

## Reforming CDC Group plc – Response to DFID Consultation

### Summary

There are major shortcomings with the current CDC fund of equity funds model which make it incapable of achieving as much as it should to foster growth and reduce poverty in low income developing countries. The submission explains why reform of the business model is necessary and how the business model can be modernised in ways that will strengthen CDC's catalytic role and enable it to make a much greater development and poverty reduction impact while also remaining profitable.

The key recommendation is that CDC should increase its risk appetite and focus more on catalysing sustainable investment into sectors with the highest poverty reduction impact. It should invest three types of capital: catalytic capital, patient capital and commercial capital, each targeted at overcoming in different ways market failures; and catalysing private investment that without its investment would not take place. Catalytic capital is low cost but high risk 'social' venture capital invested in the early stages of development to bring opportunities with high poverty reduction impact to financial close. Patient capital is low cost subordinated capital invested at financial close to overcome barriers to entry and thereby catalyse new private investment into sectors with high poverty reduction impact. Commercial capital is capital that expects to earn fully commercial returns given the nature of the risks to which it is exposed; it should be invested only to address failures in financial markets (ie it must not crowd-out private capital flows).

The submission supports the intention of the government to widen the range of instruments that CDC can provide to include debt instruments because there is evidence of market failures in forex and domestic debt markets which prevent potentially viable opportunities in low income developing countries from securing debt finance.

The submission recommends that DFID strengthen the focus of CDC investments on sectors where the evidence shows there is the greatest poverty reduction impact associated with growth. The evidence is strong that in sub-Saharan Africa investments in sustainable agriculture and infrastructure investments that facilitate productive investments will generate the greatest growth of income for the poorest people.

The submission recommends ways in which CDC's business model should be diversified to make it more effective in advancing DFID's development and poverty reduction goals. CDC should invest in a much wider range of intermediaries including debt funds, loan guarantee facilities, patient capital funds, development companies, equity funds and hybrid funds. There should be changes to the relationship between CDC and the intermediaries/managers relating to their objectives, governance, incentives and performance monitoring to give greater assurance that CDC capital is being used to advance DFID's development and poverty reduction goals; and to provide much greater transparency and accountability for what has actually been achieved.

It notes that major improvements to the business model can be achieved without a major shift by CDC to a direct investment model. It urges caution about the rate at which CDC resumes direct investments and recommends that the near-term priority should be the major improvements that would result from adopting the recommendations about tranching of capital and more diversified intermediaries.

Finally the submission addresses the twelve questions set out in the consultation questionnaire.

## **Introduction**

This response to the DFID consultation on reform of CDC Group plc (CDC) is submitted by Keith Palmer, Chairman of InfraCo and Agdevco. It summarises arguments and evidence set out at greater length elsewhere in publications that are cited at the end of this submission. It also draws on my involvement over the past decade in the development of the Private Infrastructure Development Group (PIDG) facilities.<sup>1</sup>

CDC is the UK's development finance institution (DFI) and as such has a major role to play fostering economic growth and reducing poverty in the developing world. The current fund of equity funds model has been successful in mobilising capital from the private equity markets and channelling it to businesses in developing countries. CDC has also realised significant proceeds and profit from selling assets acquired in the past, benefiting from the sharp rise in asset prices in emerging markets prior to the financial crisis in 2008. This has increased the resources available to CDC for new investment.

Despite these successes there are good reasons to believe that CDC could achieve much more to deliver the government's objectives of fostering economic growth and reducing poverty in low-income developing countries (LICs) if certain practical reforms to the business model were adopted. This note explains why reform of the business model is necessary, describes the recommended reforms and explains how, if adopted, they would result in a marked improvement in the effectiveness of CDC.

The submission is organised as follows. First, it explains the shortcomings of the fund of equity funds business model and why and how it needs to change to address these shortcomings. It then considers how CDC can be reformed so as to maximise its catalytic role and additionality and its poverty reduction impact; and then how CDC should diversify its business model. It then provides answers to the 12 questions set out in the consultation document.

## **Why reform the CDC business model?**

### *Why do we need CDC?*

Why do we need a publicly funded DFI to stimulate private investment in the developing world? What problems is it trying to solve? If we are clear about the nature of the problems then we can identify a business model for CDC best suited to address them.

In LICs there are two different sorts of market failure that deter private investment in potentially viable opportunities. The first - failure in the financial markets - is where finance cannot be raised even though the expected return of an opportunity appears to be higher than the risk adjusted cost of capital. There is evidence to support the proposition that this sort of market failure exists in the debt markets.<sup>2</sup> Both international and domestic banks sometimes reduce country and company credit limits in response to external events even when there are attractive opportunities available to lend to in-country (most recently following the 2008 financial crisis). There is also evidence of failure in the domestic equity markets where domestic savings institutions are commonly prohibited from investing in early stage opportunities which are attractive on their own merits because of regulatory constraints; and in international equity markets where investors have limited interest in many small and medium size investments particularly in LICs, regardless of the expected IRR.

