SICK DEVELOPMENT

How rich-country government and World Bank funding to for-profit private hospitals causes harm, and why it should be stopped

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Development finance institutions owned by European governments and the World Bank Group are spending hundreds of millions of dollars on expensive for-profit hospitals in the Global South that block patients from getting care, or bankrupt them, with some even imprisoning patients who cannot afford their bills. At the height of the COVID-19 pandemic, some of these same hospitals denied entry to patients suffering from the virus or sold intensive care beds at eyewatering prices to the highest bidder. These development institutions have woefully inadequate safeguards, invest via a complex web of tax-avoiding financial intermediaries, and offer little to zero evidence on the impacts their investments are having. Oxfam is calling on rich-country governments and the World Bank Group to immediately halt their spending on for-profit private healthcare, and for an urgent independent investigation to be conducted into all active and historic investments.

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For further information on the issues raised in this paper please email advocacy@oxfaminternational.org

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Cover photo: One of the leading private hospital chains in Kenya, the Nairobi Women's Hospital, regularly imprisoned patients until their bills were paid. One newborn baby was reportedly held for at least three months; a schoolboy for 11 months. Bodies of those who have died have been held for up to two years. The hospital has been funded by the development finance institutions of the UK, France and Germany, as well as the World Bank Group. Photo: Linda Oduor-Noah / Oxfam

SUMMARY

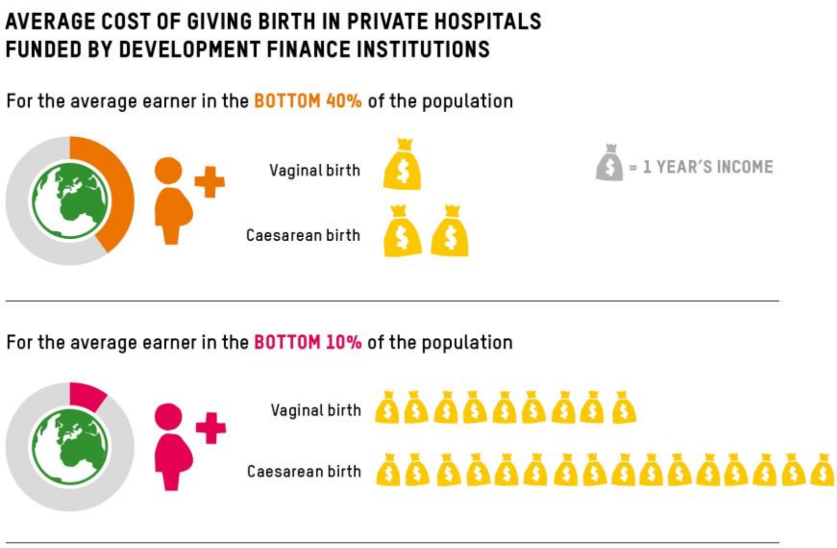
'I feel very sad seeing her… It is not easy for me because her body has changed… It does not look like a body anymore; it's more like a stone… We plead with the hospital to give us the body. We will never be able to pay the money no matter how long they keep it.' – Franciska Wanjiru, whose mother's body was detained for non-payment of a bill at Nairobi Women's Hospital, Kenya.

Across low- and middle-income countries, many private for-profit hospitals are systematically exploiting and abusing patients and denying them healthcare, causing hardship, suffering and impoverishment. A number of these hospitals are funded by European governments and the World Bank Group.

In these hospitals, patients are imprisoned for not paying their bills. The right to emergency care is denied. Treatment is impossibly expensive. Patients entitled to free care are instead pushed into poverty, having to pay high fees to access health services. During the COVID-19 pandemic, some of these hospitals behaved appallingly, profiteering from people's pain and fear in the face of this new disease.

Oxfam's research for this paper maps the money trail between the development finance institutions (DFIs) of the UK, France, Germany, the EU and the World Bank Group to for-profit private healthcare providers in the Global South. Via primary research and detailed country case studies, as well as broader desk-based reviews and investigative searches of nearly 400 investments, Oxfam assesses whether DFI promises to advance universal health coverage (UHC) are being delivered and whether obligations to protect rights are being upheld. The research finds clearly that they are not.

Instead, taxpayers' money is being used to back expensive, for-profit private hospitals that block, bankrupt or even detain patients who cannot pay – and all this with funds mandated to fight poverty and achieve development goals.



What are development finance institutions?

DFIs are wholly or majority government-owned, or multilateral agencies tasked with funding private sector development in the Global South. They are backed by taxpayers' money and guarantees.

The five DFIs assessed in this report have a mandate to help deliver the Sustainable Development Goals, reduce poverty and support inclusive growth. All DFIs have obligations and responsibilities to uphold and protect human rights.

DFIs have grown in size and influence in recent decades, as governments' enthusiasm for the private sector and private finance as a panacea to the world's problems has also grown.

Oxfam's research found:

- **Patients imprisoned until bills paid**

One of the leading private hospital chains in Kenya, the Nairobi Women's Hospital (NWH), regularly imprisoned patients until their bills were paid. One newborn baby was reportedly held for at least three months, and a schoolboy for 11 months. Bodies of those who have died have been held for up to two years.

Nairobi Women's Hospital has been funded by the UK's British International Investment (BII), France's Proparco, Germany's Deutsche Investitions- und Entwicklungsgesellschaft (DEG) and the World Bank's International Finance Corporation (IFC). Most of this funding was given a year after a media interview in which the then hospital CEO made clear that it was the hospital's policy to detain patients until bills were paid.[1] Nairobi Women's Hospital shareholder TPG told Oxfam: 'These events appear to have occurred before our ownership period'.[2]

- **Patients entitled to free care pushed into poverty**

Patients interviewed by Oxfam said that they were blocked from using their government health insurance cards at Narayana and CARE Hospitals in India, and suffered financial hardship due to bills that they should not have been charged. The hospital bill for Eva's mother cost the equivalent of more than seven years of Eva and her father's combined total income. After paying his health debts each month, Robert and his family were left with just US$16 per month to live on. Fees charged to patients who sought care at these hospitals ranged from between three-and-a-half months' to 14 years' worth of wages for an average earner in India.[3]

Narayana Health was funded by the UK's BII until 2023; CARE Hospitals is funded by the UK's BII, France's Proparco and the World Bank's IFC. Narayana and TPG, a shareholder of CARE Hospitals, deny that their hospitals reject government health insurance cards.

- **Urgently needed maternity care far out of reach**

Nigeria has the fourth worst maternal mortality rate in the world.[4] Around 90% of the poorest women give birth on their own without a midwife or other medical professional.[5] Hygeia's Lagoon hospitals are located in some of the most exclusive districts of Lagos.[6] Childbirth costs there start at the equivalent of nine months' income for the poorest 50% of Nigerians.[7] A caesarean birth at the even more expensive Evercare hospital, just a few kilometres away, would cost 24 years' income for the poorest 10%.[8]

Hygeia is funded by France's Proparco, Germany's DEG, the EU's European Investment Bank (EIB) and the World Bank's IFC. Evercare Hospital is supported by BII, Proparco and IFC.

- **Emergency medical care denied**

In India, patients have a right to emergency care from all hospitals.[9] Yet Oxfam's research uncovered multiple allegations of private hospitals turning people away. In one example, a child badly hurt and left unconscious by a traffic accident was denied treatment by a CARE hospital unless the family paid US$1,200.

CARE Hospitals is funded by the UK's BII, France's Proparco and the World Bank's IFC. The company's shareholder TPG told Oxfam that patients are always provided with treatment in an emergency irrespective of their financial situation.[10]

- **COVID-19 profiteering**

During the pandemic in Uganda, Nakasero Hospital in Kampala reportedly charged US$1,900 per day for a COVID-19 bed in intensive care.[11] The bill for one patient who died from the virus at TMR Hospital came to an extraordinary US$116,000.[12] Oxfam's research reveals numerous other examples of unethical and exploitative behaviour by private hospitals during the pandemic.

Nakasero Hospital is funded by France's Proparco, the EU's EIB and the World Bank's IFC. TMR Hospital is supported by the UK's BII and France's Proparco.

- **Patients pushed to have unnecessary treatments**

Some patients interviewed by Oxfam made serious allegations about medical malpractice and exploitation. In one case, a patient said that CARE hospital staff had told him that he had an 80% blockage to his heart and needed emergency surgery to save his life. He was suspicious and fought to be discharged. He saw a government doctor who repeated the tests and showed the diagnosis to be entirely false.

CARE Hospitals is funded by the UK's BII, France's Proparco and the World Bank's IFC. Its shareholder TPG told Oxfam: 'CARE have a robust counselling mechanism and family members are counselled by the team of treating doctors about the treatments being given. There are specific counselling forms and mechanisms properly documented'.[13]

These are just a few examples of the many cases uncovered by Oxfam in this report.

THE URGENT NEED FOR UNIVERSAL HEALTHCARE

Half the world's population are denied access to even the most essential healthcare.[14] Sixty people every second suffer catastrophic and impoverishing costs paying for healthcare out-of-pocket.[15] Instead of reducing these harmful costs, which all governments agreed to do in 2015 as part of the Sustainable Development Goals, they are rising rapidly.[16]

Achieving UHC is not possible without an explicit focus on reaching the poorest and most marginalized people at scale while protecting them from financial hardship. This cannot wait. COVID-19 showed the world that fixing deadly healthcare inequalities between rich and poor people, and between richer and poorer nations, is in everyone's interests. Proven routes to achieving this incorporate a central role for governments as both funders and providers of healthcare, a focus on comprehensive primary healthcare, training and recruiting sufficient health workers, and removing user fees.[17]

Aid and other forms of government spending on public healthcare work to save and transform lives. Ethiopia successfully used aid to achieve most of the health-related Millennium Development Goals by 2015, including cuts to maternal and child deaths of around 70 percent.[18] The Global Fund to Fight AIDS, Tuberculosis and Malaria has saved more than 50 million lives since its creation.[19] In low- and lower-middle-income countries doing most to stop poor women dying in childbirth, 90% of the care provided comes from the public sector, and 8% from the private sector.[20]

But instead of keeping aid promises and following the evidence, rich-country governments are increasingly outsourcing development to private sector-focused financial institutions with no guardrails to protect even essential services like health and education.

A poorly evidenced, but largely unchallenged, narrative has emerged that says extending healthcare to those most denied it can be done by funding for-profit, fee-charging healthcare providers and encouraging more private finance, including private equity firms, to do the same. Approaches that would likely be deeply unpopular in European nations are being exported to the Global South, with little democratic oversight and with significant taxpayer-backed budgets.

THE SCALE OF DFI FUNDING TO PRIVATE HEALTHCARE

Oxfam's research found a total of 358 direct and indirect investments in private health companies in low- and middle-income countries made by the four European DFIs (BII, DEG, EIB and Proparco) between 2010 and 2022.[21] Of this number, 56% were in for-profit hospitals or other kinds of for-profit healthcare providers – the focus of this report.

Since 2010 the four DFIs have invested at least US$2.4bn in health, both directly and indirectly via health-specific financial intermediaries (FIs). They invested a further US$3.2bn in multi-sector FIs, which invest in health among other sectors. The proportion of the US$3.2bn going to health is not disclosed.[22]

The World Bank's IFC co-invests with these European DFIs in at least 42 of the same FIs and at least 112 of the same private health companies.

