Making partnerships work for health, focusing on low-income countries

The role of the private sector

Experts' meeting – September 21, 2009, Berlin, Germany

kfw ENTWICKLUNGSBANK in cooperation with Bayer HealthCare Bayer Schering Pharma

Table of Contents

Panel discussion:

Annex

Welcome address

Wolfgang Plischke
Board of Management of Bayer AG, Leverkusen

It is a privilege and an honor to open this conference and address the experts gathered here today. It is, though, also a matter of some importance to me personally, since Bayer, the company on whose behalf I am addressing you, has a genuine interest in the topic of „Making partnerships work for health, focusing on low-income countries. The role of the private sector".

At Bayer, we firmly believe that health is a fundamental human right. For this reason, we are supporting the United Nations Millennium Development Goals, which have listed health as one of the key objectives. As a company well aware of its responsibility, we understand our role as one actor in international efforts to improve medical provision all over the world.

In our company, we have developed a strategy for Social Health Care Programmes that combines our health sector activities for developing and newly industrialized countries. In line with our company's areas of expertise, we are focusing especially on family planning and strengthening women's health. However, we also place a particular emphasis on combating neglected and tropical diseases. Moreover, we continue to support improved access to innovative medication which, for example, can treat clinical symptoms in oncological and haematological diseases.

There can only be sustainable solutions if all groups in society work together. This is why Bayer initiates targeted dialogues with actors in politics, industry, and health at the local, national, and international levels, and is committed to partnerships. I would just like to mention a few examples here.

Family planning and reproductive health

As the market leader in hormonal contraceptive products, we are particularly focused on family planning. Especially in developing and newly industrialized countries, Bayer is committed to enabling people to carry out conscious family planning and providing broad access to a wide range of family planning methods. These methods include oral contraceptives, one- and three-month injections, implants and intrauterine delivery systems, which are sold at cost or considerably reduced prices. A global network of governmental and non-governmental organizations ensures the distribution of these contraceptives at the local level.

Chagas disease

Since 2003, we have been working with the World Health Organisation (WHO) to combat Chagas disease in Latin America. Here, Bayer is providing the WHO with tablets containing the active substance nifurtimox, as well as additional funds to finance WHO activities in the fight against Chagas disease.

Malaria

Bayer supports a variety of aid organizations and other partners in public-private partnerships in the battle against malaria, supplying mosquito nets and the insecticide impregnation sets for the nets. These donations are backed by comprehensive information and educational projects. Since 2007, the company has been a cooperation partner of the Innovative Vector Control Consortium, a consortium of leaders in the development of products and information tools to improve the control of disease-transmitting insects.

Tuberculosis

We are working together with the Global Alliance for TB Drug Development to develop a faster-acting treatment for tuberculosis. We provide the Global Alliance with a modern antibiotic with greater activity against tuberculosis bacteria, supporting a global programme of clinical trials aimed

at proving the efficacy of a shorter course of therapy. If the trials are successful, the current treatment period of six months could be reduced by a third through a combination therapy using our active substance Moxifloxacin.

Such public private partnerships in the field of drug development, as briefly outlined here, represent quite a new organizational form.

Bayer is convinced that the pharmaceutical industry has a central role to play in finding the solutions for the most pressing global challenges in health care. As a research-based pharmaceutical company, we have a lot to offer. We regard our discovery and development of innovative medicaments as a highly worthwhile task. Bayer's credo is „science for a better life". As a health care company, we invest in creating innovations and products that are used by patients the world over to improve their life quality. But that is not all we also have extensive experience and expertise in logistics and demand planning, as well as in the battle against counterfeited drugs.

In that context, I would like to make a request. I would like to encourage all the governments in developing and newly industrialized countries, as well as the local politicians and experts committed to improving health in these countries, to include us more in their health programmes in future. Naturally, not because we believe that we alone have the key to resolving the challenges in the health sector. Quite the contrary! We are convinced that the Herculean task involved in „health as a human right" can only be tackled and resolved by cooperation between state, non-governmental and private actors.

Companies also need to enter into a dialogue with each other. The objective here cannot be to protect one's own interests, which every company rightly has and must have in their own operative areas. Instead, such a dialogue is motivated by moral commitment and the objective of how we can best combine our forces to help.

For that reason, I am very pleased to have been asked to open this conference today. This is the first time the conference has been held in this form, bringing you together to Germany, as the leading experts, to discuss this crucial question: What can we do to ensure health sector partnerships work effectively? I am very interested to see what results this conference brings and I am sure we can all look forward to fruitful discussions and debates.

Welcome address

Klaus Müller
First Vice President East and West Africa, KfW Entwicklungsbank, Frankfurt

This meeting focuses on important issues presently discussed internationally but also increasingly understood as one of the challenges for future development cooperation here in Germany:

- the increasing role of private sector participation in health systems development – i.e. financing and delivering of quality health services;

- the need for creating partnerships and cooperating in joint approaches – following the Paris Declaration principles and the Accra Plan of Action on the one hand, but also regarding the expansion of stakeholder partnerships in research, product development and service provision.

KfW Development Bank is mandated to implement the Financial Cooperation of the German Government with developing countries. In close cooperation with the Federal Ministry for Economic Cooperation and Development (BMZ) and other German development agencies, we are involved in developing adequate policies and finance their implementation with national partners. Cooperation in the health sector stresses health as a human right and focuses on the achievement of the Millennium Development Goals, three of which are directly and others indirectly related to health of the people. In that context, the recent sector strategy for development cooperation with partner countries in the health sector of Federal Ministry for Economic Cooperation and Development (BMZ) clearly spells out not only the need, but also the intention for closely involving private sector stakeholders in a coherent health system development in order to make better use of all existing resources for health for the achievement of

- universal access to services and products,
- integrated capacity development at all levels,
- disease control and prevention.

In line with the ongoing trends in international aid architecture, the sector strategy therefore recommends to continue our close relationship with multi- and bilateral donors, but also to further strengthen close collaboration with international non-governmental organizations (NGOs) and Civil Society Organizations (CSOs) in partner countries, with global partnerships and initiatives like Global Alliance for Vaccines and Immunization (GAVI), Global Polio Eradication Initiative (GPEI) and the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) with private stakeholders, including foundations and philanthropic donors. Cooperation with the private commercial sector, pharmaceutical companies and enterprises is yet a new field with high potential for further development and consolidation.

Sustainable financing of health services and health care provision is a particular challenge in partner countries. More than half of all the people all over the world do not have any social protection against economic shocks that may arise due to illness, accident, old age, and so on. And yet a minimum level of social protection is crucial, particularly for poor and vulnerable people. Therefore, German development cooperation is particularly promoting social protection in the health sector in many countries. Looking back on a long history of social health insurance in our own country, Germany has so far supported the development of national social health insurance systems as well as community-based health insurance schemes in low- and middle-income countries. And in recent years, innovative poverty-focused approaches have been taken up, including support for health voucher schemes (OBA) or basic social protection through conditional cash transfers, thematic areas with a high potential for private sector involvement.

We are therefore satisfied to facilitate and host an exchange between representatives of international development agencies and private sector stakeholders of a wide variety here in our premises in cooperation with our partners of Bayer Schering Pharma.

Summary of the conference day

Sonja Bartsch, Wolfgang Hein
Research Team on Global Governance and Normbuilding, GIGA German Institute of Global and Area Studies, Hamburg

Introduction

The architecture of international health policies has experienced fundamental changes over the last twenty years, with many new actors entering the field and making important contributions in terms of resources and advocacy. Global Health Partnerships (GHPs, mostly used interchangeably with Global Health Initiatives, GHI) have contributed significantly to that change. By integrating a number of different actors – government health departments, international multi- and bilateral organizations, pharmaceutical enterprises, private foundations and civil society organizations – in different combinations as required by the specific tasks and social and political environments, GHPs have not only added expertise and financial resources to the field of international health but also contributed to a higher degree of flexibility in dealing with global health problems. On the other hand, it is generally recognized that international cooperation is becoming more complex, in particular for poor countries receiving aid from a large number of different organizations. These problems have been addressed by the aid effectiveness discourse and political process, but it is still far from clear what impact the Paris Declaration (2005) and the Accra Agenda for Action (2008) are having.

About 40 experts from all the different fields involved in Global Health Governance accepted the joint invitation issued by the KfW Entwicklungsbank and Bayer Schering Pharma AG:

- „to debate the involvement of private sector,
- private sector's contribution to tackling diseases of poverty in low-income countries where health budgets are decreasing,
- the agreements reached in Accra – specifically the impact on the work of GHPs and the IHP, and
- the ongoing discussion as to the legitimacy of the GHPs and their transparency."

Welcome and opening

Klaus Müller, First Vice President East and West Africa, KfW Entwicklungsbank and Wolfgang Plischke, Board of Management of Bayer AG, welcomed the participants and presented the main perspectives opened up by GHPs. Klaus Müller stressed that the sustainability of health financing and the access to quality health services are among the biggest challenges in health. Wolfgang Plischke pointed to Bayer's work in the field of family planning, Chagas disease, malaria, and tuberculosis and explained how the company's slogan „Science for better life" transforms its activities at different levels. Both regard this meeting as an excellent opportunity to share

experiences from a range of partnerships and private sector engagements in health so far and to intensify the exchange between development agencies and the private sector. Wolfgang Bichmann, Head of Sector Policy Division Health, Education, Social Protection, KfW Entwicklungsbank explained the conference format.

Keynote

David de Ferranti is the President of Results for Development and leads the Global Health Financing Initiative at Brookings Institution. In his presentation, he gave an overview of the current situation and future trends for private sector partnerships and highlighted the most important issues and challenges facing the health sector. He pointed out that the private sector in developing countries is very diverse, with a variety of informal and formal actors. While the private sector is generally large and important, there are considerable differences across countries. A substantial portion of health spending is private with, for example, private providers in Madhya Pradesh, India, far outnumbering public providers.

The impact of the recent economic/financial earthquake presents one of the most important challenges. Although some economic indicators suggest that the worst is over and economic recovery – at least in the US – may be faster than initially predicted, there is still a possibility of more far-reaching changes posing serious problems for global health in the years ahead. In particular, the critical factors in future might include a potential decline in aid in general, a decline in health-related aid and the development of foreign direct investment (FDI). Careful note should be taken of what happens to the 50-75 poorest countries and the approximately 1-2 billion people who live in poverty today. Greater progress is needed, especially given a lack of alignment between global health spending and the global burden of diseases. Although health aid has increased considerably over the last two decades, an additional US$ 50 billion per year would be necessary to finance priority disease initiatives. This amount is small compared to, for example, global military spending, global corporate net profits or the total capital in financial markets, but substantial compared to the current health development aid, total Official Development Assistance (ODA) or even the total current health spending in recipient countries. Consequently, more money for health is needed, but the money provided should also deliver more health for the recipients.

The second challenge, David de Ferranti continued, lies in successfully managing the inevitable „economic transformation of health“. Studies

show a strong link between countries' wealth and their total health spending, and suggest that as gross domestic product (GDP) increases by 1 percent, health spending increases by 1.1 percent. Hence, if income rises further, this is also good news for health. Since economic growth is likely to be strong in sub-Saharan Africa especially, increased health performance should be possible if the money is wisely spent.

Countries also need to deal with the emerging „third great transition“ in health. While the first two transitions (demographic and epidemiological) are generally completed by now, the third transition will present a major challenge for the 21st century. This transition is characterized by a shift from old-style health care financing where the burden of ill health was mainly borne by the sick (5 percent of the population) to being shared by all (100 percent of the population). Such a transition would lead to substantial potential benefits in terms of health, equity, and the viability of health financing and universal health coverage. At present, health in low-income countries is primarily funded by out-of-pocket payments, with the cost of treating sickness cited as the second most frequent shock to household income. Transitioning to universal coverage is a complex process and, of course, will take time; however, managing this process is crucial for improving health in the developing world.

The fourth big challenge, according to David de Ferranti, is the re-discovery of health system strengthening. Today, with approximately 50 percent of health spending going to vertical disease programmes, it is becoming apparent that global health has underinvested in health systems. Health systems include a variety of components and, frequently, not enough attention has been paid to, for example, the roles and interconnections between payers/purchasers and suppliers. Health systems have multiple goals and patient satisfaction should play a key role. Neglected health systems can cause substantial problems and unmanaged health markets may lead to negative outcomes, leaving the large potential of the private sector under-realized. Performance matters in achieving good low-cost health and countries ought to introduce the policies necessary to foster mixed health systems.

In this context, critical reflection is called for in the debate, often value-driven, between proponents of a strong public sector and supporters of substantial private engagement. Both sectors are important in improving health and the evidence shows that there is no generalizable conclusion on which sector is better. Thus, a more pragmatic view would encourage a focus on the

practical questions that policy-makers are facing and help achieve better health in the developing world.

For the further discussion during the workshop, David de Ferranti suggested concentrating on the strengths and weaknesses and the future trajectory of the global health architecture, the „new" global health institutions (e.g., The Global Fund or GAVI), the country-focused global health initiatives (such as IHP, P4H), and disease-focused public-privates partnerships. The discussion should also address how the private sector could/should contribute to meeting global health needs, how financing needs will be met, and other approaches to improving aid.

The following discussion appraised a number of the challenges described in David de Ferranti's presentation. In particular, the debate turned on the connection between economic growth and improved health and the repercussions of the current economic crises. Some additional issues were also raised, including the question of accountability (who is accountable to whom in the complex environment of health?), and the role of stewardship for the private sector (required to create a level playing field). It became clear that we have to deal with mixed (public/private) systems in both health provision and financing, and the solutions required have to be capable of leveraging the advantages of both sectors.

Panel I: Involvement of private sector– cooperation and coordination (Part 1: Success stories, lessons learned)

Uwe Schmidt, Director for International Trade and Development at the Federation of German Industries (BDI) presented an initiative on „Healthcare Infrastructure in Developing Countries and Emerging Markets" which is funded by a number of German companies and supported by the Federal Ministry for Economic Cooperation and Development (BMZ) via the KfW Development Bank. The initiative brings together the know-how of both the private and public sectors and aims at making an active contribution to improving the health infrastructure by developing a concept to run hospitals in developing countries and emerging markets. The initiative consists of two components: a pilot project on hospitals in partner countries and a contact point in Germany for requests on the whole range of healthcare infrastructure solutions and technologies. The pilot project is scheduled to start by the end of 2009 and will run for two years.

Mapoko Mbelenge Ilondo, Senior Advisor for Global Diabetes Partnerships at Novo Nordisk, Denmark described the activities of the Novo Nordisk World Partner Project (WPP) in diabetes control in Tanzania. When activities started in 2001 diabetes was considered to be a problem only found in developed

countries. Developing countries were focused on infectious diseases such as Aids, TB or malaria. The WPP aims at achieving better standards in diabetes control by improving the organization of diabetes care, the education and training of doctors, and enhanced patient education and diabetes awareness. A core WPP country is Tanzania, where approximately 400,000 people are living with diabetes. However, since the government has to deal both with a substantial economic debt and high rates of infectious diseases, the level of support on diabetes left considerable room for improvement. In Tanzania, the WPP strengthened the Tanzania Diabetes Association, established diabetes clinics, trained doctors on diabetes, and developed community programmes to explain diabetes to the population at large. By helping to put diabetes on the agenda in Tanzania, the WPP's work has contributed to ensuring that now over 100,000 people living with diabetes have access to affordable care. The Ministry of Health today has far greater awareness of diabetes, and national strategies to deal with chronic diseases have been developed. The WPP's success was based on civil society involvement, promoting local ownership, and encouraging inclusive processes from the outset.

In his contribution, Klaus Brill, Vice President Corporate Commercial Relations of Bayer Schering Pharma AG, first gave an overview of the most important figures on family planning, stressing that the issue of reproductive health must be established on a par with Aids, TB and malaria. He then described the main activities of his company in this context, namely social marketing and cooperation with non-governmental organizations (NGOs). Bayer has been involved in social marketing since the 1980s, with the company participating in the USAID „Social marketing for Change" project where companies offer certain products in selected developing countries at reduced prices. Cooperation with NGOs active in the field of reproductive health (family planning programmes) also plays an important role for Bayer. Experience from these two activities has shown that the sustainability of funding is an important issue, as the projects initiated require long term financing to be successful. In addition to family planning programmes based on financial support, Bayer is also pursuing new approaches such as „second tier marketing", which is also supported by USAID. In second tier marketing, the price for the contraceptive is higher than in traditional social marketing approaches, but significantly lower than in „first tier" markets. Since the second tier marketing model can achieve 100 percent commercial self-sufficiency, the approach is also 100 percent sustainable. Pilot projects in second tier mar-

keting are being launched in Ethiopia, Tanzania and Uganda and will then be extended to other countries. Bayer's experience in the field of family planning showed that strong public-private partnerships make a valuable contribution to achieving the Millennium Development Goals (MDGs).

Christoph Bonsmann, Director of action medeor International Healthcare GmbH explained the activities of his organization in drug procurement. Action medeor is a German NGO. Its subsidiary, International Healthcare GmbH, is primarily active in East Africa where it operates as a not-for-profit pharmaceutical wholesaler. It procures drugs for the non-commercial health sector and serves clinics in health posts. While the original idea had been to buy drugs from Asian generic manufacturers, the company quickly learned that good manufacturing companies also existed in Africa. They cooperated with manufacturers in Tanzania and Kenya, financed knowledge transfer to the companies and in return obtained the rights to buy products at cost price. The difference between the action medeor International Healthcare GmbH approach and commercial approaches is that they work with a fixed catalogue, offer a one-stop-solution and only procure medicines listed by the national Ministry of Health. The goal is to procure 60 percent of the drugs from local manufacturers and to contribute to capacity building in the region.

The discussion following the four presentations considered a number of issues. In the context of procurement, reference was made to the importance of the WHO prequalification project. With regard to non-communicable diseases, the poverty impact of treating non-communicable diseases was discussed; it was stressed that diabetes occurs in both poor and more affluent people. On social programmes, the connection between health engagement and market access was discussed and it was stressed that both considerations (social aspects, market situation) belong together and new approaches are needed to enhance product availability. The question of health services in rural areas and resource-poor countries was also raised, with an emphasis placed on the need for NGO involvement.

Panel 1. Part II: GHP's impact on national health strategies. How to achieve and ensure sustainability?

Betty Nakazzi Kyaddondo from the Ministry of Finance, Planning and Economic Development of Uganda first gave an overview of the various donor projects in the context of GHPs and of the key actors in the health sector. In general, public-private partnership is a pillar of Uganda's Health Sector

Plan and is well established. However, the advent of GHPs has stimulated a plethora of different private civil society organizations (CSOs) and NGOs. Their participation depends heavily on civil society's level of maturity, capacity and strength. Managing the large variety of actors is not easy and can undermine harmonization efforts. Although partnerships have a number of advantages (e.g., they channel funding more effectively to the poor, are flexible and have a high level of resilience in conflict situations), they are associated with a number of challenges both at national and international level. At national level especially, since PPP are not covered in the Paris Declaration, there might be duplications of efforts and their funding is often unpredictable. At the international level, the most important challenges include the focus on disease-specific projects and competitive bidding processes.

Tatul Hakobyan, Deputy Minister of Health from Armenia and Board Member of the GAVI Alliance, explained Armenia's health strategy and its dependence on GHPs funding health programmes in the country (GNI/capita: US$1,470, amount spent on health/person: US$29 per annum). He then focused on GAVI's activities. Total GAVI funding to Armenia is US$758,635, and over half is allocated for new and underused vaccines. He referred to some results enabled by GAVI's catalytic financing (such as the number of children vaccinated against Hepatitis B, the introduction of safe injection tools and practices, and better surveillance and training). Experience has shown that the most critical aspect is aligning and coordinating GHP funding with country priorities. However, processes have been managed well in Armenia and GAVI has been engaged in some of the most successful measures in all the country's public health initiatives. GHPs are associated with a number of advantages (mobilization of significant additional resources, flexible funding, country driven process, collaboration/coordination opportunities, and learning opportunities), but also some important challenges (parallel and duplicative processes for different GHPs, time and human resource burden, lack of clear guidelines and clear dates of financial shipments). In order to ensure sustainability, GHP investments need to catalyze increased government financing for the health sector (e.g. through co-financing schemes).

Geoff Adlide, Director of Advocacy and Public Policy at the GAVI Alliance Secretariat, began his presentation by pointing to the increased recognition that health is not only an outcome of development, but also a driver of development. GHPs are not only considered important because of their resources,

but because of their new market-shaping approach. By pooling the vaccine demand of 72 of the poorest countries to procure vaccines in bulk volumes, prices are significantly reduced. GAVI has become a global buyer of vaccines for poor countries, buying more than 40 percent of its vaccines from manufacturers in countries such as India and Brazil. Through Advance Market Commitments, GAVI also creates incentives to the industry to develop products which otherwise would not be economically viable. On the other hand, to encourage country ownership, countries eligible for GAVI support are required to co-finance a proportion of the vaccines they apply for. GAVI's board has the largest variety of actors on any board of global health organizations; members represent developing world and donor governments, private sector philanthropists such as the Bill & Melinda Gates Foundation, the financial community, developed and developing country vaccine manufacturers, research and technical institutes, civil society organizations and multilateral organizations such as the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the World Bank.

The discussion first turned to the question of how to measure the impact of GHPs. Andrew Harmer of the London School of Hygiene and Tropical Medicine (LSHTM), for example, pointed out that Global Fund evaluations suggest they do not actually know which of their projects were effective; in general, the health information systems in many developing countries are very weak. There was widespread agreement on the problems arising from the impact of multiple GHPs on reporting and integrating the services of multiple providers (though the afternoon discussion noted that the the Accra Conference results had brought some improvement). Betty Nakazzi Kyaddondo argued that the Ugandan government had managed to achieve an effective division of labour between GHPs and church activities in health. Another point concerned the problem of access to remote areas e.g. in immunization policies. Geoff Adlide referred to the need for countries themselves to invest more in integrated service delivery platforms (not focusing only on vaccines, but on all types of services). If resources are lacking, partnering with private actors could be an option, but public sector stewardship is required. Scott Featherstone, Investment Officer of International Finance Corporation (IFC) in Africa, called for cooperation between GHPs and local private actors in poor countries; this was supported by Betty Nakazzi Kyaddondo, who pointed out that political leadership often keeps the private sector at bay for political reasons.

Panel 2: Role of the International Donor Community

The afternoon panel examined the international donor community's role in mobilizing new financial resources for global health and considered the strategic focus of different organizations.

Robert Filipp, responsible for innovative financing at the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) gave an overview of the private sector's different forms of engagement with Global Health Partnerships:

(a) Philanthropy has reached an important level in global health financing. While US Foreign Aid in 2006 amounted to US$ 23.5 billion, funds from all philanthropic sources reached US$ 34.8 billion, of which US$ 13.2 billion (in 2007) were committed to international affairs.

(b) In-kind donations continue to play an important role; the GFATM welcomes them in the form of services but not products.

(c) Cause-related sales and marketing offer an interesting strategy, with firms advertising products with a commitment to donate a certain percentage of a product's price to a philanthropic cause, e.g., RED products donating a percentage to GFATM (linking the colour with the idea of help against HIV/Aids; participating companies include Starbucks, Microsoft, Apple, and American Express).

(d) Other innovative mechanisms include UNITAID as a voluntary supplement on airplane tickets, where the funds generated are used to improve access to HIV/Aids antiretroviral drugs, or to support the International Finance Facility for Immunization (IFFim).

(e) Changing market behavior, for instance, through the systematic use of a GHP's marketing power to obtain concessions from private corporations.

David Evans, Director of Health System Financing of WHO, discussed the role of GHI in health system financing in lower-income countries. Many poor countries (37) still raise more than half of all their health funding from out of pocket payments; in the other 51 countries, this figure is between 30 percent and 50 percent. In general, the non-government sector in many low and middle-income countries accounts for more than 50 percent of all health spending. Here, the contribution from international non-state sources is important. However, it is an open question which sources should or will provide a percentage of the major health system scale up in poor countries so clearly needed. In addition, one should bear in mind that vertical programmes will continue to need financial resources to combat both infectious and

non-communicable diseases. In conclusion, Evans stressed the importance of the Paris and Accra principles in improving efficiency by gradually reducing the multiple channels of cooperation with their costly administrative and monitoring mechanisms.

Simon Koppers of the German Federal Ministry for Economic Cooperation and Development discussed the role of GHI and other non-state actors from the perspective of a public development cooperation agency. He summarized the advantages and drawbacks of public health initiatives, the Paris Declaration and the Accra Agenda, the "Global Campaign for the Health Millennium Development Goals" and outlined the successful use of a Sector Wide Approach model to health in Tanzania.

Marshall Burke, the Senior Vice President of External Affairs of the Global Alliance for TB Drug Development, especially focused his discussion of the role of product development partnerships for so-called "neglected diseases". In the case of tuberculosis, in spite of an important incidence of drug resistance, no new drugs have been developed in over forty years and no vaccines in eighty. Burke summarized the TB Alliance's experience in organizing research on new drugs against tuberculosis and referred to the cooperation with the Stop TB Partnerships' Retooling taskforce seeking to facilitate introduction of new diagnostics, drugs and vaccines in high burden countries. He stressed that the Paris Declaration's required alignment with developing country priorities is imperative and relates basically to adoption-related concerns and end-user priorities for drug design. In order to ensure the affordability of a new regimen for patients in poor countries, the TB Alliance considers the cost of goods, ease of synthesis and mode of administration when selecting and advancing specific compounds within their portfolio of TB drug candidates. The TB Alliance also works to establish channels of communication between researches and local communities to improve local knowledge of TB disease, treatment and research.

Andrew Harmer (Health Policy Unit of the London School of Hygiene and Tropical Medicine), the chair of this panel, opened the discussion by citing the Realist School argument in International Relations that cooperation between nation states is difficult because they still primarily pursue their "national interests". What is the source for the optimism that health cooperation can be effective?

The discussion turned to the relationship between the private and the public sector in securing resources for global health – a point dominating the entire second part of the meeting. Robert Filipp pointed out that, in

fact, the private sector demands clear rules on public sector cooperation and harmonization, as is evident from the climate change discourse and negotiations. The "health sector is not so bad compared with other sectors". An independent evaluation of the Global Fund called for simplifying country-level grant management and greater cooperation with GAVI. Wolfgang Bichmann stressed that the main aim of development cooperation in health is to achieve universal coverage of health services. In this context, the collaboration with leading private actors is extremely important for the private sector. David Evans noted in response that achieving universal coverage would require massively scaling up health service capacities. In this context, where scaling up the private sector might mean taking resources away from the public sector (in particular health workers), there are certain constraints on capacity. However, this might also be the case to a certain degree with financial resources (e.g. tax deduction for philanthropic activities).

Panel 3: Future Trends for Private Sector Participation in Global Health and the Role of Global Health Partnerships

Guy Ellena, the Director of the Health and Education Department, International Finance Corporation (IFC), introduced the final panel by again stressing the broadly accepted position that the poorest countries cannot locally generate sufficient resources to build up an adequate health sector. Internationally, however, not only can the private sector mobilize know-how, but it can also generate additional financial resources. Governments have to provide the right framework for making use of existing resources.

Elisabeth Sandor, Senior Policy Advisor at the Organization for Economic Cooperation and Development (OECD), started with data on the "increasing amounts of money" that are mobilized „by and with the private sector": The Institute for Health Metrics and Evaluation (IHME) estimates that the share of private sources in total health development assistance grew from 19 percent in 1998 to 26.7 percent in 2007; the global disbursements of the Bill and Melinda Gates Foundation for health alone reached US$ 1.25 billion. Sandor also referred to the new donor approaches already described by Robert Filipp – advanced market commitments, the International Finance Facility for Immunization (IFFim) and the ProductRED logo.

On the other hand, to obtain better results in particular, greater synergies can be achieved from a "broad country-level policy dialogue on development". Since the Accra Third High Level Forum on Aid Effectiveness in

2008, the participation of civil society organizations has been institutionalized through the *Working Party on Aid Effectiveness*. In general, Elisabeth Sandor is quite optimistic about the influence of private sector participation in the global health agenda. She underlined that some questions on accountability remain since the for-profit private sector and foundations "report primarily and entirely to their Boards and not to international organizations and processes" which therefore increases the complexity of the global aid architecture. However, she expressed her belief that the current OECD DAC endeavors to "improve synergies across all forms of aid" offer a positive outlook on increasing the overall effectiveness of health aid. The OECD and the World Bank (the leading organizations of the aid effectiveness process) have recognized the paradigmatic character of "health" as a problem of "aid effectiveness". They have therefore denominated health as a "tracer sector" to be used as a "litmus test for broader aid effectiveness efforts" (WHO 2008) and jointly created a "Task Team on Health as a Tracer Sector" (TT HATS).

Marie-Odile Waty, Head of the Health Department of the Agence Francaise de Développement (AFD) also noted the increasing importance of the private sector in French health aid. In focusing on the private health sector in developing countries, her presentation complemented the focus of other contributions on GHPs. The importance of the private health sector has grown considerably over the last twenty years. In low income countries, the private sector shows a higher degree of customer orientation and, in many instances, a higher quality of care, although it is heavily fragmented, often associated with high out-of-pocket payments and an overemphasis on curative care. As public funds will not be sufficient for the investments in health needed to reach the MDGs, further private sector engagement is needed. Such engagement should be supported by GHIs, private foundations and multilateral organizations. More private sector engagement has to be complemented by improving the institutional and regulatory framework and adjusting demand and supply to improve the access of the poor to private services (pre-payment, vouchers/ increase affordability and availability of services through subsidization and support of rural clinics).

Siegfried Throm, Director of Research, Development, Innovation, German Association of Research-Based Pharmaceutical Companies (VfA), referred to a paper jointly edited by VfA and the churches, requesting a solution to a number of issues concerning GHPs: (1) The need to promote more product development partnerships with (2) a sus-

tained funding of product pipelines developed by PPPs; (3) better coordination of health-related issues (e.g. by a parliamentary subcommittee for international health policies); (4) more support for health staff development in developing countries and (5) support for research development in developing countries (e.g. non-profit companies for drug development in low-income countries).

Hubertus Graf von Plettenberg, First Vice President Manufactering Industry/ Services of the Deutsche Investitions- und Entwicklungsgesellschaft (DEG), pointed out that the health industries have generated strategies to deal with health situations in developing countries. The DEG is financing a private Indian hospital chain for low- and lower middle income patients. This produces an additional provision of healthcare. As regards quality and management, the private sector could be used as a benchmark for the public sector. It should be involved in training nurses and doctors and, hence, would help to protect the system as a whole from the negative effects of brain drain. While services in public hospitals are officially free in many countries, "under the counter payments" may often reach levels that exceed treatment costs in private hospitals.

Max Lawson, Health Policy Advisor of Oxfam, presented a critical position from one of the most important civ-

il society organizations in the health field, criticizing the "myths about private health care in poor countries" as "blind optimism". The substantial proportion of private care in total health care in many poor countries is basically a consequence of state failure; this does not so much represent twenty years of public sector failure as twenty years of public sector dis-investment with some private sector investment. The proportion of the private sector delivering health care does not say anything about fulfilling the right to health. According to IFC, although the private sector provides 82 percent of outpatient care in India, 50 percent of women actually have no medical assistance whatsoever during childbirth. 73 percent of private health-care providers in Malawi are just shops which sell some medicines, while 15 percent are traditional healers. Upgrading public capacity is more effective than private sector investments. In countries where 40-100 percent of the poorest quintile of the population receives skilled birth attendance, 65 percent of births are attended by public providers and only 4 percent by private providers. Thus, the scaling-up of health services needed should be achieved through a return to the public sector.

