

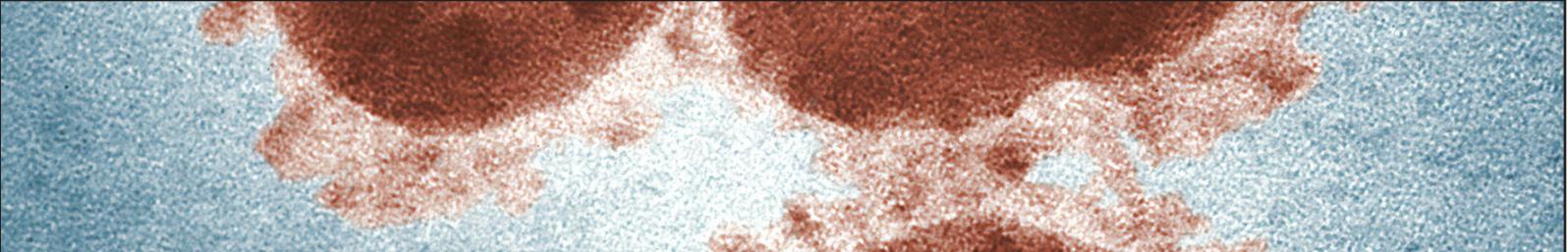
THE WORLD BANK'S RESPONSE TO COVID-19

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This paper is part of Jubilee Australia Research Centre's occasional paper series, in which we publish research papers authored by our colleagues in the field.

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About Jubilee Australia

Jubilee Australia (formal name: the Jubilee Australia Research Centre) is an Australian not-for-profit organisation engaging in research and advocacy to promote economic justice for communities in the Asia-Pacific region and accountability for Australian corporations and government agencies operating there. Through research and advocacy Jubilee Australia focuses on sustainable economies, community consent, justice and the important question of what reform is needed to ensure that Australian government and corporate practices support community wellbeing and a just and sustainable global economy.

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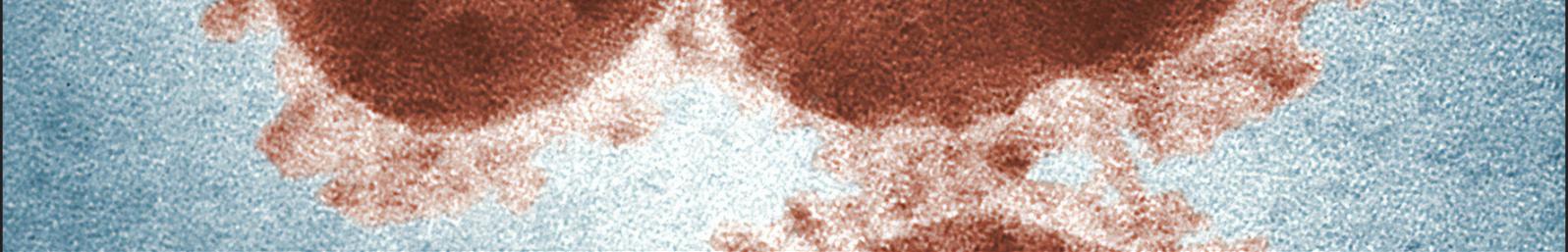
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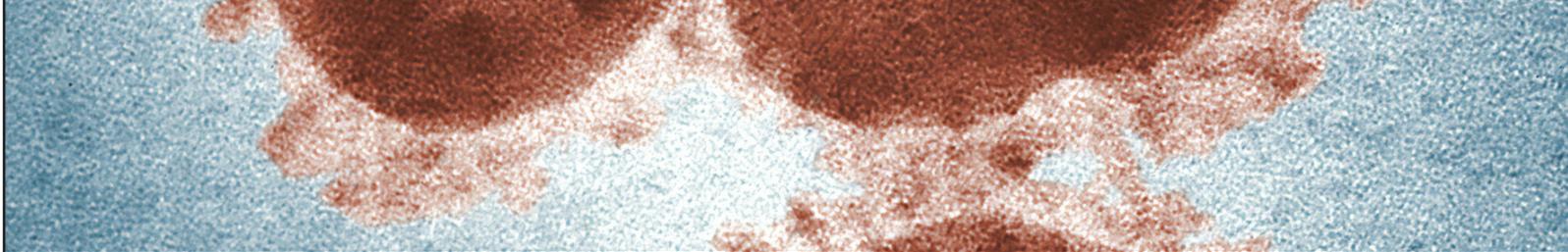
EXECUTIVE SUMMARY

The COVID-19 pandemic hit a world already struggling to find the fiscal space to adequately fund health and other social services. Further, even international financial institutions were worried about the rapid growth of debt that had taken place across much of the globe during the 2010s. Serving as provisioners of capital and lenders of last resort, international financial institutions such as the World Bank have attracted controversy since the 1980s due to the impact of their loans demanding austerity measures as conditions and the impacts these have had on the public institutions serving the poor. The World Bank is the largest multilateral development bank focused on lending to the Global South and the emphasis and policy conditions of their loans are very influential in establishing development directions. In areas like health, policies have been steadily reformulated in many countries in the Global South in line with Bank requirements or preferences. With grant aid from many bilateral donors drying up in the wake of the ‘beyond aid’ agenda, the World Bank and other development finance providers will be vital avenues of funds to combat the COVID-19 pandemic and its associated economic consequences. In April, the World Bank and G20 developed the Covid-19 Debt Service Suspension Initiative, however only a handful of countries have taken this up and it does not offer any long-term resolution of debt issues.

The World Bank’s long-term approach to healthcare has severely weakened systems and contributed to the under-preparedness for the current pandemic. The priority of limiting government expenditure has contributed to decades of under-investment in health care, and the burgeoning of private sector providers, particularly in the hospital sector, diagnostics and rehabilitation services. The weakness of

private sector provision of health services, health insurance and financialisation of health care have been exposed by the pandemic with many private providers facing financial problems. World Bank funding may end up propping up private profits in the health care sector and ensuring the viability of the private sector, where it is facing a liquidity crisis. This will only serve to ensure that the health needs of many poor people continue to go unserved, especially in rural areas. Further, it is likely that the poor will be left to pay for the debts that do not benefit them sufficiently. Case studies of Indonesia and Sri Lanka demonstrate how these policies work on the ground and how moderate and high levels of debt constrain present and future government choices. But many governments in the South have no other options but to take on additional debt to address the pandemic. World Bank loans to both Indonesia and Sri Lanka are supporting vital but floundering health systems needed to deal with the health crisis, yet they do not acknowledge the historic role that the Bank itself played in creating stressed health systems. Like many developing countries, they have public and private providers that are not integrated, private providers with little accountability and systems that fail the poorest. Both these states have predatory domestic power configurations, thus large injections of funds are likely to facilitate misdirection or misappropriation of public money (as we have seen in the North too) and corruption.

The recommendations call for an end to IFC investment in private health care, detailed monitoring and surveillance of World Bank loans made to the healthcare sector, and an extension of debt cancellation initiatives in response to the COVID-19 pandemic.



