THE MULTILATERAL DEVELOPMENT BANKS, COVID-19 AND HEALTH PRIVATISATION IN INDIA
By Associate Professor Susan Engel, University of Wollongong, email: sengel@uow.edu.au

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Cover illustration: MUMBAI/INDIA- JUNE 17, 2020: Health workers wearing protective gear monitor body temperature of people at the COVID health check up camp at Ramabai colony slum during the COVID-19 Coronavirus pandemic. [manoejp7/Depositphotos.com]

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EXECUTIVE SUMMARY

As former Special Rapporteur on extreme poverty and human rights, Philip Alston (2018, 2) so powerfully points out, privatisation “often involves the systematic elimination of human rights protections and further marginalization of the interests of low-income earners and those living in poverty.” He continues that the emaciated public sector now operates:

*alongside a private sector dedicated to profiting from running key parts of the criminal justice system and prisons, determining educational priorities and approaches, deciding who will receive health interventions and social protection, and choosing what infrastructure will be built, where and for whom* (Alston 2018, 4).

Later in the report, Alston outlines how flawed the arguments for privatisation are, and highlights the strong empirical evidence of failures in sectors from education to electricity. Some of the most damaging evidence comes from a UK National Audit Office (2018) report on their experience of the impact of private finance in providing public infrastructure, including schools and hospitals. The Audit Office found that the private programs were both less efficient and more expensive than public provision. In healthcare, despite attempts by neoliberal international organisations like the International Monetary Fund (IMF) and World Bank to promote the privatisation of healthcare, it is clear the most efficient and effective systems for providing society-wide, adequate care are public ones (for a review see Lister 2013). COVID-19 also demonstrates this point clearly: the countries in the Global South doing the best are those with strong, universal public systems like Vietnam and Sri Lanka.

India with its poorly coordinated, mostly private health system, with little cover for most citizens, has a very poor response to the pandemic, though there are significant differences between the states. As Shukla (2021) argues, these reflect differences in the states’ public health systems. For example, the state of Kerala invests quite strongly in its public health system, Maharashtra with a large private health care sector, less so. To mid-July 2021, the fatality rate for Kerala from COVID-19 was 0.48%, while that for Maharashtra was 2.04%, four times higher. As Shukla (2021) says the COVID-19 evidence is clear: “a neglect of public health systems can mean large-scale, avoidable losses of lives; hence public health services must be upgraded rapidly and massively as a topmost priority.” Equally, the pandemic demonstrates the problems of private health care with many unregulated private health providers not admitting COVID-19 patients, or not poor ones. Where they do, there are copious reports of poor standards of care and price gouging, despite some attempt to regulate prices.
This paper demonstrates the World Bank and other multilateral development banks play key roles in the creation of India's private healthcare system, providing ideological and financial support for its growth and development. The World Bank and other multilateral development banks (MDBs) also provide countries in the Global South with finance in response to the pandemic. It is important to evaluate the MDBs' health lending in response to COVID-19, focusing in particular on the extent to which they are using the crisis as an opportunity to further their privatisation agenda, as Dimakou et al. (2020) argues has been the case in general.

This paper demonstrates that the mindset of MDBs is so shaped by neoliberal ideas that, even during a pandemic clearly demonstrating the failures of this approach in healthcare, they continue to espouse them. In some ways this is not surprising, as during crises humans tend more than usual to use existing ideas, frameworks and tropes to shape action. The health loans to India in response to the pandemic appear at first as though they will be largely supporting the public sector. However, as one reads the details, it becomes clearer that much of the surge funding will prop-up (struggling) private hospitals. This simply reflects the fact that two-thirds of hospital beds in the nation overall and four fifths of doctors are in the private sector (Paliwal 2020, Jaffrelot 2020). Further, there are elements in these loans promoting further privatisation of healthcare, in particular, strong action from the World Bank's private sector arm, the International Finance Corporation (IFC), to finance private health actors.

By largely supporting the existing healthcare system, the large loans from the MDBs do not address the large inequalities in access to healthcare between: urban and rural dwellers; states with a relatively high number of hospital beds versus those with much fewer; and men and women. There is also very little attention given to care for India's Schedules Castes and Scheduled Tribes (SC/ST) who suffered from lack of access to healthcare pre-pandemic. In other words, these healthcare loans do not provide anywhere near enough support for many of the most vulnerable in India. Finally, there is little support in the loans for India's vulnerable health workforce, in particular female community health workers (called ASHAs in India) who are at the forefront of the COVID-19 response and suffer disproportionately as a result.

Times of crisis are important opportunities to review the strengths and weaknesses of existing structures and services, to identify whose needs are not being met, and to make changes to ensure they are. Our recommendations call on the MDBs to focus their support on developing inclusive public health care systems that meet the needs of vulnerable communities and protect the public health workforce. During the pandemic, at minimum, they should focus on dramatically expanding protection against catastrophic out-of-pocket health expenses, accounting for around 60% of total health are expenditure in the country pre-pandemic. Such protection should not only be afforded to the extremely poor, because health expenditures are a key reason that relatively poor people and even non-poor ones, fall into extreme poverty. The recommendations also highlight the need for greater support for the health workforce, in particular ASHAs. In terms of recommendations with a global reach, we call on the IFC not to bail out private health and microfinance institutions during the pandemic and for the international community to provide additional concessional resources to help the Global South bolster their public health services to deal with the ongoing pandemic.
INTRODUCTION

As their name implies, multilateral development banks (MDBs), are banks set up by groups of states who aim to promote development. The first MDB, established in 1944, is the International Bank for Reconstruction and Development (IBRD), or World Bank as it quickly became known. There are now 30 functional MDBs (Bazbauers and Engel 2021), all set up along the same lines as the World Bank. Member states contribute capital and creditworthiness, and this allows the MDBs to lend from their capital base and/or issue bonds on capital markets. The funds they raise are then on-lent to borrowing states at a small premium. MDBs have been key sources of finance for the Global South since their establishment but they also influence policy through their work in technical assistance and training.

The COVID-19 pandemic has led to vast economic interruptions in the Global South compounded by declining investment, remittances and tourism dollars in the Global South (Engel et al. 2020). Low and middle-income countries have very limited fiscal space to respond to the crisis: “[a]dvanced economies are expected to have taken fiscal support spending to 22.6 per cent of their GDP on average, but the comparable figures are only 6.2 per cent for emerging market and developing economies and 2.4 per cent for the low income countries” (Institute for New Economic Thinking 2021, 9). The World Bank promised the South US $160 billion in finance by June 2021 with other MDBs promising a further $80 bn and $330-350 bn by June 2023." Thus, the MDBs have been, and will be, important sources of funds for countries in the South in the health and economic aspects of their response to COVID-19.

