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ACRONYMS

ADB	Asian Development Bank
ADF	African Development Fund
AfDB	African Development Bank
AFESD	Arab Fund for Economic and Social Development
AIIB	Asian Infrastructure Investment Bank
AsDF	Asian Development Fund
AU	African Union
BADEA	Arab Bank for Economic Development in Africa
BDEAC	Development Bank of the Central African States
BOAD	West African Development Bank
BSTDB	Black Sea Trade and Development Bank
C19RM	COVID-19 Response Mechanism (Global Fund)
CABEI	Central American Bank for Economic Integration
CAF	Development Bank of Latin America
CDB	Caribbean Development Bank
CGD	Center for Global Development
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organisation
EADB	East African Development Bank
EBID	ECOWAS Bank for Investment and Development
EBRD	European Bank for Reconstruction and Development
EDB	Eurasian Development Bank
EGF	European Guarantee Fund
EIB	European Investment Bank
EIF	European Investment Fund
ETDB	Economic Cooperation Organization Trade and Development Bank
GDP	Gross Domestic Product
IDB	Inter-American Development Bank
IBRD	International Bank for Reconstruction and Development
IFAD	International Fund for Agricultural Development
IIB	International Investment Bank
IsDB	Islamic Development Bank
KPIs	Key Performance Indicators
LAC	Latin America and Caribbean
LICs	Low-Income Countries
LMICs	Low- and Middle-income Countries
MDBs	Multilateral Development Banks
MPA	Multiphase Programmatic Approach
NCDs	Non-Communicable Diseases
NDB	New Development Bank
NGO	Non-Governmental Organisation
ODA	Overseas Development Assistance
OFID	OPEC Fund for International Development
PEF	Pandemic Emergency Financing Facility
PPP	Public–private partnership
SDGs	Sustainable Development Goals
SME	Small and medium enterprises
TDB	Eastern and Southern African Trade and Development Bank
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation

INTRODUCTION

As the world is recovering from the COVID-19 pandemic and moving slowly but surely into the arms of a global recession – a context also marked by deteriorating macroeconomic conditions, pressure on national budgets, and a displacement of donor funds due to the war in Ukraine[1]; the aid funding environment for global health financing in 2023 and beyond[2] is looking preoccupying. What's more, many countries are projected to spend less on health than their pre-pandemic levels through 2027[3]. Considering the scarcity of existing funding for global health and keeping in mind that more financing will need to be mobilised to achieve Sustainable Development Goal n°3 on health and wellbeing, it is essential to question how existing resources are being spent - in other words looking at their efficiency, as well as ask what the best channels to leverage are for greater impact.

The pandemic has highlighted the urgent need of collective actions and improvements to the international architecture for global health – one that is based on equity and focused on contributing to fostering equitable, universal and affordable access to health care and services, strengthening health systems, as well as ensuring the prevention, preparedness and response (PPR) to future health emergencies. It is evident that greater investments in PPR are required, including when it comes to decentralising pandemic funding, increasing manufacturing capacity in the Global South, and strengthening health systems.

In this alarming context, the landscape of development finance has to be challenged. Many countries are calling on finance institutions and development banks to better support countries vulnerable to such shocks. Beyond helping build greater resilience at country level, these actors have a vital role to play on the international stage in the pursuit of the SDGs by 2030, which means maximising their impact on development in the coming years. The challenge is also to redefine the role of MDBs in financing global health, looking at when they are most relevant and where their model need to be readjusted. Considering the broader landscape, it will also be vital to assess how they can fit within it to avoid duplication or even competition to instead increase collaboration and closing of gaps in health financing needs.

Since 2020, MDBs have disbursed tens of billions of dollars to help countries deal with the consequences of COVID-19. Funding was provided for social protection, budget support and to respond to the spread of the virus and its many consequences – a safety net which proved vital to the health of billions on the planet. Yet, their role in the Global South is nothing new. Prior to the outbreak, MDBs were already ranking amongst the biggest funders of global health, providing an essential source of financing for LMIC health budgets.

While currently necessary, MDB health financing does not come without caveats or critique. Several are linked with the negative effects of privatisation on health care and services, as well as the lack of accountability and impact assessment of these institutions and their financing mechanisms. A more cohesive and comprehensive health financing agenda also remains to be agreed. Critics have pointed out the lack of transparency of MDBs, questioning their priority setting and governance, which is mostly Global North driven and neglects civil society technical expertise despite what it could mean for a more equitable allocation of funding.

Considering their leveraging capacity, the role of MDBs in global health is meant to tremendously increase in the coming years to help close the funding gap. Though, the question remains: does the key role MDBs play in global health is ensuring that their financing have a truly equitable and sustainable impact and do they leave no one behind?

This discussion paper therefore aims at assessing the ability of MDBs to effectively contribute to achieving global health justice. It starts by giving an overview of their health-related activities with a special focus on the COVID-19 response, before interrogating how MDBs fit within the current and future global health ecosystem. It also draws attention to the conditions under which MDBs could unlock their full potential to play an active role in improving health for all, weighing risks versus opportunities.

PART 1 - MDBS & HEALTH FINANCING: WHAT HAS BEEN DONE SO FAR?

Overview of MDBs Health Financing

The Historical Role of Multilateral Development Banks

Multilateral development banks (MDBs) are supranational institutions set up by sovereign states, which are their shareholders. Their remits reflect the development aid and cooperation policies established by these states. MDBs emerged over seventy years ago, amidst the global catastrophe following the Second World War. The goal of what became known as the "Bretton Woods" Institutions created a new international economic order, to improve lives enough to ward off the next crisis. Economic development and social progress are in broad terms included in the mandate of the World Bank (WB) and the three regional development banks – the African Development Bank (AfDB), Asian Development Bank (ADB) and Inter-American Development Bank (IDB) – that were established between the late 1940s and the mid-1960s. Regional banks, such as the IDB, AfDB, and the ADB were created in response to a desire from countries to have increased control over regional issues.

However, the interpretation of this broad mandate has changed significantly over the decades. MDBs provide loans and grants to member nations to fund projects that support social and economic development, such as the building of new roads or providing clean water to communities. Many actors have posed the questions of whether the current development finance system is working effectively and how it can be improved. Various proposals have been ideated and put forward, including adding new shareholders for MDBs, fostering more private sector opportunities and mobilising private sector capital, and increased lending from shareholders.

In 2001, the G7 also proposed a reform to the MDB system - which included (i) the restructuring of the IDA, with a part of its lending in the form of grants rather than loans; (ii) the harmonisation of procedures, policies and overlapping mandates among MDBs; and (iii) evolving the volume of support by MDBs for global public goods and the rankings and priorities among them. 21 years later, in 2022, the G20 asked MDBs to "bring forward actions to mobilise and provide additional financing within their mandates," and urged the implementation of the G20 Expert Panel Report on the Independent Review of Multilateral Development Banks' Capital Adequacy Frameworks. One objective of this review being to enable shareholders to consider potential adaptations to current frameworks in order to maximise the MDBs' financing capacity.

MDBs and Health Financing: An Overview

Multilateral Development Banks, also called MDBs, are a few of a myriad of different actors and funders in the global space. Although most MDBs do not have a health target, their weight in global health financing is undeniably important. The table below gives a breakdown of health financing by a selection of MDBs, before and during the pandemic.

Figure 1: Disaggregation of MDB health financing in 2018 and 2021 (Institute of Health Metrics & Evaluation, 2023)

MDB	2018	2021
WB IDA	$1.7 billion	$3.7 billion
WB IBRD	$920 million	$5.2 billion
IDB	$410 million	$570 million
AfDB	$31 million	$63 million
ADB	$700 million	$2.6 billion

MDBs are an essential source of financing for Low- and Middle-income Countries (LMICs) domestic health budgets since these countries often do not have favourable access to markets. In the words of Amanda Glassman, Executive Vice President & Senior Fellow at Center for Global Development:

"As a starting point, how do governments fund themselves? Governments fund themselves through taxation; local taxation on firms and individuals, value added taxes and things like that. And then they fund themselves by borrowing. They either borrow on international markets if they have access to markets, or they borrow from multilateral development banks and the IMF to be able to finance their budgets. For low-income countries, MDB debt is highly concessional. So, it is much more favourable than what they could access on the markets. And in most cases for low-income countries, they actually do not have access to the markets. So, without MDB financing, the (health) budget is gone."