INTRODUCTION

The COVID-19 virus knows no borders or territories, it has spread across the Global North and South with no respect for boundaries or levels of development. After its initial outbreak in China, the first months of the pandemic focused on the Global North, but the impacts on the Global South were soon to become apparent. While there are exceptions, [research by Imperial College of London shows a direct correlation between COVID-19 related deaths, poverty and inequality](#). Stark health inequities and broader socio-economic inequalities are producing disproportionate impacts on the world's most disadvantaged and marginalised people. The virus has proven no great leveller with respect to inequality, poverty and marginalisation.

The disproportionate primary effects of COVID play out on to pre-existing inequalities the virus interacts with these aggressively, disproportionately affecting the poor living in shared, cramped, poorly ventilated, and often inter-generational housing where social distancing is close to impossible and access to proper sanitation infrastructure is lacking. It hits those working for daily wages or in the informal economy hard, those for whom isolation and not working mean no income and no food. These are just the primary health effects of the crisis – those where health outcomes, infections and death map on to the social gradient – it is likely that the secondary downstream effects of pandemic's attendant global economic crisis will see those already disadvantaged bearing the brunt of the oncoming depression.

The pandemic's economic effects will be worse for the South and harder to recover from. More than \$100 billion in capital left developing countries in the first three months of the pandemic, which was five times the levels of

the 2008 Global Financial Crisis. [Undiversified economies](#) have seen their currencies depreciate and their balances of payments hit hard by the fall in commodity prices and the reductions and halt in trade. [Foreign direct investment will fall](#) by up to 40 per cent and remittance have also fallen by as much as 80% in many LMICs. Many of these countries also had [high levels of debt prior to the pandemic](#), indeed some were already [spending more on debt servicing than health](#). Debt limits state's capacity to borrow to respond to and rebuild from Covid-19. Grant resources are always scarce, and total ODA (which actually includes highly concessional loans) has been at around 0.3 per cent of the Northern donor's Gross National Income (GNI) since 2008 – it never reached anywhere near the UN commitment of 0.7 per cent of GNI.¹ Northern donors have been pushing the 'beyond aid' agenda for a while now – meaning more loans and fewer grants. After its huge capital increase agreed in 2018, the World Bank again became the world's largest multilateral development bank (MDB). It is a key source of finance for the South and an agenda setter in development. In the emerging crisis, it is therefore vital to keep a close eye on it.

Discussions on development finance prior to the COVID-19 pandemic were centred around utilising 'public money' to leverage private finance and the World Bank's Maximising Finance for Development (MFD) approach has been a key driver. Since 2017, the World Bank has hailed MFD as the key to meeting the UN's Sustainable Development Goals (SDG) and '[improving the lives of the poor.](#)' [Development and the SDG agenda frame the private sector as essential and the public sector as playing a supporting role. Private investment capital will supposedly](#) plug multi-trillion-dollar investment gaps. Thus, public

private partnerships (PPPs) logically became an important modality for development and socio-economic progress. Facilitation of partnerships and regulatory pathways for investment and de-risking private finance are further focal points. Regulatory and policy environments create spaces for the rollout of market friendly aid disbursements and investments. The World Bank Group has played a critical governance and investment role in creating and sustaining this process of market roll out. Indeed, the mission of World Bank's expanding private sector lending arm, the International Finance Corporation (IFC), is 'to create markets.' The Bank aims to create an amiable investment climate using instruments such as partnership facilitation and investment guarantees.² [As Daniela Gabor \(2018, p.16\)](#) says the Bank's "overall strategy is to policy-engineer a shift towards securities-based financial systems and thus render DECs [developing and emerging countries] more amenable to the forces of financialised capitalism." In other words, the Bank seeks to expand both the financial channels in LMICs and the access of large investors to them. The resultant financialisation sees investors seeking profits through small changes in the prices of securities and new classes of assets rather than through commodity production or trade and is inherently risky and destabilising, particularly in LMICs.

The negative impacts of MFD and its financialisation of public services such as health are well documented. As discussed below, PPPs rarely more cost effective than public provision. A 2018 [civil society report](#) argued that the provisions of public services through PPPs has invariably contributed to increasing inequality and financial instability for people living in the Global South. Creating investable opportunities through PPP arrangements in health, water, and infrastructure has been found to create unequal and market-driven service provisions that, in most cases, exclude poor people from receiving those services due to price and equity issues. Decades of austerity and recurrent cyclical financial crises have left many developing countries

with stifled socioeconomic development and weakened public health systems that have proven vulnerable to outbreaks such as the West African Ebola outbreak of 2014, the Zika viral crisis, as well as the current pandemic. As Kate Mackenzie argues, the innovative financial instruments that the World Bank has created for itself and for developing countries may have a strong financial structure, 'but from almost any angle, they look fundamentally ill-suited to protecting vulnerable people from disease, disaster, or climate change.'³

In response to the pandemic the World Bank have variously provided needed emergency funding and support the Debt Service Suspension Initiative through which eligible countries can suspend some bilateral debt repayments. They have committed to providing an enormous US \$160 billion to help states address the crisis and other MDBs will provide a further \$80 billion.⁴ The World Bank is frontloading grants through their COVID-19 Fast Track Facility with more lending to follow. As of June 4, the Bank had approved loans and grants totalling \$14 billion in 60 countries through their new Fast Track Facility. These loans aim to '[help countries respond to immediate health consequences of the pandemic and bolster economic recovery.](#)'

Out of these sums, the International the Bank for Reconstruction and development (IBRD - being the Bank's Middle-Income Country lending arm) and the IDA (its highly concessional arm) were allocated \$2.8 billion and \$3.8 billion respectively, while the IFC, was allocated a large \$8 billion to support the private sector. The immediate high-loading to the IDA, relative to the IBRD, follows trends of the last couple of years where that branch of the World Bank Group has grown relative to the IBRD and the IDA is issuing an increasing proportion of grants, not just credits (i.e. loans).⁵ The IFC's private sector lending is significant as it has been at the forefront of facilitating the financialization of health sectors, particularly in middle-income countries. Most of the IBRD/IDA loans have been provided as investment loans, and not

development policy loans, which are budget support instruments and tend to come with a lot of prior conditions. Investment loans require most of the funds be put out to internationally competitive tender, meaning most of the goods and services, construction contracts and so on are filled by firms. In this way, IDA/IBRD Covid-19 loans will support private health services. A number of the health loans we examined did seem to allocate a reasonable portion of funds to governments, but governments may contract private sector entities for health services. More and more less concessional loans will follow these initial investments.

The World Bank is not only providing loans for health care, loans for other sectors are still flowing, with some being fast-tracked. There is a wide variety of difference between countries as to how the Bank's funds are being allocated. While it is entirely appropriate that national governments determine how the money is spent, it is notable that in terms of World Bank loans that many countries are presently prioritising spending on infrastructure as opposed to health equipment. Funding also varies in scale considerably, for instance, to date the World Bank has allocated \$1 per head of population in Indonesia versus \$6 per head of population in Sri Lanka.

