A BRIEFING PAPER ON INNOVATIVE FINANCING

THIS PAPER IS JOINTLY COMMISSIONED BY COMMUNITIES LIVING WITH HIV, AND AFFECTED BY TUBERCULOSIS AND MALARIA DELEGATION TO THE BOARD OF THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA, AND THE CIVIL SOCIETY SUSTAINABILITY NETWORK

COMMUNITIES DELEGATION
to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria
Adding Humanity to the World of Money

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GLOSSARY

Advance Market Commitment	A guaranteed advance purchase contract, backed by donors, for a desired product, which aims to incentivise private research, development and manufacturing of a product by providing an upfront price guarantee to manufacturers in exchange for their agreement to produce and sell the product at affordable prices
Consumer Product-Based Donation	An arrangement in which a portion of the proceeds from the sale of designated branded products are contributed to health or other development purpose
Creditor	The party to whom a financial payment is owned
Debtor	The party who is in debt or owes another party (i.e. creditor) a financial payment
Debt Swap or Forgiveness for Health	A transaction where a lender forgives developing country debt under the condition that a portion of the funds are then invested in health
Financial Transaction Tax	A tax imposed on certain financial transactions, such as the purchase or sale of securities (e.g. bonds, equities, related derivatives), currency transactions (e.g. foreign exchanges, related derivatives), or banking transactions (e.g. deposits, withdrawals). It can be applied on the buyer or seller and is usually imposed only on the resale rather than initial sale of assets or issuance of securities. The tax usually consists of a small percentage on the market value of the securities or transaction (e.g. 0.1 to 0.5 percent)
Frontloading	The provision or availability of financial resources for investment and use at an earlier date in exchange for repayment obligations spread over a longer future period
Future Financial Liabilities or Future Repayment Obligations	Future obligations to make financial payments in exchange for benefits, such as loan or bond proceeds, received at an earlier date
Guarantee	A formal pledge or promise to pay another party's debt or pay another party's debt or pay another party's obligations in favour of a third party, such as giving partial default protection to lenders that provide loans for underserved sectors such as health
Junior	A financial interest where receipt of repayment does not occur, by design, until other parties with interests that have been deemed a higher priority have been fully repaid
Loan Buydown	An arrangement in which a donor agrees to pay some, or all, of a developing country's future loan repayment obligations, reducing the overall cost of borrowing and freeing funds to be directed towards health investments. The requirement to pay such obligations may be linked to the achievement of performance targets agreed in advance
Risk-Adjusted Expected Rate of Return	The minimum return expected for a party to deem an investment worthwhile given its estimation and assessment of risks and probably success
Senior	A financial interest where receipt of repayment has higher priority than any other interest, whereby full repayment shall occur before any interest of lesser priority receives any repayment
Social Impact Bond	An arrangement between outcome funders, investors, services providers and outcome evaluators whereby investors provide upfront financing for service providers to conduct health-related activities. An outcome funder, such as an external donor or domestic government, repays investors, with potential returns, based on the achievement of verified, pre-determined outcomes
Solidarity Contribution	A voluntary additional charge – either one time or recurring – on the purchase of airline tickets in certain countries to provide financing for UNITAID
Subordination	The establishment of a hierarchy of financial
Subsidy	Interventions or actions, including financial prepayments, by a public entity to raise the risk-adjusted expected rate of return for private commercial actors to entice their participation in a market or investment
Working Capital	The net difference between an organisation's current assets (i.e. cash and other assets that could be converted into cash within a 12-month period) and its current liabilities (i.e. obligations that must be paid within a 12-month period), which serves as an indicator of efficiency and short-term financial health

ACRONYMS

AFC	Audit and Finance Committee
AMC	Advance Market Committee
CSSN	Civil Society Sustainability Network
Communities Delegation	Communities Living with HIV, and affected by Tuberculosis and Malaria Delegation
FTT	Financial Transaction Tax
Gavi	Gavi, the Vaccine Alliance
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
IBRD	International Bank for Reconstruction and Development
ICSS	International Civil Society Support
IDA	International Development Assistance
MDGs	Millennium Development Goals
ODA	official development assistance
SDGs	Sustainable Development Goals
SIBs	Social Impact Bonds
STC Policy	Sustainability, Transition and Co-financing Policy
TB	Tuberculosis

EXECUTIVE SUMMARY

Innovative financing for development is a broad topic, comprised of many initiatives that seek to mobilise funds and increase the efficiency and effectiveness of resources in a wide range of global development contexts, including reducing repeat criminal offenses, tax revenue generation, or infrastructure. This paper focuses on how it applies to the global health development context, specifically in the fight against HIV, Tuberculosis (TB) and malaria.

It should be noted that across existing literature, the terms "mechanism" and "initiative" have been used interchangeably to refer to the types or categories of financing approaches that may be considered innovative. However, in other instances, "mechanism" has also been used more narrowly to describe specific institutions, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), Gavi, the Vaccine Alliance (Gavi), and UNITAID, which utilise or represent innovation in their mobilisation, pooling or channelling of resources. For purposes of this paper, "mechanism" refers to the broader types or categories of financing approaches rather than institutions that utilise or incorporate such approaches in the mobilising, pooling, or channelling of resources.

Although innovative financing emerged in 2002 to generate additional financing for global health after the International Conference on Financing for Development in Monterrey, Mexico, there has been little data or evaluation of the direct benefits or impact innovative financing has on health outcomes.

Some mechanisms focus on mobilising funds that would not otherwise be available for health. This requires that funds do not displace or replace resources that would have been available for health. Others focus on making the resources available for health more effective and efficient by redistributing and reducing risk; improving working capital by frontloading funding for earlier investment and incurring future repayment obligations; incentivise funding, research or development that may not occur otherwise; or linking funds to agreed results, outputs or outcomes. Many mechanisms exhibit several of these attributes.

