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I would like to extend my warmest thanks to the World Policy Conference for the question of governance which they are proposing to discuss. We usually do not think of healthcare first, but as Christian reminded us, it is one of the most interesting world governance questions today. He reminded us of all the questions we have to face with Ebola, which showed how many loopholes there were in terms of governance, and given the recent tragic events in Lebanon and elsewhere, part of the response is in our capacity to address the question of poverty worldwide. This cannot be done if we fail to address the question of access to healthcare. I am not a healthcare specialist, so I am something of a misfit in this panel, but I have done a bit of finance and technology in my career, so my angle will be to tell you how technology and financial evolutions can help us to tackle healthcare.

The World Bank group, as instructed by its shareholders, has two objectives for 2030. The first one is to end poverty, which also implies ending poverty vis-à-vis health, and the second is what we call boosting shared prosperity, which means basically minimising inequalities. Therefore, we want to make sure that the poorest people on earth share in the benefits of global growth and advancement, that it is not just reserved for a small proportion of the population. We believe, and this is extremely important, that investing in health offers one of the best opportunities to achieve this goal in this generation. I am not talking about 2050 or 2100 but in the next 15 years.

When we talk about shared prosperity in health, however, the global picture is still pretty bleak in many areas. Take child health – an estimated 16,000 children under five die every day in developing countries compared to 300 in developed countries. A child's chance of survival is still vastly different depending on where he or she is born. Children from the poorest households are on average almost twice as likely to die before the age of five as children from the richest households, and a staggering one-quarter of all children under the age of five globally are stunted as a result of poor nutrition and insufficient stimulation, limiting both their physical and cognitive development. This means their brains will never fully develop and they will be forever disadvantaged in their ability to learn well in school or get a well-paying job. They are more likely, obviously, to live in poverty.

However, for example, Peru, where we held our meeting earlier this year, in Lima, has shown the world that child stunting is a problem we can solve. 28% of Peru's children were stunted in 2005, and with the support of the Group, the Government came to realise that this was a huge social and economic problem that they must address. We helped them undertake a targeted effort to provide assistance to rural areas and across communities most in need, using results-based financing to incentivise social providers to tackle health, social development and sanitation problems that were contributing to stunting. The country reduced the rate of child stunting by half to 14% in just eight years with the right political leadership.

Regarding child mortality, there is also some good news. The global rate of children dying before the age of five has plummeted to less than half what it was 25 years ago, from 12.7 million per year in 1990 to 5.9 million last year. We still have a long way to go, but the evidence suggests that the world is making great strides in both maternal and child survival, and that improvement is accelerating. The best story right now is that, for the first time in history, the percentage of people living in extreme poverty around the world has fallen to less than 10% of the global population. It is still 10%, so we are not there yet, but 1990 one billion people have been lifted out of poverty, and if we can continue with this progress, then it is not finished, and ending extreme poverty is within our reach within this generation.

It is not surprising that this decline in poverty goes hand in hand with accelerated improvement in health. A couple of years ago, the Lancet Commission on Investing in Health, a team of global economics and health experts led by Larry Summers, confirmed that between 2000 and 2011 better health outcomes accounted for 24% of growth in full income in low- and middle-income countries. This 24% of growth was based on health progress, and this is really an investment. The virtuous cycle between health and wealth is why health is a smart, an essential, investment for all countries to make. It makes sense – investments that allow children to survive and thrive create a quantity and quality



of human capital that economies require for growth and resilience. It was probably obvious for many, but it was better to demonstrate it with a rigorous study.

The Commission also determined that the economic return on investment in health in low- and middle-income countries could be as high as ten to one. The Commission also found the possibility of what has been called a grand convergence in which health outcomes and life expectancy across the world will begin to equalise, meaning that a child born in Cambodia and a child born in California might have the same chance to survive and lead a healthy, productive life and help reach our goals to end poverty.

