

Innovative Financing for Global Health

A Moment for Expanded U.S. Engagement?

A Report of the CSIS Global Health Policy Center

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A MOMENT FOR EXPANDED U.S. ENGAGEMENT?

Robert Hecht, Amrita Palriwala, Aarthi Rao¹

Part I: Making the Case for Innovative Financing for Global Health

Why Does Innovative Financing for Health Matter?

Over the past decade, there has been a tremendous upsurge in attention to global health issues, and the world's wealthiest countries have made a correspondingly large increase in international development assistance for health (DAH). DAH has grown from \$7.2 billion in 2001 to \$22.1 billion in 2007, accounting for nearly one-fifth of all development aid in the latter year.²

Despite this expanded financial effort, progress on the ground toward global health goals, including those embodied in the Millennium Development Goals (MDGs)—cutting child and maternal deaths and reducing the burden of AIDS, tuberculosis, and malaria—has been slow and inadequate, and the gap in required funding remains large. A recent study by the World Health Organization suggests that an extra \$251 billion is needed over the next seven years in order to reach the MDG goals in the 49 poorest countries.³

In response to this situation, over the past few years a number of nations in the Organization for Economic Cooperation and Development (OECD) and their developing

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² N. Ravishankar et al., "Financing of global health: tracking development assistance for health from 1990 to 2007," *The Lancet* 373, issue 9681 (June 2009).

³ 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.

country partners have intensified efforts to identify and put in place new funding mechanisms that, along with increases in the traditional forms of development assistance (based on grants derived from general tax revenues), could help bridge the resource gap and thus finance essential health care for the poor. While each of these new mechanisms has limitations, taken together they could be an important part of the solution to the global funding gap.

Yet paradoxically, the United States—the richest nation and a powerhouse of innovation in finance and in health—has largely been on the sidelines of the discussions and experiments in innovative finance for global health. Why is this the case, and should the Obama administration adopt a different approach?

In this paper, we attempt to answer this question. Part I of the paper assesses some of the most promising new financing mechanisms for global health, describing their current status, actual and potential benefits, and limitations. Part II examines the prospects for increased U.S. involvement in innovative financing for global health, discusses some of the barriers that have hampered U.S. support in this area, and points to actions that could be taken to address these barriers.

Our conclusion is that these new forms of financing are important, and that furthermore, the United States should become a more engaged participant in shaping and backing efforts in this area. Doing so could yield important health and economic benefits for millions of people in the world's poorest countries and also generate important political and economic gains for the United States.

We suggest that the CSIS Commission on Smart Global Health Policy carefully consider the arguments for (and against) an expanded U.S. role in innovative financing for global health and further decide which strategies and options the administration and Congress could pursue in this area. Such actions would encourage the United States to consider and possibly support some of these new mechanisms that could help diminish the health funding gap and improve the effectiveness of U.S. assistance for global health.

What's Wrong with Traditional Aid for Health?

The first and most obvious answer to this question, already touched on above, is that the conventional approach—grants to governments and nongovernmental organizations (NGOs) in low-income countries, allocated by rich country governments from their tax base—has not yielded adequate funds to cover the gap in financing required to achieve the reductions in disease and mortality that are being sought by poor countries and that can be achieved at low cost per life saved. In 2007, the OECD countries set aside just 0.27 percent of their GDP, or about \$125 billion, for all forms of development assistance, and

of that total, about \$22 billion (0.05 percent of GDP) was for health. The high-level Taskforce on Innovative International Financing for Health Systems recently called on the affluent nations for another \$10 billion per year by 2015 to cover part of the unmet needs of the 49 poorest nations.⁴ The aids2031 working group on long-term financing estimates that by 2020, \$5 billion to \$10 billion a year will be required, on top of what is currently being spent, simply to sustain an expanded effort in preventing and treating the AIDS pandemic in the most affected countries.⁵

It is doubtful that traditional forms of aid will be able to meet these growing demands for global health, while at the same time responding to legitimate needs in other areas such as environment and climate change, water and sanitation, and education. The situation is exacerbated by the current economic crisis, which is putting downward pressures on development assistance budgets in the rich countries and on public revenues and spending by low- and middle-income countries.

But the problems with traditional aid go beyond the *amount* of money that is generated. The *ways in which it is channeled and spent* also have some serious drawbacks that innovative approaches are attempting to overcome:

- Traditional aid mostly involves short-term commitments (e.g., year-to-year appropriations) that are inherently unpredictable and unstable, making it hard for poor countries to plan ahead.
- Aid is typically paid out against health inputs (drugs, medical equipment, clinics, training, and technical advice) rather than for outputs and measurable results on the ground (for example, fewer child illnesses) and thus fails to create incentives for improved performance.
- Bilateral aid flowing from many different agencies often leads to wasteful overlaps and inefficient duplication of systems for procurement, financial management, and reporting.

