From 11/14/06 03:44 AM To 11/14/06 06:16 AM Pacific
From 11/14/06 06:44 AM To 11/14/06 09:16 AM Eastern
From 11/14/06 06:44 AM To 11/14/06 09:16 AM SA Pac
From 11/14/06 11:44 AM To 11/14/06 02:16 PM W Africa
From 11/14/06 11:44 AM To 11/14/06 02:16 PM W Europe
From 11/14/06 12:44 PM To 11/14/06 03:16 PM WC Africa
From 11/14/06 07:44 PM To 11/14/06 10:16 PM Singapore

---Begin Transcript---

(4) *Barbara O'Hanlon*: Good morning everyone!

(5) *Barbara O'Hanlon*: Good morning Noamesi.

(6) *Barbara O'Hanlon*: Welcome. Where are you joining us from?

(7) *Barbara O'Hanlon*: And welcome to Kwesi.

(8) *Barbara O'Hanlon*: We are pleased to have our colleagues from FHI join us.

(9) *Barbara O'Hanlon*: Do you know how to post your comments?

(10) *Barbara O'Hanlon*: All you have to do is type in your message in the text area and click post.

(11) *Barbara O'Hanlon*: Can you say hello to let me know if this system is working?

(12) *Barbara O'Hanlon*: We will wait for others to join us before getting started.

(13) *Barbara O'Hanlon*: Good morning Bruce.

(14) *Barbara O'Hanlon*: I am looking to your contribution this AM

(15) *Barbara O'Hanlon*: I am also looking forward to the collaboration between our 2 projects in your new capacity.

(16) *Barbara O'Hanlon*: Welcome Erick. Good to see you this AM.

(17) *Barbara O'Hanlon*: We have 2 colleagues in Ghana. We are waiting for a few more to join so dont go away!

(18) *Bruce Mackay*: Hello, I am on the phone so hang on!

(19) *Eric Derks*: Good morning Barbara and all

(20) *Barbara O'Hanlon*: Will do Bruce.

(21) *Barbara O'Hanlon*: Can Kwesi and Noamesi please join in to let us know they are on line?

(22) *Neha Suchak*: Hello everyone, my name is Neha and I look forward to hearing your perspectives on working with the private sector!

(23) *kwesi Eghan*: Hello Barbara

(24) *Barbara O'Hanlon*: Hello Kwesi!

(25) *Barbara O'Hanlon*: Lets start by having each of introduce ourselves.

(26) *Barbara O'Hanlon*: I will start.

(27) *Barbara O'Hanlon*: My name is Barbar and I am the Sr. Policy advisor for the PSP-1 project.

(28) *Barbara O'Hanlon*: And you?

(29) *Eric Derks*: I'm Eric from Action for Enterprise, we into economic development, but interested in how our tools apply to this sector.

(30) *kwesi Eghan*: I am on line now . I am working currently with FHI on the Private sector ART project amongst others

(31) *Barbara O'Hanlon*: Welcome Kwesi. Another?

(32) *Bruce Mackay*: I have just joined HLSP (we manage DFID's health resource centre) in a new post to specialise in private sector issues

(33) *Barbara O'Hanlon*: Welcome to today's live chat! It's remarkable that with this online technology hundreds of people from all over the world can join together to share ideas, experiences and dreams about healthcare solutions on a worldwide basis!

(34) *Barbara O'Hanlon*: We're going to start as an "open chat" - which means that anyone can post a comment or a question of anyone else and anyone can respond.

(35) *Barbara O'Hanlon*: We are going to get started. Any one can post a comment

(36) *Barbara O'Hanlon*: I will start with a question and hope others will present theirs.

(37) *Barbara O'Hanlon*: How do you think the private sector can contribute to public health goals?

(38) *Neha Suchak*: I think the private sector can extend the reach and coverage of services where MOH are not located.

(39) *Noamesi Amenyah*: In Ghana, Family Health International with support from the World Bank under its treatment acceleration Programme (for Ghana, Burkina Faso and Mozambique) is collaborating with Government (National AIDS Control Program) to foster public-private partnership in the health arena with the provision of HIV prevention, care and treatment services in the . FHI acts as an intermediary between the public sector (NACP as the regulatory body in HIV care) and the private health sector and this has reduce the suspicion of the private sector in engaging the public sector

(40) *Noamesi Amenyah*: FHI bridges the communication gap between the two sides to ensure that logistics are efficiently and effectively delivered as well as making sure the private sector adhere strictly to national guidelines. There is a healthy relationship between the both sides.