The MDBs, and the World Bank in particular, have been major lenders to India and strongly influence its health agenda. Since the 1980s, the World Bank has promoted the limiting of state expenditure on health, public-private partnerships (PPPs) and privatisation of health services. In India now, over 60% of hospital beds are in the private sector and the national government has very low expenditure on health care at around 1.2% of GDP. Countries with better performing systems spend more like 5-7% of GDP on health. The MDBs are providing very large loans to India's health sector in response to COVID-19. Thus, it is vital to explore the role of the MDBs in shaping the health care sector in India both pre- and post-pandemic.

1 All amounts are in US dollars unless specified otherwise.
This paper explores the extent to which MDBs have and are promoting a failed agenda of healthcare privatisation in India. India primarily borrows from four MDBs:

- **World Bank**: India is a founding member of the Bank and historically a large borrower from the IBRD and the Bank’s highly concessional lending arm, the International Development Association (IDA). The private sector lending arm, the International Finance Corporation (IFC) has also been very active in the country. The Bank now has five arms, which collectively are referred to as the World Bank Group (WBG), while the term World Bank is reserved for the IBRD and IDA.

- **Asian Development Bank (ADB)**: India is a founding member of the ADB established in 1966 but agreed not to take any loans from it initially so that it would not consume too much of the new MDB’s resources (Kapur et al. 1997, 1157). Its first loan was in 1986 and after that, India became a significant borrower mostly in the power, transport urban development sectors.

- **New Development Bank (NDB)**: set up by the BRICS - Brazil, Russia, India, China and South Africa – in 2015 due to lack of progress in reform of the WBG and its sister organisation the International Monetary Fund (IMF). The five founding states still have equal shareholdings.

- **Asian Infrastructure Investment Bank (AIIB)**: India is a founding member of this Chinese-led MDB set up in 2016.

The paper next briefly outlines the role of the World Bank in promoting the privatisation of health care in the Global South since the 1980s. Section three explores the evolution of India’s privatised health care system, including and the role of the World Bank and ADB. The fourth section briefly outlines key challenges for the healthcare system created by the pandemic in India. This is vital context for MDB lending, the subject of the fifth section. It analyses the healthcare lending of the WBG, ADB, NDB and AIIB to India for the health sector from the start of 2020 to the end of June 2021. Sections six and seven offer conclusions and recommendations.

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2 There is no single history of the WBG’s major role in India though both the Bank’s official histories have quite a bit on the relationship given that India has been one of the Bank’s largest borrowers (Mason and Asher 1973, Kapur et al. 1997). By 1971, the country accounted for almost half of IDA credits (Mason and Asher 1973) and at times, the IDA was colloquially referred to as the Indian Development Association. In the mid-2010s, India shifted from being a low-income country to a low-middle income one according to World Bank definitions. This mean it graduated from the IDA thus is now only eligible for IBRD, IFC and MIGA funding. The Country Partnership Framework for FY18-22, focused the WBG on growth, competitiveness and human capital by leveraging the private sector and using Bank leverage to achieve its priorities (World Bank Group 2018, 3).

3 India is a member of a number of MDBs that it does not borrow from including the African Development Bank, the West African Development Bank and the European Bank for Reconstruction and Development. It is not a member but has borrowed from the Nordic Investment Bank and the OPEC Fund for International Development.
The World Bank, established by ex-bankers, has an evolving investment agenda. Initially the search for bankable projects to promote (economic) development in the Third World led them to focus on infrastructure. As the Bank grew, its interests expanded to integrated rural development projects and then into the social sector under the presidency of Robert McNamara and his concept of basic needs. McNamara's interest in the broad area of health started with nutrition. In 1972 he had the Bank sponsor a donor consortium to eradicate river blindness in West Africa. In that year, projects in the agriculture, population and education sectors included health components. The Bank began funding stand-alone health projects in the 1980s, coinciding with the first wave of neoliberalism and its focus on rolling back state budgets and their provision of services and goods. Unsurprisingly, the Bank’s focus was on limiting public resources for healthcare to a bare minimum and encouraging the establishment of private providers. Later, it turned to the establishment of private insurance schemes to address healthcare, which is still the focus today. The Millennium and Sustainable Development Goals (SDGs) influenced the Bank to shift towards a slightly more progressive but ultimately misleading health agenda of universal health coverage (UHC). The World Bank supports its health agenda through training government officials, producing policy reports, conditionalities or policy actions attached to loans for governments and direct support for private provision through its private sector lending arm, the IFC.

A Health Department was established in 1979 along with the decision to fund stand-alone health projects.
The Bank developed its first health policy in 1985 but the 1993 World Development Report on Investing in Health is the clearest and most radical statement of its approach. The approach supports a two-tier health system. Publicly funded hospitals and primary health care providers in the Global South were to provide an extremely limited set of (albeit very essential) low-cost, high-return, mostly education-based activities. The private system could provide whatever the market would pay for (Lister 2013). This approach results in governments withdrawing from health, and the expansion of private providers and out of pocket payments. Private insurance and limited employer schemes become the major means of accessing healthcare.

The Bank became a leading international voice in health policy taking over from the World Health Organization (WHO) in the 1980s (Lister 2013). The US had become increasingly hostile to the WHO from the early 1980s. In 1981, the US opposed WHO’s campaign against baby formula, which had been linked to deaths in the Global South, where clean water to mix formula with was too often scarce, as was equipment to sterilise bottles. They withheld their first contributions to the organisation in 1985 (Lister 2013). A key outcome of the Bank’s increasing influence was its divergence from the primary health goals established in the Declaration of Alma-Ata. The Declaration came out of the 1978 International Conference on Primary Health Care and established health as a fundamental right for people. It highlighted that achieving health requires action across a range of policy areas including inequality.

In the 2000s, the Bank proclaimed loudly that it had moved beyond the neoliberal Washington Consensus (so-called because of its development in Washington at a gathering of the IMF, WBG and US Treasury). In practice, the shift was not significant (Engel 2010), nor were any changes in its overarching goals in health. There was a new focus on broad access to healthcare and subsidised support for the extremely poor. But the approach was still framed by a neoliberal metanarrative which demanded restricting public health expenditures and increasing private provision of services. Increased attention was directed to developing individualistic mechanisms for marketizing health services.

In the 2000s, global health governance underwent large changes with new international health organisations emerging such as Gavi and the Global Fund (to fight AIDS, Tuberculosis and Malaria). The Bill and Melinda Gates Foundation gained particular influence in health policy, becoming the second or third largest funder of WHO for many years. These organisations largely coalesced around an agenda of supporting vertical disease-specific programs for the poor, most notably to target HIV, malaria and tuberculosis. In addition, the Gates Foundation prioritised a technological approach to disease and private healthcare provision.
The Bank began to support a sector-wide approach to health at this time (Ruger 2007). This saw a broader, non-disease-specific focus combining technical and policy support with health sector financing and strengthening, and ‘sound’ macroeconomic regulations. In addition, the Bank was not so much rolling back the state as it had in the 1980s, as rolling out the market. Its two favourite tools for this in health were public-private partnerships (PPPs) and UHC. There is more on these approaches in Engel et al. (2020), here is a brief summary of key concerns.

