Health for All Now!
People's Health Movement

# Draft PHM Submission to Asian Infrastructure Investment Bank (AIIB) regarding its Draft Health Strategy

By email to HealthStrategy@aiib.org
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## About PHM

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## PHM responses to AIIB questions

### 1. Considering long-term trends, what are the key challenges and opportunities for AIIB in financing infrastructure for health?

**Realising a return on loan-based infrastructure funding.** The difficulty of yielding a return on loan-based infrastructure investment in various areas of the health value chain needs to be addressed. This applies particularly to publicly funded and administered healthcare and public health programs as compared with road and rail and public transport and WASH infrastructure which will add directly and immediately to productivity.

**Downsides of supporting the development of the private sector of healthcare.** The AIIB needs to recognise and address the deep contradictions between the Thematic Priority of private capital mobilisation and the promise of improved (and more equitable) population health and well-being. Supporting the development of the private sector in healthcare delivery carries substantive risks of inefficiency, inequity and uneven quality.

**Not exacerbating the debt pressure on many low- and middle-income countries.** Infrastructure funding through the AIIB should not add to the debt burden (including volatility) carried by many low- and middle-income countries. Funding through bilateral ODA has stagnated in recent years, leading to an increasing dependence on private lenders. The impact of high interest rates driven by Northern central banks has multiplied the debt burden. The exposure of many smaller L&MICs to currency speculation as a consequence of capital account liberalisation has added to the vulnerabilities of currency and balance of payments stability.

**Recognising and addressing economic inequality as a major barrier to health and well-being.** The Outline does not consider the structural drivers of increasing economic

inequality. Addressing these drivers would be a major contribution to health and well-being which the AIIB should commit to.

**Risks of treating 'health as a factor of production' rather than a fundamental human right.** The Outline and Strategic Priorities do not address the contradictions between health as a factor of production versus the highest attainable standard of health as a fundamental human right. On one hand, women might be 'more economically productive' if the prevalence of iron deficiency anaemia was addressed or if they had access to modern methods of contraception or if they were not exposed to indoor air pollution. However, the corollary of this way of thinking is that if a productivity dividend cannot be forecast such investment should be of a lower priority. It is essential to keep a strong focus on the human rights perspective.

**Integrating infrastructure development within more holistic development planning.** Development planning and realising such plans involve regulation, recurrent funding, workforce and employment, innovation, and various other modalities. Infrastructure development is only one 'factor of development' and needs to be planned within a holistic perspective.

**Achieving a balanced allocation of resources across three broad domains of the 'health value chain'**. The concept of the 'health value chain' depicted in Fig 1 in the Outline appears to be focused solely on healthcare delivery and public health programs. We urge the AIIB to take a broader approach which would involve recognising three broad domains:

1. **healthcare systems and public health programs**, as depicted in Fig 1;
2. Identified **social (including commercial) determinants of health**, including housing, transport, WASH infrastructure, access to education, gender equity, and much more; and
3. **Systemic determinants of health and well-being**, including equitable sustainable taxation capacity, strong policy and governance capacity, vibrant innovation systems, economic sovereignty (retaining policy controls over economic development), pathways towards a sustainable material throughput economy, realisation of democratic principles and human rights.

## 2A. What are the key needs that health infrastructure must address in the future?

This question appears to be centred on infrastructure for healthcare delivery and public health. This is very important. However, a broader perspective on infrastructure to support action on the social determinants of health is also needed, see below.

**Infrastructure which supports healthcare delivery and public health programs.** The need for such infrastructure is well canvassed in the Outline, including includes hospital and clinic buildings, diagnostic equipment, laboratories, housing for staff, ambulances and patient transport systems, digital hardware, and communications networks.

Support for such infrastructure should be made on a grant-in-aid basis without adding to government debt burden. Attention must be paid also to future flows of recurrent funds to support such institutions and services.

