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Magic Mountains of Debt

Sovereign Debt Crises as Critical Barriers to Ending TB and Investing in Sustainable Development Goals

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Introduction

Global public debt[a] grew from $51 trillion to $97 trillion between 2010 and 2023, with one-third of growth attributed to lending for Covid-19 pandemic response and associated economic shock.[1] Developing countries owe nearly one-third of that $97 trillion. Africa, in particular, has seen debt growth outpace Gross Domestic Product (GDP) growth, trapping countries in a cycle of debt and extraction by Global North lenders.[2,b]

Countries become indebted as they issue bonds or take on loans to invest in public goods or development projects. Debt itself does not intrinsically lead to crisis or reduction in public services. The threat of debt distress — the point at which countries cannot fulfill their debt and other financial obligations — arises when the country's economy (measured by GDP) does not grow enough to allow the country to repay loans. This happens regularly when commodities markets (e.g., fossil fuel, agriculture, and mineral markets) experience unpredictable, sudden, and often volatile fluctuations in pricing and revenue. In these situations, indebted countries cannot generate sufficient domestic capital to both repay lenders and pay for public services. This creates a cycle of borrowing and public sector cuts that countries struggle to escape. As was the case for Covid-19, countries often take on greater debt during economic crises caused by external shocks (e.g., natural disasters, political instability) when governments lack domestic resources for necessary services even more than usual.[3]

Quick Facts

- On average, 80% of funding for national TB programs comes from domestic funds.[4]
- 43% (21/49) of high-TB burden countries are in or at high risk of debt distress; half have large debt burdens — even if not in debt distress.[5,6]
- 90% of all debt contracts between lenders and the Global South are under the jurisdiction of either New York State or United Kingdom law.[7,8]

[a] Public debt, here defined as general government domestic and external debt, including debt held by central, state, and local governments.
[b] Three primary groups hold public debt: bilateral lenders (e.g., Germany, China); multilateral lenders (e.g., World Bank, IMF); and private lenders (e.g., Greylock Capital Management).

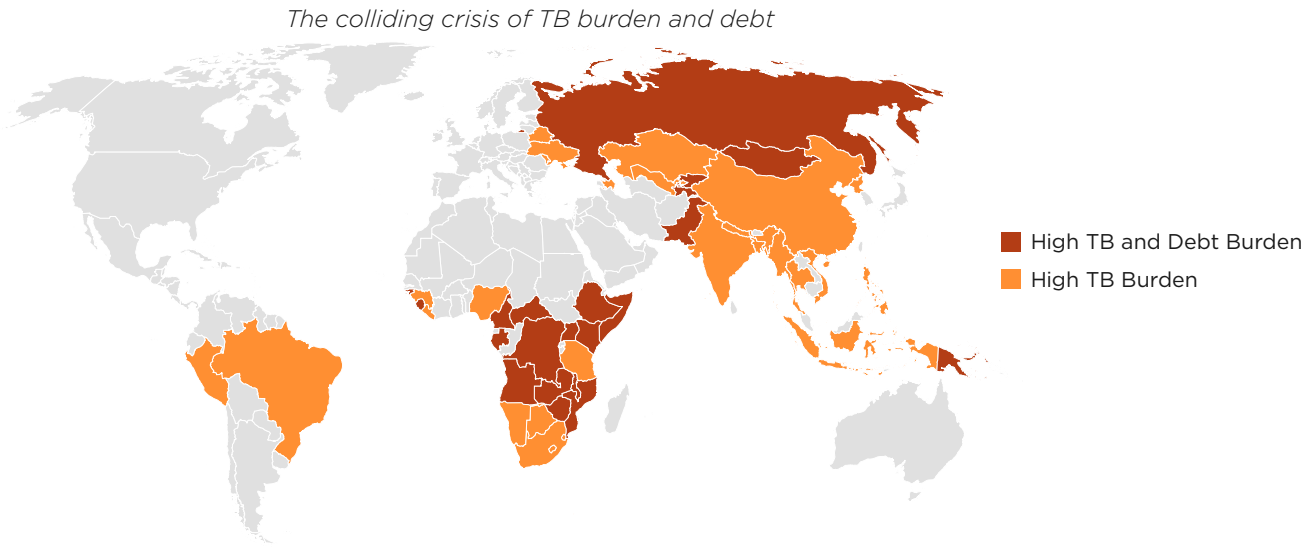
High debt burdens[c] drain funding away from investment in the public goods — such as the health, TB, and HIV services — critical to healthy and prosperous communities, with **$4 in every $10 of government revenue going to debt servicing as compared to $1 going to health** among low and middle income countries (LMICs).[9] In 2022, 46 countries made up of 3.3 billion people spent more public resources on debt *interest* than health. Across all LMICs, interest payments reached $847 billion in 2023, money that could otherwise have been spent on health and public services.[10] As debt continues to grow, austerity measures implemented to keep countries solvent further reduce spending on healthcare and public programs.[11]