Mechanisms often entail a frontloading dimension in which funding becomes available upfront with repayment shifted to or spread over a future time horizon, as in case where a developing country receives an upfront loan that must be paid over several decades. There are opportunity costs to each mechanism, often in the form of foregoing the use of some portion of existing, traditional resources and due to lengthy lead times to design or negotiate a mechanism. In the case of a loan buydown, a traditional donor may reduce funding it provides as a grant to contribute to paying some portion of the future loan repayment obligations of a country.

Each innovative financing mechanism is distinct, from the benefits, opportunity costs, long-term repayment obligations it creates for a developing country, actors involved, size and potential impact, negotiation or setup lead times, and transaction costs.

As such, the suitability of a mechanism requires a balancing of these factors, an overall evaluation of its cost-effectiveness as well as programming implications or trade-offs for the innovative financing and related traditional grant financing. Because mechanisms often link financing to the achievement of agreed outputs or outcomes, it is important to define concrete, measurable indicators, which are well linked to desired outcomes with realistic, but ambitious targets. Furthermore, due to all the diverse actors involved in the design, implementation or evaluation of mechanisms, due diligence is needed to align and mitigate any competing interests or incentives, and to ensure country stakeholders have driven and initiated the expression of funding needs and interest in exploring innovative means of financing.

The focus, to date, of blended finance, a type of innovative financing in sectors other than health, suggest the incentive structures, financial rationale or other factors needed to drive blended finance investments by private commercial investors or lenders may not exist, or remains underdeveloped, for health-related investments. To date, loan buydowns in health have only involved multilateral development banks rather than private commercial lenders.

Innovative financing may be one of the several avenues to explore for addressing funding needs for HIV, TB and malaria, but it requires prudence and diligence given the lack of data or evaluation on its impact and unknown suitability in a given health context. As such, the exploration or pursuit should be done in conjunction with ensuring all sources of financing – official development assistance (ODA), philanthropic funds, domestic government spending, and private capital – are not only fully mobilised, but also invested in a coherent, coordinated, and complementary manner to maximise the strategic focus and quality of programmes.

A. INTRODUCTION

The Sustainable Development Goals (SDGs) are ambitious and include global health targets such as bringing an end to the epidemic of AIDS, Tuberculosis (TB), and malaria by 2030. Doing so requires sufficient resources as well as efficient and effective use of resources.

Estimates of the annual external financing gap for HIV, TB and malaria for 2015 – 2030 is US$16.9 billion per year, or approximately 42 percent of the estimated annual need[1]. While development assistance for health through public sources grew 8.7 percent per year between 2000 and 2015, growth plateaued at an estimated 1.8 percent per year since 2010[2]. With an anticipated flat, even downward, trajectory for official development assistance (ODA), there is greater focus on increasing domestic government spending on health and private flows from foreign and domestic investors.

As the global health financing narrative focuses on attracting, or leveraging, additional resources, there is renewed interest in innovative financing, a concept that also garnered attention during the Millennium Development Goals (MDGs) era. Product (RED) and Debt2Health are examples used by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) to mobilise additional resources.

Innovative financing is a broad topic, comprised of many mechanisms that seek to mobilise funds and increase the efficiency and effectiveness of resources in a wide range of global development contexts, including reducing repeat criminal offenses, tax revenue generation or infrastructure. This paper focuses on how it applies to the global health development context, specifically in the fight against HIV, TB and malaria. There do not appear to be standard definitions of innovative financing, nor are there data or evaluations on their effectiveness in the health context.

At the 35th Global Fund Board Meeting, the Board approved the Sustainability, Transition and Co-financing Policy ("STC Policy") which states: "To encourage increased co-financing and programme sustainability, the Secretariat will explore the use of innovative financing mechanisms in addition to existing Debt2Health mechanisms. These may include, as appropriate, budget support and blended finance/loan buy-down mechanisms, as well as Social Impact Bonds (SIBs). 'Blended Finance' and 'Loan Buy-Downs' refer to the strategic combination of grants with government-sourced loans, resulting in a highly concessional financing that covers an identified funding need and/or ensures a smooth transition from international to domestic funding of a country's health programme. The Secretariat will update the Audit and Finance Committee and the Board on progress, lessons learned and recommendations, as appropriate, from utilising such mechanisms."[3]

At the 2nd Audit and Finance Committee (AFC) Meeting, a paper was developed to provide an update on the Global Fund's thinking on loan buy-downs as an additional tool to complement ongoing efforts to effectively implement the STC policy, leverage additional resources for health and enhance programme sustainability. The paper further outlined specific considerations to help assess the potential of loan buy-downs for the Global Fund, including a preliminary overview of the potential benefits and risks for consideration.[4]

At the 37th Global Fund Board Meeting, a decision was made on the Administration Agreement with the World Bank where the decision point approved by the Board "confirms that this decision point does not set a precedent for future investments with development partners or for existing relationships with partners and requests the Secretariat to develop a framework to guide future consideration of such investments for presentation to and review by the AFC, in consultation with the Strategy Committee, for recommendation to the Board".[5]

Two months after the 37th Board Meeting, the Secretariat presented to the 4th AFC Meeting a "Framework for Joint Investments and Update on Blended Finance" for AFC information. The paper provided a "Framework for joint

[1] USAID. (2017). Investing for Impact: Capitalizing on the emerging landscape for global health financing. Washington DC: USAID.
[2] *Id.* at 13.
[3] Sustainability, Transition and Co-Financing Policy, as set forth in Annex 1 to GF/B35/04 – Revision 1, Part 1, para. 9.
[4] GF/AFC03/05: Loan buy-downs
[5] Decision Point GF/B37/DP07 para. 3

investments in blended finance" and introduced five cases under development for potential blended finance structures, without approval of the framework by the Board, nor approval by the Board to implement "pilots".

At the 5th AFC Meeting, a paper was developed by the Secretariat on "Updated Framework for Joint Investments on Blended Finance Mechanisms", of which it states that "As the Secretariat's capacity and experience with blended finance mechanisms grows, the Secretariat will engage with the AFC for continued input, but does not expect to provide the same level of detail on every potential future investment"[6].

At the 38th Board Meeting, the Board was provided an opportunity to provide input on the developments of work that has been undertaken by the Secretariat on innovative financing, where several concerns including the approval of a framework by the Board before the implementation proceeds by the Secretariat.