The searches required to add up these figures were complex, difficult and painstaking. Data is challenging to source, and the research revealed an alarming and unacceptable transparency and accountability gap on the part of these publicly owned and supported institutions.

Of serious concern is that at least 81% of the European DFI health investments Oxfam identified are made indirectly via a complex, unaccountable and often invisible web of tax-avoiding FIs, mostly private equity funds. These out-of-sight investments are mostly undisclosed and certainly unscrutinized. Of the European DFIs, only the UK's BII routinely reports these sub-investments, and then only their names. For the other DFIs it is impossible to know how many indirect health investments may have been missed by Oxfam's research.

Of 140 financial intermediaries used, 80% are domiciled in tax havens, primarily Mauritius and the Cayman Islands.[23] This raises urgent questions as to whether and how the DFIs ensure their health investments are not complicit in tax avoidance schemes that deny governments the revenues they urgently need to bolster public healthcare services.

There is little to reassure that even those investments made under direct control of the European DFIs have any real intent to advance UHC. Only a fifth of project descriptions even mention low- or lower-income patients; only 7% make specific reference to women and girls. Shockingly, Oxfam did not find any disclosed comprehensive impact evaluation or any meaningful and substantiated impact data at all, let alone in relation to tackling healthcare inequality or financial hardship.[24]

How does IFC compare?

The World Bank's IFC has been at the vanguard of the drive to use public funds to maximize the role of both private finance and commercial providers in healthcare systems in the Global South.[25] However, independent evaluations have repeatedly raised concerns that it has failed to provide evidence for the impact of its investments on healthcare inequality or access for lower-income groups.

The World Bank's Independent Evaluation Group (IEG) in 2018[26] found that the IFC's global health portfolio performed comparatively better than its other portfolios in some respects, including environmental and social sustainability. However, it found no evidence to assess affordability, to identify the main users of health services, or to measure impact on marginalized communities. Evaluators said the overall distributional impact of the IFC's health projects remains unknown.

Previous evaluations reported that IFC health projects 'benefited primarily upper- and middle-income people at the top of the pyramid'.[27] Another reported that the IFC had not analysed how to reach poor people effectively via the private sector, had not directed investments for the benefit of poor people, and had not measured whether poor people were being reached.[28]

New research from Oxfam India has found that IFC has not disclosed any results for its healthcare lending and investments in India since they first started over 25 years ago.[29] Other findings include that IFC has mostly invested in high-end urban hospitals which are out of reach for the majority of Indians. Several IFC-supported hospitals have consistently failed to provide free care to poor patients, despite this being a government condition under which free or subsidized land was allotted to the hospitals. Indian regulators have upheld numerous complaints relating to violations of patients' rights, including overcharging, denial of healthcare, price-rigging, financial conflict of interest, and medical negligence in IFC-supported hospitals. The IFC does not acknowledge or engage with these recurring and systemic problems in its public disclosures.[30]

A FUNDAMENTALLY FLAWED IDEA

In the void of impact evidence from the DFIs themselves, Oxfam's research strongly indicates that far from advancing UHC, DFIs are doing the opposite. By funding the expansion and growing market dominance of expensive private hospitals – with inadequate regulatory oversight or safeguards – they risk driving up healthcare inequality, diverting public funding and locking out opportunities for building truly universal and equitable health systems.

Some DFIs suggest that government health insurance or other contributory social health insurance schemes can solve access barriers to private hospitals for low-income patients. Such schemes may be a lucrative source of income for profit-seeking hospitals, but in the Global South they have proven more costly, more exclusionary (especially of women) and have produced worse health outcomes and given less financial protection, than government-funded healthcare.[31] Worse still, evidence from countries like India shows that by encouraging large-scale inclusion of for-profit hospitals, poor and marginalized people, particularly women, are being exposed to even greater risk of catastrophic and impoverishing healthcare bills.[32]

DFI claims that private finance is essential to achieving UHC are directly at odds with World Health Organization (WHO) guidance that countries should reduce reliance on private financing,[33] and instead progress towards primarily publicly funded health care.[34] Evidence shows that in countries across the world, the higher the share of private financing for health, the higher the rate of women's deaths;[35] the greater the inequality in life expectancy between rich and poor people;[36] and, during the pandemic, the higher the rate of COVID-19 infection and deaths (after controlling for other factors).[37]

Profit maximization objectives in healthcare bring inherent risks to public health and patient rights. The latter go largely unacknowledged in the DFI health narrative, and this blind spot was confirmed recently by the UN Human Rights Office.[38] Oxfam's findings of alleged and confirmed unacceptable harm caused to patients and their families by DFI-funded healthcare providers in many countries expose the inadequacy of DFI governance and oversight to safeguard and protect patients.

Oxfam's research for this report has focused on the losers of this dangerous DFI experiment to help financialize and commercialize healthcare in the Global South: the patients and carers paying exorbitant, life-changing bills, paying with denial of their rights, and paying with exclusion from care.

The winners also deserve attention. They include the private equity firms, notorious for siphoning wealth out of social sectors and driving down working conditions and care standards, with women paying the greatest price.[39]

Winners also include the millionaire and billionaire owners of DFI-supported corporate hospital chains. The president of Proparco and IFC-backed Rede D'or is Brazil's tenth richest billionaire.[40] Ranjan Pal, controller of BII-backed Manipal Group, saw his real-terms wealth grow by US$1.48bn in the last year alone.[41]

What is clear is that this report is not an account of a few bad apples in an otherwise functioning system. Instead, it exposes the fundamentally flawed and dangerous idea that spending precious development funds on expensive for-profit healthcare in contexts of extreme inequality and woefully inadequate regulation, and without robust safeguards, will help fight health poverty and inequality and advance healthcare for all. It is about an approach that has been allowed by rich-country governments to flourish unhindered by inconvenient counter-evidence or meaningful accountability. It is an approach that is causing unacceptable harm and should be stopped.

TIME TO DELIVER FOR HEALTH

Oxfam is calling on rich country governments and the World Bank Group to:

- Stop all future direct and indirect funding from development finance institutions to for-profit private healthcare;
- Urgently commission an independent and comprehensive evaluation into all active and historic healthcare investments; and
- Take action to remedy any harms resulting from these investments.

All governments should stop promoting and financing the commercialization, financialization and privatization of healthcare, and instead focus on scaling up and strengthening public healthcare systems that are equitable, gender-transformative, universally accessible and free at the point of use. Government and social accountability capacities to regulate private providers must be strengthened, with priority focus on protecting and promoting patient rights.

INTRODUCTION

Eva said that she felt cheated and exploited by CARE Hospital. The bill for her mother's treatment and care came to an astonishing INR 30 lakh (over US$36,000) – nearly four times the maximum charge promised by one of the hospital's senior consultants, and the equivalent of more than seven years of Eva's and her father's total combined income. Eva said that the hospital had refused the family's government health insurance card, insisting she could afford to pay.[42] She also said that the private health insurance the same consultant had convinced her to buy and had promised would cover the bill had refused to reimburse her.

At every step of her mother's treatment Eva said that she felt threatened by the doctor, who repeatedly told her, 'If you don't follow my advice in full, if anything happens in between, I will not be held responsible.'

Eva used her life savings; borrowed from friends; took out a loan, as did her father; and sold the small family plot of land. Most devastating for her were the personal consequences of her huge financial losses and ongoing debt: 'The most damaging thing that has happened to me is that my long-time love had to marry some other person because I couldn't escape from this huge financial tangle and get married to him… I developed some mental health problems because of all the stress… I only sleep with the help of medicines. I'm unable to make decisions easily because of all the distress. I still feel trauma from the bad experience.'

When asked if she was comfortable with having her name used in this report, she said: 'I'm least bothered about my life. The doctor has already killed all my hopes and aspirations in life, so he cannot kill me anymore. I'm financially killed; I'm psychologically damaged; my family life has collapsed; my career is damaged. What else is there to fear?'[43]

Eva's story – from Odisha in India – is just one of many patient and caregiver experiences identified by Oxfam that involve life-changing financial hardship and other forms of rights violations, abuse and malpractice experienced when accessing or attempting to access treatment and care at private for-profit hospitals – which are funded by high-income country governments and the World Bank with money mandated to fight poverty and achieve the Sustainable Development Goals (SDGs).

This report is about the role of development finance institutions (DFIs) – owned or part-owned by high-income governments or multilateral development agencies like the World Bank – in financing for-profit healthcare in countries that have enormous unmet health needs, extreme healthcare inequality and unacceptably high numbers of people being pushed into poverty as a result of paying for healthcare out-of-pocket.

It is a role that has been under-investigated.[44] This is surprising, especially given the independently verified harm done by hundreds of development projects funded by these institutions in other sectors, including the displacement of communities, putting women and girls at increased risk of violence and undermining the rights of Indigenous communities.[45]

This paper focuses on three of the largest rich country bilateral DFIs, owned by the French, German and UK governments, together with two of the largest multilateral DFIs, owned by the European Union and the World Bank Group (see Box 1).

Box 1: What are development finance institutions?

The DFIs focused on in this report are:

- the UK government's British International Investment (BII, formerly CDC);[46]
- Germany's Deutsche Investitions- und Entwicklungsgesellschaft (DEG);
- France's Proparco;
- the European Investment Bank (EIB).

The role of the World Bank Group's International Finance Corporation (IFC) is also profiled, but only where its financing for health overlaps with that of the other four DFIs. A sister report from Oxfam India looks at the role of IFC in India's healthcare sector,[47] and Oxfam has previously investigated the organization's role in health in Africa.[48]

DFIs are wholly or majority government-owned, or multilateral institutions that directly invest in and mobilize private finance for private sector projects in low- and middle-income countries (LMICs). They source their capital from national or international development funds and/or benefit from government guarantees.

BII is the only one of the five DFIs featured in this report to be wholly funded by official development assistance (ODA) and uses UK ODA and the Bill's existing assets to invest. IFC receives some ODA via the International Development Association (IDA) Private Sector Window,[49] which funds for-profit companies in LMICs including in health. Global ODA rule changes in 2018 increased the likelihood that more DFI funding will be counted towards government aid budgets.[50]

DFIs fund private sector development with grants, loans, guarantees, equity investment, lending through financial intermediaries and blended instruments such as public-private partnerships (PPPs).

The five DFIs assessed in this report all have a mandate to help deliver the SDGs, reduce poverty and support inclusive growth. Job creation and improving private sector access to finance feature as objectives across almost all DFI investments regardless of sector. All DFIs have obligations and responsibilities to uphold and protect human rights.

DFIs have to make a profit from their investments.

THE PUSH FOR PRIVATE

Proven routes to achieving healthcare for all incorporate a central role for governments as both funders and providers.[51] More contested is the role that for-profit healthcare providers can play.[52] Despite a lack of evidence, since the 1980s some of the most influential development institutions have consistently promoted a greater role for such providers in their rhetoric and policy.[53]

The past decade has also seen the normalization of a new narrative that to finance the globally agreed SDGs, including in healthcare, scarce public funds must be used to leverage and 'crowd in' trillions of dollars in private finance.[54]

It is in this context that the role of DFIs in directly financing for-profit health companies, and in encouraging a bigger role for financial markets, financial institutions and financial elites in healthcare in LMICs – a process known as financialization – has gained prominence,[55] and thus deserves greater scrutiny.