Bernd Appelt, Priority Area Manager for Health and Social Protection, Department of Planning and Development, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, Eschborn added that public sector capacity/quality is important in harnessing private sector capacity to strengthen the health system. Public sector capacity plays a crucial role in the success in negotiating services, prices, quality.

In the final round of discussion, some points were made on the character of the new private financial contributions. Jeffrey Tudor, Policy Manager for Innovative Financing at the British Department for International Development (DfID) discussed the problem of the additionality of private health financing (whether it might just act as a substitute for lower funding from public sources or for other social policy purposes) and pointed out that much depends on future cash flows (e.g. in commercial funds directed to health matters).

Most of these final contributions largely concentrated on the issue of public vs. private sector in health care. The debate here focused on the quality of care. While in Guy Ellena's view, there is no general conclusion to the issue, since the quality of care essentially depends on the quality of services, Max Lawson stressed that health care quality and efficiency have to be seen in relation to equity, and here the public sector has an advantage. It was also noted that comparison between public and private providers requires a

clear definition of different typologies of providers: most modern private care in poor countries is directed towards the upper income-groups, whereas the private health shops and healers serving the poor are also characterized by very low quality. Guy Ellena underlined the need to take a more differentiated look at the situation, suggesting that – in the context of a government-led health programme – it may not be so important whether a hospital is run by a private or public operator or not; however, where it might be difficult to find private resources, it is crucially important to spend public money on educating more health personnel.

Quality is closely related to the sector's appropriate regulation which is generally accepted as the task of the state. Regulation, however, should not discriminate between public and private services. Wolfgang Bichmann insisted that public services are not necessarily "pro-poor" – and may even show a "pro-rich" bias. Scott Featherstone stressed another aspect of effective regulation: there should be neither under- nor overregulation.

Conclusion

It is certainly not surprising that the discussion on the respective roles of the public and private sector was the most controversial point at this expert meeting on improving health in poor countries. The funding, access, expertise and capacity issues discussed in this meeting not only indicated important fields for partnerships, but also pointed to an existing need for taking fundamental decisions on the character of health systems a decision which has to be taken by national governments/societies.

The IHP+ model, introduced into the discussion by David Evans, insists (in accordance with the Paris Declaration) on the public responsibility for health. National governments should have a main steering role, while external help should be aligned with national strategies. Accountability has to be accepted by both sides. The interaction between the private sector in poor countries and trans-national private actors was addressed by some speakers, but it was felt that this could be the topic for a separate conference.

In his closing remarks, Hubertus Graf von Plettenberg – as representative of the KfW group – referred to the importance of the state's stewardship role, while accepting "the general responsibility to get the sector organized" and improving the respective capacities. This was a point accepted by all the participants at the meeting.

With the focus on the Millennium Development Goals over the recent years, health systems and, in particular, primary health care have again been continuously strengthened, a de-

velopment noted in the meeting several times. Nevertheless, even though the balance between vertical and horizontal activities might have changed, since many issues in health remain related to specific diseases, cooperation in the field of vertical activities remains essential. Disease-related activities include diagnosis, identification of pathogens, research, drug development and distribution of medicines, the means of treatment, and access to medical service infrastructure. Many kinds of actors are necessarily involved in these activities and GHPs are a logical form of cooperation.

On the other hand, another aspect of the private sector, and one that is extremely important should not be forgotten: the civil society's role in voicing complaints and giving a voice to excluded people through advocacy for adaptation. It remains important to take a differentiated look at the different types of non-state actors in global health, especially since they are acting in different roles and fulfilling different functions.

What was missing and what has to be further explored in future?

While there were some remarks about the lack of discussion on the role of health insurance, another important field of debate only played an implicit role, i.e. the question of a possible lack of legitimacy and accountability. Basically, the discussion was output-oriented, considering the contribution of GHP to solving problems and, consequently, towards solving problems of coordination. If state stewardship was generally accepted, the conditions for the effectiveness of such a stewardship should have been discussed in more depth, which would have included strategies to strengthen the public sector.

In a nutshell, the following three messages on the role of private sector participation in health may be drawn from the experts' discussions:

First
The conference provided a good insight into the work of the private sector in health related to low and middle income countries. Previous private sector involvement was basically assessed positively. Including the private sector is extremely helpful in responding to the needs and challenges in these inter-related themes.

Second
There is a widespread agreement that the increased participation of private actors in global health has mobilized additional resources and contributed to the solution of many specific problems, but the effectiveness of the global health sector could be significantly increased by an improvement of coordination. Country ownership should go beyond "government ownership" and

should be based on concepts agreed among public and the private actors. Correspondingly, the private sector should be included earlier and more intensively in considerations at the international level for enhanced alignment: and harmonization who provides which services, and who makes which contributions. The stakeholders could then network better in an earlier phrase to avoid frictional losses.

Third
In the future, private sector involvement in partnerships should go beyond the traditional involvement in offering health services and participation in product development and access-oriented partnerships. It should focus more on integrating the wider-ranging issues in the fields of health financing, insurance systems and the education of more health personnel.

Opening

Wolfgang Bichmann
Head Sector and Policy Division
Health, Education, Social Protection,
KfW Entwicklungsbank, Frankfurt

The Potential of the Private Sector for Primary Health Care Strategies

Thirty years after the World Health Organisation's (WHO) declaration on *Primary Health Care*, it is reasonable to ask what changes there have been for the world's population in the global health context. People today are healthier, wealthier and live longer than they did then. Over the last three decades, the health indicators in developing countries have significantly improved. However, a more detailed analysis shows that large numbers of those living in sub-Saharan Africa are not part of this success story and in 2005 their prospects of living to 45 years old were as low as in England in 1840.

Primary Health Care in the 21st century

The WHO's World Health Report 2008 entitled "Primary Health Care – now more than ever" details strategies for health system reform [1]. The Primary Health Care (PHC) movement of the late 20th century highlighted the right to better health as well as the values of social justice, participation and solidarity. Today, health system reforms have to allow for global social change and the concrete expectations of people in a complex health market with many different actors and services. Consequently, the WHO sees a need for health system reforms in the following four areas:

1. Improving access to health care through suitable social health protection systems *(coverage reforms)*;
2. Reorganizing service provision around people's needs and expectations *(service delivery reforms)*;
3. Integrating public health actions, primary care and public policies to promote health across all sectors *(public policy reforms)*;
4. Improving accountability, transparency and communication *(leadership reforms)*

Health care provision in developing countries

In the 1960s and 1970s, many developing countries focused at extending the curative care sector and neglected already existing approaches of preventive services. They also rarely spent more than 15 percent of the health budget for primary care. In the 1980s, given the lack of economic development, rapidly growing populations, and high mortality rates from malnutrition and infection – especially for young children – , many governments found it increasingly difficult to keep their promise of providing free universal health care coverage. The percentage of the state budget spent on health care steadily declined while may countries saw the rapid spread of the HIV/Aids pandemic in the 1990s. Particularly in Africa, the lack of enabling economic conditions and, fre-

quently, clear development orientation – often combined with civil wars – led increasing numbers of qualified health care professionals to emigrate to countries with stronger economies.

Whereas health financing largely depended on state budgets and donor funds, attempts to introduce patient fees to generate decentralised sources of funding on the local authority level did not live up to expectations. UNICEF, for example, had supported the *Bamako Initiative* which called for patient fees on essential drugs. The fees were intended to be put towards the purchasing of further medicines and the payment of ongoing health care costs. Indeed, in many cases, the funds did ensure the operation of health care facilities. Nonetheless, such approaches failed to provide a solution to the general health system funding problem and, in many cases, led to a significant decrease of people using the health services [2]. There is also not enaugh evidence that decentralized public administration enhanced state service accountability towards its clients [3].

Health Care Development in poorer countries

Over the last ten years, the debate on health care development in low-income countries has been influenced by the millennium development policy agenda and the concrete measures to achieve the internationally agreed Millennium Development Goals (MDGs). Box 1 lists the key stages in this development.

Box 1: Key stages in the health system development debate

- WHO: "Primary Health Care". Declaration of Alma Ata, 1978
- World Bank: World Development Report "Investing in Health", 1993
- UN Millennium Declaration and Millennium Development Goals (MDGs), 2000
- WHO: Commission on Macroeconomics and Health Report, 2001
- The Global Fund to fight Aids, Malaria and Tuberculosis, 2002
- WHO / OECD: "Reference Paper and Guidelines on Poverty and Health", 2003
- UNDP: UN Millennium Project, "Investing in Development", 2005
- OECD: "Paris Declaration on Aid Effectiveness", 2005
- OECD / WHO / WB: Accra Report "Effective Aid – Better Health", 2008
- WHO: "Report on Social Determinants of Health", 2008
- WHO: "Primary Health Care – Now more than ever", World Health Report 2008

Health is a fundamental human right and the basis for individual well-being. It contributes to higher labour productivity and economic growth, household and per capita income, and prosperity growth. In developing countries, the incidence of infectious diseases, maternal mortality and malnutrition closely correlates with household income. Basic social service provision and adequate social security systems play a special role in combating poverty. Efficiently and effectively designed health care has a considerably impact on achieving the MDGs and the goals of a pro-poor health policy in developing countries [4]. The concrete design and financing of national health systems will vary. Health science and politics have the task of preparing and securing the "*stewardship*" needed – a task which goes far beyond the classical definition of *public health* and has more recently been termed "*health governance*".

Private health care service providers in developing countries

Health systems and their funding create a framework for organizing cooperation between many health care actors in curative and preventive health care. Today, a mixed health system is the most common. This brings together state or private financing – e.g. from budgetary funds and health insurance contributions – with the utilization of services rendered by state or private providers. However, in developing countries, private health care providers are an extremely heterogeneous group. In addition to highly-qualified medical "for profit" providers in urban environments, there are numerous non-profit private or civil society organizations offering health care in rural areas. In many instances, the latter are considerably better suited to provide services efficiently and quickly, and to align them with the needs of the target groups. In the informal sector, private services – paramedical personnel, traditional healers and medicine sellers – have always played a significant role alongside state health care facilities. They offer near-blanket services at affordable prices and, as a result, are widely used, especially by the poor sections of the population. However, the quality of their services is frequently criticized and questioned [5].

Today, as studies show, in sub-Saharan Africa service provision is split equally between public and private providers whereas the main patient services in southern Asia and Latin America are primarily offered by private providers. They serve the rural population and they are not only used by the wealthier people living there. For example, fifty percent of private sector clients in Ghana came from the poor sections of the population, while in Rajasthan this figure was 80 percent. In eight African countries, the poorest quintile of the population primarily used private health care services when a child fell ill. In contrast, the wealthiest twenty percent of the population used the state funded and subsidized health care services twice as much as the poorest twenty percent. These findings are now well

validated by benefit-incidence analyses showing that publicly funded health spending in developing countries has a definite *"pro-rich bias"* [6]. According to the latest research, sixty percent of all health spending in sub-Saharan Africa is financed privately, i.e., largely from household income *("out of pocket")*. Here, private insurance only plays a minor role and pays for less than ten percent of health spending. However, the state social health insurances hardly contribute to health costs and primarily only reach state employees. The IFC report "The Business of Health in Africa" predicts an annual growth of 7.1 percent in health spending in Africa until 2015 – from US$ 16.7 billion (2005) to 35 billion (2016) – whereby the state health budget will only grow by an average of 4.3 percent a year [7].

Nowadays, even in those countries where health care provision is largely organized by public institutions there is a notable trend to greater private sector participation in providing the population with health care. For this reason, today's health ministries and authorities are increasingly taking on controlling and regulating functions, as well as quality assurance tasks [8]. Even with greater private sector participation, under its overall responsibility *(stewardship)*, the state also retains the regulatory duty for the health care systems, supervises health care policy and retains responsibility for the general funding of

the system. In this process, appropriate incentive systems can not only enhance the integration of private service suppliers into service provision but into investment as well.

Innovative approaches to private sector involvement in developing countries

Over the last years, despite the difficult conditions, a range of promising approaches have been developed to integrate private sector providers into health care in developing countries. Box 2 lists key links on the current information platforms in this area.

Box 2: Resources on private sector involvement and health in developing countries

- PSP-one/USAID: Private Sector Health Projects Database
  www.psp-one.com/section/project/
- UCSF/Global Health Group: Private Health Care in Developing Countries.
  www.ps4h.org/about.html/
- Rockefeller Foundation/Results for Development/IHPP Thailand: The Role of the Private Sector in Health Systems.
  www.ps4h.org/about.html/
- HLSP Institute: Private Sector Participation in Health.
  www.hlspinstitute.org/projects/?mode= type&id=15043
- AED: Center for Private Sector Health Initiatives.
  https://pshi.aed.org/

The basic health care service for many people could be improved by closer cooperation between public and private facilities and innovative funding models. Two approaches that have been successful in practice are presented here as examples.

1. Social marketing/social franchising

Social marketing organizations can be entrusted with the professional marketing of simple-to-use, subsidised high-quality health products (e.g. condoms, mosquito nets) which can be sold via a wholesaler and retailer network. Such an approach relieves the public health sector of a set of tasks. The social marketing model has become well-known. This model can be further expanded by allowing clearly defined services – for example, in reproductive health or combating TB – to be professionally marketed under the brand name of a *social franchise* network. Franchisees (e.g. doctors, private clinics) offer the products at a set quality and price and use the network's brand name as a quality seal. They receive free specialised further training and advice. Public funds may be allocated to the franchiser who takes on the key tasks of awarding contracts to private suppliers and quality assurance [9]. For example, over 12000 doctors are presently working in Pakistan in the Green Star franchise network, offering 30 percent of all family planning services in the country – primarily for poor sections of the population. Although the doctors receive no financial incentives, they benefit from their use of the professionally marketed Green Star logo. They also receive free professional further training, can use a telephone hotline, and have monthly inspections.

2. Demand side financing/output based aid

The performance-based funding of measures (OBA) has proven to be an approach with particular potential for success. Instead of financing the building and equipping of health care facilities (inputs) without control over their use, the services (outputs) delivered here by public or private providers are financed by *vouchers* [10] or *contracting* [11].

The voucher system entitles members of a certain target group to use health care services at subsidized prices. Accreditation provides a basis for awarding performance contracts to suitably qualified service providers and the service provider is paid on the basis of the number of vouchers used. A voucher scheme allows the services supplied to be defined precisely in advance (service package). At the same time, voucher schemes offer a means of stimulating demand since access for the poor is improved [12] by only granting subsidies to specific groups to use the services provided [13]. Therefore, in countries without a nation-wide social health insurance system as yet, voucher schemes are excellently suited to encourage the use of those health care services ranked as central to the public interest.

Comparative private sector advantages

Contracting private service providers and leveraging the private sector's comparative advantages over the public sector is not limited to direct health care services for patients [14]. In developing countries, too, the private sector increasingly offers social services together with infrastructure services. Here, private capital is essential in those developing countries with a more advanced economy. There exists also some evidence that, precisely in developing countries, private companies work more efficiently than state-owned enterprises. However, in social infrastructure and in rural areas, private sector solutions are slow to be realized without a kick-start. In this process, the public and private sector roles are complementary and the state sets the regulatory framework for private transactions. Growing numbers of developing countries have aligned their laws to take account of the new situation, creating a basis for integrating a private sector previously primarily focused on providing services in

urban areas. Frequently, public sector reforms provide a starting point for integrating private sector solutions, and a broad spectrum of solutions is already available to realize private sector participation. Box 3 lists four types of private sector involvement which are easily put into practice [15].

Box 3: Approaches to private sector involvement in the health care sector

- Commercialization: Health care services embedded within ministries are converted into enterprises with their own legal entities and aligned with management for profit.
- Management Contract: The responsibility for the entire hospital services are transferred for a limited period to a private partner with performance-related payment, or particular activities are *outsourced* to private companies. The payment depends on the private partner fulfilling contractually defined performance indicators.
- Leasing Contract: The private partner pays a fixed leasing fee for taking over a business‘ entire economic risk. The public sector remains responsible for expansion investment – but not for servicing and maintenance.
- Long-term concession rights: Private investors participate in a previously purely public sector enterprise, using their own funds to finance necessary investments. The guidelines on service standards and the scale of charges are contractually agreed.

The possibility of graduated private sector involvement is increasingly common especially in Asia and Latin America. Since in many developing countries corruption and free-rider effects are also nothing out of the ordinary in the health sector, there is a need for a functioning regulatory system on fair and transparent controls on price structures, quality, and environmental and consumer protection. Only in this way can misuse be prevented and the gains in efficiency and quality from involving private sector providers actually be passed on to the target groups.

Conclusion in practice

Innovative solutions to expand universal health care to the poor and disadvantaged rural sections of the population in developing countries necessarily have to include the private sector. Consequently, the regulatory tasks can be extremely complex. They can, for example, be organised through contracts with fixed conditions for local non-governmental organizations to supply certain areas (contracting), voucher schemes, establishing franchise networks or by introducing suitable social security systems for cases of illness. New and innovative approaches to funding are required for such projects [16; 17]. For this reason, given the global financial and economic crisis, when extending national health care systems today international cooperation is called on to particularly ensure the support of pro-poor system solutions promoting state and private involvement.

Literature

1. WHO (2008) Primary Health Care. Now more than ever. The World Health Report 2008. Geneva: WHO.
2. McPake B, Hanson K, Mills A (1993) Community Financing of Health Care in Africa: an Evaluation of the Bamako Initiative. Social Science and Medicine 36: 1383-1395.
3. Oakley P & Kahssay H (eds) (1999) Community involvement in health development: a review of the concept and practice. Geneva: WHO.
4. Castro-Leal F, Dayton J, Demery L & Mehra K (2000) Public spending on health care in Africa: do the poor benefit? Bulletin of the World Health Organization 78: 66-74.
5. Mills A, Brugha R, Hanson K, McPake B (2002) What can be done about the private health sector in low-income countries? WHO Bulletin 80:325-330.
6. Preker A, Langenbrunner J (eds) (2005) Spending wisely. Buying health services for the poor. Washington: World Bank.
7. IFC (2008) The Business of Health in Africa. Washington: International Finance Corporation.
8. World Bank (2004) Making Services Work for Poor People. World Development Report 2004: Washington: The World Bank.
9. Montagu D (2002) Franchising of health services in low-income countries. Health Policy and Planning 17: 121-30.
10. World Bank (2005) A Guide to Competitive Vouchers in Health. Washington: World Bank.
11. Brooks P & Smith S (2001) Contracting for Public Services. Washington: World Bank.
12. Sandiford P, Gorter A & Salvetti M (2002) Vouchers for Health: Using Voucher Schemes for Output-Based Aid. Public Policy for Private Sector No. 243. Washington: World Bank.
13. KfW (2007) Voucher schemes as a financing option in the health sector - the experience of German Financial Cooperation. Frankfurt: KfW Entwicklungsbank.
14. Preker A & Harding A (2002) Private Participation in Health Services. Washington: World Bank.
15. Marek T, Yamamoto C, Ruster J (2003) Private Health. Policy and Regulatory Options for Private Participation. World Bank Public Policy Note No. 263.
16. De Ferranti D et al (2007) Innovative Financing for Global Health: Tools for Analyzing the Options. Global Health Financing Initiative Working Paper 2. Washington: Brookings Institution.
17. HLTF (2009) http://www.internationalhealthpartnership.net/taskforce.html

Keynote[1]

The Present Role, Challenges and Future Trends for Private Sector Partnerships in Global Health

David de Ferranti
President, Results for Development Institute and Senior Fellow Brookings Institution, Washington, D.C.

I would like to provide some facts and figures about health, particularly private sector activities, in developing countries in a way that is helpful for the discussion as a whole. I will do that using material that comes from many sources. I want to start by acknowledging contributions from David Evans and others of his colleagues at the World Health Organization (WHO), Scott Featherstone and others of his colleagues at the International Finance Coperation (IFC), and many others – along with my colleagues at the Results for Development Institute. What I would like to do, is to deliver information about the current situation and future trends on health and the private sector in developing countries, issues and challenges like the impact of the recent economic, financial earthquake, the inevitable "economic transformation of health", the emerging "third great transition" in health, the re-discovery of health systems strengthening and the values-driven debate on "Which is better – public or private?" with reflections also on providing health services vs. financing health services, government's role as a "steward" of mixed-health systems as well as on vertical strategies vs. horizontal strategies. I will end on some questions for today's discussions, the current situation and future trends.

1 The keynote is based on a PowerPoint presentation delivered at the experts' meeting.

I am going to focus on the private sector and developing countries. I am going to use a broad definition, covering basically everything that is not in the public sector. In addition to the formal sector – for-profit hospitals, private clinicians – I am going to include the informal sector: pharmacy shops, street sellers, village health workers, traditional health healers. I think it is important in our discussions to recognize this diversity and the many different issues that come up by this existence.

How big is this private sector in developing countries?

The data is not perfect, but some of it gives us an insight. In this particular example, what we are seeing is evidence on where women go for deliveries, taken from Demographic Health Survey (DHS) data. The top part is the public share going to public facilities, and the bottom part is the informal and the formal private share.

Slide 1 The private sector is large and important, see page 52

According to this data on this particular indicator (across the bottom and the horizontal) in many different countries of sub-Saharan Africa and South East Asia, the private sector is quite large.

There is also data available on outpatient visits for coughs symptoms and similar infections. Let me share with you the data on outpatient visits for Diarrhea.

Slide 2 Another example: Outpatient Visits for Diarrhea, see page 52

Let me now focus on spending. What share of the total money spent on health in developing countries is coming through public channels as opposed to private from households directly to providers or through intermediaries such as social protection schemes? Here again, the data is showing that a very substantial proportion of total spending is through private channels. Of course, it does vary across countries.

In some African countries, such as Ethiopia, the private sector is very high – only 6 percent makes the public sector – whereas in others, like Tanzania, the public sector makes 47 percent. Another window on this question of "how big is the private sector in developing countries?", is to ask the question: "If you take a particular geography and you list and map providers, and some are public and some are not, what do you get?" Have a look on the situation in Madhya Pradesh in India. All those blue dots on

Slide 3 Private Providers Far outnumber Public Providers, see page 53

the map are the private providers. You will realize a few red dots, but you can hardly see them; those are the public providers. From a number of different windows, it is not surprizing but interestingly a subject still of great debate: the private sector is large; some would say huge.

Our data is not perfect. I would like to demand better one in order to get a better fix on the size and the composition of the private sector. But still it proves – and therefore is useful for our discussion – that the private sector is not tiny at all. It would be good to have more information, different kind of data that goes much more to the country level, for instance about the mix within a particular country.

As a platform on which the discussion of this conference can be built and to go on to other tops, I have selected a few as I think relevant issues and challenges. I have also included some other topics that seem to me to be quite important, thinking forward for the next ten, twenty, even fifty years. The first one is about the impact of the recent economic, financial troubles or as I call it here „earthquake". What we have been discussing is: this earthquake is bad. It is going to have difficult impacts, especially for poorer countries. If the OECD countries get a cold, then the developing world gets pneumonia. There will be deep and lasting impacts.

Beyond this insight there occur further questions. Some are saying, "There is a recovery happening faster than predicted. What will that mean?" Maybe that discussion is more pronounced in the US than it is here. At the same time, very different sets of questions are saying: "The earthquake was one thing, but actually there is a deeper set of changes that will be the real problem for global health in the years ahead." People, including leadership in development institutions, are asking: "Will aid decline?" "Will aid recover to where it was, or will there be further changes as competing other priorities such as climate change, or as meeting domestic, financial, fiscal obligations, including the large debt level that now have been incurred?" "Will aid, not again, reach the high tide that is had reached?" "Will it recover?" To the extent that aid has an uncertain prospect for covering all of the needs going forward: "Will private investment, foreign direct investment fill that gap?" "Will it take a long time to find its way again into particularly lower-income, middle-income countries, because of caution as a result of this earthquake?" "Will the poorest fall further behind?" At the same time, it is discussed that sometimes crisis can be a window of opportunity to advance reform that cannot find its way forward during normal times and to achieve progress that is not possible, except in moments of great stress –within developing countries and within development in institutions. I just listed some of the questions that we hear coming up. We could talk further about it. But, with interest in timing, I am going to move on. Nevertheless, these are very real questions that we should ponder on.

Please let me step back a minute and remind ourselves that there has been a great deal of progress in health, particularly in the last decade, but there is much more progress still to be made.

Slide 4 Much more progress is still needed, see page 53

In this chart you can see that nearly 10 million children die every year, mostly from preventable diseases, largely in Africa and South Asia.

Slide 5 Global Health Spending, see page 54

Have a look at this slide. The global burden disease on the left side, maternal mortality and morbidity, is huge – 90 percent – in low- and middle-income countries, while most of the resources are accumulated in the high-income countries. It is the 90 to 10, 1 to 90 ratio, which is familiar to you.

Slide 6 Aid for Health, see page 54

Aid by its various sources has grown as we can see here. Interestingly, the major source of growth has been the direct bi-lateral aid. The little green sliver is the emergence of GAVI and the Global Fund.

My question is, what does the next page of this look like in the future? We need to keep in mind that all of this aid put together is a tiny sliver of the total money being spent on health since domestic spending, even within the poorest countries, but is still very substantial. We have – as a global community – many initiatives. What happens if you add them all up: all the Aids referring tuberculosis, malaria, and the other priorities that great attention is given to? It is not unlikely that meeting all the requirements that all of these initiatives have put forward would require an extra billion dollars a year or more – some would even say much more. Is that a large or small number? It is small compared to a few things shown there; it is large compared to others, in particular total development aid. In order to achieve that 50 billion or more, aid for health would have to significantly increase.

Slide 7 An additional 50 US$+ billion per year, see page 55

Bottom line: meeting all of the priorities that are before us. If you add on top of that the effects of the financial, economic earthquake, it is too big a problem to be solved by aid and philanthropy alone. We have to be cleverer; we have to use existing funds better. We need not only more money for health, we also need to get more health from the money that is being spent.

Moving on to this next topic, the data show us fairly compellingly that total

health spending is strongly correlated with the growth of an economy, with its gross domestic product (GDP).

Slide 8 Countries total health spending, see page 54

This has been documented from many different data sets, including bringing in recent data from developing countries. It is a very strong correlation. It has been looked at from a number of different angles. In this picture, what we are seeing is, in long terms, total health spending (on the vertical scale) and GDP (on the horizontal scale) per capita. That little blue box is just a piece at the bottom, but it is very strong with an income less than 1.1, meaning that as GDP increases 1 percent, spending on health increases by slightly more than that 1.1 percent. There is a long debate and discussion around this, which we will not have time to get into now.

Slide 9 The Economic Transformation of Health, see page 56

It seems that, when income will rise further, this would also be good news for health, since spending on health is likely to rise with income. But the crucial question is: ”Will that additional spending on health be well spent or not?” The evidence is showing us that the spending happens, but if it is not well managed, it will happen in ways that are wasteful. There is a lot more to say about that, about that look ahead for the next 50 years. What is likely to happen to economies and GDP? In spite of the earthquake, and after the recovery from the earthquake, we are likely to see, again, very substantial growth. That offers an opportunity for health.

Slide 10 Health Spending in China, see page 56

Here is some data on China. The data only goes to 2004, which means that it does not include what has happened in the past years of very significant increase, particularly on the government side in China. There are many countries we could go through in order to answer the question: ”Where will growth happen?”

Slide 11 Africa's economies may grow faster than other regions? See page 57

Growth rises and falls, as this chart underscores. Note that according to these estimates, they come from the World Bank and the International Monetary Fund (IMF), the growth in sub-Sahara Africa, particularly after the recovery from the earthquake, is likely to be strong. This also offers us some hope about what will happen to health spending.

Let us go on to what I call „the third great transition in health“. The first transition was the demographic one. Beginning in Scandinavia, nearly 200 hours ago, worldwide, first, mortality rates, and then fertility rates fell. The second one was the epidemic logical transition, when infectious, particularly childhood diseases, were effectively brought under control in many countries. This transition is not yet finished in all countries, but it is proceeding. So, what is the third great transition? The hypothesis here is that the third great transition is a shift from old-style health financing[2], which still exists in the poorer countries and did exist in the rich a hundred or more years ago, to sharing that 100 percent. This is, of course, not new. One of our opening speakers referred to social health protection. And we are guests of a country that cares a lot, and has, in fact, led the way on social health protection.

Slide 12 Health in low-income counties, see page 57

I am raising here the sort of broader formulation of a shift from essentially dependence on out-of-pocket pay at a very high burden to the small percent who are sick to the universal coverage, which has big potential benefits for health, equity, and for making it affordable to pay for health care. If you depend for health care on the 5 percent, it is a lot more difficult than if everyone chips in. This is the situation today: the low-income countries on the right side are heavily dependent on out-of-pocket, private-pooled, various kinds of community or social health protection, very limited, and government’s share. The richer the country – as you move to the high-income countries – the lower is the dependence on private out-of-pocket payments. There is one country among the rich countries that is particularly behind all the others in making this transition: the United States of America. We are working on it, so do not give up; we will get there!

But it is sad and ironic that the countries that most need this approach of solidarity and shared protection, I mean the low-income countries, are those that least have it. That is the unfinished business before us. I hope we will inform the discussion today. That is the third-great transition, which I think is the great challenge of the first half of the 21st century.

Slide 13 The cost of treating sickness, see page 58

This slide here reminds us that the cost of treating sickness is a huge shock. After losing your job, the next thing that can drive you under, as a poor household, is getting sick.

Slide 14 Transitioning to Universal Coverage, see page 58

The transition to universal coverage or social health protection is not a simple one. There is much debate about that, but this chart, and I thank WHO for this chart, is reminding us that from no financial protection on the bottom, there are various intermediate stages, which many countries are in now, before reaching universal coverage.

Slide 15 Achieving Universal Coverage Takes Time, see page 59

Here are three countries that stand out: Thailand, Columbia and the Philip-

2 Old-style health financing is, when the burden or the cost of ill health and its care is born by the sick.

pines, and how they have raised coverage. They do get there. It takes about ten years. Thailand had a great run up towards the end. It is not an overnight affair. The sooner we get started, the better. This is, by the way, a major theme for the current, very intense debate in the US about health care reform; it is going to take ten years to get it straight. So, start today! Do not wait until ten years from now.

My next issue “health system strengthening” is very much being rediscussed, and it is very relevant for the issues that will be discussed today.

Slide 16 Has global health under-invested in health systems? See page 59

The case is sometimes made that global health has perhaps been under-investing, recently in health systems, particularly after the very large emphasis in the last decade or so on the vertical disease control programmes. This is a fairly busy chart, sorry about that. Just over on the left, the grey is the vertical, and the red box in the blue is a definition of how much is being spent on health strengthening. These numbers are debatable, but the issue before is this question: Has global health under-invested in health systems? Is now a time to pay more attention to that?
What are we talking about just by health systems? Just a reminder, since often in the context of discussing public health systems, in particularly lower-income countries, we tend to focus on just the vertical part here and forget the sides.

Slide 17 A Country's Health System includes, see page 60

Namely, there is the government, its providers and users, but – as it is well known in this country and other higher-income or middle-income countries – the roles and interconnections between payers, purchasers, providers, and suppliers are fairly complex. That is why it takes ten years to get this stuff right. We need to think of the health system as encompassing all of this, and think of the government’s role as overseeing all of this and not just managing its own publicly-run health facilities.

Slide 18 Health Systems Typically Have Multiple Goals, see page 60

Multiple goals, for example ultimate goals or outcome goals such as health status, financial risk protection, patient satisfaction, and a number of intermediate goals such as access, quality, equity and efficiency, to get there. Neglecting health systems can result in a number of problems of quality, access, and affordability. These will be familiar to you – I will not pause on them. Particularly, if health markets are not well-managed, if there are not a set of rules that ensure quality and a fair playing field, there will be a number of negative outcomes.