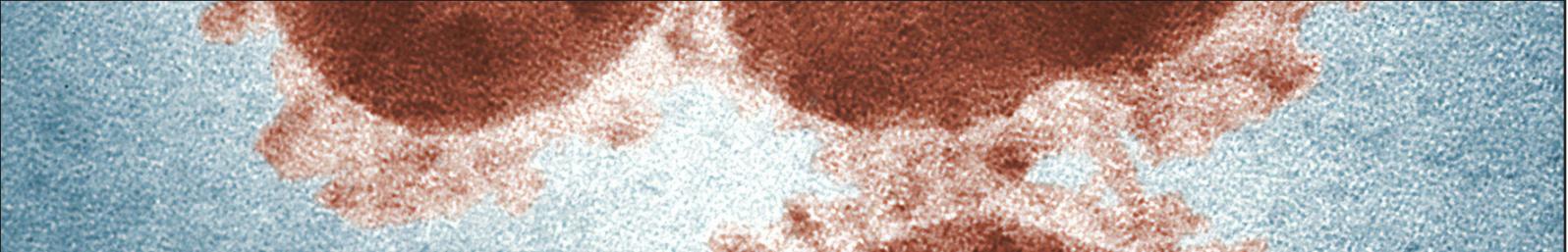
The World Bank's overarching response is not quite as business focused as we feared for this bank headed by a Trump appointee. They are frontloading grants and increasing resources for personal protective equipment (PPE), testing and other services. However, as noted above, the context is that many LMICs are already saddled with debt, financial outflows and low growth rates. Thus, many LMICs were already operating with limited fiscal space and this is being substantially eroded by the pandemic's savage economic impacts.

For some states, further debt could create excessive vulnerability or spark a financial crisis. This all means that that many countries are more susceptible to World Bank conditionalities that will surely focus

on further restructuring of their markets and change policies to favour more market-driven outlooks. Based on past performance, we expect the World Bank to respond to any burgeoning debt incurred during the pandemic by 'encouraging' the pro-market and state roll back policies it has pursued (though in different ways) for some four decades. Indeed World Bank President David Malpass, a Trump appointee, has already called for structural reforms to end ['excessive regulations, subsidies, licensing regimes, trade protection or litigiousness as obstacles...'](#) Debt conditionalities have shifted from roll-back austerity policies for health, infrastructure and social sectors, to policies that promote public-private blending with a market roll out and the ongoing expansion of private investment. Health has been one sector that has been at the centre of this double movement, and the IFC has been critical to the financialization process. These Bank and state priorities and policies have harmed human well-being, left emaciated public health care systems with inadequate capacity, and bolstered private health care systems for the rich that are at present refusing to treat poor Covid-19 patients in the most extreme country cases.

To understand what is likely to occur in terms of the Bank's medium- to long-term response to the pandemic we have to consider its actions and policies of the past, which is the focus of the next section of this paper. Consideration of its past role and orientation to health also helps understand how the Bank has helped stymie the development of effective national public health systems and how this has directly contributed to so many countries not being equipped to face the epidemics of the past and pandemic of the present. We offer two short case studies of the World Bank Covid-19 lending historically and post-COVID in Indonesia and Sri Lanka in the context of the debt situation of each state. The case studies focus on historical and contemporary health care lending. Indonesia having been through a debt crisis in 1997-98 has limited debt issues, though this depends on how debt problems

are defined for particular states. The country is now facing the pandemic after decades of low public investment in healthcare, driven in part by the agenda of international financial institutions to keep government spending low. Its health system has proven in no shape to address the COVID pandemic. In contrast, Sri Lanka has a much stronger health care system but significant problems with debt. In both cases, the World Bank has promoted a neoliberal approach (see below) to the health sector and demonstrated very little interest in long-term support for health gains. The Bank works with domestic power configurations in both countries that are predatory and target or exclude some groups, and in neither case are World Bank COVID loans ensuring inclusion of the most vulnerable.



THE WORLD BANK AND HEALTH CARE

The World Bank only began funding health projects in the 1980s, during the period when its role in the first wave of neoliberal policy was concerned with rolling back the state in the provision of public services and goods. It is not therefore surprising that the Bank focused on encouraging the establishment of private providers in the health care sector, establishment of private insurance schemes, and limiting the flow of public resources to health care, even for those people who could not afford private care. The instruments used to achieve this were loans and debt recovery measures and the imposition of state and regulatory reformulation by means of conditionalities, albeit with the lure for governments and publics of supposed efficiency gains and cost-effectiveness. For the poor, the Bank adopted a very limited definition of public health goods focused on preventative health care, infectious and easily transmissible diseases and basic maternal and child health interventions, these forming a suite of very narrow (albeit very essential) low-cost, high-return activities. The public in health was heavily circumscribed as were the financial and social risk pooling measures that were seen as valid means of paying for health systems and services. In the main, as governments withdrew from health and private providers burgeoned; and out of pocket payments, private insurance and limited employer schemes became the major means of accessing healthcare in many LMICs.

After the 2000s, when the Bank stepped away from the harshest elements of its neoliberal structural adjustment programs, it

provided a little more funds for health sector development. However, the overall goal of its health programs changed little. There was still a focus on limited public health expenditure and increased private provision of services, with an increased focus on new instruments to develop marketized health services and to fund public access to them. Since the 2000s and the beginning of the Millennium Development Goals, global health governance has undergone major changes with new international health organisations emerging such as Gavi, the Global Fund (to fight AIDS, Tuberculosis and Malaria), the Bill and Melinda Gates Foundation and UNITAD. All these organisations largely coalesced around so-called vertical disease-specific programs, most notably to target HIV, malaria and tuberculosis. Serious health aid was poured into these programs via global health's new organisational architecture.

This complex global climate forced the Bank to rethink its global health strategy. Given the narrow focus of these organisations, a key development in the Bank's health financing has been its [espousal of the sector-wide approach](#), which was popularised by its former director of the health, nutrition, and population sector, Richard Feacham. This gave the Bank a comparative advantage over other organisations by taking a broader, non-disease-specific focus that combined technical and policy support with health sector financing and strengthening, and 'sound' macroeconomic regulations. Unlike many of the new entrants to the field of global health, the World Bank alongside the WHO,

had remit over health systems development and assistance, but unlike the WHO, it had money behind it. This would develop into a crucial institutional rivalry in a number of highly contested policy areas for health, such as the role of user fees, private service provision, primary health, universal health coverage, and issues of quality services and population coverage.

On paper, the Bank's new approach to health systems seemed like a major volte face from the Bank's role of the past. In practice, while ostensibly different to the approach it took to rolling back the state in the 1980s, the Bank now took to rolling out the market in partnership with states and other institutions. It was stage two of the neoliberal agenda, and with the state in retreat from public services, it was easy to insist that the market was the answer. This is clear when the details of two of its main policy platforms for health are examined – PPPs and the approach it has chosen toward the SDG commitment to universal health coverage (UHC).