THE PROMISE FOR HEALTH

In healthcare, DFIs promise to both make a return from their investments and contribute to the achievement of universal health coverage (UHC)[56] – the globally agreed SDG that all people should have access to the full range of quality health services they need, when and where they need them, without suffering financial hardship.[57] This means protecting people from being pushed into poverty or having to use their life savings, sell assets or borrow – thus destroying their futures and often those of their children – by having to pay for healthcare out of their own pockets at the time of need.[58]

All but one of the five DFIs[59] have placed some emphasis on their role in reaching low-income, under-served and/or disadvantaged populations, and on improving the affordability as well as the quality of healthcare.[60] France's development legislation says that funding must contribute to reducing inequalities in access to health services and must prioritize mainly the populations living in the greatest poverty or those in vulnerable situations to achieve UHC.[61] IFC says that it is committed to supporting companies that are providing health services to people on low incomes in commercially viable ways.[62] The EIB told Oxfam that all its projects are required to support equity of access to quality health services.[63] BII staff told Oxfam that BII's health impact framework[64] stipulates that investments must expand access and improve the quality of patient care, and not undermine countries' overall healthcare provision.[65]

BII, DEG and IFC are all part of the Investors for Health initiative set up to help like-minded investors discuss how to build 'inclusive healthcare systems in emerging markets' and avoid approaches that might 'inadvertently undermine the goal of universal health coverage'.[66]

What is lacking is a clear and evidenced theory of change as to how DFI investments in for-profit private healthcare providers will succeed in advancing pro-poor and gender-equitable access to quality healthcare without financial hardship.

EVIDENCE IGNORED

The DFI health narrative is dangerously quiet on the known and well-evidenced risk that commercial and market-based approaches in healthcare can entrench and exacerbate the gap between rich and poor, and between women and men. They can also skew resources away from already under-funded government services while excluding those who cannot pay; lack incentives to prevent ill-health; and provide perverse incentives to misdiagnose or over-treat.[67] Evidence of effective regulation of for-profit healthcare providers is rare.[68]

IFC has pointed to high levels of out-of-pocket health spending as a leading cause of impoverishment and something it is committed to tackling, yet simultaneously presents the same spending as evidence of 'ability to pay' and of growing 'demand' for private healthcare.[69]

The DFIs all claim that scaling up private financing is essential to achieve UHC. But this directly ignores the World Health Organization's (WHO's) guidance that to achieve UHC, countries should reduce their reliance on private financing[70] and instead progress towards primarily publicly funded healthcare, because it leads to better efficiency, effectiveness and equity.[71]

Similarly, DFIs ignore inconvenient evidence showing that in countries across the world the higher the share of private financing for health, the higher the rate of women's deaths;[72] the greater the inequality in life expectancy between rich and poor;[73] and, during the pandemic, the higher the rate of COVID-19 infection and deaths (after controlling for other factors).[74]

Aid for health matters

Aid plays a critical role in tackling healthcare crises, strengthening public services, and boosting social protection in lower-income countries. With the right kind of aid countries have delivered transformative change. For example, Ethiopia, which consistently ranks among the top aid recipients, achieved most of the health-related Millennium Development Goals including cuts to maternal and under-five mortality, as well as deaths from malaria by around 70% by 2015. New HIV infections were also cut by 90% and deaths from TB were cut by half.[75] Mozambique used aid to increase its health spending by over half and cut the number of children dying by nearly 20%.[76] Health programmes supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria have saved more than 50 million lives since the fund's creation in 2002. AIDS-related deaths have been reduced by 70% and new infections have been reduced by 54%.[77]

Health has long been a stated political priority within the international community. The COVID-19 pandemic was a reminder of the urgency to invest in strengthening health systems. However, health still represents only 10% of bilateral international aid and 11% of World Bank funding.[78]

Oxfam calculates that at least an additional US$4.4 trillion is needed to meet the SDGs in the health, education and social protection sectors in low- and lower-middle-income countries, including US$2.5 trillion via aid and debt relief. Another US$4.1 trillion is required in upper-middle-income countries.[79]

Many countries in the Global South do not have sufficient resources to guarantee the right to health and to face future pandemics. Funding needs are enormous and donor countries must prioritize investments in achieving UHC and strengthening public health systems rather than diverting public resources to harmful approaches.

WHAT DO DFIS FUND IN HEALTH AND WHAT IS THE IMPACT?

This paper presents research by Oxfam that goes beyond the DFI rhetoric to examine what for-profit private healthcare companies they are funding (both directly and indirectly via private equity funds and other financial intermediaries). The research analyses whether the DFIs are advancing access to quality healthcare for poor and marginalized people without financial hardship; and whether they are fulfilling obligations to uphold rights and do no harm.

The evidence in this report was collected via three main routes:

1. A comprehensive mapping of funding to for-profit health companies over the period 2010–22 of four of the DFIs, using DFI websites, other databases and broader Internet searches.[80] These data were cross-checked against IFC's project portal to identify any overlapping projects.
2. Primary research in India – the country with the highest concentration of DFI investments in healthcare – involving individual and focus group interviews in the states of Chhattisgarh and Odisha, to better understand whether DFI-funded hospitals always uphold and protect patient rights and advance access for poor and marginalized people to quality healthcare, without financial hardship.
3. Desk-based research (including company websites, academic literature and media searches) to collect publicly available information on the affordability and accessibility of DFI-funded private healthcare providers and any information related to patient rights. Many hospitals were also contacted directly for information on fees. Oxfam utilized its global network of staff, partners and contacts to seek further information about healthcare providers where possible.

Oxfam also had at least one meeting with each DFI team responsible for investing in health. Companies named in the report were given an opportunity to comment and their feedback has been incorporated.[81]

A full methodology note for the research is available.[82]

Part 1 of the report focuses on patient and carer experiences at specific DFI-funded private hospitals in Kenya and India – two countries found by Oxfam to have the highest concentration of DFI healthcare investments.[83] It then presents broader evidence from across LMICs about the affordability and accessibility of DFI-funded private hospitals, with a particular focus on maternal health and COVID-19.

Part 2 presents Oxfam's findings on the scale and characteristics of DFI funding to health, as well as the DFIs' own evidence of health impact. It then explores issues of transparency, oversight, regulation and accountability, and makes recommendations.

PART 1: PROFITING FROM FAILURE

DFIs may well succeed in making healthy returns from their healthcare investments but, far from advancing UHC and the right to health, the following evidence – including from two countries with the highest proportion of DFI healthcare investments, Kenya and India – strongly indicates that these profits come at an unacceptably high price.

THE NAIROBI WOMEN'S HOSPITAL

The Nairobi Women's Hospital (NWH) was established in 2001 and today the group operates nine for-profit private hospitals and facilities in Kenya.[84] Despite the name, NWH is a multi-speciality hospital chain providing services to patients of different genders.

Since 2017 there have been frequent media reports[85] about patients being held hostage at NWH because they were unable to pay medical bills. Such cases are alleged to have continued even after a court ruled in October 2018 that NWH had acted unlawfully and in violation of the Kenyan Constitution.[86]

Box 2: DFI funding for The Nairobi Women's Hospital

NWH is a prolific beneficiary of DFI investments.

Germany's DEG, France's Proparco and the World Bank's IFC first invested in the company in 2010 via the Africa Health Fund.[87, 88] Other investors in the same equity fund included the Norwegian DFI Norfund, the African Development Bank (AfDB), the Southern African Development Bank and the Bill & Melinda Gates Foundation.[89]

In 2016, Proparco, the UK's BII and IFC invested US$10m, US$75m and US$100–150m,[90] respectively, in the Abraaj Growth Health Markets Fund (AGHF), which in 2017 bought a 75% stake in NWH.[91, 92] Investors in the same equity fund again include the Gates Foundation[93] and the AfDB.[94]

AGHF was at the centre of a major corruption scandal leading to the collapse of the Abraaj Group [see Box 10]. Following the liquidation of Abraaj, the AGHF has been renamed the Evercare Health Fund and since May 2019 has been managed by TPG Growth.[95]

PATIENTS OR PRISONERS?

In a media interview in November 2016, six years after a first round of DFI investments in NWH, and the year before the Abraaj health fund bought a 75% stake in the hospital on behalf of investors including BII, IFC and Proparco, the then-CEO made it clear that the hospital policy was to detain patients for non-payment of bills, including the bodies of deceased patients.[96]

The evidence below of up to 37 alleged or confirmed human rights abuses against patients by NWH since 2017 is drawn from media sources easily found in the public domain. The evidence does not, to the best of Oxfam's knowledge, apply to NWH's non-profit charitable trust, the Gender Violence Recovery Centre,[97] which provides crucially needed free medical and psychosocial support to survivors of gender violence and their families.

Published and broadcast accounts of both alleged and confirmed patient detentions at NWH include:

16 May 2017: The family of George Mwenje Mwangi make a public appeal to raise funds to pay for the release of his body, reportedly detained by NWH for five months due to non-payment of a US$9,700 bill.[98]

15 November 2017: A TV news report alleges that 12 patients have been detained at NWH facilities due to non-payment of bills. Detainees reportedly included a secondary school boy detained for 11 months for an unpaid bill of US$27,721.[99] In an undercover interview inside the hospital the student said: 'I'm not a prisoner, I need help, I need to go back to school.' The Federation of Women Lawyers and the Center for Reproductive Rights called for the patients' release.[100]

17 December 2017: A woman who lost one of her twin babies during childbirth reports that her surviving twin has been detained at NWH for over three months because she cannot afford the bill of nearly US$3,000. The mother told reporters of the psychological stress she was suffering due to having to commute daily to breastfeed her son before leaving him in the care of nurses.[101]

3 October 2018: A court rules that a patient was held illegally at NWH for non-payment of a US$10,900 bill. Judge Lady Justice Wilfrida Okwany declared that even though this was a private facility, continued detention of the client was arbitrary, unlawful and in breach of the 2010 Constitution of Kenya.[102]

23 April 2019: A refugee from Burundi is detained for non-payment of a US$9,000 bill for his treatment following an accident in September 2018 in which his 10-year-old daughter was killed. His family of seven, who were reportedly on their way to a UN refugee office when the accident occurred, had no means of paying the bill. NWH was reported to have been in discussions to resolve the matter.[103]

19 May 2019: A special report by the Ministry of Health reveals that 12 patients who should have been discharged are being detained at NWH over outstanding bills, with 15 bodies held for the same reason.[104]

July 2019: An undercover journalist interviews four patients detained at NWH for non-payment of bills. Cases include a single mother of two, medically discharged on 22 November 2018 but detained for 226 days for non-payment of her bill of US$989. The bill escalated to US$19,790 during her detention. All four patients were freed following TV coverage. The founder of NWH contacted the TV station to say: 'In cases where people are unable to pay, they reach an agreement with the hospital. For dire cases the hospital receives funding from charitable donors.'[105]

25 October 2019: Two years after the death of her mother, Franciska Wanjiru makes a public plea to NWH to release her remains as a Christmas present, as she cannot afford the US$43,000 hospital bill.[107] After four visits, she stopped going to the morgue, where a single visit cost KSH 500.

March 2021: Kenya's High Court orders NWH to pay Emmah Muthoni Njeri KES 3m (over US$27,000) in compensation for illegally detaining her for more than five months because of an unpaid bill. The judge declared the detention 'a violation of the right to liberty' and 'an affront to human dignity'.[108]

Some of the accounts of these cases indicate that patients accrued additional fees for each day of their detention at NWH. Fees also reportedly accrued for the families of deceased patients whose bodies were detained in the hospital morgue.