Especially for Low-Income Countries (LICs), MDB financing remains a critical support. However, there are particular risks and vulnerabilities countries face, including rising debt post-COVID vis-a-vis declining health budgets. Research conducted in 41 countries shows that countries with highest debt payments will spend an average 3% less on essential public services in 2023 compared to pre-pandemic levels (2019). Although the Global North continues to encourage the Global South to increase its domestic resource mobilisation, the rules imposed by the current global finance order, dominated by HIC, make it difficult for LMICs to achieve this because they have no capacity to borrow and high levels of debt.

Experts analysed government health spending in 76 LMICs during two periods when external shocks hit (including the Great Recession of 2008-2010), and reflecting upon rising debt coming out of the COVID-19 pandemic, stated that LICs "may be particularly vulnerable to reductions in domestic government health expenditure as government debt grows, and at far higher levels of debt than the Great Recession."[4] The experts stated that in consideration of this, "initiatives for debt restructuring or additional external financing will be crucial."[5]

As they mainly operate through concessional loans, MDBs financing can result in "unsustainable debt" for countries that have experienced declining expenditure on health. According to Anna Marriott, Health Policy Advisor, Oxfam UK:

"We are obviously seeing mounting crises in many countries and insufficient action at the global level to cancel, suspend, or freeze unsustainable debt, including debt repayments to the private sector. We are seeing country after country unable to spend on health and declining expenditure on health because of those burdens."

Nonetheless, MDBs financing also enables longer-term planning on health objectives as they are "on book" or essentially on the radar of Ministries of Finance. As David Wilson, Program Director in the Health Nutrition and Population practice at the World Bank, elaborates:

"A lot of the health financing that flows from organisations such as PEPFAR or Global Fund is outside of the country's national health budgets and plans, and it is often off book to the Finance Ministry, so they do not see it and do not see the need to incorporate it with future budgets. This is in contrast to finances flying through MDBs; they are part of national health budgets and plans that are "on book". The finance ministry sees them, and they understand the need to plan for them over the longer term."

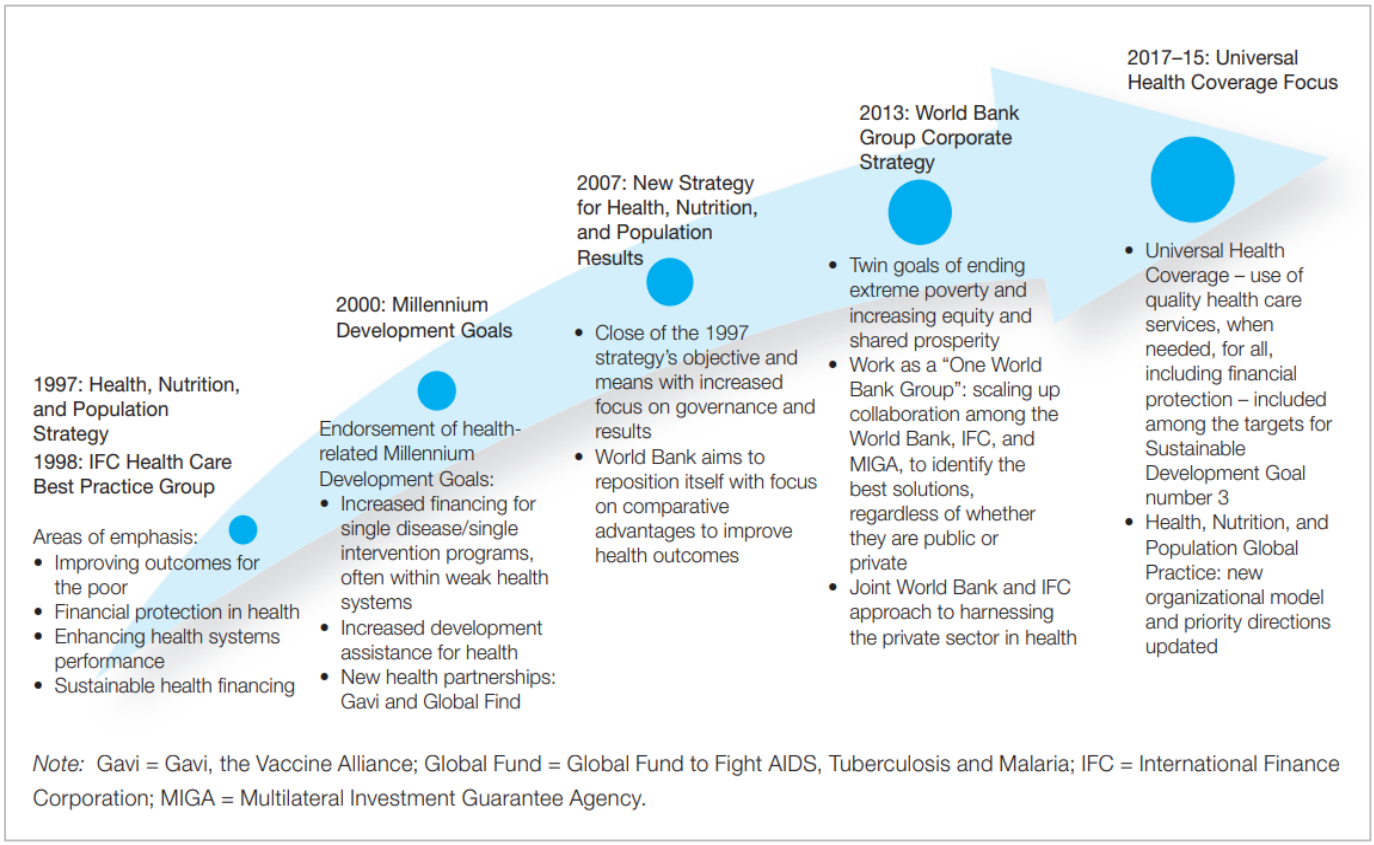
As MDBs' model can strongly vary, the following paragraphs will briefly summarise the key global health investments led by each MDBs covered by this analysis.

World Bank

Arguably the most prolific of the MDBs in terms of health investments, the World Bank has a vast portfolio in health financing spanning numerous priority areas. These occur through multiple instruments, including through loans, grants, credits, and advisory services provided through its different arms, notably the IBRD (International Bank for Reconstruction and Development), IDA (International Development Association) and the IFC (International Finance Corporation). Finance from two or more of these arms can combine to fund specific programmes, such as IDA and IBRD funding into the Global Financing Facility Trust Fund for women and girls' health[6] (GFF), and into the COVID-19 Fast Track Facility.

At time of writing, the World Bank (WB) claims a $34 billion global health portfolio[7] including over 240 projects that help countries take a comprehensive approach to improving health outcomes, especially for poor and vulnerable people, by strengthening primary care and key public health functions. Although dated, the WB strategy on health, nutrition and population[8] states the bank's clear ambition to ensure that operational support and policy advice for priority areas in health will strengthen country health systems. It is also worth noting that the WB was careful to focus its contributions on areas in which it has a comparative advantage over other players. The infographic below shows the evolution of the World Bank's engagement in Health.

Figure 2: Evolution of World Bank Engagement in Health (World Bank 2018[9])



The WB's role in analysis and agenda-setting is well-known and will continue to be seminal in the way forward in health financing. One such example of Bank agenda-setting and analyses is this 2023 report elaborating key human capital losses emerging from the COVID-19 pandemic, including regressions in achievements in maternal and child health as well as increases in depression and other mental health conditions, and poorer development of key social-emotional skills.[10]

Asian Development Bank

The Asian Development Bank (ADB) has set only a relatively small proportion of financing attributed to health in comparison to their other strategic priorities, with a 2019 corporate results framework setting a target of 3-5% for health financing as a share of total ADB financing to be achieved by 2024.[11] Although a small target, the ADB has published more documentation on recent health financing compared to the African Development Bank, making it easier to track the historical trajectory of their investments and strategic vision on health.

In 2013, the ADB established a trust fund[12] on Regional Malaria and other Communicable Disease Threats, mobilising co-financing from development partner agencies, the private sector, and foundations towards achieving goals in the ADB's Operational Plan for Health 2015-2020.[13] The plan contained several key health priority areas for country financing, including investments into quality health service infrastructure for primary health clinics and hospitals, strengthening government stewardship of health through financial management, institutions, health information, and health regulatory systems backed by ICT solutions, and financial incentives for adherence to diagnostic and treatment guidelines.

