

HEALTH SECURITY & EQUITY: A PUBLIC PRIORITY

POSITION PAPER ON THE IDA20 POLICY FRAMEWORK FROM A HEALTH PERSPECTIVE

Investing in global health equity - or equitable access to health services and commodities based on need and not the ability to pay - requires focused actions that address system faults. Not anything goes. If not well targeted, interventions may risk exacerbating existing inequalities. Health investments in countries should strengthen public - not private - healthcare, the health workforce and the public purse for health in a sustainable way. They should avoid the liabilities that come with de-risking and leveraging private finance, decrease fragmentation in national health systems and remove financial barriers that hinder people from using essential health services including those related to Covid-19. Investments should be accompanied by governments' joint action to close global and in-country disparities in access to Covid-19 vaccines, lower the price of vaccines and increase production capacity.

We call on the World Bank's IDA leadership and all involved governments - both on donor and recipient side of the IDA - to focus investments on access to vaccines for all and on resilient, universal and inclusive public health systems. In this position paper, we formulate key recommendations, explain their underlying rationales and propose changes to specific IDA policy commitments and Results Measurement System (RMS) indicators.

Our recommendations for IDA20 - from a health equity perspective - are:

1. Help close the global Covid-19 vaccination gap as soon as possible while supporting systemic changes to further universal access in the long run.
2. Prioritise investment in *public* (not private) healthcare delivery.
3. Facilitate long-term expansion of the public purse for health and refrain from using public resources to leverage private commercial funding for health.

Wemos is an independent civil society organisation seeking to improve public health worldwide. We analyse Dutch, European and global policies that affect health and propose relevant changes. We hold the Dutch government, the EU and multilateral organisations accountable for their responsibility to respect, protect and fulfil the right to health.

We collaborate with other organisations to make our (joint) messages and advocacy stronger.

INTRODUCTION

The early IDA20 replenishment, starting from December 2021 onwards, is aimed at supporting “countries to accelerate recovery and build back better for a greener, more resilient, and inclusive future in the post-Covid context”. It is well noted that Human Capital¹ is elevated to the status of a special theme in IDA20’s policy framework, and that there is more explicit attention to health and health system strengthening in light of the pandemic. As a health advocacy organisation, Wemos applauds the increased international efforts to expand public resource envelopes in lower income countries². We want to emphasise that more public investments in health are essential to fulfil of the universal right to health and progress towards health equity, and they are also instrumental for global health security and economic prosperity.

The Covid-19 pandemic revealed deep-seated economic and social inequalities and has taught the world multiple harsh lessons. As the IDA20 paper on Human Capital rightly points out, the pandemic has shown that all public health functions in national health systems need to be in order. Moreover, essential health services should be inclusive, people-centered and resilient against external shocks, first and foremost at primary healthcare level.³

¹ While the World Bank Group uses the term Human Capital, we would prefer the term Human Development. Human Capital is a more narrow concept which regards human being as a means to achieve higher productivity and thus economic prosperity, through investment in education and health. Human development is a broader concept which considers human beings as an end in themselves, which fits better in the universal human rights framework which guides our NGO’s work. This position paper, however, does not intent to change the term Human Capital.

² The World Bank’s International Development Association (WB-IDA) uses the term ‘lower income countries’ when it refers to IDA-eligible low and lower-middle income countries. In this paper we use the same term.

³ WB IDA (11 June 2021) [IDA20 Special Theme: Human Capital](#)

Other crucial health system lessons taught by the pandemic include:

- A healthcare system cannot do without well-trained and sufficient numbers of health personnel, working under the right conditions.⁴
- It is necessary to embed the core capacities for health security into unfragmented, publicly financed and universally accessible health systems.⁵
- Privatised and commercialised healthcare systems have turned out to be dramatically less effective in responding to crises such as the Covid-19 pandemic, both in higher⁶ and lower income (IDA-eligible) countries.⁷
- Countries with political leaders who took measures that unambiguously protected public health have done better, and *“for successful handling of future challenges, investment in public health is a must.”*⁸

Investing in and strengthening the public healthcare system in lower income countries is not only necessary to keep us all safe from health threats. It is also the best option to progress towards Universal Health Coverage (UHC) and to fulfil the right to health for all. Many civil society organisations with whom we interact in our work in the global South and North point this out.