Slide 19 Good Health at Low Cost: Performance Matters, see page 61

It does make a difference how one uses one's money. Here we have got income level on the horizontal and childhood mortality on the vertical. There is a relationship: poorer countries, as we know, have less to spend and have worse outcomes as a result. But look at the variation between Rwanda and Kenya in terms of where they stand with roughly similar income levels. It does, again, matter how much health we are getting for the money as well as how much money we get for health.

Slide 20 What can governments to do become better stewards of mixed health systems, see page 61

What are the tools that governments have mixed, meaning public and private health systems, with government key role as steward of the health systems? These are familiar; these are not tools to apply in countries that are not familiar with them. To take the regulatory tools to begin with, surveys show that many countries, as one would expect, experience very significant difficulties in actually getting good regulations in place and enforcing them.

Our discussion at this experts' meeting about the role of the private sector should definitely keep in the forefront an important part of the discussion about public and private, which I call here the values-driven debate about „which is better: public or private?" We all have views on this question.

There are many who think that there is evidence to support their feeling that a system that is predominantly or entirely public is the right goal to aim for. There are others who feel differently and feel that a more private-based system is better. It is very important in these debates to distinguish between provision and financing. One sees around the world many systems where public financing is predominant, and mixed public and private provision rests along side that. Some people have tried to answer this question of which is better by empirical analysis. An economist, Jacques van der Gaag, has recently done some analysis and could not find that either is better. So, that will be a continuing debate.

There is also the pragmatic view, which is the following: The private sector is there. It is large; it is not going away. It has an important role to play; government has an important role to play as steward of the whole health system. There are potential contributions, and there are potential concerns that can arise. How to maximize those contributions, minimize the concerns? How to get most of the health for the money, including health from private money and health from private activity – that activity, inevitability going to be a major factor for a very long time?

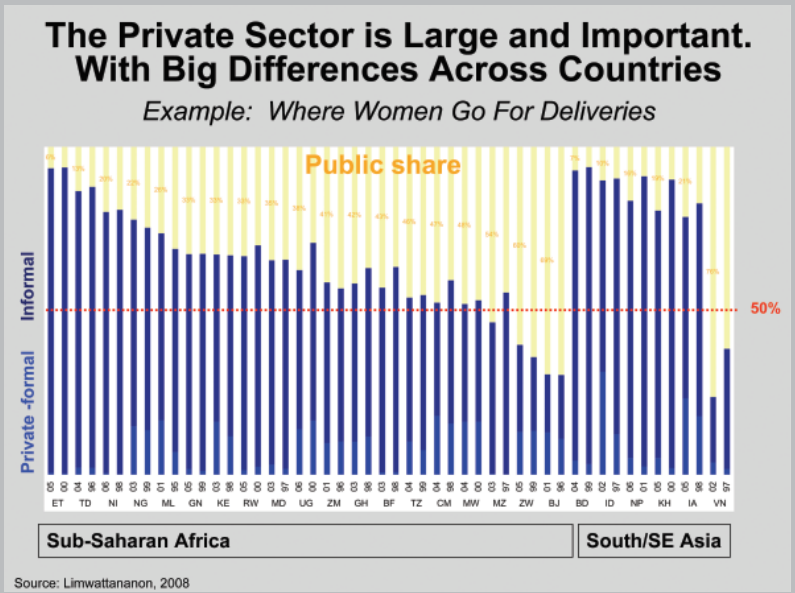
I am going to close with a few thoughts, or at least posing some of the questions. As I read the material for the conference and thought about, again, not trying to

presage what will follow, but provide a platform for thought, one can take everything I have just said as well as what is in that material and say:

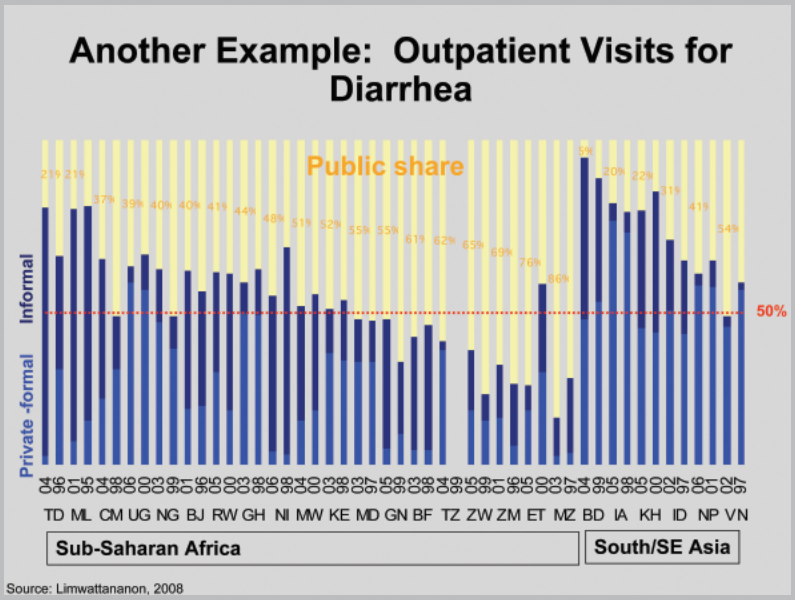
What are the implications for a number of things?
What is the future trajectory of these things?
What are the strengths and weaknesses of them?

Take the global health architecture. It is hugely complex. Those who work in many sectors have said that the health sector has the most complicated set of different of initiatives of any sector. We have the new institutions on the scene: the Global Fund and GAVI. We have a large number of country-focused health initiatives, including the International Health Partnership (IHP) and the Providing for Health (P4H). We have many innovative financing initiatives that are both product research and development stimulators, for example, the Advanced Market Commitment (AMC). We have other special purpose vehicles such as the International Financial Facility for Immunization (IFFiM) and the Solidarity Tax. We have many disease-focused Public-Private Partnerships.

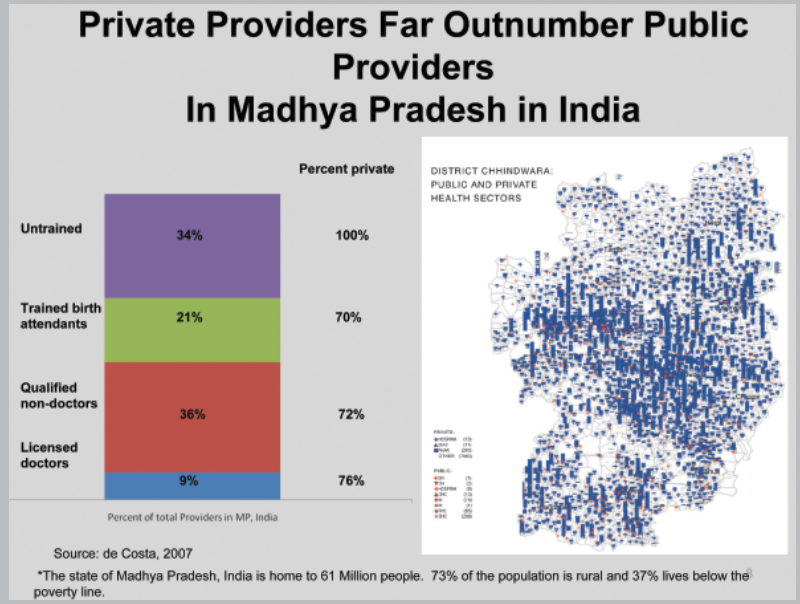
Finally, since Partnerships are going to be a theme at this meeting, these questions will be important. I have a lot of thoughts, and I am sure other people have thoughts on them. Other questions: How else can and should the private sector contribute to meeting global health needs in service delivery and in supplying input – through local enterprises? Or: What is the role of charity, for profit activity, and the combination of the two – double-bottom-line ventures?" Is there still more that these partnerships can do? How else can aid be improved? How will these very large financing needs be met?



Slide 1 The private sector is large and important

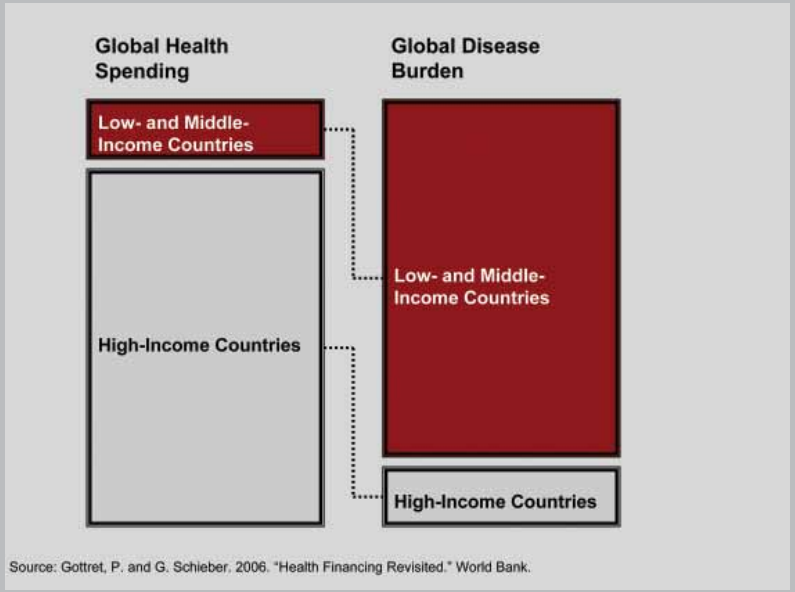


Slide 2 Another example: Outpatient Visits for Diarrhoea

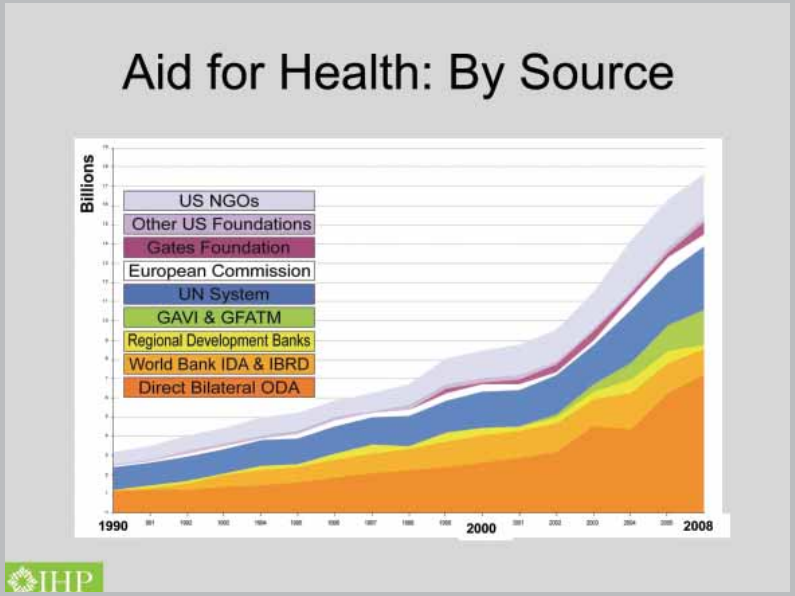


Slide 3 Private Providers Far outnumber Public Providers

Slide 4 Much more progress is still needed

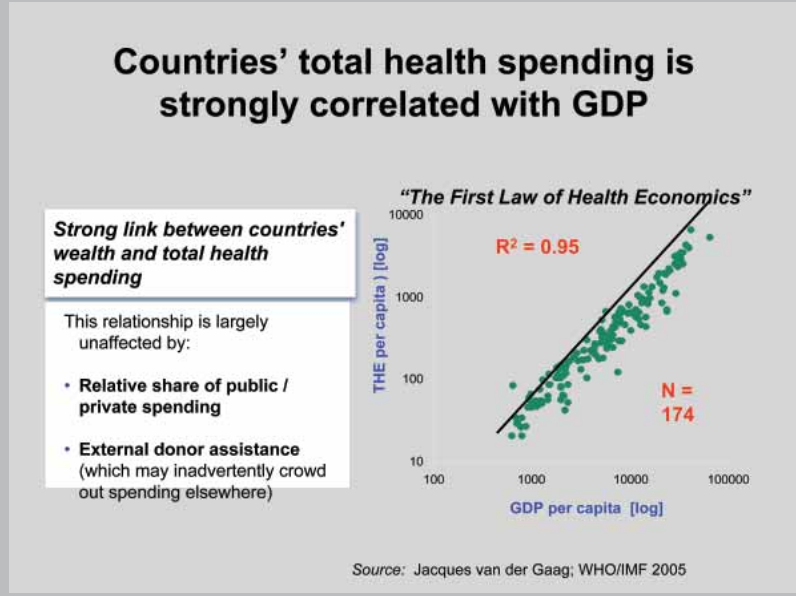


Slide 5 Global Health Spending

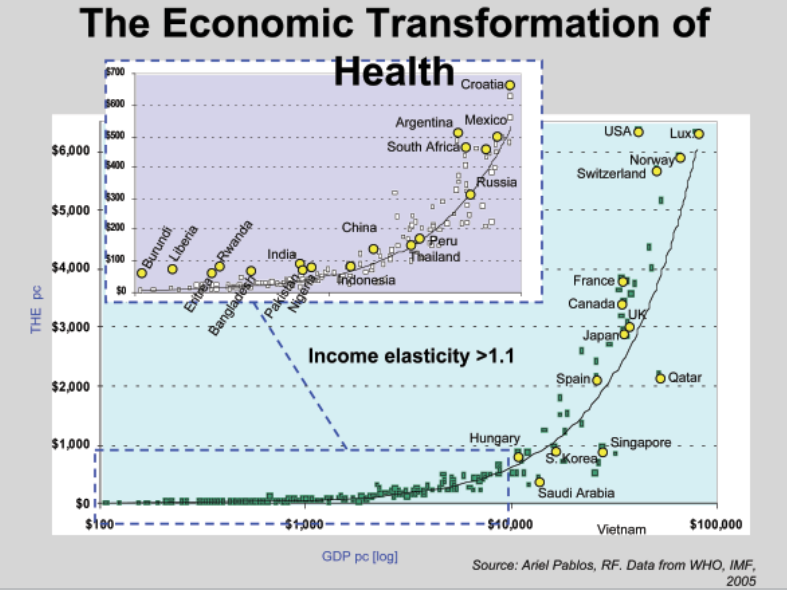


Slide 6 Aid for Health

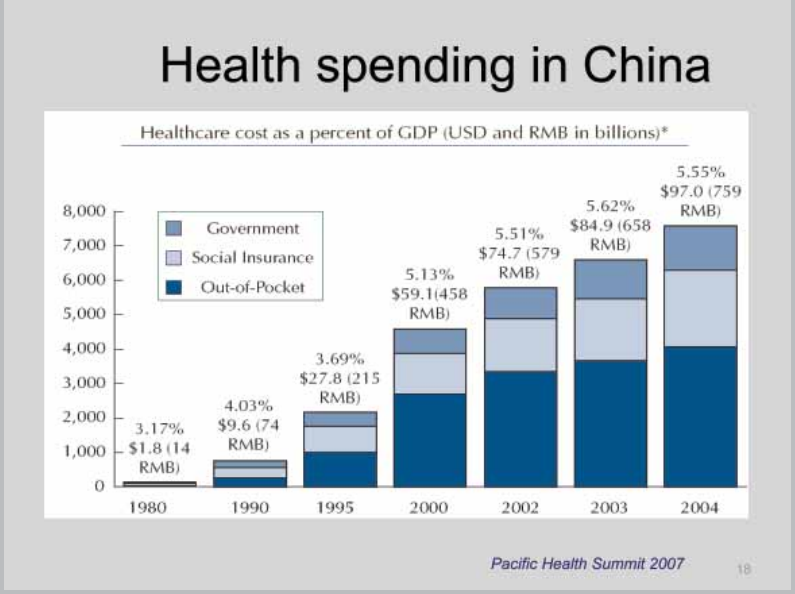
Slide 7 An additional 50 US$+ billion



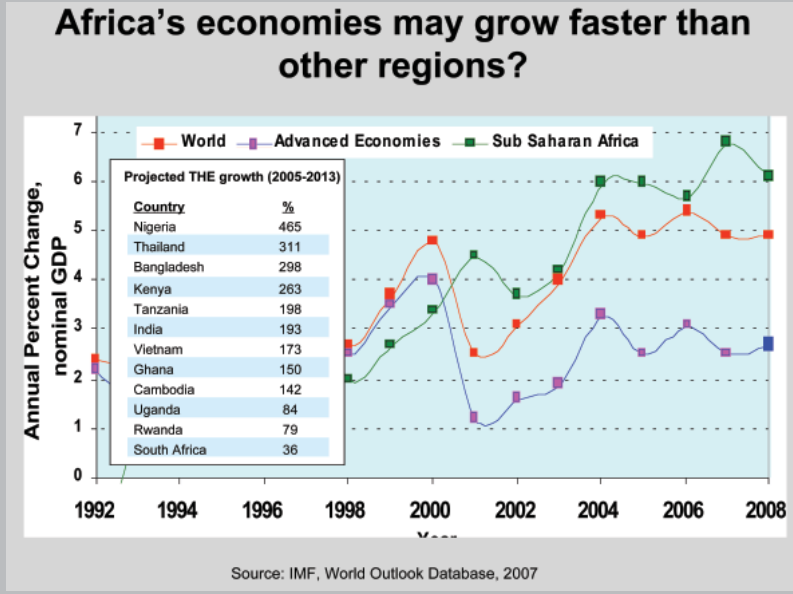
Slide 8 Countries total health spending



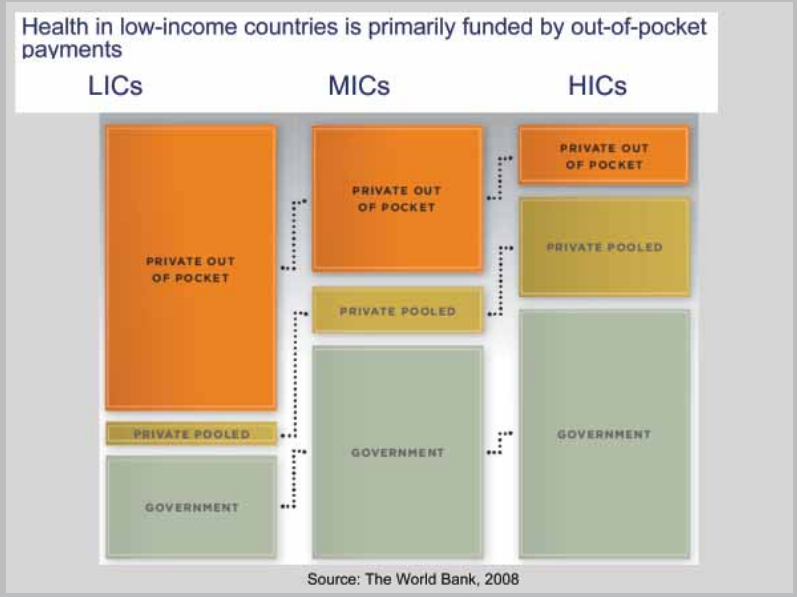
Slide 9 The Economic Transformation of Health



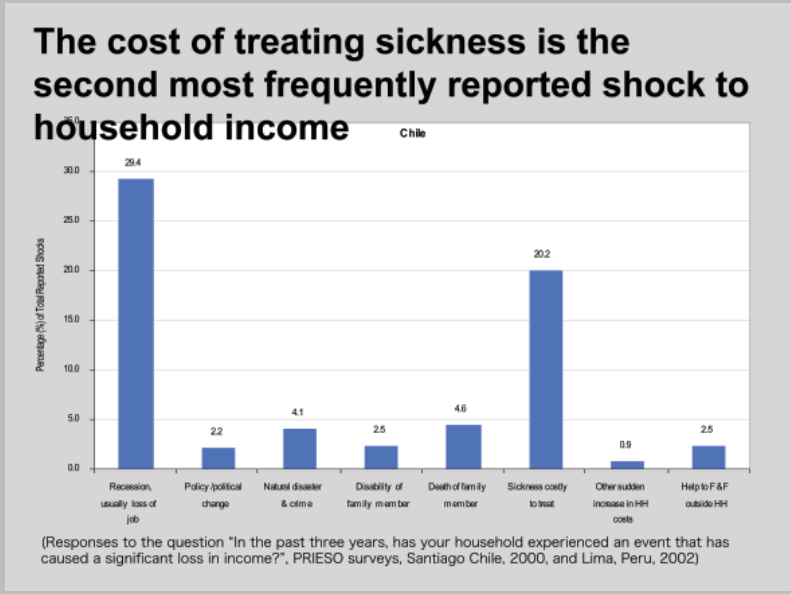
Slide 10 Health Spending in China



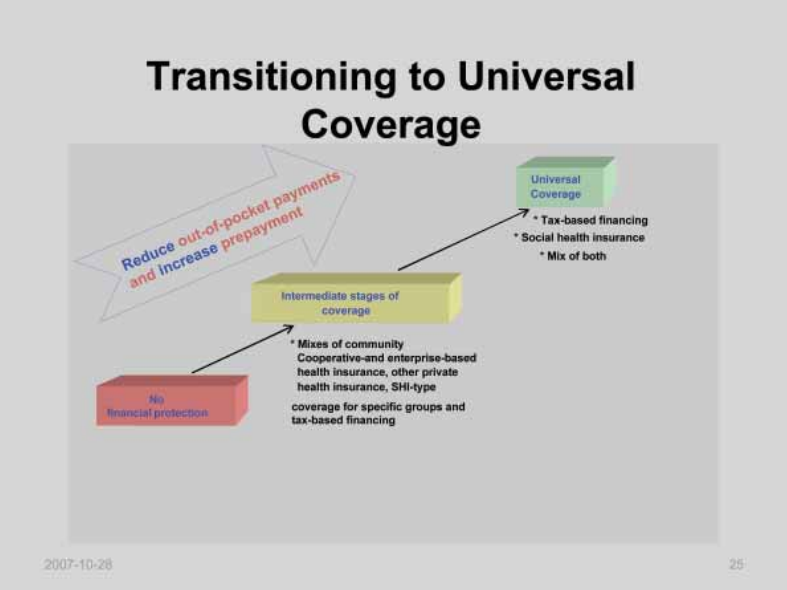
Slide 11 Africa's economies may grow faster ...



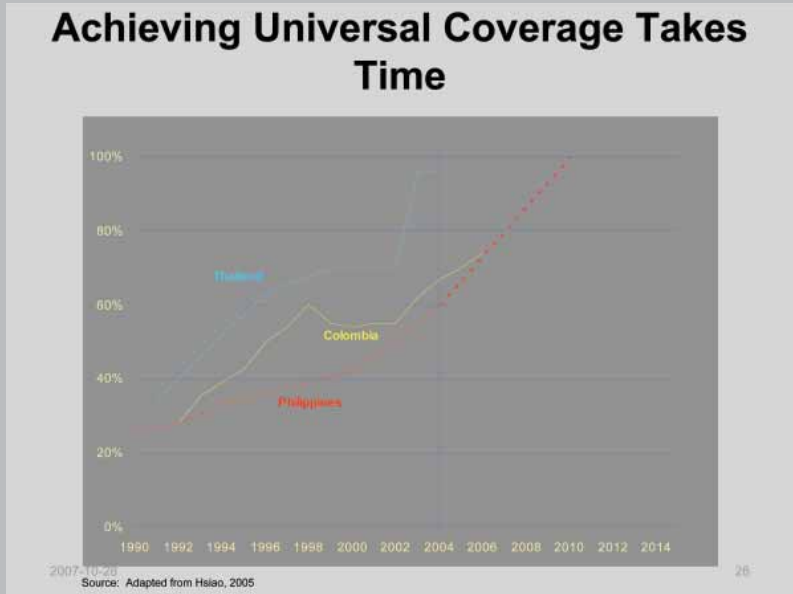
Slide 12 Health in low-income counties



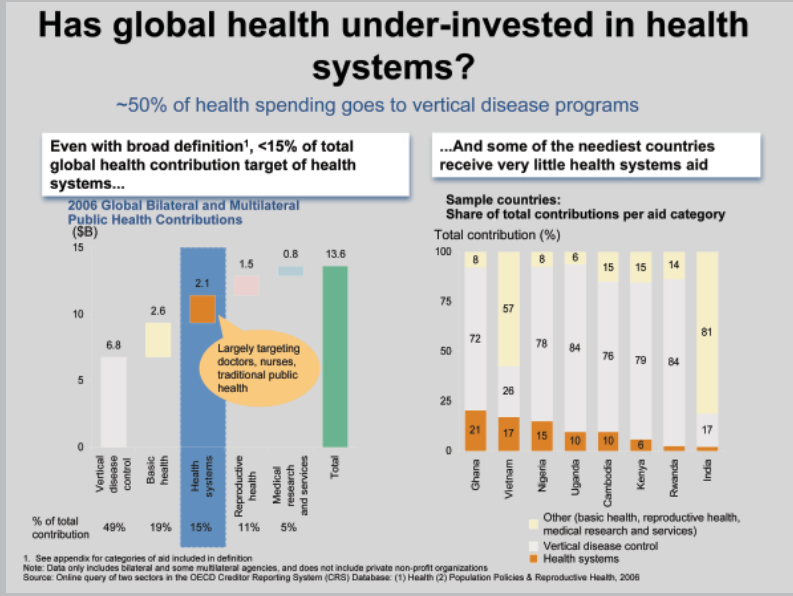
Slide 13 The cost of treating sickness



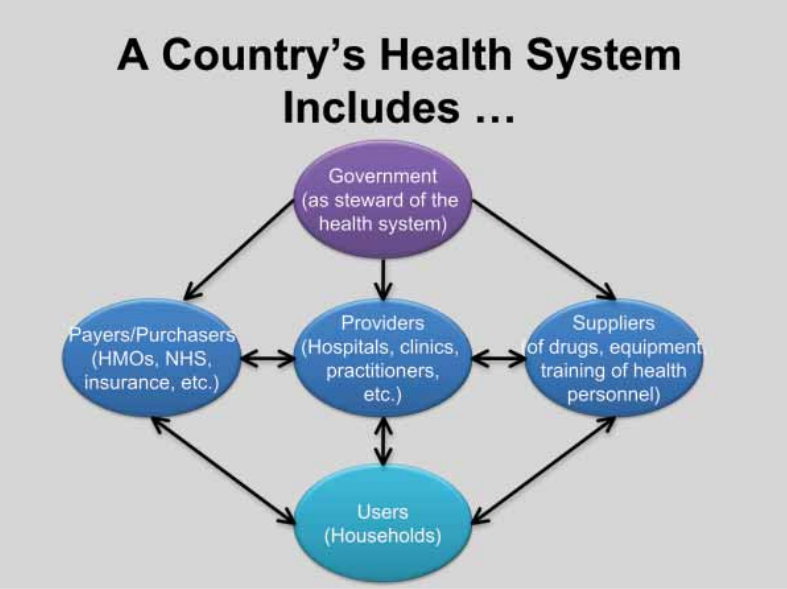
Slide 14 Transitioning to Universal Coverage



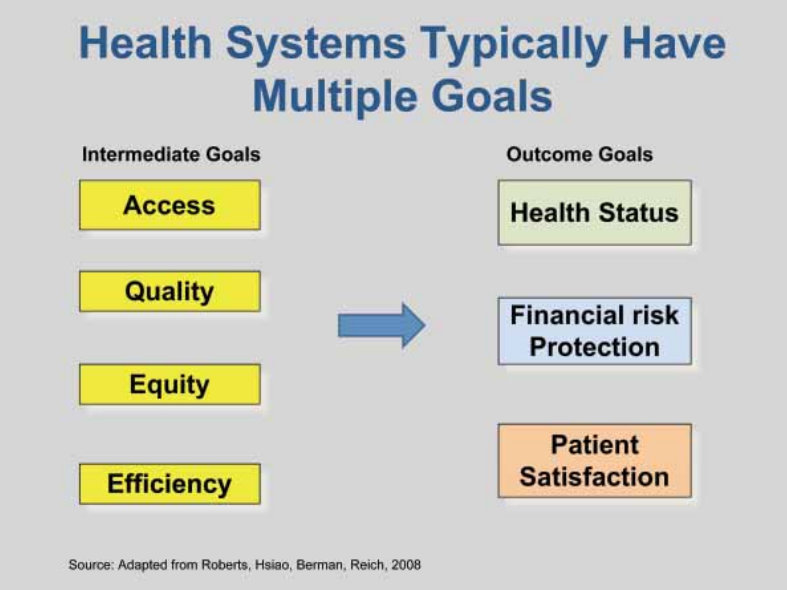
Slide 15 Achieving Universal Coverage Takes Time



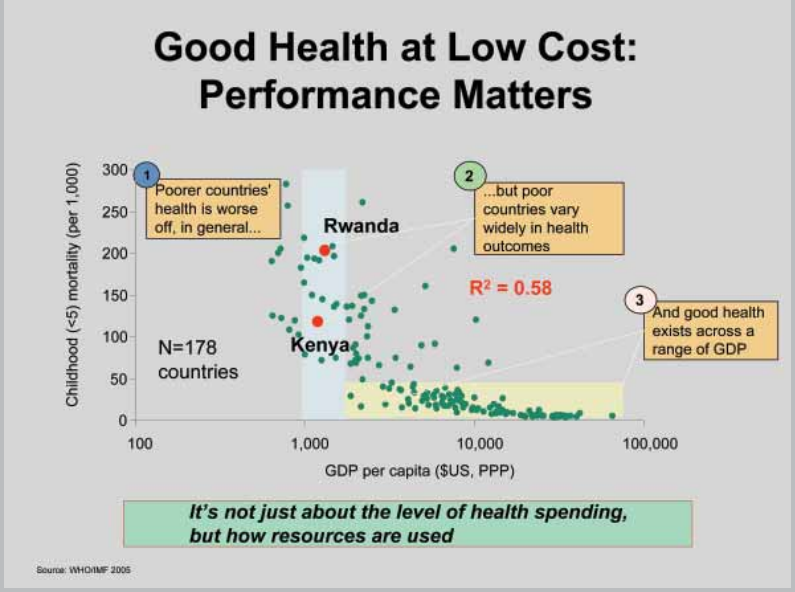
Slide 16 Has global health under-invested in health systems?



Slide 17 A Country's Health System includes



Slide 18 Health Systems Typically Have Multiple Goals



Slide 19 Good Health at Low Cost: Performance Matters

Slide 20 What can governments to do become better stewards of mixed health systems

Success story

Uwe Schmidt
Director, International Trade and Development, Federation of German Industries (BDI), Berlin

BDI Initiative: Healthcare Infrastructure in Developing Countries and Emerging Markets

It is an initiative of the Federation of German Industries (BDI), with the kind support of the KfW Entwicklungsbank and the Federal Ministry for Economic Cooperation and Development (BMZ).

Initial situation

The need for healthcare infrastructure is growing worldwide – particularly in developing countries and emerging markets. According to a recent study by the International Finance Corporation (IFC), spending a total investment of around 30 billion US dollars will be needed by 2016 for sub-Saharan Africa alone. In many countries a growing middle class is demanding substantially improved hospitals and healthcare services. Also an improved general health situation of the poor is needed. Three of the eight Millennium Development Goals are directly related to healthcare and cannot be achieved without expanding the healthcare infrastructure in developing countries and emerging markets. This all depends on efficiently run hospitals which, apart from providing direct care to patients, act as reference clinics (or reference laboratories) for subordinated primary healthcare facilities and provide training for a whole range of medical and pharmaceutical occupations. Hospitals also act as major drivers for setting up and developing healthcare financing systems (vouchers, insurance policies etc.).

German industry has a vast expertise in all of the above areas: consultancies, construction companies, suppliers of medical equipment, hospital operators, the pharmaceuticals industry and private healthcare insurers - all provide first-class services and products. From planning and equipping, to facility operation and the training of medical personnel, German industry can provide tailored solutions for hospitals and other healthcare facilities in a “one-stop-shop”.

