

1 **A Call to Expand International Debt Relief for All Developing Countries to Increase Access to**
2 **Public Resources for Health Care**

3
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6
7 **Abstract**

8 The COVID-19 pandemic has underscored how preexisting international debt has weakened health
9 systems across the Global South. The pandemic is also contributing to further indebtedness in ways that
10 threaten the ability of countries to prepare for future pandemics and achieve universal health coverage.
11 Dozens of countries are in debt crisis, and 64 countries spend many times more on external debt payments
12 than on public health or health systems. This policy statement proposes interventions advocating for debt
13 relief by urging the International Monetary Fund, the World Bank, and the G20 to eliminate debt for the
14 poorest countries and expand fiscal space for public financing of health services and public health
15 programs.

16
17 **Relationship to Existing APHA Policy Statements**

18 Two existing APHA policy statements are relevant to this submission, as follows.

- 19 • APHA Policy Statement 20053: Expenditure Ceilings Imposed on Poor Countries Must be Lifted
20 to Achieve the Millennium Development Goals
21 • APHA Policy Statement 200322: Supporting Increased U.S. Investments in Bilateral and
22 Multilateral Programs to Address the Epidemics of HIV/AIDS, Tuberculosis and Malaria

23
24 **Problem Statement**

25 The international COVID-19 pandemic has compounded an already severe international debt crisis in the
26 Global South. Growing indebtedness over many years, especially in low-income countries, has limited
27 public investment in basic social and health services, leading to weakened health systems and poorer
28 population health.[1–3] Debt has further constrained underfunded ministries of health, while the growing
29 burden of COVID-19 has overwhelmed understaffed and underresourced facilities. According to the
30 International Monetary Fund (IMF), “the COVID-19 pandemic is pushing debt levels to new heights. The
31 pandemic is adding to spending needs as countries seek to mitigate the health and economic effects of the
32 crisis, while revenues are falling due to lower growth and trade, together raising debt burdens.”[4]

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34 Global debt reached a record high of about 230% of global gross domestic product (GDP) in 2018, and
35 total emerging market developing economy debt reached an all-time high of almost 170% of GDP, an
36 increase of 54% since 2010.[4] According to the International Development Association (IDA), the
37 section of the World Bank Group that lends or provides grants to the world's 75 poorest countries (39 of
38 which are in Africa), 50% of IDA countries were at high risk of debt distress or already in debt distress as
39 of February 2020.[5]

40

41 Debt repayments to Western creditors divert scarce public resources away from health systems and other
42 vital public services, including education, social welfare programs, agricultural extension, transport, and
43 other sectors.[1] The IMF and the World Bank, together with the G7 and the G20, intergovernmental
44 groups that address major issues related to the global economy, have recognized that debt impedes public
45 fund allocations to support health systems during the pandemic. (The G7 is an intergovernmental group
46 that includes the United States, the United Kingdom, France, Germany, Italy, Canada, and Japan. The
47 G20 includes the 19 largest economies in the world along with the European Union.) Subsequently, the
48 IMF and G20 provided debt payment postponement with the Debt Service Suspension Initiative
49 (DSSI),[5] implemented from April 2020 through the end of 2021. As the DSSI acknowledged, high
50 levels of international debt are major global health concerns.

51

52 However, even while payments had been suspended the debt load continued to grow, and challenges will
53 intensify after the pandemic recedes, leaving many Global South nations in deepening crisis as they try to
54 recover and rebuild.[5] In 2020 alone, the 76 poorest nations paid more than \$18 billion in debt to other
55 governments, \$12.5 billion to financial institutions such as the International Monetary Fund, and \$10
56 billion to external private creditors, totaling \$40.6 billion.[6] The IMF often proposes debt restructuring
57 and “fiscal consolidation” programs (detailed below) to debt-distressed low- and middle-income countries
58 (LMICs), imposing harsh austerity measures on public budgets. Debt and the austerity programs deployed
59 to restructure it are hypothesized to harm health through three pathways.[2] First, debt restructuring
60 programs impose “conditionalities” requiring major constraints on public financing for public services,
61 including health systems (often resulting in privatization of public services); second, a key element of
62 stabilization requires currency devaluation that increases prices for health commodities and medicines;
63 and, finally, debt-related austerity harms health through a range of social determinants of health as public
64 funding for services in education, agriculture, transport, and social welfare is constrained.[2]