(41) *Noamesi Amenyah*: I will conclude by saying that Public-Private Partnership can be nurtured with
- Good Knowledge and understanding of the private sector
- True and proper COORDINATION, COLLABORATION and COMMITMENT of public

sector in meaningful dialogue with the private sector. All this is done through COMMUNICATION. Government has the responsibility to show political will to improve access and equity by creating an enabling environment policy wise to engage the private sector.

(42) *Bruce Mackay*: I will put in a plea that we stop using the words 'private sector' because they cover so many diffferent things, and instead be very specific about each topic. For our colleagues in Ghana is the questtion 'how can doctors and nurses in private practice contribute to rolling out ARVs?',

/Noamesi Amenyah has left./

(43) *Veronika Wirtz*: Thank you.

(44) *Barbara O'Hanlon*: Bruce, what term do you want us to use instead of private sector?

(45) *Barbara O'Hanlon*: Kwesi, Do you want to respond to Bruce's question also?

/Noamesi Amenyah has left./

(46) *Barbara O'Hanlon*: While we are waiting fo rothers to respond to earlier questions, Veronika can you introduce yourself?

(47) *kwesi Eghan*: -the current model being tested is address Bruce's question. we have had to deal with public sector players ti justify why the private sector should be involved in rolling out ARV's issues on pricing ,quality control have been and continued to be raised

(48) *Barbara O'Hanlon*: Welcome Tania. I hope you can bring some comments on financing and contracting.

(49) *Bruce Mackay*: I don't want an alternative term, it is fine as a 'catch-all', but FHI's descrption above, that they want to 'foster public-private partnership in the health arena with the provision of HIV prevention, care and treatment services' covers a multitude of possible activities, some of which I might support and some of which I might question.

For example, if a country is short of trained doctors in the public and has lots of ARVs, it may make sense to train private doctors and extend free ARVs to them. But it might make more sense in the medium term to get some of those private doctors into the MoH.

/kwesi Eghan has left./

(50) *Bruce Mackay*: Kwesi, what exactly is the problem you are trying to address in Ghana? Is it that private doctors are dispending ARVs anyway and doing it badly (like in india)? Is it that MoH or NGo facilities do not exist in some places so to achieve coverage you need to bring in private doctors? Or what?

(51) *Tania Dmytraczenko*: Bruce, what advantages do you see in bringing private doctors into the MOH? In your opinion, is the preferred model to hire doctors as civil servants or do you see a solution in which the public sector can contract services from private doctors?

/kwesi Eghan has left./

(52) *Bruce Mackay*: Tania, it depends on the problem you are trying to solve. I would make the general observation that much discussion of public/private skips this first question (what are we trying to achieve?) and goes straight into 'what shall we do?' and 'how shall we do it?'.

(53) *Barbara O'Hanlon*: Others can feel to respond to Tania's comment as well.

/Noamesi Amenyah has left./

(54) *Tania Dmytraczenko*: I am with you, Bruce. The goals need to set out first. Solutions will need to be tailored to those goals and specific country settings.

(55) *Noamesi Amenyah*: soory my line went off

(56) *Tania Dmytraczenko*: Noamesi, earlier you made some points about what is need to nurture public-private partnerships. You pointed to some to the responsibilities of government. What, in your view, are some of the responsibilities of the private sector providers?

(57) *Bruce Mackay*: Noamesi, I would like to ask you a slightly cheeky question (but I have ben in the same shoes as you, brokering a relationship between public and private) - if you did not have donor money, how would you be able to carry out those roles of coordinating and communicating between government and doctors in private practice? Are there examples of sustainable institutional arrangements for doing this in low-income countries? I ask because coordinating effectively requires skill and time, and that needs money. most of the examples I see are donor-funded.

(58) *Barbara O'Hanlon*: It looks like our colleagues are having connectivity problems therefore the lag in response time so please be patient.

(59) *Barbara O'Hanlon*: Since our colleauges in Ghana are having probles, would Veronika, Vicki and Tania like to jump in and respond to Bruce's cheeky question.

(60) *Noamesi Amenyah*: Bruce you are right to some extent because it is not easy to get the private sector involve in such level of engagement with the public sector

(61) *Neha Suchak*: Certain African countries like Uganda have new positions to coordinate between public and private, maybe this is a new model?