No support from policy-makers is necessary when hospitals in more advanced economies are planned, constructed, equipped and operated. Commercial banks provide the necessary capital while healthcare insurance systems ensure that patients can afford the treatment. The hospitals’ operating costs are covered and the banks ensure that the investment is amortized over a foreseeable period of time.

The situation is somewhat different in developing countries and emerging markets. Privately-run hospitals in urban centers are only profitable when they focus their services on the middle class. However, treatment for a significant proportion of poorer patients, as well as healthcare in rural areas, requires the backing of governmental institutions. Besides helping to secure an enabling environment for private investment, it is particularly important to establish a health financing system which guarantees long-term coverage of operating costs.

Apart from combating HIV/Aids, tuberculosis and malaria in the multilateral context, the main thrust of German development cooperation focuses on the

primary health sector. As mentioned above, there are good reasons to reemphasize the provision of quality-assured healthcare by strengthening hospitals in development cooperation.

The initiative

With its initiative "Healthcare infrastructure in developing countries and emerging markets" the BDI is pursuing two main goals:

A) To make an active contribution to improve healthcare infrastructure and provide healthcare as part of sustainable development for developing countries and emerging markets;

B) Market access for German enterprises with competence and expertise in the planning, construction, equipping and operation of hospitals and related activities in the healthcare sector.

The BDI is working to achieve close cooperation between the various segments of German industry and German Federal Government[1].

German enterprises operating in various segments along the value-added chain within the healthcare sector (consultancies, hospital operators, suppliers of medical equipment), together with private healthcare insurers and banks, have excellent know-how and extensive expertise in this area. However, cooperation between the various players could be enhanced. The initiative creates a cross-segmental cooperation platform for the German healthcare industry and also functions as a contact point for international queries regarding the whole gamut of healthcare infrastructure solutions and health facility management systems.

In cooperation with the Federal Government, the initiative is working closely with development policy-makers, while seeking to play a supportive role in trade promotion and delivering healthcare services to emerging markets. The political aspect has gained in substance as a result of the Coalition Agreement of the Federal Government in 2005, closely interlinking foreign trade and development policy. The BDI is convinced that this will benefit both sides: Without the backing of development cooperation, German industry active could only provide healthcare services for the elite in developing countries and emerging markets. However, with appropriate support from development cooperation, German industry can plan, construct, equip and operate hospitals that provide healthcare services also to poor and disadvantaged people. Such facilities can also serve as reference and training centers, even as research units, for the national healthcare system.

The project aims to provide a basis for enterprises and development policy-makers to identify common ground and to apply this knowledge through practical cooperation – initially within the framework of pilot projects ("German Hospitals") in developing countries and emerging markets yet to be selected. Depending on the experience gathered through the pilot projects, more institutionalized development models may follow over the medium and long term.

1 The government ministries involved are the Federal Ministry for Economic Cooperation and Development (BMZ), the Federal Ministry of Health (BMG), the Federal Ministry of Economics and Technology (BMWi), the Federal Foreign Office (AA) and the Federal Ministry of Education and Research (BMBF).

Project components

The initiative aims to achieve its main objectives (market access and improved healthcare services in developing counties and emerging economies) through the following methods:

1. Analysis

Cooperating closely with the Federal Government and development organizations involves extensive analytic activity which the initiative provides in the following areas in particular:

- Analysis of potentials arising from cooperation between different segments of German healthcare industry and institutionalized development cooperation in the hospital sector with regard to common priorities and interests (market access and the alleviation of poverty / sustained development), in particular evaluating the role of the hospital as a driver for quality management, training, financing of healthcare services, as well as its reference and supervisory function towards subordinated healthcare facilities;
- Analysis of the success or failure of phased-out German hospital projects in developing countries and emerging markets;
- Analysis of how other donors are approaching the issue;
- Analysis of the extent to which existing instruments and procedures of development cooperation, foreign trade promotion, healthcare and research policy are suitable support agents for cross-national cooperation for the German healthcare industry;

And expanding on these areas

- Developing potentially successful cooperation models for the hospital sector between the German private sector and German, European and multilateral development agencies, at the same time taking account of additional opportunities to cooperate with the German Federal Government's other areas of policy;
- Formulating concrete proposals for developing the Federal Government's (support) instruments.

This analytic phase will be finalized soon.

2. Developing a "German Hospital" pilot project

In close cooperation with the German business sector, the Federal Government and development cooperation institutions, the initiative is developing

a “German Hospital” pilot scheme that can be set up and operated in developing countries and emerging markets on a sustainable basis.

The pilot scheme must take the partner country’s interests, German development cooperation and domestic enterprises into equal account. The pilot project’s structure will be defined by the BMZ in accordance with the Federal Government’s existing instruments, as well as the criteria and procedures of development financing, enabling it to be implemented within a reasonable time-scale. Specific recommendations will be drawn up with regard to location, the stakeholders involved and the functional areas of the hospital, financing and risk management.

3. Creating a national contact point for requests from abroad

The worldwide demand for products and services in healthcare has changed significantly over the last few years. Today, emphazis is on comprehensive system solutions rather than individual medical technology products. Hospitals are the facilities where such system solutions in concentrated form are particularly in demand. This means that hospitals have evolved into focal points for system-oriented healthcare services.

One aspect of the initiative is therefore to set up a national contact point to handle international requests for complex German hospital solutions in a comprehensive and swift manner. Through the contact point, which acts as an intermediary between the German healthcare industry and interested international partners, information can be disseminated and contacts arranged, together with accompanying advisory services and political backing to ensure efficient and smooth transactions. As part of the joint effort to provide better healthcare services to developing countries and emerging markets, the envisaged contact point will pay particular attention to this group of countries. Nevertheless, the contact point might also deal with requests from countries which do not fall under the umbrella of German development cooperation. The geographical coverage as well as the range of services of the national contact point will be determined in the course of an approx. two year pilot phase, starting in October/November 2009.

4. Information and cooperation platform; marketing

The initiative pools and disseminates information about

- international hospital projects of potential interest to German enterprises planned by institutions in the relevant country as well as by German, European or multilateral organizations;
- areas of competence and specific interests of German enterprises prepared to invest internationally and involved in the hospital sector.

In this respect, the initiative serves as a focal point for German businesses and the Federal Government as well as for development institutions, foreign agencies and authorities interested in German know-how and German hospital technology. As such, the initiative also advances the marketing of German technologies and management know-how in the hospital sector.

Instead of competing against, the initiative aims to work closely with existing structures such as information-gathering facilities involved in promoting international trade or existing corporate joint ventures in specific industries.

Members of the German Hospital Partnership (Summer 2009)

Success story

Mapoko Mbelenge Ilondo
Senior Advisor for Global Diabetes
Novo Nordisk, Denmark

The extent of the health crisis facing the developing countries is such that no institution can solve the problem alone. New approaches are needed that include partnerships between the private sector, governments, non-governmental organizations (NGOs) and international aid and development agencies. Stakeholders increasingly expect pharmaceutical companies to play a greater role in solving the health crisis facing developing nations. The World Partner Project (WPP) is part of Novo Nordisk's efforts to address diabetes healthcare in developing countries.

The WPP has collaborated on diabetes healthcare projects in 31 countries and developed models for organization of diabetes care, education and training of doctors, raising of diabetes awareness, patient education which can be used to improve the standard of healthcare for chronic disease care in low-middle income countries.

Changing diabetes care in partnership: Tanzania, a model for healthcare in developing countries

Tanzania has had the highest level of activity and diversity of any of the countries in the Novo Nordisk World Partner Project (WPP). Not only has diabetes care improved in the country, but there may be a spill-over effect into other countries. Delegates from several African countries (including Eritrea, Kenya, the Seychelles, Uganda and Zambia) have visited Tanzania to learn from their experiences. Further requests have been received from various countries in Africa and Latin America. The lessons learned are already being used as a model for similar projects in other countries.

Introduction

It is estimated that there are approximately 400.000 people living with diabetes in Tanzania[1]. The majority of these people have to, more or less, fend for themselves, as the government is struggling to overcome the double burden of economic debt and the prevalent infectious diseases such as HIV/Aids, malaria and tuberculosis.

Strengthening the Tanzania Diabetes Association (TDA)

The WPP financed employees to work in administration and PR/awareness as well as provided office equipment. This helped the TDA expand their activities to cover regions outside the capital, Dar es Salaam.

Establishing diabetes clinics

Prior to the WPP, few diabetes care services were available to people with diabetes in Tanzania. Hence, the WPP focused on the establishment of a diabetes clinics, starting with Muhimbili National Hospital in Dar es Salaam. A few weeks after the inauguration, the clinic was

overwhelmed by people with diabetes. In order to ease the workload for doctors and nurses, it was decided to open additional diabetes clinics in three district hospitals in Dar es Salaam, thus covering most of the city with its four million inhabitants.

Although the diabetes clinics were established in collaboration with the TDA, they all operate within existing government hospitals and the Ministry of Health has pledged to integrate the activities into the national healthcare system.

The clinics are equipped with medical and laboratory equipment, allowing proper follow-up of diabetes, which will hopefully enable early detection of diabetes complications and thus improve the quality of care.

Education and training of healthcare professionals

Guidelines for diagnozis and treatment of diabetes have been adapted from regional guidelines developed by IDF Africa with a grant from the World Diabetes Foundation. Educational programmes for doctors, clinical officers and nurses have been developed and several training courses have been organized.

Conclusion

The TDA was only just beginning to take flight in 2003 after a period of dormancy. Further support for the TDA was critical when the TDA was to persuade the Tanzanian Ministry of Health to put diabetes onto the national health agenda. Today the TDA is very active, and over 100.000 people living with diabetes now have access to affordable diabetes care in Tanzania[2]. Further more, the TDA has also won funding from outside of the WPP, and enlisted the support of other organizations to strengthen their work. The set-up in Tanzania can easily be reproduced in other countries with similar conditions because it is affordable and sustainable.

1 IDF Atlas, 3rd edition, 2006
2 Tanzania Diabetes Association, 2007

Success story

Klaus Brill
Vice President Corperate Commercial Relations, Bayer Schering Pharma AG, Berlin

"The Millennium Development Goals, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women's rights, and greater investment in education and health, including reproductive health and family planning," Kofi Annan.

Did you know that...

- more than 200 million women would use contraceptives if they were able to;
- 123 million women have inadequate access to family planning methods;
- each year, 80 million juveniles and women become unintentionally pregnant, whereby abortions are carried out on 46 million women, of which 20 million are conducted under unsafe conditions;
- Each year, around 600,000 women die following birth complications.

Although contraceptives have become more widely available worldwide, the need for contraceptives has still not been met. The commitment to family planning and health must also be reflected in the readiness to provide funding in national budgets, enabling reproductive health to become firmly established as an issue along with HIV/Aids, tuberculosis, malaria.

For Bayer Schering Pharma, contraception and family planning are a major issue. Thanks to our expertise in women's health, we have a long regarded the support of family planning in more than 130 developing countries as a fixed plank in our involvement in social issues and public private partnerships. As the market leader for hormonal contraceptives, we consider our particular responsibility to be involved here, and we have been actively supporting family planning programmes for nearly 50 years.

We want to use our knowledge and skills to help find sustainable solutions for these health care tasks.

During the course of longstanding commitment, we have actively participated in various programmes and are endeavoring to develop new methods to enable women in developing countries to achieve improved access to contraceptives.

1. Social marketing

Bayer Schering Pharma has already been involved in the 'Social Marketing for Change' project, called SOMARC for short, since the 1980s. This project was developed by the USAID and is organized as follows: companies working within the project are prepared to offer a specific product in a selected developing country to a considerably reduced price. This therefore enables women on low incomes to afford the product. In return, the organization – in this case the USAID – provides support by instigating market development measures and offering education campaigns and training programmes.

2. Cooperation with non-governmental organizations (NGOs)

Over the years, non-governmental organizations have successfully established family planning programmes that have improved access to contraceptives and made them more widely available. Bayer Schering Pharma has also been active here in partnership with corresponding NGOs. Partners with large networks in the field of family planning include the United Nations Population Fund (UNFPA), the International Planned Parenthood Federation (IPPF), Population Services International (PSI) and Marie Stopes International (MSI). The NGO model is intended to reach as many young people women and men as possible through education and marketing campaigns so that the number of users of family planning methods increases further. These programmes are funded by the public and non-public sectors. In this cooperative model, the contraceptives are provided by the NGOs either free of charge or for an extremely low price.

'Lessons learned' from both models

Both methods provide elementary cornerstones in disseminating family planning methods and making them available to a greater number of women. However, a perquisite for the success and sustainability of the family planning programmes is the continued provision of funding during financial crises.

In terms of sustainability, the following aspects should be considered:

• The projects initiated by the various family planning organizations can be deemed to be sustainable and viable in the long term if long-term financing is secured and companies and NGOs provide a sustained basis for cooperation. This improves the provision of contraceptives (planning security for both partners) and facilitates market development measures that extend beyond the respective project phase. In other words: develop strong partnerships.

• In both models, the contraceptives are provided free of charge or at cost price. This means that most of these schemes are not in themselves commercially viable in the long term but are dependent on subsidies.

• This in turn means that it is often not possible to guarantee the sustainability of the projects since the projects mostly do not provide measures to guarantee the continued existence in the market on completion of the project phase.

A new approach: '2nd tier marketing'

In addition to family planning programmes based on financial support, new approaches can help increase the availability of the contraceptives while at the same time considerably anchoring the concept of sustainability in terms of 'lessons learned' and 'best practices'. We therefore need approaches which, following a phase of financial support, are able to pay for themselves commercially.

The '2nd tier marketing' approach provides such as possibility for Bayer Schering Pharma: a worldwide available and proven oral contraceptive (Microgynon) is being launched on the market in developing countries and made available at an affordable price to women with low to middle incomes on a sustainable and permanent basis. The price is greater than is usual for a social marketing project but nevertheless significantly lower than the standard brands in so-called high-price private markets, also known as 'first tier' markets. Particularly middle class women in developing countries benefit from such a marketing and sales model. Since this '2nd tier marketing' model can also achieve 100 percent commercial self-sufficiency, this approach is also 100 percent sustainable.

With USAID we have concluded a collaboration agreement as the first industrial partner. This partnership in '2nd tier marketing', which is called the 'Bayer Schering Pharma Contraceptive Security Initiative', will enable a large number of women in first of all 11 African countries to access high quality reliable hormonal contraceptives. The pilot project is beginning in Ethiopia, Tanzania and Uganda and will then be extended to other countries. If this marketing and sales approach proves successful, we also have plans to extend this model to other products.

Conclusions

Strong private-public partnerships make a valuable contribution to achieving the MDGs. Here the proven family planning programmes must receive long-term financial support and new approaches, such as the Bayer Schering Pharma Contraceptive Security Initiative, must provide additional impetus.

Success Story

Christoph Bonsmann,
Director, action medeor International Healthcare gGmbH, Tönisvorst, Germany

action medeor International Healthcare Ltd. was founded in 2004. It is a subsidiary of the German Medical Aid Organisation action medeor e.V. Both organizations which are non profit making provide medical aid to developing countries. action medeor e.V. has always purchased its pharmaceuticals from the European market. But in the last 20 years there has been significant switch from this market to the Asian market i.e. India and China. action medeor e.V. had to decide whether to follow this general procurement trend or develop a new idea of providing help.

In 2003 experts from action medeor went to Ethiopia, Tanzania and Kenya to observe the East African pharmaceutical market. We noticed that in these three countries a growing and vital pharmaceutical manufacturing market existed from poor to reasonable quality of production. It was further observed that the local drug regulatory authorities (DRA) in these countries were reorganized and reinforced compared to the past. In consequence the existing laws and regulations were enforced so that all pharmaceutical products had to be registered. The DRAs started too to conduct regular on-site audits of the pharmaceutical production units.

After a more detailed survey was carried out in Tanzania the decision was taken by the board of action medeor e.V. to found a new entity with the aim to set up a distribution network in Tanzania with the clear focus on local or regional procurement as long as GMP-Quality (Good Manufacturing Practice) according to World Health Organization (WHO) could be achieved.

In 2005 action medeor International Healthcare Ltd. was registered in Tanzania and a warehouse was rented in Dar es Salaam. Before purchasing pharmaceuticals from the regional market all relevent manufacturers were audited and pre-qualified as vendor. Since then action medeor International Healthcare acts as a non-profit medical wholesaler in Tanzania. The turnover of medicines and medical items has increased from 150,000 Euro in the first year to more than 1 million Euro in the year 2008. Our clients are mostly hospitals from faith based organizations but recently a growing number of international NGOs and governmental institutions in Tanzania are ordering from us.

The difference between action medeor International Healthcare and a commercial wholesaler in Tanzania is that we

- publish a price list at least twice a year for our customers;
- supply only to the non-commercial market (private pharmacies and clinics are excluded);
- keep a stock availability of >90 percent;
- stock niche products like injections;

- keep only products which are listed by the Ministry of Health for the use of public health facilities;
- have our own quality assurance including vendor audits and random sample testing.

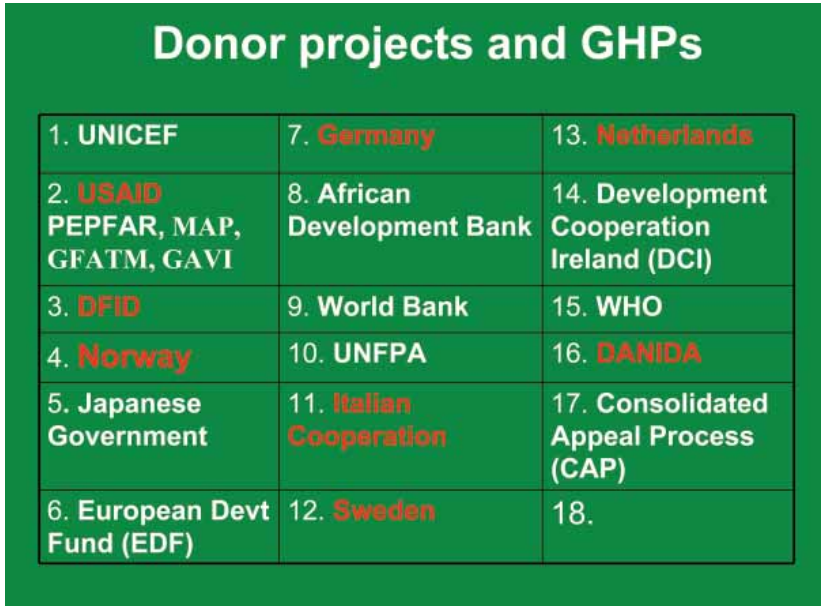
Meanwhile action medeor International Healthcare employs nine persons in Dar es Salaam including one expat and two Tanzanian pharmacists. Each year we have grown between 20-40 percent and purchase about 60 percent from regional sources i.e. Kenya, Tanzania and South Africa. Our engagement in Tanzania covers also pharmaceutical technology transfer. In 2008 a pharmaceutical laboratory at the Muhimbili University and Allied Sciences was renovated and equipped with state of the art small scale manufacturing equipment for tablets and capsules. This laboratory enables the university to adequately educate and train pharmaceutical students. Further the lab is a platform for training courses for pharmaceutical experts in East Africa. This project was co-financed by Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH.

Beside the success of our entity in Tanzania one has to realize the limitations as well. The international financial crisis hit Tanzania hard. The Tanzanian currency depreciated significantly in the last quarter of 2008. Within six weeks the Tanzanian shilling lost 19 percent against the Euro – for a country with major debts in Euro a devastating situation. But also our young entity was hit hard as we do have most of our liabilities in Euro. As a consequence we had to declare a loss for the financial year 2008. Another limitation is that it is difficult to get well trained staff in Tanzania. We will need an expat for at least another five years until we have trained Tanzanian technical and administrative staff.

action medeor International Healthcare has been trying to set up a sustainable organization in Tanzania complementing the existing health structures. Care has been taken not to counteract existing policies and local organizations. From our point of view political and economical stability is the main guarantor for further development in a low-income country. The mix of philanthropic objectives and a non-profit mentality while using commercial tools could be our role model for future endeavors in other developing countries.

Input
Global Health Partnership's impact on national health strategies. How to achieve and ensure sustainability?

Betty Nakazzi Kyaddondo
Head, Family Health Department
Population Secretariat, Ministry of Finance, Planning and Economic Development, Uganda



Slide 1 Donor Projects and GHPs

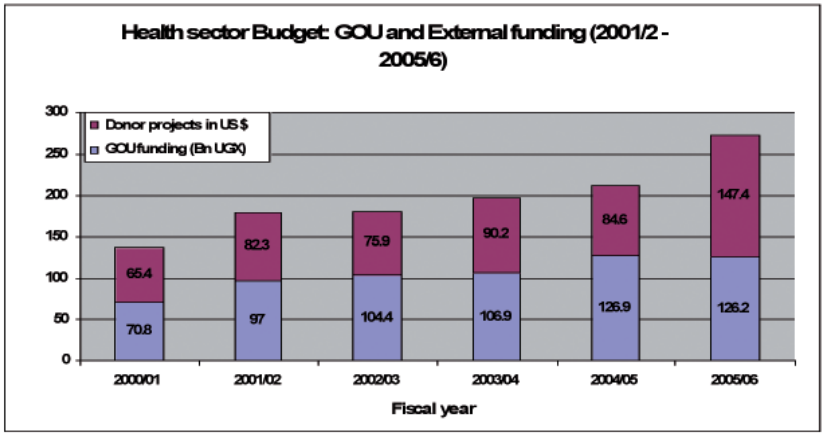
I am delighted and honored to be sharing experiences from one of the poorest countries; that is Uganda. We are two people from the developing world in the meeting and I am the only one representing a "black" country. So, I am very delighted at the opportunity that I have been given.

Slide 1 Donor Projects and GHPs

My presentation will highlight global health partnerships (GHPs) with private sector in Uganda. I will start off by sharing what are some of the global health initiatives. I will refer to them "donor projects", because that is the most common word used in my country. They stretch from the United Nations supported (UNICEF, UNFPA, WHO, UNAids etc), USAID, Japanese Government, Danish International Development Agency (DANIDA); GTZ, SIDA, CIDA, etc. Many different developed countries are also putting in money to improve the health systems.

Health system reforms

Addressing health in poor resource countries requires financial flows and technological support beyond the current public funding levels and therefore, foreign AID is crucial. For Uganda's health system to become more



Source: Ministry of Health Annual Sector Performance Reports

efficient, reforms in coordination and management of donor aid and resources have been essential. Several reforms have been made within the Health Ministry, for example, partnership principals were discussed and sector wide approaches (SWAps) developed, Public-Private Partnerships (PPPs) and decentralization which led to abolish of user fees were also part of the reforms. The combination of all these different reforms has led to a dramatic increase in health outputs, in particular harmonization of the work of the different stakeholders in the health sector.

There has been a general increase in the support that we are getting over the years from 1990 to date. As seen in the figure below, there was general improvement in the global funds until we realized a drop between 2001-2002. This was mainly because of the partial interruption in the release of HIV funds to the country as a result of Uganda failing to manage the Global Funds to Fight Malaria, HIV/Aids, and Tuberculosis. Once the ban was lifted, there has been an increase over the years.

Who are the key actors in the health sector?

There is a public sector and a private not for-profit sector; mainly facility based and non-facility based institutions. Then we have private health providers and traditional and complimentary medicine practitioners. There are challenges in tracking the private health providers and complimentary practitioners. The private not-for-profit organizations are easier to track because they are registered and tap on government funding in the service.

Public Private Partnerships and Global Health Partnerships (GHPs)

The PPP in Uganda dates back to 1956, and was mainly generated by faith-based organizations (FBOs) such as the Uganda Catholic Medical Bureau together with the Uganda Protestant Medical Bureau. Between 1996 and 1999, these FBOs had a series of discussions with the government and both parties agreed 1) to work as non-competitive partners in a complementary way to serve the people of Uganda without discrimination, ethnicity, religion, gender and social economic status; 2) address the same goals and objectives of providing quality affordable services to the poor in alignment with the government structures.

PPP and GHPs

PPP is a pillar of the health sector plan and it is very well established. GHPs have stimulated the emergence of a plethora of a mixed bag of private civil society organizations (CSOs) and non-governmental organizations (NGOs). This has been easily facilitated in the era of HIV/ Aids mainly. The participation of civil society in health systems depends heavily on the level of maturity and on the capacity and the strength of a civil society to address to health issues. But, what we are seeing is that management of the civil society or the private sector poses many challenges, because of potential to undermine harmonization and partnership outlined in the Paris Declaration, but also the policy of our government.

Why are we interested in PPP?

1. The FBOs through the PPP contribute 30 to 70 percent of health care system strengthening in sub-Saharan Africa. In Uganda, in particular, 40 percent of the hospitals are private and are manned by faith based organizations; 25 percent of lower level facilities are being catered for by the private or faith based organizations; 75 percent of training institutions are under the care of FBOs. The health sector, therefore, gets a lot of support from the private sector.

2. The private not for-profit organizations (PNFPs) are more accepted by the people, because they have a religious connotation. That means people believe they are providing services with one heart and thus demand for the services.

3. The FBOs better reach the grassroots, because they are rural based.

4. The private institutions are important partners in determining national priorities and also ensuring efficiency of funding, because they are CSOs and they question government: why are the things taking the trends they are?

5. The private sector are also an effective channel for funding to the poor, because they are based in the rural areas.

6. They respond easily to new needs where government bureaucracy may take time, especially when it comes to policy issues within the government, issues of management; when the government is a bit relaxed the private sector quickly takes on responsibility.

7. They also have a high-level of resilience in conflict situations. An example: in Northern Uganda, the Lords Resistance Army and government have been fighting in a war and the communities blame the government for all the atrocities suffered. Government found it hard offering services, yet the private institutions were able to serve the suffering communities.

8. They also provide credible health and HIV/Aids services. There is a lot of value for money from the private sector.

9. They are also important in limiting pervasive powers over State, where the State seems to be resistant; the private sector will come in more hands.

Challenges at the national level

Despite all the good things that the private sector is able to do at different levels, there are also exist challenges that come with the provision of health services with the private sector at the national level.

First, international frameworks, especially the Paris Declaration, are silent on the roles of the private sector. However, some frameworks bring the CSOs clear on this.

Second, there is limited participation of the private sector in dialogue around sector budgets making it ineffective in guiding allocative priorities. Private-sector parties are not given room to discuss their needs. This is discussed more with bi-lateral and multinational organizations, and with the ministries. The private sector is locked out.

Third, civil society is forced to seek most of the funding from government, and less directly from the Global Health Initiative since most of the global funding comes into the general budget support. Because of this, there is limited creativity of the private sector. It becomes difficult for the private companies to undertake their advocacy role, especially in ensuring and delivering proper accountability to the constituents because they don't know how much money is coming to the health sector. Then, there are also difficulties in holding the government accountable, not to the donors but to the citizenry, because the private sector does not know how much is coming in and what it is meant for. This leads to abuse and miss-management of donor aid.

Fourth are challenges in duplicating. The entire plan is duplicated, because different projects are doing fragmented workyet there is know one holding them accountable, Who do they account to?

Fifth, Global health funds have a potential to displace the government of Uganda's budget funds. This is a major obstacle in Uganda where through the SWAp all the money has to come to one common basket and then it is distributed (Budget support). Funds that are meant for HIV in Uganda or funds that are coming from the GHPs in Uganda are so big, that if it goes into one basket and then the health sector gets a location, then government is going to put in less to address the entire health sector due to the budget ceilings per sector. This displaces part of the money that the government would be giving to the health sector.

There are also issues of credibility and unpredictability of the support to the private sector in Uganda. Most of the support is short lived with many concerns on sustainability. Then, we keep asking ourselves, "How long will this money be available for the project?" These are the issues and the questions that David de Ferranti has already put to us. If it comes to an example of contraceptives or the family planning services, how much is going to be disbursed? All of these are concerns.

At the institutional level

At the institutional level, direct funding from the Global Health Partnerships to the private sector has markedly decreased in the past seven years. This is attributed to basket funding requirements. Then, there are resources from developed governments that also are channeled directly to the government of developing countries, leaving southern CSOs less able to access funding from the northern CSOs; thus a scale down of services or turn to user fees, ultimately affecting the poor. Then, the large international NGOs are also pooling funds into the common (but not government) basket funding for the country.

Direct donor funding is largely constituted by disease-specific projects (PEPFAR, GFATM). If we look at HIV, the Global Fund limits the flexibility and responsiveness of CSOs, because they are working in the entire health sector. They are not only addressing HIV issues, TB, or malaria. There is competition in the bidding processes, which limits access to funding as many local and remote CSOs lack capacity in proposal writing and information management. Therefore challenges in accessing global funds. There is also an issue of corruption, because of failure to account for the resources that we are receiving.

How can we improve PPPs through the GHPs?

I suppose we need to do more work. The government has to remain strong in providing leadership, but also in ensuring equity. Accountability issues need to be addressed effectively, and the private sector has a role to play. GHP agendas and principals should recognize the roles

of the private sector and go beyond.de advocacy, information sharing and mutual learning and communication.

If I also borrow an example that David de Ferranti used, we have to ask for the impact, we are only looking at the money that we are getting from the GHPs. But what is the impact of this money on the health of the nation? We also need to continue joint planning and setting of priorities. Let us not leave it to GHPs to give us money in their own interests. We also need to embrace more innovative and proactive funding solutions that foster sustainability on both sides: sustainability for the global health partnerships to continue, but also sustainability in the countries to provide better health care for its people. Finally, the need to devise ways to increase the health sector spending from our own country resources.

Global Funds should also be provided in a more efficient and flexible mode, depending on the country's capacity, systems, and structures to help our countries to build these systems. An example is the Global Fund to Fight Aids, TB and Malaria (GFATM): it is using existing structures, for example, Country Coordinating Mechanisms (CCMs), and existing channels of disbursing funds are clear. We have also innovative global health initiatives in Uganda, which could support the importation of essential commodities to get around ceiling restrictions.

Input
Global Health Partnership's impact on national health strategies. How to achieve and ensure sustainability?

Tatul Hakobyan
Deputy Minister of Health
Government of Armenia
Board Member GAVI Alliance
Armenia

This input provides a quick overview of Armenia's health sector and the Global Health Partnerships (GHPs) supporting Armenia, focusing on Global Alliance for Vaccines and Immunisation (GAVI) as an example. It then summarizes from my perspective as a Government recipient and a GHP Board member, the advantages of GHPs, but also some of the challenges which we are aiming to address. Finally, I will speak about ways to ensure the sustainability of GHP investments and provide an outlook into the future.

Background on Armenia

Armenia is a small country with about three million inhabitants bordering on Turkey, Georgia, Azerbaijan and Iran. The annual gross national income is at US$ 1470 per capita. Annual spending on health per capita is at US$ 29 per annum

The key objective of the Health Care system is to ensure sustainable, accessible and good quality health care services for the entire population. Armenia has developed strategic and operational plans in a number of different sectors, such as reproductive health, maternal and child health, and primary health care but there is not yet one overarching, strategic framework which sets objectives to guide future work on health, and puts in place the effective instruments and actions to achieve them[1].

GHPs have played an important role in funding health programmes in Armenia. Currently, the country receives financial support from GAVI and the Global Fund to Fight Aids, Tuberculosis and Malaria (GFATM) to improve health care services and ultimately health indicators. Since 2000, the GAVI Alliance has provided assistance to improve immunization services and increase coverage. GFATM funding complements the national TB programme, blood safety services and Aids control and prevention services.

GAVI funded programmes in Armenia. Armenia is one of the GAVI eligible countries of the EURO region. It started to receive GAVI support in 2000. All parties involved in immunization (such as EPI, WHO VPI coordinator, relevant specialists from Ministry of Health (MoH) and State Hygiene and Antiepidemic Inspectorate) are actively engaged into both proposal preparation process, and the programme implementation process. The whole process is overseen by the Ministry of Health, and the financial part is overseen by the Ministry of Finance.