TB and Debt

TB programs are funded from a mix of domestic and international sources. Globally, domestic resources cover 80% of TB programs.[12] Amongst high-TB burden countries, domestic investment in TB programs averages 46%. In high-TB burden LMICs, domestic investment in TB programs is lower, averaging 27%.[13] The debt crisis threatens existing and expanded investments in domestic TB programs and undermines the ability of high-TB burden countries to invest more in TB research and development (R&D). TB R&D remains greatly under-resourced and dependent on a small group of funders, e.g., U.S. National Institutes of Health and Gates Foundation. To advance important innovations and secure the sustainability of the TB research funding landscape, other funders — including those from TB-high burden countries must invest more in TB R&D.[14]

In Africa, the debt crisis is already causing widespread domestic divestment from health services and TB and HIV programs.[15] Countries unable to increase domestic revenue will be forced to further divert funding for public services to debt to stave off the threat of defaulting on loans. TB programs and services will bear an outsized brunt of divestment as debt crises grow — as was the case during the Covid-19 pandemic.[16] Further, Covid-19 demonstrated that even temporary interruptions to TB services can reverse hard won gains, with TB incidence rising 4.6% between 2020 and 2023 as countries reallocated existing TB infrastructure to respond to the Covid-19 pandemic.[17]

Figure 1: High-TB Burden Countries in or at High Risk of Debt Crisis According to International Monetary Fund (IMF) Analysis

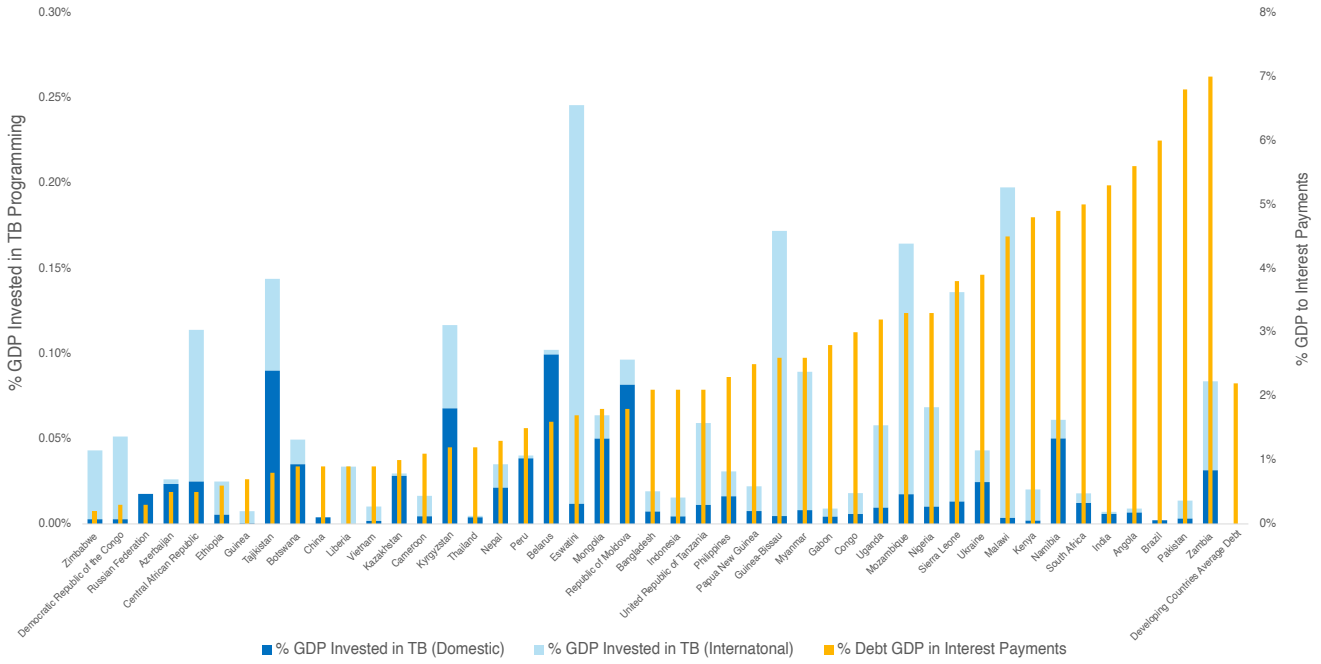


[c] Defined here as debt burdens that are higher than the average for LMICs.

