countries issuing these bonds be unable to service their debt payments, since they diaspora investors have current or contingent liabilities in their home country and hence may not be averse to accumulating assets in local currency. They make more stable investors. These investors are even likely to pay premium rates, since they be confident to do “*good in their country*”⁵¹. Finally, diaspora often constitutes a well-established community, with a strong web, which makes it a “*ready-made marketing network*”⁵².

In order to be attractive and efficient, these bonds issuance would need to be targeted on a specific area, as diaspora are often sensitive to their home community, either in their home country or in their community geographically-bound area – since the notion of local community often goes beyond the borders of one state. To make it even more appealing, diaspora bonds should address a specific project funding, such as building a regional – within a whole strategic plan. It may be even easier to sell it to potential investors since they like to see that their money services specific and streamlined projects. However, the

⁴⁹ Ketkar, S. and Ratha, D., “Diaspora bonds: tapping the diaspora during difficult times”, *Journal of International Commerce, Economics and Policy* Vol. 1, No. 2 (2010) 251–263

⁵⁰ Ibidem

⁵¹ Ibidem

⁵² <http://www.nytimes.com/2011/03/12/opinion/12ratha.html>

investors must be confident in the governments of their home countries if they are to invest in diaspora bonds. Therefore, there needs to be guarantee on the governance as well as on the use of funds raised. These bonds would require credit enhancement from multilateral or bilateral donor agencies.

4.5.2. What's innovative?

There is evidence that such bonds would:

- be additional in terms of ODA flows;
- be sustainable and predictable, should these bonds be part of multi-year national strategic plan;
- foster country ownership, since country would be the bonds' issuers;
- be focused on results, should diaspora bonds help fund targeted projects. Positive results would also trigger appetite and confidence for future issuances.

4.5.3. Limits

Such bonds have already been issued in some developing countries. It seems feasible, but:

- There is uncertainty about the guarantee that countries can bring to investors in terms of use of funds;
- There is uncertainty about the guarantee that investors get repaid. Therefore, coverage instruments could be established either with international institutions or regional institutions to cover the risks;
- Depending on the maturity of the bonds, future debts could mortgage next generations.

4.6. A vaccine against Tuberculosis: TBVI's proposal

4.6.1. Context and concept

Against the backdrop of millions of deaths every year because of tuberculosis and a third of the world's population infected with the bacterium responsible for tuberculosis, TBVI, an independent non-profit foundation that facilitates through a consortium of more than 40 universities and research institutes the development of safe, more effective vaccines to protect future generations against tuberculosis, proposes a funding scheme to bring to the market two vaccines against tuberculosis by 2020.

Developing new vaccines against TB is crucial, since the current available and widely used vaccine, the Bacille-Calmette-Guérin (BCG), is not suitable for pulmonary TB prevention notably. To achieve its goals, TBVI, through its research network, has developed a portfolio of 39 vaccine candidates, in different development stages. Out of the 39 vaccine candidates, TBVI's research plan is to support the development of the 19 promising and most advanced ones with a view to have 2 vaccines ready to enter the market by 2020. Should this goal be achieved, it could generate additional resources to fund the remaining vaccine candidates.

TBVI estimates that €560 million are needed over 10 years to bring 2 vaccine candidates from its portfolio to the market. To meet this financial goal, TBVI has developed a funding plan where participating governments would bring a financial guarantee of a maximum of €560 million that would allow TBVI to borrow up to €560 million from international financial institutions, such as the European Investment Bank (EIB). Governments offer therefore collateral to the loan, rather than grant the project. The payback of the investment can be done twofold: either beneficiaries of the funding (universities, research institutes) reimburse received funds with interests and a fee if they decide to terminate the collaboration during the

development process, and/or thanks to royalties on the sales of the successful vaccines paid to TBVI. Guaranteeing parties are liberated of their obligation, when the loan is fully paid back to the financial institution supporting the project.

Sales prices may vary according the market segment, i.e. Least Developed Countries (LDCs), emerging countries or developed countries.

With respect to governance, a dedicated separate foundation – TBVI Funding Foundation – will be created.