OUR IDA20 POLICY RECOMMENDATIONS

1. HELP CLOSE THE GLOBAL COVID-19 VACCINATION GAP AS SOON AS POSSIBLE WHILE SUPPORTING SYSTEMIC CHANGES TO FURTHER UNIVERSAL ACCESS IN THE LONG RUN

STEP UP WITH ADDITIONAL GRANT FUNDING FOR VACCINATION

Disparities in access to Covid-19 vaccines between high- and low-income countries are unacceptable and hamper the fight against the pandemic. In early September, 64 percent of the population in high-income countries has received at least one vaccine, versus 24 percent

⁴ ActionAid (2020). [The Pandemic and the Public Sector](#): ActionAid policy brief.

⁵ Lal et al (2020). [Fragmented health systems in COVID-19](#): rectifying the misalignment between global health security and universal health coverage. The Lancet

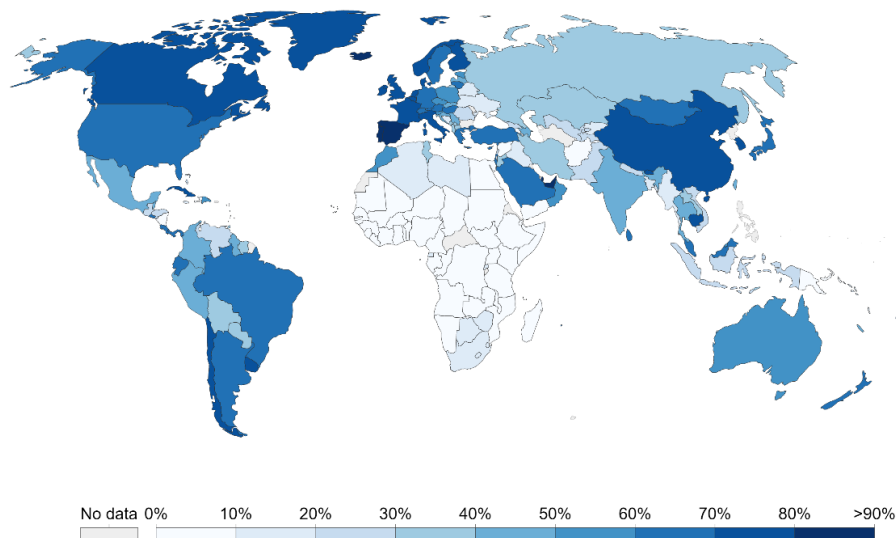
⁶ De Falco, Aubry and Angelo, GIESCR Policy Brief (2021) [Italy's experience during Covid-19](#)

⁷ ISER Uganda (2021) https://www.iser-uganda.org/images/downloads/Profiteering_off_a_pandemic.pdf

⁸ Narain, Sodani and Kant (2021) [Covid-19 Pandemic: Lessons for the Health Systems](#)

in lower-middle-income countries and just 1.8 percent in low-income countries⁹ (see image below). Using the words of the World Health Organization (WHO) Director-General: “The unequal distribution of vaccines is not only a moral outrage, but economically and epidemiologically self-defeating” (20 April 2021).

Share of people who received at least one dose of COVID-19 vaccine
Total number of people who received at least one vaccine dose, divided by the total population of the country.



Source: Official data collated by Our World in Data – Last updated 22 September 2021, 21:40 (London time)
OurWorldInData.org/coronavirus • CC BY

People should not have to pay for vaccination because this widens inequality gaps. Moreover, vaccine procurement and rollout should not go at the expense of lower income countries’ already limited public purse for recovery and much needed resources for long-term development. None of the lower income countries should have to go deeper into debt to purchase vaccines that save lives in their country – while also safeguarding the rest of the world from the risk of new mutations.

Universal vaccination should be made possible in the short-term through every possible avenue. Therefore, we support IDA20’s first objective under the special theme of Human Capital, which revolves around containing the Covid-19 pandemic and strengthening

⁹ Our World in Data (2021) [Share of people who received at least one dose of COVID-19 vaccine](https://ourworldindata.org/coronavirus)

pandemic preparedness. Universal vaccination requires immediate action with global level leadership, including that of the World Bank's IDA (WB-IDA).