'I feel very sad seeing her… It is not easy for me because her body has changed… It does not look like a body anymore; it's more like a stone… We plead with the hospital to give us the body. We will never be able to pay the money no matter how long they keep it.'

Franciska Wanjiru, daughter of patient who died at NWH[106]

HOSPITAL OR TRADING FLOOR?

In January 2020 alleged internal NWH communications, dating mainly from 2018, were leaked, exposing the hourly and daily pressure apparently exerted by senior hospital managers on staff to increase admissions and delay discharges to ensure that income targets were met.[109] In one message the CEO, Dr Felix Wanjala, reportedly told a staff member to 'urgently fix' discharges, because 'yesterday you discharged 14, today planned 12' and this is 'not sustainable'. In another, he wrote, after listing the current statistics: 'Very slow movement. Let's walk patient's journey. Keep pushing for more ip [inpatient] numbers… keep calling for referrals… keep occupancy locked.'[110]

In response to the leaks, many members of the public shared their personal experiences of alleged unethical practices, including overcharging, over-testing and over-treating at NWH and other private hospitals in Kenya.[111] The Association of Kenya Insurers blacklisted NWH and extended its investigations to other hospitals owned by the donor-backed Evercare Health Fund.[112]

Some of the commentators covering the leaked hospital communications directly blamed the rapid and large-scale injection of global finance via private equity firms into Kenya's private healthcare market and claimed that the intensified drive for profits had translated into hospital managers being pushed to 'make money from patients by any means necessary'.[113]

The case of NWH is illustrative of the dangerous inadequacy of due diligence, oversight and monitoring mechanisms for DFI investments. In response to a direct question in a UK parliamentary evidence session in April 2023 about what action BII had taken in response to patient detentions at NWH, BII's CEO said: 'We fired Abraaj as the manager of the fund and replaced them with TPG. TPG, in turn, fired the entire management team at the Nairobi Women's Hospital. They put in place a whistleblowing mechanism in 2021, and, to my knowledge, there have been no incidents reported since then.'[114]

BII's response mischaracterizes what happened. Management of the Abraaj health fund was changed because of identified financial mismanagement and because Abraaj filed for liquidation in June 2018 (see Box 10). BII and the other DFIs first appointed forensic auditors to investigate this in December 2017. Patient detentions happened before and continued beyond this point and for at least another two years. There is no evidence that these human rights violations formed part of DFI investigations into Abraaj.

Oxfam shared evidence pertaining to patient detentions with both NWH and its shareholder TPG. TPG told Oxfam: 'based on the limited information contained in these media reports, these events appear to have occurred before our ownership period... Since then, Evercare has taken numerous steps to prevent such issues from occurring... We have established and reinforced various oversight mechanisms to ensure that the measures are effective to the best extent possible.'[115]

In response to overcharging allegations in early 2020, TPG told Oxfam that independent investigations had cleared the hospital of overcharging but had made several recommendations to improve policies and practice, which have been embraced. It said the Association of Kenyan Insurers reinstated NWH on its list of accredited providers after both parties agreed on measures for improvement.

If proven effective, changes to the management of NWH made by TPG are to be welcomed. However, one measure taken – the introduction of a minimum deposit on admission – would seem to reinforce the point that private hospitals are inaccessible to those least able to pay.

Serious questions remain for the DFIs. Firstly, did these multi-billion-dollar institutions simply fail to identify these widely publicized crimes before and during their investments, or did they know about them and take insufficient or no action to stop them? Secondly, will they act now to remedy the significant harm caused to patients and their loved ones?

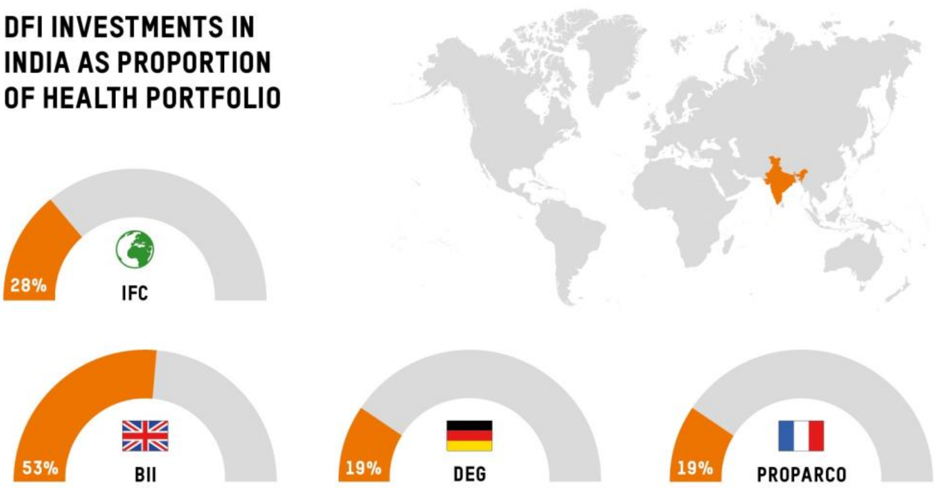
There is nothing to give confidence that concrete and systematic scrutiny of investments is now in place to prevent this happening again in other investments. Indeed, patient detentions by private hospitals, particularly patients on low incomes admitted in emergencies, have been reported to be widespread in many countries[116] in which DFIs are investing, including India,[117] Uganda[118] and Nigeria.[119] This includes a reported case in another DFI-funded hospital in Uganda in which DEG, EIB, Proparco and IFC have invested.[120] In response to this report, both EIB and DEG have questioned their investment in this hospital. Oxfam's evidence indicates both are invested indirectly via private equity funds.[121]

Imprisoning patients is not only a violation of fundamental human rights and illustrative of inadequate hospital regulation, it is of course also indicative of the fact that these private hospital services are unaffordable. The failure of DFI due diligence to identify such practices in even one hospital should raise legitimate questions and concerns about all DFI healthcare investments.

NARAYANA HEALTH AND CARE HOSPITALS, INDIA

India is home to the highest concentration of health investments by four of the five DFIs researched for this paper (see Figure 1). These DFIs have chosen to invest heavily in a country where patient rights abuses by private hospitals are widespread, where out-of-pocket spending on health is a leading cause of impoverishment and where government regulation is inadequate.[122] For all these reasons, India is an important context in which to better understand whether DFI healthcare funding decisions are working to uphold and protect rights and advance the access of poor and marginalized people to quality healthcare without financial hardship.

Figure 1.



Note: IFC has been funding corporate hospital chains in India since 1997 and the country accounted for 28% of IFC's global health portfolio in 2016. For the European DFIs, percentages are of the number and not US$ value of direct and indirect health investments. Oxfam's research identified only one indirect EIB investment in health, or 4% of its total number of health investments. See methodology note for this paper for more information.

Oxfam conducted primary research on patient and caregiver experiences when accessing or attempting to access treatment and care at two DFI-funded hospital chains – CARE Hospitals and Narayana Health – in the Indian states of Chhattisgarh and Odisha in early 2020. The research involved interviews with individual patients, and/or their families, who were identified by community health workers and local patient advocates on behalf of Oxfam. Focus groups with local residents, patients, community organizations and community health workers were also conducted. A methodology note provides further information.[123]

The two states of Chhattisgarh and Odisha were chosen as they have some of the highest proportions of people living in multi-dimensional poverty in the country; both also have large private sectors in healthcare and well-established government health insurance schemes that incorporate private hospitals and aim to improve access to healthcare and financial protection, especially for people living in poverty.

The two companies were chosen because they have hospitals in Chhattisgarh and Odisha; because together they are funded by three of the five DFIs; and because they provide examples of both direct and indirect (via a private equity firm) DFI funding decisions.

To protect identities, the names of all research participants have been changed and the exact dates of their experiences, which all fall within the years 2018 to 2020, are not provided.[124]

Box 3: DFI funding to CARE Hospitals and Narayana Health

CARE Hospitals

CARE Hospitals Private Limited is an Indian, multi-specialty, for-profit healthcare provider with 16 healthcare facilities across six states in India, including in Chhattisgarh and Odisha.

France's Proparco, the UK's BII and the World Bank Group's IFC, along with other donors including the African Development Bank and the Bill & Melinda Gates Foundation, invested in CARE Hospitals in 2016 via the Abraaj Growth Health Markets Fund (a private equity fund), later renamed the Evercare Health Fund and now managed by TPG. BII also invested US$30m directly in CARE Hospitals in 2016.

At the time of publication, private equity firm Blackstone had reportedly signed a binding agreement to acquire a controlling stake in CARE Hospitals, with TPG staying on as a minority shareholder.[125] The sale is reportedly being challenged in court by another IFC investee, Max Healthcare Institute.[126] TPG told Oxfam it could not comment as these matters pertain to ongoing litigation.[127]

Narayana Health

Narayana Hrudayalaya Limited (brand name Narayana Health) is a publicly listed Indian company that owns or manages a network of 21 hospitals,[128] including one multi-speciality hospital in Chhattisgarh, known locally as MMI-NH.

The UK's BII directly invested US$48m in Narayana Health in 2014. BII exited this investment in March 2020, after Oxfam's case study research had been conducted.

FREE HEALTHCARE DENIED

Narayana and CARE Hospitals are both officially registered providers in the Chhattisgarh[129, 130] and Odisha[131] government-funded health insurance schemes. This means that they are required to provide free, cashless healthcare to eligible families with a government health insurance card or other authorized identification,[132] up to a value of INR 5 lakh (approximately US$6,000) per year.

In all cases, enrolled patients should not be required to pay any of the healthcare cost at any stage, and the hospitals must reclaim the costs from the government.[133] Benefit coverage is extensive, covering a comprehensive range of procedures and treatments, including diagnostics, medicines, surgery, implants and bed charges, among others.[134] Neither scheme covers outpatient care.

In both states the objective of the government health insurance scheme is to reduce the financial burden, especially for poor and vulnerable groups, of accessing quality health services. In Chhattisgarh, government health insurance eligibility is universal and around 90% of households are enrolled.[135] In Odisha, the scheme covers over 7 million families identified as 'economically vulnerable'.[136]

Oxfam conducted five interviews with patients (and/or their relatives) with government health insurance cards who sought care at Narayana and CARE hospitals. Three of the patients, including Eva's mother (see introduction), were blocked from using their cards altogether; one patient's card was used only selectively; and the final patient did not know whether or not his card had been used at all due to a lack of transparency about his bill. In no case did the patient or caregiver say that they were given a valid reason for rejection or only partial use of the insurance card. All five patients and/or their caregivers suffered catastrophic financial consequences due to hospital fees that they should never have been charged.

Santosh was visibly emotional, recalling how instead of staying by the bedside of his brother Ravi, critically injured in a traffic accident, he spent the first 20 days desperately running around trying to raise funds to ensure that his life-saving treatment at CARE Hospital could continue. Santosh explained: 'They took the [government insurance] smart card from us, but the hospital staff said that for this case the smart card would not work. I pleaded with them, but the staff refused…I didn't challenge too much because I was so disturbed, I was giving all my attention to my brother…The smart card would really have helped…it would have saved us INR 5 lakh [approximately US$6,000].'