4.6.2. What's innovative?

The design of the funding scheme seems promising, and meets innovative financing criteria:

- **Additionality:** though this criteria may not be relevant - there is no additional fund generated -, it is worth noting that TBVI funding scheme does not uptake governments budgets neither qualify as debts (minimal or no risk for tax payers), since they “only” bring collateral. Therefore, there is no conflict with other funding priorities;
- **Sustainability:** the mechanism is likely to be sustainable over the long run, both because of the 10-year funding plan and the royalties generated by the sales of successful vaccines;
- **Predictability:** predictability is guaranteed over the 10-year funding plan;
- **Focus on results:** The funds are earmarked for tuberculosis vaccine development, and TBVI's portfolio has very promising and advanced vaccine candidates.

4.6.3. Limits

TBVI seems to offer a securely founded proposal. Yet, due to the current economic situation, some financial institutions may be reluctant to lend money, should the funding scheme be backed by uncertain assets given the recent credit rating downgrading and sovereign debt crisis.

Summary of recommendations

International Solidarity Levy on Airline tickets

We recommend:

- UNITAID, WHO and donor countries to seek solutions, e.g. through multi-year pledges, to bring further sustainability
- to countries that have already implemented this mechanism, to consider a broader tax base with respect to the air levy applying progressive rate depending on destinations and travel classes
- to increase advocacy and communication to win new donors among developed, emerging and developing countries

IFFIm

We recommend:

- to pursue its advocacy and communication efforts with a view to attract new donors, in particular 'AAA' donors, therefore making IFFIm more efficient
- to target "promising" capital markets, such as Japan, and make IFFIm and its purpose more visible to potential investors, in order to strengthen IFFIm's financing capacity
- to consider how can IFFIm help graduating countries meet their future health expenditures
- to analyze, as suggested by IFFIm's donors, to what extent could GAVI absorb a larger amount of resources generated through IFFIm
- to examine new applications potential for IFFIm: funding the eradication of a disease, e.g. end-stage polio, and/or boosting Health Systems Strengthening

AMC

We recommend:

- to review in the AMC 2012 evaluation the efficiency and effectiveness of the AMC design.
- to ensure that future AMC designs help secure broad competition, including the participation of developing country manufacturers, as well as adequate quality supply to meet the need of developing countries
- to explore the feasibility of a second AMC or other financial instruments for market dynamics in the broader context of mid-long term health commodity supply and procurement strategies, specific to the commodity's market characteristics

Debt2Health

We recommend:

- to establish a global framework for debt swaps
- to consider more coordinated actions between creditors.
- to consider the feasibility of entering into debt swap agreements within Debt2Health. Major donors, like the US, "*could also explore the scope for its possible involvement in debt swaps for global health*"

Private Sector

We recommend:

- to mobilize substantially private resources to contribute to global health
- to consider a broader participation of the private sector in health financing, beyond mere additional financial resources: co-investments in recipient countries, expertise sharing, advocacy in multiple directions – with respect to this, we recommend to bring unconditional support to successful initiatives such as the Global Fund Red Initiative and Dow Jones Index, and the GAVI Matching Fund -

Overall recommendations

Considering the abovementioned elements, we recommend to:

- **Adjust existing models to evolving environments**, e.g. IFFIm's structure with 'AAA' donors, future AMC and specific market dynamics, and a new air levy tax class for intermediate travel class;
- **Enhance advocacy and communication** for existing mechanisms and their allocation to health with a view to attract new partners/contributors, in particular emerging economies;
- **Explore flexible options** that could help gather new partners around existing tools: e.g. sharing proceeds of the air levy between UNITAID and a national health budget, loans/contributions from middle-income countries to IFFIm, allocating a portion of debt swaps to Debt2Health;
- **Set up adequate tools for private sector's commitment**: tools to match private funds, capital-market based mechanisms, cause marketing mechanisms, expertise sharing;
- **Develop concrete action plans for new mechanisms**: malaria bonds, tobacco tax, TBVI's funding scheme for a tuberculosis vaccine. Valuable new mechanisms should:
 - ensure domestic resources in favor of health for resource limited countries that decide to implement the mechanism
 - follow aid effectiveness principles of country ownership in identifying health priorities within comprehensive national health strategies and plans
 - investigate on possibilities to support comprehensive national health strategies and plans through resources raised by innovative financing mechanisms, channeled through country systems where the conditions are in place (IHP+, Joint Assessments of National Strategies...)