- ⇒ To maximise accessibility and inclusiveness, WB-IDA leadership should insist that vaccines are provided to people free of charge.
- ⇒ To prevent displacement of other priority investments, including in health, funding for vaccine procurement and rollout under IDA should be grant-based and additional, provided for instance through an expanded crisis response window.
- ⇒ See our recommendation for more specific wording in Human Capital policy commitment #1, and related Tier 2 RMS indicator in Table 1.

SUPPORT THE TRANSFER OF KNOWLEDGE AND TECHNOLOGY

Resources for the public good are under stress in all countries due to the pandemic. If countries need to pay exorbitant market prices for vaccines, and (IDA) donor countries are asked to step up and provide money for the procurement of vaccines at such prices, this causes an even higher a strain. Money of taxpayers around the world has gone into the development of Covid-19 vaccines. Today's emergency calls for maximum public return on that money: control the pandemic as soon as possible.

It is therefore our position that manufacturers should be transparent about the costs of vaccine research and development and make vaccines available at cost price. Mechanisms that facilitate procurement of Covid-19 vaccines at cost or relatively low prices are needed.

We support the donation of vaccines as an emergency response that saves lives and stops the pandemic. However, this model maintains the dependence of lower income countries on vaccine-producing countries. Over the past year and a half, we have seen that donation-based supplies are unpredictable and grossly insufficient. Predictions are that the pandemic will continue for years to come, with new strains requiring new generations of vaccines. New pandemics will likely arise in future. In other words, the need for large numbers of life-saving vaccines will remain in the foreseeable future.

All influential institutions, including the WB-IDA should quickly support the call for a TRIPS waiver and technology transfer through WHO mechanisms such as the [Covid-19 Technology Access Pool \(C-TAP\)](#) and the mRNA hubs. These mechanisms enable facilities all over the world to produce lifesaving vaccines for those who need them. Within the context of IDA funding, receiving countries that wish to reduce their dependency on vaccine-producing countries should have the opportunity to collaborate to expand and build regional and local manufacturing capacity. This is not solely key in curbing today's pandemic. It is also part of the global and local future preparedness response as facilities will have grown capacities for the production of future vaccines. As such, it provides a sustainable way for low-income countries to reduce dependencies in future global health crises too.

- ⇒ We urge the World Bank's leadership, together with all countries joined in the current intensified IDA replenishment and operations, to lean in with political weight and actively support the TRIPS waiver, WHO C-TAP and the mRNA hubs.
- ⇒ See recommendation related to HC policy commitment #1, and related Tier 2 and Tier 3 RMS indicators in Table 1.

EXPANDING LOCAL AND REGIONAL MANUFACTURING CAPACITY

IDA20, in its paper on the special theme Human Capital, points at the importance to increase local and regional manufacturing capacities.³ While we support this ambition in principle, we do want to emphasise that manufacturing should be done in or regulated by public institutions, where investments come with conditions around transparency, prices, and production for local or regional need. And we want to stress again that, to achieve optimal manufacturing capacity, it is essential that pharmaceutical companies share their intellectual property rights, know-how and technology. Expanding manufacturing capacity and the transfer of knowledge and technology should go hand in hand.

IDA20 links the ambition to increase local and regional manufacturing capacity to the [IDA Private Sector Window](#) (IDA-PSW) which financially support projects of the World Bank Group's private sector arm (consisting of the [International Finance Corporation](#) (IFC) and the [Multilateral Investment Guarantee Agency](#) (MIGA)) and the [IFC Global Health Platform](#).



'Vaccine production' by Mike Mareen (via Canva/Getty Images)

However, our check into the database of the projects and programmes supported through the IDA-PSW¹⁰ shows a mismatch between this aim and the projects currently listed. Of the three projects related to healthcare, listed in Box 1, only the investment in Cerba Africa seems to be aligned with the goal to strengthen the service capacities regarding infectious disease control. The other health-related investments support private healthcare providers and insurers. Of these, [the Africa Medical Equipment Facility](#) (AMEF) involves the largest amount of IDA money (18 million USD). However, instead of directly supporting manufacturing, the AMEF helps private healthcare providers to buy medical equipment. While in theory the facility exists to support local manufacturers, the only manufacturers involved to date are two multinational companies, [Philips](#) and [General Electric](#). Thus, as it stands, the AMEF programme is expanding private healthcare providers' service capacity and multinational companies' exports of medical equipment, rather than strengthening local manufacturing and supply chains.