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66 In 2015 the United Nations launched the Sustainable Development Goals (SDGs), as a follow-on to the
67 Millennium Development Goals set out in 2000, to measure development progress toward a range of
68 targets by 2030, including “universal health coverage” (UHC).[7] As the World Health Organization
69 (WHO) defines it, “UHC includes the full spectrum of essential, quality health services, from health
70 promotion to prevention, treatment, rehabilitation, and palliative care across the life course.” The debt
71 crisis had already created major challenges to UHC progress and planning.[1] Deepened by the pandemic,
72 the debt crisis will provoke new rounds of austerity that analysts predict will block progress toward UHC
73 and undermine efforts to protect against future pandemics.[8]

74

75 Deferred payments under the DSSI are expected to be paid in full between 2022 and 2024. According to
76 European Network on Debt and Development calculations based on World Bank data, the 46 countries
77 currently participating in the DSSI will be required to pay back not only the \$5.3 billion of postponed
78 payments but also the \$71.54 billion of preexisting debt contracted.[9] Rather than rebuilding health
79 systems and their economies, debt-distressed nations will be faced with debt repayments and austerity. In
80 November 2020, the G20 also initiated the “The Common Framework for Debt Treatments” to extend
81 beyond the DSSI.[10] This framework is an agreement among the G20 and Paris Club countries to
82 cooperate on debt relief for as many as 73 countries that are eligible for the DSSI on a case-by-case basis.
83 Importantly, it includes not only members of the Paris Club but also G20 official bilateral creditors such
84 as China, India, Turkey, and Saudi Arabia.

85

86 Debt and public financing: The debt crisis in the Global South has a 40-year history dating back to the
87 late 1970s, when international sovereign debt soared in response to the global economic downturn of that
88 period.[2,11] International Financial Institutions (IFIs), primarily the IMF and the World Bank, developed
89 the “Enhanced Structural Adjustment Facility,” which provided the foundation for “structural adjustment
90 programs” (SAPs) for indebted countries to restructure their loans. SAPs normally consisted of
91 concessionary loans combined with conditionalities that typically included government deregulation,
92 economic liberalization, and privatization with reduced public spending and a limited role of the
93 state.[1,2]

94

95 The IMF provides short- and medium-term loans to member countries to design policy programs that aid
96 in balancing payment problems.[4] By reducing government budgets to repay debt and, in principle, to
97 reduce the threat of inflation, SAPs often diminished the so-called “fiscal space” for public financing of
98 health services as well as public education and other sectors. The IMF defines fiscal space as “room in a

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99 government's budget that allows it to provide resources for a desired purpose without jeopardizing the
100 sustainability of its financial position or the stability of the economy. The idea is that fiscal space must
101 exist or be created if extra resources are to be made available for worthwhile government spending.”[12]

102

103 Over ensuing decades, SAPs were roundly criticized for their harm to health systems and other public
104 services as well as their role in limiting economic growth and exacerbating social inequality, especially in
105 sub-Saharan Africa.[3,11,13–15] In part because of growing criticism, the IMF and World Bank have
106 evolved over the past few decades in their approaches to debt relief. The IFIs created the “Heavily
107 Indebted Poor Countries” (HIPC) initiative in 1996, which designated 36 countries as so deeply in debt
108 that special policy support was needed.[16] SAPs were then replaced with the “Poverty Reduction
109 Growth Facility,” operationalized through poverty reduction strategy papers (PRSPs) for HIPC countries
110 in the late 1990s up to the present. Key national strategy development processes were modified and made
111 more inclusive, in principle, of local actors, agencies, and civil society. However, PRSPs have continued
112 to include austerity measures similar to those established under structural adjustment and limited fiscal
113 space for public financing of all sectors (including health) in HIPC countries.[17] Before the COVID-19
114 pandemic, many HIPC countries were already weak from continued debt-related underinvestment and
115 were not prepared for the arrival of COVID-19. Debt had accumulated to crisis levels in many middle-
116 income countries as well, impeding their response to the pandemic and recovery.[4]

117

118 Some observers argue that government corruption and mismanagement is widespread and both a cause of
119 high debt levels in many countries and a major barrier to ensuring that debt relief will result in increased
120 public spending to support health and other social services.[18–20] SAPs are therefore ostensibly
121 designed to mitigate corruption and monitor or restrict use of public resources. However, SAP critics
122 contend that some conditionalities, including privatization of state resources, public sector retrenchment,
123 and deregulation, can actually produce more corruption.[21] Either way, careful monitoring of potential
124 government corruption and use of freed-up funds for public financing can be included in debt relief
125 packages.