**Infrastructure which protects and restores biodiversity protection.** The links between environmental degradation and human health are complex and varied; ranging from

homelessness, loss of sustenance, to toxicity and infectious disease. The AIIB needs to recognise and learn from the environmental degradation caused by the support provided by the multilateral development banks to extractivist and mega projects (in particular mines and dams).

**Infrastructure which supports small farmers and agroecology.** The AIIB needs to address the needs of rural communities and the associated pressures of rural to urban migration. This must involve the recognition of the impact on urban poverty of large scale, low employment, high fossil fuel, high chemical input, monocropping. Infrastructure which supports regenerative agroecology could make a huge difference to the health and well-being of small farmers and rural communities and to biodiversity.

**Infrastructure which improves the lives of women.** The Outline promises infrastructure support for maternal and menstrual health, for osteoporosis and cancer screening.

These are important issues although in each case the benefits of infrastructure funding are conditional on wide range of other resources (planning, workforce, healthcare products, etc). In terms of contributing to the health and well-being of women and girls, targetted infrastructure support for WASH capacity, home insulation, electricity for cooking and heating, and road transport would make a comparable impact.

**Infrastructure which addresses inequality.** Economic inequality is a major determinant of avoidable disease burden, including the specific vulnerabilities of particular populations. The AIIB should explore the contribution that infrastructure investment can make to redressing economic inequality.

## 2B What characteristics ensure long-term resilience and sustainability of health infrastructure?

**Healthcare and public health infrastructure**

The resilience and sustainability of health infrastructure depends in large degree on the resilience and sustainability of the programs which such infrastructure serves. There have been many instances reported of development assistance programs which focus on capital equipment for health care without regard to the institutional context – and recurrent expenditures - upon which the deployment of such equipment depends.

The literature on health workforce brain drain identifies ‘push factors’ as very significant in driving emigration. These include lack of jobs, poor management, low work satisfaction, and lack of career development.

The long-term resilience and sustainability of healthcare and public health infrastructure depend on the resilience and sustainability of the programs of which they are part.

Elsewhere in this submission we have emphasised the importance of developing healthcare services and public health programs in a systemically integrated, person centred and primary health care oriented framework; funded and governed through the public sector.

The resilience and sustainability of such services and programs depends on security of recurrent funding as well as strong planning and effective governance structures. Fiscal space is critical

**Infrastructure which supports health workforce development**

Infrastructure support for health workforce development includes buildings and equipment for training institutions, ranging from community health workers to specialists. Such investments could make a big difference to health system performance.

However, funding support for capital outlays, without security regarding the recurrent expenditures entrained by such developments, is likely to be unsustainable.

Student fees (and student debt) is a very poor solution to the need for recurrent resources. This model either excludes students from disadvantaged regions, or saddles them with heavy debts which drive them into private practice or emigration. It also encourages the development of private training institutions, commonly characterised by very suboptimal training standards.

Too often in the Asian region governments encourage the over-production of certain professional categories in order to gain the economic benefits of currency support and balance of payments through remittances.  The AIIB should not encourage this model.

The better solution is to widen the fiscal envelope so students can access subsidised or free education and are not saddled with student debt on graduation. This is why the failure of the Outline to address the limits on public sector revenues – in particular corporate taxation - is so disappointing.

**Infrastructure which supports action on the social determinants of health**

We urge the AIIB to give closer consideration to the health benefits of infrastructure investment which addresses the social determinants of health, at least those which are amenable to such funding. Appropriately targeted investment in housing, WASH infrastructure, secure cheap electricity, and improved road transport could make a big impact on health and well-being.

The resilience and sustainability of such investments may depend in the short term on continuing funding for maintenance and for the training and supply chains needed for such maintenance. In the longer term they will depend on a combination of public funding and well-functioning markets which in turn will depend upon equitable and sustainable economic development.