Regardless of its application in the area of health, or the Covid-19 health-related response in particular, critical evaluations of the IDA-PSW suggest that this financing mechanism is very problematic in general. Reportedly problems include a lack of transparency, undue subsidies for firms based on unsolicited proposals, a lack of evidence on the development effectiveness and financial additionality, and inability to leverage private finance.¹¹ Thus, it is highly questionable whether the IDA-PSW is the best instrument to expand local or regional capacity in vaccine production and supply chain.

- ⇒ We urge the WB-IDA leadership to assist lower income countries to expand local or regional manufacturing and supply chain capacity in ways that truly respond to the needs of those countries and their people - but not via the IDA-PSW.

2. PRIORITISE INVESTMENT IN *PUBLIC* (NOT PRIVATE) HEALTHCARE

'BUILD BACK BETTER': REINVEST IN THE PUBLIC HEALTH SYSTEM, THE SYSTEM THAT IS DESIGNED TO LEAVE NO ONE BEHIND

IDA supports "core social service delivery systems", through any type of system, but now is the time to refocus efforts and explicitly invest in service delivery through the public system.

¹⁰ IDA-PSW database: <https://ida.worldbank.org/financing/ida-private-sector-window/private-sector-window-projects> (last checked 16 September 2021)

¹¹ Ghosh and Sial (2021), [A Wrong Turn for World Bank Concessional Lending](#).

The Covid-19 pandemic has been a wake-up call on the need for strong public health systems and strong government stewardship for population health and healthcare's building blocks. Public health systems, with primary healthcare at their foundation, have been structurally underfunded and deprioritised. Multiple decades of austerity policies and privatisation strategies are among the main causes. Public healthcare systems are not merely essential for health security, they are the only viable way to ensure universal health care and health equity, especially in lower income countries.

In Uganda, for instance, people in communities, together with physicians, lawyers, and politicians, put pressure on their government to 'build back better', to invest in public - instead of for-profit private - healthcare as the most responsive and inclusive health system.¹²

"It is essential for a country's healthcare system to be public if universal health coverage is to be legitimately achieved: it is, in my view, the only way that every person in a country can receive effective healthcare. This cannot be provided by the private sector, which is profit driven and thus will always exclude those who cannot afford its services. So, the private system should always remain a supplementary health system (...). But as for a public health system, it is, and should always be regarded as, a public good, for the benefit of all society, and hence to be provided by public institutions." (Dr. Kizza Besigye – Physician, Politician and Human Rights Activist quoted in ISER 2021)

Public and private healthcare actors are moved by two different – and often colliding – motives. In the public healthcare system the driving motive is to reach universal healthcare, private actors in healthcare are generally driven by profit motives. Hence, the private health sector often does not voluntarily operate in a way that is consistent with a country's health goals and objectives.¹³

Strengthening public delivery of services is also important in the other areas that resort under Human Capital: education, water and social protection.¹⁴

- ⇒ We recommend the World Bank and member countries to explicitly focus their efforts on service delivery through the public system in their negotiations on the policy framework of IDA20.
- ⇒ See our recommendation related to HC policy commitment #3, and related Tier 2 and Tier 3 RMS indicators in Table 1.

¹² ISER (2021), Economic and Social Rights Advocacy (ESRA) Brief, [Reclaiming public health services in Uganda](#).

¹³ World Health Organization. (2018). The private sector, universal health coverage and primary health care (No. WHO/HIS/SDS/2018.53). World Health Organization.

¹⁴ Oxfam (June 2021), [Position Paper on IDA20 Replenishment](#)

REFRAIN FROM INVESTING IN PRIVATE HEALTHCARE

In our research into the healthcare related projects and programmes supported via the IDA-PSW, and thus via the World Bank's private arm (IFC and MIGA), we observed that the lion's share of financial support goes into the strengthening or expansion of private healthcare providers and insurers (see box 1). This doesn't address and even risks widening of inequality gaps in access between those who can and those who cannot afford to pay for essential health services and commodities.