126

127 International sovereign public debt comes from a variety of sources. Since 1980, most debt in LMICs has
128 originated as loans from multilateral lending agencies such as the World Bank and IMF, as well as
129 regional development banks (the African Development Bank, the Asian Development Bank, the European
130 Bank for Reconstruction and Development, and the Inter-American Development Bank), and bilateral
131 (government-to-government) loans.[4] The IMF often collaborates with the Paris Club, which consists of

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132 22 countries primarily from Europe in coordinating foreign aid from member countries. The G20 has
133 regularly addressed the global debt crisis and helped organize debt relief (as described below). China has
134 also emerged in recent years as a major creditor for the Global South.[22] Debt “relief” can come in the
135 form of debt cancellation (forgiveness), payment moratoriums (delayed or suspended payment), grants to
136 pay off loan balances, or concessionary (low-interest) loans to pay back higher interest debt.[4,5] Debt
137 has also been growing from private commercial creditors, including bonds either publicly issued or
138 privately placed; commercial bank loans from private banks and other private financial institutions;
139 private credits from manufacturers, exporters, and other suppliers of goods; and bank credits.[8] Private
140 creditors rarely provide debt relief, creating new challenges for debt restructuring in the deepening
141 international debt crisis. However, low-income countries still pay on average only about 16% of debt
142 service to the private sector, while 84% goes to bilateral and multilateral repayments.[8] While private
143 debt is a growing burden, major restructuring or cancellation of multilateral and bilateral debt can still
144 have a substantial impact on fiscal space for health and social services, especially in low-income
145 countries. However, debt cancellation is not without risk. The cost of debt cancellation to multilateral
146 lenders in some instances could imperil the availability of concessionary loans and undermine the
147 confidence of creditors whose funds are vital for long-term development in LMICs.[16]

148
149 Debt, austerity, and population health: Increased levels of debt, and the conditionalities imposed to
150 restructure that debt, often require governments to restrict public expenditures on health services and
151 sometimes replace public resources with private financing, including aid.[1] Sharp reductions in public
152 health spending patterns can undermine the volume and quality of services provided (e.g., number of
153 health facilities).[23,24] WHO has recommended that countries spend a minimum of \$86 per capita per
154 year on health services[25] to achieve UHC and a minimum of 5% to 6% of GDP. Most low-income and
155 HIPC countries spend only between \$20 and \$40 per capita.[26] In 2018, before the pandemic, 46
156 countries were spending more resources as a share of GDP on public debt service than on their health care
157 systems.[9] Low-income countries spent on average 7.8% of GDP on public debt service and 1.8% on
158 public health services. In the case of the 25% of countries with the highest debt service to revenue ratios,
159 debt service increases to 68.9% of public revenues, while health care expenditures decrease to 1.8% of
160 GDP.[9] WHO estimates that meeting SDG 3 will require countries with poor health care systems to
161 spend at least 8.6% of GDP on health care by 2030. Several years away from that goal, 59 LICs are
162 currently spending less than half of this amount. No country that spends more resources on public debt
163 service than on health care meets this basic expenditure threshold for SDG 3.[27]

164

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165 Even in countries where debt vulnerabilities are considered financially under control and sustainable, debt
166 service is still prioritized over other key areas of public expenditure. In 2019, Angola spent 6.4% of
167 government revenue on health services but 42.6% on external debt services; Sri Lanka spent 13% on
168 health and 47.6% on debt repayment.[6] By 2020, 64 countries spent far more of government revenue on
169 external debt repayments than on the health sector.[6] The IMF acknowledges this in promoting the
170 emergency DSSI, meant to help countries redirect funds away from debt repayment to public financing to
171 tackle the crisis. WHO recognizes that increases in public spending are essential for UHC and
172 recommends that countries allocate at least an additional 1% of GDP for public spending on primary
173 health care.[27]