The second type of market failure is at the project level. Early stage investment in certain industries such as agribusiness, infrastructure and manufacturing involves incurring high “front

end” fixed costs and high risks because there are long lead times to develop new markets and achieve optimum factor productivity. High fixed entry costs and small scale depress the expected return in the early years, often to below private investors’ risk adjusted cost of capital, so the opportunity cannot access finance and does not proceed. But, if the initial investment had been made, then over the medium term, as the benefits of economies of scale and learning by doing were realised, costs and risks would fall and the businesses would become competitive and profitable. The high fixed entry costs constitute a classic market failure and a barrier to entry by private investors. If the barrier to entry can be overcome then a virtuous cycle of investment, reducing costs and risks, rising profitability and further investment will be initiated, resulting in sustainable growth and rapid poverty reduction. There is extensive evidence that this sort of market failure is widespread in LICs particularly in early stage agriculture and agriculture supporting infrastructure (see Palmer 2010 for evidence and a more extended discussion of this point) and that it is the major reason why there has been so little commercial investment in agriculture in sub-Saharan Africa over recent decades despite the excellent resource potential.<sup>3</sup>

Figure 1 distinguishes conceptually these different sorts of market failure. The risk return frontier (dotted line) shows the minimum expected return required by private investors, increasing as risk increases. If investment opportunities are "above the line" then private investment will flow to them because they offer an expected return greater than the risk adjusted cost of capital, unless there is a failure in financial markets. If that is the position then CDC should mobilise additional capital to fill the gap left by the failure in financial markets. If investment opportunities are "below the line" then private investors will not invest because the expected return is lower than their risk adjusted cost of capital, even if there is no failure in financial markets. If the evidence suggests that the reason that an investment opportunity maps below the line is that there are barriers to entry that could be overcome by investing in early stage development; and that the result is likely to be a profitable business in the medium term, then CDC should seek to invest so as to overcome the barriers to entry and catalyse new private investment that otherwise would not take place.

#### *Why reform the CDC business model?*

The current fund of equity funds model necessarily involves CDC investing its capital alongside (*pari passu* with) private equity investors. Its capital is exposed to the same risks and expects the same return as private investors. Consequently its capital is always invested in opportunities which the private sector would have been willing to invest in anyway i.e. investment opportunities "above the line" in figure 1. Investments made using this model will only be additional (mobilise private capital that would not otherwise have been invested) if there are equity investment opportunities offering attractive returns which sponsors nevertheless are unable to finance -- because of failures in the equity markets. The fund of equity funds model cannot be additional or catalytic if the market failure is at the project level i.e. maps "below the line" in figure 1; nor if investment opportunities map "above the line" and the failure is in the debt markets.

There is a great deal of evidence which shows that many investment opportunities in key sectors such as agribusiness and infrastructure map "below the line" in figure 1 because of market failures at the project level.<sup>4</sup> The current CDC business model is incapable of addressing them. There is also clear evidence of failure in some debt markets in some countries at certain periods of time. Again the current CDC business model is incapable of addressing them. Therefore the CDC business model needs to be reformed to enable it to address the full range of market failures and thereby enable it to catalyse much more additional private investment into potentially viable opportunities than is possible with the current business model. To address market failure at the project level i.e. where opportunities lie "below the line", CDC must invest in

ways which reduce private investors' entry costs and risks and thereby offer them an expected return greater than their risk adjusted cost of capital (pushing the opportunity "above the line"). To address market failure in debt markets CDC must widen the range of instruments used to include debt instruments and loan guarantees.

What practical reforms would address the shortcomings of the fund of equity funds model so as to maximise CDC's catalytic role?

### **Maximising CDC's catalytic role/additionality**

#### *Risk appetite and expected return on CDC capital employed*

The greatest shortcoming of the current business model is its inability to catalyse private investment into early stage investment when there are market failures at the project level. If CDC is to successfully catalyse private investment into opportunities that are "below the line" then it must invest part of its capital on the basis that it accepts greater risk and earns a lower return on capital than would be acceptable to private investors. This would shift the return available to private investors "above the line" and thereby catalyse private investment that otherwise would not have taken place. This type of capital is referred to here as "patient capital".

Patient capital is medium term, low-cost (5-6%) subordinated capital invested by CDC at financial close in the early stages of private sector ventures which have national or regional sponsors and particularly pronounced poverty reduction impacts. It is used to defray part of the start-up costs including the cost of installing necessary infrastructure and to fund part of the working capital requirement. The low cost and subordination of patient capital increases the expected return and reduces the risk of private investment in the early stages of development. The result is to catalyse additional private investment into early stage ventures with high poverty reduction impact which would not have been able to secure finance without CDC's investment of patient capital.

There must be clear rules regarding the deployment of patient capital. It should only be used: first, when there is evidence of market failure at the project level and that the business can be profitable without additional patient capital once the barriers to entry are overcome; second, when there is evidence that the investment will achieve high poverty reduction impact; and third, when, as a result of the deployment of patient capital, additional private investment will be stimulated (ie patient capital is genuinely catalytic). Patient capital should be structured to avoid perverse incentives and distortions in capital allocation. Further discussion about how this can be achieved is set out in Palmer (2010).

