G20 BRASIL 2024

BUILDING A JUST WORLD
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Third Joint Finance and Health Task Force (JFHTF) Meeting

PRESIDENCY NOTE

G20 Presidency Note on Debt-for-Health Swaps

October 2024

The Brazilian Presidency of the G20 and the Joint Finance and Health Task Force (JFHTF) recognize that the right to health is enshrined in Article 25 of the Universal Declaration of Human Rights (UDHR), and stress the urgency of mobilizing additional resources to fund investments in health-related Sustainable Development Goals (SDGs) and pandemic Prevention, Preparedness, and Response (PPR). These efforts are critically important in addressing global health challenges, and they are a priority for the Presidency.

According to the World Health Organization (WHO), most indicators suggest that the world is falling short of the Sustainable Development Goals (SDG) target of universal health coverage by 2030.[1] For example, progress in coverage has stalled since 2015, while inequality in access to health services remains a significant and pervasive challenge. Today, approximately 4.5 billion people lack comprehensive health coverage; 2 billion people are facing financial hardship, one billion are exposed to catastrophic out-of-pocket health expenditures, and 344 million people are forced deeper into extreme poverty due to health costs.[2] The costs and losses due to the COVID-19 pandemic have demonstrated the importance of coordinated responses to health emergencies as well as further work on pandemic PPR.[3]

In many countries, the burden of debt limits the resources available for health programs. The United Nations Conference on Trade and Development (UNCTAD) has stated that, in 2024, debt servicing by the poorest countries, with over 3 billion people, will exceed their combined investments on health, education, and infrastructure, disproportionately affecting the most deprived populations. Debt burdens also make nations more susceptible to external shocks, which compromises investor confidence, credit ratings, and growth prospects.[4]

In this context, it is crucial to tackle inequalities in health and finance, and guarantee that all citizens have access to quality healthcare regardless of socioeconomic status. To this end, the JFHTF has been tasked by the Finance and Health Ministers under the Brazilian Presidency of the G20 with evaluating the potential, challenges, and strategic value of Debt-for-Health (DfH) swap arrangements.[5] This is in line with the JFHTF Workplan Priority 2: *"increasing resource mobilization to the health sector through assessing debt for health swap arrangements".*[6] This innovative mechanism can help to unlock additional resources for urgent health priorities, especially in countries grappling with severe fiscal constraints.

1. WHO (2024).

2. See JFHTF (2024).

3. HWG (2024); Rockefeller Foundation (2024); JFHTF (2024). An encompassing view of PPR can include not only health emergency measures, but also work focusing on animal and environmental health issues, for example, emerging zoonoses and antimicrobial resistance.

4. HWG (2024); Rockefeller Foundation (2024), UNCTAD (2024).

5. G20 (2024a, 2024b); Rockefeller Foundation (2024).

6. JFHTF (2024).

DEBT-FOR-HEALTH SWAP ARRANGEMENTS

Debt swaps are voluntary transactions in which a creditor cancels a limited amount of outstanding external debt in exchange for an agreed spending commitment by the government of a developing country. Consequently, swaps can deliver outcomes at three levels: (a) they reduce the developing country's debt service disbursements, alleviating the balance of payments constraint; (b) they shift fiscal spending in domestic currency away from debt service towards socially impactful investments in priority areas, typically health, education, infrastructure, poverty reduction, environmental protection, mitigation of climate change and children's services, and (c) where the debt relief exceeds the agreed investment, the swap provides a net fiscal transfer, that is, it expands fiscal space. In doing this, swaps prioritize SDG-related investments over the external debt service, which can have positive implications for social welfare, reduce sovereign risks, and improve the credit outlook for the debtor country.[7]

UNCTAD has identified 235 debt swap operations in 58 countries since 1987, with a face value of US$11.5bn. Debt swaps have involved less than 0.4 percent of total public and publicly guaranteed debt, suggesting that it may be possible to utilize this instrument more widely in the right circumstances. The scope of swaps to mobilize resources to fund development priorities has attracted interest, especially after the conclusion of recent debt-for-nature swaps by Barbados, Belize, Ecuador and Indonesia.[8]

Debt-for-health (DfH) swaps convert external debt into funding for health programs, offering an alternative way to boost health expenditures, and allowing governments to improve public health systems, increase access to essential medical services, address such pressing challenges as child and maternal health and infectious diseases, and enhancing their ability to respond to health crises and pandemics.

Despite the importance of these issues, only a few bilateral DfH swaps have been agreed between creditor and debtor countries,[9] and, currently, the only active program in the area is the Global Fund's "Debt2Health" (D2H) initiative, launched in 2007. Under D2H, the participating creditors provide voluntary relief, on condition that the debtor spends an agreed counterpart amount, generally around half of the face value of the debt swapped, on health programs in line with the national strategies in HIV, tuberculosis (TB) and malaria, and in resilient and sustainable systems for health (RSSH).

So far, the three creditors involved in D2H have signed 12 agreements with a face value of US$367 million (expected to reach US$500 million in 2024). Although this corresponds to only 0.38 percent of the US$60 billion disbursed by the Global Fund, the additional US$225 million in health-related funding in 10 developing countries has contributed to affordable treatments, such as anti-malaria drugs for US$0.15, and anti-retroviral therapy

7. The G20 Presidency Note on Debt-for-Development Swaps provides additional details on the types of swaps currently available and their respective advantages and limitations.