ADB has explored innovative financing mechanisms such as the creation of theme bonds for Sustainable Development - as response to a growing demand among its investor base to highlight key initiatives. The "water bond" was launched in 2010 and since then, ADB has expanded its theme bond offerings to include education, health, and gender. As of 2022, ADB has issued $2.3 billion worth of health bonds, the second highest bonds after gender. The net proceeds from the bonds have been used to finance projects across the region. For example, in 2017, ADB raised approximately $97 million equivalent in health bonds to finance health projects in Asia and the Pacific region, including projects on air quality and health in Mongolia and on improving health sector governance and rehabilitating rural health infrastructure in Papua New Guinea.[14]As a result of shifting health financing demands, and lower amounts of disease-specific grant financing, governments are increasingly needing options and innovative instruments to catalyse country-led investments for the health sector. There remain critical health gaps in Asia, including in difficult operational environments in Afghanistan and in LICs such as Laos. ADB's health bonds were meant to respond to that need.

Inter-American Development Bank

The Inter-American Development Bank (IDB)'s current health investment portfolio comprises $2.8B in financing over 29 sovereign-guaranteed projects, with the largest proportion of projects focused on health systems strengthening (55%) followed by disease prevention and control (21%).[15] Overall, the IDB lists 152 sovereign-guaranteed health projects since the IDB's inception with a cumulative $11.01B of financing with health services projects having the largest proportion by investment sector (74 projects).[16]

The Bank has in recent times disbursed substantial financing for the region – for example through a December 2022 $97 million loan to expand the capacity of seven hospitals in Guyana in multiple regions of the country,[17] and with its *Salud Mesoamerica* investments linked to reduced adolescent pregnancy rates in Costa Rica.[18] Despite these recent investments and a framework document outlining health investment priorities, neither the new President's inaugural speech[19] nor the LAC opinion-leaders welcome letter,[20] positioned health as a central or substantial priority.

Yet, in the LAC region, public health spending is 3.6% of GDP (compared to an average 6.6% of GDP in OECD countries)[21] – perhaps illustrating value for IDB health financing to buttress health budgets. The IDB's 2021 Health Sector Framework illustrates key areas where IDB investments will be important, including through "supporting the development of integrated healthcare service delivery by continuing to support countries seeking to reduce social and cultural barriers to healthcare, to reduce income differentials in healthcare access, and to improve the distribution of services between healthcare levels; as well as introducing or improving referral systems; supply and logistics management; digital health; and information systems." [22]

European Investment Bank

Despite being historically a predominantly European focused ban, the European Investment Bank (EIB) has also provided a total of €42B for health-related projects around the world since 1997[23]. The EIB takes a market-based approach to health financing, looking to mitigate market failures in healthcare through its financing instruments,[24] but also has a strong primary health and health systems focus, for example through its partnership with the WHO on SDGs and through a €500 million commitment last year to support primary healthcare in Africa.[25] This focus was echoed in an interview for this paper with Maria Shaw-Barragan, the Director of Global Partners at the European Investment Bank, overseeing the implementation of EIB Global, the bank's specialised arm created in 2022 for activities outside the EU:

> *"Primary Healthcare is very much about supporting the resilience of health systems. And we have seen (this) in particular during the COVID crisis. And now that we are looking at pandemic preparedness (and) preparing for whatever could come in the future, if you have strong primary healthcare, you are always much better equipped for whatever might come and you are able to react when shocks come."*

In general, EIB eligible projects are hospitals and infrastructure investments; medical research, education and training; health informatics and innovation; integrated and people-centred approach to healthcare networks (especially involving cross-border cooperation); and services providing universal access to safe and affordable care and designed to meet the varying needs of people across the course of their lives.[26] Maria Shaw-Barragan elaborated in her interview with us:

"Last year we signed a loan with Ecuador of $100 million so that they could buy more vaccines to catch up for a whole generation of children[27]. And we are working with PAHO to make vaccines available in the bulk. There is also an operation that we are putting together with the Gates Foundation for the eradication of polio, (with) the European Commission already approving the guarantee of €500 million available for the joint work of UNICEF and the Gates Foundation for polio eradication - and if we manage to eradicate it, it would be the second disease globally that is eradicated. (That) will be a major achievement. Other cause very close to my heart is malaria. In this case, we are working together with BioNTech to use mRNA technology for malaria."

African Development Bank

The African Development Bank (AfDB) directly invested over $5 billion in health operations over the period 1975 to 2020, with the rate of investment peaking in the 1990s.[28] Recent pre-pandemic health financing initiatives from the AfDB were few and far in between, owing to a deliberate strategic shift at the Bank in 2020.[29] A 2006 evaluation of AfDB's assistance effectiveness in the health sector spending (from 1980-2005) highlighted a range of challenges across the bank's health sector project portfolio.[30] Overall, there was a lack of sufficient health focus in countries' strategies, and the AfDB did not clearly define strategic priorities for support in the sector which can guide project identification.

Despite these challenges and the aforementioned strategic shift, the AfDB conducted a number of essential pre-COVID health investments, including during the Ebola crisis. As further developed in the next section the COVID-19 was a wake-up call for the AfDB. This notably came, with the development of an AfDB's Strategy for Quality Health Infrastructure in Africa 2022-2030,[31] which draws from the bank's expertise in infrastructure development.

The development of this strategy was spurred by a paradigm shift on how insufficient health investments have underlined the shocks to African health systems inflicted through the COVID-19 pandemic. Babatunde Omilola, Manager, Public Health, Nutrition and Social Protection Division, African Development Bank, elaborated:

"The reality of the matter is that health is an economic imperative in Africa. We realise that Africa is losing $2.4 trillion on average every year as a result of lack of investment in health."

Poor health outcomes reflect a lack of access to quality health services as a third of Africans live more than two hours away from health services,[32] and there are severe shortages in hospital beds, medical equipment, and drugs. The AfDB's Strategy for Quality Health Infrastructure is the bank's first step towards addressing this. The Bank intends financing to be "catalytic" in nature, although no financial targets have been included in the strategy, citing "the demand-driven nature of the portfolio."[33] The Bank noted that its investments in the 1990s were approximately $75 million annually, and adjusted for inflation this would be $300 million annually today[34] - representing a source of regular and predictable financing for health in Africa.

As explained by Babatunde Omilola, this new strategy hopes to build on its health emergency and outbreak financing:

"During the Ebola crisis, the bank responded with about $225 million to support the recovery process in Guinea, Sierra Leone, and Liberia in terms of health. Now, for the COVID 19 pandemic, the board of the bank approved up to $10 billion for the bank to engage and support our regional member countries to respond to the COVID 19 pandemic. And that was done in terms of the social, the health impact, and also the economic impacts of the pandemic. So that, of course, led the governors of the bank to request us to articulate our vision going forward on health in Africa, because all along the bank did not have a coherent strategy to anchor investments in infrastructure. So, it is what the very first time in the history of the bank, that we put together a strategy for quality infrastructure in Africa, which was approved by the board of the time in February of last year."

The Strategy already has a number of projects in the 2022-2024 pipeline, including debt financing of hospitals in Egypt, Kenya, and a number of other North African countries,[35] although questions remain about its investments in African

LIC who arguably need it the most. AfDB announced will to adapt its model taking into consideration the need to deliver better on health financing, the COVID-19 pandemic had called for strong reactions, including by MDBs.

COVID-19 Financing: Banks Spur into Action

The COVID-19 pandemic saw an overall increase in MDBs health financing, mainly to address COVID-19 specific consequences. This is illustrated by pre-pandemic figures versus mid-pandemic funding compiled by the Institute for Health Metrics and Evaluation at the University of Washington. In 2018, MDB financing accounted for $3.7 billion out of a total of $43 billion spent on all development assistance for health.[36] In 2021, owing to the COVID-19 pandemic, this proportion had tripled – with MDBs accounting for $12 billion of the total spend of development assistance for health.[37]

From April 2020 to March 2021, the World Bank committed $200 billion to public and private sector clients to fight the impacts of the pandemic.[38] In comparison, previous years (2015-2019) had seen the World Bank make an average annual commitment of $63 billion). When it comes to health financing, 2021 saw the World Bank disbursed the most development assistance for health (DAH) for COVID-19 (an estimated $5.6 billion), followed by the Global Fund ($5.1 billion) and regional development banks as a group ($2.4 billion).[39]