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1. List of persons interviewed

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Anton	Kerr	Aidsalliance	In-person (Brighton)
Olga	Golichenko	Aidsalliance	In-person (Brighton)
Tim	Poletti	Ausaid	Conference call
Dan	Kress	Bill & Melinda Gates Foundation	Conference call
Orin	Hasson	Bill & Melinda Gates Foundation	Conference call
Michael	Klingberg	BMZ	Conference call
Dirk	Gehl	BMZ	Conference call
Jacky	Mathonnat	CERDI	Conference call
Aka	Kakou	CHU de Treichville	Conference call
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Sally	Waples	DFID	In-person (London)
Gavin	Mc Gillivray	DFID	In-person (London)
Simon	Wreford-Howard	Drivedev ISC	In-person (Geneva)
Andrea	Milkowski	European Commission	In-person (Brussels)
Walter	Seidel	European Commission	In-person (Brussels)
Eric	Satin	European Commission	In-person (Brussels)
Elisabeth	Ferret	European Commission	In-person (Brussels)
Carlos	Passarelli	Fiocruz	Conference call
Julien	Meimon	French Ministry of Foreign and European Affairs	In-person (Paris)
Brigitte	Arthur	French Ministry of Health	In-person (Paris)
Agnes	Leclerc	French Ministry of Health	In-person (Paris)
Agnès	Surry	French Treasury	In-person (Paris)
Carol	Piot	GAVI consultant	In-person (Paris)
Christopher	Egerton-Warburton	GAVI consultant	Conference call
Paolo	Sison	GAVI	Conference call
Anthony	Brown	GAVI	In-person (Geneva)
Quinton	Ng	GAVI	Conference call
Tony	Dutson	GAVI	In-person (Geneva)
Nina	Schwalbe	GAVI	In-person (Geneva)
Ranjana	Kumar	GAVI	In-person (Geneva)
Indra	de Lanerolle	GAVI consultant	Conference call
Wael	Benromdhane	GFATM	In-person (Geneva)

Stefan	Emblad	GFATM	In-person (Geneva)
Pallavi	Rai	GFATM	Conference call
Arsoni	Buana	Indonesian Ministry of Finance	Email
Robert	Filipp	Innovative Finance foundation	In-person (Paris)
Leone	Gianturco	Italian Treasury	Conference call
Sophie	Rousseau	Ligue Contre le Cancer	In-person (Paris)
Emmanuel	Ricard	Ligue Contre le Cancer	In-person (Paris)
Yannick	Lucas	Ligue Contre le Cancer	In-person (Paris)
Christophe	Leroux	Ligue Contre le Cancer	In-person (Paris)
Yana	Dimitrova	Ligue Contre le Cancer	In-person (Paris)
Yoro	Diallo	Malian Ministry of Foreign Affairs and International Cooperation	Conference call
Tom	Hunstad	Norwegian Ministry of Foreign Affairs	Conference call
Elisabeth	Sandor	OECD	Conference call
Guillaume	Grosso	ONE	In-person (Paris)
Friederike	Röder	ONE	In-person (Paris)
Marame	N'dour	Oxfam France	In-person (Paris)
Alexandre	Naulot	Oxfam France	In-person (Paris)
Mohga	Kamal-Yanni	Oxfam UK	Conference call
Baseerat	Memraiz	Pakistanese Ministry of economic affairs	Email
Carole	Presern	PMNCH	Conference call
Michel	Lavollay	Public Private Partnership Europe	Conference call
David	De Ferranti	Results for Development	Conference call
Robert	Hecht	Results for Development	Conference call
Silvia	Ferazzi	Rollback Malaria	In-person (Geneva)
Sanne	Fournier-Wendes	Rollback Malaria	In-person (Lausanne)
Eric	Fleutelot	Sidaction	In-person (Paris)
Jose Luis	Solano Gadea	Spanish cooperation agency	Conference call
Miguel	Casado	Spanish cooperation agency	Conference call
Maria	Villanueva	Spanish Ministry of External Relations and Cooperation	Conference call
Lucica	Ditiu	Stop TB	Conference call
Anders	Nordstrom	Swedish Foreign Ministry	Conference call
Anders	Molin	Swedish SIDA	Conference call

Joris	Van de Putte	TBVI	Conference call
Makan	Coulibaly	UNICEF	Conference call
Frédéric	Martel	Unitaid	Conference call
Philippe	Duneton	Unitaid	Conference call
Pascale	Daou	Unitaid	Conference call
Alex	Ross	WHO	Conference call
Johannes	Kiess	World Bank	Conference call

2. Thinking on health funding priorities

Raising money should not be an objective alone. Development and Health Financing concerns have led and fed international debates over the past years. It makes no sense if there is no accurate thinking on how and where to spend the money to make sure money leads to expected results and impact at country, regional and global levels. The whole thinking should be based on an adequate knowledge of health challenges at country level, their determinants, as well as on previous experiences, studies and evaluations.