- PPPs are promoted as a way of gaining access to private sector capital and expertise to scale-up development, but their equally relevant effect is to underwrite or guarantee private profits, shifting risk and liability for projects to the public domain. When projects fail, the public are left to pick up the bill, but the often-excessive profits earned earlier, remain in private hands. In health care, PPPs drive up prices, focus care on expensive surgical or pharmaceutical treatments over primary health care (PHC), and result in poor coordination between the public and private sectors. There is little evidence that for-profit healthcare schemes improve healthcare outcomes and strong evidence that they increase costs and reduce efficiency (Lister 2013).

- UHC does not mean publicly provided health systems, rather health sector “reform” to maximise access and coverage of all socio-economic sectors of society in a way that is supposedly equitable and financially progressive. However, health insurance is an individualistic and medicalised approach to public health and, in almost all cases, it leaves huge gaps in cover and levels of care – you get what you can pay for and if you cannot pay, expect limited services, if any. Further, the UHC approach ignores the findings of the WHO Commission on the Social Determinants of Health, which clearly demonstrates that achieving health for all requires addressing broader social inequality (WHO 2008).

The consequences, as outlined in Engel et al. (2020, 10-11), are that most states in the Global South 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 system.” The majority of hospital beds are in the private system. Health insurance is promoted as the pathway to UHC, but insurance is designed for people working in formal sectors with regular incomes. Governments are encouraged to provide subsidies to ensure the extremely poor have coverage but the resulting cover is partial and reach, “in some cases to the extent of hardly offering insurance at all” (Lister 2013, 13). Thus, most insurances schemes leave large gaps. Private hospitals and private insurers now face financial difficulties thanks to the pandemic. The reasons for this are outlined in section 4, after the evolution of India’s healthcare system is described.
The private healthcare sector was very small in India until the mid-1980s, but the public system was neglected and under-funded. This created an opportunity for the gradual establishment of private services focused on the wealthy. Successive governments began to encourage the growth of these services (Sengupta and Nundy 2005). This early underfunding of the public system likely suited World Bank officials predominately concerned with the country’s macroeconomic stabilisation and capacity to meet foreign exchange requirements. In India, the Bank was interested in population or family planning ahead of health. According to Mason and Asher (1973, 680), the Bank was very conscious of the importance of family planning for India from the 1960s but did not support any loans for this purpose. The first loan came in 1972 and the next in 1980. During the 1980s, there were nine loans in the population, health and nutrition sectors. However, these accounted for only a tiny fraction of Bank lending to the country (Guhan 1997) and were controversial, as the Bank funded coercive approaches to population control.5

In the 1990s, Bank lending in the sector expanded with 22 new projects in the decade, involving a lending commitment of $6.8 bn (World Bank Group 2007, 3). Between 2001 and 2007, there were a further ten projects and supplemental financing for some old projects, committing a further $1.5 bn. Health was a noteworthy 37% of World Bank new financial commitments from 1990 to the mid-2000s (World Bank Group 2007, 3).6 The Country Assistance Strategy (CAS) of the period was very much in line with the Bank agenda for health in this period, outlined above. It promoted improving the private health market and combatting communicable diseases, though notably even then (as now) it called for increased state spending in the sector, reflecting the very low level of

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5 Then Bank President McNamara wrote during a trip to the country in 1976 that India was at last addressing the issue and that as “sterilization will be the major contraceptive method” the “authorities believe that some form of pressure (sterilization laws, loss of government jobs, increase in the marriage age, compulsory abortion) will be required” (cited in Kapur et al. 1997, 295).

6 The World Bank Group’s (2007) review of five key projects found “significant indicators of fraud and corruptions” in all the projects, in procurement, project implementation and under-delivery of services. On one project, 90% funds misappropriated (Lister 2013, 102) Apparently, the Wall Street Journal said, in 2008, that it was a scandal on the scale of the UN Oil for Food Scandal.
government outlay. Following the Bank’s focus on vertical, disease-specific projects, they supported projects in HIV/AIDS, tuberculosis (TB) and malaria. The support for HIV and TB continues to current times because these have “large externalities which more strongly justifies public intervention” (World Bank Group 2018, 78). This statement indicates that the crude cost-benefit analysis that drove WBG thinking on health in the 1980s has not yet dissipated.

The IFC started lending to the health sector in the late 1990s, with its first loan in 1997 to establish a private hospital in Calcutta (Kolkata from 2001). Its lending for private health was predominately for private hospitals and the expansion of private pharmaceutical production. Activity took off from 2005—there were 13 loans overall in the 2000s. It also invested in the sector through venture funds that targeted healthcare amongst other sectors. The development financing institutions of other countries supporting private health investments in India included: UK (Commonwealth Development Corporation), Germany, Sweden and the US (Chakravarthi et al. 2017). But the IFC was the largest and it even “prepared a Guide to Investors in Private Health Care in Emerging Markets, as part of its Health and Education Advisory Services” (Chakravarthi et al. 2017, 54). The IFC was signalling that the Indian healthcare sector was a profitable investment, and encouraging wider interest. By the late 2000s, the sector seemed “to be flushed with private equity funds” and the value of private equity and venture capital deals for 2013 was reported as $1.11 bn (Chakravarthi et al. 2017, 53).

By 2007, India became one of the most dependent countries on private health spending. The World Bank Group (2007, 31) reported the private sector in India accounted for “64 per cent of all hospital beds and 80 per cent of doctors nationwide.” This is still the situation today (Paliwal 2020, Jaffrelot 2020). The profile of private providers is: a handful of very large providers like Apollo, Max and Fortis but with most being very small with fewer than 25 beds. Hospitals are largely unregulated or minimally regulated, with varying standards of quality of care. Improving quality standards is a key WBG focus. Private hospitals are frequently required to provide some level of free treatment to the poor, often in return for free land during establishment. However, there are regular reports in the media of private hospitals not fulfilling this duty and, in some cases, they are prosecuted by state governments. Many of the large private providers have a strong focus on medical tourism as part of their profit strategy.

7 Apollo Holdings has a number of private-equity investors, Lister (2013, 51) identified Apax Partners and noted a number of other interested partners.
There are geographic disparities in provision of hospital services. Private hospitals are mostly “situated in large metros or urban neighbourhoods leaving a great deficit of health services for the underprivileged population of India” (National Health Authority 2021). Notably, in 2011, a Bank staffer authored an article in the Times of India saying that state provision of health service is best in rural areas (Lister 2013). There are also large differences between states. Seven states with just under half of the country’s population have 65% of hospital beds, while the other 21 states and 8 Union Territories have just 35% of hospital beds (Sarwal et al. 2021). The public hospitals that do exist are “understandably overburdened” and as the Government of India (GoI) National Health Authority (2021) website also notes, they “lack of sufficient funds, a shortage of trained health workers and the erratic and often deficient supply of drugs and equipment which adversely impacts their functioning.”