Through technical, and policy support and lending, PPPs have been one of the main policy prescriptions promoted by the Bank to expand privatisation of the healthcare sector. In a [joint paper](#) by academics from the Wharton School in Pennsylvania and World Bank officials, PPPs were rationalised as a way for central governments to provide health care more affordably and efficiently, while shifting the burden of raising capital for development projects to the private sector. PPPs are deeply problematic and there is extensive criticism about their damaging effects on health and government spending in the literature. Private sector bidders demand significant profits, long-term contracts and government guarantees or underwriting of risk - they keep liabilities in the public sector but give profits to the private sector. Often large infrastructure investments, most notably hospital projects, are plagued by over-spends and cost the public purse many times more than similar publicly grounded investments. Administration of complex service models

and shared arrangements for staff, services and sites are very burdensome. Notably, there is very little evidence that for-profit healthcare schemes improve healthcare outcomes for the poor. Indeed, the Independent Evaluation Group (IEG), which evaluates the effectiveness of World Bank projects, found that the Bank's approach to PPPs in the health sector had [worsened access to needed health care services by the poor](#). PPPs are a [more expensive way for governments to invest in health-related infrastructure](#) than bank loans or bond issuances. Despite that, publicly financed health services have not been properly assessed by the Bank as a reliable alternative to its flawed system. But that is not the point of the policy or model.

The roll out of UHC in the SDG-era dictated the creation of healthcare and services that are accessible, have good population coverage and quality, and involves arrangements for risk pooling and social risk protection. While many assume that UHC implies supporting publicly provided health systems, this is not the case, and the global policy drive for UHC is much contested on this point. What is certain is that it implies that necessary health sector reforms towards UHC maximises the access and coverage of all income groups in a manner that is equitable and financially progressive. Progress has been made toward greater coverage in national systems, however, schemes are generally designed for people working in formal sectors with regular incomes. They tend to exclude the majority of people in low income countries who rely on the informal sector for access to health. The Bank's focus has been to promote these systems, largely by means of private providers, and has concentrated much of its energy on tertiary care and on public and private insurance schemes that support access to services.

The result is that many countries now have a tiered health system with a handful of large private hospitals based almost exclusively in urban areas, a tier of smaller private hospitals and providers, and one of public sector

hospitals, an informal health sector (such as corner shop pharmacies), and primary care facilities and community health worker programs, these serving poor and rural people who are left in the hands of a withered public systems. In most LMICs, [private hospitals are providing some 50-80 per cent of tertiary care capacity](#), so they are vital to responding to the pandemic. But, in the wake of the pandemic, many [private hospital and providers are facing a crisis](#) because government regulations have led to the withdrawal of some services, people are delaying elective procedures, and there has been a substantial hit to the medical tourism industry that is a major source of hospital revenues in some middle income countries.⁶ Privatised services run on tight margins often servicing substantial debts, so there is an emerging financial crisis in the sector and governments in a number of countries are already having to bail private health providers out.⁷ Some, [private providers are using the crisis as an opportunity to price gouge](#) from governments or individual patients for providing medical treatments to COVID-19 patients, and this is particularly true for the large multi-site providers. Worse still, there have been many examples of private hospitals refusing treatment and admission to COVID-19 patients, particularly in India.

The World Bank has helped facilitate the financialization of investment in hospitals and other health services such as laboratories and diagnostics. For example, in 2008, the World Bank's private sector arm, the IFC, launched the Health in Africa initiative, a \$1bn investment project, to catalyse access to healthcare to the underserved through equity and debt vehicles to private healthcare actors. In Nigeria, the IFC partnered with the Nigerian company, Hygeia, to launch a subsidised health coverage scheme to low income IT workers in Lagos over a period of five years. Since the scheme required enrollees to be in formal employment, as Oxfam showed in their 2014 [report](#), it automatically excluded 80 percent of all Nigerian workers. The cost of enrolling was also prohibitive for most people, starting at \$10 in the first year and rising to

\$55 in its fifth year due to a reduction in IFC subsidy.

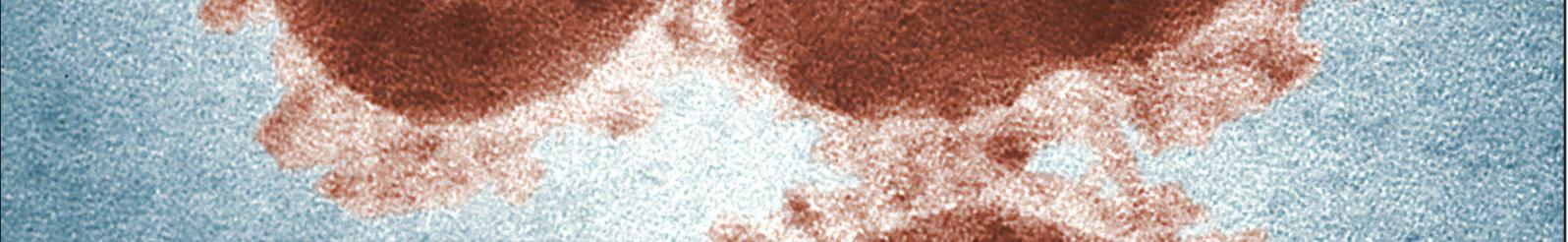
The Bank's sibling, the IMF, has been encouraging countries to return to austerity policies like cutting or freezing public sector wages. They recommended over the past couple of years that 18 low income countries that do not meet WHO's recommended nurse-to-population threshold [cut public employment](#). For example, in Liberia, where many health workers were lost to the Ebola outbreak, they recommended cutting public employment by 17 per cent. Similar cuts to the public workforce and public sector health have been 'negotiated' in the last five years alone in Mexico and Ecuador, all with IMF participation in the policy approach.

On the financing side it is clear that the WHO has drifted with the World Bank, in large part because of the de-emphasis of primary care as the route to UHC in that organisation, and due ascendancy of World Bank economic thinking on financing health services within its Geneva headquarters. WHO moved from a pro-public and primary care stance quite quickly, from the publication Primary Care Now More than Ever in 2008, to a model that puts insurance as the route forward in Financing for UHC in 2010. In short, the mode of service delivery became less relevant just as the World Bank took an interest in health systems strengthening via leveraging private investment. While the WHO still focuses on strengthening the public systems of LMIC countries, this leaves the Bank with free reign to do what it can with the remaining 60 or 80% of national systems operating on the basis of private provision.

In short, the World Bank has played a notable role in the establishment of a global structural context for health services, whose ownership and orientation reduces emphasis on primary care and increases the focus on private health care provision. Many countries of the South have large private health sectors with little state oversight, these systems are largely not assimilated in any meaningful form into any semblance of a cohesive national health

system, and indeed governments often do not even know how much capacity the private health system actually has. In and of itself, this has created problems for harnessing the private sector for pandemic response. Private health care providers are facing financial stress thanks to COVID-19 and there is strong likelihood that World Bank loans will bail them out.

The paper now turns to case studies of Indonesia and Sri Lanka to look at developments in more depth.



THE WORLD BANK, INDONESIA AND COVID-19

The mantra of limiting public health care expenditure has had disastrous consequences for many countries like Indonesia. Like many decolonising states, it started to build the basis of a sound public health system by the 1980s, but there was a tapering off in the 1990s with decreased growth and the Asian Financial Crisis.⁸ The World Bank only funded population or family planning projects before the 1980s, funding five in Indonesia between 1972 and 1991. During the peak period of neoliberalism in the 1980s and much of the 1990s, Bank lending to the health care sector in Indonesia used the standard two-pronged approach: ‘the introduction of market forces into the health care sector, and the allocation of public resources according to criteria of technical and instrumental efficiency.’⁹ But Bank support for the health sector was small until the fall of Suharto. In the early 2000s, health sector lending jumped significantly as a percentage of Bank loans to Indonesia – though in the wake of the Asian Financial Crisis, the World Bank lending program was smaller and strongly focused on structural adjustment. These loans continued the Bank’s broadly neoliberal approach to health care in Indonesia, expanding private insurance for the better-off and private health care provision, with very limited services for the poor.¹⁰

Currently, Indonesian public health expenditure is just 1.4 per cent of GDP and 7.8 per cent of all government expenditure, which is around half of what most countries with a commensurable income spend. In contrast, in 2018, debt service was 5.6 per cent of Gross National Income according to the World Bank.