8. G20 (2024b); Rockefeller Foundation (2024); UNCTAD (2024).

9. For details, see Rockefeller Foundation (2024).

for US$250 annually.[10] Moreover, as the instrument earmarks funds for approved health programs of the debtor country, there is greater local ownership, no need for new competitive funding rounds, and important resourcing gaps can be closed without the need for new administrative structures. In this way, D2H brings only minimal additional costs for creditors and debtors.

LIMITATIONS OF DFH SWAPS

The literature suggests that swap operations may be appropriate for small economies facing temporary liquidity pressures, but they are generally unsuitable for countries with strong credit ratings or that can access cheaper funding sources, or to countries in debt distress, since in these cases the cost of the swaps can outweigh their potential benefits.

Given the complexities involved in each swap, the costs and benefits of each potential transaction must be carefully scrutinized *ex ante* to decide whether a swap would be superior to the alternatives. The decision will depend on several criteria including: the initial debt position; the fiscal and currency savings; the implications for debt sustainability; the country's debt management capacity; the degree of expenditure earmarking; the implementation arrangements; the mechanisms for monitoring, verification and accountability, and the opportunity costs of the swap.[11] It follows that, in order to scale up health swaps, it would be necessary to reduce transaction costs, adopt less stringent earmarking, and increase reliance on local systems to enhance ownership and improve the sustainability of outcomes.[12]

In summary, DfH swaps may be beneficial to countries where the main constraint to health investments is a lack of fiscal space, countries unable to mobilize sufficient domestic resources to fund their own health programs, and countries unable to obtain concessional loans and grants, which are usually cheaper than swaps. In greater detail, swaps – including health swaps – tend to be limited in six important ways.[13]

First, swaps are limited by the availability of willing creditors and borrowers with sufficient managerial capacity. These constraints limit the potential of swaps to support development goals.

Second, swaps are less financially efficient than grants, conditional loans, and debt relief. The potential advantages of swaps in terms of fiscal and balance of payments relief, and support to health and other SDG-related goals, must be balanced against the fact that swap operations are both complex and unique, and carry high information, transaction, and other costs. This is especially the case for countries with limited human and financial resources and lacking strong debt management capacity.

10. Rockefeller Foundation (2024).

11. World Bank and IMF (2024).

12. G20 (2024b); UNCTAD (2024); World Bank and IMF (2024).

13. G20 (2024b); Rockefeller Foundation (2024); UNCTAD (2024), World Bank and IMF (2024).

Third, the spending commitments in swaps are usually earmarked. The funds are normally managed through a trust fund or similar entity, increasing budgetary rigidity and fragmentation, which is inefficient, especially in countries that are already struggling with limited fiscal space and balance of payments restrictions. Swaps can also imply long-term commitments which developing countries may be unable to afford (e.g., if a swap is used to finance a new hospital). In turn, the use of Special Vehicles and ringfenced offshore trust funds reduces transparency in budgetary execution.

Fourth, being project-specific, swaps do not tend to generate stronger debt management capacity or support macroeconomic reforms leading to long-term debt sustainability.

Fifth, swaps involve a risk of losses for the debtor country, if the agreed expenditures exceed the external debt servicing costs or, alternatively, if the net present value of the legacy debt is lower than the cash required to fund the agreed projects.

Sixth, the conditionalities included in swap agreements can expose the debtor country to additional risks, while the introduction of new senior creditors adds complexity to debt restructuring and debt relief operations.

WAY FORWARD AND POTENTIAL IMPROVEMENTS FOR DFH SWAPS

Given the limitations in sources, eligibility and volume of development funding, countries may look pragmatically to debt swaps as an additional tool to expand fiscal space and direct funds to health and other SDG-related initiatives.

The expanded use of swaps in health and other sectors would require addressing the limitations outlined in the previous section. This involves encouraging greater participation from a wider range of creditors, including multilateral institutions and private lenders, and streamlining procedures to reduce transaction and administration costs, reinforce governance structures, and increase transparency, especially in countries with limited management capacity.[14] Swaps can also benefit from greater integration with other innovative financing tools, such as blended finance and health impact bonds. Specific measures could include pre-approved agencies providing technical assistance, assessing the suitability of swaps, supporting negotiations and monitoring the use of funds; a dedicated special purpose vehicle; a pipeline of pre-approved projects; transparency mechanisms including an information-sharing platform; greater standardization of practices and reporting, and common key performance indicators (KPIs). In addition, debt restructuring negotiations could include voluntary options for countries to engage in bilateral swaps.

In summary, achieving universal health coverage, enhancing PPR, and building pandemic- and climate-resilient health systems while avoiding fiscal crises or sacrificing spending on other development priorities will require much larger funding and bolder initiatives than those that have been implemented recently. In this context, DfH swaps can be a useful

14. World Bank and IMF (2024) suggest a formula to calculate the potential costs and benefits of swaps.

tool contributing to the consolidation and expansion of public health systems, supporting targeted health programs, addressing SDG-related goals, and helping to fulfil the right to health that belongs within the UDHR and other binding global covenants. DfH swaps could also help to devolve the ownership of health policies to developing countries, ensure that these policies align with the needs of local communities, and enhance program accountability. This can be achieved as part of wider efforts to reduce the costs and complexity of swap operations but, also, within ambitious efforts to respond to health crises and the needs of the poorest and least protected members of society.

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