To further increase CDC's leverage it should also invest a limited amount of catalytic capital. Catalytic capital is in essence "social venture capital" which is invested in the very earliest stage of development of ventures with high development and poverty reduction impacts to make them 'investment ready'. Catalytic capital is invested as deeply subordinated low coupon convertible debt, converted or repaid at financial close. It should never constitute more than 10% of the total investment cost. Evidence from the PIDG<sup>5</sup> shows that small amounts of catalytic capital invested in PPP development companies such as InfraCo and AgDevCo, or via catalytic venture capital funds, can catalyse additional private investment into early stage pro-poor investments in amounts greater than 20 times the amount of catalytic capital invested.<sup>6</sup>

Therefore the first recommendation for reform of CDC is that its capital should be split into three tranches. One tranche – called commercial (debt and equity) capital – would, as now, seek fully commercial returns and be targeted at those situations where investments are "above the

line” but there are failures in the debt and/or equity markets. The second tranche – patient capital – would be invested at financial close in early-stage ventures in sectors with high poverty reduction impact, accept exposure to higher risks and seek to earn a less-than-fully commercial return on capital employed (say, 5 to 6% on the portfolio) given the risks incurred. The countries, sectors and circumstances in which catalytic capital may be invested would need to be aligned with DFID’s objectives and ex ante targets for leverage of private investment agreed with DFID. The third tranche – catalytic capital – would be invested pre-financial close to bring a larger number of pro-poor investment opportunities to financial close.

The amount of capital allocated to each capital tranche will depend on DFID’s desired trade-off between financial profitability of CDC and the desired leverage and development and poverty reduction impacts that it aims to bring about. The greater the concern to maximise the catalytic and poverty reduction impacts, the larger will be the patient capital and catalytic capital tranches. If, say, £1billion of CDC’s £2.5 billion of capital were deployed over time as patient capital and £250 million as catalytic capital and the balance earned a fully commercial return then the average target return on capital employed by CDC would be about 10%. Compared to the current business model, additionality and the development and poverty reduction impacts would be much greater.

It is important that the three tranches of capital are segregated and that CDC’s performance is assessed separately for each tranche. Segregation is necessary for several reasons: first, so that co-investors in each tranche are clear about the risk and return expectations of the funds in which they co- invest; and so that there is clear transparency and accountability about the performance of CDC investing the different tranches of capital. Revised governance and performance measurement and monitoring arrangements and different incentive structures for the fund managers would be needed for each tranche of capital separately (more on this below).

#### *Types of instruments*

For the reasons noted earlier CDC needs access to debt instruments if it is to address failures in the forex and domestic debt markets. DFID is correct to allow and encourage CDC to deploy a wider range of instruments including loans, loan guarantees and convertible debt when these are the appropriate instruments to address identified market failures. The experience of Emerging Africa Infrastructure Fund (a PPP debt fund) and GuarantCo (a PPP debt guarantee facility for local currency loans) – both facilities within the PIDG – shows that this sort of financing facility is needed and can be highly effective in catalysing additional debt finance from the forex and local currency debt markets, both banks and the bond market.

If the proposal to tranche CDC’s capital is accepted there are consequential implications for the pricing of debt and loan guarantees. When making loans or guarantees backed with the commercial capital tranche it is appropriate to price them broadly in line with commercial markets. However when they are made to catalyse private investment into ventures that are “below the line”, the cost of the debt or loan guarantee to the borrower needs to be priced at a lower level in order to successfully catalyse additional private investment. This is because if the borrower has to pay the full market cost of the loan or guarantee then the expected return net of finance charges will remain “below the line” and the desired catalytic impact will not be achieved.

### **Maximising CDC’s poverty reduction impact**

#### *Sector focus*

CDC should maximise its poverty reduction impact by increasing the share of its investments in LICs which are committed to those sectors where the evidence shows growth is associated with

the highest poverty reduction impact. There is a wealth of evidence indicating that agriculture and agriculture-supporting infrastructure are sectors where the poverty reduction impact resulting from economic growth is particularly great. Janvry and Sadoulet (2009)<sup>7</sup> summarise the conclusions of numerous recent research studies across many regions including Africa which all show convergent results that “GDP growth originating in agriculture induces income growth among the 40% poorest which is of the order of three times larger than growth originating in the rest of the economy.” If CDC is to contribute more to reduction of poverty in LICs it must have much greater exposure to sustainable agribusiness and agriculture-supporting infrastructure; and most of the opportunities in those sectors in LICs are early stage and therefore will need investment of catalytic capital and patient capital to get them started. Studies also show that other sectors where high poverty reduction impacts are associated with growth are those with high unskilled labour intensity including construction, urban infrastructure and rural factory employment.

CDC currently has minimal exposure to these sectors and none in early stage agriculture in LICs because the business model mitigates against investment in them. The recommended changes to the business model – especially the tranching of its capital – would enable CDC to play a much greater catalytic and poverty reducing role in these pro-poor sectors.

#### *Country focus*

There is no compelling reason for major change to the current requirements to focus on the poorest regions, to invest more than 75% of total investment in low-income countries and more than 50% in sub-Saharan Africa. Too narrow a geographic focus is inadvisable given the need to maintain diversification across countries and sectors. Rather than change the country allocations there should be greater focus on sector allocations, with more capital required to be committed to pro-poor sectors, and support for early stage ventures, within the current country allocations.

There are undoubtedly many poor people in the poorer regions of the MICs. There is a case for considering a further constraint, namely that investments using CDC commercial capital in MICs should be primarily committed to businesses where the majority of their activities are in the poorer regions; and that catalytic and patient capital may only be committed in MICs to investments in the poorer regions.

CDC may have a particular role to play investing in fragile states during the period after hostilities have ceased but when confidence of the private sector to invest has not returned. CDC could only invest in such situations using the catalytic and patient capital tranches; and DFID should explicitly acknowledge that were it to do so CDC would be exposed to particularly high risks and the result could be to achieve sub-target financial returns on these investments.