Most Indonesians are covered for health insurance under a single payer social health insurance program (JKN), but that does not mean they can access care. Around two thirds of Indonesia’s 2,400 hospitals are private, as are many primary health care clinics. As with many other LMIC countries the Indonesian government does not have or collect any systematic data on these private facilities. The Indonesian government spends US \$49 per capita on health and this is less than the World Bank’s (inadequate) recommended minimum package of health care services, estimated to cost \$110 per person per year. This minimum package provides virtually no support for noncommunicable diseases, which now account for two-thirds of the burden of disease in Indonesia. The Bank and Indonesian government’s minimal approach to spending and coverage has helped to create a health sector with limited capacity to respond to emergencies or pandemics.

The consequence of this situation is the Indonesia has a life expectancy of 73.9 for females and 69.2 for males compared to Sri Lanka with only has a slightly higher income per capita but a life expectancy of 81.1 for females and 73.9 for males.¹¹ Vietnam has a significantly lower income and a higher life expectancy. Indonesia performs significantly worse than the mean of countries with similar socio-demographic indicators in terms of performance on a range of causes on premature deaths and disability, while Sri Lanka is about average or above, though it has problems with diabetes, self-harm and asthma.

The World Bank paid only limited attention to health in Indonesia over the last decade. Only three projects were directly for the health sector, though there are other projects with health components. The last large project in 2018 was all about addressing technical and financial efficiency through performance monitoring, which seems rather problematic when capacity has been the major factor. Despite this context, the Bank's Country Partnership Framework (FY2016-2020) for Indonesia gave very little attention or priority to health, the top three priorities were infrastructure, energy and connectivity. Health got some, minimal attention under priority four, delivery of local services. The Framework argued that regulatory hurdles limit the private sector's opportunity to help fill the gaps with health care and that their support from the IFC in particular would focus on strengthening and promoting the private sector model and investments to deliver health care services.¹²

Between late July and late August, Indonesia went from 90,000 recorded cases of Covid-19 to over 143,000, with over 1,600 new cases per day for the last few days and 6,277 identified fatalities. The real numbers are much higher as testing has been minimal and deaths underreported. The government was slow to respond to the pandemic, it has only had partial lockdown in some cities, and some ministers have even publicly stated that prayer and eucalyptus necklaces would ward off the virus. Further, the country has specific health challenges that may contribute to mortality, like an adult male smoking rate of 68 per cent and generally poor sanitation, with one quarter of people still openly defecating. There are only around 8,000 ventilators across the archipelago of 268 million people.

The World Bank's Emergency Response to COVID19 IBRD loan was announced in late May. It provides a \$250m loan, with a co-financing component of \$250m from the Asian Infrastructure Investment Bank (AIIB). The Islamic Development Bank (IsDB) is also expected to support the Government Expenditure Program under parallel financing, with a proposed financing envelope of \$200

million. Its aim is to prevent, detect and respond to the threat posed by COVID-19 and strengthen national systems for public health pandemic preparedness. These funds for the health care sector are to be distributed over 18 months and have a substantial grace period (i.e. involving no immediate repayments) of six years, but a short repayment period of 13.5 years. The loan will cover recurring costs for hospitals such as salaries and top-ups for health care providers, especially COVID-19-related specialists, training for human resources, and additional medical equipment, PPE, and test kits that may be needed. So, the loan supports government and private capacity and services, while procurement of goods is only estimated to be around 30% of the loan. The fact that it supports at least some direct funding of public sector services is positive, though it is not clear how much will go to the public versus private health care providers. Further, it comes with substantially fiduciary risk arising from endemic corruption in the Indonesian government and health system.

The Program Appraisal Document for the loan neatly outlines a number of the key challenges the health sector is facing in Indonesia including the grossly inadequate public expenditure. However, the document fails to acknowledge that the Bank has pushed limiting public health care expenditure on states like Indonesia since the 1980s. A degree of irony should also be found in the concern expressed in the document regarding Covid-19 patients being stigmatised because the World Bank promoted active shaming of open defecators in its Indonesian sanitation programs.¹³

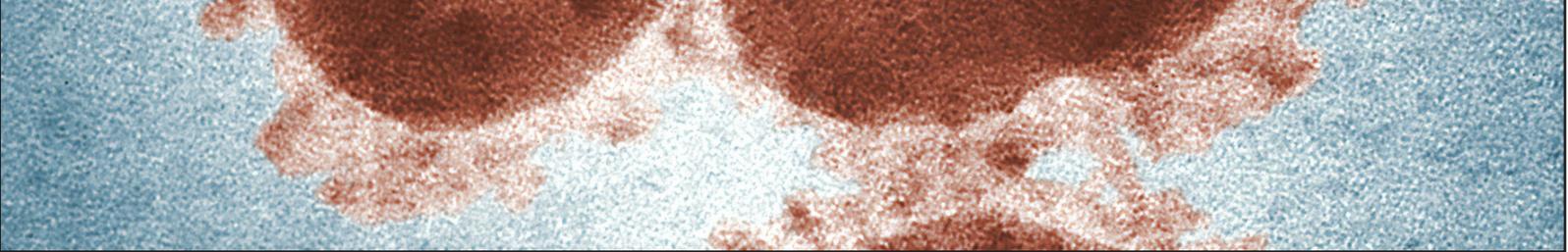
Turning to the IFC, it has not invested a lot to the health care sector in Indonesia despite the focus on it, in the Country Partnership Framework (FY2016-2020). There was a small loan in 1996 to a private hospital in West Jakarta, a 2016 loan to the multinational corporation, B. Braun, for a plant producing sterile preparations, and a further loan in 2017 to a medical distribution company. In terms of post-COVID loans, the IFC approved one to the conglomerate PT Famon Awal Bros Sedaya

to help support the construction of three new private hospitals (\$35m) as well as expansion and refurbishments in some of the group's other eight private hospitals (\$40m). These are clearly substantial amounts being injected into a company and could well set the pattern for further investments. The three hospitals under construction are all in the Greater Jakarta area, perpetuating the urban bias in health care in Indonesia (as in many other LMICs). Notably, the project was exempted from the IFC's test of 'broad community support' for no stated reason. This project was clearly in the pipeline before the current pandemic, but it would be interesting to know whether the \$40 million for the existing hospitals was part of the original request or is a post-COVID response to help support the group.