The Communities Living with HIV, and affected by Tuberculosis and Malaria Delegation (Communities Delegation) to the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) in collaboration with the Civil Society Sustainability Network (CSSN)[7] has commissioned this paper which sets out aims, challenges, and aspects that cannot be guaranteed by innovative financing, and key considerations when determining the appropriateness of a mechanism. It provides examples of different mechanisms, including loan buydowns, a form of blended finance, and social impact bonds. It also discusses unique aspects of blended finance with private commercial investors, an innovative financing mechanism that has gained traction in the health and broader SDG funding discussions.

B. INNOVATIVE FINANCING

I. A SUMMARY OF INNOVATIVE FINANCING

Innovative Financing for Health	
What are the aims?	• Mobilise additional resources • Redistribute or reduce risks for new funders or actors • Frontload funds for earlier investment by incurring future financial liabilities • Incentivise funding, research or development that may not occur otherwise • Linking funds to agreed results, outputs or outcomes
What are the challenges?	• Opportunity cost of foregone investments and delays for design and negotiations • Ensuring innovative financing use is coherent with broader health programmes • High transaction costs and long lead times to design and negotiate • Ensuring demand remains strategically focused and driven by country stakeholders • Potential future repayment obligations • Limited evidence on health impact or best practices for replication • Individual, context-specific tailoring is required • Lack of transparency and data may hinder upfront cost-effectiveness analysis • Quantifying full economic benefits of health outcomes compared to other sectors
What cannot be guaranteed?	• Improved programme quality or outcomes, which rely on broader programme coherence • Focus on prevention, behavioural change, advocacy or structural interventions, as they can be more challenging to directly measure or quantify • Attracting new investors, particularly those seeking financial returns • Alignment of interests among the increased set of parties involved • Replication or transferability of experiences from other sectors

[6] GF/AFC04/06: Updated Framework for Joint Investments in Blended Finance Mechanisms. para. 10.
[7] CSSN is hosted by International Civil Society Support (ICSS)

II. CHARACTERISTICS

a. **Additionality of Funds**: The purpose of many mechanisms is to mobilise funds that would not otherwise be available for health. This requires that funds do not displace or replace *existing* domestic or external resources. For there to be additional funds that would not otherwise be available, the total present-day value of funds available from the innovative financing mechanism, less the costs it takes to create, manage and repay investors or lenders, should exceed the funds that would have been available through traditional financing.

b. **Frontloading of Funds**: Innovative Financing Mechanisms often entail a frontloading dimension in which funding becomes available upfront with repayment shifted to or spread over a future time horizon. This creates the potential for greater impact given the opportunity to invest more at an earlier stage. In the case of a loan buydown, where a developing country takes out a loan and a donor agrees to pay some portion of its repayment obligations, the loan proceeds become available upfront while payment obligations may be spread over future decades. Similarly, with social impact bonds, private investors provide an upfront amount of funding on the basis that a government or donor will pay them back over the life of a programme (e.g. three years), based on the achievement of agreed timebound targets. In each case, a programming decision must be made on what would be the most strategic, cost-effective use of the frontloaded funds.
    i. In the health context, there is inherent cost savings when investing in prevention activities early as their success in averting infections reduces future costs associated with treatment and care, and contributes added productivity to the work force and other parts of society.
    ii. Both benefits – reduced future health costs and increased productivity – factor into the overall cost-effectiveness of a mechanism, though the latter, and other benefits through the positive externalities related to health outcomes, may be more difficult to measure or quantify and therefore link to activities.
    iii. The process of ensuring strategic, cost-effective investments of frontloaded funds can face greater challenges when the benefits – direct and indirect – from desirable investments are harder to measure or quantify and depending on the priorities or interests of the actors involved in the process. As such, even where innovative financing generates additional resources, programme quality and outcomes still depend on programming choices that need to be tailored to specific country context in coherence with broader health investments.

c. **Opportunity Cost**: Many mechanisms create an opportunity cost, both in the form of foregoing the use of some portion of existing, traditional resources as well as delays in utilising funds raised through an innovative financing mechanism due to the time required to design and negotiate them. This opportunity cost must also be factored into the overall cost-effectiveness of the mechanism, as it is a key part of the so-called "price" of the mechanism.
    i. For example, in a loan buydown, the donor agrees to pay some, or all, of the future loan repayment obligations of the developing country as opposed to providing those funds as part of a traditional grant. This decrease in grant funds to finance a loan buydown would require some programming adjustments to the grant, such as reducing the scope and scale of testing, screening, community-led outreach, preventing maternal-to-child transmission, needle exchange, condom distribution, advocacy to remove legal or policy barriers, developing comprehensive sexual reproductive health education programmes, or other activities that could have been funded through the grant.
    ii. The full implications of such reductions require an analysis of the investments that would be made with the loan proceeds, to understand whether reduced prevention activities in the grant are adequately covered by loan proceeds, or how loan proceeds would adequately cover the purchase of antiretroviral drugs that might be reduced from the grant. Furthermore, as described further below, any delay due to the upfront time required to design and negotiate a loan buydown, contributes to overall opportunity costs as neither the activities that could have been conducted through the grant or those proposed for the loan proceeds can begin, which could offset, to some degree, the advantages of frontloading investments.
    iii. In the example above, the risk of reducing a current grant is that it triggers an exercise to deprioritise activities. Like the discussion on frontloading above, the full benefits of prevention,

behavioural change, advocacy or structural interventions may be harder to identify than those of treatment and care activities, or even procurement of tangible products. They may also include activities that lack political will, including human rights, gender equality, programmes for key and vulnerable populations, or cross-sector structural interventions that are not health-sector specific, but have impact on desired health outcomes (e.g. social protection, education, economic empowerment). A reduction in traditional grant funding may then lead to a de-prioritisation of such activities, in part because of the challenges with measurement or quantification as well as political will, or lack thereof, but also because patients cannot be taken off treatment.