What about Innovative Financing for Health: Is it Real, and Does it Work?

Mechanisms Currently Being Implemented. In order to tackle the shortcomings in traditional DAH, a number of innovative approaches have been formulated in recent years, and several are currently being implemented. These include the *International*

⁴ Taskforce on Innovative International Financing for Health Systems, *More Money for Health, and More Health for the Money* (Geneva: International Health Partnership, 2009), <http://www.internationalhealthpartnership.net/pdf/IHP%20Update%2013/Taskforce/Johansbourg/Final%20Taskforce%20Report.pdf>

⁵ R. Hecht, L. Bollinger, J. Stover et al., "Critical choices in financing the response to the global HIV/AIDS pandemic," *Health Affairs* 28, no. 6 (November/December 2009).

Financing Facility (IFF),⁶ which uses long-term pledges by rich country governments to collateralize commercial debt financing; the *Advance Market Commitment (AMC)*,⁷ in which legally binding commitments to pay for new life-saving vaccines aim to stimulate faster and larger industry investments in research and development (R&D); *UNITAID*,⁸ a new international fund that receives revenues from levies on the purchase of airline tickets and uses these resources to promote lower prices and improved access to drugs, malaria bed nets, and nutritional supplements for children; and *debt swaps*,⁹ in which rich country creditors agree to write off debts owed by developing nations, provided that a fraction of the face value of the debt is converted to local currency payments targeted for basic disease control activities.

These four innovative schemes, their salient features and revenue potential, benefits and possible risks and limitations, are described in the summary profiles (see annex 1). Three of the four approaches are already operational and yielding more than a billion dollars annually for global health. Under the IFF, bond financing provides “frontloaded” access to funds to pay for important health products such as childhood vaccines needed in poor countries, while delaying the costs to donors over a 20-year period. UNITAID offers aid additionality because revenues are generated from airline taxes, a new source of funding. Debt swaps have the benefit of encouraging poor countries to spend more of their scarce funds for health than they might otherwise do, but are less certain as a sustained long-term source of additional financing.

The AMC is just getting under way this year, but it shows promise: there is already strong interest from at least two of the leading multinational vaccine companies in capturing a portion of the \$1.5 billion in legally binding payments being offered for a new vaccine to

⁶ Brookings Global Health Financing Initiative, “International Finance Facility for Immunization,” Brookings Institution, Washington, D.C., 2008, <http://www.brookings.edu/projects/global-health/~media/Files/Projects/globalhealth/healthsnapshots/iffim.pdf>.

⁷ Brookings Global Health Financing Initiative, “Advance Market Commitments for Vaccines,” Brookings Institution, Washington, D.C., 2008, <http://www.brookings.edu/projects/global-health/~media/Files/Projects/globalhealth/healthsnapshots/vaccines.pdf>; and Ruth Levine et al., *Making Markets for Vaccines: Ideas to Action* (Washington, D.C.: Center for Global Development, 2005), <http://www.cgdev.org/doc/books/vaccine/MakingMarkets-complete.pdf>.

⁸ Brookings Global Health Financing Initiative, “Airline Solidarity Contribution,” Brookings Institution, Washington, D.C., 2008, <http://www.brookings.edu/projects/global-health/~media/Files/Projects/globalhealth/healthsnapshots/airline.pdf>.

⁹ Brookings Global Health Financing Initiative, “Debt2Health: Debt Conversion for the Global Fund to Fight AIDS, Tuberculosis, and Malaria,” Brookings Institution, Washington, D.C., 2008, <http://www.brookings.edu/projects/global-health/~media/Files/Projects/globalhealth/healthsnapshots/debtconversion.pdf>.

combat childhood pneumonia and associated meningitis, which kills hundreds of thousands of children each year. The AMC is structured to reward vaccine manufacturers that come up with a new product that meets a high technical standard and in this way creates a strong incentive for improved performance.

All of these new funding mechanisms have a longer multiyear time horizon and thus offer greater predictability than traditional aid. The IFF and AMC provide sustained financing for a long but time-limited period (until the pooled funding for these mechanisms is exhausted), so they might be best suited to pay for one-time investments rather than recurrent expenditures. However, since it is expected that the prices of the vaccines that these mechanisms support will decline over time, the gains from these initial investments could be sustained beyond the life-time of these mechanisms.

In political and financial terms, the driving force behind these innovative financing mechanisms has come from the other side of the Atlantic, mainly from London, Rome, Paris, and Oslo. The United Kingdom and Italy have been the champions for the IFF and AMC, while France has been the leader in backing the airline tax scheme as one form of what it calls “global solidarity levies.” Germany was the first country to enter into the debt swap program run by the Global Fund, called Debt2Health. The Norwegian government has used its deep budget pocket to help float several of these initiatives.