(62) *Noamesi Amenyah*: Donor money is necessary sto jump start the process to set up systems that will stand the test of time especially where there the public sector sees the private sector as contributing to national targets

(63) *Tania Dmytraczenko*: Bruce, you make a good point. Some of the examples that I can think of are in Latin America and South Africa where civil society organizations have pushed for stronger coordination--without much or any donor funding.

(64) *Noamesi Amenyah*: The public sector in Ghana is willing to support the private sector if both sectors see their activities as mutually re-enforcing

(65) *Barbara O'Hanlon*: In Peru, the decentralized and participatory planning processes were jumped started by donor funds. They were so successful that the local governments assumed the financial and technical support of this coordination and planning processes.

(66) *Vicki MacDonald*: In my limited experience, you need a catalyst to create partnerships--and as donor representatives, we have often played that role. In fact, we have just hired a staff member in Indonesia to be that catalyst--particularly with corporations and NGOs. Hopefully, over time both the private providers and the NGOs with whom we work will see the advantages. In our POUZN project, we are trying to get local manufacturing and pharmaceutical distribution firms to take on the supplier role. And the donor can just contribute the BCC.

(67) *Noamesi Amenyah*: In response to Tania about what the private sector needs to do, i will say The private sector should also show the same level of commitment to true partnership a sthe public sector, on issues of public health importance, subsidizing their cost/charges in return for capacity enhancement from the public sector in areas of equipments and other logistics can help foster the needed partnership

(68) *Tania Dmytraczenko*: Veronika, you have worked with the pharmaceutical sector in Mexico, are there any interesting examples of partnerships involving the pharmaceutical sector in Mexico.

(69) *Bruce Mackay*: I suspect that successful engagement of the two sides in health is either specific and quite narrow (for example TB drugs for DOTS, or MoH paying for IUD insertions) or it is part of a change broader than just the health sector, as in Uganda, or Peru by the sound of it. So the lesson may be 'be very clear on your objectives, abnd understand the context'.

/Eric Derks has left./

/Vicki MacDonald has left./

(70) *Barbara O'Hanlon*: The other lessons in PPPS is to reach common ground and find areas of mutual benefit.

(71) *Bruce Mackay*: Noamesi, when you say 'what the ;private sector needs to do', who exactly are you referring to? Doctors in private practice? Doctors and nurses in private practice? Commercial drug distributors? The reason I ask is that these different groups have different self-interests - for example, doctors as a group in their Medical Association often want to restrict what nurses are allowed to do, even though public health obectives could be achieved by extending nurses raneg of practice.

/kwesi Eghan has left./

(72) *Noamesi Amenyah*: I mean the leardship of those private sector facilities as well as the providers of those facilities. It must first start with the leadership to have a common understanding of the issues at stake before showing ineterest

(73) *Barbara O'Hanlon*: Tarry has just joined us from Nigeria. Are there any questions or issues related to the private sector in Nigeria that you would like to raise? For example, what are some specific barriers to working with the private sector?

(74) *Noamesi Amenyah*: in the type of partnership that is to be struck

(75) *Tarry Asoka*: Yes, Barbara plenty of examples. I my last life

as DFID Health Adviser I activetly engaged the private sector in achieving a lot public sector goals. The key barrier I think is the lack of understanding of the public sector (and donors) in how the private sector works. It is not all about profits - which I consider quite legitimate, in increasing the business confidence to enable the private sector to invest.

(76) *Barbara O'Hanlon*: So what did the public sector do in Nigeria to increase private sector confidence to invest in health?

(77) *Tania Dmytraczenko*: I would add that another barrier is lack of understanding in the private sector about the objectives and constraints of the public sector, no?

(78) *Tarry Asoka*: For example by removing or lowering taxes and tarrifs for such inputs as drugs, ITNs etc. Allowing the private sector to under marketing communication on behalf of the private sector. Essentially by recognising the comparative advantage of the private sector in undertaking certain tasks.

(79) *Noamesi Amenyah*: Tania, i agree with you that ack of understanding of the the private sector is an important issue and that was why i said the ppp can be achieved with good knowledge and understanding of both sectors

(80) *Barbara O'Hanlon*: We keep talking about lack of understanding. Can you give me specific examples of how you can increase each other's understanding?

