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Pandemic bonds: designed to fail in Ebola

The World Bank's funding scheme for disease outbreaks drained potential resources from the Democratic Republic of the Congo, says **Olga Jonas**.

The final toll of the Ebola outbreak in West Africa in 2014–16 was more than 11,000 lives, plus an estimated US$53 billion from economic disruption and collapse of health systems. In the outbreak's wake, the global health community scrambled to deliver initiatives for increased health security. One flagship programme was the World Bank's Pandemic Emergency Financing Facility (PEF). Under the scheme, investors who buy pandemic bonds receive generous 'coupons', which annually pay about 13% interest. This compensates investors for the risk that the bonds will make 'insurance' payouts to fight pandemics under certain conditions. Otherwise, cash returns to the investors when the bonds mature in July 2020.

The world's second-largest Ebola outbreak, in the Democratic Republic of the Congo (DRC), has now entered its 13th month and has caused at least 1,800 deaths. In July, the World Bank announced that it would, independently of PEF mechanisms, mobilize up to $300 million towards the Ebola outbreak. Meanwhile, the PEF has cost much more than it has brought in. The World Bank, where I worked for 3 decades as an economist, has not advertised the bonds' exact terms, but I have ploughed through the confusing 386-page bond prospectus. The PEF has already paid around $75.5 million to bondholders as premiums, but has not disclosed how much they have been paid in interest — and it is set to pay much more. However, outbreak responders have received just $31 million from the PEF, and the much-touted potential payout of $425 million is highly unlikely. Twice as many investors signed up to buy pandemic bonds as were available. It was a good deal for investors, not for global health. Absurdly, discussions on a second PEF are under way.

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The PEF was backed by about $190 million in donations from 3 countries and the World Bank's International Development Association (IDA), a fund that provides around $20 billion to the world's 75 or so poorest countries each year. 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 or on building up the Contingency Fund for Emergencies at the World Health Organization (WHO) so that all money would go to countries in need. Former World Bank chief economist and US treasury secretary Larry Summers described the PEF as "financial goofiness" motivated by government and World Bank officials eager to boast about a creative initiative that engaged the private sector.

Early action against outbreaks is imperative because it is both more effective and less costly. But making the bonds attractive to investors meant designing them to reduce the probability of payout. 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. Given that the WHO lists only one multi-country outbreak amid more than 30 that occurred in a single country, this requirement is inappropriate. The DRC is much bigger and more populous than all three countries involved in the West African outbreak.

The World Bank has said that the PEF is working as intended by offering the potential of 'surge' financing. Tragically, current triggers guarantee that payouts will be too little because they kick in only after outbreaks grow large. What's more, fanfare around the PEF might have encouraged complacency that actually increased pandemic risk. Following false assurance that the World Bank had a solution, resources and attention could shift elsewhere.

Rather than a lack of funds, vigilance and public-health capacity have been the main deficiencies. When governments and the World Bank are prepared to respond to infectious-disease threats, money flows within days. In the 2009 H1N1 influenza outbreak in Mexico, clinics could diagnose and report cases of disease to a central authority that both recognized the threat and reacted rapidly. The Mexican government requested $25.6 million from an existing World Bank-financed project for influenza response and received the funds the next day.

For the 2014–16 Ebola outbreak, substantial funds started flowing nine months after it began. Financing was slow because the affected countries, the World Bank and the WHO were not adequately monitoring the disease, and global health leaders did not pay attention until the outbreak became a full-blown crisis.

Increasing surveillance, diagnostics and other capacities for response to outbreaks will do more than flashy financing schemes to reduce threats from infectious disease — including antimicrobial resistance. World Bank analyses show that poor countries' investments in core veterinary and human public-health systems bring returns of 25–88% annually. The World Bank can provide robust financing and operational support for such investment; it should make this a priority.

The Ebola outbreak in West Africa should have been a sufficient wake-up call for the international community to establish a plan to get ahead of outbreaks. There have been important improvements since 2016, including reforms of WHO emergency programmes, and external evaluations of individual countries' core public-health capacities.

But the best investment of funds and attention is in ensuring adequate and stable financing for core public-health capacities. The PEF has failed. It should end early — and IDA funds should go to poor countries, not investors. ■

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