Not surprisingly, the IFC documentation does not mention that Awal Bros is owned by the Saratoga group whose core business is now coal. The Saratoga group was created by Edward Soeryadjaya; the family originally made their fortune by creating the automotive empire – the Astra group, thanks to special privileges given to the family and group by the corrupt Suharto regime.¹⁴ After a poor business deal, they lost majority ownership of the empire. The Saratoga group is closely affiliated with Suharto's children and the cronies formed during the so-called New Order period. These networks have re-formed in post-Suharto Indonesia and continue to dominate the economy through what the Indonesian's call *Korupsi, Kolusi dan Nepotisme* or KKN – corruption, collusion and nepotism. Even if the World Bank investment could benignly be assumed to be ignorant of the company's ownership and genealogy, the failure to canvass community support for a private hospital project in the milieu of such poor government investment in healthcare is damning enough.

World Bank loans run up country debt. Indonesia's government and overall debt has increased to just over 36 percent of GDP. The government feels that this is manageable and that it can therefore take on additional debt in response to the pandemic, however, it should be noted that Indonesian debt payments are

already significantly more than government spending on health care. Still, the end of commodities boom after the Global Financial Crisis hit the countries' exports and reduced economic growth, which means caution is needed. The World Bank is more transparent than it used to be but the IFC remains relatively opaque. But it is still often difficult to ascertain who will benefit from World Bank loans and precisely how they will be delivered, and these concerns increase during a rapid response. Civil society need to be vigilant to ensure that loans benefit those who need it most and do not just bail out private healthcare providers or other firms. And that may be challenging as decades of World Bank and IMF guidance have interacted with Indonesia's patronage-based domestic political elite to produce a country reliant on natural resource extractivism and pro-private sector and market-based policy prescriptions that cause increasing inequality and limit focus on human well-being.



THE WORLD BANK, SRI LANKA AND COVID-19

Sri Lanka is classified by the World Bank as a lower middle-income country. It has made laudable achievements in health outcomes such as a significant increase in life expectancy, reduction in maternal and child mortality, and decreased levels of communicable diseases.¹⁵ Similar to Indonesia, Sri Lanka's health care system is decentralised and managed by provincial or state councils. It is financed through a combination of government expenditure and private out-of-pocket payments, individual and employee insurances, and NGO contributions. While Sri Lanka's health care outcomes have been improving, healthcare expenditure lags when considered as a percentage of GDP. Between 2000 and 2017, total healthcare expenditure dipped to 3.81% of GDP in 2017 from 4.24% in 2000. In that period, private health expenditure as a percentage of total health expenditure has increased by 22.5%, while government health expenditure has declined by 20%. Still, the use of the PPP modality in health care has been minimal in Sri Lanka, compared to other countries in its region.

The World Bank has given a total of \$3,434.61 million in IBRD and IDA loans to Sri Lanka since 1947. Out of this, only \$530 million was committed to the health sector through four projects. The World Bank signed a \$200 million loan agreement in 2018 to help increase the use of Sri Lanka's primary healthcare services. Sticking with its neoliberal approach, the Bank recognised the 'thriving role' of the private sector in supposedly providing a better

consumer experience. It did acknowledge the private sector's capacity limitation compared to the public system, which remains the dominant source of care in Sri Lanka due to its free provision. By 2011, the number of private hospital and care facilities had increased by 17% and the World Bank embraced this transition with open arms in its recommendations for the sector.¹⁶

Similar to its approach in Indonesia, the World Bank's Country Partnership Framework for FY17-20 for Sri Lanka had limited focus on health care, focusing on governance and accountability and calls for an enabling environment to attract private investment into health care.¹⁷ The push for privatisation comes as no surprise since, according to the Sri Lankan central bank, the central government is already saddled with heavy foreign debt totalling more than \$55 billion, with the debt to GDP ratio a rather large 67.6% in 2019. To accelerate repayments, the World Bank called for an overhaul of the public finance system, and this was paired with an unapologetic push towards privatisation of social and public services including healthcare.

Despite the push for privatisation, the IFC has only made one commitment in health in Sri Lanka totalling \$20 million to the Asiri Group of Hospitals. It is important to recognise that the private provision of health in Sri Lanka remains at an early stage. [A World Bank report on health care in Sri Lanka](#) showed private hospitals in Sri Lanka are concentrated in the Western Province, a region known to generate 40% of the country's GDP and populated by higher income residents. These are also the population that are the primary user of private

health care facilities and quality of care is an area of concern for them. However, a cross-sectional comparison on inpatient quality found that the public sector performed better in most aspects of inpatient care where resources are not constrained.¹⁸ Many people in Sri Lanka, regardless of socioeconomic status, still favour the public system for its reliability and affordability of care. This is to say that the public sector has the capacity to supersede the private sector and even cover the whole treatment and management of inpatient admissions, but it needs additional financial resources. This raises questions about the World Bank agenda and the extent to which the Bank follows the democratic choices of states versus its own neoliberal policy and ideological preferences.

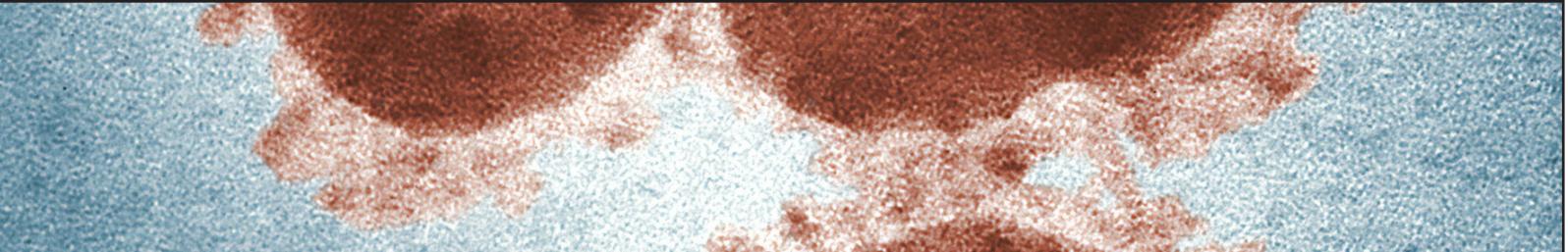
Sri Lanka reported 2,037 confirmed cases of COVID-19 as of late July and only 2,890 in late August, with just 11 deaths. It is doing remarkably well despite neighbouring India having over 2.7 million cases. To assist with its response to the COVID-19 pandemic, Sri Lanka received a \$128.6 million loan from the World Bank's COVID-19 Fast Track Facility. The 'Sri Lanka COVID-19 Emergency Response and Health Systems Preparedness Project' was devised to assist the country with its public health preparedness and comprises \$35 million from the IBRD and \$93.6 million from the IDA. It has a generous five years grace period and a 24.5 years repayment period. The IFC has not provided any loans to the private health care sector yet but it did approve a \$50 million loan to support the Sri Lankan Commercial Bank of Ceylon – a financial intermediation project to be on-lent to businesses affected by the economic slowdown. Expanded loans to financial intermediaries is a core part of the Bank's MFD agenda and civil society groups have long expressed significant concerns about how this outsourcing is reducing transparency, nevertheless they have documented many cases of community harm from [outsourced development](#)

The COVID-19 related economic slowdown is compounding Sri Lanka's economic problems. A ramp-up in the application of austerity measures demanded by the World Bank and IMF of President Gotabhaya Rajapakse's government, seems to have contributed to a push to re-open the economy, which may prove harmful to people's health given the regional spread of the virus. W.D. Lakshman, governor of Sri Lanka's Central Bank [warned the](#)

[government about its foreign debt obligation due this year](#) with payments of \$3,420 million due between May and December and another \$4,310 million next year. Given the scale of these issues and World Bank concerns about debt, Sri Lanka has looked beyond the MDBs and agreed a [large \\$500 million loan with the China Development Bank](#). Although the headline for the loan was combatting COVID-19, its focus on better managing the country's finances is code for new debt to cover repayments on existing loans.