Ravi's injuries were serious and complex. While it is possible that some of his treatment needs were not listed as eligible under the government health insurance scheme, the scheme does include procedures related to injuries suffered in traffic accidents.[137] The scheme also has allowances for non-listed interventions.[138]

Santosh had to take out loans to pay the majority of CARE Hospital's INR 9 lakh (US$12,700) bill and to pay the INR 8 lakh (US$11,300) bill for medicines he was permitted to buy from cheaper providers outside the hospital. He has not yet been able to repay the loans. The financial difficulties mean that, despite Ravi's serious ongoing health issues, the family cannot afford to take him back to CARE Hospital or pay for the physiotherapy that is critical for his recovery.

Similarly, when 73-year-old Hammond was admitted to CARE Hospital with breathing difficulties and severe discomfort in his chest, his wife Gietta asked if they should bring his government health insurance card from home to pay for his treatment. She said: 'The staff told us not to bring the card because it was of no use here. They told me it was for survey purposes and was not used for treatment.'[139]

Hammond had to spend around 30% of his total pension income at CARE Hospital – which is above the threshold deemed catastrophic by the WHO. He and Gietta were concerned about how they would continue to support family members in need.

Narayana Hospital accepted Joshi's government health insurance card but used it selectively. It was refused as payment for Joshi's first eight-day admission but when he was readmitted some weeks later, the hospital staff this time said that he could use the card for his heart surgery. Joshi was told that any other costs associated with his treatment and care while in hospital would have to be paid for in cash. This seems at odds with the rules of the government scheme, which say that tests and medicines are included as part of insured procedures.[140] Research in India suggests that selective use may be explained by private providers 'cherry-picking' more profitable packages for reimbursement through the insurance scheme and charging patients out-of-pocket for others.[141]

Joshi had recently sold his only plot of land to rebuild his family home and help his unemployed son set up a business. Instead, he had to use all the money to pay Narayana's bill of INR 2.5 lakh (US$3,024). He said: 'Now there is no money left. Our budget is over.'

Similarly, Robert's heart surgery was covered by a state support scheme, but CARE Hospital charged him INR 1.35 lakh (US$1,600) for tests and treatment, despite him having a government insurance card. To pay, he had to mortgage his family's plot of land and take out three private loans totalling INR 95,000 (US$1,500). The World Bank Group's IFC invests in and stands to profit from both the hospital that charged Robert out-of-pocket fees and the company he borrowed from to pay them.[142]

After his repayments, Robert and his wife and child are left with just INR 1,300 (US$16) per month. He is unable to repay the mortgage on his plot and, until he does, his lender takes all the produce from the land. Robert said: 'I'm barely managing. I get free rice from the government as well as some help from my nephew.'

Focus groups and stakeholder interviews conducted by Oxfam indicate that these patient and caregiver experiences of unexplained or unjustified refusal or selective use of government health insurance cards by private hospitals are not isolated cases.

In focus group FG5[143] in Chhattisgarh, women working as community health workers in the area around the Narayana Health facility shared their experiences of how the hospital refused to treat patients unless a deposit had been paid, even if they had a government insurance card.

A healthcare assistant who worked at the CARE Hospital in Odisha for two years told Oxfam that she was aware of cases where the government health insurance card was accepted by the hospital but knew of no case where a patient with or without a card was treated free of charge.

Two different state legislators in Odisha told Oxfam researchers that private hospitals commonly refused their constituents' government cards or alternatively admitted patients for a short period and then discharged them before they had recovered, claiming that all the money on the card had been spent. Both legislators said that the practice was most common in the treatment of tribal people and those from scheduled castes. Evidence across India suggests that these same groups are the least likely to seek care at private hospitals or to benefit from government insurance if they do.[144]

The patient experiences documented by Oxfam, together with similar recent qualitative research,[145] provide valuable insight into some of the factors that explain why, despite over 10 years of trying, government health insurance is not working to reduce catastrophic or impoverishing out-of-pocket health spending in India.[146] The evidence suggests that these experiences are repeated across other hospitals and states in India, with out-of-pocket expenditure for patients attending private hospitals many multiples higher than expenditure at public hospitals, regardless of insurance coverage (see Box 7).[147] The proportion of households pushed into poverty by hospital bills is 11 times higher when a family member is hospitalized in a private hospital in comparison with a public hospital.[148]

EXPENSIVE AND OUT OF REACH

The DFIs have stressed the importance of their role in terms of financing affordable or low-cost private healthcare. The fees reportedly charged by both CARE Hospitals and Narayana Health to the people Oxfam talked to for this research ranged from INR 60,000 to INR 30 lakh (about US$730 to US$36,000). That's the equivalent of between three-and-a-half months to 14 years of wages for an average earner in India.[149]

'All private hospitals are the same. They are a death knell, especially for poor people. If even I, a retired government officer on a pension, cannot afford to pay, what must it be like for a poor person?'

Hammond, 73-year-old retired teacher and former patient at CARE Hospitals

Sanjit's bill for 20 days of treatment and care, including two weeks in intensive care, at Narayana Hospital came to INR 5 lakh (US$6,060). Even with the INR 1.5 lakh discount he received as a former government employee, his bill was the equivalent of over two years' wages for the average person in India.[150]

Sanjit's son Aabharan explained that, despite splitting the hospital costs with his brothers and their families, the consequences for his own family were still devastating: 'We used the small amount of money we had saved. That money was for our children's future. Now we have great worry how we will marry our daughters. Our savings would have been used in supporting our children...But we had to save his life. Now all our savings are gone.'

Many of the carers interviewed said that they were aghast at the rapid escalation of their loved ones' hospital bills. Some spoke of an unrealistically high frequency of billing and unreasonable charges for basic items such as protective gloves and hand sanitizer. Others questioned the number of trips they were told to make to the hospital pharmacy and the high cost of medicines, and in some cases doubted whether those medicines were being administered in the quantities prescribed.

Rajesh spoke of his disbelief at receiving a bill of INR 90,000 (US$1,100) just for medicines during his 36-hour stay at a CARE Hospital for what he said was an uncomplicated operation to remove a gallstone.[151] But he conceded: 'You can't really fight with the doctors, you have to pay that bill. I am the patient.'

Ramesh, a medical and sales representative who worked across the central and eastern region of India, claimed that the corporate hospitals make their 'maximum profit from medicines'. He said that the average mark-up on medicines at private hospitals was around 50% but could be more than five times the purchase cost. He added: 'There is a nexus between pharma and the corporate hospitals...Hospitals and pharma are together looting the people.'

He asserted that government policy was also to blame, as the maximum retail prices it sets are unjustifiably high. Even so, he claimed that hospitals still try to charge more than the regulated price: 'One of the tricks played by the corporate hospitals is that they rarely give you a full prescription listing all the medicines. The nurse just gives you a slip. That way it is difficult to know the prices they are charging.'

The problem is widespread in India. Recent analysis found that profit margins for medicines, consumables and diagnostics ranged from 100% to 1,737% in four of the largest private hospitals in Delhi, and these items made up almost half the cost of patient bills.[152] The Competition Commission of India is undertaking an inquiry into inflated drug pricing in three of the biggest corporate hospital chains in the country, all of which are financed by IFC.[153] The Commission's four-year investigation has so far concluded that the hospital chains have been abusing their dominance in the market by overcharging patients for both services and medical products.[154] In a separate case, the Maharashtra state government has filed cases in court against seven hospitals – at least two of them funded by the DFIs[155] – after investigations found that they were reusing single-use catheters and charging multiple patients for the same equipment.[156] The chair of BII-funded Sahyadri Hospitals is quoted as saying: 'We reused catheters only for poor patients and didn't charge them.'[157]

The drive to maximize fees from patients may be one explanation for the view expressed by at least two research participants in each of the six focus groups that people living in poverty are not made to feel welcome at corporate hospitals. For example, a woman from focus group FG5 of women community health workers in Chhattisgarh told Oxfam: 'My 23-year-old son was in an accident. He had been run over by a car. We took him to CARE. They told us it would cost INR 5,000 per day to treat him there. We said we couldn't pay that. The doctor was abusing me, saying "What kind of a mother are you putting money before your child?"'

A woman in focus group FG2 in an informal settlement in Odisha said: 'They don't behave well to us when they know we are from the slum. When they learn that we are from the slum the hospital staff make us leave... We don't take people there now... It is not for us. It is not for the poor families. It is for the rich people.'

EMERGENCY MEDICAL CARE DENIED

As per national legislation, patients in India have a right to receive emergency medical care even if they cannot pay for it.[158] Of eight emergency cases Oxfam heard of where patients were reportedly turned away by CARE Hospitals and Narayana Health, Kanaklata's experience seems the most perverse and iniquitous. This is because she said that her injuries were sustained because of building works that were for the benefit of the hospital that refused to treat her (see Box 4).

Box 4: Kanaklata's story

Kanaklata, a domestic worker, mother and widow, lived in an informal settlement in Bhubaneswar, Odisha that in 2019 was being cleared to make way for an access road to the recently built CARE Hospital.

She said that she was in her house gathering her things when the bulldozers came to demolish the settlement.[159] Her friends said that they found her unconscious in the rubble and rushed her to CARE Hospital next door. She had blood running out of her nose and clear damage to her skull. Her friends said: 'The people there asked us for money. We told them she was an accident victim; that she was a widow with only a girl-child and that she had no money. They told us that her treatment would cost a lot of money and you people cannot afford it. They told us to go.'

Kanaklata's friends took her to a government hospital further away.

She still suffers health problems and bleeding from her nose. Kanaklata said: 'CARE Hospital is not for the common people. It is for big people with big money.'

In focus group FG2 of families displaced from their homes to make way for the new CARE Hospital in Odisha, one woman explained how her 15-year-old son was involved in a traffic accident and was left badly hurt and unconscious. She said that they took him to CARE Hospital, but that the staff demanded INR 1 lakh (US$1,200) to treat him.[160] They couldn't pay, so she said they had no choice but to take him elsewhere.[161]

In focus group FG5 in Chhattisgarh, one community health worker recounted the case of a boy who was stabbed near Narayana Hospital. She took the boy to the hospital herself and, despite having his government insurance card, the staff demanded a deposit before they would treat him. The community health worker acted quickly to try and collect money from the community and raised INR 20,000 (US$240). She said that it was only when she returned with the money that the hospital began treating the boy.

EXTRACTION AND EXPLOITATION

'The corporate hospitals are unethical; they take money for unnecessary treatment; they over-diagnose; they keep patients for more days than necessary; they even detain patients on ventilators, keeping them going so that they can charge additional costs. I also know of cases where dead patients have been detained.' **– Odisha state legislator**

'The private hospitals will tell you that you can be cured even if you have already died.' – **Participant in focus group (FG3)**

Except for one doctor, all those interviewed by Oxfam said that the drive to maximize income and profit had contributed to unethical, exploitative, extractive or in some cases incredibly dangerous and harmful behaviour on the part of private hospitals. Three interviewees had some knowledge of the ownership of CARE and Narayana and suggested that this kind of behaviour had got worse with increasing corporatization and under the ownership of private equity firms and foreign investors.[162]

Four of the patients or caregivers interviewed made serious allegations about medical malpractice and exploitation at CARE Hospitals in both Odisha and Chhattisgarh.

Rajesh was persuaded to go to CARE Hospital by his family doctor to have a problematic gallstone removed. Several tests, including an ECG and echocardiogram to check the health of his heart, were performed ahead of his surgery. Immediately following the surgery, Rajesh said that a different team of doctors approached his bed and without explanation ordered another ECG and echo scan. He said that this time the doctors told him he had an 80% blockage in his heart and that they would need to operate to save him.