iv. The example also demonstrates the difficulty in determining how much can be taken away from a traditional grant to go towards the loan buydown without causing harm to the purpose and aims of the grant, as this requires an evaluation on the coherence of programming across the loan, reduced grant financing and broader health programme.

v. As such, the opportunity cost dilemma becomes greater when upfront prevention, behavioural change and other structural interventions – which need to be the activities to frontload – are sacrificed without assurances that they will be programmed and implemented in a timely fashion through the loan.

d. **Monitoring, Evaluation and Reporting**: There has been little data or evaluation on the impact of innovative financing mechanisms to date. As such, it is important to establish monitoring and evaluation systems with concrete, measurable indicators as well as a system of reporting. Doing so facilitates data collection, transparency, and enables agreement on the prospective, in-term of post-hoc evaluation needs. It will also help to strengthen the evidence base around the impact and cost-effectiveness of innovative financing mechanisms in comparison to traditional financing approaches, given opportunity costs, and the time and effort required to ensure strategic, coherent programming. As such, potential indicators may relate to measuring the success in mobilising additional funds without displacement existing resources as well as increasing the effective and efficient use of such generated funds.

e. **Lead Times to Negotiate and Setup**: The time to design, structure and negotiate a mechanism varies, but for social impact bonds they have taken up to 12 – 24 months[8]. Loans can also take several months to develop and negotiate, particularly as the parties involved increase and different conditions need to be introduced in how the loan proceeds would be programmed. This is the likely scenario for a loan buydown where the donor, given the opportunity costs of agreeing to buydown debt repayment, has an interest in prescribing the activities financed by a loan. While this may be a necessary part of developing and testing mechanisms, the time it takes for them to begin operating and the delay in generating benefits, if any, also need to be included in the overall assessment of their cost-effectiveness, particularly given foregone current investments and the future repayment obligations they place on developing countries.

f. **Transaction Costs**: Related to the lead times to negotiate and setup a mechanism, mechanisms such as loan buydowns and social impact bonds increase the number of roles, and therefore parties, as well as intermediary steps, in the overall process. At each stage or level, there may be management costs, the need to pay professional experts (e.g. lawyers, bankers, accountants, outcome evaluators) to conduct due diligence and analysis, and expected financial returns to investors. Mechanisms such as social impact bonds and loan buydowns likely require separate evaluators of performance and results, adding costs as well as the need to agree among parties on the evaluator. These financial costs also become part of the overall cost-effectiveness analysis.

g. **Size, Term and Potential for Impact**: The financial amount per transaction varies across mechanisms. The loan amount of health-sector loan buydowns have ranged from US$ 50 million to approximately US$ 230 million[9]. Loans generally span decades. Social impact bond amounts, however, have been in the US$ 2 to 4 million range for a few years (e.g. the social impact bond component in the Global Fund HIV grant for South Africa is US$ 3 million over three years[10]). The amount of funding generated by a mechanism, and

[8] Devex – Saldinger, A. Have development impact bonds moved beyond the hype? 8 July 2016
[9] Results 4 Development (2013). Final Report on Buying Down Loans for Education to the Global Partnership for Education. Washington D.C.: Results 4 Development.
[10] Devex article – Politzer, M. Going for Goals: How to innovate on health sector financing. 15 May 2017. Devex article –Saldinger, A. Development impact bonds gain momentum. 18 July 2017.

the scale of activities that could be financed needs to be balanced against the transaction costs, lead times and overall level of effort required to design, negotiate and implement a mechanism. Doing so would help to determine whether instruments of a smaller scale, and therefore less potential impact, remain worthwhile to pursue. These considerations also need to factor into the overall cost-effectiveness assessment of a mechanism.

h. **Actors**: Many public and private actors come together to perform a variety of roles such as donor, investor or creditor from a funding perspective. They can also play an intermediary role by pooling and channelling funds, implement activities or perform monitoring and evaluation functions. Each actor brings different incentives and interests – financial, social or strategic – that require alignment and reconciliation.

III. PURPOSES AND EXAMPLES OF INNOVATIVE FINANCING

Across the range of different definitions of innovative financing, the common purposes or aims of innovative financing are to[11]:

- Mobilise additional resources that would not otherwise be available for health – it does not displace or replace existing resources.
- Make the resources available for health more effective and efficient by redistributing or reducing risk; improving working capital by frontloading funding for earlier investment and incurring future repayment obligations; incentivise funding, research or development that may not occur otherwise; or linking funds to agreed results, outputs or outcomes.

Examples of how innovative financing mechanisms mobilise resources include:

- **Product (RED)**: A type of voluntary consumer product-based donation, where additional funds come from commercial retail proceeds from the sale of specifically-branded products outside of traditional bilateral, multilateral or philanthropic sources of aid.
- **Debt2Health**: A type of debt forgiveness for health, where a developing country is allowed to redirect a portion of its loan repayments towards HIV, TB or malaria activities instead of repaying the country that gave it a loan.
- **Solidarity levy on airline tickets**: A tax placed on the sale of airline tickets in certain countries, which has mobilised approximately two-thirds of the funding of UNITAID since its inception[12].
- **Financial Transaction Tax (FTT)**: A tax imposed on certain financial transactions, usually the purchase or sale of securities (e.g. stocks, bonds, related derivatives), but also currency transaction (e.g. foreign exchange, related derivatives) or banking deposits and withdrawals, which could raise proceeds for investments in health outcomes. The tax is usually a small percentage (0.1 to 0.5 percent) of the market value of the traded security or asset[13].

Examples of how mechanisms incentivise funding, research or development by manufacturers, designers or other goods or service providers that would not occur otherwise include:

- The pneumococcal vaccines advance market commitment (AMC) of Gavi gave manufacturers a price guarantee that incentivised research, development and manufacturing capacity. In return, manufacturers agreed to provide vaccines at affordable prices.
- Tax credits where costs incurred for an activity can be subtracted from the amount of taxes that need to be paid. Furthermore, awards or prizes, which may be given to designers that present the first viable version of a product or good, are similar examples of incentivisation.