Proposed Mechanisms. Other innovative financing ideas—entirely new or incorporating elements of existing mechanisms—are currently on the drawing board. Several were given impetus in 2009 by the Task Force on Innovative Financing for Health Systems, led by UK prime minister Gordon Brown and World Bank president Robert Zoellick. Among them are levies on currency transactions, a voluntary rebate by businesses on their value-added taxes (VATs) that could be used for international development (called “de-tax” by its proponents), other kinds of pooled voluntary consumer contributions, a second IFF and another AMC. Many of these schemes aim to generate new revenue to bolster global funding available for health.

France has advocated for a levy on all foreign exchange transactions, a measure that has been estimated to generate \$33 billion annually from a very small charge on the world’s four major currencies, the U.S. dollar, the UK pound, the Japanese yen, and the EU

euro.^{10, 11} Although the proposed tax rate would be very low, some critics argue that such a levy could create inefficiencies in currency markets.¹²

Italy has proposed the “de-tax” approach that would earmark a share of VAT revenues for health.¹³ Like currency levies, a de-tax would provide a sustainable source of new revenue,¹⁴ and might be implemented quickly by individual countries to augment their foreign assistance.

France has been the main advocate for a wider range of voluntary consumer contributions, which move away from the tax-based approach to capture the willingness of individuals to raise new streams of funds for health causes.¹⁵ The Millennium Foundation has just launched a scheme (called the “Massive Good”) under which consumers can make voluntary \$2 contributions when purchasing airline tickets and other travel products; it is claimed that this scheme could raise up to \$3.2 billion by 2015,¹⁶ to help finance UNITAID.

A second IFF has been proposed to raise and streamline delivery of funds for health systems strengthening. Like the first IFF for immunization, it will frontload DAH through bond financing. The first round of pledges for the second IFF, made in September 2009, will again be managed by the Global Alliance for Vaccines and Immunization (GAVI), a system that has already been tested; this predictable stream of funds will then be channeled through GAVI, the Global Fund, and the World Bank.¹⁷ Furthermore, discussions have already begun on a second AMC, possibly to incentivize R&D for early-stage development of vaccines, such as one for tuberculosis.

Results-based Financing Approaches. In addition to the innovative financing mechanisms discussed above, a range of approaches are currently being tested and refined to link the payment of DAH with improved performance on the ground by ministries of health, health care providers (hospitals, clinics, doctors), and patients seeking care. These

¹⁰ Taskforce on Innovative International Financing for Health Systems, *Raising and Channeling Funds: Working Group 2 Report* (Geneva: International Health Partnership, 2009), 56.

¹¹ P. Douste-Blazy, “A Tiny Tax Could Do a World of Good,” *New York Times*, September 24, 2009.

¹² Taskforce on Innovative International Financing for Health Systems, *Raising and Channeling Funds*, 56.

¹³ *Ibid.*

¹⁴ *Ibid.*, 58.

¹⁵ *Ibid.*, 66.

¹⁶ International Health Partnership, “Leaders commit new finance to tackle women’s and children’s health in the developing world,” press release, September 23, 2009, http://www.internationalhealthpartnership.net/en/news/display/leaders_commit_new_finance_to_ta.

¹⁷ Taskforce on Innovative International Financing for Health Systems, *Raising and Channeling Funds*, 72.

approaches are sometimes collectively referred to as “results-based financing” (RBF) in global health (see annex 2 for specific examples).

At its core, RBF relies on rewards to incentivize stakeholders to produce tangible results. Global health programs can implement RBF through both demand and supply side mechanisms. For example, multilateral organizations such as GAVI and the Global Fund provide results-based transfers of donor aid to ministries of health, triggered by achievement of certain levels of pre-specified coverage of immunization and AIDS, TB, and malaria services.¹⁸ In the same vein, the World Bank has agreed to “buy down” interest payments on loans to countries for polio vaccination campaigns, converting the loans to grants, when the government demonstrates progress toward eradicating polio.¹⁹

Results-based financing for health care providers has shown impressive results and improved the quality of health care in a number of countries (e.g., Guatemala and Cambodia), especially when donor funds are used to pay bonuses to clinics that reach poor families through mother and child health programs.²⁰ Also, results-based payments to low-income families (known as “conditional cash payments”) who bring in their children for vaccinations, nutritional supplements, etc, or encourage women to deliver their babies in clinics, have proven to be effective in poor, remote villages in Mexico and elsewhere.

RBF approaches to global health programs have a number of positive features that could be attractive to the U.S. government. RBF is flexible enough to be applied to any type of health programs and can be implemented bilaterally or multilaterally. Elements of RBF can be incorporated in innovative financing mechanisms; the AMC, discussed above, rewards companies only after specific health products are developed and purchased by developing countries. RBF can encourage country ownership of development projects by engaging local governments and stakeholders in setting performance targets. However, RBF programs can be challenging to design and implement. Creating the right incentives, as well as monitoring programs for inflated results, requires strong technical expertise. Since funds are released on the basis of performance, strong health information systems

¹⁸ Global Alliance for Vaccines and Immunization (GAVI), “Immunization Services Support (ISS),” <http://www.gavialliance.org/support/what/iss/index.php>; and The Global Fund, “Performance-based Funding,” <http://www.theglobalfund.org/en/performancebasedfunding/?lang=en>.