Rajesh insisted that he wanted to recover from his gallstone surgery first, but he said that without consulting him or his family the doctors brought medicines for his heart and started trying to inject them in his leg. Rajesh said that when they refused to listen he called in his son, who forced the doctors to stop. He said that the hospital first refused to discharge him and then insisted that it should transfer him to a specific doctor at a different hospital. Rajesh said that it was not until the family involved an influential local figure that the doctors agreed to release him. He then went to a different recommended government doctor, who repeated the tests and told him: 'Whoever is telling you that your heart is blocked is not telling you the truth.'

Rajesh said: 'For our family the money was not an issue… it was the unnecessary treatment that was the problem. We had connections. We were able to raise our voices. But others might get trapped.'

Hammond had a similar experience at CARE Hospital in Odisha. Following tests for breathing difficulties and dizziness, a different doctor approached his bed and started examining him without consulting him. Hammond said: 'When he felt a lump on my tummy, he moved the gown aside and saw my enlarged tummy button. He told me it was a big problem and that I would have to go for immediate surgery. I told him that it's been there since 1994 and I had been told a number of times that it was an abdominal hernia and it's just fine.'

Eva said that after her traumatic experience at CARE Hospital (see introduction) she sought the help of a police officer, who went to question the doctor about the alleged mis-selling of private health insurance and her mother's much higher than promised US$36,000 bill.[163] The doctor reportedly told the police officer that he did not remember the case and asked him to return the next day. When he returned as instructed, the doctor claimed that there was no record of Eva's mother ever being a patient there.

In response to the issue of unnecessary treatment or diagnostics without consent, shareholder of CARE, TPG, said: 'CARE have a robust counselling mechanism and family members are counselled by the team of treating doctors about the treatments being given. There are specific counselling forms and mechanisms – properly documented'.[164]

UNABLE TO CHALLENGE

'You cannot challenge the doctor because the doctor has all the authority. You are at their mercy.' **– Gietta, whose husband was a patient at CARE Hospital**

Inequality and fear seemed to be powerful obstacles to the family members of patients feeling able to challenge unreasonable or unethical behaviour by doctors and other staff at CARE and Narayana hospitals. More than a dozen interviewees and focus group members said that they felt it was simply not their place to challenge a doctor, either because they were poor or because of their perceived inferior status. At least five interviewees said that they felt discouraged, belittled or intimidated by doctors' attitudes and behaviours. Two respondents felt that doctors intentionally exacerbated fear with unnecessary drama and exaggeration. In almost every interview, respondents told Oxfam researchers that challenging the doctor was impossible because they felt it might have a detrimental impact on the quality of care and treatment given to their loved ones.

'The thing is that if you ask something today, if you complain, they will not treat the patient properly…This is our fear. So how can we complain?'
– Joshi, patient at Narayana Hospital

Inequality in power, status and information between provider and patient is inherent in healthcare provision. What is different in for-profit healthcare is the incentive to exploit this inequality for commercial gain. All of Oxfam's interviews with patients and their relatives for this research laid bare the brutal reality that exploitation and extortion of patients and carers by for-profit healthcare providers are frighteningly easy, due to the universal willingness of human beings to make infinite sacrifices to save the life of a loved one.

'Even if the person loses his entire wealth, a person's life should be saved.'
– Sanjit, son of a patient at Narayana Hospital

Box 5: Company responses

Narayana Hrudayalaya (NH) told Oxfam that it does not reject treatment of 'genuine beneficiaries' of government reimbursement schemes, but said that when insufficient beds were available for such patients, they could join the waiting list or were advised about other hospitals. NH said that it does not collect deposits from patients admitted under government reimbursement schemes[165] or charge any additional amounts, including for associated generic medicines, once authorization is received for an approved package. It also said that it does not refuse emergency medical treatment to any patient, regardless of their ability to pay, and that 'our goal is to make high quality healthcare accessible to all. This includes poor people, and they are welcome in all our hospitals.' It added that it has well-developed protocols for processing patients; that all practices at MMI-NH are independently reviewed to ensure that standards of care are maintained; and that it has a robust feedback mechanism that collects patient complaints across multiple channels.

TPG, shareholder of CARE Hospitals, told Oxfam that patients are never refused in CARE facilities 'empanelled under the [government insurance] scheme, as per the specialties approved' and that 'CARE adheres to the terms and conditions of the MOU with the Ministry of Health of the relevant state'. It said: 'CARE neither runs any insurance scheme of its own nor does it promote any private insurance company' and that 'patients are always provided treatment in emergency irrespective of their financial situation… CARE provides treatment to many below poverty line… patients. By way of example, in the past 12 months, CARE has treated +90,000 such patients as inpatients (approx. 15% of total number of inpatients)'.[166]

TURNING A BLIND EYE?

It is implausible that anyone carrying out even a cursory fact-finding review of India's private healthcare market would not have found plenty of evidence pointing to large-scale violations of patients' rights in a context of woefully inadequate and highly problematic government regulation.[167] And while public hospitals can also deny access to treatment and mistreat patients, especially if they are incentivized to generate their own revenue, the pressure placed on private hospitals to generate a profit and their relative lack of accountability to the public make them much more problematic and more of a threat to people on low incomes. A horrifying example of the latter is that of the thousands of women forced into debt and even slavery following entirely unnecessary hysterectomies carried out by private healthcare providers for profit.[168, 169]

The extensive evidence of harm caused by private hospitals in India should serve as a red flag for responsible investors tasked with fighting poverty and boosting development. Despite this, Oxfam has been unable to find any publicly available indication that the four DFIs choosing to invest heavily in private healthcare in India have seriously considered such substantial risks of harm.

The cases reported by Oxfam of both alleged and confirmed human and patient rights violations, together with alleged extractive, exploitative and unethical practices on the part of DFI-funded private hospitals in Kenya and India, require urgent independent investigation and response.

MORE THAN A FEW BAD APPLES

Oxfam's mapping of and research on all identified healthcare providers funded by the four European DFIs (together with overlapping investments by IFC) across all LMICs not only reveal more alleged cases of abusive, exploitative, unethical and potentially illegal behaviour, including during the COVID-19 pandemic, but also point to a systemic pattern of funding expensive and out-of-reach hospitals in countries where millions of women, men and children living on low incomes and in poverty face urgent unmet healthcare needs.

COSTLY CHILDBIRTH

All governments have committed to dramatically reduce maternal mortality as part of the SDGs, but in most regions of the world numbers of deaths have either stagnated or increased since the SDGs were first agreed in

2016.[170] Extreme inequality in access to skilled birth attendants between rich and poor expectant mothers is a major cause.[171] Oxfam's evidence below strongly suggests that, instead of working to close this deadly access gap, the DFIs are exacerbating it by directing development resources to hospitals that reach only women on higher incomes.

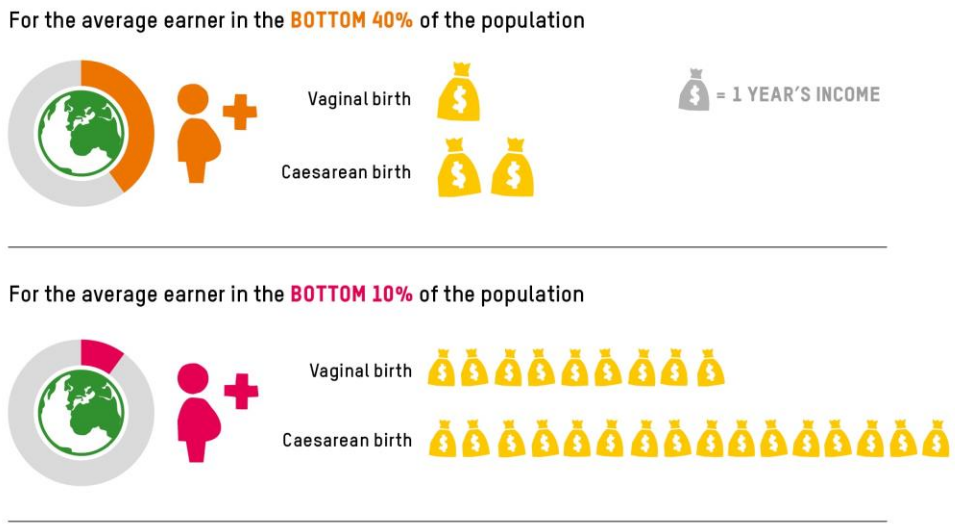
Oxfam has identified 224[172] direct and indirect investments in private healthcare providers made by the five DFIs.[173] Via website searches and/or direct communication with the private hospitals, Oxfam researchers managed to find information on fees charged for maternity services for half of these investments (110, or 49%).[174] This large-scale lack of transparency on fees by both DFIs and the private hospitals they fund undermines public scrutiny and accountability.

By comparing the available information on fees with income data in each relevant country, Oxfam finds that the average starting cost of an uncomplicated vaginal birth delivery at a DFI-funded private hospital amounts to over one year's total income for an average earner in the bottom 40%. The cost of a caesarean birth amounts to over two years' total income for the same person.[175]

For an average earner in the bottom 10%, the starting cost for an uncomplicated vaginal birth at a DFI-funded private hospital rises to over nine years' total income, and over 16 years for a caesarean birth.

Figure 2.

AVERAGE COST OF GIVING BIRTH IN PRIVATE HOSPITALS FUNDED BY DEVELOPMENT FINANCE INSTITUTIONS



Box 6: Maternity care for the rich in Nigeria

Nigeria has the fourth worst maternal mortality rate in the world.[176] Among the richest 10% of women in the country, just 6% go without a skilled birth attendant during childbirth. The access gap for skilled birth attendance for the poorest 10% of women is 91%.[177]

The Nigeria-based healthcare company Hygeia must count as one of the most prolific beneficiaries of DFI funding. Oxfam has identified a minimum of 11 direct and indirect investments in Hygeia by DEG, EIB, Proparco and IFC since 1999 (see Figure 5 in part 2).