The use of hospital services has significant personal economic impacts, often leading to poverty. The World Bank Group (2007) noted that an average patient spent 58% of their annual income when using hospital services, 40% of people in hospital borrowed money to cover their expenses, and at least 25% of people who borrowed ended up in poverty as a result. Indeed, they opined India’s “two-track’ system discriminates against the poor by shunting them to inadequately funded public facilities” (World Bank Group 2007, 33, emphasis added). Being shunted into inadequate private facilities is also expensive, though perhaps more acceptable to private providers and the Bank Group. Private sector services in India are much (20-54%) more expensive than public sector care, and inpatient care is 100-740% more expensive (Lister 2013, 103). Some private sector services may be better quality than public ones, but the reality varies between private providers given regulation of them is poor and between states given very different levels of state health provision.

Underfunding by government of public hospital and health care, also leads to reduced access to health services, poverty and poor health outcomes. As the National Health Authority (2021) acknowledges, a major cause of poor access:

> is the persistent underfunding of the country’s public health care system. Over the last two decades, the Government of India’s overall expenditure on health has remained stagnant at about 1.2% of its GDP. Of its total expenditure on health, India spends only 21% from the Government revenue and as high as 62% from out-of-pocket expenses.

They acknowledge too, that increasing health care needs along with high OOPPs are a leading cause of poverty (National Health Authority 2021). The results of this chaotic system are that India’s life expectancy is five years lower than the world average, and 40% of the malnourished children in the world today live in India (World Bank 2013).

The Indian government’s lack of commitment to the provision of affordable, comprehensive and equitable public health services is a reflection of their neoliberal ideology. As Chakravarthi et al. (2017, 55) argue, the GoI’s “neglect
of public health infrastructure... is a deliberate strategy to promote the large private health interests,” which is in line with “neo-liberal thinking against healthcare as a social good and provision of welfare services by the state.”

Health insurance systems have also been framed by neoliberalism. In 2008, the GoI launched its first health insurance scheme for extremely poor, which was cheap but offered very limited coverage and does not cover primary health services. This is the government’s key strategy for achieving UHC. Many state governments also have insurance schemes, assisted by loans and technical assistance (TA) programs from the WBG and ADB. For example, in 2012 and 2013 the IFC provided TA to help the Government of Meghalaya establish an insurance scheme. State governments provide most insurance schemes, with an additional 40 private health insurance providers in operation by 2017. Still few people are insured: the 2018 National Sample Survey data indicate that close “to 80.9% of people in urban India and 85.9% in rural India” have no insurance (Bhuyan 2020b). Chakravarthi et al. (2017) also point out that health insurance is a mechanism to divert public funds to the private sector, given the reliance on private providers in the secondary and tertiary care system in India.

Development lending to India benefits the private sector both overtly and covertly. While, India has borrowed very little historically from the ADB specifically for the health sector, components of its loans focused on other sectors have impacted the health sector. For example, two loans to Mizoram 2009 were classified by the Bank as public expenditure and fiscal management loans but, according to the WBG, one of these contributed to the development of a state health insurance program. In 2009, the ADB had a TA project called Sustaining the Government of India-ADB Initiative for Mainstreaming Public-Private Partnerships. It targeted five sectors, one of which was health, and there were specific projects in this sector in 2010 and 2014. These programs trained health staff to draft enabling legislation, draw up PPP systems and procedures, and develop a pipeline of PPP health projects. The first loan specifically for health systems development was 2015: a $300m loan and TA to build the urban primary health network. The loan documents acknowledge the fragmentation of India's health system, the problems created by previous donor programs focusing on vertical diseases, and the huge OOPPs associated with the reliance on private healthcare. Still, such challenges were overlooked and the project continued the mixed public-private system, indeed, it expanded private sector participation and PPPs, with no indication of how the two systems will achieve better coordinated (ADB 2015).

Health was a prominent focus in both the World Bank’s Country Partnership Strategy 2013-17 and the Country Partnership Framework 2018-22 for India. In both cases, it was a key emphasis in the Bank’s third pillar of support called “inclusion.” This pillar comprised an interesting mix of health, education, financial inclusion and social protection (World Bank 2013, World Bank Group 2018). In these strategies, the Bank notes the problems with poor oversight of private health providers, lack of accessibility for the poorest, and high levels of OOPPs often resulting in debt and poverty. In response, it proposed its standard prescriptions of the era, UHC and expanding PPPs, despite the failure of these approaches to improve fundamental healthcare.
To reach UHC, they promoted the expansion of health insurance coverage, including among disadvantaged groups, but notably there were no specific activities identified for expanding coverage among the so-called non-poor. The IFC continued its lending to private hospitals and pharmaceuticals over the 2010s with a further 18 loans. Key beneficiaries included the Apollo and Max hospital groups, both significant providers of medical tourism, while in pharmaceuticals Granules India, Hikal Ltd, Glenmark Pharmaceuticals and Biological E were major beneficiaries. All of these firms received two or more IFC loans.

The ADB's current Country Partnership Strategy India, 2018-2022 has, in contrast, minimal focus on health. Health appears briefly under Pillar 2 of “inclusive access to infrastructure networks and social service” (ADB 2017, 1) but there is virtually no discussion of the sector. Still, the strategy notes the ADB's continuing commitment to private operations in health.

The focus in the WBG’s 2018-2022 country strategy is on a “leveraging Bank” rather than a “lending Bank” (World Bank Group 2018, 3). A leveraging approach had already been applied in the health sector. The GoI’s New Health Policy in 2017, embraced the private sector in order to achieve UHC via strategic purchasing of private infrastructure (Jaffrelot 2020). This was followed in September 2018 by the launch of a new insurance scheme, replacing the 2008 one. The Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PMJAY for short) is “the world’s largest state-sponsored health assurance scheme. Ayushman Bharat covers forty percent of the country’s population, focusing on those who are poor and most vulnerable” (Dhara 2020). Covered families receive up to Rs 5 lakh (approx. US $6850) per annum for treatment in empanelled public or private hospitals. However, the scheme was chronically underfunded from the outset and by September 2020, only 23,300 hospitals had been empanelled, half of those public hospitals. Many private hospitals did not enrol because the rates offered for consultations and surgery were very low (Jaffrelot 2020). Still, PMJAY helps to institutionalise private healthcare because of the many empanelled private hospitals.