¹⁹ World Bank, “WB’s Additional Support for Pakistan’s Polio Eradication Initiative: US\$21.14 million,” <http://siteresources.worldbank.org/INTPAKISTAN/Resources/Polioeradication.pdf>.

²⁰ R. Hecht and R. Shah, “Recent Trends and Innovations in Development Assistance for Health,” in *Disease Control Priorities in Developing Countries*, 2nd ed., ed. R. Hecht and R. Shah (Washington, D.C., World Bank, 2006), <http://www.dcp2.org/pubs/DCP/13/FullText>.

are needed to measure results accurately and deliver data to donors and governments in a timely manner.²¹

Part II: Engaging the United States to Play an Active Role in Innovative Financing for Global Health

What Has Been the Degree of U.S. Involvement thus Far?

Other than in the area of RBF (see next section), there has been little U.S. government involvement to date in innovative financing for global health. While U.S.-based academic institutions and think tanks developed and promoted the AMC, and the U.S. Treasury Department and other officials took part in the initial discussions in 2005–2006 on designing and implementing the scheme, in the end the U.S. government did not provide support for the AMC. The United States has shown little interest in the IFF or in mandatory or voluntary levies for UNITAID and has not seriously considered using debt swaps to expand donor resources for global health.

There appear to be three reasons why the United States has not engaged strongly in the broader international effort to create a suite of innovative financing instruments for global health. The first two apply to all proposals, while the third is specific to the AMC, IFF, and other schemes that require long-term, legally binding financial commitments—something not easily done under normal U.S. government budget processes. The three barriers include:

1. *Fragmentation of responsibility* across multiple federal agencies, leaving no single department or program with clear lead authority for global health financing. The Department of the Treasury; several branches of the Department of Health and Human Services (HHS), including the National Institutes of Health and HHS headquarters; the U.S. Agency for International Development (USAID); and the National Security Council all followed the AMC deliberations, but leadership on the U.S. side was unclear. By contrast, in the United Kingdom and Italy, the Finance Ministries were in charge on the AMC and strongly backed the work to put the scheme into practice.

²¹ Rena Eichler and Amanda Glassman, “Health Systems Strengthening via Performance Based Aid. Creating Incentives to Perform and To Measure Results,” Working Paper 3, Brookings Institution, Washington, D.C., 2008.

2. The predominantly *bilateral orientation and structure of U.S. aid for health*, which has made it difficult to build strong support for many of the innovative financing proposals that have been designed primarily to expand the funds that move through multilateral institutions like GAVI and the Global Fund. Consequently, to date there has been no internal champion for innovative financing in the U.S. government, nor is there a technical unit or team responsible for U.S. strategic thinking and technical assessment of the innovative financing proposals. In the current U.S. institutional environment, discussions on health financing have tended to focus on a single program or developing country of interest (e.g., insurance in Indonesia) rather than on new forms of financing.
3. *Legal and administrative structures*, especially congressional budget processes that make it difficult for the U.S. government to enter into multiyear or contingent financial commitments. The U.S. appropriations process differs from those of many European countries, which have been able to make long-term commitments for the IFF and AMC. Under current practice, the United States can only make “statements of intent” to fulfill future commitments, that are not legally binding. However, during discussions on the AMC in 2005–2007, the Treasury Department carefully considered several options to address this problem. The Congress could create a reserve fund to hold appropriated commitments upfront and authorize the Treasury to enter into legal arrangements, or it could agree to cover a financial guarantee by the World Bank or other international organization, with this guarantee serving as the legally binding commitment for an AMC. Even though the Treasury was interested in pursuing one of these options, there was inadequate political support from other U.S. government agencies so U.S. participation in the AMC did not materialize.

Recent events suggest that some of these political, legislative, and administrative barriers can be overcome. With the launch of the Obama administration’s Global Health Initiative (GHI), there are signs that the government wants to engage more with other donors and to expand its involvement in multilateral programs, increasing its share of financial support that flows through multilateral, as opposed to bilateral, channels. There is also a movement toward making U.S. assistance for global health more predictable by developing multiyear efforts. The Millennium Challenge Corporation (MCC), established in 2004 to provide results-based development assistance, receives funding up front from Congress to cover five years of grants to eligible countries. Similarly, members of key congressional committees have recently proposed development assistance reforms that would require USAID to set aside the full amount of funding for a multiyear (three- to

five-year period) activity at the outset, in order to provide predictable aid flows to countries.²²

An Area of U.S. Global Health Leadership: RBF

One area where the United States has demonstrated leadership is results-based financing for health, through projects funded by USAID, the MCC, and others. Over the past decade, USAID has supported RBF approaches in a number of countries including Afghanistan, Guinea, Haiti, Malawi, Nicaragua, Rwanda, and South Africa (see box). To date, USAID has not developed an overall policy on RBF; interest in RBF has been driven by individual USAID country offices, resulting in an ad hoc program with various applications of RBF principles on the ground.