Hospitals managed by Hygeia, under the name Lagoon Hospitals, are located in some of the most exclusive commercial and residential districts of Lagos. The company's website states that it provides healthcare at 'affordable rates', but access is via private insurance, corporate cover or cash payment. The hospitals are inaccessible to most Nigerians: 97% of the population have no health insurance, rising to 99% for the poorest 60% of women of reproductive age.[178]

At Lagoon's Ikeja and Ikoyi facilities, starting prices for unassisted childbirth range from NGN 280,000 to NGN 430,000 (US$728 to US$1,118), and for caesarean birth they cost as much as NGN 790,000 (US$2,054).[179] Even the most basic maternity package here, without any complications, would cost nine months' income for the bottom 50% of people in Nigeria. This rises to nine years' total income for people in the bottom 10%.[180]

The company told Oxfam that it has lower entry barriers for low-income earners and caters for patients on the National Health Insurance Scheme (NHIS). However, despite requests, no further information was provided.[181] In 2022 just 3% of Nigerians were enrolled in the NHIS.[182]

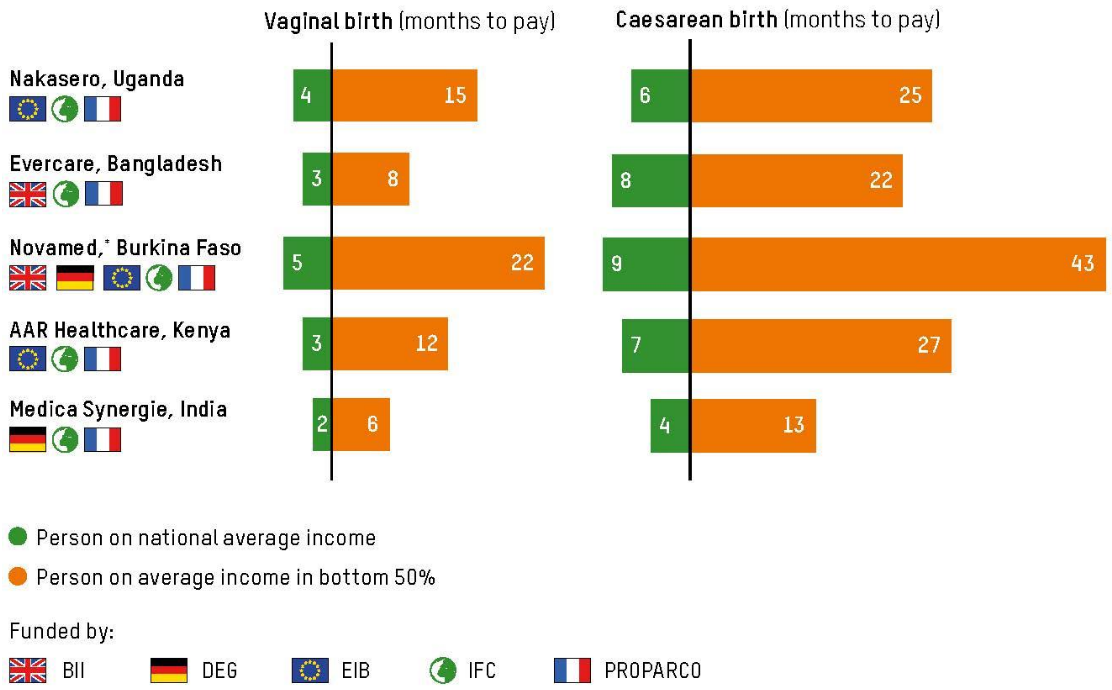
At Evercare's hospital in Nigeria, funded by BII, Proparco and IFC, maternity fees are 30–100% higher than those at Lagoon Hospitals. The lowest cost delivery here would cost an extraordinary 12 years of total income for the poorest 10%, rising to 24 years for a caesarean birth.[183]

Far from making maternal health services more affordable and accessible, the demand for returns by investors, including the DFIs, can result in even higher fees for pregnant women. In Uganda, BII and Proparco first invested in TMR Hospital, located in an upmarket residential area of Kampala, via the Africa Rivers Fund in 2018. Starting prices at that time for an uncomplicated vaginal birth were UGX 1.6m (US$425)[184] and for a caesarean birth UGX 3.4m (US$929).[185] Just four years after the DFIs' investments, those prices had increased by an incredible 60%.[186]

Figure 3, overleaf, presents examples of the costs of childbirth at different DFI-funded hospitals as the number of months' wages for different income groups.

Figure 3.

THE COST OF GIVING BIRTH AT SELECTED DFI-FUNDED HOSPITALS



*Germany's DEG told Oxfam that this investment is not known to them. Information available indicates DEG is funding Novamed via its investment in private equity fund Euromena III.

With reference to Rainbow Hospitals, a private hospital chain in India that BII funded directly alongside the Abraaj Group (see Box 10),[187] BII staff told Oxfam that while the hospital might not be affordable to those living in extreme poverty, it helps to reach people living on around US$5.50 a day.[188] At that same hospital in 2022 a mother was reportedly charged INR 52 lakh (US$63,000) for treatment of her premature twins, who both sadly died. This reported bill was the equivalent of 35 years' total income for someone living on US$5.50 per day.

CASHING IN ON INEQUALITY – HEALTHCARE FOR THE RICHEST

Some of the DFI-funded hospitals target elite customers more overtly.

Arrail Dental in China, which is funded by BII, describes itself as 'the leading premium dental services brand in China and targets affluent patients with high purchasing power, primarily in Tier-1 cities'.[189]

Proparco is explicit that its support to Oncologie et Diagnostic du Maroc to expand access to cancer diagnosis and treatment in Morocco will 'mostly benefit Morocco's salaried middle class'.[190]

The marketing materials of Indian home-based care company Portea, financed by IFC and BII, show images of elderly patients in comfortable, expensive-looking homes.[191] While fee information is difficult to access, another DFI that is invested in Portea reports that its home-based ICU care costs start at US$133 per day,[192] or 62 times the minimum daily wage in

India.[193] Providing ICU care at home of course also presupposes, at the very least, a reliable electricity supply and good access to water and sanitation.

Sírio-Libanês Hospital in São Paulo, Brazil, funded by DEG and Proparco, is well respected and known for treating the rich and famous, including Latin America's presidents and other senior politicians.[194] To protect their privacy and keep them safe, at the time of the DFI investments the hospital reportedly had 500 security cameras, 250 electronic access controllers and 250 proximity sensors, along with 100 agents guarding its interior and surroundings.[195] Doctors were provided with media training to deal with their frequent encounters with journalists outside the hospital's front doors.[196] Still today the hospital does not treat patients as part of the government's universal healthcare system but does conduct charitable work, training of doctors and investment in research for which it receives tax exemptions.[197]

Several DFI-backed hospitals also target wealthy expatriates or medical tourists as potential inpatients, with separate pages for international patients on their websites.[198]

The Pacific Plaza in Costa Rica, funded by BII via the Emerge Central America Growth Fund, is a 22-hectare continuing care retirement community development with an integrated medical complex, including a hospital. It is marketed to expats, tourists and those seeking an alternative to the US healthcare system. Health diagnostic packages cost US$1,040 for seniors.[199]

Box 7: Government health insurance schemes – a dead end for UHC?

Those promoting a greater role for for-profit healthcare providers in LMICs also often advocate for government-funded health insurance schemes as a route to financing UHC. This is not surprising. Being part of such schemes means that private providers can benefit from public funding. The concern is that vested interests have created a blinkered approach.

With encouragement from the likes of the World Bank Group[200] and bilateral donors such as Germany and the US,[201] many LMICs are implementing health insurance schemes with the stated aims of providing greater healthcare access, choice and financial protection to people living in poverty. BII's new strategy says that any new hospital investment it makes will ensure that a significant proportion of users are on government payment schemes.[202] This assumes that these schemes work for people living in poverty. The evidence shows otherwise.

For health insurance to be universal and equitable, everyone must contribute according to ability, but contributions become de facto voluntary for up to 90% of people in LMICs because they work in the informal economy.[203] Together with frequently unaffordable premiums and insufficient free coverage, this leads to low coverage and large-scale exclusion and reinforces inequalities.[204, 205] Most informal, low-paid precarious workers are women and, despite facing higher out-of-pocket (OOP) health costs, they are the most likely to be excluded from health insurance schemes across the world.[206]

Countries moving from OOP to government-funded healthcare perform better on improving life expectancy, under-five mortality rates and financial protection than those choosing social health insurance.[207, 208] The latter schemes cost more, can lead to declines in government commitment to spending on health and have no significant impact on OOPs.[209]

India and Kenya both have government health insurance schemes that encourage greater participation of private providers and have been criticized for fast-tracking privatization.[210] Both schemes are failing to deliver on equity, gender equality and financial protection, yet are diverting ever-increasing public resources to for-profit private providers.

Government health insurance schemes in India have failed to improve financial protection.[211] By encouraging greater use of for-profit providers, evidence indicates that they are exposing poor and marginalized people, and especially women, to even greater risk of financial hardship.[212] OOPs for hospitalization for elderly people in India are six times higher in private facilities than in the public sector, regardless of health insurance enrolment.[213] In one state, median OOPs for government-insured patients are eight times higher in private facilities than public ones;[214] nationally, the figure rises to 25 times higher for women.[215]

More men make claims at private hospitals and more woman rely on public hospitals.[216] Inequality in insurance use is reported across income, caste, education and rural/urban residence status.[217]

Government insurance is contributing to an 'infrastructure inequality trap' as higher utilization and costs of private healthcare in urban areas are diverting ever greater proportions of public funding away from rural and the most under-served areas.[218, 219]

Kenya's National Hospital Insurance Fund (NHIF) is nearly 60 years old, yet only covers 20% per cent of Kenyans;[220] 75% of people say that they cannot afford the premiums.[221]

Informal workers, mostly women, made up 83% of the Kenyan workforce in 2017, but just 24% of NHIF members (and 73% of these informal worker members did not renew).[222] Other barriers to women include insurance cards frequently only being issued to male heads of households and inadequate priority in the scheme for sexual and reproductive health services.[223] A 2018 national survey found households with at least one person covered by health insurance were more likely to experience catastrophic healthcare payments.[224]

Most Kenyans, and especially those on low incomes, continue to rely on public provision, but government funding to for-profit providers has skyrocketed under the NHIF – rising 30-fold between 2010 and 2021. Sixty-four per cent of NHIF expenditure now goes to private providers, compared with just 20% to public facilities.[225] Private providers get significantly higher reimbursement rates and, astonishingly, the most expensive private hospitals get to negotiate bespoke rates, which the NHIF does not disclose.[226] All of the DFI-funded private hospitals in Kenya that Oxfam has information for, including Avenue, Metropolitan, Aga Khan, AAR, Nairobi Women's Hospital and Diani Beach, fall into this most expensive category.[227]

'LOW-COST' PRIVATE HEALTHCARE FOR PEOPLE LIVING IN POVERTY?

Most of the for-profit private healthcare providers identified in this research charge fees that are far out of reach for those living on low incomes. However, Oxfam's research identified a small number of funded private providers that appear, at least on the surface, to be of relatively lower cost.

Vaatsalya hospitals, supported by BII and Proparco, are located in smaller tier 2 and 3 cities in India and are described as no-frills budget hospitals with a strong focus on primary and secondary care. It is suggested that fees are 15–20% cheaper than average hospital costs.[228] Outpatient consultations with a doctor could be as little as INR 140,[229] but inpatient maternity fees are still prohibitively high, in some hospitals costing as much as INR 70,000 (US$800).

Penda Health, funded by BII, EIB and Proparco, is marketed as providing low-cost primary healthcare in Kenya, with some of its facilities located close to major informal settlements in Nairobi. Antenatal check-ups cost around KES 1,500 (US$8.80) and GP consultations KES 2,000 (US$12).[230] These fees, while lower than other DFI-backed private hospitals in Nairobi, are still very much out of reach for pregnant women living in poverty.

There is a real danger that the marketing materials of DFIs[231] and the growing agenda to explore and promote profit-making in primary healthcare will distract attention from decades of research showing how even supposedly nominal user fees of US$1 or US$2 exclude, impoverish and kill.[232] After years of civil society campaigning, the World Bank Group has in recent years finally acknowledged this evidence on the harmful impacts of user fees for healthcare; has said their elimination or sharp reduction is a common feature of all UHC successes;[233] and is now categorical that primary healthcare should be free at the point of care.[234] Oxfam's position is that all user fees should be removed.