[11] Dalberg Global Development Advisors. (2014). Innovative Financing for Development: Scalable Business Models that Produce Economic, Social and Environmental Outcomes. New York: Dalberg Global Development Advisors.
[12] The nine countries that have implemented the levy are: Cameroon, Chile, Congo, France, Madagascar, Mali, Mauritius, Niger and the Republic of Korea.
[13] Jim Nunns and Steve Rosenthal (2016), Financial Transaction Taxes in Theory and Practice Leonard E. Burman, William G. Gale, Sarah Gault, Bryan Kim,, *National Tax Journal*, 69:1, pp. 171-216.

Examples of how mechanisms link funds to agreed results, outputs or outcomes include:

- In addition to social impact bonds describe above, other results-based financing models with milestone-based payments in which the timing and amount of disbursements depend on verified delivery of agree outcomes or outputs.
- Loan buydowns may also include conditions where the obligation of the traditional donor to pay some of the future repayment obligations of the developing country is only triggered if certain performance targets have been met by the programme financed through the loan.

Some mechanisms may exhibit several of the features described above as they are not mutually exclusive categories. For example, while loans improve working capital by frontloading funds for earlier investment and incurring future repayment obligations, through the inclusion of different features such as "subordination", as described above, they can also redistribute or reduce risk for an investor by creating "senior" and "junior" interests. Social impact bonds and loan buydowns, while both exhibiting the frontloading effect, also can include results-or performance-based elements as the returns provided to investors or the buydown payments, respectively, depend on the achievement of programmatic results, outputs or outcomes agreed in advance.

IV. EVIDENCE

Although innovative financing emerged in 2002 to generate additional financing for global health after the International Conference on Financing for Development in Monterrey, Mexico, there has been little data or evaluation of the direct benefits or impact innovative financing has on health outcomes[14]. Studies that exist have focused on establishing ways to group existing mechanisms and estimate the level of funds mobilised and disbursed through them.

Because there is no standard definition of innovative financing, the comparability of available data across the literature has also been limited. Combined with the lack of uniform monitoring, evaluation and reporting, there is significant room for improvement with respect to transparency and data.

Without data and evaluation, the specific factors or implementation contexts in which one mechanism or model is best structured to achieve a desirable health outcome are unknown. This poses significant risks as the ability to replicate innovative financing experiences from other development sectors in the health context, let alone to achieve impact, is unknown. Given the opportunity costs, transaction costs and lead times described above, its likely each mechanism needs individual tailoring based on the specific country context (e.g. epidemiological, social, economic, political) and strategic priorities.

As such, robust cost-effectiveness assessments are needed to determine if, and under what circumstances, a mechanism could be appropriate and impactful. Given the risks, costs and current unknowns, exploration of such mechanisms should be guided by aspects such as: the key questions, which if answered provide a strong indication of their viability; measurable indicators of success and the process for collecting such data; meaningful inclusion of relevant stakeholders throughout design, implementation and evaluation stages; and risks, mitigation measures or assumptions to monitor.

V. DETERMINING APPROPRIATENESS

Each innovative financing mechanism is distinct, from the benefits, opportunity costs, actors involved, size and potential impact, negotiation or setup lead times, and transaction costs. These factors need to be part of any framework used to determine the suitability of a mechanism for a given programme context.

The appropriateness of a mechanism depends on its coherence with desired outcomes and overarching strategic or programmatic aims, and its ability to be an effective and efficient vehicle for achieving those outcomes and aims.

[14] Atun R., Silva S., Knaul F., Innovative Financing Instruments for Global Health 2002 – 2015: A Systemic Analysis. Lancet Glob Health 2017; 5: e720–26.

As such, outcomes need to be articulated and the activities or interventions required to achieve them need to be identified. This demand should be the product of multi-stakeholder country-level processes to ensure alignment with national and community priorities, including those of affected people and communities.

Assessing Cost Effectiveness: With outcomes, activities and interventions established, analysis of the cost effectiveness of the mechanism should follow to determine whether, on balance, there is a rationale for pursing it. Using the example of a loan buydown for health, the cost-effectiveness analysis would include:

- In the case where frontloaded loan proceeds fund prevention activities, the benefits anticipated from successful prevention activities include averted future health costs and increased productivity from the retention of healthier people in the workforce, both of which can have further positive impact on society
  - Unlike a road construction project where future vehicle taxes and road tolls provide a direct future income stream to payback a construction loan, successful prevention may be more difficult to measure, quantify or directly link to a future income stream.
  - This point is not to dissuade using loan buydowns to fund prevention activities, or other activities that are beneficial when frontloaded (e.g. behavioural change, advocacy, structural interventions). It is to note that there can be inherent tensions that make the parties to a loan buydown less inclined to fund such activities, as the noted measurement, quantification or linkage challenges and potential lack of political will for such activities could act as barriers to programming funds in these areas. For a donor, given the opportunity cost of contributing to a loan buydown, efforts must be taken to ensure it can influence programming of the loan proceeds in these key priority areas.
- The cost associated with the loan buydown comprised of:
  - The future loan repayment obligations of the developing country consisting of the principal, or upfront amount received to conduct activities, and interest payments, or cost of financing through a loan;
  - Opportunity cost due to foregone activities through a traditional grant due to the reduction of grant funds of a donor to pay a portion of the future repayment obligations of a developing country (note, this is not double counted in the future loan repayment obligations of the developing country) as well as time costs and lost opportunities to deliver frontloaded prevention activities due to the setup lead times to design, structure and negotiate the loan buydown; and
  - Transaction costs such as fees associated with the management and administration of the loan buydown, returns for the lender, separate evaluations, professional support fees (e.g. lawyers, bankers, accountants), and due diligence of counterparts in the transaction.