Given where the funding has been allocated over the last ten to twenty years⁵³, as well as developing countries' more pressing issues in the coming decades, we would propose to focus on the following, keeping in mind a country-centered approach throughout our proposal. This is not about meetings, theories or assumptions shared at global level; this is about stepping out of the box, responding to needs and improving real every-day life and peoples' health at country level, with empowered national policy-makers and stakeholders working in well-managed institutions.

There needs to be further analysis of the impact of global funds and innovative financing for health in terms of reducing new infections, disease burden and mortality, and improving access to not only essential drugs but also for medicines for non communicable diseases; at the end of the day make sure that the moneys raised help respond to needs adequately identified in the coming years.

One of the purposes of this report is to provide ideas on how the funds raised through innovative mechanisms could be used, in addition to what is already implemented. We know what the problems are. We need to have a better understanding of their determinants and to contribute to addressing major challenges in a rapid changing world. Funding is needed, not only to buy research or health products and technology, but to improve health outcomes overall, selecting efficient interventions. To reach this, we need high-level policy makers and strategic designers, as well as excellent capacity of implementers at country level. Funding is needed to train, and do institutional strengthening.

2.1. Policy-making and top leaders in Health and Development and Global Health

In the years 2000, we understood we needed innovative mechanisms to raise additional money at global level. Let's understand today that we need **innovative IDEAS** to feed development strategies, global health thinking, but more specifically to feed health and development thinking. Knowledge raising, policy-makers, strategic designers, innovative leaders, implementers and stakeholders with strong capacity at country level in health and development is what we need above all; In a global context of the lack of human resources, health professionals, doctors nurses, should give up on public health and go back to care, where ever they are trained and work. Policy-makers could be (should be) trained outside health sector, also to sensitize them to health challenges and so that they feel confident dealing with complex social and health issues. What are the options for this:

- A. At country level
 - a. Building research capacity for decision-making at country level
 - b. Conducting research in social sciences and health

⁵³ IHME. Distribution of development assistance to health. 2010. http://www.healthmetricsandevaluation.org/sites/default/files/policy_report/2010/financing_global_health_report_chapter2_IHME_1110.pdf; <http://www.healthmetricsandevaluation.org/publications/policy-report/financing-global-health-2010-development-assistance-and-country-spending-economic-uncertainty>

- c. Training leaders and stakeholders
- d. Building capacity in sharing experience and knowledge through support to regional meetings, seminars, writing and publications to be shared on line⁵⁴ or journals; see ACP experience sharing through their network, as well as other regional networks⁵⁵
- e. Founding relevant Master's degrees in universities; The MDP programmes founded by Mc Arthur Foundation is a good start but should be assessed and evaluated; lessons learned from this experience could be used to feed in a new wave of Master's programmes in the area of development; the same applies to training in global health and health and development in OECD countries or throughout the developing world.
- f. Build expertise of national and international level at country level through a specific agency training and mobilizing the youth
- g. Ensuring continuous training, and adjusting existing training
- h. Set up data management systems
- i. Set up monitoring and evaluation systems for strategies and interventions, as well as funding operations and mechanisms

B. At global level

- j. Building societies on common values such as solidarity, charity, etc. This means including education and knowledge sharing about low-income countries in schools in OECD countries, and the other way around about OCDE life-styles and values and systems in schools in low-income countries; the experience in Norway is interesting⁵⁶
- k. Founding universities and providing massive training in development areas in rich countries, making clear distinction between development or migration issues, policies and strategies
- l. Promote experience sharing between southern countries, between emerging economies and low income countries, facilitating North south field visits south-north visits, etc.
- m. Building an international expertise where ever human resources come from

2.2. Priority given to Africa

Equity of the distribution of ODA to health, according to the level of population, the burden of disease, the threats, etc. has not been assessed or analysed. Over the last five to ten years, ODA has increased everywhere in the developing world except in Africa, despite the continent hosting the poorest countries in the world besides Haiti. Our hypothesis is that West and Central Africa have not received as much assistance, both human and financial, that the situation needed in the past two decades. Choices made at global level have had consequences, not only in relation to health status, but also on political instability and the extension of armed conflicts in the region. Research is needed to test the hypothesis.