Health insurance coverage has increased but not all intended beneficiaries have been reached. PMJAY is implemented by state governments (Dhara 2020) and coverage varies, reflecting the pre-existing, wide diversity between the states in health systems related to socio-economic status, state health expenditure and the level of growth in private hospitals. For example, in Mizoram only 55% of eligible poor people are enrolled in either the state insurance scheme or PMJAY, still, the state has a relatively high level of public provision of healthcare (World Bank 2021a, 12). PMJAY also leaves most of India’s “non-poor” uncovered. It does not address issues of caste and gender - most hospitals, particularly private ones, persistently discriminate against Dalits and Other Backward Castes (OBC) (Dhara 2020). There is also a large disparity in healthcare expenditure and insurance between men and women across the country. For example, in Mizoram only “17 percent of women against 44 percent of men ages 15–49 years... are covered by any health scheme or health insurance” (World Bank 2021a, 12).

The GOI’s New Health Policy (2017) also included development of 150,000
Health and Wellness Centres building on and significantly expanding the existing PHC network, and filling in some of its gaps. This number of centres still leaves very limited coverage across the country. These centres provide a wider range of services than hitherto, and the federal government promised to target two-thirds of its health spending to them, pre-COVID.

Overall, it seems that the Modi government is aligned with the World Bank’s neoliberal approach to healthcare as an individual responsibility through insurance, with the result that that the poor only get minimal, low-cost health services. This approach helps the government to meet its commitment to deficit targets and is in line with the IMF’s calls for further fiscal consolidation and support for large physical infrastructure projects (in the form of PPPs) over state employment in areas such as health and education (IMF 2019). Such policies, as ActionAid (2020) point out, prevent countries investing in health workers and are a major impediment to achieving the SDGs.

One of the last major health projects approved prior to the COVID-19 pandemic is also insightful regarding Bank priorities. The Andhra Pradesh Health Systems Strengthening Project (P167581) was approved in May 2019 ($328m IBRD loan). It has a strong focus on public institutional strengthening of the health sector, or stronger at least, the Bank says, than its 2019 Tamil Nadu Health System Reform Program (P166373). Nevertheless, there is a strong focus on improving private sector performance and substantially increasing the percentage of community health centres contracting core packages of clinical and non-clinical services to the private sector (World Bank 2019, 12). Within the document, discussion on whether private sector

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8 In 2018, the government system consisted of 1,003 district hospitals, 5,568 community health centers and 29,899 primary health centers (Dhara 2020). The latter will be upgraded to Health and Wellness Centers.
9 As ActionAid (2020, 67) noted, India’s public sector wage bill at 1.1% of GDP was the lowest wage bills of 43 countries they found data on, and yet the IMF recommended maintaining this level of expenditure and indeed warned in 2018 about the spending pressure resulting from the Seventh Pay Commission (IMF 2018, 13).
engagement improves the quality of care was excruciating. Over two sentences it jumps from acknowledging that the private sector may not improve care, to supporting contracting out because “the private sector may be better placed than the government to deliver certain services,” with sets of references to support both arguments (World Bank 2019, 25). Later on, the Project Appraisal Document (PAD) acknowledges that “the evidence on PPPs is more mixed” but immediately continues that PPPs, like the proposed electronic-Subcentre, “can allow the state to quickly achieve health gains by leveraging their know-how and limiting public expenditure as the private sector takes on some capital investments” (World Bank 2019, 83). Finally in the section on the budgetary implications and fiscal sustainability analysis, the PAD reveals that given the project’s “approach of leveraging the private sector, payments to private providers would constitute the bulk of additional costs” (World Bank 2019, 84).
4. THE IMPACT OF COVID-19 ON HEALTH CARE IN INDIA

Covid-19 initially caused a liquidity crisis for some private sector health providers internationally, particularly in low- and middle-income countries (LMICS) (Engel et al. 2020, Williams 2020). There are four main reasons, all of which apply to India to a greater or lesser extent:

1. Access to private finance dried up in many LMICs making refinancing difficult for private health providers, particularly those who are highly leveraged.

2. Elective and outpatient services were temporarily shut down and demand dropped as patients delayed treatments and medical tourism was dramatically curtailed. In India, pre-COVID, the Max chain of hospitals reported that medical tourism accounted for just under 10% of revenues pre-Covid and this took a hit (Suri 2019).

3. Some people and firms whose incomes reduced due to unemployment or reduced hours cancelled private health insurance. In India, reports suggest people initially rushed to take up private insurance in the wake of COVID-19 but as a result premiums increased 20-25% between January and March 2020 (Paliwal 2020). However, the new clients and increased premiums are unlikely to cover increased payouts due to the pandemic (Bhuyan 2020b).

4. The costs of COVID patient care are high because of the need for strong infection control systems and high levels of personal protective equipment (PPE).
In India, the balance sheets of hospitals were hit during the early months of the pandemic, for example Fortis reported an income drop of 46.8% for the first quarter of the 20-21 financial year (Bhuyan 2020a). The larger chains have likely recovered the losses, though some were struggling with profitability pre-pandemic. Smaller hospitals and clinics may not recover, increasing the pace of consolidation, which was happening before the pandemic.

The pandemic has also highlighted a range of fundamental weakness of the healthcare system in India, some key ones include:

- The lack of system-wide planning, coordination and communication between the public and private systems. The government did not have a detailed grasp of total hospital capacity, ICU beds, ventilators, etc. Gathering data from hospitals has been a challenge in India, indeed there was one case of a private hospital withholding data on a COVID-19 case, which led to an outbreak at that hospital (Williams et al. 2021).

- Geographic gaps in all levels of medical services. These gaps proved costly and the system demonstrated limited surge capacity. Further, the pandemic highlighted that insurance is little use for geographically remote communities (Dhara 2020).

- The absence of regulation to ensure that private hospitals take COVID-19 patients or provide poor patients with quality healthcare. India has had many reports of poor regulation, despite a health ministry advisory that treatment for suspected COVID-19 patients was not to be refused (Williams 2020). In a systematic review of English language media reports on the role of the private sector in response to COVID-19 in LMICs, Williams et al. (2021) found that the majority of reports on private hospitals refusing to admit COVID patients were from India. While data remain limited, it is likely that many of those refused treatment are Dalits and OBCs.

- Many people are simply not accessing health care because of the costs. This was the case even once state governments introduced caps on COVID treatment costs during the second wave. The enormous OOPPs are also frequently being covered by loans. Capacity to repay has been dented by the huge economic impacts of the crisis in India and the loss of life. The pandemic is pushing many people back into extreme poverty and medical costs are a large part of this.

- Private providers price gouging. India dominated Williams, Yung, and Grépin’s (2021) study in terms of reports of price gouging and demands for up-front fee payments prior to admission. This continued despite state government efforts to cap prices (at very different rates) or regulate access. Loopholes include charges for pharmaceuticals, tests and PPE. PPE cost has risen dramatically, and this cost tends to be borne by individuals not by insurance. Pre-Covid, PPE was around 10% of hospital bills but now is up to 25-50% of the bill (Paliwal 2020, Mathew 2020). The bill for a two-week hospital stay in Delhi is over what 94% of the Indian population earn in one year.

The paper turns now to how the MDBs responded to the health crisis in India.
5.