174
175 Lower public investment in health systems constrains the size and strength of the health workforce. Debt-
176 related austerity programs limit the workforce through hiring freezes, wage cuts, and mandated
177 government “wage bill ceilings.”[1,2,23,24] In some instances, this contributes to “brain drain” from
178 public sector systems, as frontline health care workers seek higher-paying positions abroad or locally with
179 nongovernmental organizations (NGOs) or other agencies.[23,28,29] The IMF has argued that it no
180 longer imposes such ceilings as loan conditionalities, but wage bill limits have still been incorporated into
181 many recent IMF programs.[15] While explicit wage ceilings may be less common now, the reduction in
182 fiscal space caused by severe indebtedness and austerity budgets leads to workforce reductions or hiring
183 caps that are still de facto results of fiscal consolidation. Kenya and Ecuador have debt agreements with
184 wage bill ceilings.[1,8]

185
186 As a result, according to WHO criteria, the Global South suffers major health workforce shortages.[30,31]
187 To meet the health workforce requirements of the SDGs and UHC targets, more than 18 million
188 additional health workers are needed by 2030. WHO has set a minimum standard of one physician per
189 1,000 population to support UHC, as defined in the SDGs, and 4.5 per 1,000 for all skilled health workers
190 (physicians, nurses, and midwives combined).[32] Most LMICs fall far below this minimum standard,
191 and the African region is the hardest hit among WHO regions, with only 0.3 physicians per 1,000
192 population. In 2018, physician ratios per 1,000 population were only 0.084 in Mozambique, 0.038 in
193 Liberia, 0.014 in Tanzania, 0.093 in Zambia, and 0.036 in Malawi. Beyond Africa, physician ratios per
194 1,000 population are only 0.234 in Haiti, 0.309 in Honduras, 0.355 in Guatemala, and 0.373 in the Lao
195 People’s Democratic Government.[33]

196

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197 Debt-related constraints on public investment in health systems have limited health service access more
198 broadly.[1,34] Significantly greater public investment in infrastructure is required for UHC.[35] Data
199 from 2006 (the most recent data available) indicate that, in HIPC countries, the average number of
200 hospital beds per 1,000 people was just 0.75. By contrast, there were 4.6 beds per 1,000 in the European
201 Union and 2.8 in the United States.[33] Other sources report even more extreme deficits among LMICs
202 during the pandemic.[36] Most LMICs are far from reaching even the minimal standards of access
203 identified in the SDGs. In part because of a lack of facilities, only 12% to 27% of the populations in low-
204 income countries are covered by essential services (according to the UHC definition).[27]
205

206 Debt-related structural adjustments and PRSP programs have also introduced user fees and copayments
207 for public sector health services in many countries to support new revenue and cost recovery after debt-
208 related budget cuts.[15,37] User fees have now been linked to reduced access among the poor, high
209 administration costs, and bureaucratic inefficiencies.[38] Debt and austerity have contributed to increases
210 in individual and household out-of-pocket health care expenditures. The World Bank has warned that out-
211 of-pocket fees have reduced access and contributed to increased poverty: “The incidence of catastrophic
212 health expenditure (SDG indicator 3.8.2), defined as large out-of-pocket spending in relation to household
213 consumption or income, increased continuously between 2000 and 2015.”[27] One major review of user
214 fee studies showed growing evidence of households in LMICs pushed into poverty when faced with
215 substantial medical expenses.[37] A consensus has emerged that user fees in LMICs are an important
216 barrier to accessing health services for individuals and families, especially those seeking already difficult-
217 to-access care for more challenging health conditions. For individuals, fees often undermine adherence to
218 long-term expensive treatments. Fees may encourage inappropriate self-treatment or become a barrier to
219 early use of health facilities.[39] Even a small fee can contribute to the impoverishment of poor
220 households that may need to sell key assets, cut down on other necessary expenditures, or borrow. User
221 fees often contribute to growing household debt among those who use the health system and prevent
222 others from using services at all.[40] In addition, fees add to the other immense barriers, such as distance
223 and abusive treatment by health care providers, that poor people face when seeking health care.[39]
224

225 Official user fees have been critical in some cases to health systems that are underfunded because of debt
226 and austerity. Gilson and McIntyre have warned that removal or modification of user fees must be done as
227 part of more comprehensive reform to ensure that new sources of revenue replace lost fees and that
228 unofficial under-the-table payments demanded by underpaid health workers do not replace legal
229 fees.[39,40] Debt relief can provide increased public financing to support removal of fees.