The following aspects make the cost-effectiveness assessment above more complicated, but need to be fully understood and included:

- When there is uncertainty in the direct source of income to repay future debt obligations, as in the case of the prevention example above, further considerations are needed to assess the fiscal space and ability to repay debts of a country. This is also a reason why there needs to be a mechanism-by-mechanism, case-by-case analysis to determine appropriateness given the context.
- Uncertainty in the ability to repay loan obligations of a country also make it difficult to determine the appropriate amount of future repayment obligations to "buydown". As noted above, the amount of the "buydown" also impacts the balance of programming on the remaining traditional grant, as there could be risks that prevention, behavioural change or structural interventions for key and vulnerable populations, human rights, gender equality and community responses are deprioritised as grant budgets fall.
- Related to the points above, the lack of transparency makes it difficult to assess the perception of risk and risk-adjusted expected return for a loan of the potential lender. Without this information, it is also difficult to assess whether the fees, as well as any management or administrative costs, are too high, too low or appropriate. The degree of this problem changes depending on the type of lender (e.g. multilateral development banks like the World Bank versus private commercial lenders), but it requires analysis and evaluation to ensure there is a complete understanding of the costs and their reasonableness.

Programming of Funds: A traditional donor that is considering using grant funds for a mechanism such as a loan buydown must track all the different funding streams and how they are likely to be programmed to protect strategic priority areas of funding that may face duress from several fronts. Again, using the loan buydown example, where a traditional grant-making donor reduces grant funding to buydown a loan, it must ensure programming of both

its remaining grant and the proceeds of the loan, and any additional fiscal space created by the buydown, remain focused on the key activities and interventions in line with the broader health programming aims.

- As mentioned above, with the frontloading of resources with a loan buydown, there is added benefit and gain in using these funds for prevention, behavioural change, advocacy or structural interventions, including human rights, gender, or programmes for key and vulnerable populations. As innovative financing is rooted in the principle of using traditional financing to catalyse additional financing, these catalytic activities would appear to be the type of activities to programme through mechanisms such as the loan buydown.
- However, at the same time, prevention, behavioural change and structural interventions that may relate to social protection, access to justice, sustainable communities, and key and vulnerable populations may be deprioritised because of political or cultural challenges or difficulties in measuring programme baselines, outcomes and anticipated financial gains.
- Given the opportunity cost associated with shifting grant funds to a loan buydown, it becomes incumbent on a traditional donor to ensure the proceeds from a loan buydown are programmed appropriately in these areas by being involved in their design, ensuring meaningful multi-stakeholder participation, and linking the triggers for its buydown payments to outputs in these areas.
- The championing of such activities or interventions of donors does not stop there, as it must also safeguard programming in its remaining grant. As described above, budget reductions place pressure on such activities, particularly as patients cannot be taken off treatment and because outcomes directly linked to treatment may be easier to measure than prevention.
- As described above, the donor must remain engaged, ensuring that at a minimum, funding levels for those key strategic activities or interventions, when appropriate given the context, are protected across is remaining grants, proceeds from the loan and any additional fiscal space created by the loan buydown.

Monitoring, Evaluation and Reporting: For mechanisms such as loan buydowns or social impact bonds where achievement of performance targets trigger the payment obligations of a donor, the indicator must be concrete, measurable, and sufficiently linked to the desired outcome; and targets should be set at realistic, but ambitious levels.

- Using the loan buydown example above, an indicator that is difficult to measure will create challenges in terms of evaluating achievement or impact, but also complicates determination of whether performance targets that trigger the buydown payments have been met. Setting the targets too low would mean the efficiency and effectiveness of funds have not been optimised.
- In the case where performance targets that trigger a buydown payment have not been met, the borrowing developing country could face higher debt repayment obligations than expected given that it would not benefit from the loan buydown, emphasising the importance of fully assessing the ability to sustain or carry such obligations of the country.
- Furthermore, the need to set up separate evaluation systems and evaluators, as could be necessary for social impact bonds or loan buydowns, would add transaction costs and contribute to setup lead times that need to be factored into the overall cost-effectiveness assessment.

Aligning Incentives and Managing Conflicts Across Actors: Due diligence of investors, intermediaries, implementers, evaluators or other actors involved in a mechanism are important to identify political, financial or other interests that may create conflicts or misaligned incentives. It is also important to ensure that the allocation and utilisation of programme funds and programme aims are not negatively influenced by the introduction of new actors due to the innovative financing mechanism.

- For example, political or institutional beliefs could lead to deprioritised programming despite national strategies, programme epidemiology and normative guidance. To ensure programming remains coherent with broader health programmes and priorities, demand for innovative financing should be strategically focused and driven by country and community stakeholders, including affected populations.
- Personal or institutional financial interests could also influence the organisations or products procured through the programme. Ethics and conflicts screening may need to be instituted to identify and manage any actual or perceived conflicts of interest.
- As alluded to above, and described further in the blended finance discussion below, certain investments in health may not be as compelling to investors or lenders seeking financial returns, as measurement and quantification of the full economic benefits gained through the positive externalities created by improved

health outcomes are more difficult to link or identify as may be the case in other development sectors. This could affect the attractiveness of such investments to investors, and also the direction of programming they would support and the returns, and therefore added costs, required to attract them.

C. BLENDED FINANCE

I. CHARACTERISTICS

Blended finance is a subset of innovative financing mechanisms. Despite being a part of policy dialogues in the leadup to the post-2015 agenda, there has been little standardisation of blended finance definitions and little data or evaluation on its results, impact or effectiveness. Broadly speaking, they have the following characteristics:

- Public and philanthropic funds are used to catalyse or leverage private commercial investments that would not be otherwise available.
- Investments must be targeted towards social, economic or environmental goals that align or harmonise with global, national and community development agendas.
- Public and philanthropic funds subsidise private investment, shifting risks away from private commercial investors, which incentivises them to overcome hesitation from entering what would otherwise be perceived as a risky or unprofitable market.