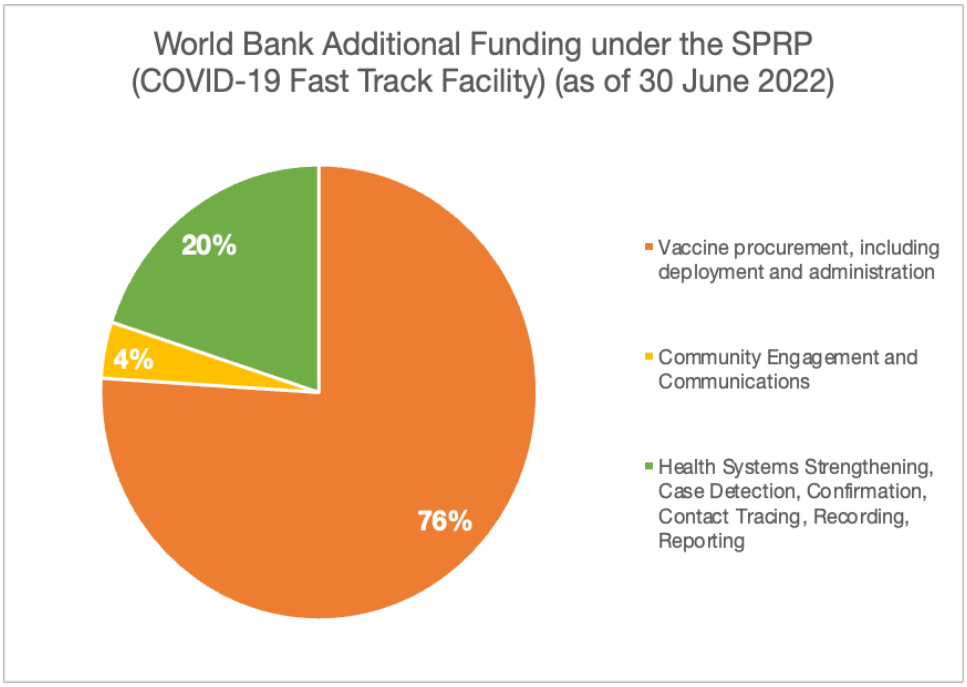
In response to the pandemic, the World Bank set up a dedicated COVID-19 Fast-Track Facility (also called the COVID-19 Strategic Preparedness and Response Program (SPRP)).[40] The SPRP had two phases, with the first Multiphase Programmatic Approach (MPA) approved by the World Bank Board on 2 April 2020 (approving $6B from the International Bank for Reconstruction and Development, and $6B from the International Finance Corporation for the SPRP, and the second phase (MPA Additional Financing) approved by the Board on 13 October 2020, bringing the total sum of COVID-19 vaccine financing to $20B over the next 18 months.[41]

The first phase of the SPRP saw the World Bank deploy resources quickly - but an effective response was curtailed by commodities shortages. In the words of David Wilson, Team Lead for the COVID-19 Fast Track Facility:

> *"(The SPRP) was launched very fast with 26 projects approved by the board in a single day, some of them prepared over a weekend, and 100 projects prepared within 100 days. So that was easily the fastest response in the Bank's history across all sectors. The first phase experienced some of the problems we were going to see with the second phase. And that was a shortage of critical commodities, particularly PPE, diagnostics, and later oxygen. So our analysis is we were able to get the money out very fast. And we did have Bank-facilitated procurement to try to assist countries to get scarce commodities quickly. But I think our assessment is we got the money out more quickly than there were critical commodities available. The money went for a host of things, including for strengthening core public health functions, for PPE, for diagnostics, and for some therapeutics. And it also went to social protection to enable countries to provide social grants to assist during lockdowns and closures."*

By 30 June 2022, the World Bank had approved 115 operations under the SPRP Additional Funding amounting to $10.1 billion, of which 76% went to vaccine procurement, deployment, and administration (see Figure 3 below).[42] This included funding for, inter alia, Benin, Burundi, Cambodia, and Sao Tome e Principe.[43]

Figure 3: Disaggregation of Funding under Phase II (Additional Financing) of the COVID-19 Fast-Track Facility



Phase II of the SPRP, while also enabling quick disbursement of emergency funding, saw an expansion of the commodities constraints seen in this first phase. In the words of David Wilson:

> *"The second phase began in October 2020, and we were quite fast to get the money on the table. But then we encountered an even greater version of the problem that we encountered in the first MPA. Vaccines were extremely scarce. Higher income countries had pre-purchased very large quantities up to 10 (doses) per capita and lower income countries were not easily able to get the vaccines they needed. Quite a lot of larger countries were able to make arrangements, buying a variety of vaccines, including Chinese and Russian vaccines, AstraZeneca, some mRNA vaccines, and we were able to assist them to do that. In all, we have supported the purchase of almost half a billion vaccines through this facility."*

An initiative by the World Bank to support vaccine procurement and deployment was the partnership with COVAX, which consisted of a new financing mechanism to allow COVAX to make advance purchases – beyond the fully subsidised doses they are receiving from donors – to help speed up vaccine supply.[44] In June 2021, the World Bank partnered with the African Union on their Africa Vaccine Acquisition Task Team (AVATT) initiative, signalling the availability of $12 billions of vaccine financing resources via the SPRP to the AVATT. The partnership involved the Africa Import Export Bank (Afrexim) and the Africa CDC and aimed to increase vaccination capacity for up to 400 million people in Africa.

In June 2020, the IFC provided $4 billion through its Global Health Platform to increase the supply and local production of vaccines and personal protective equipment in developing countries. In June 2021, the IFC partnered with French, German, and U.S. development finance institutions on a €600 million investment in South Africa's Aspen Pharmacare to produce COVID-19 treatments, therapies, and vaccines on the African continent.[45] In addition to investments during the pandemic, in 2022, the World Bank put out strong messaging and recommendations to countries for the operationalisation of health systems resilience post-COVID, including the need to improve supply chain management (SCM)[46] The focus on health systems resilience was echoed by David Wilson from the WB, who stated that in preparation for the New Global Financial Pact, the Bank's priorities would be focused on strengthening preparedness for future outbreaks, and restoring essential health services and other human capital services.[47]

The World Bank and the ADB were identified as quick disbursers during the COVID-19 pandemic.[48] The Centre for Global Development also noted that performance in this regard is also dependent on the specific bank's relations and close working habits with its lender countries. Similarly, Oxfam reviewed the World Bank's SPRP MPA programme framework to support WASH services and public health promotion, finding its response rapid and significant.[49]

In December 2020 the Asian Development Bank launched a $9 billion Asia Pacific vaccine facility to ensure the region would be able to access financing to mainly procure vaccines[50], as well as to support plans to safely and equitably manage the vaccination process.[51] This represented a major growth in their health sector operations - in 2020 ADB commitments reached 12% of their share of total financing, more than double of their targets set pre-pandemic (3-5% of total available financing).[52]

MDBs took a broad approach to their pandemic financing, not just targeting the immediate effects of the outbreak, but also the socioeconomic impacts. The pandemic highlighted how health outcomes are intrinsically linked to the global economy, and that any investment in health is also an investment in the lives and livelihoods that run the economy. However, in the acute phases of health emergencies priority investments in public health systems are needed, with a particular focus on the health workforce. Analysis by the WHO saw an overall increase globally in health spending in 2020 mainly driven by government spending, as average per capita public spending on health reached an all-time high in real terms across all income groups. This, notably, as a result of declining out-of-pocket spending per capita terms due possibly to lower health service utilisation. These global figures strongly hide the enormous disparities in the ability for countries, depending on their revenues, to mobilise such domestic health fundings. **What has been done in the Global North could not be done at the same scale in LMICs. In 2020, less than $100 billion was raised to help low- and middle-income countries (LMIC) tackle the health crisis compared to the combined $13.7 trillion fiscal packages set up for G20 countries. Solidarity mechanisms were not able to correct these drastic inequalities witnessed during the pandemic. Questions are raised as to what extent LMIC can governments sustain higher spending on health and other social sectors in the coming years and after such an outbreak and its economic impacts.**

Financing health as only one pillar of the pandemic response was exemplified in the AfDB's COVID-19 resource mobilisation. In the words of Babatunde Omilola of the African Development Bank:

"For the COVID-19 pandemic, the Board of the bank in April 2020, approved up to $10 billion COVID-19 Crisis Response facility for original member countries. We really engaged with the regional member countries, to do an analysis of what would be required. And based on that, we focused on three main priority areas. One was in terms of the health impact itself, how to get the medical supplies that will be needed across different African countries. The second was in terms of social impact, the social protection component, to cater for the poor and the vulnerable on the continent, but also to provide opportunities and some resources for small and medium enterprises, to keep governments float, thought was, or to call the economic impact of the pandemic, by looking at the macroeconomic indices, but also by providing liquidity for African governments themselves at that time, through that, what we call the budget support operations. Most of what we did around that time was around budgets or port operators, over 90 percent of our operations for the COVID-19 pandemic were devoted to budget support operations for original member countries."