(81) *Tarry Asoka*: Tania, It is not lack of understanding in the private sector about public health goods - after all this is business of everyone in the health sector. But the frustration in the private sector of not knowing the sort of levers to pull that can allow engagement with the public sector.

(82) *Noamesi Amenyah*: Tarry won't the frustration be due to lack of understanding of the sort of levers the private sector has to pull?

(83) *Tarry Asoka*: Naomesi, I hope we are not assuming that PPP can indeed bring about this understanding - it could, but only if this partnership is entered into on equal basis. The present situation I think is very patronising of the private sector.

(84) *Moises Rosas*: Hi there from Peru....

(85) *Moises Rosas*: Reading about Mexico's public programs was very interesting last night!!

(86) *Noamesi Amenyah*: Tarry, you are partly but not entirely right from my pooint of view, it takes a lot of efforts to build partnerships and this is only doable when the platform has beeen created

(87) *Tarry Asoka*: Well Noamesi, You see the public sector has been in charge all this while. So it is up to them to open up and let other actors no where they can add real value. It is not enough to use the private sector when it is convenient and side line them at other times.

(88) *Moises Rosas*: the main theme was "How to limit private rol trought strong public sector involvment" I think...

(89) *Barbara O'Hanlon*: Welcome Moises. What do you think about

that premise?

(90) *Moises Rosas*: Yeah, the private sector has a rol, buy its better is the public sector is strong, leaving the private services to whom can afford it...

(91) *Noamesi Amenyah*: I agree with you entirely Tarry and this is why the partnership has to be guided with history and past experiences. In a resource poor country like Ghana, the public sector is big and well resourced. However, the private sector has its role to contribute to the National response to health issues and that is why the engagement has to be mutually beneficial even though the public sector with its huge resources has to delibrately support the private sector to achieve a meaninful partnership

(92) *Bruce Mackay*: it is fairly clear 'who' the government is (though you can have arguments between different bits of it). It is also fairly clear what their objectives are (though MoH plans for universal coverage are often contradicted by them spending half their budget in the capital city). But it is often not at all clear 'who' these private sector people are, and it is always difificult for government to negotiate with a fragmented, or conflicting sector.

Working for Tarry in Nigeria, we used donor money to 'create' a trade association of net-makers and insecticide distributors, thus giving the government someone to negotiate with. But let's be honest about self-interest - one of the things these guys did (with our encouiragement) was lobby to keep tarriffs high on ITNs, in direct opposition tot he Abuja commitments on malaria!

(93) *Noamesi Amenyah*: I don't know what others think about this

(94) *Moises Rosas*: Here we are in the middle of a pilot study of capitation payment to public services, and it seems to foster the public services, and there is much room to improve public services using payment mechanisms...

(95) *Kathy Banke*: Just trying to catch up on your discussion so far this morning. As you know, I am new to private sector work and have a lot to learn!

(96) *Tania Dmytraczenko*: Moises, in other Latin American countries, there are many examples of the public sector contracting private providers to deliver publicly financed services--through capitation or other payment methods. Are there any examples of the public sector contracting the private sector for services in Peru?

(97) *Barbara O'Hanlon*: Thanks Kathy for introducing yourself. Welcome!

(98) *Bruce Mackay*: Noamesi, , how come the MoH in Ghana is willing to share its scarce resources with private providers? Last week in nairobi the chief of the MoH in kenya said 'if my budget was doubled I would first fill vacant posts, refurbish my health centres and get a full suppl;y of drugs to every one. Then, if I had any money left, I might look at working with private doctors and nurses'.

(99) *Moises Rosas*: I'm not aware of any (big) examples here, as many shows concerns about weakening the public sector, wich is deemed as not ready for the public-private competition

(100) *Moises Rosas*: some services (dyalisis, TAC, etc) are subcontracted to private providers, but only in case the public

providers don't have the facilities

(101) *Tarry Asoka*: Well Bruce, 'there is no vacuum in nature'. We know these people do exist and they are working hard on the margins trying to relieve critical constrainst. My experience with working with faith-based health facilities showed that instead of helping these organisations overcome some known obstacles, the public sector was in direct competition with them. So I would rather suggest a new role definiton especially as it affects service delivery. 'You cannot be a center referee as well as be a player'. There should be a level playing ground.

(102) *Moises Rosas*: It seems that the way fordward here is to enhance public-public competition first, to ger ready for public-pirvate competition later..