CDC should be allowed to invest in Special Economic Zones because these are the locations where many infant industries first establish themselves; and investment in early-stage development of industrial/export activities often has high development and poverty reduction impacts.

### **How should CDC diversify its business model?**

#### *A more diversified business model*

There are two distinct aspects to diversification of the business model: how CDC changes the risk appetite and types of instruments deployed (covered above); and the extent to which it shifts away from a fund of funds model towards making direct investments. It is the latter question that is addressed in this section.

At present CDC operates exclusively through intermediaries i.e. private equity funds. It makes no direct investments itself; nor does it have the required in-house expertise to do so. The government has indicated that it intends that CDC should restore some direct investment capability and the consultation questions seek views on the appropriate balance between funding intermediaries and direct investment. The discussion here is based on the assumption that the business model will be diversified by changing the risk appetite and deploying tranches of capital and a wider range of instruments.

There are two alternative ways of diversifying the business model:

*CDC could retain the fund of funds model but invest in a much wider range of types of intermediaries* including debt funds (like EAIF), loan guarantee facilities (like GuarantCo), patient capital funds, development companies (like InfraCo)<sup>8</sup>, private equity funds (as now) and/or hybrid funds (funded with patient capital and commercial capital – see figure 2). If this approach were adopted CDC's mode of operation – funding intermediaries - would remain as now but the fundamental business model would in fact change radically. The objectives of CDC, the investment policies and governance of each fund, the incentives on the fund manager and performance measurement and monitoring would all be very different from the current model (see below). Fund managers would be selected case by case for their specialist expertise and for their ability to deliver the objectives set for each fund. Investment policies would reflect the aims and constraints with regard to risk appetite, sector, product and geography and would be very different depending on the fund's specific aims and capital structure. Fund managers would be contractually bound to act within the investment policies and there would be enhanced performance measurement and monitoring and greater transparency and accountability. Incentives built into fund management agreements would differ greatly from a standard private equity fund with rewards for fund managers linked directly to the extent to which they deliver explicit development impact and poverty reduction targets as well as financial targets.

This approach has been successfully adopted in the PIDG and could be readily adapted for use by CDC. It would give DFID/CDC much closer control over the use of public money, ensuring it serves the purposes for which the funds were intended, while retaining access to the expertise of specialist developers and fund managers in the private sector. It represents a major change and significant diversification of the business model and addresses the major shortcomings of the current fund of equity funds model.

*Alternatively CDC could rebuild the capacity to make a high share of its investments as direct investments* This would require creation of marketing, execution and back-office capability across the full range of sectors, products and geography. This would give CDC direct involvement in decision making about individual investments and therefore potentially greater control over the investment process and transaction selection. However there are considerable disadvantages including: the loss of access to the diversified expertise and knowledge base available among fund managers and development companies in the private sector; and the challenge of recruiting and retaining the high calibre staff that would be required into a public sector entity constrained by public sector remuneration policies.

In my view the best approach for CDC to adopt over the next few years is to focus primarily on diversifying the business model as described in the first alternative above. This in itself is a major challenge. In parallel CDC should consider the extent to which the new approach adequately addresses the shortcomings of the current model; and in which areas rebuilding a direct investment capacity is necessary in order to achieve even greater effectiveness delivering DFID's

agenda. My experience with start-up of EAIF and GuarantCo suggests that direct investment by CDC should initially focus on participation in transactions led by other DFIs with greater experience of direct investment. In my view the balance over the next few years should be tilted firmly towards making the new approach to funding funds work before there is a major push to make direct investments.

*Aligning CDC/fund manager incentives and appropriate remuneration policy*

There are two issues to consider: how to align fund manager incentives with DFID objectives; and how to align incentives on CDC senior management with DFID objectives. There is also the question about the appropriate level of remuneration.

The incentives embedded in private equity fund management agreements encourage fund managers to raise large funds and to maximise the value of the assets in which they invest over the term of the fund. This is appropriate for private equity funds because investors are seeking to maximise profit. They are not appropriate for a DFI with development and poverty reduction objectives and a shareholder that is much less concerned about financial returns on CDC capital than with development and poverty reduction impacts. These incentives are particularly inappropriate for funds investing patient capital and catalytic capital. CDC will need to redesign remuneration structures to ensure that going forward there is an explicit matrix of success indicators that encompass development impact, extent to which additional capital is mobilised and poverty reduction impact as well as financial performance. The performance framework should be symmetric, rewarding managers more who achieve fully the ex ante performance standards but reducing remuneration if performance is less than fully satisfactory. Useful lessons can be learned from the experience of the PIDG which has been using this approach for some time.

The incentives acting on CDC senior management should also be aligned with achievement of explicit development goals agreed with DFID, not for maximising the return on capital employed. Remuneration should be graduated according to the extent to which senior management succeed in achieving explicit performance targets including leverage of private capital flows, development and poverty reduction impacts and financial performance for each of the three tranches of capital.

Remuneration for fund managers must reflect the market. However, given that public money is being spent, 'upside' should be bounded so as to avoid payment of actual or perceived 'excessive' remuneration and a significant part of remuneration should be linked to achieving DFID's objectives. Remuneration of CDC senior management should be set to enable recruitment of quality individuals but should also reflect the fact that there are quality individuals who would be willing to accept a reasonable discount to 'market' as measured by remuneration for comparable roles in the private sector because they are motivated in part by non-pecuniary interest.