- ⇒ WB-IDA should refrain from financing initiatives in private healthcare delivery and insurance, whether through the IDA-PSW or other IDA related financing instruments.

Box 1 - List of healthcare-related projects in the IDA PSW (in order of investment size)

1. **The Africa Medical Equipment Facility (AMEF)** aims to facilitate local financial institutions to lend money to private healthcare providers, allowing them to buy medical equipment to improve healthcare delivery. The IFC de-risks the financing through risk-sharing facilities (blended finance). *Total cost of the project: up to 124 million USD.*
2. **Cerba Africa**, a network of clinical diagnostic laboratories across Sub-Saharan Africa. The IFC intends to provide a loan and mobilise a parallel loan of an equal amount from another development finance institution. *Total cost of the project: up to 20 million USD.*
3. **Ciel Healthcare Limited**, a Mauritius-based company that invests in private healthcare provision and insurances in Nigeria (with **Hygeia Nigeria Ltd**) and in Uganda (with the **International Medical Group**). The role of the IFC is to use blended finance to mobilise affordable long-term local currency financing for the company. *Total cost of the project: up to 6.5 million USD.*

In the IDA-PSW there are also loans that support funds and financial intermediaries which include healthcare in their investment portfolio. Examples include Union Bank Nigeria PLC, Cardinalstone Capital Advisers Growth Fund, and Highland Private Equity and Mezzanine Fund. The nature of these "second-level investments" in healthcare is, however, not disclosed.

3. FACILITATE LONG-TERM EXPANSION OF THE PUBLIC PURSE FOR HEALTH AND REFRAIN FROM USING PUBLIC RESOURCES TO LEVERAGE PRIVATE COMMERCIAL FUNDING FOR HEALTH

Adequately functioning and resilient health systems allowing equal access to all and leaving no one behind, require sufficient *public* funding. Public revenue that is mobilised in ways that are progressive and secure for the long term. The health systems of countries that have made significant progress towards UHC rely predominantly on public funding from compulsory funding sources and effective pooling of resources for redistribution and cross-subsidisation. Human resources for health is an essential building block of health systems, which relies on stable and predictable public financing.¹⁵ Both WHO¹⁶ and World Bank expert staff on health financing¹⁷ underscore this. We applaud the fact that ‘public finance’ is explicitly mentioned in Human Capital policy commitment #8.

That said, the WHO and the World Bank fail to point out that the ‘innovative’ financing mechanisms that use public resources to mobilise and de-risk private commercial funding, are not a panacea in development. At least not in an area such as healthcare, where market rules tend to fail to deliver better development outcomes. The financing mechanisms often drive commercialisation in services, impacting negatively on poor households and women in particular. This is the exact opposite of what we should aim for.

“The social contract that exists between the Ugandan government and its people, positions basic, quality and free – or at the very least affordable – healthcare provision, as one of the public goods citizens expect their government to facilitate. To deliver such a public healthcare system, Government must prioritise several things, including the progressive allocation of health sector resources, revisit its public-private partnership models to one that centers the health needs of the poor, marginalized, stigmatized and the elderly.”¹⁸

¹⁵ WHO (2013), [No Health Without a Workforce](#).

¹⁶ WHO (2019) [Financing for Universal Health Coverage: Dos and Don'ts](#); WHO (2020) [Guidance paper](#) – Assessing country health financing systems: the health financing progress matrix.

¹⁷ World Bank (2019) report, [High-Performance Health Financing for Universal Health Coverage](#); World Bank (2021) discussion paper, [From double shock to double recovery](#).

¹⁸ Mafioli (2021), [The Political Economy of Health Epidemics: Evidence From the Ebola Outbreak](#)

Moreover, private finance leveraged through Public-Private Partnerships (PPPs) in healthcare¹⁹ makes healthcare more costly, and draws in a relatively large share of the government's health budget (and/or external public resources) for a long period of time. Thus, the government's budget becomes less flexible to respond to sudden health system needs. Besides, it can create additional fiscal risks for governments akin to debt and can be associated with outflows of funds in the long-term.²⁰ This weakens the public purse in the long run, instead of strengthening it. It makes the system less resilient, instead of more.