Two months ago in September, the UN endorsed the 17 Global Sustainable Goals. Their ambition is high, is universal, and incidentally quite costly. The new global goal for health is a healthy life for all. This is about universal health coverage, so every person everywhere can get essential, quality, life-saving healthcare, and more importantly, no one mired in poverty is forced to pay for the care they need. It will not be easy. Slowing economic growth, chronic crisis in fragile and conflict-affected countries, forced migration, as seen this summer, uncertainty in terms of climate change and disease outbreaks, are all obstacles in the way. Reaching those still living in extreme poverty will be our hardest task, as they are living in some of the most desperate situations and some of the most remote corners on earth.

What is clear is that if we are to achieve these ambitious global goals, we need to think and act differently; it will not be more of the same. Therefore, let us start to think differently on health, technology and innovation. We will have to innovate within the public sector as well as to enable the public sector to embrace and leverage innovation in the private sector. This is one of the areas where public and private cooperation will be of the essence and will not be obvious. We need to make sure that technology is harnessed for the problems of the poorest and most marginalised populations, as too often innovations cater to the needs of the privileged as opposed to the needs of the poor.

Two of this year's Nobel Laureates in medicine, Dr Campbell and Dr Omura, were honoured for their discovery of Ivermectin, a drug that kills the parasitic worms responsible for river blindness and lymphatic filariasis. These worms impact about 125 million people worldwide and have been the leading cause of blindness in West Africa in particular. Ivermectin was originally designed to de-worm dogs, but it ended up being adapted for this disease which afflicts some of the poorest people on earth. How many other life-changing breakthroughs might there be? Science, as Christian said, can help, if the pharmaceutical and tech industries more deliberately and systematically focus their innovations on solving the health problems that most affect the poorest people around the globe.

We believe that over the next five years technology development, connected with digital health solutions such as m-health and e-health, mobile and electronic health, will revolutionise how health services are delivered and offer new ways to address gaps in access to and affordability of care. It is already happening. Mobile technology, and Christian mentioned some examples, is being used to get health information out to mothers for baby care. An immunisation worker in Bangladesh realised that despite high coverage for the first in a series of vital child immunisations, there were significant drop-offs for the subsequent two that children need to be protected from these childhood killers. Therefore, the worker started to write down the mobile numbers of mothers on the immunisation record and to remind them by text to come for the second and third immunisation. It seems pretty obvious, but it worked, and with SMS phone reminder messages, full vaccination coverage jumped to almost 90%. The Mama programme, as it is called, is now delivering vital health and nutrition information to more than two million caregivers in Bangladesh, South Africa, India and Nigeria, for instance.

Another example is deploying biometric identification technologies to ensure that every person can access the essential services they need. One of the most successful and well-known is India's deployment of the Aadhaar card, a 12-digit unique identification number with a ten fingerprint scanner which has now been issued to more than 900 million people so they can receive the benefits and subsidies to which they are entitled. However, the development benefits go even further than that, giving every citizen an identity, which says that everyone counts and has legal status regardless of caste, income or ethnic group, and this will help us close the data gap.

Stopping mothers and young children from dying means that we first need to know who is dying, from what causes and where, and in some countries in Africa as many as 80% of deaths go unreported. Universal registration of bio-identification, preferably at birth, will enable us to better target the sources of mortality and have a baseline for

measuring progress. Data is also of the essence. We are now starting to see the enormous potential of dedicated innovation diagnostics and vaccines for deadly diseases like Ebola, and I will echo what Christian said in his introduction.

Although the first outbreak of Ebola occurred in 1976, the absence of any diagnostic drugs or vaccines for this deadly virus meant that when the Ebola crisis erupted last year in West Africa, no sufficient technologies were in place to help contain the outbreak. Sadly, more than 11,000 people have died and millions have lost family, friends and livelihoods, but once the world came to grips with the magnitude of the Ebola threat, unfortunately a little too late, we began to see a massive outpouring of innovation in both technology and approach. A previously untested candidate vaccine went through an accelerated clinical trial protocol to test its effectiveness in record time, taking five months instead of what might normally take five years.

Now we are seeing the emergence of the world's first mobile devices that enable gold standard real-time diagnosis of any disease, including Ebola, with a genetic fingerprint, at a cost ten times cheaper than any comparable test on the market today. Technology can be a tremendous engine to reach the Global Goals. It is not enough, but it will help the financing side, because technology is cheaper and cheaper.