## 3. Which parts of the health value chain are most critical for fostering sustainable economic development in Asia?

Action on capital dependent SDH (housing, energy, WASH, transport, etc) will contribute immediately to better health and well-being while fostering sustainable economic development. Such investment should be a priority.

Healthcare systems and public health programs are also critical but the deployment of capital for infrastructure must be part of system-wide planning and development. There are many areas where support for infrastructure investment would be valuable - buildings, equipment etc – but it should systemically integrated, be grant based (rather than loan based) and be provided as a funding stream to government, not tied to project-based applications and approvals.

The AIIB should eschew any funding support to the private hospital sector because of the impacts on equitable resource allocation, equity of access, system wide integration of programs and services, efficiency in resource use and quality of care. These system wide objectives are difficult, if not impossible to achieve in private sector dominated health systems.

## 4. In which areas of health can AIIB add the most value, and how?

Systemic investment in governance capacity, while not explicitly focused on health could make a big difference. Equitable sustainable taxation capacity including regional cooperation around corporate taxation to prevent the race to the bottom, should be a priority. We note with disappointment the lack of any reference to fiscal space in strategic priority 5 which deals with funds mobilisation.

Another example of systemic investment would be support for the development of policy capacity including research, evaluation, technology assessment, pilot studies, etc. The Outline mentions that other MDBs have provided policy advice on health system governance and health system strengthening and technical assistance on health policies, regulations and institutions.

However, the policy advice and technical assistance provided through the World Bank has consistently supported the market opening objectives of Northern capital, including privatisation and marketisation of utilities and health systems. It appears from this draft strategy that the AIIB plans to follow suit.

We urge the AIIB to invest in infrastructure for democracy and human rights, including, in particular, support for independent policy research and research synthesis. Such supports will take different forms in different countries and at different levels. In some countries it could focus on the universities, in other settings support should be provided for community-based NGOs.

## 5. What approach should AIIB take to its partnerships in health?

We have argued for recognising three domains along the health value chain: healthcare and public health, identified social determinants of health, and systemic capacities (taxation, governance, democracy, etc). These involve different partnerships.

In terms of **healthcare and public health** we urge priority to be given to public sector capacity development and that support to the private sector of health care be avoided. We suggest that support to public sector health services be grant based rather than loan based because the monetisation of returns on such investment is very difficult to realise. That way lies debt entrapment. We suggest that such public sector capacity support be disbursed through a general funding stream through government with minimal earmarking and minimising explicit project application/ approval/acquittal funding.

The partnerships through which **investment to address the social determinants of health** might be disbursed will vary according to jurisdiction and programmatic focus. Integrating capital funding within a broader framework of planning, the mobilisation of non-capital resources and governance capacity remain critical.

**Investment to support systemic capacities** (taxation, governance, policy, democracy, etc) will require high level liaison; should be grant based for reasons set out above; and should clearly be disbursed through government although without the top heavy bureaucracy associated with project application, assessment, evaluation and acquittal.

## 6. How can the current strategic priorities be articulated to better provide strategic direction for AIIB?

### *6.1 Strategic Priority One: Enhancing Infrastructure across the Health Value Chain*

As argued above, infrastructure development to support healthcare delivery is urgently needed. However, it must be introduced as part of a planned approach to health system development. Accordingly, we recommend a single funding stream to provide health planners in government, with resources to develop infrastructure in accordance with whole of health system development (service development, workforce development) plans. Such a funding stream should be grant based rather than loan based because realising a return on such expenditures is very problematic.

### *6.2 Strategic Priority Two: Bolstering Regional and Global Health Security*

Health security involves much more than capital expenditures on specific assets. It requires research, policy development, training programs, regulatory and funding initiatives (including but broader than simple asset purchases).

It is critical that health security investment is subordinate to national and regional health security planning. Accordingly, we recommend a single funding stream, without tight earmarking, so that government can allocate infrastructure funding in accordance with national priorities.

It is also important to recognise that realising a return on such investments is very problematic. Accordingly, it should be funded through grant rather than loan funding.