Approved GAVI funding for Armenia between 2000 and 2009 totals US$ 768,635. More than half of this additional money is dedicated to rolling out new and underused vaccines, most notably Hep B vaccine and, more recently, the introduction of pentavalent vaccine (DTP3, Hep, Hib). In addition, funding

has been committed for increasing immunisation safety, general strengthening of immunization services and health systems strengthening.

Some results enabled by GAVI's catalytic financing

With the additional finance from GAVI, Armenia has been able to:

• Introduce the HepB vaccine and vaccinate 265,371 additional children against HepB between 2000 and 2009.

• Introduce the pentavelant (combining DTP3, HepB and Hib) vaccine in 2009. This was a great opportunity for our country, as without GAVI support the vaccine would not be affordable for Armenia right now, because of the high) cost of the vaccine in the market.

• Introduce safe injection tools and practices in 2002 (achieved 100 percent use of AD syringes, and 100 percent availability of safety boxes), with financing taken over by Armenia in 2006 ensuring sustainability.

• Develop new policies, better surveillance and training and improve the cold chain.

Aligning and coordinating GHP funding with country priorities

The objective of different programmes supported by GHPs in our country is to ensure, that their activities fit well into the overarching national strategies.

The process of coordination starts with the proposal preparation process. The Working Group preparing the proposal usually includes not only officials from the Ministry of Health, but also representatives of technical partners (WHO), and NGOs working in the health care sphere. If the proposal is to target one disease, the WG usually includes leading specialists from that sphere, who ensure, that the implementation plan is well integrated to reduce the burden. During the preparation process, the representatives of each organization ensure that the activities included in proposal are not duplicating the activities already carried out by their organization. Each proposal is reviewed by the specialists of MoH and the Ministry of Finance to ensure they are in line with existing strategies and planning.

Once approved programme implementation is overseen by a coordination committee formed by representatives of all interested parties.

Advantages of GHPs

GHPs offer significant additional financial support to countries like Armenia. This support is usually very flexible and, most importantly, it is country-driven. Countries write the proposals for funding focusing on their actual needs and their country circumstances. Moreover, the proposal preparation process itself is a very helpful exercise for the organizations working in the health care sphere,

as during the process these organizations are collaborating closely, and their activities in the field become clear, visible and transparent for other organizations. This process brings together organizations, which – under usual circumstances – hardly would cooperate at country level, if there were no such opportunities. This helps to identify opportunities for synergies, to coordinate activities and to avoid duplication of effort. Also, the process gives an opportunity to draw out lessons about best practice, and support the development of common principles of engagement.

Challenges of GHPs

A key challenge in preparing proposals for different GHPs is that countries are sometimes burdened with parallel reporting systems. GHPs use different reporting forms/systems to oversee programme implementation, which requires significant human and time resources. It would be good, if different GHPs could harmonize their reporting procedures at country level, so that transaction costs are reduced for countries. The same applies for grant proposal applications.
Also, it would be very helpful if GHPs and other donors could provide clear dates for the financial flows or issuing trenches. Armenia and other countries, have at times faced difficulties caused by the delay of financial transfers which impacts the timely implementation of programmes.

Financial sustainability of GHP investments

Immunization and maternal and child health more broadly remain a priority among Armenia's country health care objectives. Over the past years, the Government has consistently increased the Health Budget by 20 percent per annum, which allowed important investments. This year, despite the financial crisis, the budget remained stable.

Co-financing schemes employed by GHPs are very helpful for country planning and to ensure sustainability of programmes. With these schemes, countries can make projections for future financial needs, and be prepared to take the financing responsibility once the support provided by ends.

Two examples are worth mentioning:
Up to 2007, GAVI provided the entire amount of needed doses of the HepB vaccine to Armenia. In 2007, the Government bought 10 percent of the needed doses, and 90 percent was provided by the Alliance. In 2008 government co-financing increased to 40 percent, with the GAVI Alliance providing 60 percent. In 2009, the all required doses of the HepB vaccine was purchased by the Government. The country thus gradually shifted to the Government financing for HepB vaccine, which made the process smooth and ensured the sustainability of the delivery of the vaccination.

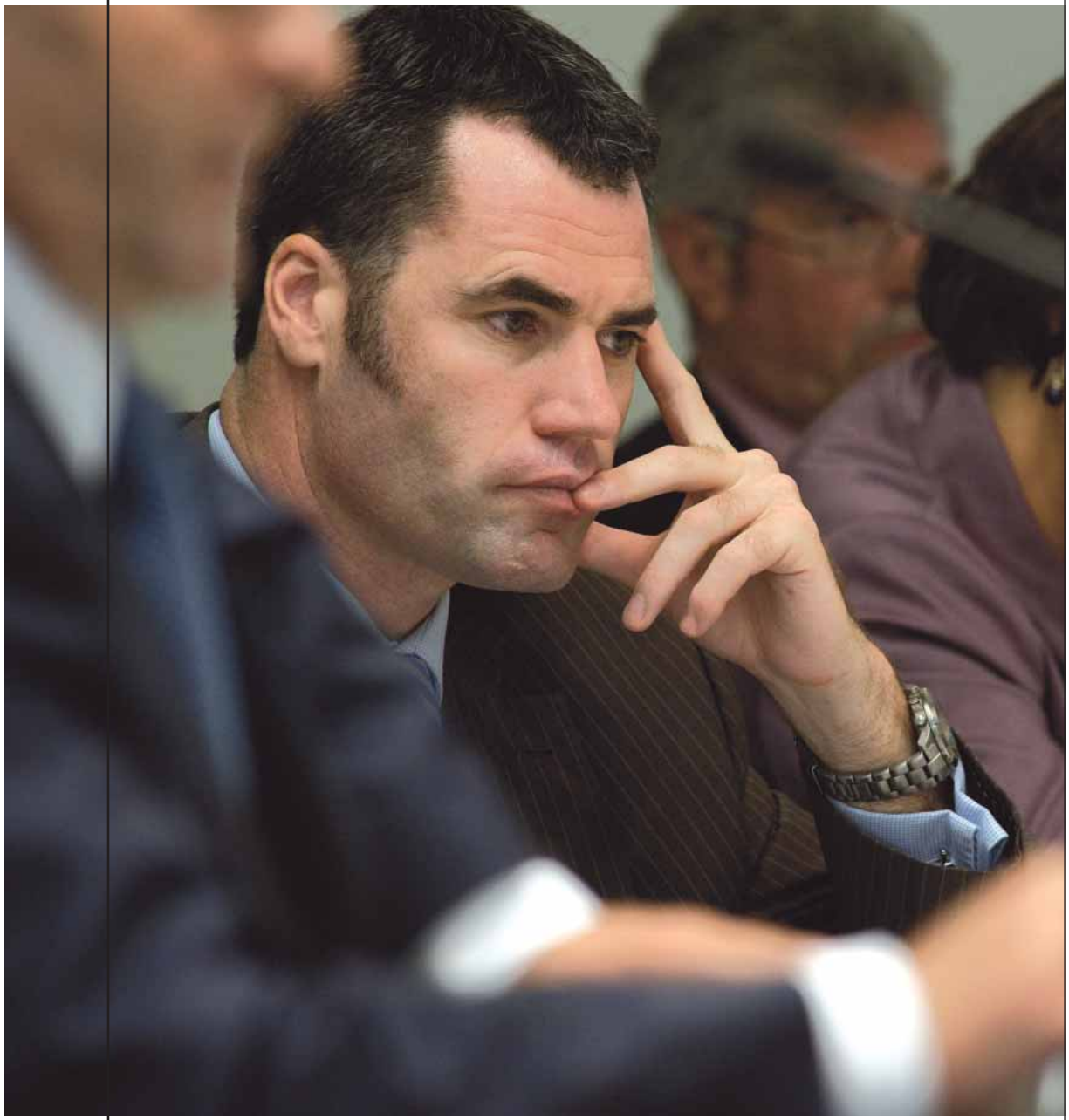
In 2009 Armenia introduced the Pentavalent vaccine (vaccinations just started). From the required total 81,600 doses, the Government pays for 6800 doses (about US$ 0.30 per dose per the co-financing policy), and the GAVI Alliance provides 74,800 doses. The co-financing share will increase by 15 percent annually. This gradual increase helps the country to plan financially for future years. The country is prepared in advance, that year by year the co-financing share will increase, and plans the budget accordingly. Gradually, the financing burden shifts from the Alliance to the country.

Conclusions

Working with GHPs is not without challenges. However, their model and financing power present important opportunities for countries to take advantage of. Beyond mobilize urgently needed funding targeted to countries' needs, GHPs ensure a broad participation of stakeholders, and offer the opportunity to catalyze joint action and innovation and share lessons learned. I see my role as a GAVI Board member as ensuring that GHPs further harmonize and align their operations with each other and with country programmes. This will help us continue the development in the right direction.

We live in a time when operating alone is no more effective and where concerted action of all key players in partnership around key public health issues is critical. As resources are limited, we also need to ensure that aid is shared with those who need it most and who use it to produce health results. Global Health Partnerships, with their focus performance, country ownership and involvement of a all necessary stakeholders, in this context represent a great opportunity for most of countries to attain sustainable health outcomes.

1 The current national documents which set priorities and define strategies in health care are the following: the Strategy for Maternal and Child Health (MCH) (2003-2015), the Poverty Reduction Strategy Paper (2003-2015), National Immunization Programme (2006-2010) as well as the Medium Term Expenditures Framework (MTEF) (2007-2009) and the cMYP, which was adopted in 2008, and covers all the relevant fields of health care.



Input
GHPs impact on national health strategies. How can sustainability be achieved and ensured?

Geoff Adlide
Director Advocacy and Public Policy
GAVI Alliance Secretariat, Geneva

The GAVI Alliance was created to address a fundamental inequity; that children in low income countries do not have access to cost- effective, life- saving vaccines easily available to children in higher income countries. GAVI brings together developing and donor country governments, UN agencies and civil society together with vaccine manufacturers, academics and independent experts, fusing the resources and skills of both public and private sectors to lower prices and improve access to vaccines for the poor.

A principle of GAVI's work is to support activities that over time become financially sustainable. GAVI's efforts towards sustainability are reflected in its business model, policies and programmes, some of which are outlined below:

• As a global financing instrument for new vaccines, GAVI's added value lies in its ability and potential to create and impact the vaccine markets. By pooling vaccine demand of 72 of the poorest countries to procure vaccines in bulk volumes, prices are significantly reduced thanks to economies of scale. In this global arrangement, the vaccine industry gains access to a huge market that is otherwise not considered viable due to the lack of purchasing power of governments in poor countries. In return for this access, manufactures have offered GAVI significantly lower prices in a so-called multi-tiered pricing system, where buyers in the industrialized world pay a higher price for the same product that GAVI buys at a lower price. The launch of GAVI as a global buyer of vaccines for poor countries has changed the vaccine business considerably. Many new manufacturers, particularly those from emerging economies, have entered since to serve this new market, and the resulting competition has caused further drops in vaccine prices. Increasingly these new manufacturers come from emerging market countries. GAVI now buys more than 40 percent of its vaccines from manufacturers in countries like India and Brazil.

• A unique financing instrument piloted by GAVI, which will further contribute to a more equitable and more sustainable vaccine market for the poor, is the Advance Market Commitment (AMC). An AMC creates incentives for the vaccine industry to develop those products that are needed specifically in the developing world and to provide them at an affordable price to help countries achieve vaccine sustainability. A pilot AMC for pneumococcal vaccines has been launched this year and is supported by US$ 1.5 billion in funding from six donors.

• A crucial element of GAVI's operations intended to encourage financial sustainability is the unique GAVI co-financing policy. This policy requires GAVI-eligible countries to co-finance a portion of the vaccines they apply for, which encourages country ownership

and evidence-based decision making, while helping countries work towards sustainability after GAVI's support ends. Countries are divided into groups according to their expected ability to pay. Those in the least poor group are expected to co-finance an increasing portion of the required vaccines each year, while the poorest countries are asked to contribute only a small fixed amount. For the first time this year, not a single GAVI-eligible country is defaulting on its co-financing requirements, demonstrating countries' extraordinary commitment for immunization and making them true partners in the GAVI Alliance. Importantly, several countries co-financed an amount significantly higher than the GAVI minimum. African countries recently provided GAVI with very positive feedback stating that the co-financing policy helped facilitate the decision making process of introducing new vaccines, increase ownership of the process and budgets for vaccines, and raise awareness of immunization in the health sector.

Panel 2: Role of the international donor community

Global Health Public-Private Partnerships: What they are, what we know, and why they matter.

Andrew Harmer
Research Assistant, Health Policy Unit
London School of Hygiene and
Tropical Medicine, UK

Do partnerships impact positively or negatively on countries' health systems, and if they do how do we know? What is the role of the private sector in strengthening health systems in low-income countries? Indeed, what constitutes the 'private' sector in this context? What are we to make of private partners in public-private partnerships: what are their roles and responsibilities, and how might they contribute to making partnerships work better? These are difficult questions, and there are no easy answers.

Fortunately, where once there was an intractable ideological divide between proponents of 'the public' and proponents of 'the private' – making debate and dialogue between the two camps all but impossible – now there is open space and open minds for constructive rather than adversarial discourse. This conference is one example of this open space and, hopefully, open minds.

The emergence of global health public-private partnerships is one radical output from this shift in understanding; something tangible occupying the grey area between public and private spheres where magic happens. What do we know about these partnerships?

To begin with, they are few in number; certainly not the 100+ so often cited in the literature. In fact, if by global health public-private partnerships we mean partnerships where both public and private sector representatives have a meaningful voice on their Board of Directors (i.e. where the real decision-making takes place) then we barely get into double figures. That means that they are rare: rare, but special.

GHPs are special for three fundamental reasons. First they are a forum for the exchange of ideas and values – a place where the World Bank and the World Health Organization (WHO); where McKinsey and Bill and Mellinda Gates Foundation; where NGOs such as Medecins sans Frontieres and Rockefeller can get together regularly and talk to one another. This forum simply didn't exist ten or twenty years ago.

Second, they re-define public and private sector actors as *partners* with clearly defined roles, responsibilities, and expectations about appropriate behavior. Transgressors lose credibility as bad partners; good partners earn respect and praise. Crucially, partners *learn* from one another, and by increments their identities are re-shaped: from public or private to public-private partners.

Third, they function as an accountability mechanism. Being a partner matters because commitments made are made transparently, documented, uploaded to the partnership's website and thus available for scrutiny by the global health community. The Global Fund to Fight Aids, Tuberculosis and Malaria and GAVI have championed this global

public-private good and more recent partnerships, such as the International Health Partnership, are following in their footsteps. If the public and private sectors want to hold each other to account, then global health public-private partnerships are one way that they can do this in the health sector.

With these essential functions of partnerships in mind, it is clear that what partnerships *are* matters as much as what they *do*. Language evolves quicker than a teenager's wardrobe, and in recent years we have witnessed a drift in terminology from 'global health public-private partnership' to 'global health partnership' and, most recently, to 'global health initiatives'. With each subtle shift in terminology, the danger is that the quintessential public-private*ness* of partnership is lost: open space and minds to share different values; a learning environment for public and private sectors; and accountability and transparency.

The term global health *initiative* (GHI), for example, is not the same as global health *partnership*. The Global Fund, bilateral actors such as the President's Emergency Plan for Aids Relief (PEPFAR), and international economic organizations such as the World Bank are frequently lumped together primarily on account of their wallets: these three actors account for almost two-thirds of external funding for HIV/Aids control in low-income countries. Whilst it makes sense, and is clearly important, to analyse and synthesize the impact of GHIs on health systems, as a unit of analysis there is little else that the individual initiatives have in common.

Putting terminology to one side, what else do we know about global health partnerships? Data provided by researchers within the Global Health Initiatives Network (www.ghinet.org) show rapid scale-up in HIV/Aids service delivery, greater stakeholder participation, and channeling of funds to non-governmental stakeholders, mainly NGOs and faith-based bodies. From weak beginnings, these partnerships and initiatives have improved alignment and participation in annual planning activities, and harmonized their actions with one another through participation in national coordination structures.

Not surprisingly, there is still room for improvement. Different fiscal years, and different and unpredictable disbursement mechanisms of each initiative have made it difficult for countries to draw down funds and integrate these resources into coordinated national plans. Stringent financial management requirements have also led to duplication and poor alignment with country systems, although there are signs of improvement.

Fundamentally, of course, what we know about the effects of global health partnerships and initiatives is dependent

on good data at country level. Strengthening health monitoring and information systems (HMIS) lies at the core of better health outcomes. Regrettably, poorly aligned monitoring and evaluation systems are a continuing weakness of partnerships and initiatives, as two recent evaluations – one on the Global Fund and one on the World Bank – have highlighted. Strengthening HMIS should be a priority for both the public and private sectors: if we don't have good quality baseline data, how can we measure progress towards the fundamental goals for good health?

Public and private sectors have a role to play in ensuring good health: this is a truism. Each sector has different values. Indeed, perhaps it makes more sense to talk of public and private values rather than public and private sectors? The revolving door from public to private sector employment means that a senior public health specialist working for the WHO on Tuesday may be working for a soft drinks manufacturer on Wednesday, and vice versa. What is important is that there are forums where these values are allowed to breathe, are shared, and evolve. In a world of increasingly complex global health architecture, hopefully GHPPPs will continue to perform this important function.

Panel 2: Role of the international donor community

Robert Filipp
Head of Innovative Financing
The Global Fund to Fight Aids,
Tuberculosis and Malaria, Geneva

When I prepared for this session, I understood my task to be to speak about how the Global Fund works with the private sector and to reflect systematically about the opportunities, the experience and the results to-date and to look a little bit into the future.

By way of introduction let me say that the Global Fund is a unique partnership in which the private sector has been included by design and from the very start. For example, the private sector has an important governance role in the form of a seat on the Board, which is reflective of the true spirit and intent of partnership. The last Chair of the Board was Rajat Gupta, a prominent member of the private sector. As most of you know, the kind of dynamic you get when you have these kinds of groupings around the tables as equal partners with the same voting rights and the same abilities to change the course of an event or policy is really phenomenal. In addition to the role in governance, there are several areas in which the private sector supports the mission and the work of the Global Fund:

- Advocacy, marketing campaigns and financial contributions
- Pro bono services and core competencies
- In-country co-investments and other operational contributions

In terms of advocacy for global health, there are the big picture issues: where are we on the Millennium Development Goals (MDGs); keeping the global health on the international agenda, which is also a challenge itself and not to be underestimated. There are a lot of different groupings, like the Global Business Coalition (GBC), which play in this area of global advocacy in a very helpful way just like Civil Society Organizations (CSOs).

In terms of pro-bono services, experience exists in the area of non-pharmaceutical products because in-kind donations of such products are not envisioned at the moment. At the Global Fund board there have been discussions how to treat this quite difficult subject. It is obviously a critical area for a GHP. So far the policy has been to accept or to welcome in-kind services but not donations of pharmaceutical products. The pro bono services are really all about bringing to bear the core competences of business to public-private venture, to learn from business and business efficiencies only available in the private sector. I think efficiency gains and learning from business how business is conducted and apply that to public finance has been very beneficial for the Global Fund. In fact, our performance-based funding model and the independent verification by private companies of the results reported is part of the new approach in development finance. This is also something that has matured and benefitted from the merging of cultures

between public finance and the experience of the private sector.

Slide 1 Cause related Marketing and the Appeal of the Global Fund Cause, see page 107

Of course, the issue of the potential of the private sector to participate also financially in the work of the Global Fund is also very important. Let me mention the biggest success in this area, the consumer marketing initiative called RED. RED is a global initiative, whose objective is to engage the private consumers in the fight against Aids in Africa by channelling funds from the sale of specifically branded and marketed RED products directly to the Global Fund. RED is an initiative created by Bono (U2, singer and activist) and Bobby Shriver (Chairman of One) has been designed to deliver a sustainable flow of private sector generated funding to the Global Fund. Companies whose products take on the RED mark contribute a portion of profits from the sales of that product to the Global Fund to finance Aids programmes in Africa. Current partners just to name a few are: Apple, American Express, Converse, Gap and Giorgio Armani. We have had wonderful rewarding experiences with a special edition of iPod models and iTunes Gift Cards; Apple gives a portion of the purchase price to the Global Fund in Africa.

RED has raised about US$130 million to the Global Fund so far. The main proposition for the private sector is either a pick up in sales or customer or employee loyality. The entire Product RED business line is based on the proposition that there can be a new revenue stream from specifically branded socially responsible products. This explains why for companies it pays to engage with RED and even pay a licensing fee for the use of the brand. But I think RED has still more potential and if you consider the total picture of consumer goods and even totally different areas such as financial products.

It is, obviously, the right time to think about concrete partnerships with the financial services industry because this industry is open to new impetus and is looking for a lot of things. Among other things, something that interests us is, of course, how to bring them closer into the philanthropic area. We are just in the middle of launching a number of innovative investment products aimed at institutional investors. We essentially follow the lessons from RED and consider how to apply and translate the for-profit model with a social return to the financial services industry.

Slide 2 Market Behavior: Ceiling Prices, see page 107

The whole area of markets, market imperfections, consumer behavior and prices, price ceilings, differential pricing and the production of goods related to health and health systems. This is a complex area but nevertheless a critical area for better collaboration with manufacturers, distributors and the private sectors. Let me mention one small example of how we at the Global Fund made small steps in this area. Some time ago, we reserved a certain amount of money in an escrow account and said, “This money is for a certain product” in order to demonstrate to manufacturers that they should scale up the production of this particular product and have better predictability in their costs of production. There are several other important actors involved in markets and prices. The Clinton Foundation for example or the airline solidarity funded organization called UNITAID. UNITAID receives about 300 million Euros from the airline solidarity levy every year. There are about 20 other countries that participate. There are new levies that are going to be proposed or are on the table, this also involved the private sector such as the currently transaction levy or also know as financial transaction tax.

Slide 3 philanthropy to International Affairs (1987-2007) see page 108

Areas such as technology, knowledge, communication and information systems are still in the early stages of experience. There is a lot of room for improvement in applying all the know-how available in the private sector to grant management but important elements to build on already exist within the Global Fund business model.

Local Fund Agents

The Global Fund does not have a country-level presence outside of the Secretariat located in Geneva. Instead, the Fund through an open bidding process hires Local Fund Agents (LFAs) to oversee and verify local reports on grant performance and results. The LFAs are specialised accounting firms that verify the success and the progression of the grants and the financial data of grants. So there is a very direct relationship between the Global Fund and the private sector as part of the business model.

Slide 4 Financial Products, see page 108

Slide 5 US. Philantropy vs. US. Foreign Aid, see page 109

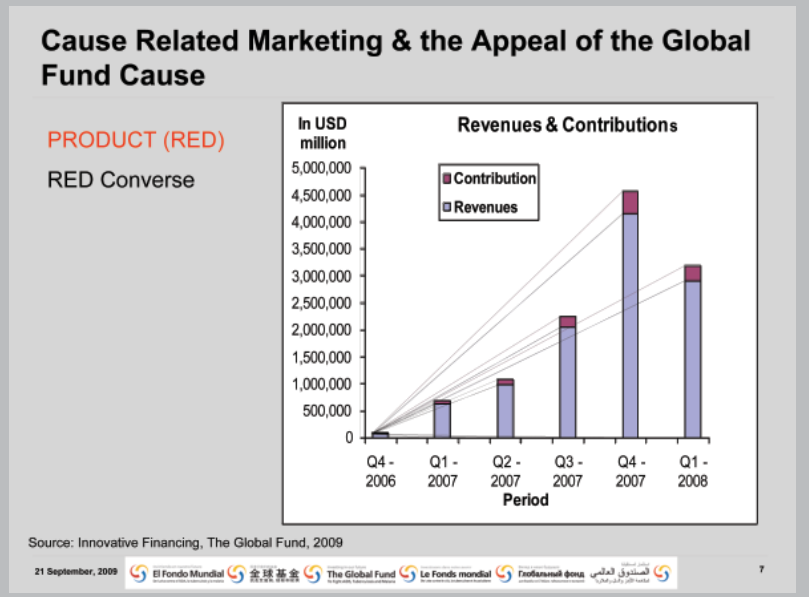
Here I listed some means of engagement with the GHPs. The private sector is working with us in the field of philanthropy as well. I just want to show you that there is a much bigger world out there then I think we often acknowledge. Let us consider that US philanthropy in the year 2006 exceeded total US foreign aid. So there is potential but also a challenge or coordination, harmonization, perhaps especially in the area of reporting to funders and the transaction costs that such reporting and relationship management may involve.

Slide 6 US. Philanthropy to International Causes, see page 109

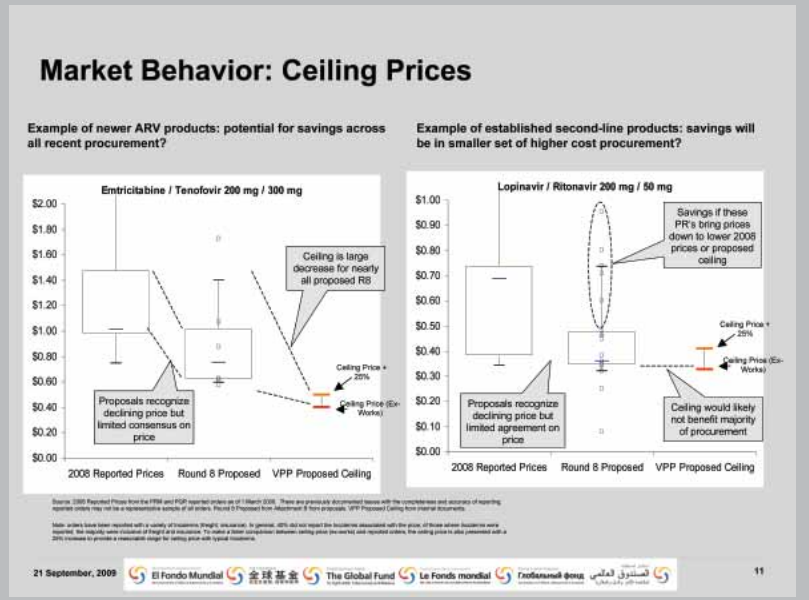
We all know that with the emergence of the Bill and Melinda Gates Foundation as a prime global health supporter, the

spending of US philanthropy towards health has increased but so have most other international causes. You can also see that private giving to health from the US. stands at US$720 million. In addition, there should be data from Europe, from Asia and from traditional Islamic giving. Of course, the question remains how is all this interest and engagement coordinated to make the most impact it can?

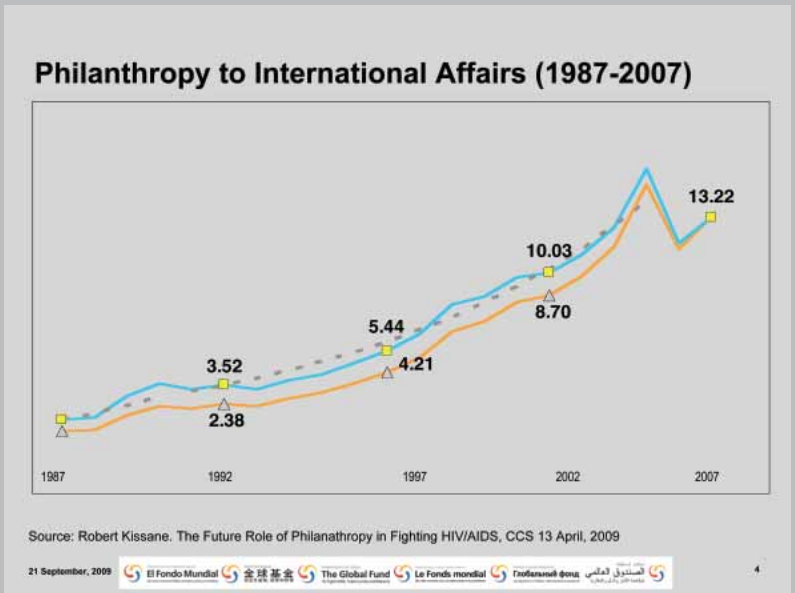
My last quick point is about the motivations of the private sector. There is strong interest in impact of the contribution, usually driven by very direct and personal connection to the cause or an interest in operating efficiency, in governance or in influencing the brand image of the brand involved. For some, it is important to gain or improve access to global media, political leaderships and or the markets.



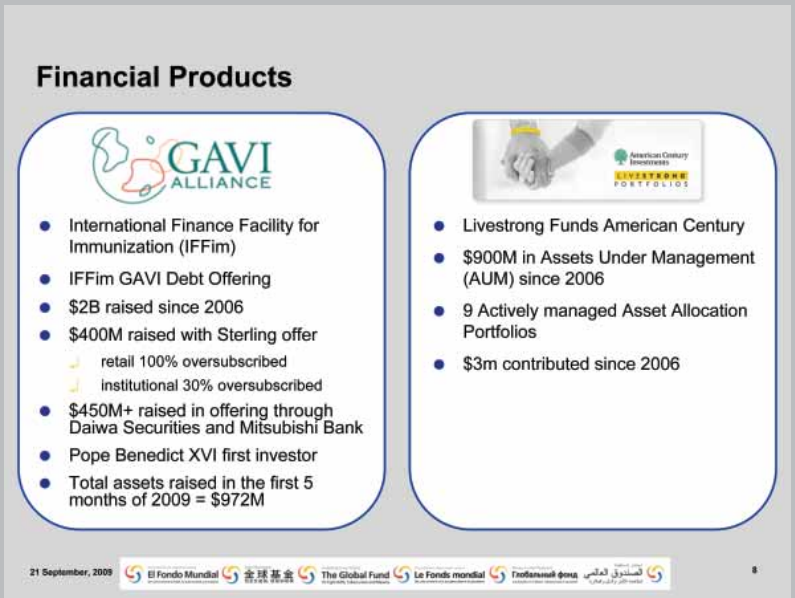
Slide 1 Cause related Marketing and the Appeal of the Global Fund Cause



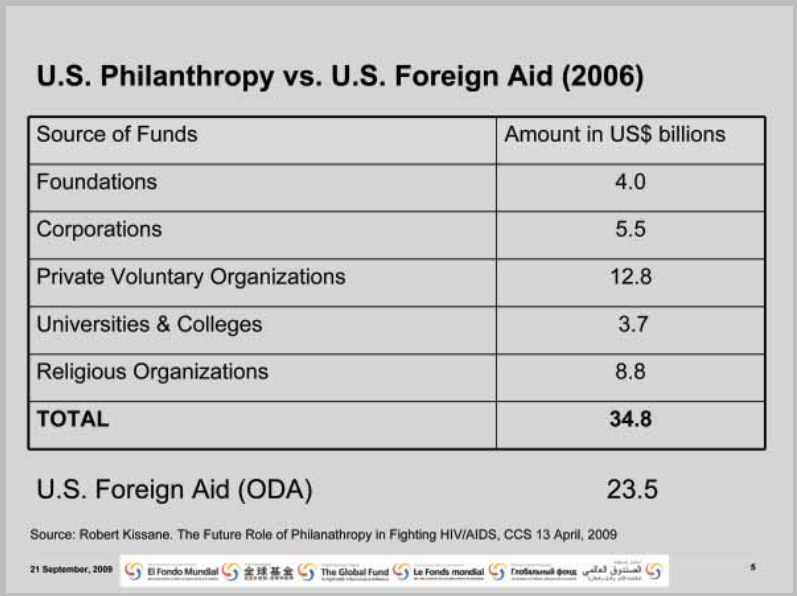
Slide 2 Market Behavior: Ceiling Prices



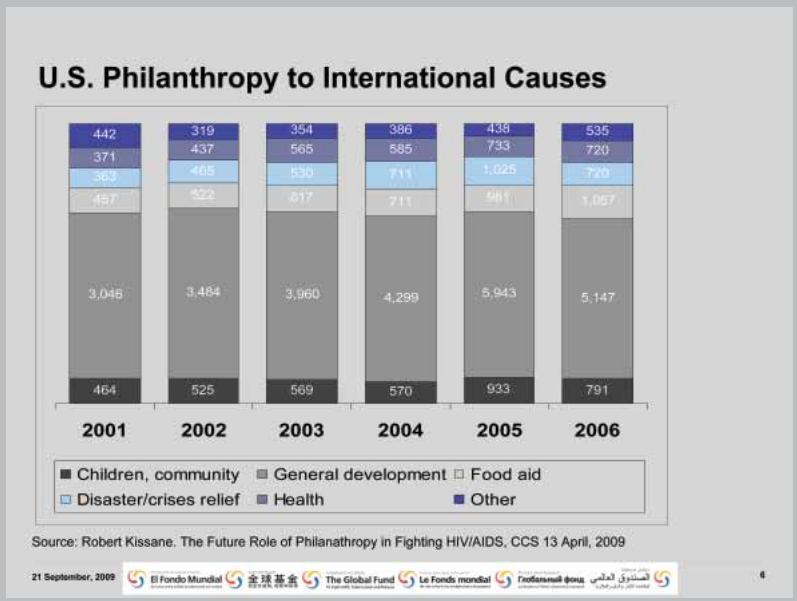
Slide 3 Philanthropy to International Affairs (1987-2007)



Slide 4 Financial Products



Slide 5 US. Philantropy vs. US. Foreign Aid



Slide 6 US. Philanthropy to International Causes

Panel 2: Role of the international donor community

David Evans
Director of Health Financing
and Social Protection, World Health
Organization (WHO), Geneva

Comments

1. Rather than talk in generalities, I set my comments within the context of my current role as Director of the Department of Health Systems Financing in WHO.