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230

231 As debt has undermined health system strengthening and expansion in many countries, debt and austerity
232 have similarly reduced public financing for education, agricultural extension services, transport, housing,
233 social welfare, and food security.[2,41] These policies affect population health through their impact on
234 the social determinants of health, that is, the constellation of social and economic conditions that
235 influence population health through a range of pathways.[2] As a result of these constraints on public
236 sector health systems, nonstate actors, including international organizations and NGOs, have been
237 recruited by foreign aid donors to offer health and other social services to vulnerable groups to fill the
238 gaps left by retreating state services. NGOs often bypass governments in planning and coordination. They
239 have been linked to coordination problems, limited range and quality of services, and fragmented service
240 delivery.[11,15,42]

241

242 Debt and pandemics: Debt-ridden countries with underresourced health systems were underprepared for
243 the COVID-19 pandemic, as they will be for future pandemics unless action is taken for debt relief. Most
244 LMIC health systems lacked strong surveillance systems, health workforce personal protective equipment
245 (PPE), testing and contact tracing capacity, hospital bed capacity, and community education resources to
246 mobilize against the arrival of COVID-19.[36] Nearly 2 years into the pandemic, many health systems in
247 Africa were still without these basic services and capacities.[43,44]

248

249 The 2014 Ebola epidemic in West Africa also underscored how debt and austerity, imposed by IMF SAPs
250 and PRSPs, undermined the capacity of health systems to respond to a major infectious disease outbreak.
251 The rapid spread of Ebola in West Africa in 2014 can in part be attributed to the weak health systems in
252 the three countries most affected.[45,46] Guinea, Liberia, and Sierra Leone, the main hosts of the
253 epidemic, had implemented IMF structural adjustment programs in the years leading up to the crisis.
254 Guinea and Sierra Leone informed the IMF that low public investment in health systems was due to
255 decades of austerity-imposed reductions in spending and retrenchment of the health workforce.[15] While
256 IMF relief was forthcoming after the Ebola epidemic began, critics argued that public investment in
257 national health systems well before the outbreak could have both mitigated the crisis and been more cost
258 effective than emergency aid.[15] Strong health systems can provide trained and equipped health workers
259 for testing and contact tracing immediately and can offer immediate treatment. Proactive community
260 engagement and education can be rapidly launched.[43,44]

261

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262 Although the DSSI, which temporarily paused loan repayments, provided vital short-term relief, the
263 challenges ahead for HIPC countries are daunting; the IMF and the World Bank have recognized that
264 many of these countries will require substantial debt restructuring for sustainable economic
265 development.[47] In the wake of the COVID pandemic, it is anticipated that debt levels will increase
266 substantially for all country income groups and especially for HIPC countries, which risk widespread
267 sovereign debt distress and defaults.[9] The newly worsened debt crisis among LMICs will undermine
268 effective global mobilization against future outbreaks and pandemics.[48,49]

269 The COVID pandemic is just one recent example of the many shocks that can affect vulnerable LMICs
270 with high debt loads. Global economic downturns, war and conflict, climate change, and other natural
271 disasters present major challenges for debt-ridden countries with underresourced health
272 systems.[16,50,51] Long-term debt relief is essential to building resilience in health systems to endure
273 myriad shocks.

274

275 Evidence-Based Strategies to Address the Problem

276 Over the last 40 years of Global South debt crises, IFIs have deployed a range of debt relief strategies that
277 provide evidence-based lessons learned. The proposed action steps borrow from these strategies.

278 Creditors include bilaterals such as wealthier Global North countries (i.e., members of the G20 and Paris
279 Club) and multilateral agencies (e.g., the World Bank, the IMF, and multilateral regional development
280 banks) that prioritize development goals through low- or no-interest loans or grants.[52] The institutional
281 actors involved in these strategies tend to be convened by the IMF and World Bank and can include the
282 G20, the Paris Club, and regional development banks in efforts to reduce debt burdens.[16] While the
283 IMF and World Bank are creditors and can provide debt relief for loans they have made, they also can
284 provide technical support to develop and monitor debt relief strategies for other creditors to join.[4] Few
285 strategies have successfully engaged private creditors.