To date, blended finance mechanisms have generally fallen into one of these categories[15]:

- Public or philanthropic entities jointly provide a loan to a developing country with a private commercial lender but agree that the private commercial lender will receive full repayment before they receive any.
- Public or philanthropic funds may make a direct subsidy payment to increase the risk-adjusted expected returns of the private commercial investor. The risk-adjusted expected returns are the minimum profits that a private commercial investor, considering its perception of the risk of investment (e.g. default risk of a developing country). This expected rate of return increases when a public or philanthropic actor provides a direct subsidy, which essentially compensates the private commercial lender for a possible default by the developing country.
  - For example, a public grant element may be provided alongside a commercial loan to co-finance the investment. The grant may flow directly to the developing country and pay for certain parts of a project. While the private commercial investor can benefit from the potential returns from the whole project, it would not have to cover this portion of activities.
  - In addition, public funds could be used to bring down some of the interest or principal owed on a loan, essentially turning it into a concessional loan. Loan buydowns fit into this category of blended finance.
- Public or philanthropic actors could provide a guarantee or otherwise insure against a risk to improve the risk-adjusted expected returns of the private commercial investor. The timing of the potential financial payment from the public or philanthropic actors occur only if a negative event occurs, which differs from the case of a direct subsidy where payment occurs upfront.
  - For example, a public institution may guarantee a portion of a commercial loan or pay the private commercial investor an agreed amount if political instability stalls or thwarts a project.
- Public or philanthropic funds provide other forms of guarantees or in-kind services, which may transfer risk away from a private entity and incentivise research, development and investment.
  - For example, public entities may provide an advance market commitment to remove the uncertainty of undeveloped market places to entice private industry to invest in its own research, development and manufacturing capacity, such as by guaranteeing the price and volume for future purchases in exchange for the agreement of manufacturers to sell at affordable prices.
  - Technical assistance or capacity building may also be provided in conjunction with the private investment to increase the likelihood of project delivery and investment returns.

[15] Development Initiatives (2016). Blended Finance: Understanding its Potential for Agenda 2030.

II. CONSIDERING APPROPRIATENESS OF BLENDED FINANCE FOR HEALTH

The same set of considerations to factor in the review of all innovative financing mechanisms apply to blended finance mechanisms, as outlined with the loan buydown for health example discussed above.

However, a distinguishing factor for blended finance arrangements that aim to leverage additional financing from private commercial investors is the need to provide a commercially viable rate of return, and to have accurate estimates of the perceived risk of the investment and its risk-adjusted expected return of a private commercial investor.

To understand the cost-effectiveness of a blended finance option, attention should first focus on developing good estimates of the benefits from desired health outcomes to compare against the cost of financing the outcome (e.g. public subsidy, risk-adjusted expected return for an investor).

- For example, if a blended finance instrument finances the construction of private health clinics, a direct economic benefit could be the various tax revenues collected from hospital operations, related job creation and ancillary activities. Beyond this, healthier people increase workforce retention, contributing additional productivity and benefits to society, but the financial case may be harder to demonstrate.
  - This example shows the difficulty in estimating or quantifying financial returns for certain beneficial health investments. Prevention, behavioural change, advocacy or other cross-sectoral structural interventions face this challenge, as previously discussed.
  - This does not diminish their importance but shows the financial case for one type of health investment may be harder to demonstrate than another type of investment, which could lead financially-driven private commercial investors to gravitate more towards the type of investment where the impact and direct financial gains may be easier to measure and use as a basis for collecting a financial return.
- The risk-adjusted expected return that a private commercial is willing to accept is a key factor to understand when evaluating blended finance:
  - Underestimation of the minimum returns a private commercial investor is willing to accept could mean missing a potentially beneficial opportunity to finance and achieve desired outcomes.
  - Overestimation could mean overpaying, or blending more traditional financing than needed, which then goes against the principle that innovative financing should only be used to increase the resources available, as in this example, some displacement is happening and not all funds are additional.
- Critics have highlighted the lack of transparency of blended finance arrangement, noting the overall lack of information or comparable information about the mechanisms and parties involved, making it difficult not only to evaluate their use, but also to determine the appropriate blended finance structure for a given context. This lack of transparency and data coupled with the incentive to conceal the risk profile or expected return of a private investor, make it difficult to understand what the right amount is to blend to attract the optimal amount of private investment.
- Altogether, it is difficult to assess the financial gains from the investment, and therefore the sources of funds and ability of the developing country to pay the private commercial investors returns. It is also difficult to understand the actual minimum return required for the private commercial investor to enter the blended financing arrangement.

The implication here is that blended finance may not be equally applicable across health and development goals, and within each goal it may not be equally applicable to the varied types of activities or interventions that could be financed.

- For example, most of the private capital mobilised through blending has gone to energy, mining construction, industry and banking sectors, accounting for roughly two-thirds over the 2012 – 2014 period. Despite health accounting for 13 percent, 21 percent and 13 percent of ODA globally, in lower income countries, and in lower middle-income countries, respectively, over this same period, the amount of health-sector blended finance was negligible across all categories[16].
- Of the loan buydowns in health known to date, they have all been either by a World Bank lending entity (e.g. International Bank for Reconstruction and Development (IBRD), International Development Assistance

[16] Development Initiatives. (2016). Blended Finance: Understanding its Potential for the 2030 Agenda. London: Development Initiatives.

(IDA)) or the Islamic Development Bank, suggesting the incentive structures, financial rationale or other factors needed to drive blended finance investments by private commercial lenders may not exist, or remains underdeveloped, for health-related investments.

- Within health investments, there can be varying types of interventions ranging from systems-related infrastructure, health products or equipment, prevention and structural changes, each with varying degrees of alignment with models such as blended finance that depend heavily on underlying financial rationales.

Other implications are that the market for private commercial investment in health remain underdeveloped. But rather than try to develop the market from the supply side by increasing the amount of blending, there may need to be more focus on the demand side in the articulation, measurement and evaluation of key outcomes, and the activities or interventions needed to achieve them, to readily measure and link their outcomes and financial rationale.

D. GLOBAL HEALTH FINANCING LANDSCAPE

The expectation is that ODA and other traditional donor financing will have a smaller share of overall financial flows for health. As such, innovative financing aims to catalyse additional financing from new funders, such as private investors or lenders. Proponents believe this potentially larger pool of resources, if fostered and sustained, can contribute significantly towards addressing the funding gaps associated with the SDGs, specifically for HIV, TB and malaria.