Going forward, the U.S. administration could embrace RBF as an explicit overall strategy for financing global health, integrating these hitherto ad hoc and fragmented efforts, and sharing its ideas and experience across U.S. agencies and with other donor organizations. In doing this, the government could draw on the substantial pool of technical expertise that its RBF projects have already fostered. GAVI, the Global Fund, and others could use this expertise to strengthen their own RBF planning and implementation activities. At the same time, the United States could consider combining its own financial support for RBF with resources from European aid agencies and the World Bank, both at country level and through multilateral channels, as RBF becomes an increasingly popular approach to global health.

²² U.S. House Foreign Affairs Committee, “Discussion Paper #1: Development Assistance Reforms 10-6-09.”

Results-based Financing for Health: A Decade of U.S. Experience

U.S. government assistance for RBF initiatives has included both capacity development and the design and implementation of supply- and demand-side mechanisms, which flow directly to the interface between service providers and patients to incentivize results at the micro level.

The USAID Health Systems 20/20 project, for example, has developed a training methodology and collaborated with the World Bank, Norway, Australia, and the Center for Global Development to train teams from most priority countries in Africa and Asia for maternal, newborn, and child health, resulting in a number of nascent initiatives.²³ USAID has supported a project in Haiti since 1999 that contracts with NGOs and pays them based on results, leading to gains in the numbers of fully immunized children and of women with safe deliveries.²⁴ Similarly, USAID has worked with the Ministry of Public Health in Afghanistan to implement results-based contracts for NGOs to provide essential health services throughout the countryside. As a result of this initiative, the proportion of women receiving their first antenatal care visit doubled, and basic child immunization coverage increased by over 10 percent.²⁵

Other U.S. government offices have likewise adopted RBF approaches. The President's Emergency Plan for AIDS Relief (PEPFAR) has supported results-based financing programs such as rewarding health centers in Rwanda that increase and improve the quality of service provision for basic health services and HIV/AIDS care.²⁶ The U.S. government's Millennium Challenge Corporation is built on the tenet of results-based funding, and the Centers for Disease Control has participated in buy downs for polio.

²³ Rena Eichler and Susna De, *Paying for Performance in Health: Guide to Developing the Blueprint* (Bethesda, Md.: Health Systems 20/20 project, Abt Associates Inc., December 2008).

²⁴ Rena Eichler et al., "Haiti: Going to Scale with a Performance Incentive Model," in *Performance Incentives for Global Health: Potentials and Pitfalls*, ed. Rena Eichler and Ruth Levine (Washington, D.C.: Center for Global Development, 2009).

²⁵ *Ibid.*, 154–55.

²⁶ G. Fritsche et al., "Performance-Based Financing for HIV Services in Rwanda is Strengthening General Services Nationwide" (paper presented at 2009 HIV/AIDS Implementers' Meeting, Windhoek, Namibia, June 10–14, 2009), http://www.hivimplementers.com/pdfs/Posters/PosterSession_1418.pdf.

Why Should the United States Do More in Innovative Financing for Health?

Despite its status as the world's largest economy, the United States spends a small share of its national income on development assistance, with only 0.16 percent of GDP dedicated to this purpose, compared with 0.36 percent for the United Kingdom, 0.38 percent for France, 0.81 percent for the Netherlands, and 0.93 percent for Sweden.²⁷ While the United States should allocate more funds to traditional forms of aid, embracing innovative funding approaches would be another way to rapidly do more to contribute to high-impact investments in global health.

The new financing instruments being sponsored by many key European partners are also built on principles that U.S. leaders often cite as part of our larger values as a nation: rewarding scientific and other forms of innovation; paying for performance and results and not just for effort; restructuring unserviceable debts in return for fresh commitments to prudent and disciplined investing. In this sense, it seems entirely appropriate that the United States should take a hard look at, and in some cases support, these new proposals for financing DAH.

Despite the fact that the U.S. government has not yet engaged seriously in the area of innovative financing for global health, it is not too late to come to the table. Several of the new initiatives announced in September 2009 at the United Nations, including the second IFF for health systems (with pledges allowing for up to \$1 billion in debt financing), would benefit greatly from U.S. participation. A second AMC is likely to be pursued in 2010, perhaps to support development of a tuberculosis or malaria vaccine, and U.S. involvement in it would certainly be welcomed by other countries. Voluntary levies are being readied for implementation, and debt swaps remain a viable part of the Global Fund's financing program.