## **DFID's 12 consultation questions**

My answers to the 12 consultation questions draw on the analysis and observations set out above.

*Q1 Where should CDC invest and why?*

My answer is set out above – see sub-heading *Country focus*.

*Q2 Should CDC emphasise some sectors more than others?*

Yes. For the reasons set out above CDC should be required to seek to invest a higher share of its commercial, patient and catalytic capital in sectors where the evidence indicates growth has a particularly high poverty reduction impact. In particular this means a higher share of investment in early stage agriculture and agribusiness and infrastructure supportive of productive investment in urban and rural areas.

Although there is no general case for emphasising some infrastructure sectors more than others, there is a strong case for focusing on infrastructure which directly facilitates profitable investment in productive sectors with high poverty reduction impact. In particular, coordinated investment of patient and commercial capital in bulk water supply, electricity connections and feeder roads can catalyse profitable agricultural investments by the private sector resulting in large improvements in agricultural productivity and incomes, including for smallholder farmers, thereby achieving a large poverty reduction impact.<sup>9</sup> Similarly coordinated investments in coastal industrial estates/Special Economic Zones can catalyse private investment in processing and manufacturing investments by private investors which otherwise would not take place.

CDC should support investment by micro- or SME businesses as well as medium and large scale businesses. However the importance of economies of scale in many sectors is such that investments sometimes need to be medium or large scale to be profitable. Where patient and/or catalytic capital is deployed it should be a requirement that medium and large scale businesses commit to develop formal business linkages with SMEs and micro-enterprises, and failure to do so should be a condition of default.

*Q3 What role, if any, should CDC play with respect to climate change?*

Climate change imposes the greatest costs on those least responsible for causing it. It is vital that CDC resources destined for the poorest countries are not diverted from their primary objective of fostering growth and poverty reduction in those countries. Nevertheless investments to mitigate the impact of climate change in poorer countries are clearly important. In my view CDC should focus on supporting sustainable investments which serve to foster growth, reduce poverty and address climate change issues. In sub-Saharan Africa the three most obvious types of investment which serve all three ends are hydropower generation, irrigation for agriculture and weather insurance. Hydro-power produces renewable, non-carbon emitting energy that is usually inexpensive and can be combined with schemes for irrigated agriculture. Irrigation investment improves agricultural productivity, reduces rural poverty and increases resilience to increasing weather risks. Financially sustainable weather insurance businesses are now being rolled out in poorer countries. Because these investments are aligned with DFID's development objectives as well as addressing climate change issues, CDC should consider expanded investment in these areas. Often this will require catalytic and patient capital investment in the early years.

*Q4 Should CDC emphasise some types of investment instruments more than others?*

The answer is given above – see section *Maximising CDC's catalytic role/additionality*

Regarding the sub-questions:

- The balance between different types of instruments (equity, debt, guarantees) should be determined by need, given the nature of the financing constraints encountered case by case. Likewise the balance between forex and local currency instruments.
- The greatest market failures at the project level are encountered in the early stages of development in sectors with high front-end fixed capital costs and uncertain rates of growth.

Hence broadly speaking catalytic capital will generally be invested in the very earliest stages of start-up/early stage ventures, patient capital will generally be invested at financial close of early stage ventures and commercial capital to a limited extent at financial close but increasingly over time in expansions of mature businesses and refinancing of patient capital (figure 3).

- There clearly are circumstances where there is a trade-off between poverty reduction and financial returns in the short term. This is why we need catalytic and patient capital. However over the medium term both the poverty reduction impact and profitability usually grow together.

*Q5 How should CDC measure and monitor poverty reduction impact?*

The approach to measuring and monitoring poverty reduction set out in the Annual Development Report can be characterised as a ‘good start’. It is right that considerable effort should be put into identifying and measuring outputs, outcomes and impact of investments funded by taxpayers. But the current approach can definitely be improved. There are well established methodologies for identifying and quantifying the ‘external’ socio-economic benefits and costs and development impact arising from investments; and for measuring the poverty reduction impacts (which are not the same thing) of investments in different sectors. Some of these approaches have been developed by InfraCo in an attempt to supplement and build on the standard approach. There may be some useful lessons for DFID/CDC from the PIDG about improving the approach to measuring and monitoring development and poverty reduction impacts. In any event it is clear that going forward CDC should be subject to more explicit development and poverty reduction targets than in the past; and required to put in place measurement and monitoring arrangements that provide appropriate transparency and accountability about ex post performance.

The assessment and measurement of additionality is fraught with difficulties. Conceptually it can be difficult to determine whether financing could have been secured if a DFI had not been involved. The best that can be done in this area is to incorporate into investment policies that investments must be additional and then making fund managers explain ex ante the justification for asserting that an investment is additional to the satisfaction of the investment committee. With the current business model there are major problems in this area. First, equity fund managers are subject to perverse incentives because there are strong incentives to invest in the most attractive opportunities which by definition are those least likely to be additional. Second, the governance arrangements and reporting requirements are such that CDC can do little to ensure that investments are truly additional, even if it wanted to. And third, it is not currently even clear that it is CDC policy to strive for additionality – it has been suggested that the policy was dropped some time ago. In future there should be a clear policy that CDC capital should be used to achieve additionality, governance and incentives in fund agreements should ensure oversight and avoid perverse incentives and the reporting framework should provide the information required to ensure compliance.