Despite the shifts in global health financing, attention and advocacy should continue with traditional sources of financing – its mobilisation and utilisation – even in the exploration and pursuit of innovative or alternative approaches. This requires first evaluating whether all means for investing traditional resources in the most effective and efficient manner have been used to maximise the strategic focus and quality of programmes.

Focus should remain on understanding the distribution of traditional financing across external donor financing, domestic government spending and private investment – foreign and domestic. It is important to ensure complementarity and coherence across the different sources of financing, both in the level and type of existing investments and their future trajectory.

- For example, while domestic government spending has grown approximately 7.6% annually in low-income and lower middle-income countries over the 2000 – 2015 period, growing by threefold in aggregate terms[17], many countries continue to rely heavily on donor support, particularly where impactful interventions may extend beyond biomedical or health-sector investments alone. As such, beyond continued advocacy to increase domestic government spending and external financing, donors and countries must coordinate the strategic focus of their respective areas of investment and the progressive domestic uptake of all areas of funding.
- Private investment, a target of innovative financing, has and can continue to contribute to health outcomes, though levels have varied across countries and populations. Given the interests, incentives and other challenges outlined above, there are probably limits to its ability to fund large-scale, equitable health responses. To date, private investment in health has focused on health infrastructure, pharmaceuticals, medical devices, information and communication technology, human resources, digital and mobile platforms, and insurance[18]. These areas overlap with private-sector areas of expertise, suggesting investments are likely to be in the areas where there is greater potential for skill or resource transfer. These also tend to pose less of a challenge in terms of measuring or quantifying outcomes or direct financial rationales. As such, rather than view leveraged private capital as the solution, focus should be on understanding where and how private investments can be most effective, efficient and complementary to other sources of financing.

Altogether, exploration of new or alternative financing approaches should be done in conjunction with ensuring all sources of financing – ODA, philanthropic funds, domestic government spending and private capital – are not only fully mobilised, but also invested in a coherent, coordinated and complementary manner to maximise the strategic focus and quality of programmes.

[17] USAID. (2017). Investing for Impact: Capitalizing on the emerging landscape for global health financing. Washington DC: USAID.
[18] *Id.* At 10.

E. CONCLUSION

Innovative financing can mobilise additional resources for health; redistribute or reduce risk for new investors or lenders; frontload funds for earlier investments by incurring future financial liabilities; incentivise funding, research or development that may not occur otherwise; and link funding to agreed results, outputs or outcomes.

However, each innovative financing mechanism is distinct, from the benefits, opportunity costs, long-term repayment obligations it creates for a developing country, actors involved, size and potential impact, negotiation or setup lead times, and transaction costs. Each of these aspects introduces challenges that need upfront assessment to determine the cost-effectiveness, suitability and individual tailoring required for a given context.

As innovative financing is rooted in the principle of using traditional financing to catalyse additional financing, catalytic activities such as prevention, behavioural change and structural interventions that may relate to social protection, access to justice, sustainable communities, and key and vulnerable populations would appear to be the type of activities to programme through mechanisms that frontload funds for earlier investment in return for future repayment obligations, as with loan buydowns.

However, they may be deprioritised because of political or cultural challenges, or difficulties in measuring programme baselines, outcomes and anticipated financial gains. Given the opportunity cost associated with shifting traditional use of funds (e.g. grants) to a loan buydown or other mechanisms, it is important to ensure the programming of the proceeds from a loan buydown, any added fiscal space generated by it, and the remaining grant remain coherent and appropriately focused in these key strategic activities or interventions according to national strategies, programme epidemiology, normative guidance and other relevant context. Despite the promise and interest associated with innovative financing for health, they cannot guarantee strategic focus and quality of programmes as this depends on coherent programming across all sources of funding.

Furthermore, monitoring, evaluation and reporting systems need to be developed to supplement the lack of data or evaluation on the impact innovative financing mechanisms have on health outcomes. Given financial payments are often linked to the achievement of results, indicators need to be concrete, measurable and sufficiently linked to the desired outcome; and targets should be set at realistic, but ambitious levels.

Transaction costs, long setup and negotiation times, the size and potential impact of a mechanism, as well as the repayment obligations created by a mechanism need to be factored into the overall cost-effectiveness analysis, together with the benefits and opportunity costs of engaging in a mechanism. Conflicts or misalignment in incentives and interests that can arise among actors also need to be managed and mitigated to prevent undue influence over strategic funding decisions.

Blended finance may not be equally applicable across health and development goals, and within each goal it may not be equally applicable to the varied types of activities or interventions that could be financed.

Within health investments, there are varying types of interventions ranging from systems-related infrastructure, pharmaceuticals or equipment, to prevention, behavioural change and structural interventions, each with varying degrees of alignment with models such as blended finance that depend heavily on underlying financial rationales and returns. As such, the market for blended finance with respect to private commercial investors and investments in health remains underdeveloped.

Exploring and pursuing innovative or alternative financing could lead to a potentially larger pool of resources, which if nurtured and sustained, could contribute to closing the funding gaps associated with the SDGs, specifically with respect to HIV, TB and malaria. However, there has been little data or evaluation on the impact of innovative finance for health, the replicability or transferability of experiences from other development sectors, or the specific mechanisms that suit given contexts or aims.

The predicted trajectory of traditional sources of financing may warrant exploration of new or alternative financing approaches. However, this should be done prudently and in conjunction with ensuring all sources of financing – ODA, philanthropic funds, domestic government spending and private capital – are not only fully mobilised, but also invested in a coherent, coordinated and complementary manner to maximise the strategic focus and quality of programmes.

The role of the Communities Living with HIV and affected by Tuberculosis and Malaria Delegation (Communities Delegation) is to advocate, influence, and shape the decisions on the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). This is so that communities living with HIV, and affected by Tuberculosis and malaria can gain equitable access to quality services and support needed to prevent, treat, and/or live with these infections within a conducive environment that respects human rights. www.globalfundcommunitiesdelegation.org

The Civil Society Sustainability Network (CSSN) is a global initiative that communicates, coordinates and supports communications between stakeholders that play a crucial role in the response to HIV and Tuberculosis epidemics for increased transition preparedness and quality of transition. www.sustainabilitynetwork.org