(103) *Moises Rosas*: in most cases, private investment is directed to urban services here, not to rural areas...

(104) *Tania Dmytraczenko*: Noamesi, in response to your question about what others think --in regards to the private sector having a role to contribute to the national response to health issues--I agree with you. I think, though, that the private sector also has a role to play in clarifying misperceptions about private providers (profit mongers, unskilled, not interested in public health goals).

/iCohere Support has left./

(105) *Noamesi Amenyah*: Well, well, Bruce, your question is indeed a big one and i think the example from Kenya clearly shows that the public sector does not understand the private sector. Our healthcare systems are really very weak and ministers will surely find excuses not to engage the private sector when thepublic sector is not yet satisfied. However, a normal playing field is what we want as Tarry said

(106) *Bruce Mackay*: I would like to raise the issue of decentralisation.

It sems likely to me that if decisions and budgets are at district level, you are more likely to get pragmatic engagement between govt, NGOs and for-profits - partly because the stakes are smaller, partly because they can see each other face-to-face, and partly because the MoH offocial in the morning is probably in private pratcice in the afternoon and on the board of the local NGO in the evening. At the national level, positions are much more entrenched, and institutions such as the doctors or nurses association gets 'captured' by special interest.

(107) *Noamesi Amenyah*: I remember, a few months ago when the PPP group in Ghana circulated a mail and i used the phrase 'the so-called public-private partnership'. This did not go down well with some of the members but this was to show a clear frustration about commitment to PPP

(108) *Barbara O'Hanlon*: Bruce
This is exactly the situation we had in Peru. As a result, we were able to overcome many of the entrenched positions of public/private when doing participicatory budget planning and truly engage all segements of society. This maybe one way to effect a true collaboration.

(109) *Susan Scribner*: Hi everyone. Trying to catch up on the conversation. I was struck by the comment about Kenya. If the Minister would use additional resources to hire staff, fix health centers and buy drugs, these are obviously the missing inputs. If these are available in Kenya, which they certainly are in some areas, then the MOH has the

opportunity to reach out and partner with the private sector rather than duplicate what already exists. Ministry resources could be concentrated in the areas where the private sector does not have capacity, such as rural areass.

(110) *Tarry Asoka*: The situation can be quite manageable at the district level as suggested by Bruce, but as we all know capacity at this level is very weak. Attempts at organising district level health systems in Nigeria supported by a DFID funded programme has been limited to the public sector only. So where is the leverage? I would like to know what happens elsewhere - is it different?

(111) *Barbara O'Hanlon*: Tarry
In my limited participation in the decentralized planning process, the private sector was at the table in the formation of district health committees. It was mandated by law that all segments of society be present in these health committees. Interestingly, the private/NGO sector were included as a result of individuals in the MOH and visionary governors who wanted them at the table.

/Luis Mauricio Pinet Peralta has left./

(112) *Barbara O'Hanlon*: We have 10 minutes left to this interesting conversation. Are they any new threads of conversation or questions that you would like to introduce before we wrap up?

(113) *Bruce Mackay*: Just as it is here in the UK, health in Kenya is a highly political business. What is the MoH going to say to an MP who comes complaining that the clinic in his constituency is out of drugs or has no nurse. She is not going to keep her job for long if she replies 'Oh, I have allocated that budget line to enable private doctors to join the ARV training programme'.

From a self-interested point of viw, this is an increasingly important issue for those of us in the DFID business, because DFID wants most of its money to go to government, and wants to persuade other donors to do likewise.

(114) *Luis Mauricio Pinet Peralta*: Thanks, good morning. I realized it was too late but will catch up by the end of the day.

(115) *George Greer*: Thanks - I guess I'm really late on this one.

/George Greer has left./

(116) *Susan Scribner*: Bruce, I am curious about why DFID wants to support the public sector. Shouldn't we be looking for the most effective solution in a given context, as mentioned above, not coming in with a predetermined agenda?

(117) *Tania Dmytraczenko*: But Bruce, would the parlamientarian care who delivered the services? Wouldn't they just be concerned that services were delivered? In Central America, NGOs have been used to provide publicly financed services in remote, formerly war-torn areas of the countries.

(118) *Noamesi Amenyah*: Bruce, i think you have made a great point. In my view, donors may be killing PPP if they resource governement to foster PPP. It might not work in African countries with politicians so strong to get all the resources for themselves and for the public sector

(119) *Noamesi Amenyah*: Parliament can say one thing and the

technocrates with their political affiliation will do otherwise

(120) *Moises Rosas*: Great point, Bruce...