This strategic priority mentions One Health but does not properly consider the reforms needed in relation to agriculture, mining, mega projects, food supply chains in order to slow the emergence of pathogens of pandemic potential.

In adopting ‘health security’ as a strategic priority, the AIIB needs to recognise the global tensions around WHO having its own financing mechanism to support pandemic prevention, preparedness and response rather than being forced to depend on the WB Pandemic Fund. The need for WHO to have its own finanancing mechanism for PPPR was widely advocated during the recent revision of the IHRs and during the negotiations of the proposed pandemic accord but was blocked.

We urge the AIIB to investigate cooperation with WHO to disburse funding for pandemic prevention and preparedness (as envisaged in the new IHRs) rather than administer such funding independently.

### *6.3 Strategic Priority Three: Greening Health Systems and Associated Supply Chains*

While the introduction to this strategic priority speaks in general terms of buildings, air, water, energy, transportation etc – which could refer to public goods infrastructure generally – the project examples all envisage the greening of healthcare facilities.

We endorse the creation of a funding stream through government to support capital investments in healthcare, including greening healthcare facilities. Such a funding stream should be grant based and not loan based because realising a return on such expenditures will be very difficult. Such grant funding should not be tightly earmarked so that health system planners have discretion in allocating such resources in ways which promote integrated person centred PHC oriented healthcare systems.

However, in terms of yielding equitable and sustainable health outcomes such green funding directed to low-income communities would have a bigger impact on health outcomes and on economic productivity than instituting a special greening program in the health sector.

### *6.4 Strategic Priority Four: Improving Health through Technology-based Solutions*

A case exists for investing in technological innovation (employment, new markets, export earnings etc) as part of increasing productivity, employment and export earnings. However, we deplore the narrative which seek to justify such investment in terms of a 'strategic' contribution to health outcomes.

For advanced technology to be deployed to improve the operations of the health care system it needs to be strategically introduced in ways which strengthen the integration of the health system, including person centred care and a strong primary health care orientation. Healthcare development and the deployment of new technologies needs to be guided at a broad level by government decision-making. There is no reference in the Outline to technology assessment programs which have a critical role in managing the introduction of new technologies into health care. (Refer Thai experience.)

It is very disappointing that there no reference in the Outline or the strategic priorities to promoting local production of vaccines and medicines and other health care products, given the importance of this has been so strongly recognised in the wake of the Covid pandemic. The AIIB should also give consideration to the role of extreme IP which is a recognised barrier to local production.

### *6.5 Strategic Priority Five: Mobilizing Finance for Health*

Under this Strategic Priority:

> *AIIB aims to mobilize private sector financing, address barriers to the flow of private sector capital and ensure private health financing is not only focused on highly profitable segments of the health value chain. […]*
>
> *AIIB will seek to invest with the private sector and address barriers impeding greater private financing, through, for example, risk sharing/reduction instruments.*
>
> *By creating greater financing certainty, the objective will be to deepen and broaden private provision of infrastructure and services to a wider spectrum of income and population groups. For example, through better risk sharing, AIIB financing can spur greater private participation in the construction and operations of a wider range of*

*medical facilities beyond private hospitals and diagnostic facilities for high income groups. […]*

PHM Comment

This strategic priority is deeply misconceived:

- It neglects entirely the need for and barriers to the mobilisation of public sector finance, including tax reform;
- It ignores the overwhelming evidence that private sector healthcare funding promotes inequity and inefficiency and sets high barriers to effective regulation for efficiency, quality and safety;
- It ignores the evidence regarding the distorting effects of private health care on workforce distribution and access to care and integrated health system development;
- There are already large flows of private funding to medical tourism in SE Asia which sucks financial and human capital away from providing basic primary health care.

## 7. Conclusion

We thank the AIIB for the opportunity to contribute to the development of its health strategy.

We stand ready to elaborate on this submission or to otherwise engage with AIIB strategists.