This was seen mirrored across many of the MDBs. For the IDB, analysis by the Institute of Development Studies in the UK estimated that out of the $7.2 billion for the first phase of COVID-19 response, $666 million went towards the immediate public health response (representing 9.25% of total financing). The IDB expanded the originally agreed size of its 2020 lending programme, complemented by additional resources mobilised by reprogramming the existing portfolio of health projects and redirections from undisbursed loan balances in other sectors. The increase in the level of disbursements from IDB for the year 2020 (estimated at slightly over $15 billion) is related in large part to a higher share of policy-based loans, with the aim of better tailoring the support provided to the current financing needs of borrowing countries.

The IDB also began a "fast-track" procedure to facilitate the approval of projects, with a 66%-time reduction, leading to procedures that allow the bank to issue a loan in one and a half months or maximum two.[53] The IDB reacted quickly, increasing both the number of funded projects and the amount disbursed compared to the same period in 2019. For example, for loan operations, IDB almost tripled its disbursement and more than doubled the number of funded projects.

According to estimates, the main focus of IDB intervention over the first phase of the 2020 pandemic has been towards the areas of "Vulnerable populations" and "Productivity sector and employment", both receiving financial

resources of $2 billion.[54] Among the other areas of IDB intervention, "Public policy and fiscal management" and "Special development lending" have both received $1.2 billion. While "immediate public health response" received $0.6 billion.[55]

Similarly, the EIB states that of the financing made available to support the COVID-19 recovery, 13% went directly to health while the vast majority was to support SMEs.[56] The EIB put together an immediate COVID-19 response package of €28 billion (made available as bridge loans or top-ups to existing EIB and European Investment Fund (EIF) operations),[57] as well as a pan-European Guarantee Fund, the EGF, which helped businesses get through the crisis by mobilising €200 billion in new financing. Overall, the EIB financed 299 operations in the EU and 68 operations globally, including financing for the COVAX initiative, and the EIB's support for the development of the Pfizer/BioNtech mRNA vaccine.

As a result of COVID-19, financing has been considerably higher in recent years than it was before the pandemic. For example, in 2022, the EIB provided €5.1 billion for health and life sciences projects.[58] This included EIB's involvement in the "Infectious Disease Finance Facility" (InnovFin) and other financial instruments shared with the European Commission to finance projects that work towards halting the spread of COVID-19, finding a cure, and developing a vaccine against the coronavirus.[59] The EIB supported emergency measures to finance urgent infrastructure improvements and equipment needs in the health sector, using existing framework loans or undisbursed amounts from existing health projects.

MDBs also worked through direct country support, other regional institutions such as ECOWAS, as well as in collaboration with other MDBs and regional banks. This increased articulation that should be welcomed (see the dedicated section below). Maria Shaw-Barragan of the EIB elaborated on how co-financing is becoming increasingly commonplace:

"In every country, we have what we call donor tables where multilaterals or the donors - because sometimes they are bilaterals - exchange on the areas that we are working on, and very often we co finance. Some of the health resilience loans that we have done were together with the World Bank, for example, they have been very active. The African Development Bank last year approved their health strategy, and therefore they have become more active in the sector. And they asked us whether they could co-finance with us in existing projects so that they could start their activity accompanied by someone that has more experience."

In recent years, the EIB has been increasing its involvement with the EU's development cooperation actions, as a key partner of the Team Europe Initiatives.[60] Team Europe being a new approach to ensure a coordinated and comprehensive response between the EU and its Member States to the COVID-19 pandemic and its consequences. The initiative consists of the European Union, EU Member States — including their implementing agencies and public development banks — as well as the EIB and the European Bank for Recontruction and Development (EBRD).

- The COVID-19 pandemic highlighted the importance of having strong and resilient health systems, and how good health and wellbeing is crucial for economic prosperity. An overview of MDBs health financing before and during COVID-19, shows that lending from MDBs have been scaled up remarkably as part of the immediate response to the pandemic. However, it has been noted that MDBs support during COVID-19 has been significantly less than what was provided in the wake of the global financial crisis in 2008, despite the COVID-19 pandemic causing much more of an impact[61].

- It is also worth noting that funding mobilised by MDBs during the COVID-19 response were partially coming from re-programmed health programmes, it is unclear how much of health financing was new funds compared to re-allocated funds. MDBs have demonstrated their flexibility and ability to adapt, but at the same time, we question the sustainability of their health financing, since beyond the COVID-19 response, there were pre-existing health challenges, some of which have worsened by the consequences of COVID-19, and most of MDB health funding during the pandemic prioritised vaccine procurement, neglecting other relevant aspects of health systems that needed support.

- Furthermore, from our analysis we found that, except for the IDB, other MDBs analysed do not provide detailed breakdowns of their health financing, and only the ADB has a target for health financing (3-5%). Looking at other sectors that MDBs finance, we found that they have produced detailed breakdowns of climate financing. This could be taken as a good example to be replicated in the health sector in order to support identifying the gaps and possible avenues for collaboration with other global and regional health actors.

In a world dealing with multiple crises, and in a context where MDBs are being called to reform their operations and mandates to better respond to global challenges, we question what needs to be changed in order for MDBs to sustainably support health for all. How can MDBs maximise their added value? What are the challenges and opportunities of including MDBs in health financing?

PART 2 - HOW TO MAKE IT WORK? Avenues for efficient contribution from MDBs to the health for all agenda

Working towards the Same Goals

To what extent are we confident the Multilateral Banks can adhere to the whole-of-government and whole-of-society approach to build resilient UHC oriented health systems? The discussion may start by clarifying shared goals and what their contribution should be. MDBs should ensure their health financing has a catalytic effect on domestic resource mobilisation, and that their support to LMICs increases countries' fiscal space to build strong, sustainable, equitable, health care services.

In order to do so, MDBs need to address the remaining doubts on the efficiency of their development finance instruments to deliver health for all. They have to commit to build more robust health systems and assure that these are better structured and sustainably financed. To maximise this potential, MDBs must be dedicated to generate greater autonomy and integration at regional level and play their part toward genuine health sovereignty.

Prioritising Health Financing in a Sustained Basis

Overall resilience of health systems is an important facet of global health financing that has been overlooked, not only in recent decades but also during the pandemic. Amidst other critical global challenges such as food security, climate change, and ongoing regional conflicts, the fundamentals and building blocks of health systems should not be forgotten, because they are essential to achieve universal health care. MDBs can play a key role in creating capable health systems, to allow countries to deliver equal access to health care and be better able to deal with emergencies, as Babatunde Omilola, from the African Development Bank pointed out:

> *"Regional member countries should really take advantage of getting big amounts of resources to invest in health infrastructure in a way that they can deal with future epidemics and pandemics. When they have long term investments in health systems strengthening in place, they have the infrastructure that they need to be able to deal with health emergencies so when emergencies occur, they should not be running everywhere for support."*

The World Bank was shown to have missed vital opportunities to strengthen public health systems while delivering COVID-19 response, in order to deliver health for all in the future. Research by Oxfam found that 89% of WB projects did not plan to support any action to remove financial barriers, including user fees, that exclude millions from life-saving care; and two-thirds lack any plans to increase the number of healthcare workers. In this context, Oxfam reviewed the SPRP MPA programme framework, and the project documents from 71 countries available as of 30 June 2020, to analyse whether the first phase of World Bank COVID-19 funding did enough to support key areas of the public health response to the pandemic and to build resilient and fair universal healthcare systems for the future.[62] Similarly, analysis by PSI found that WB funding did not address the large inequalities in access to healthcare.[63]

A coalition of West African civil society organisations also performed an analysis of the implementation of WB's health emergency response mechanisms during the COVID19 crisis. They pointed to a series of shortcomings, including the short-term approach when projects focused solely on managing the COVID-19 crisis, not taking into account either of pre-existing issues or of the long-term consequences of the health emergency. "Even when they are designed to provide an immediate response, projects must also envisage solutions to tackle the long-term consequences of these crises. To do that, part of the funding received through these mechanisms must be directed towards addressing weaknesses in the healthcare systems of the countries concerned, on the basis of needs identified in national documents[64]".

MDBs can do more to address the long standing inequities in global health, including by integrating equity considerations in leveraging its longstanding relationships with ministries of finance, which some experts argue have more influence over health financing than ministries of health do.[65] The World Bank's 2013 African Health Forum on "finance and capacity for results", which brought together ministers of finance and health from 30 African countries

to discuss countries' health needs and promote the link between health interventions and economic growth,[66] is an example of how MDBs can advance global health. Another interesting initiative is the work toward a common investment agenda in health institutions. This commitment, taken during the 2022 Finance in Common Summit, aims at aligning public development banks to support regional, national and global networks of public health institutions.