*Q6 How can CDC best catalyse private investment in the poorest countries?*

The answer is given above – see *Maximising CDC’s catalytic role*.

Regarding the sub-questions not already addressed:

- With the proposed model CDC should catalyse additional private investment at both the fund level and the project level. A CDC debt fund could be structured on similar lines to the EAIF debt fund (which catalyses private debt at the fund and project levels) and a loan guarantee facility along similar lines to GuarantCo (which also catalyses private debt at the

facility and project levels). A patient capital fund or a catalytic fund could similarly catalyse funding at both the project level and the fund level (by raising additional patient or catalytic funding from other public and private sources).

- In theory there is merit in CDC leveraging its balance sheet by raising capital from the private sector for investment in funds and direct investments. In practice this may encounter insuperable problems in that it would score as additional public sector borrowing; and this is unlikely to be approved by the government in present circumstances. In any event there are few disadvantages in raising capital at the fund level; and DFID has stated that if CDC is subject to capital constraints it can provide additional capital to support highly developmental, pro-poor new initiatives.
- In the proposed approach CDC's return on capital will be a function of the relative size of the capital tranches and its success in meeting financial targets. A lower return on capital will result in slower growth of the balance sheet but I agree with statements by the government that growth of the balance sheet should not be an objective. To maintain continued activity over time CDC should seek to revolve capital by selling assets as soon as the market failures have been addressed and seeking to replace the CDC capital with new capital from the private sector.
- CDC should not establish an advisory capacity. There is an active private sector market in advisory services and CDC has no comparative advantage in doing that. Nor should it fund advisory services except in relation to its fund activities, this being a role played by DFID..

*Q7 What should CDC's policy be with regard to investing or operating in jurisdictions that operate a preferential tax regime?*

A balance is needed between on the one hand not investing or operating in jurisdictions which are in effect tax havens or otherwise do not comply with international standards; and on the other hand recognising that it is important that CDC funds invest and operate in the countries and regions with which it is concerned. Moreover one external benefit of operating out of a country within the developing world is that it enables capacity to undertake financial services to international standards to be developed. Specifically, it is important that sub-Saharan African funds are domiciled in the region; and as a practical matter Mauritius is by far the best location for African focused funds. It is important that CDC is able to continue to use Mauritius as the domicile for its African funds.

*Q8 Where should the balance of the new more diversified model lie, and why?*

The answer is set out above – see *How should CDC diversify its business model?*

*Q9 In what areas should CDC seek to increase the level of disclosure and transparency?*

The level of disclosure and transparency achievable under the current business model is unsatisfactory. The recommendation made above is that requirements for disclosure and transparency for future funds be improved dramatically. At the same time it is essential that co-investors remain satisfied that CDC will comply with the standards of commercial confidentiality that they expect if they are to invest in its funds. The experience of the PIDG indicates that much can be done to improve disclosure and transparency without breaching confidentiality undertakings.

*Q 10 What would represent an appropriate remuneration policy for CDC and why?*

The answer is set out above – see *Aligning CDC/fund manager incentives and appropriate remuneration policy*

*Q 11 How can CDC ensure that it complements and adds to the capital and other support available from other DFIs and IFI's?*

At present most other DFIs and the private sector arms of IFIs adopt similar investment criteria (risk appetite and expected returns) as those of CDC (ie they seek fully commercial returns on capital invested). In this sense their business models are subject to similar shortcomings as that of CDC. This is reflected in their investment behaviour; they make few early stage investments in those sectors with the greatest poverty reduction impact such as agriculture.<sup>10</sup> The main differences to the CDC model are threefold: first, most of them already deploy a full range of instruments including debt and loan guarantees; second, most of them make a lot of direct investments as well as funding funds; and many of them gear their balance sheets by raising capital from the private markets at the level of the institution. Other DFIs argue that the advantage of making direct investments is that they have greater flexibility than CDC to influence the investment process and transaction selection; and therefore to achieve greater development impact.

It is important that CDC collaborates closely with other DFIs and the private sector arms of the IFIs. They have in varying degrees important expertise and experience making direct investments in MICs and LICs and funding specialist sector funds. If CDC is to rebuild capacity to make direct investments it will need at least initially to participate in transactions led by these more experienced organisations. CDC already partners with other DFIs co-financing equity funds and this partnership working can be extended to a wider range of instruments in future.

If CDC adopts the recommended approach of deploying catalytic, patient and commercial capital and structuring new funds to target more aggressively the achievement of explicit development and poverty reduction outcomes then it will have forged a distinctive and unique model for DFIs. Just as the novel PIDG initiative was innovative and others have followed, so this approach would also put the UK in a leadership position in the search for more effective ways of stimulating pro-poor growth using DFIs and private sector arms of IFIs. Others are likely to follow.

*Q 12 If we could do only one thing to increase CDC's impact on economic development and poverty reduction, what should it be and why?*

The one thing that would do most to increase economic development and poverty reduction in poorer countries would be to allocate CDC's capital to three tranches with different risk appetite and return requirements and to make the necessary changes to the governance, incentives and reporting requirements of funds and their managers.