The pandemic is expected to have moderate to strong impacts on the Sri Lankan economy, hitting remittances, tourism and export income in particular. The government is spending very little either to support the poor or equip the country's struggling health care system with the necessary testing and protective equipment. Not surprisingly, the World Bank said nothing in the COVID loan about the extent of the military's involvement in Sri Lanka's Covid-19 response with soldiers controlling key public service posts and the police [arresting 55,000 people for violating curfews](#). It also did not discuss the impact on the country's Tamil population and Muslims who continue to be worse off than the majority Sinhala Buddhists. A range of commentators see the government's response as yet another way the [government is militarising the state](#) since the civil war. Further, the military consumes a good deal of the state budget and undoubtedly accounts for a big proportion of Sri Lanka's debt burden. Covid is likely to fuel socio-economic and ethno-religious divisions in the country, and the World Bank loans do not acknowledge let alone address these social and ethnic based inequalities. This is not in keeping with its [Strategy for Fragility, Conflict and Violence 2020-2025](#), which emphasises strengthening the resilience of the most vulnerable and marginalised.

Overall, in the case of Sri Lanka, any crisis in private health care provision will not have the level of detrimental impacts on health care that it will have in many other LMIC, including Indonesia. Rather, the major concern is that existing debt situation will exacerbate the economic crisis and further shrink the country's fiscal space. A key issue for civil society monitoring needs to be ensuring that loans from the World Bank and other MDBs are not excessive or misappropriated, as a widened debt crisis will have major implications for the



CONCLUSION

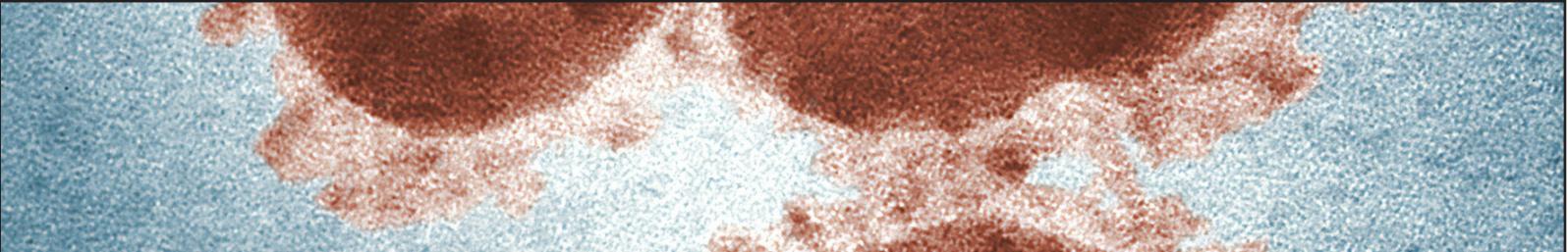
well-being of the population going forward. This context also highlights the importance of increase grant support in response to Covid-19. The COVID-19 pandemic has highlighted the deep crisis of state-market relations that is unfolding across the world, and health sectors have proven no exception. This is clearest in densely populated and often poorly resourced low-to-middle income countries where the consequences of neoliberal programs on and in healthcare have been brought into stark relief by the pandemic. In the crisis, most states need private sector capacities, not least beds in private hospitals. There is the danger that the World Bank will use loans as a mechanism to bolster support for a private health sector facing present financial crisis and build a platform upon which these providers will emerge from the pandemic and continue to dominate tertiary and allied care despite their failings in comprehensive health care provision. Indeed, loans might serve as the mechanism for yet more investment in private sector providers and privatisation, exacerbating the situation of crumbling public health systems and making true UHC illusory.

At the same moment, countries with problematic levels of either public or private sector debt are also facing turmoil and shrinking policy space. As the two case studies show, increased lending by the World Bank and other development finance providers will have different impacts depending on the historical state of the public health sector. Overall levels of indebtedness and a range of associated factors are very important considerations in how countries respond to COVID-19 and the economic crisis. The World Bank is clearly rather worried that large swathes of the private healthcare ‘market’ may collapse, thus in Indonesia we see signs that Bank loans will directly or indirectly bail out the sector. However, this approach does not address the main challenge in Indonesia, which is inadequate access to health care, particularly

in rural areas. In Sri Lanka, with its relatively strong public health system, the major challenge is not collapse of private health providers, but rather the potential long-term consequences of a debt crisis not least on maintaining the public system. We know from previous debt crises and the subsequent austerity programs that health sectors invariably suffer and provide windows for the market to be rolled out. These dynamics are presently playing out in many LMICs and due caution is needed to what may transpire in global health.

There are examples of countries taking quite different health responses to the crisis. In Spain and Ireland, governments exercised emergency powers to nationalise the whole private hospital sector, highlighting that nationalisation of health care is possible and perhaps desirable both in a crisis and beyond. Many in India are calling for greater public investment in health systems and for the nationalisation of hospitals. The crisis might provide an opportunity to challenge structure of health care, the presence of markets and the need for UHC in primary and tertiary care. What COVID-19 also demonstrates is that comprehensive health care can never be de-risked enough for the private sector to provide effective cover and that market failure is always on the horizon. Public provision is the best option for UHC and for loans or aid that assists the reconstruction and orientation of health systems.

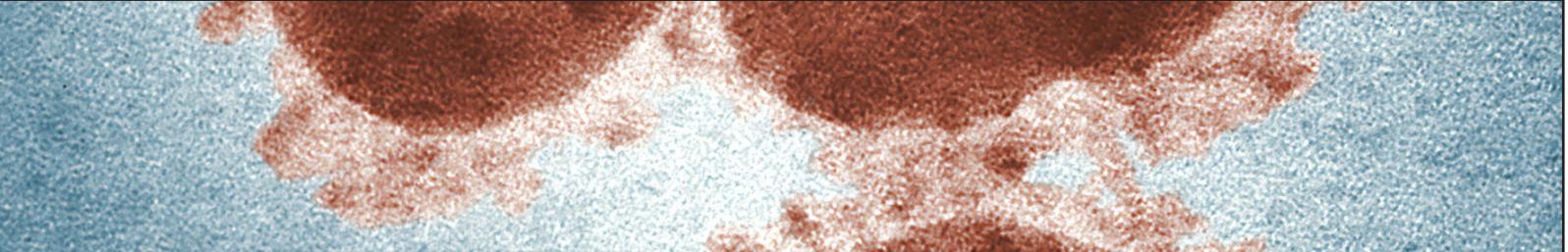
Awareness raising about World Bank directions and the details of COVID-response loans in general needs to be ongoing. This report makes some specific recommendations below about steps that the World Bank should take to improve its policies with respect to health care. However, we note that civil society will need to play an important role here. Advocacy groups could consider using the crisis to develop joint campaigns around the limitations of private health systems and financialised health care.