The creation of the Human Capital Index (HCI) by the World Bank aimed to encourage countries to consider health as a profitable investment. However, some global health researchers understood the HCI "as an expression of human capital theory subsumes healthcare to the goals and logics of economic growth" and pointed out "conceptual shortcomings in terms of equity"[67].

This approach to health financing from the Bank is echoed by experts from the Independent Evaluation Group. "The World Bank Group is addressing all the key drivers of universal health coverage, though with different levels of emphasis across the key drivers. The most frequent objectives sought by the World Bank Group–financed projects are the improvement of access, quality, or health systems. Objectives related to health outcomes and equity are pursued less frequently."[68] A purely financial logic cannot be suitable for health. Finance must remain a means to an end, not an end in itself. The case of the PEF is a perfect illustration of a mechanism designed by and for finance where in the end the public health objectives are largely forgotten. A case that anyone should have in mind when considering the role of banks for good.

Failure of the World Bank's Pandemic Bonds

In 2016, the bank set up the Pandemic Emergency Financing Facility (PEF) to quickly release funds to the world's poorest countries and agencies to mitigate the humanitarian and economic consequences of potential pandemics caused by specific viruses. PEF created a market for pandemic risk insurance that draws on funds from the private sector through (catastrophe) bonds and swaps (a temporary agreement between two parties to exchange cash flows or liabilities from other financial instruments, often used to reduce financial risk) in return for highly lucrative interest rates.[69] Trumpeted by the World Bank at their launch as an innovative example of a public-private partnership, pandemic bonds were the subject of intense criticism for failing to divert money fast enough to battle deadly waves of Ebola in 2014 and COVID-19 in 2020.

The PEF whose bond payouts were too strict and slow to enable quick disbursement during pandemic times[70]. It had inappropriate criteria for payout, greatly benefiting investors but not global health. Former World Bank economist Olga Jonas elaborates: "All the resources devoted to the PEF would have been better used elsewhere. Instead of spending its funds and attention on partnering with reinsurance firms, the IDA should have focused on improving public-health capacity directly… The PEF stipulates a payout of $45 million for Ebola if the officially confirmed death toll reaches 250 (which occurred in the DRC by mid-December last year), but only if at least 20 deaths occurred in a second country."[71] These triggers were not only inappropriate for a country as populous as DRC, but also meant that payouts were only triggers when outbreaks were large.[72] The PEF was finally closed in April 2021[73], without even an assessment to provide lessons learned. Instead, the World Bank kept creating new mechanisms, the Health Emergency Preparedness and Response Fund (HEPRF) then the Pandemic Fund, to bring additional resources to PPR. These new Funds risk adding a new layer of fragmentation to the current global health architecture.

Private Sector's Involvement and Health Equity

The role of the World Bank in expanding private sector healthcare delivery has been hotly debated. As many observers pointed out, for over two decades, the World Bank in particular had promoted an expansion of private-sector health care delivery, including through conditions on loans to poor countries that included the introduction of health user fees.[74]

In response to these critics, the World Bank released a rebuttal to several points, including that there is "very mixed evidence about the equity performance of the public and private sectors" and that "for a number of priority health problems – treatment of children's acute infections for example, private providers may deliver a larger share than public in reaching the poor."[75]

However, when assessing the contribution of the World bank Group in supporting health services in client countries in 2018, experts noted that "the inadequate integration of IFC investments within public financing reduces their potential to expand coverage among the poor and their contribution to universal health coverage."[76]

The World Bank continues to this date to make investments to "unlock the power of the private sector" in healthcare delivery. For example, this is done through GFF work on integrating the private sector across health systems, including in "health financing, service delivery, policy and regulations, and health information systems", and supporting countries "to engage the private sector through a country-led stakeholder platform to develop priorities for the health system as part of the investment case for women, children and adolescents."[77]

Private sector delivery continues to be championed by the Private Sector Lead of the Global Financing Facility Sneha Kanneganti, who calls for the integration of the private sector across the health system[78]. This promotion of privatisation trend was seen not only in the health sector but on other social services, including education. The World Bank, for instance, has increasingly supported private and market-oriented approaches to schooling through public-private partnerships (PPPs)[79], despite the growing body of evidence[80] showing they deepen inequalities and fail to reach the most vulnerable children. Fortunately, the World Bank has recently taken the important decision of ending permanently IFC investments in primary and secondary private schools[81], after a critical report by the WB Independent Evaluation Group (IEG) was published. A similar evaluation should be done by the IEG when it comes to health sector investments.

The World Bank Evolution Roadmap provides an opportunity to change how the WB sees the role of the private sector in health care provision. Marco Angelo, Global Health Advocate at Wemos, shared with us his aspirations:

"(In the evolution roadmap), there is a very detailed overview on how the World Bank intends to re-engage private investors on the investment gap. And these strategies include blended finance, social impact bonds, securitization, and other kinds of strategies that are aimed at bringing in private investors. A really familiar critique of the World Bank is its approaches on privatisation and public private partnerships… Taking UHC seriously requires big institutional change, which would require change into how we see the role of the government versus the role of the private sector."

Being Accountable for the Common Goal

The extent to which MDB lending promotes social safeguarding for health is unclear, particularly given MDBs engagement in the privatisation of health delivery, as outlined above. An analysis by the World Bank of safeguarding policies across all major MDBs found safeguards to cover gender, climate change, labour rights, and community health themes.[82] Safeguards are a special set of rules employed by MDBs that a country must abide by when using MDB resources for a development project and are intended to mitigate any potential unintended project impacts on the environment or vulnerable social groups. However, safeguards as employed by MDBs require MDBs to bypass national frameworks, are imposed over and above national laws, calling into question country ownership and sovereignty.[83]

MDBs are no different from other major global health actors in that their self-reporting of their programmatic impacts, and these may differ substantially from the downstream effects of these programs on local health systems or lived realities of communities. Especially, since ultimately, banks measure success as cost-benefit and cost-effectiveness analyses. However, in interviewing subjects for this paper, certain strands point to financing that is in line with regional priorities that may lead to more autonomy of countries in the global health landscape.

Oftentimes, funding comes with significant influence for MDBs to assert their own ideologies onto countries. This may occur via multiple modalities, including via technical assistance, conditionalities, and policy-based loans that MDBs provide, and include an agreement by the borrower country government that it will undertake particular policy reforms.

Arguably conditionalities in lending can drive and has driven major progress in countries, particularly when attached to conditions on child immunisation[84] or which are aligned with global goals such as the SDGs or Paris Climate agreement, or even with the country's own development agenda. However, this has also historically opened the door to MDBs exerting their preferences vis-à-vis private sector healthcare delivery, therefore reducing health equity for those in need.

Reflecting on the value add and shortcomings of MDBs, Marco Angelo, Global Health Advocate at Wemos stated that:

> *"The main pro is that they bring in a lot of money and they provide concessional loans to governments. This is quite important for the government budget. The main challenge would (pertain to) their continuity. In lending money, MDBs might issue conditionalities (and) might drive their (own) agenda. In the case of the World Bank, they might stimulate foreign direct investment in the private sector, which really does not contribute to universal health care. This is a key challenge."*

Towards Health Sovereignty

A sustainable health financing agenda will require a shift towards domestic financing and the weaning off dependence on foreign aid.[85] This will require the reduction of illicit financing flows and increase in internally-generated revenue for health financing. As Olusoji Adeyi, President of Resilient Health Systems and former Director of the Health, Nutrition and Population Global Practice at the World Bank Group, described the current state of play in some African countries:

> *"When you study the spending patterns in a number of those countries, you see that the priorities are very heavily out of line with human development. In some of these countries, the tax revenue to GDP ratio is extremely low. These are areas on which they can work to realise more internally generated revenue."*

Countries' abilities to nurture and protect an effective health system is a key element of health sovereignty and MDBs should play a key role in providing the catalytic financing needed for countries to increase their domestic financing for health.

Truly catalytic MDB health financing should result in a country progressively reducing its dependence on MDB financing for their health budgets or a specific health programme, and increasingly relying on internal revenue. For the purposes of this report, we use the following definition from Health Policy Plus: "Catalytic Investments for Domestic Resource Mobilization refers to an activity, program, or mechanism that leverages existing political, social, and financial opportunities to increase the likelihood that decision makers will raise allocation of domestic resources or improve execution for domestic resources".[86]

Some examples from middle income countries indicate that countries eventually wean themselves off MDB financing for health, although this is contingent on overall economic growth. In contrast, this study found examples of LICs with financial difficulties, debts distress and decreasing national health budget where the MDBs health financing, although important, couldn't be considered as catalytic.