286

287 Structural adjustment programs: As described in detail above, in 1980 the IMF and the World Bank
288 developed SAPs for indebted countries to reduce overall debt burdens.[3] SAPs consisted of
289 concessionary loans from the IMF and World Bank combined with conditionalities that typically included
290 government deregulation, economic liberalization, and privatization of the economy with reduced public
291 spending.[1–3,10] The SAP-led economic restructuring was intended to spur economic growth, which in
292 principle would eventually help reduce debt and provide a greater base for public spending.[16]

293

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294 As noted, however, over the ensuing decades SAPs were criticized for their stringent conditionality
295 constraints on public spending for public services, while their economic reform and privatization
296 conditionalities exacerbated social inequality and other social determinants of health, especially in sub-
297 Saharan Africa.[3,11,13,14,53] While SAP defenders pointed to increased economic growth and
298 increased public spending in some countries into the 1990s,[54,55] critics argued that the debt crisis
299 continued or worsened in some cases and that public spending for services declined or remained
300 anemic.[1–3] SAPs provide one evidence-based model for debt relief, but conditionalities often
301 excessively capped increases in public spending.[1–3]

302
303 Debt relief for HIPC and PRSPs: The HIPC initiative described in detail above provides another
304 evidence base for debt relief and public spending.[16] As discussed earlier, SAPs were replaced with
305 PRSPs for HIPC countries in the late 1990s up to the present.[17] The IMF has identified 39 countries
306 that qualify for HIPC status, which has led to immediate debt relief plans and measures by the IMF such
307 as additional concessionary loans and debt forgiveness (i.e., cancellation of debt) in some cases.[16] In
308 2005, the HIPC initiative was supplemented by the Multilateral Debt Relief Initiative, which allows for
309 100% cancellation of eligible IMF, World Bank, and African Development Fund debts for countries
310 completing the HIPC initiative process, including a PRSP.[16] PRSPs have continued to include austerity
311 measures similar to those implemented under structural adjustment and have limited the fiscal space for
312 public financing for HIPC countries.[15,17] There is mixed evidence on the impact of PRSPs and HIPC
313 programs on public and health system spending.[55] The IMF claims that in most HIPC countries public
314 spending, including health services, has increased.[56] Some studies suggest that certain low-income
315 countries show modest increases in health spending, but higher-income countries show no significant
316 change.[3,15] The total cost of providing assistance to the 39 countries that have been found eligible is
317 estimated to be about \$76 billion in end of 2017 net present value terms. The IMF's share of the cost is
318 financed by bilateral contributions and IMF resources, mainly investment income on the proceeds from
319 off-market gold sales in 1999 deposited to the IMF's PRG-HIPC Trust.[16]

320
321 The CCRT and debt cancellation for countries most affected by Ebola: The IMF created the Catastrophe
322 Containment and Relief Trust (CCRT) in 2015 to fund debt relief through donations from member
323 countries. The \$100 million debt cancellation, along with some new concessionary lending, allowed the
324 three most affected countries to channel major additional resources into health system strengthening and
325 Ebola mitigation.[57,58] This effort focused on a critical health emergency and may not provide an exact

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326 model for long-term nonemergency system building, but it does show that debt cancellation can have a
327 direct impact on public financing of health services if managed carefully.[58]

328

329 In March 2020, the IMF adopted a set of reforms to the CCRT to enable the fund to provide immediate
330 debt service relief for its poorest and most vulnerable members affected by the COVID-19 pandemic and
331 any future pandemics.[59] A total of 31 CCRT-eligible countries with eligible debt service to the fund
332 received \$930 million in debt relief and grants for a 2-year period from April 2020 to April 2022.[60]