2. In this respect, our work is guided by a World Health Assembly Resolution in 2005, adopted unanimously by all countries that were members of the Organization at that time. It urged countries to develop health financing systems capable of attaining and maintaining „universal coverage". This was defined as ensuring that all people had access to needed services without the risks of severe financial consequences associated with paying for care. It also urged WHO to provide the necessary technical and informational support to countries seeking to do this.

3. This was recently reinforced in the 2008 World Health Report on Primary Health Care (PHC), in which universal coverage was recognized as one of the four core principles of PHC and the role of the financing system in ensuring and maintaining universal coverage was highlighted.

4. However, it is not simple to achieve this regardless of the income level of the country. Problems vary in scale and magnitude across countries, but all must find solutions to the three fundamental questions of health financing: - how to raise sufficient funds for health; how to raise and pool funds in a way that allows people to access services and spreads the financial risks of ill health across the population; how to ensure that the available funds are used efficiently and equitably.

5. In high income countries, most attention is focussed on efficiency questions as part of the desire to restrain the growth of costs. In the lower-income countries in which the GHPs are active, all three are critical.

6. There are still 53 countries that spend less than US$ 50 per person per year on health, from all sources, public, private and donor funded. This is despite the vast increase in external support for health in lower income countries since the millennium declaration was signed. This is simply insufficient to ensure universal access to even a very basic set of health interventions that span prevention, promotion, treatment and rehabilitation.

7. A second issue is that 37 (19 percent) countries in the world raise more than half of all their health finance through out of pocket payments made directly by patients to providers at the time they are ill, and another 51 (26 percent) raise between 30 percent and 50 percent of their finances in this manner. These ratios are higher in sub-Saharan Africa and in low income countries in general. For example, in the former region, 56 percent of countries raise more

than 30 percent of all health finance through direct out of pocket payments.

8. This method of revenue generation is regressive - the poor pay the same as the rich. It also means that millions, and possibly billions, of people simply do not seek care or continue care because they are unable to pay. The other side of the coin is that 150 million of those who do seek care suffer financial catastrophe each year because of the need to pay, while 100 are actually pushed below the poverty line.

9. User charges are not the only financial barrier to access, with transport costs sometimes being prohibitive. Nevertheless, user charges pose formidable barriers to access. They also mean that the sick bear the full costs of their illness, with no solidarity between rich and poor, or between the healthy and the sick - or even the ability to spread risks across the life cycle of the individual through periods of relatively better and worse health.

10. The third question is that health finances are often used inefficiently and inequitably. In about half of the countries where studies have been done, public services are used disproportionally by the rich. Patterns of exclusion differ across countries, but in almost all settings, the poor and other vulnerable groups use services less than the rich even though their needs are greater.

11. Inefficiency takes many guises, through waste and corruption, to the provision of high cost, low impact services when low cost, high impact services are not fully funded.

12. WHO seeks to work with countries to develop their health financing systems in ways that increase the funds available to health; that remove financial barriers to services by moving more towards forms of prepayment and away from out of pocket payments; and that increase efficiency and equity.

13. It does this in collaboration with external partners including the Global health Partnerships (GHPs) and the other members of the international community, partly in an attempt to raise additional external funding for health in poor countries.

14. GHIs and the „new“ foundations have supplemented the traditional bilaterals to ensure that there has been very large additional funding for some types of health interventions since 2000. This is welcome. But much more is needed, and more is needed for a broader range of health system improvements and types of services.

15. It is important to note that few of the rich countries have met their international promised in terms of overall development assistance, and there is growing fear at country level that the richer countries will use the current financial crisis as a reason for moving

further from these promises. Much more is needed than is currently available - as shown by the recent High Level Task Force (TF) on Innovative Financing for Health Systems. In our calculations for Working Group 1 of that task force, we projected that the gap between needs and the funding available would grow to US$ 30 billion by 2015 if the rich countries did not move towards meeting their commitments.

16. Some of the additional funds will be needed for the diseases and conditions mentioned in the Millennium Develepement Goals and indicators. Some is needed for other conditions such as noncommunicable diseases (NCDs) and injuries that now are as important in poor countries as communicable diseases. Some is needed to develop the health system so that it is capable of scaling up multiple activities more rapidly.

17. Certainly, more can also be raised at the country level and WHO is exploring with countries the extent to which some of the recommendations of the High Level TF could be applied at country level as well as at the international level. There is also a question of government commitment in the lower income countries, as there is in the richer settings. Since the Abuja declaration was signed (in which African heads of state promised to devote 15 percent of their total government expenditures to health) almost as many countries have moved further away from the 15 percent than have moved closer to it.

18. The non-government sector at the country level, and the international community globally, can play various roles in the move towards universal coverage.

19. It is worth noting that the non-government sector accounts for over 50 percent of all health spending in many low and middle income countries. What this means, however, can be a bit confusing. If a country spends US$ 20 per person on health each year, and 50 percent is channelled through the non-government sector, but the country requires US$ 100 per person to reach the Millennium Development Goals, the options for scaling up are infinite. All could be scaled up through government, resulting in a final public/private mix of 90 percent; all could be scaled up through the non-government sector, resulting in a public/private mix of 10 percent; and any combination in between is possible. It is important that are careful, pragmatic assessment of the costs and benefits of all options is made, rather than trying to decide based on dogma.

20. The international community can also help in the move towards universal coverage by supporting the development of domestic financing institutions that allow for more pooling and prepayment, in preference to direct out of pocket payments. The Global Fund

has certainly shown that this is possible in Rwanda, the EU and UK to some extent offers general budget support, and many European partners have bought into sector wide approaches (SWAps) and other forms of sectoral contributions. We would hope that more funds from international partners are used to strengthen, rather than duplicate, domestic channels and pooling arrangements.

21. Finally, the Paris and Accra principles could be an important way of improving efficiency by reducing over time the multiple channels with their costly administrative and monitoring mechanisms. This reduces transaction costs at the global level as well as at the country level (by allowing governments to reduce substantially the transaction costs of dealing with a myriad of financing channels and rules). Ideally, this will be an important outcome of the International Health Partnership (IHP+) process in which partners buy into the health plan produced by the country, without requiring different application, reporting and financing processes.

Panel 2: Role of the international donor community

Simon Koppers
Head of Sector health,
German Federal Ministry for Economic Cooperation and Development (BMZ),
Germany

Global Level: Increasing resources for aid to health and its fragmentation

After stagnating in the 1980s and 1990s, aid to health has risen sharply in recent years: aid for health has more than doubled. Total development assistance to health (DAH), including private non-profit organizations, reached US$ 16.7 billion in 2006.

At the Heiligendamm summit in 2007, the G8 jointly committed to make available US$ 60 billion for health activities in developing countries within five years. Even before, the German government has increased its support significantly (almost tripled commitments since late 90s) and will continue to fulfill its obligations. Germany's total bilateral and multilateral commitments for Millennium Development Goals (MDGs) 4, 5 and 6 and relevant health system development were well over 500 million Euro in 2008 (compared to about 300 million Euro in 2005) and will continue to be at this level.

Total global aid for health also includes large flows from multinational agencies and private entities/foundations. More than one hundred new global health initiatives (GHI) – mostly for specific diseases or topics – came into live in the past decade, including the Global Fund to fight Aids, Tuberculosis and Malaria (GFATM), the Bill and Melinda Gates Foundation, and the Global Alliance for Vaccines and Immunization (GAVI). Activist groups have had a substantial influence on international health policy – most notably in the field of Aids treatment. Advocacy groups continue to exert their influence positively in arguing for greater attention to the issue of human resources for health and the need for greater investment in health systems.

The new GHIs show the increasing involvement of the non-state sector (private companies, philanthropic and faith based organizations and the civil society) in health care and substantially contribute to the increased global funding for health. They have been very successful in leveraging new sources of financing. For example, the Bill and Melinda Gates Foundation has committed more than US$ 1 billion per year since 2000 to address the health needs in developing countries, including making substantial contributions to GAVI and GFATM.

All these health initiatives aim at achieving the health-related MDGs. They have led to successes in improved health in some areas. They have shown the benefits that can be drawn from the inclusion of new partners such as civil society and the private sector.

However, financing to meet the health MDGs 4, 5 and 6 is still insufficient. There are some important imbalances within the allocation of health aid which cannot only attributed to different governance levels. Countries with compa-

rable levels of poverty and health need to receive remarkably different levels of aid. Also, the multitude of new global programmes has added to duplications and ineffective use of resources. Moreover, it presents a burden for partner countries to deal with the many different partners and their specific systems of appraisal, implementation and monitoring and evaluation. Analysis reveals a high level of fragmentation in health aid, with an excessively high volume of small projects. This is not to say that smaller projects are of less value – they have an important role in piloting new approaches, testing innovation, etc. Analyzed in light of the Paris Declaration, however, small activities are likely to be associated with high transaction costs for governments.[1] Donor assistance in the health sector is highly fragmented, volatile and often unpredictable for partner countries. In addition, some of the non-state actors see themselves more as charity institutions for short-term needs, not as contributors to a sustainable and country-owned development.

There is a need for harmonization and alignment of all actors, including the non-state actors.

At country level: Increasing role of the non-state actors in the provision of health services in developing countries

At country level, health services are to a large part provided outside of the public sector. A wide range of non-governmental actors are responsible for the provision of services in many low- and middle-income countries. For example, 40-70 percent of health care in sub-Saharan Africa is provided by faith based organizations. This reflects the long-established role of faith based groups that work in otherwise under-served areas, often ignored by more formal service providers. Also, the role of the private actors in the provision of health services in developing countries is increasing. The greater activitiy of non-state actors has several advantages:

- additional funding in health reacting to the increasing demand in developing countries;
- in many countries, the public sector is not able to provide full coverage of health services for the population;
- the non-state actors take burden from the state.

However, it also has drawbacks:

- As long as private sector services are not integrated in a functioning social security system, poor patients have high out of pocket expenditures, which can be catastrophic for households.
- For economic reasons, services of the private sector usually concentrate on urban/peri-urban regions and do not cover rural areas.
- Special attention has to be attributed to assure quality control and regulation for public and private sector service delivery.
- In the absence of comprehensive health financing mechanisms, private sector services almost exclusively focus on therapy and not on prevention. This, therefore, usually remains the duty of the public sector.

All health delivery providers are part of a country's health system. In many developing countries, however, strategies are needed to systematically integrate the non-state actors and use their comparative advantages. Health ministries view the private sector as competitor in health service delivery instead of using their regulatory power.

International agreements to improve aid effectiveness

Since the Rome meeting in the year 2003, OECD/DAC High Level Fora had developed the vision of increased aid effectiveness as a joint international agenda. The Paris Declaration on aid effectiveness in 2005 was the major breakthrough and the Accra Agenda for Action adopted in 2008 adds additional value to its implementation. The following key concepts govern the international agenda for implementation:

- *Ownership:* Countries need to invest in the development of results-oriented national health strategies, plans and budgets in order to facilitate better harmonization and alignment of health aid on a more sustainable and predictable basis. These health strategies need to ensure a broad dialogue with and participation of all non-state actors including the private sector and Civil Society Organizations (CSOs) in order to improve universal access to health services.
- *Alignment:* Strengthening the capacity of countries' health institutions and systems for planning, budgeting, monitoring, and better sector dialogue need to be in place and operating well for donors to align their support. Development partners need to set the right incentives for their staff, develop coordination with other agencies and encourage the move towards programme-based approaches under the leadership of countries.
- *Harmonization:* Global health programmes are attaching increased attention to acting jointly with other donors, in order to reduce transaction costs for partner governments. They participate in-country donor groups or in joint missions and analyses.

• *Managing for development results:* This remains central to the aid effectiveness agenda in health. There is a need for increased consideration how diversity can help bring about results and how the health sector can benefit from a range of partners with different ways of doing business. Development partners and countries need to continue to track progress and results in health from an aid effectiveness perspective.

• *Mutual accountability:* At international level there exist standards of good practice on accountability and transparency among donors. Mutual accountability is more difficult at the country level, partly because of a lack of in-country representation of global programmes or other donors. The greater involvement of civil society and the private sector in country strategy and implementation structures is key to development. It also adds a new dimension to mutual accountability.

Germany – through BMZ – is the first (and so far only) country, which has published an action plan on how to implement the Accra agenda in its work.

The Accra Agenda has great relevance for the health sector, which is defined as a "tracer sector" by OECD/DAC. Increasingly, the role of new Global Health Partnerships has been recognized in the process. At the 2003 OECD/DAC High Fora meeting in Rome, Global Health Partnerships were barely on the agenda of aid effectiveness. In 2005 in Paris, their importance was recognised in the declaration which addressed "insufficient integration of global programmes and initiatives into partner countries" broader development agendas...". In 2008 in Accra, Global Health Partnerships are an established part of the aid architecture in health, complementing and adding to existing sources of development aid, particularly in HIV.

For our discussion at this Experts' meeting, it is important to note that the Accra Agenda was signed by representatives of the GFATM and the Bill and Melinda Gates Foundation and has binding character not only for governments, but also for private initiatives. According to the WHO/OECD/WB report *"Effective aid – better health"* prepared for the Accra meeting, it might even be said that the Global Health Partnerships are adapting more rapidly to the Paris Agenda than some of the traditional bilateral donors that provide the bulk of the funding of the global initiatives. The Global Health Partnerships' contribution has been particularly notable in institutionalizing the involvement of civil society and the private sector in both the development and implementation of proposals.

Activities supported by Germany to translate Paris and Accra into the Health Sector

Because health is central to development, it has traditionally been a priority for donor support. However, this has been associated with high levels of fragmentation as well as duplication and high transaction costs. The introduction of sector wide approaches (SWAps) in the health sector predates the Paris Declaration and had already been based on the underlying principles of harmonization, alignment and managing for results.

Germany is supporting the integration of the private sector into the health system in developing countries among other mechanisms by supporting private sector participation in health delivery and hospital management in the context of SWAp.

Example: Health Sector SWAp in Tanzania:

The health sector in Tanzania has for the last nine years implemented a SWAp that has supported a government-led health sector development programme aimed at improving access, delivery and quality of health-care services available in the country. The years before, health service provision was poor; under resourced, highly fragmented; and with limited cooperation and coordination among the various stakeholders involved in supporting the sector.

During 2007 an external joint evaluation – fully responding to the 2005 Paris Declaration on Aid Effectiveness and led by Tanzania's Ministry of Finance and Economic Affairs supported by all stakeholders – was undertaken in an attempt to assess how well the sector has done since the establishment of the SWAp. The findings from this evaluation indicate that the health SWAp has largely been a success with enhanced national ownership and access to higher levels of financing – which led to real improvements, including reductions in infant and child mortality, greater drug availability and improved service provision. The SWAp has been underpinned by far-reaching reforms, in particular decentralizing power to the district level. However, the evaluation highlights a number of critical challenges for the sector, including the need to improve tertiary care and to strengthen public-private partnerships. Although the evaluation recognizes the benefits from the Global Health Initiatives and large bilateral programmes in channeling critically needed resources into diseases which are national priorities, it finds that they generally operate outside existing health planning processes, distorting local priorities and threatening sustainability and the achievement of the MDGs.

Beyond SWAps, Germany is involved in international mechanisms which help to mitigate the unhealthy fragmentation in the health sector. In order to coordinate

the multitude of global initiatives in the health sector, the "Global Campaign for the Health Millennium Development Goals" was established as an overarching mechanism. It aims at improving the coordination of donors for achieving the MDGs without creating yet another institution.

Within the Global Campaign, the International Health Partnerhip (IHP+) was established in 2007 among leading international health organizations, bilateral donors and a number of developing countries. The goal of IHP+ is to improve health-related MDG outcomes by increasing the efficiency and effectiveness of financing for health through better aid coordination. IHP+ attempts to take the SWAp concept a step further by developing „country compacts". These should provide a country specific framework on how to address fragmentation and volatility, enhance predictability of financing and reduce transaction costs based on the principle of mutual accountability. It remains important to link the country compacts in an effective manner to the existing mechanisms for sector coordination (like SWAPs) in order to avoid parallel processes. IHP+ donor countries which have signed the "IHP+ Global Compact" agree to be accountable for their commitments in health. In short, IHP+ can be seen as an attempt to operationalise the Aid Effectiveness-Agenda within the health sector. The GFATM is a member of the International Health Partnership and has made efforts to improve aid effectiveness in the past years.[2]

The IHP+ supports the active involvement of civil society in strengthening health systems. Civil society is represented in almost every group or committee of the IHP+ at the global level and is coordinated through the Civil Society Consultative Group. IHP+ specific guidelines were developed to promote and support civil society engagement at country level. The IHP+ thus contributes to a better coordination of the public sector, civil society and the private sector at global and country level.

Proposal to improve the impact of the international donor community on health at the country level

• Bring together in a global *workshop* the main *working level* players (one government official, one non-state actor and one donor coordinator from each relevant developing country; one from each donor and Global Health Initiative headquarter):
- Analyze the main short-comings at the country level;
- the analysis should be differentiated, e.g by utilizing the five categories strategy – finance – decision – implementation – monitoring and evaluation;
- establish a vision and a road map.

• Outcomes of this exercise may be (after formal agreement by the decision-takers):
- Integrate GFATM funded work at the country level through integrating the CCMs into the Health Groups;
- integrate CSOs into the Health Groups at country level wherever this is not yet the case;
- define the role of IHP+ as coordinating, supportive and accepted.

1 In 2002-2006, the CRS records 20,485 health and population activities. Of these, just 4.6 percent or 926 of all aid activities reported to the DAC was for more than $10 million representing 68.3 percent of total health ODA commitments. The CRS records 5,720 activities between US$ 0.5 million and US$ 10 million, representing 28.1 percent of the total value of health ODA and 27.9 percent of all health activities. However, there were some 13,000 commitments for activities each less than US$ 0.5 million, representing 67.5 percent of all health activities in the period but providing only 3.6 percent of health ODA.

2 GFATM strives to improve aid effectiveness by introducing National Strategy Applications to simplify application and reporting procedures and by financing civil society directly. Weaknesses exist in a consistent approach to salaries for health workers, which has the effect that health workers from the public sector leave to take advantage of the improved working conditions offered by GHI financed non-state actors. The GFATM measured progress against the Paris principles in 2006, 2008 and will do so in 2010.

Panel 2: Role of the international donor community

Marshall Burke,
Senior Vice President, Head of External Affairs, Global Alliance for TB Drug Development, New York

Introduction

Every day more than 35,000 people die from infectious diseases such as Aids, tuberculosis, malaria and other neglected diseases. These diseases primarily affect people in developing countries where they exert a heavy economic, developmental and public health toll. The Millennium Development Goals (MDGs) call for immediate action to reverse the incidence of these diseases. The Taskforce Reports published by the UN Millennium Project in 2005 outline a comprehensive approach to achieving these goals, emphasizing the need to harness scientific advancement to support development.

Because of the limited market potential of these neglected diseases in the developing world, less than 10 percent of worldwide research and development funding is dedicated to creating new technologies to fight diseases that affect 90 percent of the world's population. In the case of TB, for example, no new drugs have been developed in over forty years, no vaccines in eighty and no diagnostic test in a hundred years, despite known challenges with existing interventions. Product development Partnerships (PDPs) are non-profit enterprises created to address this need for new tools to fight Aids, TB, malaria and other neglected diseases. Typically, they manage resources and partnerships from across public, private and philanthropic sectors to drive the development of new products that could save millions of lives every year. Most PDPs were established in the last 10 years, and have greatly catalyzed neglected disease research and development with a combined pipeline of close to 143 candidates (drugs, diagnostics, vaccines, microbicides), compared to only five projects in 1990. These new tools, along with existing interventions, are critical elements of the arsenal against neglected diseases. A recent study using a mathematical model to examine TB in Southeast Asia, for instance, showed that a combination of vaccination, new drugs and diagnostics could reduce incidence of the disease by 71 percent by 2050.[1]

PDPs and aid effectiveness

The PDP model embodies many of the ideas for aid effectiveness proposed in the Paris Declaration and the Accra Agenda for Action including managing for results, accountability, harmonized use of resources for greater impact, and alignment with host country priorities. Though each PDP varies operationally, the portfolio management approach the PDPs employ is geared to achieving maximum quality and efficiency. At the TB Alliance for example, portfolio projects are evaluated against predetermined milestones to determine whether allocation of resources is justified. Approximately 30 percent of the discovery and preclinical projects have been stopped over the past four years allow-

ing those resources to be reassigned to programmes with the greatest potential.

Partnerships are the heart of the PDP model. They allow PDPs to bring leading edge expertise to bear on neglected disease R&D, while keeping overhead costs low. Investments by PDPs are leveraged by substantial in-kind contributions from partners in the form of personnel, know-how, infrastructure, often more than doubling the value of projects that the PDP donors fund. In a 2005 report prepared by the London School of Economics and Political Science funded by the Wellcome Trust,[2] PDPs reported that industry in-kind contributions averaged a 1:1 match for PDP cash contributions and even reached two times the value of their investment. Increasingly, PDPs are also exploring potential synergies through collaborations among themselves. One such example is the PDP support initiative coordinated by the Bill and Melinda Gates Foundation with input from numerous bilateral donors, which seeks to enhance harmonization among PDPs. Efforts focus on key functional areas such as discovery science, clinical development and regulatory approval.

Aligning with developing country priorities

Coordination of PDP efforts with standard-setting bodies which have programmes, technical experience and recognition in disease-endemic countries, such as WHO, is critical to ensuring that the tools, once developed, reach and are useful to the populations that need them. The TB Alliance, therefore, has been actively involved in the Stop TB Partnership's Retooling Taskforce. The Taskforce, which includes product developers along with TB control implementers, seeks to facilitate introduction of new diagnostics, drugs and vaccines in high burden countries.

At the crux of any neglected disease R&D effort is the vision that products, once developed, will be adopted, will alleviate morbidity and mortality, thus having a positive impact on the countries bearing the disease burden. Aligning PDP efforts with the programmes and priorities of each developing country, therefore, is imperative. The TB Alliance has undertaken research over the past few years to understand adoption-related concerns and end-user priorities for drug design, map global and country-specific TB drug procurement and distribution systems, and explore barriers to treatment adherence. This information, in addition to supporting its strategy to introduce drugs once developed, also informs project selection, research and clinical development. To ensure the affordability of a new regimen for patients in high-burden, low-income countries, for example, the TB Alliance considers the cost of goods, ease of synthesis, and mode of administration during selection and advancement of portfolio compounds.

The TB Alliance's local involvement in high-TB burden countries also includes working with communities around its clinical trial sites through its community engagement programme. This programme aims to establish meaningful channels of communication between researchers and local community members to improve local understanding of TB disease, treatment and research; to facilitate trial implementation in consideration of local cultural norms and expectations; to minimize the risk of community rejection of the trial through transparency and community empowerment; and, ultimately, to facilitate uptake once new drugs are available. To date, several clinical trial sites in South Africa, Zambia, Kenya and Tanzania have been awarded small annual grants to design and implement their own community engagement programmes. More recently, the TB Alliance created a discreet Access Department, whose sole purpose is to understand and interact with processes and stakeholders in high-TB burden countries and ultimately chalk out a plan for the introduction of new drugs and treatments that is compatible with the TB control efforts within those countries.

System strengthening

As part of their product development efforts, PDPs work with country health systems and contribute to strengthening capacity. During the course of its moxifloxacin trial, for example, the TB Alliance has provided training and infrastructure enhancements at several clinical sites in Africa, Asia, and Latin America, resulting in much stronger clinical and laboratory capabilities.

New tools and health system strengthening – reciprocal relationship

The PDPs objectives and practices are aligned with and in fact mutually support the actions and outcomes proposed in the Accra Agenda for Action. For example, an understanding of and alignment with in-country systems is critical to ensuring that the new products reach the people that most need them. The mission of PDPs will remain incomplete without this outcome. Similarly, adoption of new technologies in disease-endemic countries will not occur unless the tools address key concerns and hurdles to use among stakeholders that both administer and use them. On the other hand, technologies that simplify interventions and make them more effective will reduce the burden on health systems and free up valuable financial and human resources for other priority initiatives. In the case of TB for example, the total annual cost of the disease to the global economy is as high as US$ 16.0 billion, with US$ 12.0 billion attributable to lost earnings and the remaining US$ 4.0 billion spent on treatment and diagnostics. A shorter, im-

proved treatment can have a significant impact on both these numbers. In fact, with challenges such as drug-resistance increasing against existing tools, efforts to buttress health programmes within countries will be easily derailed without these new tools.

While global health funding has increased somewhat in recent years, greater and sustained funding will be needed to realize all health MDGs. As economically developed donor countries face financial constraints, it is important that programmes within developing countries be funded alongside research and development efforts so that aid is not only effective, but over the long-term reaps transformative health and developmental outcomes.

1 Abu-Raddad, L. et. al. (2009). Epidemiological Benefits of More Effective Tuberculosis Vaccines, Drugs and Diagnostics.

2 Calculated based on World Health Organization Data in Bloom. *Political and Economic Implications of Infectious Diseases.*

Panel discussion

Future trends for private Sector participation in global health and the role of the global Health partnerships – Prospects for the private sector

Elisabeth Sandor,
Senior Policy Advisor
Development Assistance Committee,
Organisation for Economic Coorporation and Development (OECD), Paris

Introduction

The landscape of aid, particularly in the sector of health, has become more and more complex in the recent period with the emergence of new stakeholders, new channels of funding and several "global initiatives" to tackle specific Millennium Development Goals or health systems bottlenecks. This trend has come with advantages – more money is available to help improve the health status of poor people in developing countries, new partnerships have been created, contributing to a wider mobilization and more collective engagement in support of health – and disadvantages – the aid architecture in health has become much more complex, with additional transaction costs for partner countries and donor agencies, as well as governance and accountability questions. An important challenge before us is to help partner countries manage a more complex aid, ensuring that more funding from various sources and entities contributes to national strategies and fits into local settings, capacities and priorities. The commitments taken in Paris (2005) and Accra (2008) offer a practical roadmap to move in that direction.

The participation of the private sector[1] in global health: an uncompleted process

A – The role of the private sector in the health sector takes several forms and is increasingly significant at both global and country levels

In discussing on the role of the private sector in the health sector, one needs to differentiate the in-country role of the private sector and the role of the private sector from the donor level and at the global level.

a) In developing countries themselves, the private sector continues to play a critical role in service delivery and supply chain, purchasing and contracting, risk pooling and health insurance schemes. Many countries, particularly in South Asia and sub-Saharan Africa have developed complex mixed health systems in which the contribution of the private/informal sector is a factor of dynamism whilst presenting challenges in terms of accessibility, equity and quality of services. Many developing countries, including least developed countries, depend significantly on out of the pocket expenditures (OoPs) by impoverished population to finance total health expenditures. Recent studies from the Interntional Finance Corporation (IFC)[2] and Brookings Institution[3] have showed that in sub-Saharan Africa, the OoPs represent about half of total health spending and in South Asia, total pri-

vate spending in health (OoP and other private funding) represents 80 percent of total spending. Countries like Cameroon, Guinea, Mali, Nigeria and Niger have experienced significant increases in private sector share of maternal and child services.

Furthermore, some countries like Mali are engaged in ambitious reforms to improve health outcomes (PRODESS II) which imply an increasing contribution by households and the private sector in general, in addition to an increased health budget.

b) On the donor side, which is the main focus of this note[4], the contribution from the private sector has also increased significantly, coming from international non-governmental organizations (NGOs), foundations, pharmaceutical companies or other international companies which have developed in-countries health activities.

– Increasing amounts of money are being mobilized by and with the private sector

There is no single database for tracking the flows from these various sources, but the Institute for Health Metrics and Evaluation (IHME) provides an interesting first set of information.[5] Out of total Development Assistance for Health (DAH) which accounts for US$ 21,8 billion in 2007, roughly two-thirds are funded by donor governments (76 percent in 2007), whilst private sources of funding are responsible for a growing share of total health assistance (from 19 percent in 1998 to 26,7 percent in 2007). Overseas health expenditure from US-based NGOs accounted for US$ 5,4 billion and the Bill and Melinda Gates Foundation (BMGF) global disbursements in 2007 represented US$ 1,25 billion.

The structure of the BMGF's spending in global health is also of interest as it helps to understand through which types of activities and at which levels, an actor such as the Gates Foundation can have impact on countries' activities. BMGF's funding flows to universities and research institutes as well as to public-private partnerships (GAVI and GF) and other product-development partnerships. Finally, it supports NGOs, corporations and multilateral organizations such as the World Bank.[6]

– New donor approaches are supported by the private sector participation

Looking at the global health landscape, the picture has become more complex with new important stakeholders such as the Global Fund and the GAVI Alliance which scaled up rapidly from less than 1 percent of health assistance each in 2002 to 8,3 percent and 4,2 percent respectively in 2007[7], benefiting most from the recent increase in DAH (by contrast with multilateral institutions like the World Bank or WHO). Both GAVI and the Global Fund present

themselves as unique Public-Private Partnerships, bringing together donor and recipient countries governments, civil society, the private sector and specific communities[8]. In DAC statistics, both GAVI Alliance and the GF have been re-classified from PPPs to multilateral organizations. This decision was taken in full agreement with both organizations and allows for more reliable tracking of resources flows in partner countries. But it does not question the fact that both have introduced new approaches to funding partner countries, including through innovative financing mechanisms, building on the increasing involvement of private sector representatives such as the BMGF or international private companies.

Benefiting from the upsurge in private philanthropy for development, both GF and GAVI have hosted and tested new approaches for funding development, using new revenue streams and public private partnerships in order to address the lack of incentives and/or market failures that impede development outcomes, particularly in the least developed countries.