Therefore, we need not only to think but to act differently, not only in technology but also in partnering public and private financing. This will be my last point. A growing number of health and other development challenges are so complex that no single individual or institution can solve them alone, not the World Bank, the WHO, the UN or anybody else. This requires a dynamic ecosystem of actors, government, businesses, academics, civil society, politicians, citizens, etc., all of whom must collaborate in new ways.

I would like to highlight two critical globalised areas where we need to act differently. The first is around managing pandemic risk, as Christian highlighted regarding Ebola. The Ebola crisis exposed serious weaknesses in the global system for outbreak preparedness and response. What do we need? We need a stronger WHO that can enforce international health regulations. We need governments to make sure trained health workers and smart clinics are accessible in the most remote communities. We need businesses to be ready to fill the supply chain and medical teams to be ready to activate on short notice. We also need money to enable responding agencies to move quickly.

That is the part where I have spent most of my time in the last six months. That is the part the World Bank Group is working on, by developing a new pandemic emergency financing facility, PEF. We are working with industry, particularly the insurance and reinsurance industry, and with governments to create a new market for pandemic risk insurance that we believe can change incentives for preparedness and response. You cannot insure Liberia against Ebola, but you can insure the world against pandemic. We have hundreds of years of pandemic track records, so we know we can calibrate the risk we are willing to take, and then we can price it from an insurance perspective. Therefore, the point is that, for a few dozens of millions of insurance premium paid every year, I believe we can get enough money fast, meaning within weeks, several hundreds of millions of dollars, to help contain the pandemic, so we are not insuring the people or the goods, but we will make sure we have the appropriate money available within weeks to contain the pandemics, and that is a big change. It is a new way to progress, and this should be presented to the G7 and G20 next year. We are about to finalise a modelling and pricing analysis.

The second area is maternal and child health. The World Bank Group, with many public and private sector partners, recently launched a Global Financing Facility for every women and child, in particular with the support of Canada, Norway and the Gates Foundation. The GFF, the Global Financing Facility, is a country-driven financing partnership that brings together, under national government leadership, stakeholders in reproductive, maternal, newborn, child and adolescent health to provide smart, scaled and sustainable financing to accelerate efforts to end preventable maternal, newborn, child and adolescent illness by 2030. It is about combining the efforts of public and private sector in a new way. We want this to serve as a major vehicle for financing the proposed Sustainable Development Goal on healthy life. This will play a special role in scalable financing to support the global strategy for women, children and adolescent health.

We want to pioneer models that shift away from a focus solely on official development assistance, the traditional ODA approach, to an approach that combines domestic financing – taxation in rich countries – external support, ODA and



innovative sources for resource mobilisation and delivery, including, of course, the private sector, all in a synergistic way. Building universal health coverage on top of this structure will improve our ability to prevent pandemics and increase opportunities for everyone everywhere to live a healthy, productive life.

The momentum for this movement is growing. Germany, which hosted a G7 leaders' conference in Bavaria in June, issued a new framework in September for global cooperation to strengthen health systems. Ebola was a wakeup call from that perspective, and not only Ebola but a series of pandemics we have been seeing in the last ten years. Next year we expect to have a substantial platform to advance this plan. Japan, which will host the G7 leaders' conference in 2016, has been a long-time champion of universal health coverage and disaster risk management, institutional framework that are extremely relevant for robust pandemic response capability. We have a goal, we have evidence, and now it is time to step up for action. 2030 is just around the corner.

Just to conclude, let me share a personal experience. I was part of President Chirac's team in 2003, and we started to work on what has become the tax on plane tickets, so you can argue that French people are pretty good at inventing taxes, which is true. What is important is that it was a new way to finance development. The idea of this small tax on each plane ticket was to raise a limited amount of Dollars or Euro per ticket, but all in all, this small amount has been capable of providing more than USD 2 billion to Unitaid and to provide hundreds of millions of vaccines to children all over the world.

Therefore, we have to be innovative. There are ways to finance this global health effort that is deeply needed to eradicate poverty, which is within our reach within 15 years.