Among these mechanisms, the AMC and the voluntary levies on travel products ("Massive Good") may be the most promising candidates for U.S. support, given the compatibility of these mechanisms with prevailing U.S. ideology and politics and their technical feasibility.

Ideologically, the AMC should be a good "fit" for the United States, since it is essentially a market-based solution to stimulate biomedical innovation, which is one of the comparative strengths of the United States relative to other countries. Much of the creativity behind the first AMC came from U.S. universities and think tanks. Certainly

²⁷ UN Data, "Net ODA as a Percentage of OECD/DAC Donors GNI," Millennium Development Goals Database, <http://data.un.org/Data.aspx?d=MDG&f=seriesRowID:568>.

there will be new challenges in setting up an AMC focused on early-stage development of vaccines, where scientific and commercial risks are large and it is difficult to define the “target-product profile.” On the other hand, the experience gained in developing the original AMC concept²⁸ could make the second AMC easier and shorten the time it will take to get it off the ground. As discussed earlier, there are technical solutions available to address the U.S. budget challenges of making long-term commitments, assuming there is strong political leadership from Congress and the administration.

There is unlikely to be much political appetite in the United States for compulsory earmarked taxes to raise additional funds for global health, but voluntary contributions such as those proposed under the “Massive Good” could be more palatable to the American public. Proceeds from such a scheme could provide substantial and sustainable resources to UNITAID to help accelerate access to medicines and diagnostics for HIV/AIDS, malaria, TB, and other infectious diseases that the United States is already supporting through its bilateral aid programs. In terms of technical feasibility, there is nothing preventing the United States from joining this initiative. Flagship companies of the travel industry, including the three major global distribution systems (Amadeus, Travelport, and Sabre), have already signed on, as have some of the largest travel agencies in the world.²⁹

U.S. government support for a second IFF would also be consistent with one of the stated objectives of the Obama administration’s Global Health Initiative: building strong health systems in low-income countries. By contributing to the second IFF, the United States could partner with other nations and coordinate its assistance with funds from these other donors who are also involved in health systems strengthening. Further technical analysis would need to be carried out to understand better the financial and legislative issues related to U.S. backing for the IFF.

The United States could also explore the scope for its possible involvement in debt swaps for global health, something that would continue the history of U.S. backing for debt relief under the heavily indebted poor countries (HIPC) programs. There is also precedence for U.S. involvement in debt swaps for social returns through USAID’s Tropical Forest Conservation Act (TFCA), which has contributed \$15 million to \$25

²⁸ Alliance for Case Studies for Global Health, *Case Studies for Global Health: Building relationships; Sharing Knowledge* (Deerfield, Ill.: Alliance for Case Studies for Global Health, 2009), http://www.casestudiesforglobalhealth.org/case_study_PDFs/GlobalHealthCaseStudies.pdf.

²⁹ Millennium Foundation, “The Voluntary Solidarity Contribution,” Geneva, <http://www.millennium-foundation.org/article/how-it-works-1/how-it-works-vc>.

million annually to debt-for-nature swaps in at least six countries.³⁰ Given the U.S. government's large stake in the Global Fund (an expected contribution of \$1.05 billion for fiscal year 2010),³¹ it might also consider joining Australia and Germany in the Debt2Health initiative as a way of augmenting U.S. backing for the fund and encouraging recipient countries to invest more of their own resource in infectious disease control.

What Can Be Done to Get the United States More Involved?

Based on the analysis presented above, there are many compelling arguments in favor of an expanded U.S. role in innovative financing for global health. Such an expanded role should include greater intellectual and political engagement and increased U.S. government financial backing for some of the existing and proposed financing mechanisms. The analysis in this paper points, for example, to the second AMC as one of the areas where the United States could become involved with its European partners.

Under a more supportive policy on innovative financing, one immediate action to jumpstart U.S. engagement would be to establish a multiagency team to review the leading proposals, develop a clear U.S. position on them, and enter into discussions with other international partners. The National Security Council could take the lead in creating a U.S. Center for Innovative Financing and Practices in Global Health, in collaboration with other agencies, including the Office of Management and Budget, State Department, Treasury Department, USAID, and HHS. This center could sponsor meetings on innovative financing for global health that would regularly bring together U.S. government officials, experts, and institutions, as well as international counterparts on the cutting edge in this field.

A second action would be to charge a government task force with assessing the budgetary obstacles to having the United States fund multiyear or contingent commitments in global health and identify ways to overcome these barriers. This task force could review previous financial engineering solutions proposed for the AMC by the Treasury Department and others. The task force could advise on how to structure U.S. support of the next AMC and whether similar support for the IFF is warranted and possible.