Examples of these new mechanisms include:

- The Advanced Market Commitment for vaccines through which public and private donors commit to subsidize a vaccine which would otherwise not be commercially viable.
- Another example is the frontloading of health aid through the International Finance Facility for Immunisation (IFFim) by which aid donors borrow from private investors on the financial market against legally binding long-term ODA commitments.
- Entirely private aid funding mechanisms are also being developed such as the ProductRed trademark, which is licensed to global companies which pledge a percentage of their profits from RED sales products to Global Fund programmes, or the current proposal of a voluntary air-ticket solidarity contribution.

Although there is currently no agreed definition of innovative financing and therefore no single integrated database for tracking resource flows from these, nor a unique place for assessing and monitoring progress and impact in this area, there is now evidence that they mobilise and/or channel a significant portion of aid to health[9]. In doing so, innovative financing mechanisms build on the role of the private sector as a source of funding (IFFim, ProductRED), as a sponsor/facilitator (BMGF supporting the development of the Unitaid/airline ticket solidarity contribution), as a development partner (AMC) and as an incubator/main recipient (Global Fund, GAVI Alliance). Finally, the various dimensions of the private sector's participation in global health indicate that the private sector has become a significant

funder and actor which contribute to shape aid policies and impact aid activities at the country level.

B – An uncompleted process

The role of the private sector in global health financing has become more powerful and visible. At the same time, the private sector has not yet found its "right" place in the high-level discussions related to aid policies.

Up to a recent period, high-level discussions and agreements on aid had involved mainly public sector representatives such as bilateral donors and international organizations. The preparation and the outcomes of the 2008 Accra Third High Level Forum on Aid Effectiveness have marked a change with the increasing involvement of civil society representatives and a call for a stronger participation of all development actors including the civil society and private sector in a "broaden country-level policy dialogue on development"[10]. If progress has been made with the institutionalisation of the participation of civil society organizations in the Working Party on Aid Effectiveness and the overall policy debates on aid, more efforts are required to associate, through the most appropriate forms, representatives of the private sector, including foundations and for-profit private sector, to the debate on aid effectiveness.

Whilst there are obvious benefits of sharing lessons and evident common interest for obtaining better results including through more synergies across all forms of aid, questions about private sector representativeness and the fact that private sector entities may have reservations about donor accountability processes seem to remain, up to now, an obstacle for progress.

By contrast, at the sector and country levels, more positive synergies can be found and there are many examples of effective contributions from the representatives from the private sector including international NGOs, foundations, for profit companies in national health or Aids policies. A global health process like the International Health Partnership which focuses on promoting more harmonized and aligned donor aid, was set out by donor governments and international organizations but is also supported by the BMGF which contributes to its core management team.

More private sector participation in global health: is this good or bad?

In trying to assess the increased contribution of the private sector in global health, a set of important questions come to mind.

A – How does the participation of the private sector affect aid quantity?

Is the participation of the private sector additional to all official health funding? Overall, and when looking at the increasing volume of DAH from 2000 to 2007, it is clear that the increased participation of the private sector has brought more funding for development health activities.

But, the question of a potential substitution or disengagement from donor governments or from partner countries themselves to health which they could consider as well enough funded by new development partners and initiatives might also arise. This would certainly not be good news.

New sources and forms of aid should not discourage partner countries from their responsibility and emphazis on raising domestic revenues and developing equitable and fairly administered fiscal policies as a fundamental pillar of development.

Also, innovative financing mechanisms supported by donors need to be additional to existing ODA commitments. There can be a good case for raising quickly money through financial markets to support interventions with effective and sustained impact on the population. This has been possible for immunization for instance (IFFIm). But one should probably think twice before replicating such approaches that rely on the finance sector dynamism and create public finance liabilities for the future, with legitimate questions about their impact on ODA future trends.

Finally, new partnerships and new initiatives supported by the private sector might also involve new spending for technical assistance. Although the ultimate goal of these new initiatives is to improve the health status of the population, this could translate in less resource available for country aid allocation to support national strategies.

B – How does the participation of the private sector influence the global health agenda?

The private sector has a natural and strong interest for output or results-based approaches. This has driven the involvement and funding decisions of the BMGF in areas such as results based financing (with the World Bank) or support to global health data and health information system development (IHME and Health Metrics Network).

The involvement of global companies to fund Aids prevention and treatment programmes or health insurance schemes for their staff and relatives, with the support of the International Finance Corporation also derives from the interest from the private sector in cost-benefit and profitability.

International NGOs have specific focus and areas of interest. Through advocacy, some have been particularly efficient in raising more funding for Aids which, as illustrated by many including the OECD, World Bank, WHO and IHME, benefited

from the bulk of the increase in DAH. In areas such as sexual and reproductive health, the role of the private sector (international NGOs and private Foundations like Hewlett Packard) remained critical to maintain public attention and support, although the funding has been – and still remains - insufficient in comparison to other activities and given the development needs and objectives.

These examples show that the private sector, through its various components, can have an influence which is positive on the health agenda. For instance, the focus on results has come back as a strong area of priority for donor agencies, alongside with the accountability question. It raises a number of critical questions, such as: “How to measure results?”, “How can one link inputs to outputs and outcomes?”, “Which results are we talking about? Are these the donor’s results or the countries’ results?” “How to make sure that the outputs or results based approaches are integrated into the overall health programme?” But this is certainly a welcomed development - in this time of global financial crisis and ongoing questions regarding the effectiveness of aid - that aid practitioners and all development partners give a new impetus to the results of aid policies. Also, managing for development results being a key piece of the aid effectiveness monitoring, lessons from the health sector in this area can usefully influence the broader discussion

on the ways to make aid more effective and achieve development results and contribute to more public support to aid in general.

As illustrated in the first paragraph of this note on innovative financing, the pragmatic and cutting-edge approach from the BMGF has also contributed to influence the decisions by donors to fund specific activities. Some of them aim to work more efficiently with the informal and private sector in developing countries as in the case of the Affordable Medicines Facility on Malaria which the Global Fund Board has approved to support in a pilot phase, with the key initial support from the BMGF together with the World Bank.

Finally, looking at Public Private Partnerships such as the GAVI Alliance and the Global Fund, they are actively contributing to - and influencing - important debates through the IHP+, the High level task force on innovative financing for health and other initiatives related to health system strengthening. These discussions have an impact on country activities and strategies for donor support to their national strategies.

C – How does the accountability work?

The global debate on aid has been shaped by donor governments and the international organizations they fund and are represented into, together with partner countries representatives. In addition to their own domestic accountability mechanisms which take them to decide and report openly on aid budget, priorities and policies, donor governments have created a specific global accountability system through a set of institutions including the UN/Financing for Development cycle or the Paris Declaration and Accra Agenda for Actrion (AAA)/aid effectiveness process.

Although a number of private sector representatives such as for-profit private sector and foundations have been – and are regularly – invited to these debates, they have their own ways of participating which is different from the government participation as they report primarily and entirely to their board and not to international organizations and processes.

Moreover, international organizations that have benefited less than others from the increase of DAH might be tempted to look for new financial support to fund their activities from new stakeholders or new initiatives. This may raise accountability and governance issues within these institutions with regards to their board and these new partners. For all these reasons, finding the right way to involve the private sector in all its forms in the aid debate has become all the more important given the significance of funding and influence it has now gained in global health.

D – How the participation of the private sector fit in the global aid architecture

An increasing number of health donors, including global health partnerships and initiatives, have contributed to increasing the complexity of the global health aid architecture. Very well known and publications illustrate the significant number of global partnerships in health today. Whilst diversity of the funding sources is theoretically not a problem and can help in securing more total available funding for partner countries, the latest are not equipped and ready to deal with more requests, proposals, reporting, monitoring and auditing which sometimes accompany the emergence of new initiatives or partnerships.

Also, an increasing number of initiatives and partnerships to support similar agendas (MDGs 4 and 5, Health System Strengthening...) can raise legitimate questions at the global and the country levels about a clear division of labour amongst implementing agencies. Finally, bilateral donors, international organizations and private sector representatives themselves sometimes devote a high proportion of resources for the managing and overseeing of new partnerships which added value needs to be monitored and assessed and, in the absence of positive impact and results, closing down decisions should be taken.

3) The need to improve synergies and ensure more effectiveness of total aid

In addition to the reasons mentioned above, the global financial crisis reinforces the need for better synergies and complementarities amongst the various forms of aid, building on a better understanding and knowledge of all contributions and comparative advantage of each of them. This implies specific actions and work plans for the OECD.

A – The OECD/DAC commitment to improve synergies across all forms of aid

On May 27, DAC members endorsed an Action Plan which includes important commitments to respond to the development challenges and consequences of the global economic and financial crisis in poor countries. DAC members have reaffirmed their existing ODA commitments and confirmed they will refrain from any budgetary action that would undermine these commitments. They also confirmed their intention to support more predictable aid to partner countries, in line with their existing commitments entrenched in the Paris Declaration and the Accra Agenda for Action (AAA). Moreover, they acknowledged the wide array of instruments, channels and sources that are available, beyond and alongside to ODA, for contributing to important development results.

This has two practical implications for the OECD DAC:

First, we have to seek a comprehensive picture of the different flows of development finance, not just ODA. We need to be pragmatic and look for complementarity and synergies and we need sound, monitorable information on these various sources. This should be done also in the health sector.

Second, as our objective is to ensure effectiveness and demonstrate results, it is essential to set out best practice and recommendations for making the most of possible synergies between these various funding mechanisms.

Increasing the volume of aid and increasing the quality of aid are equally important. All forms of aid must contribute to achieve progress in both ways and they can only do so if they comply with key agreed aid effectiveness principles. The first of the PD principle is related to country ownership. All forms of aid, including the one supported by the private sector and PPPs, need to strengthen country ownership rather than setting up top-down approaches and new institutions that partner countries need thereafter, to accommodate with their institutional setting and capacities.

Secondly, all forms of aid including the one supported by the private sector and PPPs should contribute to more effective and inclusive partnerships and avoid complicating furthermore an-already complex aid architecture. Additional resources should be channeled through existing institutions, also building on an improved division of labour amongst all donors.

Thirdly, all forms of aid including the one supported by the private sector and PPPs, need to align within country priorities, settings and institutions. Interesting discussions are taking place on the possibilities for the GF and GAVI Alliance – together with the World Bank - to better comply with the aid effectiveness principles, in particular with the ones of alignment and harmonization.

Finally, all forms of aid need to pursue the objective of delivering and accounting for development results. But let's be aware that there is a risk that more initiatives and mechanisms increase the burden of partner countries through additional reporting and indicators. Additional resources need to contribute to overall results which are the countries' results. Let's make sure new donor accountability does not undermine local accountability. It's even more important in institutional settings with limited capacities.

B – Monitoring progress in the PD and AAA in the health sector also includes the private sector

As a part of its support to the Working Party on aid effectiveness and the overall monitoring of the progress in the implementation of the PD and AAA, the OECD has developed with a set of key partners a work stream on aid effectiveness and health[11]. A dedicated working group (task team on health as a tracer sector[12]) aims to promote and report about progress in more effective aid, focusing on priority areas: ownership and accountability, use of country systems, transparent and responsible aid, managing for development results. These are the priority areas as agreed by the working party on aid effectiveness. They are directly deriving from the PD and AAA frameworks.

The TT HATS includes representatives from PPPs (GAVI Alliance and GF), an international NGO and a foundation which actively supports innovative financing approaches in the health sector. Planned activities include an interim report on progress and bottlenecks for a more effective aid to health. This report will include contributions from the various private sector representatives.

Conclusion

This note has tried to highlight some of the main critical challenges and questions for all forms of aid, including PPPs and other forms of aid supported by the private sector, to be more effective and contribute to sustainable development results in countries. Although the OECD membership and mandate provide specific conditions for the OECD to work on and with the private sector on global health, the interest of OECD DAC countries for PPPs and new approaches to health funding, the financial crisis and the commitments taken by DAC members to look at a more comprehensive picture of aid, including ODA and non ODA sources, as well as the mandate and ongoing work on aid effectiveness at the sector level offer new opportunities for us to contribute, with others, to a better understanding and assessing of the contribution of the private sector to global health.

1 There are various definitions of private sector. In this note, we use a broad definition which goes beyond for-profit activities and includes all service and funding providers working outside governments.

2 "The business of health in Africa", IFC

3 See "The role of the private sector in health systems: challenges and opportunities", Gina Lagomarsino. Presentation at the World bank Human Development Forum, 3 November 2008

4 This note does not address the ways to support effective health systems in partner countries, building on the role of the in-country private sector. Recommendations and guidelines from the OECD on this topic can be found by consulting "DAC Guidelines and reference series, Poverty and Health", 2003

5 See "Financing Global Health 2009", IHME. The OECD was part of the health financing advisory panel which guided the research efforts

6 See IHME

7 See IHME report, page 20

8 See the Global Fund's website:"This partnership between governments, civil society, the private sector and affected communities represents a new approach to international health financing"

9 For instance: the Unitaid-international purchase facility funded by UNITAID-airline ticket tax has collected 251 M USD per year (source: UNITAID); the IFFIm has mobilized 2.4 bn USD as of today and is expected to raise up to 4 bn USD in the first 10 years (Source: GAVI). ProductRed has collected 134.5 M USD (Source: Global Fund).

10 See paragraph 13 of the Accra Agenda for Action

11 See: www.oecd/dac/effectiveness/health

12 Co-chaired by Mali and the WHO

Panel discussion

Marie-Odile Waty,
Head of the Health and Social Protection Division, Technical Operation Department, Agence Francaise de Developpement (AFD), Paris

I will bring the perspective of bi-lateral donor. Just a few words on the French Development Agency (AFD) a development finance institution that works on behalf of the French government.

Slide 1 AFD Group, see page 147

AFD uses a complete set of financing instruments that are attractive to the private sector. AFD provides grants to central governments, soft (subsidized) loans, loans at market conditions, guarantees and equity shareholding. AFD works with all kinds of stakeholders. It is somehow similar to KfW, except that AFD has also a mandate as the bilateral arm of the French government. AFD provides also subsidies to low-income and crisis countries and has a specific financing window for non-governmental organizations (NGOs) support. AFD has a private arm called PROPARCO (Société de Promotion et de Participation pour la Coopération Economique), which lends to the private sector at market rate. AFD is active in five continents, working in 60 developing countries. AFD interventions are aimed at reducing poverty promoting economic growth and protecting global public goods. It can lend to the private sector at subsidized rates providing that the investment bears some specific social and development objectives that can be quantified.

Just to give you an idea of the importance of AFD commitments to the private sector: Last year AFD committed 4.5 billion Euros on development projects; nearly 40 percent of those commitments were made to the private sector, including in sub-Saharan Africa. AFD believes that the private sector can contribute significantly to development. It is a very important actor for AFD –not so much in social sectors, because these sectors are new to AFD-, but more so in water and sanitation, small-scale enterprise, environment, transport and energy.

Slide 2 AFD health interventions in synergy with French global health support see page 147

How do we approach the private sector? I would like to come back to what David de Ferranti said; we take a very pragmatic approach. It is not either-or; it is both. AFD works both with central governments and with the private sector. We actually acknowledge three facts concerning the role of the private sector in health. First: In most countries we are working with, including low-income countries, the private sector is already a major player. This cannot be ignored. Second: Health expenditures are expected to grow, and more investment will be needed to meet new demands. The issue is how to make these additional investments meaningful, in terms of outcome and efficiency gains. Third: With respect to low-income countries, we all know now that most countries are off track for meeting the Millennium Development Goals (MDGs) and that public funds will not be sufficient enough to help those countries reach the MDGs.

The issue is really how to further engage the private sector in providing affordable and quality health products and services that reach a large population? It is true that it will not target the poorest, but it can reach a large population, including the poor, and build local capacities. This is also another important objective for AFD: the engagement of the private sector should help to upgrade or build in-country capacities in the production of healthcare services, pharmaceuticals, tests, or health-related products.

How do we do it? Since health is now globalized, one cannot only work at the country level. AFD partners with the French Ministry of Foreign Affairs and tries to advocate at the global level for a more active role of the private sector. France is a major contributor of the global health initiatives (Global Fund, UNITAID, IFFim, etc.). France is the second bilateral contributor to the Global Fund with 300 million Euros per year. France was instrumental in creating the levy on airline tickets with UNITAID and also supports the International Finance Facility for immunizations. Through our active participation in these global health initiatives, we want to push an agenda that focuses on a stronger participation from the private sector.

We think that a lot of progress in that regard has been made in the fight against communicable diseases. We have learned from our colleagues from the TB Alliance and the Global Fund, that these initiatives have succeeded in better integrating the private sector and that some impact is already measurable. However, less progress has been made in terms of health systems initiatives, such as, for example, the International Health Partnership (IHP) and Providing for Health (P4H). France is also a member of those two initiatives and would like that further work be done with regard to the integration of the private sector.

AFD also partners with private foundations such as the Bill and Melinda Gates Foundation, William J. Clinton Foundation, and other foundations and philanthropic businesses. Also, we think that multilateral organizations have also an important role to play in advocating for a stronger role and integration of the private sector. We heard that the World Health Assembly this year will pass a resolution on the role of the private sector. That is what we were told, and we welcome these developments.

At the global level, it is also important to push for the development of innovative financing mechanisms. We should think of other ways to finance health systems that can include the private sector as well. AFD has developed a lot of thinking about dedicated investment or financial instruments to promote private sector's activities in developing countries. AFD has established an investment fund for Africa and is developing dedicated lines of credit and guarantees for local banks. We are thinking more and more about how to harness the private parties in those two sectors that are more difficult: health and education. We are also developing our subsidized-lending activities in order to make the loans more attractive to private stakeholders whose investments also have a social objective.

At country-level, we want to work on three pillars in parallel:

- on the policy side, which includes the regulatory, accreditation and business environment framework;
- on the demand side, by focusing on social protection and health insurance; the challenge in most low-income countries is that the demand is very low; people cannot just afford the services, including in public health facilities;
- on the supply side, by directly supporting private investments.

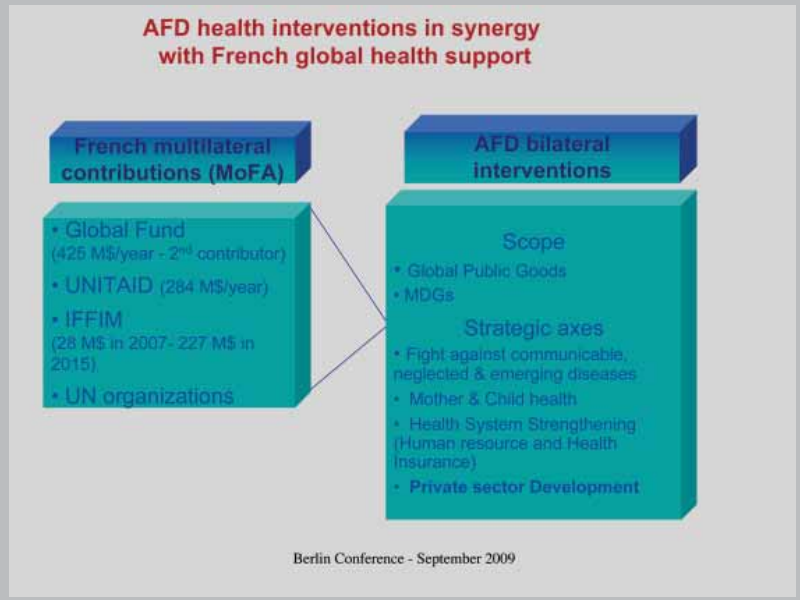
Before, donors tended to work only on the policy side: they were funding projects managed by ministries of health that would include a component on the regulatory framework, but without really addressing issues with the private sector. Somehow, these projects didn't make a very big impact. We therefore believe that it is important to address these three pillars in parallel. You cannot support a scaling up in the supply of services in the private and the public sectors if there is no demand for those services. That is why AFD supports the development of health insurance and pre-payment mechanisms, voucher systems.

Regarding the policy side, we also believe that it is important to help governments separate the financing from the provision of health services. Whatever financing system a country has developed, whether it is budgetary, or through insurance, the separation of financing for provision allows a country to enter into a contracting mode with health care providers – both public and private – and to bring into the system the right incentives for more performance.

On the supply side, AFD finances private investments mostly through loans: it can only give grants to the private sector, if it is, for example, an NGO, or a faith based organization. But AFD can provide soft loans to the private sector in the case of investments which also include a social component. AFD enters into a dialogue with the private actor on the size and scope of its social project. The rule is that the cost of the social project should match the amount of subsidy that is integrated into the loan. Social projects can include: (a) the establishment or the increase of some form of cross-subsidization of services from rich to poor (in order to increase the number of poor who can access the services); that was done in many instances; (b) the increase

in the volume of services in order to reduce unit costs, (c) the development of preventive services, (d) the reduction in the costs of inputs, (e) student loans – that was for education and training, etc. There are many ways in which you can help the private sector in developing investments that have a wider social impact and enhance quality.

Slide 1 AFD Group



Slide 2 AFD health interventions in synergy with French global health support

Panel discussion

Siegfried Throm,
Director Research, Development, Innovation, vfa – German Association of Research-Based Pharmaceutical Companies, Germany

It is widely recognized that there is a need for increased and ongoing funding for research and development towards diseases primarily affecting developing countries. There are ten so-called "neglected diseases", as identified by WHO-TDR, which are responsible for a large health burden on the poorest and most vulnerable populations across the developing world. Current control efforts for these "neglected diseases" are hampered by – among other barriers, such as insufficient infrastructure – a lack of appropriate treatments and diagnostics. As these diseases affect the poorest of the poor, the opportunities for recouping the investment in Research and Developement (R+D) as it is the case for "regular" diseases do not exist or are associated with a higher level of risk, which discourages investment.

Product Development Partnerships (PDPs) are non-governmental organizations (NGOs) that have been created in the last decade to fill this gap and reduce the risk undertaken by each partner. As a sign of success, the PDPs have begun to build pipelines both in the initial discovery phase as well as in the development phase, the latter being particularly costly due to its length and complexity. To ensure uninterrupted progress, additional funding needs to be secured.

Public sources, often those responsible for economic cooperation and development, play a key role in this funding. Also, governments and other structures of a state have a responsibility to facilitate the cooperation between public and private entities in research and development of new and innovative drugs for diseases of the poor.

vfa and the Joint Conference Church and Development (GKKE) therefore have recently published jointly a list of policy recommendations regarding health in developing countries, on the occasion of this year's elections to the German Bundestag. Some key recommendations of this paper are:

- Promote the value of Product Development Partnerships (PDPs) such as Drugs for Neglected Diseases initiative (DNDi) and Medicines for Malaria Venture (MMV), so that more such PDPs are established.

- Ensure sustainable funding of the pipelines created by such PDPs so that there is enough money available to finance the testing in the later stages of development.

- The new German Government should better coordinate the various government departments charged with health-related issues by a high level coordination agency (one stop shop for industry, churches, civil society). The Deutsche Bundestag should establish a parliamentary sub-committee for international health.

- Effective measures should be developed to train and retain qualified personnel in developing countries.

- Industry is willing to participate in suitable projects to build capacities for the research, development, production and distribution of medicines in developing countries.

Panel discussion

Hubertus Graf von Plettenberg,
First Vice President, Manufacturing Industry/Services, Deutsche Investitions- und Entwicklungsgesellschaft (DEG), Member of KfW banking group
Cologne

In Asia and Africa the private sector (i.e. private health service providers) plays a huge role – in some countries as India and Pakistan an overwhelming one.

The private sector in health systems is potentially larger than the public sector and therefore indispensable to meet the growing demand in developing countries over the next years – even for decades. Therefore, this has to be acknowledged when discussing about health systems strengthening. This presents a not yet fully used potentiality for improvements in health care delivery in low and middle income countries – e.g. through contracting of „Service Level Agreements“ between government, faith based or other non-governmental/ civil society organizations in order to make health services available for poor communities.

Private non-governmental providers often are renowned for their outstanding services at good quality and reasonable price – able to compete with public services.

Outsourcing of services to the private sector may help ministries with organizing complex tasks (e.g. transport, support services, pharmaceutical logistics, maintenance and repair of equipment) and, thus, contribute to efficiency gains in the health sector. The private sector is usually more flexible and quickly reacting to changes in demand.

From a health system´s and policy perspective, specific challenges need to be accommodated while opting for increased private sector participation: poverty focus, quality of service providers and focus on prevention. These are not always primary priorities in the business concepts of private sector stakeholders.

In low income countries often there is a lack of strategic vision to value systematic involvement of the private sector and many health ministries view themselves as service providers – instead as regulating authority – and, thus as competitors.

Ministries of Health should rather take the stewardship role as regulators of mixed health systems and introduce stringent certification, accreditation and quality control functions. Division of tasks and sharing responsibilities requests particularly to differentiate between financing and service delivery functions within a health system.

Panel discussion

Max Lawson
Advisor, Health Development Finance
and Public Services, Oxfam, UK

Oxfam works in over 100 countries around the world; we work to some extent in health care in many countries, mostly on the advocacy and campaigning side and policy work. The first thing to say is we have a different starting point. We would like to be convinced that the private sector is a good thing in the first place. Often we hear the statistic; we heard it from David de Ferranti. For example, in India, 80 percent of health care is already in the private sector, so we have to work with the private sector. It is a very common argument. If you will forgive me, I will try a bit of an analogy: in Somalia, 100 percent of security services are in the private sector. That is a situation that is unbearable. It is a situation that has emerged because of state failure. It is very important, and it is no coincidence, that the huge proportion of private care is in the low-income country settings, where governments have failed to step in. In high-income countries, the vast majority of financing is in the pubic sphere. That is a really important point.

We really think that governments in many of the poorest countries have failed their people and that we need to address that. The private sector does have a role to play, but there is this huge gap of unmet need and unmet care that we need to fill, and we need to be convinced that the private option is the best way to go, or whether we should look at more of a mixture. To use a phrase from the US debate, we are very much in favor of the public option, which is getting a lot of discussion at the moment.

There are broadly three kinds of private sector in the poorest countries. We have talked today about the private sector, and sometimes we differentiate it and sometimes we do not. Oxfam has no problem at all with many of the not-for-profit, particularly church-based services that you see for example all over Africa. We think there is a need to regulate them, to integrate them, and to work with them. But there is a very big difference between an organization that is set up to make money and an organization that is set up as a value-based service to deliver services to the poor. I think it is important not to conflate the two.

The other two big chunks of private sector are for-profit that is largely aimed at the richer segments of society. The kinds of upper quintile private health services in many of the poorest countries are maybe not quite the standard were are used to in the Organisation for Economic Cooperation and Development (OECD) countries, but certainly, if you have got the money, in most countries of the world you can get pretty good care. As Oxfam, we do not think that donor aid and donor taxes should really be involved in supporting the development of that sector. If that sector develops, that is great, but we do not

think donor aid or government revenue should be involved in subsidizing it.

The third area, which I think is the reality for the vast majority, is the for-profit private sector that aims at the poorest people. This is a very dangerous threat to people's health in many situations. It is largely unregulated, often very unqualified and often not even pretending to be run by health professionals. Often shop keepers are selling medicines. This is a big issue. The premise all day has been that the private sector automatically is a positive good that we need to work with. But there is a need to improve quality and regulate the private provision that the poorest access. It is important to get out there and do this. There are many poor people who are getting misdiagnozed; they are being treated for the wrong diseases; they are being given medicines that are out of date. In many instances counterfeit drugs are given to sick people. This is really a serious problem for public health in poor countries. That is a problem of private sector. There is a need to deal with that.

What is the answer; what are we saying? We are not suggesting for a second that the private sector doesn't have a role in the answer, as it does at the moment. We would favor more looking at the not-for-profit sector and really trying to make it work, particularly in Africa where we know that the church plays a huge part in provision of existing services. But, in terms of the scale-up, where are we going to get that scale-up from? We think we have to revisit the public option. We have to be talking about this. We have to have meetings as important as high profile as this one, looking at how to scale up public sector provision. Because for twenty years, we have been neglecting the public sector. It has been underinvested in by poor country governments and donors alike. In the last ten years, we have seen, as we have heard today elaborated, a big increase in donor funding, but at the expense of massively "balkanizing" and fracturing health systems in poor countries. We are dealing with multiple donors and multiple providers. There has been a big opportunity cost there, again, driven largely by different donors and their different priorities.

It is not the fact that to say that we have had twenty, thirty years of trying this public option and it has failed. I think we have had twenty years of firstly huge disinvestment; now ten years of investment which has had its pluses. But the investment certainly hasn't been enough in public health systems at all. It has been in this fractured way that we have heard about at this conference. We think that there should be investment in scaling up the public sector. That can be done, and it is not the case that it is automatically a win-win to invest in the private sector at the same time. There are trade-offs; just simple basic trade-offs. In Malawi, we talked about earlier on; it is the same small group of managers in the Ministry of Health. Either they could spend two-thirds of their week trying in vain to regulate a multiplicity of private providers, or they could spend two-thirds of their week trying to manage and expand public provision. Those are the real trade-offs that we are talking about. Regulating the private sector is not an easy option; it is incredibly difficult.

I will finish by saying that one of the more interesting studies that I have heard about recently was at a conference in Ghana, comparing Sri Lanka and India. I think this is really important, because we need to look at the developing countries, low- to middle-income countries that have really succeeded in achieving the aim of universal coverage. Sri Lanka is one that has done exceptionally well, and has a mix. Here the private sector is big and substantial. We are not talking about Cuba here; we are not talking about some communist Utopia, we are talking about a mixed situation, but where the investment in public provision has been significant for decades. What is really interesting and what this study was showing is that as a result, the quality of the private sector in Sri Lanka is significantly better than in India, largely because of the competitive influence. By investing in the public option, you drive up quality across the board. This is the best way to regulate the private sector. The best way to achieve universal access is to invest in the public option in tandem with exploring private alternatives. "Public" first is what we would say.

Panel discussion

Bernd Appelt,
Priority Area Manager for Health and Social Protection, Department of Planning and Development, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, Eschborn

Public Private Partnerships (PPPs) in the health sector in low and middle-income countries have the potential to strengthen health systems in their capacity to deliver quality health services. However, a crucial factor is the competence of the public sector to regulate effectively health care services. In many low and middle income countries there is no regulatory frame work for health care service providers neither for government health care service providers nor for private health care service providers and if there is one it is not enforced. This results in a situation where the public and private health care sector work side by side often without any formal linkages - this barrier does not exist for patients and health care workers. Patients choose the service the need and which they can afford irrespective of the ownership of the institution in the same way as health care professionals choose the employer which serve their needs best. And one has to keep in mind here that private services can at times be cheaper than public services and that private health care institutions sometimes pay their employees less than public institutions.

Therefore the capacities of governments – and here I include besides the Ministries of Health all other ministries which own or run health care institutions as well as Ministries of Finance, Ministries of Planning, Ministries of Local Government, Civil Service Institutions, General Accounting Offices – need to be developed and strengthened. This means, first, their ability to recognize the potential of public-private-partnerships and incorporate this in a comprehensive health policy and secondly, their capacity to be able to deal and contract with the private sector, to negotiate services, prices, quantity, access and subsequently monitor and evaluate results. This would mean in effect that governments and their institutions would need to develop the technical skills to manage results rather than inputs. This fundamental change of the role of government requires strong political will and leadership and is therefore primarily a political rather that a technical question.

Summary of the day's discussion

David de Ferranti,
President, Results for Development Institute and Senior Fellow, Brookings Institution, Washington D. C.

We have had three panels so far. We had a great diversity of opinions and issues, some common themes. We considered the economic, financial issues, the questions around the future of aid; maybe there was a fatigue with creating more global health initiatives. I do not disagree that the context looks a little more challenging, little less certain, and it may pose more difficult choices going forward. But, even beyond that, there are always changes in the geo-politics, and they are driven by national political leadership changes. Some of them are likely in the year and years ahead. That is one thing to keep in mind and perhaps return to.