Of 49 high-TB burden countries, 21 are currently in or at high risk of debt distress (Figure 1). The true overlap between the TB epidemic and debt crises is more extensive as IMF analysis of debt burden does not factor in all economic impacts of prioritizing debt payment and divesting from social, cultural, and economic programs in advance of debt default.[18] High debt burdens — even if not in debt distress according to IMF analysis — threaten investment in TB programs and progress toward political commitments made at the 2023 United Nations High Level Meeting on Tuberculosis — including commitments to invest $22 billion in TB programs and $5 billion in TB research annually by 2027.[19 - 21]

Debt distress and loan default often results in austerity measures that restrict expenditure on social services, including TB programs, to divert funds to debt repayment. This practice threatens access to TB prevention, diagnosis, and treatment and other critical government services for millions of people.[22, 23] Countries deploying austerity measures are forced to rely more heavily on donors for critical TB drugs, purchase fewer TB diagnostic test cartridges, employ fewer community health workers, and are unable to invest in necessary TB R&D to advance science relevant to the populations and communities they serve.[24]

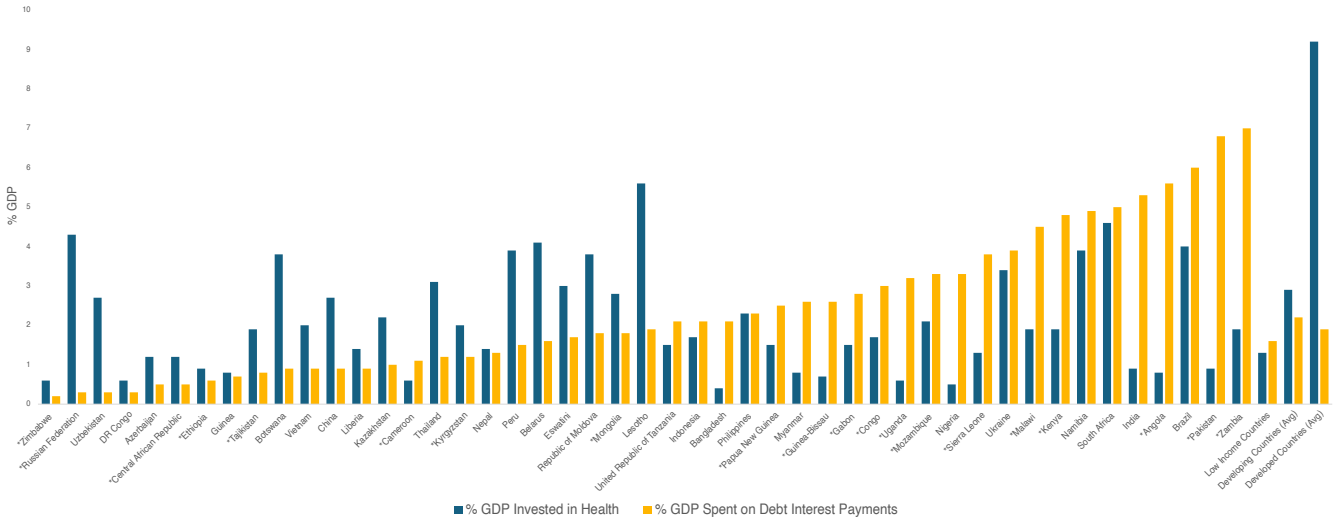
Figure 2: Percent of GDP Going to TB Programs from International and Domestic Sources as Compared to Debt-Share



Countries are arranged in order of increasing debt burden, as represented as % GDP going to debt interest payments (yellow); with investment in TB programs indicated as % of GDP from domestic (dark blue) and international (light blue) sources.