'Ugandan Shilling' via Pixabay

Publicly backed financing mechanisms to leverage private finance are often promoted on the premise that there is not enough public funding to fill funding gaps. This doesn't have to be true. Raising public funding is a political choice that needs action at domestic and global level. To support countries in raising public resources, problems in the broader global financial architecture - tax injustices, illicit financial flows and the debt burden – need to be addressed in structural ways. This is rightfully noted in the cross-cutting issues of IDA20's policy framework, yet it needs more focused joint action by governments. Moreover, countries should not be asked to implement austerity measures during or shortly after the pandemic.

The approach through which the World Bank Group aims to create commercial markets for the mobilisation of private finance for development, the 'One WBG' approach or [Maximizing Finance for Development](#) (MFD) approach, is reflected in the IDA result indicator: 'Total private mobilization of WBG-supported operations/transactions in IDA countries.'

- ⇒ We urge the WB-IDA leadership and member countries to operate through strategies that maximise domestic public revenue in lower income countries in the long run,
- ⇒ and to specify that in principle private mobilisation is not a good strategy when it comes to essential services that should not be ruled by commerce, including healthcare.
- ⇒ See our recommendation related to Tier 3 RMS indicators #6 and #7 in Table 1.

¹⁹ Wemos (2021), [Risky Business](#); Jubilee Debt Campaign UK (2017), [Double standards](#); ISER (2019), [Achieving equity in health: are PPPs the solution?](#); ISER (2020), [Failing to reach the poorest?](#)

²⁰ Eurodad (2021): [Pandemic Papers](#) and ['Rebuilding Better', but for whom?](#)

RECOMMENDATIONS FOR POLICY COMMITMENTS AND RESULTS MEASUREMENT INDICATORS

The table below shows our recommendations for IDA20 policy commitments and the Results Measurement System (RMS) indicators. Our additions to the proposed policy and RMS framework are indicated in **bold**, whereas omissions are indicated in ~~strike through~~.

Table 1

Our recommendations	IDA20 policy commitments	Results Measurement System (RMS) indicators
<p>Help close the global Covid-19 vaccination gap as soon as possible, while supporting systemic changes to further universal access in the long run</p>	<p>HC-1: To contain the pandemic, support all IDA countries in the procurement of vaccines at cost price, capacitating local manufacturing and roll-out of COVID-19 vaccinations including broader public health care system strengthening and pandemic preparedness.</p>	<p>Tier 2, 17a: Number of people vaccinated free of charge for COVID-19 (million)</p> <p>Tier 2, 17b: Percentage of operations that provide additional, debt-free financing for COVID-19 vaccination-related interventions</p> <p>[new] Tier 3, x: Number of countries supported by IDA to procure essential vaccines at cost price.</p> <p>[new] Tier 3, x: Number of countries supported by IDA to expand local manufacturing.</p>

<p>Prioritise investment in <i>public</i> (not private) healthcare</p>	<p>HC-3: To address gaps exacerbated by the COVID-19 crisis in at least 40 IDA countries, of which 10 are FCS, support access to core, quality, inclusive public social services focused on: (i) social protection for urban informal workers, or (ii) students' return to school and accelerated recovery of learning losses, or (iii) children's immunizations.</p>	<p>Tier 2, 13: People who have received essential health, nutrition and population services through the public system (million).</p>
<p>Facilitate long-term expansion of the public purse for health and refrain from using public resources to leverage private commercial funding for health</p>	<p>HC-8: To strengthen public finance for human capital investments, support at least 20 IDA countries, of which 10 with the lowest HCI through (i) the availability of resources to match needs for the development and expansion of public services and the efficiency of expenditure management avoiding known risks such as guarantees for private investments and/or (ii) the efficacy of human capital investments measured through output/outcome indicators that reflect progress towards universal, equitable and non-discriminatory access to essential services.</p>	<p>Tier 3, #6: Total private mobilization of WBG-supported operations/transactions in IDA countries, except in those that affect public services where market rules usually fail to deliver development results (e.g. health infrastructure development and service delivery).</p> <p>Tier 3, #7: Number of IDA countries with the lowest Human Capital Index supported to maximize and improve the sustainability of public finance for human capital financing.</p>
<p>Note: more information with regard to the World Bank IDA Results Measurement System and its three-tiered indicators can be found here.</p>		