³⁰ USAID, "Introduction to the Tropical Forest Conservation Act (TFCA)," Washington, D.C., http://www.usaid.gov/our_work/environment/forestry/intro_tfca.html. For example, in Guatemala, the United States forgave \$24 million of the country's debt in return for tangible forest conservation; The Nature Conservancy, "\$24 Million of Guatemala's Debt Now Slated for Conservation," <http://www.nature.org/pressroom/press/press2641.html>.

³¹ Andrew Quinn, "U.S. AIDS chief sees new goals in global battle," Reuters, January 5, 2010, <http://www.alertnet.org/thenews/newsdesk/N05115086.htm>.

Third, USAID should review its experience with results-based financing and develop a coherent policy and long-term program for RBF. The United States can further solidify its global leadership in RBF by better coordinating its efforts in this area with other bilateral and multilateral agencies.

These task forces and other policy setting exercises should then be followed by significant U.S. financial allocations for some of the innovative financing instruments for global health. After a period of review and analysis in 2010, the United States could begin to actively support one of the innovative financing mechanisms by 2011. By participating financially in the innovative schemes already under way or being proposed, the United States would also be in a stronger position to join other bilateral and multilateral funders in the monitoring and evaluation of these new funding mechanisms.

Annex 1: Summary Profiles of Current Innovative Financing Mechanisms

Advance Market Commitment (AMC)

Unique Features: Donors make commitments to fund the purchase of new health products, stimulating private-sector research and development. Potential manufacturers can gauge market size for new products. Funding rewards real results (new vaccines) rather than inputs.

Revenue Potential: \$1.5 billion in commitments for pilot pneumococcal vaccine AMC, channeled through GAVI Alliance.

Core Supporters: Bill and Melinda Gates Foundation, Canada, Italy, Norway, Russia, United Kingdom

Benefits:

- Incentivizes private companies to develop health products for developing countries, providing long-term predictable financing until the AMC funding is depleted.
- Resolves market failures to provide specific health products needed in developing countries.
- Has high potential impact since financing is directly linked to results and includes quality-assurance mechanisms. The pilot is expected to save an estimated 7.7 million lives by 2030.
- The pneumo AMC is pro-poor because the vaccines will be channeled through GAVI to the poorest countries.

Risks and Limitations:

- Can be technically complex to establish in terms of pricing and legal issues. A pilot AMC took several years to get off the ground.
- Has not been tried for vaccines in early stage of development, such as against malaria.
- Depends on donors' willingness to support future AMCs; most flows are expected to come from official development assistance (ODA) or other financing mechanisms.

Debt2Health

Unique Features: Debt swap instrument for health. Donors cancel a fraction of debt held by recipient countries in return for specific investments in health projects financed by the Global Fund.

Revenue Potential: Several hundred million dollars in debts have been cancelled thus far. It is estimated that Debt2Health could raise about \$100 million per year.

Core Supporters: Australia, Germany

Benefits:

- Effectively uses the limited available resources in developing countries toward specific health investments rather than debt repayment.
- Makes use of existing multilateral channels to target financing for health, yielding lower transaction costs compared to using disparate bilateral channels.
- Proceeds finance health projects by the Global Fund, which applies a results-based disbursement system.
- Trilateral arrangement among creditors, grant-recipient countries, and a multilateral institution could potentially strengthen recipient country ownership and accountability.

Risks and Limitations:

- Revenue potential depends on donors' willingness to cancel debt and the stock of debt available to be cancelled.
- May have limited potential unless there is a significant mass of sovereign debt that can be managed through a single debt relief program.

International Financing Facility for Immunization (IFFIm)

Unique Features: Allows donors to frontload their assistance and recipients to access long-term predictable funding. Funds are raised in capital markets based on donor countries' pledges of future contributions and channeled through the GAVI Alliance to pay for underused vaccines in poor countries.

Revenue Potential: Borrowing authority up to \$5.3 billion currently available, but further donor pledges could lead to additional debt financing.

Core Supporters: France, Italy, Norway, South Africa, Spain, Sweden, United Kingdom

Benefits:

- Frontloaded investments could make significantly more cash resources available in the near term and address urgent funding gaps. Using funds sooner can have an immediate impact—the IFFIm allows more children access to vaccines early than otherwise would have been available.
- Donors face lower upfront costs as their outlays are delayed until the repayment of bonds—over a 20-year period.

- Bond financing is predictable and long term, creating a defined overall resource envelope that can be accessed with minimum delay.
- Is pro-poor because its funds are channeled through GAVI to support immunization programs in the poorest countries.

Risks and Limitations:

- IFFIm’s start-up costs were at least \$3.6 million. Administration costs and fees of 3.5 percent of total commitments.
- It took several years to design and implement the IFFIm and issue its first bond.
- Frontloading could reduce donors’ capacity to finance aid in the future.
- Frontloaded funds are best used to finance one-time investments rather than recurrent expenditures.

UNITAID

Unique Features: Provides a new source of health funding through a tax on airline tickets levied in donor countries. Additional resources help scale up access to medicines and diagnostics for HIV/AIDS, malaria, and TB.