## **Conclusions**

There is a great opportunity to re-establish CDC as a development institution that 'punches above its weight' fostering growth and poverty reduction in the poorest countries of the world. If the opportunity is to be grasped then the CDC business model must be modernised in the ways described above. Catalytic funding in the earliest stage of development and patient capital at financial close can catalyse a large amount of private investment into viable nationally owned businesses in ways that generate large improvements in the income and welfare of the poorest people in the poorest countries. Moreover over time sustainable growth and continuing reduction in poverty will be possible without any further investment by CDC.

Keith Palmer  
January 29 2011

Figure 1

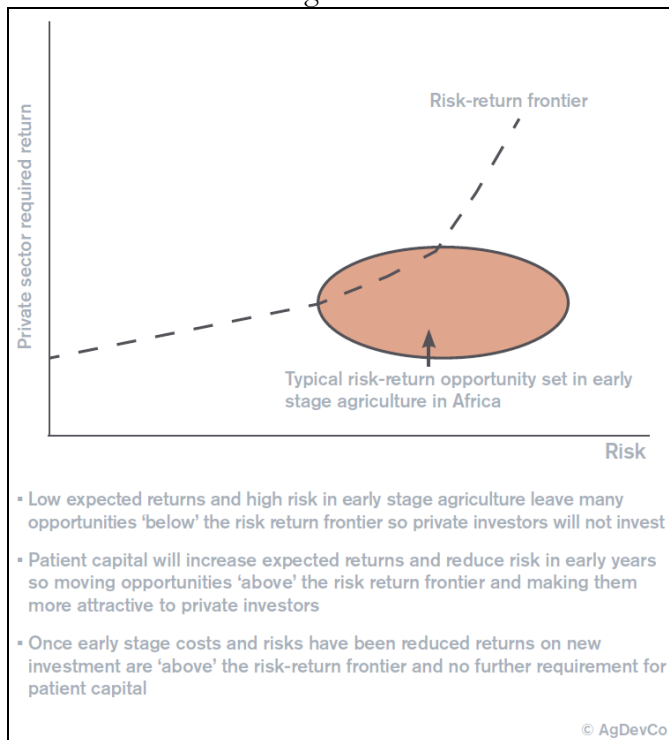


Figure 2 Hybrid Private equity – patient capital – catalytic capital fund

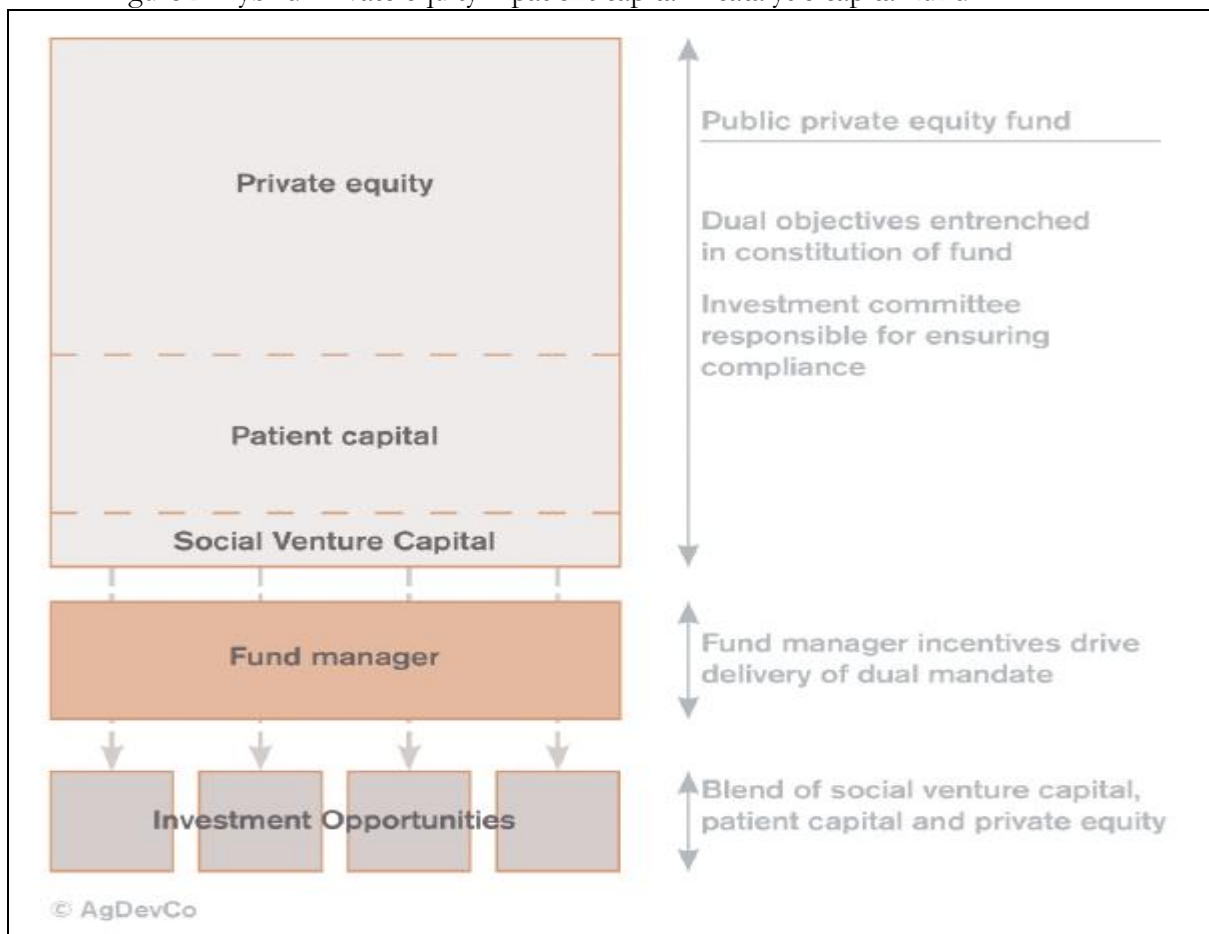
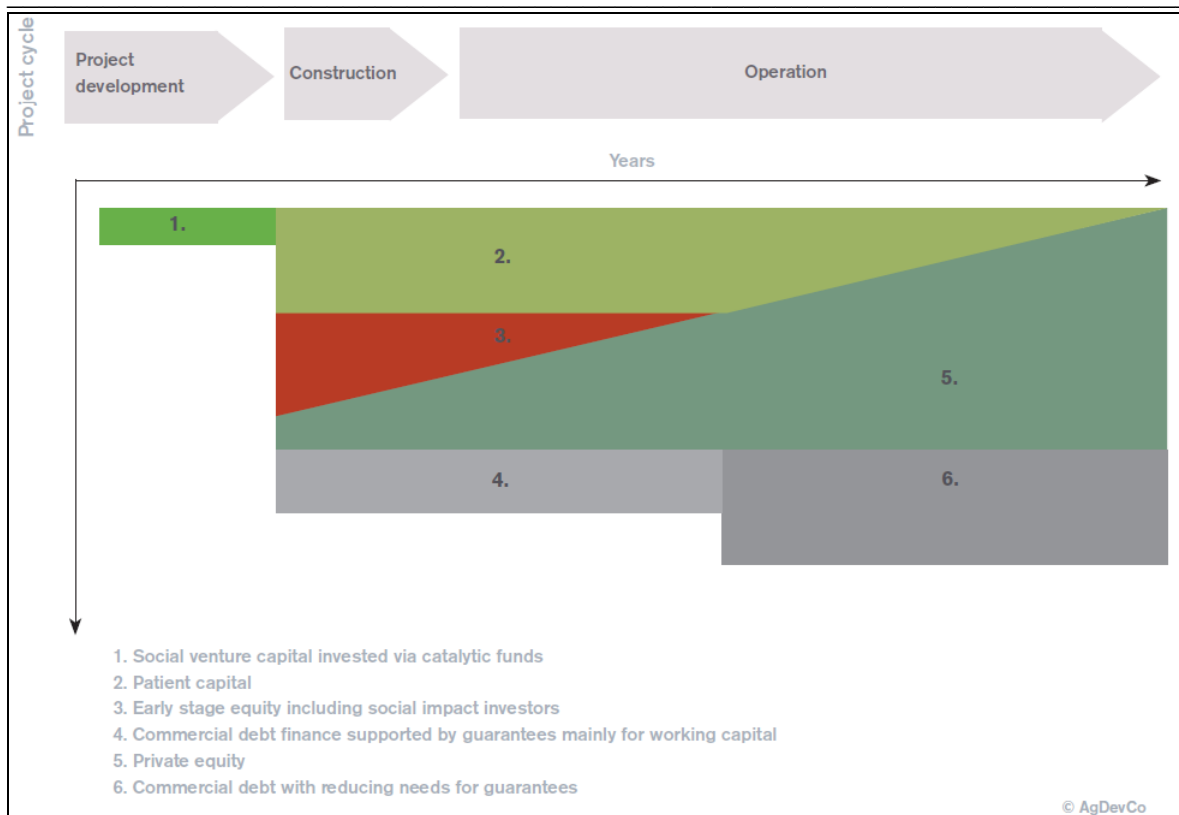


Figure 3



<sup>1</sup> See ([www.pidg.org](http://www.pidg.org))

<sup>2</sup> The experience of the PIDG facilities eg EAIF, GarantCo and InfraCo confirms that market failure in debt markets is prevalent in many LICs.

<sup>3</sup> “Agricultural growth and poverty reduction: the case for patient capital” Keith Palmer, AgDevCo briefing paper 2010 ([www.agdevco.com](http://www.agdevco.com))

<sup>4</sup> Some of the evidence is summarised in Palmer 2010.

<sup>5</sup> InfraCo is a PIDG funded infrastructure development company. It deploys funding akin to catalytic capital to make infrastructure opportunities investment-ready ([www.infraco.com](http://www.infraco.com))

<sup>6</sup> A recent independent review of InfraCo shows that it achieves average leverage (new private investment per pound of catalytic finance) across its portfolio in excess of x20.

<sup>7</sup> See “Agricultural growth and poverty reduction: additional evidence” Janvry and Sadoulet, World Bank Research Observer Advance Access Nov 2009.

<sup>9</sup> For a concrete example of this see ‘Chiansi irrigation: patient capital in action’ Keith Palmer and others, AgDevCo briefing paper, 2010.

<sup>10</sup> Eg see “Growth and productivity in agriculture and agribusiness” 2010 an independent review of the World Bank involvement in agriculture over the previous ten years which notes that ‘the IFC has had little engagement in agriculture in sub-Saharan Africa.’[quote from executive summary]