Our discussions have focused a lot on partnerships and not only public-private but also external support to countries. A second set revolved around the private sector, or lets say non-state sector. We, the non-state sector, need to know how we can do our jobs better. There is a need for capacity building, so we can fulfil our function better.

Though not very extensive, we also discussed private sector initiatives from developed countries. Our first panel included some thoughts and suggestions about that. There is a lot more there that could be discussed. Referring to partnerships: it is worth recalling that there is actually quite a variety of partnerships. There are the new institutions: GAVI and Global Fund, and there have been issues of discussion useful around that. There are, what I am going to call, the country-focused partnerships meaning they seek to work with countries to help them wrestle with problems better, of which the International Health Partnership (IHP) is one, and Providing for Health Initiative (P4H) is another. We have raised questions about whether the IHP is actually achieving that country focus, of putting the country in the driver seat. The thought came to my mind what would happen if it were ten years from now, and we were all gathering again. What would we likely be able to say at that point? What would we like to know relevant to the topics that we have talked about? I have listed eight items. I am sure that they are not the only or the best, but maybe they will stimulate you all to think of some more.

First: The record we have seen of donor coordination, which involves sector wide approaches (SWAPs), pools, funds, HIP, the ACRA, going back to Paris, donor coordination discussions, GAVI, Global Fund, World Bank coordination. These are all different things and I am not putting them all in the same pot. But there is a theme running through them which is what promises for working together are and can be achieved. Maybe anarchy is the natural state of affairs; maybe it is how change happens. It is creative destruction. But, clearly, we all know that duplication does have its costs. The record thus far

has not been overwhelmingly positive. So, what do we have to do so that ten years from now we can look back and say that something good has happened? That would mean that we are getting more money for health. That requires these issues. There is more to say about that, but I wont take up that time.

Second: The record of the number of global health initiatives. I do not see too many hands raised that there should be twice as many as there are now. There could be some consolidation, some success. What if GAVI and the Global Fund ten years from now were able to look back and say, "We made a lot of progress; we should be talking about how to phase down, combine, shift". Hopefully that is not too impossible ten years from now. The first area is the record of all the attempts to work together. The second is the global initiatives. By the way, the notion came up at a discussion at lunch; for every new initiative, three should be retired through folding in. I will sign up for that; I think that is good.

Third: The number of countries where government stewardship of the whole health system, state and non-state has improved. I do not know how you would measure that, but we could think about how to measure that. It would be nice in ten years to look back at that. Certainly, looking back at thirty years, I do not see as much progress as really the billion or three billion people living on less than $2.00 a day deserve. Maybe we can make a step up in the next ten years.

Fourth: A number of countries where public facilities are improved and are stepping up to the mark. All of us would like to see governments do well. Can we make that happen?

Fifth: The number of countries where the non-state side has improved on its part. I mentioned, when you sit down with them, including the for-profit side, local organization, desperate to have the kinds of things that we often talk about as within the public sector: capacity building, knowledge sharing; you are pretty much alone if you are running something out there without a chance to connect.

Sixth: The number of countries where key regulatory role that enables government to be steward is working better.

Seventh: The number of countries who are making significant progress towards universal coverage, as David Evans talked about it, or what I have called the "third great transition".

Eighth: The number of countries where impact assessment and the information systems and the evidence-generating capability that needs to underpin it is really making serious project. Question in that regard? We have always assumed that making significant advances in that area is a purely public-sector activity – at least the information gathering, where we tend to. But is that necessarily the case? A lot of other sectors, a lot of other activities find ways to evaluate, rate, score, reaching beyond overstretched ministries of health and others. How to actually ensure that ten years from now we have all that information? I am a mischief person, so, of course, I have to propose that a new global initiative on that subject with a coordinating group to orchestrate the association of federated associations should be established to do that.


Experts' meeting
Making partnerships work for health, focusing on low-income countries
The role of the private sector
September 21, 2009, Berlin, Germany
in cooperation with
kfw
Bayer HealthCare
Bayer Schering Pharma

Curricula Vitae

ADLIDE, Geoff

is Director of Advocacy and Public Policy at the GAVI Alliance in Geneva, a position he took up in July 2007. His previous experience ranged across international development, indigenous land rights and radio broadcasting and production. Prior to joining GAVI, Geoff worked for the Australian Agency for International Development (AusAID), based at the Australian Permanent Mission to United Nations in Geneva. He was active on the Boards of UNAids and the Global Fund to Fight Aids, Tuberculosis and Malaria. He previously managed AusAID country programmes in Cambodia, Myanmar and Thailand and was a resident AusAID representative in Fiji. Before joining AusAID in 1995, Geoff spent seven years in media and policy advisory roles. Geoff has a BA (Communication) from the University of Technology Sydney and has also studied anthropology and participatory development.

APPELT, Bernd

is a general physician and health economist. He has worked in developing countries across Africa and Asia for more than 20 years for the German Development Service (DED) and Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH as a practitioner and health policy advisor. At the beginning of 2008, he took the position of a Priority Area Manager for Health and Social Protection in the Department of Planning and Development at GTZ head office in Eschborn, Germany. As a health policy advisor for low-income countries he is particularly interested in the role of the private sector and believes that there is great potential for governments to improve the quality of and access to health service delivery also for poor people in our development corporation partner countries.

BICHMANN, Wolfgang

is head of the Sector and Policy Division Health, at KfW Entwicklungsbank (KfW Development Bank), covering sector policy tasks as well as German Financial Cooperation's programme financing for health, population and HIV/Aids in sub-Saharan Africa. With working experience overseas as well as in research and lecturing at Heidelberg University, he joined KfW development bank in 1993 and held positions in sectoral divisions for social infrastructure and development. He is going to co-chair the international Reproductive Health Supplies Coalition together with a Netherlands representative from 2006 onwards.

BRILL, Klaus

is Vice President Corporate Commercial Relations at Bayer Schering Pharma AG, Berlin. 1982 he joined Schering as Medical Advisor in various fields (fertility control, hormone replacement therapy, prostatic cancer). Further career milestones at Bayer Schering Pharma are: Head of Department Medical Affairs Gynaecology/Marketing Gynaecology, Head of Business Unit Gynaecology in the German operations and Head of Strategy and Portfolio Management Global Business Unit Women's Healthcare.

BONSMANN, Christoph

The pharmacist Christoph Bonsmann works for the German medical aid organisation action medeor and is head of the department pharmacy and development cooperation. Since 2004 he is managing director of action medeor International Healthcare, a not-for-profit pharmaceutical wholesaler.
His special focus is pharmaceutical technology transfer to East Africa. In Tanzania he set up a non-profit pharmaceutical wholesaler using existing regional manufacturers as source for medicines after they had been inspected and approved.
Currently he is working on an EC financed project of setting up a pharmaceutical factory in Northern Tanzania for the production of high quality antiretrovirals.

BURKE, Marshall

leads the TB Alliance's resource mobilization efforts and oversees the TB Alliance's Advocacy and Policy Department, including its community engagement efforts. He was most recently Senior Vice President of Resource Development for CARE International. Dr. Burke spent 20 years at CARE in a number of positions of increasing responsibility in the United States, Latin America, and Africa. While working oversees, he was responsible for introducing CARE's HIV and Women's Health Program. He earned a Ph.D. from the University of Arizona.

de FERRANTI, David

is the President of Results for Development and leads the Global Health Financing Initiative at Brookings Institution. He joined Brookings as a Senior Fellow in 2005, when he retired from the World Bank, where he worked as Regional Vice President for Latin America and the Caribbean for six years. From 1994 to 1999, he oversaw the Bank's research and financial support to countries worldwide in the areas of health, education, nutrition, and other social services. In addition, he has been a Senior Advisor at the United Nations Foundation, an Adjunct Professor at Georgetown University, an advisor to several enterprises. Earlier in his career he held management positions at Rand (the think tank), and in the U.S. government. He is presently the Chair of the Board of the Center on Budget and Policy Priorities, and serves as Chair of The Health Financing Task Force, The Task Force on Health Workforce Costs and Financing, and The Working Group on Aids Costs and Financing. He holds a Ph.D. in Economics from Princeton University, and a Bachelors degree from Yale University.

ELLENNA, Guy

is the Director of the Health and Education Department of the International Finance Corporation (IFC). He is in charge of a growing portfolio of health and education investments of over US$ 294 million in more than 30 emerging market countries. Dr. Ellena joined the World Bank in 1986 and occupied successive operational positions as a Health Economist in several regions where he carried out policy work for the World Bank. He joined IFC's Latin America and Caribbean Department as its first Senior Health Specialist in 1998, as part of the Department's new Health Care Unit. Between April 2000 and November 2001, Dr. Ellena was the Technical Manager for the Global Practice Group for Social Sectors (now the Health and Education Department). Before joining the World Bank Group, Mr Ellena was a researcher and health economics/policy consultant for the French Government's development agencies. He holds a Master's degree in Economics as well as a Ph.D. in Health Economics from the University of Aix-Marseille.

EVANS, David B.

is Director of the Department of Health Systems Financing in the Cluster on Health Systems and Services at the World Health Organization. He has a Ph.D. in economics and worked as an academic in Australia and Singapore before joining WHO in 1990, initially working on social and economic aspects of tropical disease transmission and control. Subsequently his work has covered a variety of areas including the assessment of health system performance and the generation, analysis and application of evidence for health policy. This work now focuses specifically on the development of effective, efficient and equitable health financing systems. He has published widely in these areas.

FILIPP, Robert

is the Head of Innovative Financing at the Global Fund to Fight Aids, Tuberculosis and Malaria. Mr Filipp is responsible for the development and implementation of new financing instruments for the Global Fund, aimed at augmenting and diversifying financial resources for health. Previously, he was in private business being involved in development. From 1992 until 1998, he held management positions at the United Nations Development Programme (UNDP), the Global Environment Facility and the World Bank. Mr Filipp has degrees in international law and in economics from Bonn University, Harvard University and the Fletcher School of Law and Diplomacy (Tufts).

HAKOBYAN, Tatul

was appointed Deputy Minister of Health in the Armenian Ministry of Health in July 2002. From December 2000-July 2002, he served as a senior technical advisor for USAID's Armenia Social Transition Program (ASTP). Tatul Hakobyan previously held director positions with the Armenian Ministry of Health (1999-2000). In addition, he worked as an expert for the European Community TACIS project and as an independent consultant for the World Bank Project Implementation Unit (1997-2000). He also worked as a medical coordinator and program manager for the United Methodist Committee on Relief (1996-1999). In his early career, he served as director of Synaps Co. LTD (1985-1995). Mr Hakobyan holds a MPH and a MBA from the American University of Armenia (AUA), Yerevan as well as a Bachelor of Science, Major Pharmacology from the Medical University, Yerevan.

HARMER, Andrew

is a global health policy analyst with a background in International Relations. He is currently working as a research assistant with the Global Health Initiatives Network (GHIN) at the London School of Hygiene and Tropical Medicine. Previously, he has worked for various think tanks including responsible action (2008-2009), Institute for Development Studies, Sussex University (2008), the Overseas Development Institute, London (2006), and HLSP, London (2004, 2008). He graduated from Southampton University in 2006 with a Ph.D. in Global Health Public-Private Partnerships.

ILONDO, Mapoko Mbelenge

is senior advisor for Global Diabetes Partnerships at Novo Nordisk A/S. He joined Novo Nordisk in 1990 and has worked over the years to build up the company's World Partner Project and access to diabetes care approach.
Dr. Ilondo is associate professor at the University of Kinshasa. He obtained his degree as a medical doctor in 1975 from the University of Kinshasa, Democratic Republic of Congo and holds a Ph.D. in endocrinology from the University of Leuven, Belgium (1989).

KOPPERS, Simon

has served as Head of the Education, Health, Population Policies Division at the German Federal Ministry for Economic Cooperation and Development (BMZ) since April 2009. He joined the BMZ in December 1996 as Advisor in the West Africa; Evaluation; Controlling; Organisation; Infrastructure; Southern Africa Division. From February 1994 to November 1996, he worked as a project manager for KfW, focusing mainly on Central Africa. Simon Koppers studied economics at the University of Bonn and at UC Berkeley. He received his Ph.D. in 1994 from the University of Bonn.

LAWSON, Max

is a senior policy advisor at Oxfam, working on aid, debt cancellation, governance, public services and Africa. He has worked for Oxfam for nine years, in a range of different jobs, including living and working in Malawi and South Africa and supporting Oxfam programme work on governance across the world.

MÜLLER, Klaus

is First Vice President East and West Africa of KfW Entwicklungsbank, Frankfurt. He began his professional career as Project Manager at KfW Entwicklungsbank in 1995. His responsibilities were health, water and sanitation programmes in Indonesia and the Philippines. In 2000, he joined the division of Export and Project Financing of KfW, where he was responsible for the energy sector. In 2001, Klaus Müller was appointed Director of the KfW Office in Vietnam. After his return, in 2005, he joined the Strategy Department of KfW Entwicklungsbank and was nominated First Vice President of the department in 2006. One year later, he was appointed the same position at the Corporate Policy Department of the KfW Group. Since 2009, Dr. Müller has been Regional Director of the Department East and West Africa Sahel. He studied agricultural economics at the Universities of Bonn (Germany) and Edinburgh (Great Britain) and received his Ph.D. on agricultural trade issues of the ASEAN countries.

NAKAZZI KYADDONDO, Betty

heads the Family Health Department at Population Secretariat, an institution mandated to spearhead advocacy and coordination of the implementation of the National Population Programme. Major role is to conduct advocacy at national and district levels for promoting family health related components of the population programme including reproductive health, maternal health, child survival, family planning, HIV/Aids in the context of mainstreaming gender and development. In the past, Dr. Nakazzi Kyaddondo has been grossly involved in HIV/Aids programming, capacity building and research. Her current and past work experiences have given her skills for designing, managing, monitoring, evaluating and reporting projects' performance funded by government and multi-national donors. She has also fully participated in the exercise (s) for developing Strategic Plans such as for PPD, EARHN, Population Secretariat and the Adolescent Health Strategy for Lesotho, Uganda and Kenya. Dr. Nakazzi Kyaddondo is a Medical Doctor with a Master of Arts in Demography, from Makerere University Kampala.

VON PLETTENBERG, Hubertus Graf

is head of the Manufacturing Industries and Services Department with DEG – Deutsche Investitions- und Entwicklungsgesellschaft mbH, Cologne, Germany, appointed in 2003. DEG, member of KfW Banking Group, finances investments of private companies in developing and transition countries. As one of Europe's largest development finance institutions, it promotes private business structures to contribute to sustainable economic growth and improved living conditions. Graf Plettenberg joined DEG in 1996 as spokesman of the Company. From 1992 to 1995, he was working in Slovenia as an advisor to a Slovenian bank. Before 1992, Graf Plettenberg was personal assistant to the vice minister with the Federal Ministry for Economic Cooperation and Development. After serving voluntarily as an officer with the German paratroops, he studied medieval philosophy and history.

PLISCHKE, Wolfgang

has been a member of the Board of Management of Bayer AG since March 1, 2006. He is responsible for Innovation, Technology and Environment, and for the Asia/Pacific region. From July 1, 2002 until his appointment to the Bayer AG Board, he was a member of the Bayer HealthCare Executive Committee and head of the Pharmaceuticals Division. In 2000, Dr. Plischke took over as head of the Pharmaceuticals Business Group in North America. In 1995, he became President of Bayer Yakuhin Ltd., Japan, with responsibility for Pharmaceuticals and Consumer Care. He studied biology at Hohenheim University before starting his career in 1980 with Bayer's subsidiary Miles Diagnostics. In January 2002, he was appointed head of the Pharmaceuticals Business Group at Bayer AG with responsibility for the global business with prescription drugs. Dr. Plischke holds a number of offices outside of Bayer AG. He is Chairman of the Board of the Association of Research-based Pharmaceutical Companies (VFA), Berlin, and a member of the boards of the German Diabetes Foundation (DDS).

SANDOR, Elisabeth

is senior policy advisor in the aid effectiveness division of the OECD Development Cooperation Directorate (DCD) which she joined in September 2007. She is responsible for leading a work stream on aid effectiveness and health, managing a Task Team on "health as a tracer sector" which supports the Working Party on aid effectiveness. Previously, she worked in the World Bank, first at the Board level where she was advisor on social issues (November 2002-January 2005) and then in the Human Development Network, in the Health, Nutrition and Population Department where she contributed to the High Level Forum on the health MDGs and aid effectiveness issues (January 2005-April 2007). Before that, she has been advisor in the President of the French Republic staff on social issues (December 1995-June 2002) and advisor to the French Ministry of Health and Social Insurance (May 1995-December 1995). She's post-graduated in political sciences from the Universities of Paris I Panthéon and Nanterre.

SCHMIDT, Uwe

is Director for Development Policy of the Federation of German Industries (BDI) and thus in charge for the BDI/KfW initiative „Healthcare Infrastructure in Developing Countries and Emerging Markets". From 2005 to 2008, he was responsible for Germany's development cooperation with two prominent partner countries in Asia before changing to BDI within the framework of an 18 month Personnel Exchange Programme. After working as a Senior Advisor to the Vietnamese Ministry of Trade (1999-2001) and a short stopover as a researcher and university lecturer he entered the Federal Ministry for Economic Cooperation and Development (BMZ) in 2003 and provided sectoral expertise in private and financial sector issues. Dr. Schmidt received a Master in Development Economics at the Aachen University of Technology and holds a Ph.D. in Economics.

THROM, Siegfried

has been holding the position Director Research, Development, Innovation since 2001. Dr. Throm worked from 1983 up to 1986 in a hospital pharmacy. He then joined the pharmaceutical department of the Bundesverband der Pharmazeutischen Industrie (BPI) in Frankfurt. In 1995, he changed over to the newly founded German Association of Research-Based Pharmaceutical Companies (vfa) to become Head of Production, Quality and Environment. He is i.a. member of the expert group Scientific, Technical, Regulatory Policy Committee of the European Federation of Pharmaceutical Industries and Associations (EFPIA) and of the Biologicals Committee of the International Federation of Pharmaceutical Manufacturers Associations (IFPMA). He studied pharmacy and obtained is Ph.D. from the University of Heidelberg.

WATY, Marie-Odile

serves as head of the Health and Social Protection Division at the French Development Agency (AFD). She worked in India as technical assistant for an NGO from 1981-1984, in charge of a small scale industries programme. She joined a consulting firm in international health as the administrative and financial director and senior health economist (1986-1992). She was then senior health economist at the World Bank, Washington, D.C., from 1992-1999 (working in the Africa and Latin America regions); she was a senior health advisor at the Council of Europe Development Bank, Paris, from 1999 to 2003. Ms Waty has a MBA from HEC School of Management in Paris as well as a graduate diploma in development at EHESS, in Paris (1984-1985) and a diploma in Health economics at CEPE, Paris (1989).

List of Participants

Geoff Adlide
Director of Advocacy and Public Policy, GAVI Alliance
Chemin des Mines, 2
1202 Geneva, Switzerland
T +41 22 909 2920
gadlide@gavialliance.org

Ulrike Anders
Senior Manager Family Planning
Bayer Schering Pharma AG
Müllerstr. 178, 13353 Berlin
Germany
T+49 30 468193257
ulrike.anders@bayerhealthcare.com

Bernd Appelt
Priority Area Manager for Health and Social Protection
Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH
65726 Eschborn, Germany
T +49 6196 791664
bernd.appelt@gtz.de

Renate Bähr
Executive Director
German Foundation for World Population (DSW)
Göttinger Chaussee 115
30459 Hannover, Germany
T +49 511 9437314
renate.baehr@dsw-hannover.de

Sonja Bartsch
Senior Research Fellow
GIGA – German Institute of Global and Area Studies
Neuer Jungfernstieg 21
20354 Hamburg, Germany
T +49 40 42825592
bartsch@giga-hamburg.de

Wolfgang Bichmann
First Vice President East and West Africa, KfW Entwicklungsbank
Palmengartenstr. 5-9
60325 Frankfurt, Germany
T +49 69 74313520
wolfgang.bichmann@kfw.org

Christoph Bonsmann
Director action medeor
International Healthcare gGmbH
St. Töniser Str. 21
47918 Tönisvorst, Germany
T +49 2156 978888
christoph.bonsmann@medeor.org

Klaus Brill
Vice President Corporate Commercial Relations, Bayer Schering Pharma AG
13342 Berlin, Germany
T +49 30 46816985
klaus.brill@bayerhealthcare.com

Marshall Burke
Head of External Affairs
Global Alliance on TB
40 Wall Street, 24th floor
New York, NY 1005, USA
T +1 32497258042
asmita.barve@tballiance.org

David de Ferranti
President, Results for Development Institute and Senior Fellow, Global Economy Development, Brookings Institution
1875 Connecticut Avenue
N.W. Suite, Washington, D.C. 2009
USA
T +1 202 4705721
david@deferranti.org

Guy Ellena
Director of Health and Education Department, International Finance Corporation (IFC)
2121 Pennsylvania Ave., NW
Washington, D.C. 20433, USA
T +1 202 458 8139
gellena@ifc.org

David B. Evans
Director Health Financing and Social Protection, World Health Organization (WHO)
20, avenue Appia, 12110
Geneva 27, Switzerland
T +41 227913270
evansd@who.int

Scott D. Featherston
Teamleader Health in Africa, Investment Officer, International Finance Corporation (IFC)
2121 Pennsylvania Ave., NW
Washington, D.C. 20433, USA
T +1 202 458 8139
sfeatherston@ifc.org

Robert Filipp
Head of Innovative Financing
The Global Fund to Fight Aids, Tuberculosis and Malaria
Chemin de Blandonnet 8
1214 Vernier, Geneva
Switzerland
T +41 22 791 1939
robert.filipp@theglobalfund.org

Tatul Hakobyan
Deputy Minister of Health
Government of Armenia
Board Member GAVI Alliance
9, Alek Manukyan str.
AUA Business Centre
Yerevan 0070, Armenia
T +374 10 512258
Health@bc.aua.am

Andrew Harmer
Research Assistant London School of Hygiene and Tropical Medicine
Keppl St.
London WC 1E 7HT, UK
T +44 2079272267
andrew.harmer@lshtm.ac.uk

Wolfgang Hein
Research project „Global Health and Governance“, GIGA – German Institute of Global and Area Studies
Neuer Jungfernstieg 21
20354 Hamburg, Germany
T +49 30 42825558
hein@giga-hamburg.de

Angelina Hermanns
Com Consult, TB Alliance
Rue du Magistrat 10
1000 Brussels, Belgium
T +32 2 3452961
angelina.hermanns@skynet.be

Torsten Hilscher
Journalist, ddp
Panoramastr. 1a
10178 Berlin, Germany
T +49 30 23122151
Fax +49 30 23122146
berlin-brandenburg@ddp.de

Mapoko Mbelenge Ilondo
Senior Advisor for Global Diabetes Partnerships
Novo Nordisk, A/S
Novo Ale
2880 Bagsvaerd, Denmark
T +45 4444 8888
millo@novonordisk.com

Judith Kallenberg
Senior Manager, Donor Relations, External Relations, GAVI Alliance
2 Chemin des Mines
1202 Geneva, Switzerland
T +41 22 9096563
jkallenberg@gavialliance.org

Marion Kneesch
Teamleiterin Gesundheit, Bildung, Soziale Sicherung Sub-Sahara Afrika
KfW Entwicklungsbank
Palmengartenstr. 5-9
60325 Frankfurt, Germany
T +49 69 74314051
marion.kneesch@kfw.de

Simon Koppers
Head of Sector Division Health
Federal Ministry for Economic Cooperation and Development (BMZ)
Dahlmannstr. 4
53113 Bonn, Germany
T +49 228 99 535 3530
simon.koppers@bmz.bund.de

Max Lawson
Health Policy Advisor
Essential Services Campaign
OXFAM, GB
London, UK
T +44 7789397666
mlawson@oxfam.org.uk

Tobias Luppe
Global Health Advocacy
Oxfam Deutschland e.V.
Greifswalder Str. 33a
10405 Berlin, Germany
T +49 30 45306950
tluppe@oxfam.de

Klaus Müller
Vice President
KfW Entwicklungsbank
Palmengartenstr. 5-9
60325 Frankfurt, Germany
T +49 69 74313520
klaus.mueller@kfw.org

Betty Nakazzi Kyaddondo
Head Population Secretariat, Ministry of Finance, Planning and Economic Development
Statistics House, Plot 9, Colville Street
P.O. Box 2666
Kampala, Uganda
T +256 41 705401
bettykyad@yahoo.com

Dhaval S. Patel
Marie Stopes International (MSI)
Fitzroy Square
1 Conway Street
London W1 T 6LP, UK
T +44 20 7034 2419
dhaval.patel@mariestopes.org

Wolfgang Plischke
Member of the Board of Management
Bayer AG
51368 Leverkusen, Germany
T +49 214 30-1
wolfgang.plischke.wp@bayer-ag.de

Sandra Rotzinger
Project Advisor
Sector Initiative Sexual & Reproductive Health and Rights, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH
Postfach 5180
65726 Eschborn, Germany
T +44 6196 79 1659
sandra.rotzinger@gtz.de

Elisabeth Sandor
Senior Policy Advisor
Organisation for Economic Co-operation and Development (OECD)
2, rue André Pascal
75775 Paris Cedex 16, France
T +33 145248983
mia.gruget@oecd.org

Uwe Schmidt
Director, International Trade and Development, The Federation of German Industries
Breite Str. 2
10178 Berlin, Germany
T +49 30 2018 1502
u.schmidt@bdi.eu

Christina Schrade
Senior Advisor, GAVI Alliance
Hans Otto Straße 2
10407 Berlin, Germany
T +49 30 24728996
christina.schrade@seekdevelopment.org

Ulrike Schröder
Programme Manager, Global Media Relations and Issue Management, BHC Global Corporate Communications, Bayer Schering Pharma AG
Müllerstr. 178
13353 Berlin, Germany
T +49 30 468 192206
ulrike.schroeder@bayerhealthcare.com

Benedikt Simon
Project Manager, The Federation of German Industries
Platz der Republik 1
10117 Berlin, Germany
T +49 30 2028 1571
b.simon@bdi.eu

Siegfried Throm
Director Research, Development and Innovation, German Association of Research-Based Pharmaceutical Companies
Hausvogteiplatz 13
10117 Berlin, Germany
T +49 30 20604102
s.throm@vfa.de

Jeffrey Tudor
Policy Manager for Innovative Financing, Department for International Development (DFID)
1 Palace Street
London SW1E SHE, UK
T +442070230000
J-Tudor@dfid.gov.uk

Annette Velleuer
Director Social Healthcare Programs
Bayer Schering Pharma AG
Müllerstr. 178
13353 Berlin, Germany
T +49 30 468 193166
annette.velleuer@bayerhealthcare.com

Hubertus Graf von Plettenberg
First Vice President Manufacturing Industries and Services, DEG – Deutsche Investitions- und Entwicklungsgesellschaft mbH
Kämmergasse 22
50676 Köln, Germany
T +49 221 4986 1366
pb@deginvest.de

Marie-Odile Waty
Head of Division Health, Agence Française de Développement
5, rue Roland Barthes
75598 Paris, Cedex, France
T +33 1 53444066
watymo@afd.fr

Philippe Walfard
Hospital director, Agence Française de Développement
5, rue Roland Barthes
75598 Paris, Cedex, France
walfardp@afd.fr

Harald Zimmer
Senior Manager International Affairs
German Association of Research-Based Pharmaceutical Companies
Hausvogteiplatz 13
10117 Berlin, Germany
T +49 30 20604503
h.zimmer@vfa.de

COORDINATION TEAM

g+h communication
Leibnizstraße 28
10625 Berlin, Germany

Rhan Gunderlach
T +49 3023624602
rgunderlach@gundh.com

Annette Hornung-Pickert
T +49 30 23624603
ahornung@gundh.com

Grit Schmalisch

in cooperation with

Bayer HealthCare
Bayer Schering Pharma

Programme

Making partnerships work for health, focusing on low-income countries
The role of the private sector
Experts' meeting, September 21, 2009, Berlin Germany
Charlottenstraße 33, 10117 Berlin

9:00 am Registration

9:30 am Welcome
Klaus Müller, First Vice President East and West Africa, KfW Entwicklungsbank, Frankfurt
Wolfgang Plischke, Board of Management of Bayer AG, Leverkusen

9:45 am Opening
Wolfgang Bichmann, Head Sector and Policy Division Health, Education, Social Protection, KfW Entwicklungsbank, Frankfurt

Keynote
David de Ferranti, President, Results for Development Institute and Senior Fellow, Brookings Institution, Washington
"The present role, challenges and future trends for Private Sector Partnerships (PSP) in global health"

10:15 am Discussion

10:30 am -1:00 pm Panel 1: Involvement of the private sector - cooperation and coordination

10:30 am Opening Panel 1
Chair: Wolfgang Bichmann, Head Sector and Policy Division Health, Education, Social Protection, KfW Entwicklungsbank,

10:35 am Input i: Success stories, lessons learned (short case studies)

Speakers:

Uwe Schmidt, Director, International Trade and Development, Federation of German Industries (BDI), Berlin
Mapoko Mbelenge Ilondo, Senior Advisor for Global Diabetes Partnerships, Novo Nordisk, Denmark
Klaus Brill, Vice President Corporate Commercial Relations, Bayer Schering Pharma, Berlin
Christoph Bonsmann, Director, action medeor International Healthcare gGmbH, Tönisvorst, Germany

Discussion

11:30 am Coffee break

11:45 am Input ii: GHPs' impact on national health strategies. How to achieve and ensure sustainability?

Betty Nakazzi Kyaddondo, Senior National Programme Officer, Family Health Department, Population Secretariat, Ministry of Finance, Planning and Economic Development, Uganda
Tatul Hakobyan, Deputy Minister of Health, Government of Armenia, Board Member GAVI Alliance, Armenia
Geoff Adlide, Director Advocacy and Public Policy, GAVI Alliance Secretariat, Geneva

Discussion

1:00 pm Lunch

2:00 pm Panel 2: Role of the international donor community

Opening Panel 2
Chair: Andrew Harmer, Research Assistant, Health Policy Unit, London School of Hygiene and Tropical Medicine, UK

Speakers:

Robert Filipp, Head of Innovative Financing,The Global Fund to fight AIDS, Tuberculosis and Malaria, Geneva
David Evans, Director of Health Financing and Social Protection, World Health Organization (WHO), Geneva

Simon Koppers, Head of Sector Division Health, Federal Ministry for Economic Cooperation and Development, (BMZ), Germany
Marshall Burke, Head of External Affairs, Global Alliance on TB, New York

Discussion

3:45 pm Coffee break

4:15 pm Panel discussion: Future Trends for Private Sector Participation in Global Health and the Role of Global Health Partnerships

Chair: Guy Ellenna, Director of the Health and Education Department, International Finance Cooperation (IFC), Washington

Panellists:

Elisabeth Sandor, Senior Policy Advisor, Development Assistance Committee, Organisation for Economic Coorporation and Development (OECD), Paris
Marie-Odile Waty, Head Division Health, Department Development. Agence Francaise de Developpement (AFD), Paris
Siegfried Throm, Director Research, Development, Innovation, German Association of Research-Based Pharmaceutical Companies, Germany
Hubertus Graf von Plettenberg, First Vice President, Manufacturing Industry/Services, Deutsche Investitions- und Entwicklungsgesellschaft (DEG), Member of KfW banking group, Cologne
Max Lawson, Health Development Finance and Public Services, Oxfam, UK
Bernd Appelt, Priority Area Manager for Health and Social Protection, Department of Planning and Development, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, Eschborn

5:45 pm Closing remarks
Hubertus Graf von Plettenberg, KfW banking group

End of conference
Reception