(121) *Tarry Asoka*: Certainlty Susan, that has been my thesis. Who ever does the job better should do it. Bruce, you will recall in the ITN project in Nigeria we worked mainly with the private sector in distributing the nets. But at the same time we allowed the public sector to negotiate a new role they intend to play in the new arrangement.

(122) *Tania Dmytraczenko*: Susan, in Uganda and Kenya, KfW has been supporting voucher programs that subsidize provision of select services in the private sector. Their goal is to achieve greater utilization of quality services, which in these specific cases, has led them to private sector providers.

(123) *Bruce Mackay*: DFID is pretty clear that the most effective way to achieve the MDGs, which involve scaling up essential services such as health and education, is via a strong and effective state. This is aprtly an ideological position, adopted by the previous strong DFID Minister, who felt development had been hi-jacked by the NGO sector (international and local); partly it is a response to the failure of both NGos and for-profits to do much more than interesting but small-scale projects, and show little interest in or capacity for really going to scale. DFID is intereste din seeing governments contract NGOs and even for-profits if it helps to achieve the MDGs, but not contracting or PPSs for their own sake.

(124) *Susan Scribner*: I think contracting, or the vouchers in Uganda and Kenya, are the types of partnerships that make use of private/NGO capacity and afford the possibility of scaling up. We need to invest in partnerships that produce results, not for their own sake.

(125) *Tarry Asoka*: Bruce, I think that mantra about a strong state to deliver services is stale. Most people even in DFID know this. They will continue to stick to it because most of the Advisers are technical people and have very little experience in trying uncharted waters.

(126) *Bruce Mackay*: But donor-funded schemes like these do need to be designed from the outset as if they will, if successful, go to scale. Most donor-funded 'innovative' interventions (don't they just love that word) have no chance of going to scale, because either the donor would never commit that much funding, or the government would never take it on.

(127) *Tarry Asoka*: Again I quite agree with Susan, we should be less patronising about engaging the private sector. If this sector can not add real value.

(128) *Noamesi Amenyah*: Tarry, i think the private sector can add value to services no matter how small their contribution can be

(129) *Bruce Mackay*: Tarry, I don't think DFID is saying the state necessarily has to deliver - but that it does have to face up to the enormous task of achieving the MDGs. For a astrat, this means increasing budgets for the social sectors and making sure they reach the people at the bottom. The problem is that most of the pople who run the state are unable or unwilling to face up to this task - if they were, there would be a lot more government support for NGO and for-profit delivery. So we started with contracting private sector and end with the democratic deficit, maybe even regime change!

(130) *Barbara O'Hanlon*: We are over time. If anyone would like to make a final or summary comments this would be a good moment.

/Kathy Banke has left./

(131) *Bruce Mackay*: Many thanks, let's do this again, but maybe on a more tightly defined topic.

(132) *Noamesi Amenyah*: I want to thank all contributers for their insightful views about PPP

(133) *Barbara O'Hanlon*: Good feedback Bruce. There will be anothe opportunity for this Friday.

(134) *Barbara O'Hanlon*: Thank you for joining us and remember, the next live chat is scheduled for Friday, November 17th from 1:00 to 3:00PM EST

(135) *Bruce Mackay*: I would also just refer you all to the latest WHO Bulletin, which is devoted to contracting, and has some interesting case studies. Good and bad.

/Ting-Hway Wong has left./

/Noamesi Amenyah has left./

(136) *Barbara O'Hanlon*: Thanks to all for your lively contributions. In the meantime, enjoy the conference and share your thoughts in each of the presentation areas of the Conference Hall

/Luis Mauricio Pinet Peralta has left./

/Susan Scribner has left./

/Tania Dmytraczenko has left./

/Tarry Asoka has left./

/Moises Rosas has left./

(137) *Bruce Mackay*: Thanks Barbara, a first for me to do this kind of thing (though my teenage son spends his life doing this on IM). One practical suggestion, but probably for iCohere more than you. The panel listing the participants should include their affiliation as well as their name, it is tiresome to have to click on each one to find out who they are.

/Bruce Mackay has left./

/Bruce Mackay has left./

/Neha Suchak has left./

/This meeting is now closed./

---End Transcript---