Across all high-TB burden countries, total funding for TB programs including international sources does not exceed 0.25% of GDP; and domestic expenditure on TB programs does not exceed 0.10% of GDP (Figure 2). In countries with high debt burdens, domestic investment in TB reaches a mere 0.025% of GDP. Malawi, for instance, has a total investment in TB programs of 0.20% GDP, but only 0.01% GDP is invested from domestic resources (dark blue) with the bulk of funding coming from international investment (light blue). Meanwhile, around 4.5% of GDP in Malawi is going to debt interest payments (yellow). This pattern holds true in other high-TB burden countries: higher debt is generally correlated with lower domestic investments in TB.[25,26]

Figure 3: Percent of GDP Going to Debt Interest Payments Alone vs Health Spending in 49 High-TB Burden Countries



Countries are arranged in order of increasing debt burden, represented as % GDP going to debt interest payments (yellow) with % of GDP going to health indicated in dark blue.

Zooming out to health expenditure at large, 23 of the 49 high-TB burden countries spend more on debt interest payments than health overall (measured as a % of GDP). Looking again at Malawi, the government spends 2.1 times more on debt interest (yellow) than on health (dark blue). Other countries, like Angola, are spending six-times more on debt interest than health programs. Investment in health is not the only area affected by debt burden — the capacity to invest in locally led R&D is also hindered.[27] Across the high-TB burden countries for which data on investments in TB R&D funding is available, expenditure on TB R&D represents less than 1/5000 of funding going towards debt payments, regardless of overall debt burden or income status (Table 1).[28] This reflects a dynamic in which debt not only limits funding for TB services but also prevents investment in R&D infrastructure and projects to support future TB innovation.

Table 1: Ratio of Funding Going to Debt Interest Payments as Compared to TB Programs and TB R&D

Country	Income Status	% GDP to Debt Interest	% GDP to TB R&D	% GDP to TB Programs	Ratio of Debt Interest to TB R&D	Ratio of Debt Interest to TB Investment
Ethiopia	Low Income	0.6	0.000039	0.00544	15920	109.5
Thailand	Upper middle	1.2	0.000026	0.00392	46360	304.1
Peru	Upper middle	1.5	0.000090	0.03852	16720	38.9
Philippines	Low middle	2.3	0.000412	0.01624	5588	138.1
South Africa	Upper middle	5	0.000944	0.01230	5297	377.5
India	Low middle	5.3	0.000629	0.00592	8422	809.3
Brazil	Upper middle	6	0.000278	0.00216	21570	2461.0

Looking Ahead

Without urgent action on debt relief and reform, debt burdens will continue to grow. Debt distress and the cost of debt servicing will prevent countries from investing in critical TB and health programs today and threaten future investments in all Sustainable Development Goals (SDGs) — hindering the realization of prosperous communities worldwide.[29]

Official development assistance (ODA) has historically funded many health services in LMICs and the bulk of TB services in 14 low-income, high-TB burden countries (Figure 2). In 2025, **termination of thousands of USAID awards** has precipitously decreased funding for TB and other global health programs (e.g., HIV).[30] European governments are continuing to reduce foreign aid, with ongoing **cuts to development and aid budgets**.[31] Collectively, this new landscape demonstrates that ODA is an unstable and unreliable source of sustained funding for TB and other health programs. Debt relief and reform are tools to create fiscal space for countries to invest domestic revenues in TB, health, and research programs.

Debt burdens also **limit the uptake of innovations to fight TB** in the communities that need them most. 52% of high-TB burden countries in or at risk of debt distress will also face Gavi ineligibility within 5 years as they transition to self-financing — just as new TB vaccines are poised to enter the market.[32] Without addressing the debt crisis, the same countries will experience difficulties securing capital to procure the new TB vaccines necessary to stem the tide against TB. As TB tools such as **new treatment regimens, point-of-care diagnostics, and potential new TB vaccines enter the market**, up-front domestic investment will be critical to ensuring access to these innovations. Growing debt burdens eat into available resources to support implementation of forthcoming TB tools, which in turn weakens national TB programs and denies citizens their right to the benefits of scientific progress.

Recommendations

Advocacy efforts from civil society, labor, health sector, and TB-focused organizations and allied groups are required to protect TB programs, health systems, and research from divestment during debt crises, and to push for broad debt relief and reform to protect investment in health and the SDGs in the years ahead. Further, targeted efforts are required to push lenders and Global North institutions to adopt equitable financing reforms and to facilitate dialogue between communities, civil society, Ministries of Health, Ministries of Finance, and central government borrowers to ensure that freed domestic resources are equitably invested in TB, HIV, health programs, research, and other SDG aligned efforts. These efforts must be multipronged, focused on policy solutions that pair immediate relief with reforms to future lending, targeting lending bodies and borrowers in tandem. The following policy solutions should be considered and pursued:

Debt Relief from all lending partners to reduce or eliminate debt burdens with no requirements of repayment. This approach is limited to addressing existing debt crises and creating immediate fiscal space for high debt burden countries to invest in health, education, and development.