333

334 In August 2021, the IMF also allocated “special drawing rights” (SDRs) equivalent to \$650 billion to
335 support pandemic relief efforts, which was the largest such expansion of the asset in the organization’s
336 nearly 80-year history.[61] SDRs were created in the 1960s and are essentially a line of credit that can be
337 cashed in for hard currency by IMF member countries. They are intended to help countries bolster their
338 reserves and create fiscal space for public spending.[62] When the IMF allocates SDRs to its member
339 countries, these countries can exchange those reserve assets for hard currency (e.g., U.S. dollar, euro, yen,
340 pound, or renminbi). This currency can be used for various purposes, including finance of cross-border
341 payments or spending on imports, and does not add to debt burden. This allows countries to import
342 vaccines, personal protective equipment, and other necessities; they can use the money to support
343 domestic spending and cover debt obligations.[63] Data show that sub-Saharan Africa is the region that
344 has most benefited from the use of SDRs, with 41 of 45 countries using SDRs in some way for debt
345 reduction and health services. In addition, countries have used SDRs for procurement of vaccines and
346 other pandemic relief; for ration cards, welfare payments, and wages; and for budget support. Fifty-five
347 countries have used SDRs for IMF debt relief totaling about \$7.6 billion. The new SDRs were a lifeline
348 for 23 of these countries, which otherwise would not have had enough resources in their holdings to pay
349 the IMF.[63]

350

351 The DSSI and debt payment suspension through the COVID-19 pandemic: The DSSI initiated in May
352 2020 (as described above) through 2021 for debt distressed countries[5] provides another debt relief
353 strategy example that has led to greater public spending. Forty-eight of 73 countries participated, and by
354 December 2021 the initiative had suspended \$12.9 billion in debt service payments to their creditors,
355 which included multilateral and bilateral lenders.[5] The World Bank and IMF supported the DSSI by
356 monitoring spending, enhancing public debt transparency, and ensuring prudent borrowing. “Accordingly,
357 a requirement to participate in the initiative was that the beneficiary country commits to use these
358 resources to safeguard social, health or economic spending in response to the crisis.”[5] The debt service

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359 has resulted in significant increases in public spending for health services. Debt payments were
360 postponed, but the debt remains and payments must resume. (The Common Framework is currently being
361 implemented by the G20 and Paris Club as a follow-on effort, but to date only four countries have
362 initiated the process.[22])

363
364 The DSSI, CCRT, and SDRs have helped relieve debt burdens for many debt-distressed countries in
365 sustaining financing health and other public services through the pandemic.[63] The action steps proposed
366 below draw from these strategies and call for more extensive cancellation and relief. It is unlikely that the
367 major debt relief proposed here will have a negative impact on donor country economies, including the
368 United States.[64] IMF members contribute to IMF resources through a quota system, and contribution
369 levels are unlikely to be greatly affected by the debt relief under way and proposed.[60,65] Additional
370 financing can be secured through the SDRs and gold sales to help finance relief and reduce demands on
371 donor countries.[61,66,67]

372
373 Opposing Arguments/Evidence

374 There are arguments both against debt relief/cancellation and against using the resources saved for
375 significant increases in public spending for health and social services in low-income countries. These
376 arguments center on several key and related concerns, as follows.[20,56,68]

377
378 Debt relief can imperil creditor confidence and jeopardize future credit: Following strict payment
379 schedules is considered important to attract future investments and future credit. Unless debt is
380 restructured in a way that promotes investor and creditor confidence, debt relief could lead to less access
381 to capital and credit in the future.[4] Some observers also cite “moral hazards” as a key risk. Debt relief
382 may encourage borrowers to recklessly take on an excessive amount of new loans expecting that they will
383 also be forgiven.[20] The IMF has argued that total or near total debt cancellation would entail such large
384 losses and write-offs among multilateral (IMF, World Bank, and regional development banks) and
385 bilateral creditors that it would cripple future lending and credit.[68] This would not only undermine
386 sustained public investment in health but impede economic growth.

387
388 Counterargument: For those countries in debt distress (both low- and middle-income countries), investor
389 and creditor confidence is already undermined, and debt relief is required to stabilize their economies and
390 redirect spending back toward domestic investment in health, education, and infrastructure to restore
391 confidence.[15] The debt relief principles proposed in this resolution do not call for 100% debt

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392 cancellation but, rather, targeted cancellation for countries at highest risk of debt distress accompanied by
393 other measures for other LMIC debtor nations. The activation of SDRs added substantial resources for
394 multilateral creditors for debt relief, mitigating concerns about exhausting resources from lenders.[61]
395 Debt relief programs can include monitoring of new debt obligations to prevent reckless borrowing.[69]

396

397 Inflation and economic growth: Because SAPs and PRSPs have often been implemented in part to control
398 inflation, proponents argue that debt relief should include conditionalities that cut or severely constrain
399 public spending to reduce demand that contributes to inflation. Severe constraints on public spending are
400 required to hit very low inflation targets and stabilize local economies in order to attract investment, spur
401 economic growth, and instill confidence among creditors.[70–72] The resulting economic growth will
402 eventually lead to greater tax revenue for public investment.