RECOMMENDATIONS

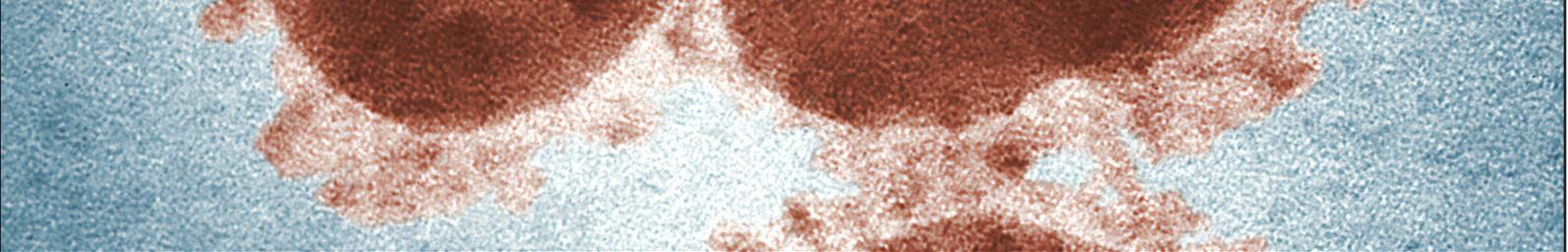
Health workforce unions and medical associations could be engaged to assist in monitoring. The World Bank needs to pay greater attention to ensuring its health sector support is both pro-poor and adjusted for the wide rural-urban divide in access to healthcare. To that end, this report makes the following recommendations:

1. First, this report calls for an end to IFC investment in for-profit health care.
2. Second, the World Bank should increase the assiduousness of its monitoring of the impact its programs have in health care systems. Specifically, it should implement greater monitoring to:
 - prevent loans from bailing-out for profit health care providers and insurers;
 - ensure that loan documentation specifies the most vulnerable groups and strategies for ensuring they receive equitable health treatment;
 - ensure that World Bank loans do not underwrite private sector profits in other sectors or get lost to corruption, as this will result in average citizens being left to pay back loans; and
 - increased monitoring of the convening power played by the World Bank Group in bringing private investors, insurers, and hospital groups to LMIC governments and regional fora to plug ‘investment gaps’.
3. Third, this report recommends a long-term evaluation of World Bank Group policy and engagement with governments respect to Public Private Partnerships in health, particular focus on conditionalities for health sector reforms that promote increased private provision of health services is needed.
4. Finally, the World Bank should support greater calls for debt cancellation – beyond the G20 DSSI initiative, which only postpones the problem. To this end, the Bank should support the establishment of an independent international debt work out mechanism and expand COVID-related grant support to IBRD countries.



ABBREVIATIONS

AIIB	Asian Infrastructure Investment Bank
GNI	Gross National Income
IBRD	International Bank for Reconstruction and Development
IEG	Independent Evaluation Group
IFC	International Finance Corporation
IsDB	Islamic Development Bank
LMICs	Low and middle income countries
MDB	Multilateral Development Bank
MFD	Maximising Finance for Development
ODA	Overseas Development Assistance
OECD	Organisation for Economic Cooperation and Development
PPPs	Public private partnerships
SDG	Sustainable Development Goals
PPE	Personal protective equipment
UHC	Universal health coverage



ENDNOTES

- 1 Northern donors here meaning members of the Organisation for Economic Cooperation and Development's (OECD), Development Cooperation Directorate.
- 2 During the annual World Bank and IMF meeting in October 2019, World Bank President David Malpass argued that the World Bank looks '[for private sector solutions to development challenges and direct World Bank programs to over-come obstacles in the private sector framework.](#)'
- 3 Kate Mackenzie, 'Climate Change Is a Complex Problem, but Complex Financial Products Aren't the Solution,' Bloomberg Wire Service, 7 May 2020.
- 4 All figures are in US dollars.
- 5 This greater level of grants and low interest loans seems positive on first sight but the sting in the tail is that most of the funds for the IDA come from profits on IBRD loans, so from the somewhat richer and more credit-worthy developing states, like India which still has 273 million people living below the national poverty line with at least 12 million expected to join them due to Covid-19. The number increases to over one billion using the still low \$5.50 a day poverty line.
- 6 See also Mark Hellowell, 2020. 'Covid-19 and the collapse of the private health sector,' 27 May <https://ghpu.sps.ed.ac.uk/covid-19-and-the-collapse-of-the-private-health-sector-a-threat-to-countries-re-sponse-efforts-and-the-future-of-health-systems-strengthening/>
- 7 There is an interesting parallel here to the bail out of banks during the Global Financial Crisis, if banks were too big or important to the economy to be left to fail, then this should be applicable to the private health system during this unprecedented crisis.
- 8 Rosser, A. (2010) Realising Free Health Care for the Poor in Indonesia: The Politics of Illegal Fees. *Journal of Contemporary Asia* 12(2): 255-275
- 9 Laurell, A. C., & Arellano, O. L. (2002). Market Commodities and Poor Relief: The World Bank Proposal for Health. In V. Navarro (Ed.), *The Political Economy of Social Inequities: Consequences for Health and Quality of Life*. New York: Baywood Publishing Company Inc, pp. 191-208, p.192.
- 10 Engel, S. (2010). *The World Bank and the Post-Washington Consensus in Vietnam and Indonesia: Inheritance of Loss*. London: Routledge.
- 11 Data source: <http://www.healthdata.org/>
- 12 The Country Partnership document also points out the damaging impact of energy subsidies on the Indonesian government's capacity to support other priorities. The central government was spending three times more of its budget on energy subsidies than was on health and infrastructure. President Widodo initially reduced fuel subsidies though increased them again before he faces re-election in 2019.
- 13 See Susan Engel and Anggun Susilo, 2014. Shaming and Sanitation in Indonesia – a return to colonial public health? *Development and Change* 45(1): 157-178.
- 14 Thanks to Ari S. Widodo Poespodihardjo from LSPR Jakarta for his insights here.
- 15 Samarakoon, S, Madurawela, S, Bandara, S 2015, Health Sector Reforms, Sri Lanka State of the Economy Report, accessed June 26 2020 <<https://www.ips.lk/wp-content/uploads/2018/07/Health-Sector-Reforms.pdf>>
- 16 See page 15 of the [Project Appraisal Document](#)
- 17 Objective 2.2 under Pillar 2 (Promoting Inclusion and Opportunities for All) correlates the improvement of health and social protection systems to demographic changes.
- 18 Ravindra P Rannan-Eliya, Nilmini Wijemanne, Isurujith K Liyanage, Shanti Dalpatadu, Sanil de Alwis, Sarasi Amarasinghe, Shivanthan Shanthikumar, Quality of inpatient care in public and private hospitals in Sri Lanka, *Health Policy and Planning*, Volume 30, Issue suppl 1, 1 March 2015, Pages i46–i58, <https://doi.org/10.1093/heapol/czu062>



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