It is this objective of leveraging resources for health that the Global Financing Facility (GFF) was created. Its impact on increasing IDA financing for women and girls' health is clear, with a 37% increase of World Bank IDA financing for GFF countries compared to earlier years.[87] While IDA financing consists of zero- or low-interest loans and enables the continuation of RMNCH services in countries, an ideal picture of sustainability would involve governments gradually increasing domestic resources to replace MDB financing. However, it has been difficult to attribute increases in domestic resources for health as having causative links with MDB funding. For example, while increases in health budgets have been noted in 8 GFF partner countries, the causal effect toward increased budgets and increasing maternal and child health spend more specifically is "difficult to verify" given "the impact of broader economic trends on revenues and spending in LMIC, the nonlinear nature of government decision-making and the involvement of other health multilaterals with co-financing requirements."[88] Each GFF dollar has been associated with $19.17 in counterpart financing from country governments, although this relates to general health sector spending and does not offer causality.[89]

Working on Decision Making Power

MDBs Governance Systems and their Impact on Priority Settings

MDB investments in health are largely determined by the priorities and agenda of their donors and stakeholders. Voting power is aligned to ownership shares. At its founding, ownership shares were closely related to financial contributions. However, some major shareholders, especially the United States exercise influence that is out of proportion to their current costs. This has led some commentators to call on restructuring the shareholder model at the World Bank.[90] In general, MDBs are controlled largely by a small group of countries. An analysis by the Overseas Development Institute (ODI) shows that over half of MDBs have more than 60% of their voting shares concentrated among the five biggest shareholders. Such disparities undoubtedly lead to misalignment of priorities between lenders and borrowers. As seen in the table below, Germany, Japan and the US are the countries found most commonly among the top five shareholders.

Figure 4: Largest Shareholders (adapted from ODI report):

MDB	1st	2nd	3rd	4th	5th
World Bank	US	Japan	China	Germany	France/UK
AfDB	Nigeria	US	Egypt	Japan	South Africa
ADB	Japan/US		China	India	Australia
IDB	US	Argentina/Brazil		Mexico	Japan
EIB	Germany/France/Italy/UK				Spain

Often, influential shareholders use MDBs to push their priorities and create markets for domestic industries. At the WB IFC, for instance, development contracts have been shown to follow an interesting pattern: the more shares a country has, the more IFC loans accrue to companies from their own countries[91].

However, the power balance varies a lot among MDBs. IDB exhibits a 50/50 voting share distribution. The AfDB stands out as the one where the governance arrangements, including the distribution of shares and votes between borrowers and non-borrowers, most favours borrowers.[92] Having the inverse ratio of the WB, AfDB borrowers (African member countries) account for 60% of the vote shares while non-borrowers (high income countries) account for 40%. These disparities in the governance system proves that MDBs can allow borrowing countries to be more integrated within the priority setting process of activities that will mainly affect them.

Still, even when priorities are aligned, interpretation and implementation of those priorities can differ from bank to bank. How implementation is translated at the national level is broadly dependent on the specific relationship of the bank with the particular country. For example, to the World Bank, strengthening health systems involves "enhancing public-private partnerships," "setting up the right payment mechanisms," and "ensuring the right logistics," among many other interventions.[93]

Certainly, more can be done to maximise the interplay of expertise at country level (including civil society) and expertise within MDBs to impact decision making at board level and MDB governance structures. Overall, this means better systems are needed for priority setting at MDBs.

In this context, regional MDBs show positive trends, likely also precipitated by the COVID-19 pandemic. The AfDB's Strategy for Quality Health Infrastructure in Africa 2022-2030[94], for instance allows for more regionally - and locally determined health investments and priorities, although questions remain about the "de facto veto" or influence that financing from non-regional member countries can exert on AfDB's financing. The Bank's funds are derived from subscriptions by member countries, especially non-regional member countries (France and Germany being strong players[95 96]), borrowings on international markets and loan repayments, as well as capital increases on the African Development Foundation (ADF) and Nigeria Trust Fund (NTF), although given that Nigeria is its largest shareholder, these influences on priorities may be more muted. There may be a different problem with their investments, however,

given recent hospital infrastructure investments towards African MICs, but none towards African LICs such as the Central African Republic, Chad, and Madagascar, who have fractured health systems with poor access to primary health care for its people.

Will the Future be Regional?

Inequities in the COVID-19 pandemic has resulted in an increased focus on shifting the power dynamic to the Global South. This is illustrated, for example, by critical assessments of COVAX and various financing commitments to regional manufacturing,[97] as well as Africa CDC's call for a New Public Health Order comprising, inter alia, expanded manufacturing of vaccines, diagnostics, and therapeutics on the continent, investment in public health workforce and leadership programmes, and increased domestic investment in health.[98]

Based on the testimonials of experts interviewed for this paper, improving health financing in the Global South will arguably require a combination of measures, including decentralisation of funding to regional entities, greater participation and coordination by regional and national leadership on the global level, increased South to South strategizing and partnership, increasing the capital available to regional development banks, decreasing illicit financial flows and corruption, and increasing the tax base relative to GDP.

Olusoji Adeyi emphasised the need for shifting decision making to the Global South. In Adeyi's own words:

> *"One of the big intents is to shift the locus of decision making and therefore the locus of accountability from mainly the global level to a combination of the regional and country levels. And that means that countries need to be increasingly self-financing. Nobody thinks this is going to happen in just one year, it is a trajectory. And during that transitional phase, the focus of deliberation and decisions on financing needs to be moved from global entities more to regional entities. Countries feel strongly about regional development banks. There is the Asian Development Bank, Inter-American Development Bank, the African Development Bank, for example. And to me, each of those could play a much bigger role in the next dispensation. Why? There are the instruments to do it (at these banks), and if they had a broader capital base to (dispense financing), they will be able to do it."*

This sentiment was also echoed by Agnes Soucat, Head of the Health Department, *Agence Française de Développement* (AFD), which is a French public financial institution that implements government policies to promote sustainable development. As Soucat described:

> *"(To respond to) the next pandemic, it will be key to invest in regional institutions and in country institutions. We need to decentralise global health. We have seen that having highly centralised funding and purchasing and concentrating functions when there is a global crisis leads to the countries that are the poorest and have less access to markets to be at the end of the queue. So, we really need to strengthen regional processes, regional institutions like Africa CDC, the new ASEAN outfit, so that regions can develop their own capacity to respond to (any) crisis by having stronger public health institutions, stronger data institutions, but also having the sovereign capacity to develop the products they need."*

The question remains as to how much of a capital base can serve the needs of the Global South to sufficiently reduce dependence on the Global North, mitigate or prevent inequities, like hoarding of commodities seen during the COVID-19 pandemic, and develop the capacity to regionally manufacture products that they need, as well as to finance basic health care services and health systems strengthening in the inter-pandemic period.

Financing of health in the Global South is of course wider than just the role of RDBs. And while RDBs have been touted as a crucial next step in addressing the question around the effectiveness of the global order, in bolstering markets, and in saving lives in future pandemics,[99] financing regional health institutions should be a key target of national governments.

This push for increased regionalisation should also be read in line with claims that regional banks are thought to be able to deliver development results better at a fraction of the cost compared to the big development finance

institutions such as the International Monetary Fund and the World Bank,[100] who have been called out for insufficient progress on the climate crisis and social inequality with the agility and scale needed.

There is also a need to acknowledge that, although there are several discussions at international level on how to best reform the international financing landscape, in researching this work – we encountered a number of refusals of African health agencies to engage with us, citing that they are not paying attention to Global North health financing discussions. The lack of involvement of Global South entities can and will distort priorities further. While Global South inter-Continental discussions are necessary, Global South actors must ensure they are represented and centre their priorities in MDB investments and financing discussions.

Make the Governance More Inclusive

At the global, regional, and local level, the inclusion of CSOs within the governance structure, their participation in the strategy planning, in the implementation, in activities oversight and evaluation, has been recognised as a strong addition to the effectiveness and impact of different projects. Within MDBs ways of operating, the lack of involvement of Civil Society is obvious. There are some positive examples of civil society engagement within MDBs, such as the Asian Development Bank, which has an official strategy and commitment in engaging civil society organisations to improve the effectiveness of its efforts in "selected operational areas"[101]. Yet, most MDBs approaches to CSOs are inadequate, given the technical expertise CSOs could bring. Their strengths in advocacy, accountability, technical expertise, as well as knowledge of the countries and communities they serve is often absent from MDBs and even from many northern-based global health initiatives.