MDB COVID-19 RESPONSE HEALTH LOANS

The WBG, ADB, AIIB and NDB provided a set of very large loans to support the health response of the GoI. The WBG and AIIB co-financed the India COVID-19 Emergency Response and Health Systems Preparedness Project for $1.5 bn using WBG environmental and social policies (or safeguards) and the ADB and AIIB have co-financed the COVID-19 Active Response and Expenditure Support Program for $2.25 bn using ADB safeguards, while the NDB has funded a stand-alone project for $1bn (see Table 1). All of these projects support the GoI’s own COVID-19 Response and Health Systems Preparedness Project announced on 24 March 2020, however they still support private interests, do not protect health workers or the most vulnerable and will result in many people being pushed into poverty.

Table 1 Large MDB health loans in response to COVID-19

<table>
<thead>
<tr>
<th>Bank</th>
<th>Approval Date</th>
<th>Amount</th>
<th>Project Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>WBG</td>
<td>2 April 2020</td>
<td>$1bn IBRD loan</td>
<td>India COVID-19 Emergency Response and Health Systems Preparedness Project (P173836)</td>
</tr>
<tr>
<td>AIIB</td>
<td>7 May 2020</td>
<td>$500m loan</td>
<td>India: COVID-19 Emergency Response and Health Systems Preparedness Project (000380)</td>
</tr>
<tr>
<td>NDB</td>
<td>30 April 2020</td>
<td>$1bn loan</td>
<td>Emergency Assistance Program in Combatting COVID-19</td>
</tr>
<tr>
<td>ADB</td>
<td>30 April 2020</td>
<td>$1.5bn loan</td>
<td>COVID-19 Active Response and Expenditure Support Program (54182-001)</td>
</tr>
<tr>
<td>AIIB</td>
<td>16 June 2020</td>
<td>$750m loan</td>
<td>COVID-19 Active Response and Expenditure Support (000409)</td>
</tr>
</tbody>
</table>
The ADB/AIIB loans are both for healthcare and social assistance/social security measures for people most impacted by the crisis (ADB 2020, 11). The social components align with the Prime Minister’s Welfare Scheme for the Poor (PMGKY) announced on 26 March 2020, while the WBG has two separate loans supporting this aspect, totalling $1.2bn. The healthcare loans are in line with the GoI program but the loan documentation contains few details. The WB/AIIB loan program provides a little more indication of priorities. The first four components of these loans follow the four components of the GoI program and there are two additional components:

1. Emergency Covid-19 response – key activities: updating training of workers; improving lab capacity including “engaging private laboratories to expand capacity and test and manage COVID-19,” procurement of PPE, oxygen delivery systems and medicine; additional payments for health workers across the public and private system; and new isolation wards in public health facilities. Note that the latter includes the arguably unhelpful goal of “single occupancy negative-pressure isolation rooms in infectious disease hospitals and districts hospitals”, as such services would only be accessible to the very wealthy (World Bank 2020b, 14). The Stakeholder Engagement Plan provides further clarity of where the funds will be spent when it notes that “[g]iven the limited public sector capacity for isolation and intensive care services for COVID-19, the private sector will be contracted to surge India’s capacity for diagnostic and intensive care treatment services for the disease. This will be critical in the event of an escalation in the pandemic. The component will support the MOHFW to collaborate with and engage the PM-JAY to pilot private sector engagement for COVID-19 in patient care services” (World Bank 2020a, 1-2).

2. Strengthening national and state health systems to support prevention and preparedness – key activities include: building a network of high containment laboratories; expanding molecular testing capacity at point-of-care; enhancing disease surveillance systems; developing district level epidemic response institutions; and improving referral transport systems.

3. Strengthening pandemic research and multi-sector, national institutions and platforms for One Health – this component focuses on biomedical research to generate evidence to help the COVID-19 response. Key activities include reviewing and strengthening detection, surveillance, management and staff training systems for zoonoses. It also has a strong focus on the animal health workforce.

4. Community engagement and risk communication – key activities include marketing physical distancing measures and behaviour change programs.

5. Implementation management, capacity building, monitoring and evaluation

The activities supported are logical responses to the crisis, though they lack urgency in many of the efforts and direct inadequate attention on medium to long term activities under components 2 and 3. Indeed activities like high containment laboratories, a One Health Centre of Excellence and surveillance in the dairy sector were removed from the project in March 2020 (World Bank 2021b).

A deeper examination highlights that a neoliberal metanarrative both frames and constrains the GoI/MDB response. As Kahneman (2011) explains, strong commitment to particular heuristics means that evidence to the contrary is easily ignored and MDB experts, like experts in other fields, believe in their own skills even though it is an illusion. Relying on standard heuristics or ways of thinking is even more prevalent during times of crisis. Thus, these loans sought to address the pandemic by expanding support for India’s mostly private, complex and not terribly efficient health system. The health system a) does not provide any cover for the majority of the population; b) leaves many people both with and without insurance with debilitating OOPPs; c) drives a notable portion of the population into poverty each year; and d) promotes systemic inequalities for women, SC/STs and other vulnerable and disadvantaged people. However, the officials involved still thought this was the best option.

The vulnerable health workforce has some limited support, extra payments under Component 1 to help retain and surge the workforce. However, this is not included in the loan monitoring and evaluation documents and will not be reported. These payments may extend to India’s Accredited Social Health Activists (ASHAs) – these are female “volunteer” community health workers, who receive small performance-based incentives for achieving immunisation targets and referrals to reproductive and child health services. There are approximately one million ASHAs across India and they function as a first point of contact for health-related concerns in a community (Ved et al. 2019). Essentially, they are underpaid and informal government workers. ASHAs have become frontline health workers since COVID-19, conducting tests and undertaking patient visits (Ganeshan 2021). Some states provide ASHAs with a fixed monthly payment for periods during the pandemic or increase their support payments. Also, they have death cover under the Pradhan Mantri Garib Kalyan Package Insurance Scheme, along with other workers in the public health system and private providers providing COVID-19 care. But the general health insurance does not cover them. In some states their income has fallen since the pandemic as they cannot meet immunisation and other targets, due to the focus on COVID-19 (Ganeshan 2021). Further, the death toll among ASHAs is high and access to the promised compensation payments is a challenge (Ganeshan 2021).

On a surface reading, the loans seem to prioritise state funding and systems, yet given the dominance of the private sector in the tertiary system, it is highly probably that the bulk of the funding will flow to them directly, or indirectly through insurance schemes like PMJAY. Indeed, the PAD for the World Bank (2020b, 17) loans notes that “private sector engagement will be done through states and central agencies to surge the capacity for laboratory and intensive care services for COVID-19, as maybe necessary during the response to the COVID-19 pandemic.” As noted above, the Stakeholder
Engagement Plan makes a similar point (World Bank 2020a). Implementation reports do not provide any data on the relative funding of the public versus private healthcare systems.