So in the coming future, we need to catch up on many aspects. For many reasons Africa should come first: population is going to double in the coming decades, most of HIV, TB and malaria new infections arise on the continent, the population suffers from neglected diseases, over 50% of maternal deaths and abortions as well as deaths by abortions occur on the continent, corruption prevents people from accessing care services, etc.

Massive support is needed in all sectors on this continent.

⁵⁴ See the interesting experience of FACTS Initiative <http://www.institut.veolia.org/fr/facts-initiative.aspx>

⁵⁵ www.acp.int

⁵⁶ <http://www.fredskorpset.no/en/FK2/>

2.3. Health and armed conflict prevention

Over the past decade, UNAIDS has worked on HIV/AIDS being a security issue and the epidemic a factor of destabilization in countries as the military and peace keeping forces are also hit. It would be interesting to wonder to what extent the conflict that occurred in Côte d'Ivoire in 2011, as well as political instability over the last ten years, are linked to health status and systems and access deteriorating in the country, as well as the decline of the level of education. This approach, if proved relevant, combined with social protection, would contribute to conflict prevention.

2.4. HSS

Massive funding is needed to health systems strengthening at country level, across all areas, especially as allocation has been unbalanced over the last decade within and between countries, and between health components (disease/sector; technical or strategical/managerial or financial).

Here we are not going to redefine the contents of the health systems' 6 pillars; let's refer to WHO's definition⁵⁷, and rather insist on areas that have not been sufficiently valued so far across the pillars.

2.4.1. Governance

Policy-makers could be (should be) trained outside health sector, also to sensitize them to health challenges and so that they feel confident dealing with complex social and health issues. In doing so, we also prepare leaders to be legitimate interlocutors to health professionals, particularly doctors.

2.4.2. Human resources for health

The HRH crisis is to be looked at worldwide, as well as country by country, as the shortage of doctors and nurses, lab technicians, etc. and public health professionals as a whole, will increase in the coming years, as the aging population number increases everywhere, both in emerging and rich countries. Is there political will and responsibility in relation to this at country or global level? Have the Douala, Kampala and Bangkok meetings and declarations led to concrete changes at country level in respect to HRH training and management?

At country level, financing needs are huge in relation to health management, to expand the training of health professionals and specialists, as well as train doctors, nurses, public health specialists, lab technicians etc. Cuba has much to offer, let's spend some time examining their success and why not publish a WHO "Best practice" document on their experience?

In addition, new specialists should be trained and new institutions anticipated, built and managed, to meet the medical, psychological and social needs of patients living with NCDs, as well as patients with infectious diseases, at hospital, long term care institutions, or at home. Palliative care units will be needed in poor countries too.

2.4.3. Information systems and disease alert and surveillance

The needs are huge. Poor countries need massive technical support including expertise and logistics and systems in the area. WHO and IHME have the expertise. Let's set up the systems at country level. A bulk of innovative funding could go there too.

⁵⁷ http://www.who.int/topics/health_systems/en/

2.4.4. Service delivery

Besides what is currently done or mentioned, ensuring blood safety and universal precautions, as well as a better access to specific diagnosis through well equipped and managed laboratories are key. Our interviewees have insisted on this, as the highest share of AIDS funding was allocated to ARV drugs as opposed to care and treatment of opportunistic infections and AIDS patients as a whole.

2.4.5. Access to medicines

The priority must be given to the access to quality drugs, but also access to the quality of the use of medicines at health centre or hospital levels, even more so since task shifting is more and more a favored strategy in many countries where the shortage of health workers is major.

2.4.6. Health financing and social protection

It's probably the most obvious area where innovative financing is expected, as health financing today relies on States' very limited contribution and decreasing public ODA to health. In relation to social protection, let's await the work and recommendations being processed by the Commission Bachelet to come at the next G20 (to be held in Cannes in November 2011). As well as to existing work in health systems financing through the Health Systems Platform. The major issue with respect to aid to development, be it public or private, is to improve equity and efficiency of health spending. And to understand efficiency, not as being about cost reduction, as we can read it all over, but as a measure of adequate and relevant interventions and strategies to respond to a given situation in a cost effective way.