Example: *Jubilee 2000 campaign to forgive debt for investment in HIV/AIDS programs.*[33, 34]

Use of Special Drawing Rights (SDRs) to allow indebted countries to draw World Bank/IMF SDRs. SDRs can be sold and converted to hard currency[d] to fund development projects, invest in health and SDGs, or pay off debt. SDRs can alleviate the impact of debt distress by growing hard-currency reserves and creating fiscal liquidity for domestic investments.[35, 36]

> ***Example:*** *The issuance of $650 billion in SDRs for Covid-19 response, through which 22 countries paid down outstanding debt.*[37 - 39]

Debt Reform (Legislative) that would require all lenders to negotiate debt restructuring, accept equitable decreases in investment returns, and close loopholes to end sovereign debt-profiteering. Legislative reform efforts concentrated in New York State and England can effectively address the vast majority of all sovereign debt contracts and generate protective frameworks responsive to future economic shocks.(40)

> ***Example:*** *New York State Senate Bill S.5623/A.5290, if passed, would close loopholes in champerty laws that currently allow vulture funds to purchase defaulted bonds with the sole purpose of litigating full payout, even while other lenders accept losses.*[41, 42]

Expansion of Concessional Financing that offers favorable terms to borrowers (e.g., lower interest rates, longer repayment timelines) to replace traditional, market rate terms and allow countries to invest in development goals.[43] Concessional financing must be paired with debt relief to ensure that concessional loans are directed towards investments in public services and not paying off existing, market-rate loans.

> ***Example:*** *The World Bank's International Development Association (IDA) provides loans to 78 eligible countries (Gross National Income lower than $1,335 in 2025) with lower interest rates and longer maturity than market rate lending. Previously, concessional loans have gone to Ebola crisis response in West Africa, Covid-19 programs, and health system strengthening.*[44 - 46]

(Some) Historic Debt Cancellations[51 - 55]

- **2400 – 1400BC**
  Recurring debt cancellation in Babylon
- **1792BC**
  King Hammurabi of Babylon forgave all citizens' debts owed to the government
- **1934**
  Europe, WWI and Great Depression debts forgiven
- **1941**
  Mexico, debts incurred from the Revolution to support WWII Labor in the Americas
- **1953**
  West Germany, WWII debts forgiven as part of London Debt Agreement
- **Jubilee 2000**
  Relief for heavily indebted poor countries
- **Jubilee 2025 *(proposed)***
  Debt relief for Global South countries to address the global debt crisis

[d] Globally traded currencies that are considered stable and unlikely to quickly lose value (e.g., U.S. Dollar, Japanese Yen, Euro, British Pound, and Chinese Yuan).

What About Debt Swaps?

While there has been support for Debt-to-Health swaps in the TB field, other debt swap schemes have shown little evidence of effectiveness at increasing investment in health or other public programs or projects.[47, 48] Debt swaps are too narrow an intervention and often fail to create fiscal liquidity, especially for countries with debt held by private lenders.[49] Debt-to-Health swaps do have the benefit of creating forums for lending countries to administer bilateral "unofficial" ODA which may serve to raise political will.[50] Overall, Debt-to-Health and similar schemes are insufficient to address the debt crisis, especially in the absence of larger scale debt relief from all lenders and overarching debt reform and restructuring. Further, existing Debt-to-Health programs rely on multilateral organizations reliant on ODA for funding — leaving these schemes vulnerable to political whiplash and funding sustainability challenges. Debt-to-Health programs may have a role in broader concessional financing schemes, but ultimately fall short of producing the domestic resource mobilization and locally led investments necessary to fight TB in the years ahead.

Conclusion

Failure to address the ongoing and accelerating debt crises in high-TB burden countries threaten progress towards the SDGs and political commitments made during the UN High Level Meeting on TB. As U.S. and European budgets for foreign assistance and development are slashed, debt relief and reform, SDRs, and broader concessional financing offer an alternative path forward — providing fiscal autonomy to nations, allowing for localized efforts to end TB, enabling investments in health systems suitable for each community, and ensuring wealth generated in a country is invested back into the country.

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