The program documents do not indicate any specific measures to reduce OOPPs, despite their acknowledged role in pushing people into poverty. The PAD did note the substantial risks “to marginalized and vulnerable social groups (women, the elderly, the differently abled, scheduled tribes [ST], scheduled castes [SC], communities in remote and hilly locations, etc.) in accessing the benefits and services of the project” (World Bank 2020b, 28). Still, there was no useful analysis of these issues and strategies to mitigate these risks were limited to: updating guidelines for healthcare professionals; developing awareness campaigns specifically for the poor; “prioritizing districts and vulnerable areas within those especially the poorer localities, remote and hilly areas with building awareness about the risk and services associated with Covid19”; and recommending extra support for informal workers. However, the results framework and monitoring did not cover these issues and did not mention gender or women. Finally, it is worth noting that the economic analysis for the project indicates that a key benefit is “[p]reventing loss of human capital” not human lives (World Bank 2020b, 19). This is a strong indicator that neoliberal logic still permeates the Bank. The MDB efforts to protect the poorest from catastrophic healthcare costs is markedly insufficient and those just above the poverty line may be even harder hit as they do not have the meagre coverage the PMJAY offers.

1. OTHER WORLD BANK AND ADB LOANS AND TAS

In addition to the large COVID-19 response loans, the World Bank and ADB provided two other loans to the health sector and the ADB a number of TAs – one of its favourite mechanisms. These are also insightful regarding development bank priorities.

WORLD BANK MIZORAM HEALTH SYSTEMS STRENGTHENING PROJECT (P173958, $32M IBRD)

Approved on 31 March 2021, this project aims to improve health system in the small north-eastern state of Mizoram. The state has the second highest spending on health in the country, though OOPPs remain significant. It also has one of the larger state healthcare systems with private providers concentrated in large urban centres. The World Bank highlights that the state population is “more dependent on government health services than is usual in the rest of India” (World Bank 2021a, 11). The state has overlapping insurance schemes, a program developed in 2009 from a ADB loan as well as PMJAY. Only 55% of eligible people are enrolled in a scheme, which the Bank attributes to low awareness. Given the WBG’s commitment to insurance as the pathway to UHC, it is notable there is no discussion of whether or precisely how an insurance system can equitably work in this context or whether it can effectively address the large gender disparities in insurance noted. In the result framework, the measure of success for gender is just the percentage increase of women-headed households covered by health insurance, not an overall increase in the coverage of women and girls.
The loan has a large component of performance incentive grants to health agencies and facilities to improve governance and management structures. These have the new public management goal of shifting the state from “input-based financing to performance-based financing systems” (World Bank 2021a, 17). New public management is neoliberalism applied to state management, supposedly to improve efficiency. All too often, its focus shifts service provision to the private sector regardless of efficiency, particularly in the health sector. The loan documents offer a business-as-usual approach. Despite being in the midst of a pandemic, it aims to strengthen a health system that has demonstrated failures, with little acknowledgement of the pandemic itself.

**ADB LOANS AND TAS**

Approved in December 2020, the Strengthening Comprehensive Primary Health Care in Urban Areas Program under Pradhan Mantri Atmanirbhar Swasth Bharat Yojana Loan and TA (53121-001, $300m) presents as a sound project designed to strengthen the urban HWCs program. It mostly focuses on the public sector. Nevertheless, under output three, the goal to develop “scalable models to engage the private sector to partner in improving health outcomes,” links “innovative approaches and best practices” directly to “private sector engagement,” with one performance indicator to achieve “at least 20 innovations or private sector engagements practices implemented in 13 states” by 2024 (ADB 2020, 10). The associated $2m TA also has a strong focus on private sector participation.

The ADB also approved two other TAs. One, for $1.4 m in May 2020, supports implementation of the PMJAY to accelerate the achievement of UHC in India, including via promotion of private sector responses, an odd priority in the midst of the pandemic. The second, a $7.0m TA approved in June 2020, supports the COVID-19 response, in particular emergencies supplies of oxygen, and builds capacity for the proposed Responsive COVID-19 Vaccines for Recovery (RECOVER) Project under APVAX, which again includes building private sector capacity.

2. **PRIVATE SECTOR OPERATIONS: THE IFC AND ADB**

The IFC has been tasked with a major part of the World Bank’s response to COVID-19. Of the $14 bn in the initial COVID-19 Fast Track Facility, the IFC target was 57% or $8bn. This reflects the WBG’s Maximising Finance for Development agenda, which places the private sector at the centre of development and tasks MDBs with de-risking public and private projects for private investors (Dimakou et al. 2020, Gabor 2018). The IFC tasks are to provide direct loans to clients and support partner financial institutions. In the Indian healthcare sector, some loans are to healthcare sector clients, but the far larger allocation is to one group of financial institutions, private equity funds that promise investments in healthcare, among other sectors.

10 In July 2020 it also provided a $3m grant for COVID-19 Emergency Response.
As of the end of June 2021, the IFC has two direct loans/investments in the healthcare sector, with a further one pending.\(^\text{11}\) The loans are to Glenmark Pharmaceutical $50m for an ongoing capital expenditure program and refinancing of foreign debt maturities; and Biological E. Ltd $30m for expanding its vaccine manufacturing capability. The pending project is equity financing for Medgenome Inc., a leading genetic diagnostics, research and data licensing player. Private equity investments from January 2020 to June 2021 noting healthcare include: Seabright IV LP (headquartered in the tax haven of Delaware) $30m; Faering Capital International Growth Fund III $40 m; Gaja Capital India Fund 2020 LLP $50m; Stellaris Advisors LLP $60m; Endiya Partners Fund $19.84m; and India Alternatives Private Equity Trust $10.5 m. In addition, there is a proposed $50m investment in Everstone Fund IV (headquartered in the tax haven of Singapore) for India and Southeast Asian investments. What is also notable in the IFC documents is the large number of the projects funded for an amount higher than suggested in the initial recommendation, rarely the case in earlier IFC activities. Long before the pandemic, a range of NGOs and academics have pointed out the problems of lack of transparency and accountability associated with funding financial intermediaries. Much of this work rightly focuses on whether these intermediaries are funding fossil fuel investments. However, their role in funding for-profit healthcare for the wealthy is important too.

So far, the ADB Private Sector Operations Department (PSOD) financed three loans during the pandemic for healthcare. First, a $20m debt security for the “India: COVID-19 Hospital Service Delivery Project to Global Health Private Ltd” who operates in India under the Medanta brand. Second, a COVID-19 Hospital Capital Support Project, for Apollo Hospitals Enterprise Ltd to support “short-term financing needs for operations during the” pandemic. Third, a $20m in non-convertible debentures for the Krsnaa COVID-19 Diagnostic Services Project to Krsnaa Diagnostics Private Ltd to help scale up their coronavirus screening and detection capacity.\(^\text{12}\) The PSOD have not funded any private equity projects in India so far during the pandemic but had financed quite a number prior to it, for example Tata Capital Growth Fund II (2019) and Multiples Private Equity Fund III Ltd (2018). The support for Apollo and private equity investments indicates that MDB private sector funds prop up private healthcare providers. These providers may be facing financial difficulties during the pandemic but equally have shown gross disregard for the wellbeing of the sick and poor in refusing treatment of COVID patients and/or people who cannot pay up-front.