Civil society can also play a key role in implementation of health financing, particularly due to experience in partnering with other global health initiatives at the regional and national level. If properly involved, CSOs could even foster a stronger articulation among global health financial partners. For Jackline Kiarie, Interim Civil Society Representative to the Pandemic Fund Board, representing Amref Africa elaborates:

> *"We have the opportunity to leapfrog by learning from others, because others have walked that journey. Global Fund already has very clear structures at global, regional and country level. We want to see the same for the Pandemic Fund. We want to see how the banks can work together to ensure that they can leverage the existing structures, such as the Country Coordination Mechanisms (CCM), a very robust mechanism that has been set up at the country level and supports Global Fund implementation. It has CSO representation, as well as representation from different stakeholders in the country. All the different functions are performed with its proposal writing, accountability, and reporting. Would it add value to try and establish a separate mechanism in the same sector? Would it add value to just look at how we can expand CCM to also manage Pandemic Fund priorities?"*

Working with Others

Foster Collaborations

As previously stated, the global health landscape fragmentation is a well-documented issue. While the ecosystem undergoes deep evolutions, it is crucial for MDBs to effectively coordinate between each other, as well as with communities, other stakeholders, and national level actors in order for the financing to represent good value for money and deliver for those that need it most. MDBs, given their differing missions, have limited (even though sometimes overlapping) mandates. Our findings suggest that a more articulated role with respect to global health is needed if they are to act against the fragmentation of the increasingly complex global health landscape.

In 2016, MDBs established the Global Infrastructure Forum which aims to enhance coordination among MDBs and their development partners to better develop sustainable, accessible, resilient, and quality infrastructure for developing countries, and focuses on how governments and their working partners can attract more resources for infrastructure.[102] The forum is jointly organised by the several MDBs in close partnership with the UN.

During the pandemic, across-Bank initiatives also increased. In one account from the David Wilson, Team Lead for the COVID-19 Fast Track Facility at the World Bank, stated:

> *"We worked very closely with the ADB helping to advise each other on the regulatory standards and trying to harmonise our work, and also to share lending across countries such as Indonesia, the Philippines, Bangladesh and others. And we started speaking for the first time to the European Investment Bank, which is very large but does not usually cross up with the World Bank because of its primarily EU focus. And we found that extremely helpful. So I would say that our connections with other MDBs were closer during COVID than they had been before… The only thing that is somewhat slowing us is that we are all trying to find our priorities in a post-COVID world.*

Although the EIB's primary focus is within the EU, its external lending mandate has been in place since 1976 and in 2019 alone, the EIB's financing outside of Europe was worth €7.9 billion[103].

The fact that there were not many interactions between the EIB and the WB raises a crucial question around complementarity and redundancies of different MDBs. If EIB had been investing in development concurrently with the World Bank, but had limited interaction with them, are there and have there been missed opportunities for synergies and for optimisation of resources?

Avoiding Duplications and Filling Gaps

The complexity of the myriad of different and sometimes diverging global health actors is visible during the implementation phase of any global health programme. Collaboration is essential, not only between banks but also between MDBs and other Global Health Initiatives. Babatunde Omilola, from the AfDB stressed the importance of increased collaboration:

> *"It is also crucial for all the key actors and stakeholders working in this sector to engage and have robust partnerships with clear definitions of roles and responsibilities of all actors (working) in health delivery, so that the comparative advantages of the different institutions can be leveraged."*

This critique reflects the overall challenges of operating within the global health landscape, particularly with other global health initiatives. An evaluation of AfDB's effectiveness in the health sector spending (from 1980-2005) highlighted a range of challenges across the bank's health sector portfolio. The corresponding AfDB Management response to the evaluation noted a challenge being the appearance of new partners who have tended to work vertically and principally on specific diseases, listing the Global Fund and GAVI by name. Specifically, the Bank noted that while these initiatives bring in vast resources mainly in the form of grants, they are often creating parallel structures and are not uniformly working to support countries' health systems.[104]

The global health architecture was already fragmented before the COVID-19 pandemic. There is recognition that the existing tools and ways of working of MDBs are not efficient enough. For instance, the WB has been creating Trust Funds (PEF, HEPRF, Pandemic fund) and financing facilities (GFF) to aim at increasing its impact on health. But by doing so, it is admitting that its own ways of working (regular IDA and IBRD financing) are not efficient enough and only with additional resources it will be able to increase its impact on health. It would be important for the WB to focus on adapting its ways of working to ensure they actually deliver for health and to better coordinate with other actors of the global health field rather than contributing to the growing fragmentation of the landscape.

Crucially, Shaw-Barragan spoke in depth about their collaborations and partnerships with different actors, including how Ministries of Health in countries guided their priorities:

> *"We take a lot of guidance from WHO and UNICEF, sometimes UNDP as well, because it is clear that there is a lot of expertise in the UN agencies that are very present on the ground. But then all of this comes together at the level of the Ministries of Health because it is the relevant Ministry of Health in each country that tells us exactly what it is that they need. For example, (this happened) when we financed Rwanda's biomedical laboratories – the need there was very much about having better equipment and better know-how for doing*

tests. (This included) blood analysis, but also very sophisticated equipment for which they also needed training."

This testimony indicates the direct relationship that some countries have with MDBs as a key financing solution to infrastructure deficiencies. In addition, there may be critical areas where MDBs can collaborate and partner more efficiently with GHIs with specific market shaping and price negotiation expertise, such as the Global Fund and Unitaid. They need to collaborate better to jointly identify what dimensions of health financing remain to be covered and which institutions are best suited to do so. MDBs and GHIs maintain a close dialogue, with a sincere vision on what their respective value add are, so they can avoid duplication and ensure there are no important gaps to be filled. During COVID-19, most of the resources mobilised to address the pandemic, both by MDBs and GHIs (taken all together), targeted vaccine purchases, with little consideration for what the other institutions were doing nor the demand or availability of doses.

These sentiments are notably reflected in the words of Agnes Soucat:

"It is very important to foster a reform of the global health architecture, which has not really happened… More reforms that are needed. In particular, the model of development aid needs to be adjusted to invest in health systems such as investing in human resources, training, and infrastructure, and not only be focused on purchasing medical products and distributing them."

Indeed, the WHO estimates that there will be a shortage of 10 million health care workers by 2030[105]. Investments in health care workers and decent working conditions will be paramount to ensure the right to health for all. This will require political leadership and coordination across different sectors, such as education, employment and finance. Maria Shaw-Barragan from the EIB shared her views on this:

"In general, reinforcing health systems is essential, and we need not to forget. There's not going to be enough doctors, and we also need to train more doctors. We need to create incentives for doctors that are trained in developing countries to want to stay in these countries. Creating those incentives is about reinforcing the systems. If they have a good decent job and good equipment in their own country, they are more likely to want to stay."

The critical aspect of reinforcing the health workforce appears to be an area where MDBs could play a bigger role and thus have a determining impact on access to health.

THE EVOLVING GLOBAL HEALTH ARCHITECTURE AND ROLE OF MDBs: Concluding Remarks

Arising from widespread inequity during the COVID-19 pandemic, Africa CDC has called for a new public health order comprising of, inter alia, expanded manufacturing of vaccines, diagnostics, and therapeutics on the continent, investment in public health workforce and leadership programmes, and increased domestic investment in health. Similarly, the G20 Joint Finance and Health Ministers have called for "local and regional manufacturing capacity in LMICs, including through voluntary technology transfer hubs in various regions, [...] such as the newly established mRNA Hubs in South Africa, Brazil and Argentina, and through joint production and processing arrangements." For their part, the WHO has created a Prototype Working Group towards established models of governance and ways of working on a medical countermeasures platform.

To date, questions of financing remain nonetheless open and unclear, and MDBs are presently not involved. For sure the future of the global health architecture must not exclude MDBs from the picture. Their financing power is too significant to be neglected. With relevant adjustments to their operating modes to deliver on expanding access to quality healthcare and with more coordination, MDBs, alongside other actors, could contribute to countries getting closer to achieving Universal Health Coverage. As they are undergoing internal reforms, it is essential that the said institutions truly embrace this goal.

Intense discussions underway on the global health architecture and aspirations to improve development financing offer a unique momentum to efficiently place MDBs in the desired new global health order.

How MDBs can help redress global power imbalances to focus more on the needs of the people and communities most affected by current and future health threats should be central tenets of upcoming discussions on future financing architectures.

For these very reasons, decentralisation, adjusted governance systems with a fairer power balance, priority granted to public systems, greater accountability and impact assessment, civil society engagement, and equity focus, need to be central motivating forces for any rewriting of the current rules.

This way, MDBs' role within the future Global Health architecture that is meant to emerge, will be better recognised and moreover articulated with other players to leverage the needed resources to close the funding gap for health needs of Global South countries and populations.

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