Revenue Potential: Since 2006, has raised over \$700 million in fresh funds, with revenues reaching \$350 million in 2008.

Core Supporters: Brazil, Chile, France, Norway, United Kingdom

Benefits:

- Provides additional funds from a new source and does not rely on ODA.
- The levy has already been implemented, and its technical feasibility has been proven in countries.
- Transaction costs are expected to be low, and technical implementation for new countries is expected to be faster, given the proven experience of early supporters.
- Air travel could provide a sustainable source of funding.

Risks and Limitations:

- Consumers may not be supportive of a tax burden that does not support investments in their own country.
- Relies on airline industry, thus vulnerable to declines and volatility in airline travel—for example, in the current economic crisis.

Source: Adapted from Taskforce on International Innovative Financing for Health Systems, “Raising and Channeling Funds” (Working Group 2 Paper), 2009; and authors’ analysis.

Annex 2: Examples of Results-based Financing in Practice

RBF Approach	Description	Incentive Structure	Benefits
Performance Incentives	Performance incentives are an innovative way to expand and enhance service delivery by motivating stakeholders, such as Ministries of Health or even healthcare users, to buy into beneficial health policies. In Rwanda the <i>mutuelles</i> program has institutionalized RBF throughout the country by tying health worker salaries to the quality of their individual performance. ³² A conditional cash transfer program in Nicaragua rewards households when children both attend school and make primary healthcare visits. ³³ This program encourages families to make positive decisions for their children’s well-being.	Performance incentives can target multiple actors from public health management to direct providers.	As was the case in Rwanda, performance incentives can encourage healthcare providers to expand their range of services and patient populations. Ongoing performance incentives may be one of the best-suited RBF mechanisms for long-term programs.
Output-based Aid	Output-based aid is an extension of performance incentives, which compensate implementers for incremental gains. For instance, a program in Kenya supplies vouchers to low-income populations, which providers can redeem only when a service has been successfully delivered. ³⁴ Similarly, a project to rebuild the health system in the DR Congo relied on contracts that partially tied provider payments to the incremental fulfillment of pre-specified health indicators such as immunization coverage and the number of assisted deliveries performed. ³⁵	In output-based aid programs, the incentives usually target the service provider.	Output-based aid is an effective mechanism for projects contracted to private groups that may otherwise perform at the minimum level to fulfill a contract.

³² Dorothy E. Logie, Michael Rowson, and Felix Ndagije, “Innovations in Rwanda’s Health System: Looking to the Future,” *The Lancet* 372, issue 9634 (July 2008): 256–261.

³³ Andrea Vermehren, “Nicaragua Social Investment Fund: Conditional Cash Transfers; A New Avenue for Social Funds?” *Social Funds Innovation Update* 2, no. 2 (February 2002), <http://siteresources.worldbank.org/INTSF/Resources/395669-1124228277650/SFInnUpdatesV2No2.pdf>.

³⁴ Kenya Voucher Program, “Creating an Efficient and Quality Health Care System,” <http://www.output-based-aid.net/>.

³⁵ Lars Johannes et al., “Performance-based Contracting in Health: The Experience of Three Projects in Africa,” *OBA Approaches*, no. 19 (April 2008), http://www.gpoba.org/gpoba/sites/gpoba.org/files/OBAApproaches19_Africa_Health.pdf.

Annex 2 (cont'd)

<p>Buy downs</p>	<p>Buy downs turn development loans into grants through demonstrated programmatic outcomes. If a country achieves predetermined targets, then the creditor can choose to convert the initial start-up loan into a grant with the country owing either nothing or a reduced amount. The creditor can forgive the loan, or a third party can choose to pay the loan on the country's behalf once a program has been successfully implemented.</p> <p>Both Nigeria and Pakistan have received no interest loans from the World Bank to administer polio vaccines³⁶; if the countries meet their vaccination targets, then the loans will be forgiven.</p>	<p>Buy downs incentivize governments to carefully implement programs so that they can successfully meet programmatic targets; otherwise, governments will face debt.</p>	<p>In addition to encouraging performance, buy downs encourage country ownership of development programs.</p> <p>If the country or organization providing the buy down sets aside the funding in advance, then the principal can accumulate interest while the program is being implemented; this could serve as a small source of revenue.</p> <p>Buy downs can be implemented for existing projects.</p>
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³⁶ World Bank, "WB's Additional Support for Pakistan's Polio Eradication Initiative US \$21.14 million," n.d., <http://siteresources.worldbank.org/INTPAKISTAN/Resources/Polioeradication.pdf>; and UN Foundation, "World Bank Loans \$28 million to Nigeria, Plans Debt Buyouts," *U.N. Wire* (April 30, 2003), http://www.unwire.org/unwire/20030430/33458_story.asp.