A March 2021 report by the GoI’s premier policy think tank NITI Aayog outlining opportunities for further private sector investment across the whole health sector reaffirms that the MDB’s health privatisation agenda has become “common sense” (Sarwal et al. 2021). Positioning the pandemic as an opportunity, it blithely ignores the failings of the private sector during the first wave of COVID, instead highlighting key past private equity investments in health (in two of the seven cases presented the IFC is a key investor), FDI access and tax incentives available to investors. In the section on hospitals, NITI Aayog even outlines a new model for facilitating privatisation of district

\(^\text{11}\) All the data on the IFC is derived from the IFC (2021), Project Information & Data Portal, correct as of 22 June 2021.  
\(^\text{12}\) ADB PSOD data is from ADB (2021).
hospitals. A government think tank promoting privatisation in the health sector reflects the closeness of the NITI Aayog with the World Bank and Asian Development Bank over many years, with the banks providing training for many officials each year and a range of other forms of cooperation.\(^{13}\)

The MDBs also provide substantial support to financial institutions or intermediaries to on-lend to micro, small and medium enterprises (MSME) in India. There are projects in this area from the IBRD/IDA, the IFC and the ADB. Some of these funds are almost certainly flowing to the health care sector in one of two ways, as loans to small healthcare providers or as microfinance loans to people to pay their healthcare costs. Prior to the pandemic, the World Bank estimated that 4% of Indian households fell below the poverty line each year because of OOPP (World Bank 2020b, 10). There are no data yet from the pandemic, though there are many news reports of families struggling with health debts. One small survey of general debt levels covering 75 households (518 people) across eight villages reports close to two-thirds had taken on debt since the pandemic. They have “taken out 6.12 million rupees ($82,250) and more than 80 percent” of it is not being serviced (Aljazeera 2021). This creates great stresses for microfinance institutions. But microfinance is a deeply problematic industry, which indebts the poor. They need and are getting financial subsidies, with MDBs as a major source. Without this, many institutions will and should - collapse. As Bateman (2020) argues, the crisis resulting from COVID-19 should be used as an opportunity to restructure the sector, not support it.

Finally, this analysis demonstrates that MDBs are helping to build a healthcare system with complex financialization built-in from the macro to the micro levels. Such financialization was disastrous during the 2007-08 Global Financial Crisis and debt build-up at the nation-state level was a global concern prior to the pandemic. Kose et al. (2020, 111) argues that the build-up in emerging markets and developing economies between 2010 and 2018 is the “largest, fastest and most broad-based increase” in the past half century. Since the pandemic began, a growing number of states have debt restructures. Still, there are no limits to the Maximising Finance for Development agenda.

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\(^{13}\) There were for example, 45 officials trained in 2018-19. Annual Reports over the past three years also highlighted cooperation with the World Bank in forums and workshops, Bank provision of technical assistance to created new indexes for health, schools and energy, and collaborations in a range of areas including battery storage, irrigation and urbanisation. They were also working together on introducing PPPs to the public transit service. I learned about this report and its privatization intent from an email discussion from Jan Swasthya Abhiyan.
CONCLUSION

India is heading inexorably towards a US-style, private healthcare system replete with all its gaps in coverage, inefficiencies and profit focus. The move to privatisation of healthcare started in the 1980s, reflecting both the government’s neglect of the sector and a consequence of the focus on macroeconomic fundamentals pushed by the World Bank and IMF. In the 1980s, the WBG started taking an interest in healthcare. Its neoliberal metanarrative applied to healthcare for the Global South produced a vision of a two-tiered system with publicly funded hospitals and PHC providers providing only a very limited set of low-cost, high-return activities, while private providers could do whatever the market would pay for. The Bank promoted this through influencing policy debates, training public officials and lending. In the 1990s, the ADB stepped in to lend support through TA and loans.

In 2017, the BJP’s New Health Policy adopted an intensified level of engagement with the private sector in achieving UHC via strategic purchase of private infrastructure (Jaffrelot 2020) and an individualistic insurance model. At the start of the pandemic, 62% of health infrastructure was private (Jaffrelot 2020), 80.9% of urban people and 85.9% of rural ones had no insurance (Bhuyan 2020b), men were far more likely to be insured than women, and 70% of health expenditure was paid for by patients from their own pockets (Rao 2018).

Since the pandemic, India accessed large loans from the WBG, ADB, NDB and AIIB. On the surface, the loans seem to be meeting the call of World Bank shareholders at the Spring Meetings 2020 to fund governments and public health interventions (Dimakou et al. 2020). However, substantial parts of the MDB loans will likely flow to private health care providers. Dimakou et al. (2020) argue that the WBG used the crisis to expand its private sector agenda, which is clearly the case with the IFC projects analysed here and to a lesser extent with the other MDB loans. Equally troubling is that the GoI and the MDBs are so constrained by the neoliberal health metanarrative that they do not know how to step outside of it, even in a pandemic. Indeed, crisis times promote standardised thinking and, in this case, thinking outside the box is made even more difficult by the fact that the Indian health system is now very complex and technocratic. Funds are being channelled through the government to insurance schemes, public and private hospitals, public and private testing facilities, and other complexly structured services. The business-as-usual approach is striking. The MDBs did not propose building emergency medical facilities, emergency measures to end OOPPs even for the poorest, or actions to ensure that women, the poor and marginalised, in particular the SCs/STs, receive adequate healthcare during the largest global pandemic in a century.
7. **RECOMMENDATIONS**

That:

**THE MDBS:**

1. follow the call of their shareholders to support public health services and immediately suspend their support for private healthcare provision;
2. focus on building public sector capability and infrastructure to achieve UHC;
3. substantially expand protection for the poor in India, and around the world, against catastrophic out-of-pocket health expenses during the rest of pandemic. In the Indian case, they should implement a far stronger and more focused mechanism to ensure that women, Scheduled Castes and Tribes, otherwise abled and other marginalised groups have access to high quality primary, secondary and tertiary care;
4. support proper pay and healthcare coverage for the health workforce and recognise ASHAs as formal healthcare sector workers through the provision of formal recognition and pay; and
5. provide financial support during the pandemic in ways that do not deepen debt problems for states or their citizens in the short or long term.

**THE IFC:**

6. not use funds to bail out private health providers and microfinance institutions during the pandemic.

**THE HIGH-INCOME COUNTRIES AND DEVELOPMENT ASSISTANCE DONORS:**

7. provide countries in the Global South with additional concessional resources to bolster their public health and other social systems.


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