403

404 Counterargument: SAPs that have provided debt relief but then included conditionalities to cut or
405 constrain public spending and privatize many public services have sometimes led to continued recession
406 rather than economic growth.[1,8,15] Where economic growth was achieved, it often did not benefit the
407 poor majority because of deepening social inequality and concentration of wealth among elites benefitting
408 from the privatization, while this growing wealth could not be redistributed through more generous public
409 spending.[1,2,15] Although the IMF HIPC program and PRSPs recognized these shortcomings and
410 sought to allow modest increases in public spending in debt relief packages, low spending caps have
411 remained, undermining investment in health systems.[41] Debt relief must be accompanied by rejection
412 of austerity and support for increases in public spending on health, education, and social
413 services.[1,15,24]

414

415 Government corruption and misuse of resources from creditors: Some argue that, in many cases,
416 indebtedness in the Global South is a result of government mismanagement of public funding or even
417 corrupt diversion of government resources.[56,73] Providing debt relief without addressing government
418 mismanagement or corrupt use of public resources will not only reward bad behavior but also imperil
419 future access to credit. There is also no guarantee that the resources saved through debt relief will be used
420 for public investment in social services such as health and education, and these savings could be diverted
421 to the military, vanity projects, or corruption.[20,56,73]

422

423 Counterargument: While government corruption leading to illegitimate “onerous” debt is not uncommon
424 across the world, the major debt crisis waves in the Global South over the last 40 years have been created

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425 by external shocks, including global recessions, natural disasters, and most recently the COVID
426 pandemic.[56] Most debt distress has been created by circumstances beyond local control, and nations
427 require relief to recover from such shocks. Debt relief and public spending are crucial to regain creditor
428 confidence, and responsible social sector spending is key to economic growth and recovery.[72]
429 Requirements can be monitored through debt relief agreements to ensure that funding saved is spent on
430 public services. The DSSI, CCRT, and, to some extent, HIPC initiatives have shown that this can be
431 accomplished. Debt relief through debt cancellation in some cases and concessional lending in others,
432 coupled with redirection of those saved resources to public spending on health services and other social
433 sectors, is vital to improving public health and reducing health disparities.[69]

434

435 Action Steps

436 A global movement of civil society organizations is driven by a moral imperative to mobilize for debt
437 relief. This growing movement includes voices from the Global South, faith-based organizations (such as
438 Jubilee USA and the UK Jubilee Debt Campaign), international NGOs (such as Oxfam and Doctors
439 without Borders, among many others), and other advocacy groups.[6,74,75] In support of demands
440 articulated by the global movement to expand debt relief,[74] APHA calls on the United States Congress
441 and U.S. president to advocate for the following actions to be taken by the World Bank, the International
442 Monetary Fund (and its members and executive directors), the G20, the Paris Club, and regional
443 development banks to reduce global health disparities and better prepare for future pandemics and other
444 shocks:

- 445 1. Cancel debt among those countries in greatest debt distress (the DSSI countries identified as
446 at high risk of or in debt distress[22]) and expand debt relief for all indebted LMICs through
447 the Catastrophe Containment and Relief Trust, the Common Framework, and other expanded
448 processes.
- 449 2. Mobilize additional grant and financing resources through supporting regional development
450 banks (multilateral regional financial institutions chartered by two or more countries for the
451 purpose of encouraging economic development in poorer nations), drawing on emergency
452 reserve funds, and supplementing standard reserve currencies in indebted countries through
453 special drawing rights (to augment international liquidity).
- 454 3. Enhance debt restructuring by issuing debt payment moratoriums (legally authorized
455 postponements of payment).

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456 4. Ensure that debt relief plans reject imposition of austerity programs and integrate
457 mechanisms for substantially increased public spending on health systems and other critical
458 public services.

459

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