It is also worth remarking on the hypocrisy of European governments pouring development funds into private fee-charging primary healthcare facilities that target low-income patients when such a concept is so at odds with well-established and publicly supported models of universal and equitable healthcare in their own countries. In the UK, for example, 94% of people think that healthcare should be provided free at the point of need.[235]

COVID CRIMES

A global health emergency is perhaps the best test of a theory of change which posits that investing in commercial healthcare providers can advance UHC, increase access for the under-served and add capacity to complement and relieve struggling public health systems.

However, research across LMICs reveals alarming and widespread trends of unethical behaviour by private healthcare providers at the height of the COVID-19 pandemic, including the withdrawal of health services and refusal to admit COVID-19 patients; filtering of patients based on their ability to pay; price-gouging; and holding governments to ransom by charging unjustifiably high fees for desperately needed hospital beds.[236] Also evident was widespread evasion of emergency pandemic regulations by private providers and gaming of new requirements on pricing and bed availability, in many instances leading to government interventions to take over beds, threats of legal action and/or the introduction of price caps.[237] In many countries, including India, where investments by some DFIs are heavily concentrated, patients were left overwhelmingly dependent on public healthcare provision for COVID-19 treatment and care.

Reports suggest that at least some recipients of DFI funding sought to exploit the pandemic, and families' desperation, by charging eyewatering prices to maximize their income.

Maputo Private Hospital in Mozambique, which was previously backed by several European DFIs including DEG and EIB,[238] reportedly charged COVID-19 patients an upfront deposit of over US$6,000 if they needed oxygen, and over US$10,000 if they needed a ventilator.[239] Despite these extraordinary fees, IFC made a new investment of US$28m in the hospital's parent company in early 2023.[240]

'This is not a hospital for ordinary Mozambicans.'

Director of a local health NGO

In Uganda, International Hospital Kampala (IHK) is financed via at least seven overlapping investments made by DEG, EIB, Proparco and the IFC.[242] It reportedly charged around UGX 1m (US$270) per day for the treatment and care of moderately ill COVID-19 patients, rising to UGX 3m (US$812) per day for serious cases.[243] At the height of the pandemic, IFC bailed out this private hospital with a US$4m loan using aid allocated to it by the World Bank Group via the International Development Association (IDA) Private Sector Window.[244]

'If you are unable to fork out less than Shs 3 million per day, don't trying peeping into IHK.'

Edris Kiggundu, Ugandan journalist[241]

Other examples of excessive charging and/or unethical practice by DFI-funded private hospitals in response to COVID-19 are listed in Table 1.

Table 1: Examples of excessive fees and unethical behaviour during COVID-19

Hospital, country (DFIs funding)	Alleged excessive charging or unethical behaviour
Nakasero Hospital, Uganda (EIB, IFC, Proparco)	Charged UGX 7m (US$1,900) per day for treatment and care of COVID-19 patients in intensive care. The journalist reporting on this claimed that 20 days at this hospital would cost the equivalent of a decent house in some of the most expensive residential areas around Kampala.[247]
TMR International Hospital, Uganda (BII, Proparco)	Reportedly charged UGX 118m (US$32,000) for two weeks of treatment and care for a COVID-19 patient.[248] Later reports about the same patient, who died from the virus, suggested that the total bill had risen to as much as UGX 430m (US$116,000).[249]
Avenues Clinic, Zimbabwe (BII)	One Avenues facility reportedly charged between US$800 and US$1,000 per day for a COVID-19 ICU bed, while a five-day stay in its other facility reportedly cost US$7,600.[250] The country's Community Working Group on Health[251] called for urgent government intervention to regulate the fees charged in private hospitals.[252]
AAR Healthcare, East Africa (EIB, IFC, Proparco)	In Tanzania, AAR Healthcare withdrew its services altogether during the pandemic due to financial problems that had been worsened by COVID-19.

'How can hospitals charge this much when they know the situation isn't favourable? ... Enough is enough Ugandans, let's say no to those making money out of blood by having a campaign against these hospitals.'

Response on social media to TMR hospital COVID-19 billing[245]

'Most patients cannot afford the bills, and we cannot support them because we also have to pay other bills.'

Director of TMR International Hospital, Uganda[246]

	The parent company AAR Healthcare Holdings made clear that it was 'no longer willing to support the financial requirements of the company'.[253]
Evercare Hospital, Pakistan (BII, IFC, Proparco)	The hospital charges a minimum daily bed rate of PKR 55,000 (US$194) for COVID-19 patients with no interventions or medicines; also excluding PPE charges of up to PKR 10,000 (US$35) per day. A bed with a ventilator costs PKR 75,000 (US$265) per day. An injection of Tocilizumab (one of the few treatments available for patients seriously ill with COVID-19) costs PKR 59,764 (US$211) per vial.[254]
Sahyadri Hospital, India (BII, IFC)	The Municipality of Pune ordered the hospital to repay an average of US$790 each to 34 patients who were overcharged above government price caps for COVID-19 treatment and care.[255] However, it did not refund the fees until the government threatened to revoke its licence.[256] BII exited its investment in Sahyadri in 2019.
Medica, India (DEG, IFC, Proparco)	The West Bengal Clinical Establishment Regulatory Commission fined Medica's hospital in Kolkata for refusing to admit a COVID-19 patient in the early days of the pandemic.[257] Medica's hospital in Jharkhand was also accused by the health department of 'dumping' critically ill COVID-19 patients on government hospitals hours before they died.[258] This latter allegation has been denied by Medica but is included because searches have revealed several other complaints against Medica that were upheld, especially for overcharging patients.[259] DEG provided additional financial assistance to Medica during the pandemic.[260]
CARE Hospital, India (BII, IFC, Proparco)	The state government of Chhattisgarh issued a court order stating that a patient was forcibly evicted from the hospital in March 2020 after doctors suspected that she was infected with COVID-19. This was at a very early stage in the pandemic when surveillance was critical, and the government condemned the hospital for failing in its legal duty to report this suspected case.[261] In Telangana state, CARE Hospitals was ordered to refund over INR 7 lakh (over US$8,500) to COVID-19 patients who were overcharged.[262]
Krishna Institute of Medical Science, India (DEG, IFC, Proparco)	In Telangana state, KIMS hospital reportedly charged the family of a COVID-19 patient a deposit of INR 1

	lakh (US$1,212) before admission and another INR 3.25 lakh (US$3,940) to release the patient's body eight days later, after they died. The reported bill was nearly four times the maximum state government price cap.[263] In June 2021 the same hospital was one of many private hospitals in the state to lose their licence to treat COVID-19 patients in response to patient complaints, including in relation to excessive charges and mismanagement.[264]
Rainbow Hospital, India (BII)	The director of this hospital in Bihar was arrested in May 2021 for allegedly selling the COVID-19 treatment Remdesivir on the black market for between seven and 29 times the price cap set by the government.[265]

Reports about private hospitals refusing to admit and treat COVID-19 patients and other unethical and unacceptable behaviour appeared to be most widespread in India. There are countless media reports of patients dying outside the doors of private hospitals that refused to let them in.[266]

An unprecedented survey of over 2,500 COVID-19 patients in India's second most populous state, Maharashtra, found that despite a clear government price cap, 75% of patients who were treated at private hospitals were overcharged, and by an average of INR 156,000 (US$1,890).[267] Further research revealed that average amounts of overcharging were far greater in larger corporate hospitals.[268]

Box 8: Opportunities for DFIs to contribute to better health

Oxfam's research for this paper focussed on DFI health investments in healthcare provision. It does not look at investments by the DFIs in other aspects of the healthcare system, and Oxfam encourages others to do this.

One area where Oxfam sees more potential for positive and more progressive health impacts by DFIs is financing for research and development (R&D) and the local manufacturing of medicines, tests and treatments in the Global South. If done well, with the right expertise and experience on board, such support could play a meaningful role in redressing deadly inequalities in access.

While the forming of a consortium[269] between DFIs and Biovac in South Africa – which is partnered with the WHO-led mRNA technology transfer programme[270] – look promising, a lack of detail prevents greater understanding of DFI objectives and added value here.

Oxfam recommends that DFIs lead a full and transparent consultation involving access to medicines experts, especially from the Global South, to explore and develop a new progressive DFI vision and strategy for investing in this area.

PART 2: MAPPING THE MONEY

This section provides an overview of the scope and scale of DFI funding to all for-profit health actors and some of its characteristics. Exploring the money trail between DFIs and private health companies reveals an alarming transparency and accountability gap that needs urgent remedy and might help to explain the worst of Oxfam's findings.

Attempting to identify the full portfolio of DFI health investments to enable Oxfam's research and analysis in part 1 of this report proved to be an unacceptably difficult task.

Except for BII's, the websites and databases of the DFIs are inconsistent and difficult to navigate. Several of the investments identified by Oxfam were not reported in the DFIs' databases but were found indirectly via press releases or third-party sources. Many were simply stumbled upon by chance. While BII's project portal is more comprehensive and better structured, even here there is an unacceptable time lag in its disclosure of new investments as well as exits.[271]

Finding information on DEG's health investments was especially opaque challenging. There is no means of searching for health-specific investments, and staff told Oxfam that they were unable to confirm any of the organization's health investments made prior to 2015, due to confidentiality issues. DEG reported some important improvements in disclosure from 2022 but available information is still very limited.[272] Oxfam still does not know the value of at least 14 DEG health investments identified.[273,274]

SCALE AND SCOPE

Oxfam's desk-based research of European DFI project portals and other sources[275] identified a total of 358 direct and indirect investments in any kind of private health company (not just healthcare providers) in LMICs made by the four European DFIs (BII, DEG, EIB and Proparco) between 2010 and 2022.[276] These consist of:

- 67 direct investments in health sector companies, totalling US$2.2bn.[277]
- at least 85 investments in health sector companies via 18 health sector-specific financial intermediaries, totalling US$289m;
- at least 206 investments in health sector companies via 122 multi-sector financial intermediaries. The total investment in these financial intermediaries amounts to US$3.2bn, although how much of this has gone to the 206 health sector companies is not disclosed (see Tables 2–4).[278]

While health constitutes a relatively small proportion overall of the DFIs' investment portfolio, these sums are significant. Of the four European DFIs, BII invests the most in health in terms of both value and number of direct and indirect investments.

A full review of IFC's health portfolio was beyond the scope of the research for this paper, but Oxfam's searches did identify widescale co-investment by IFC (both directly and indirectly) in at least 42 of the same financial intermediaries and 112 of the same private health company beneficiaries that are supported by the four European DFIs (see Annex x). The Dutch organization Wemos, however, reviewed IFC's full health portfolio between 2017 and 2021, and raised concerns about a lack of focus on equitable and universal access to healthcare, and challenges in transparency of investments through financial intermediaries.[279]

Table 2: Direct investments in health (including PPPs)

DFI	Number of investments	US$ value
BII (formerly CDC)	12[280]	US$712.53m
DEG	25[281]	US$489.5m*
EIB	3	US$357m
Proparco	27	US$597m
Total	**67**	**US$2.2bn**

*Four out of 25 are missing investment value.

Table 3: Indirect investments in health via health sector-specific financial intermediaries (FIs)

DFI	Number of health sector FIs	US$ invested in health sector FIs	Number of ultimate health company beneficiaries
BII (formerly CDC)	4	US$130.2m[282]	12
DEG	6	US$55m*	31
EIB	2	US$29.4m	8
Proparco	6	US$74.4m	34
Total	**18**	**US$289m**	**85**

*Three out of six are missing investment value.

Table 4: Investments in multi-sector financial intermediaries (FIs) that sub-invest in health

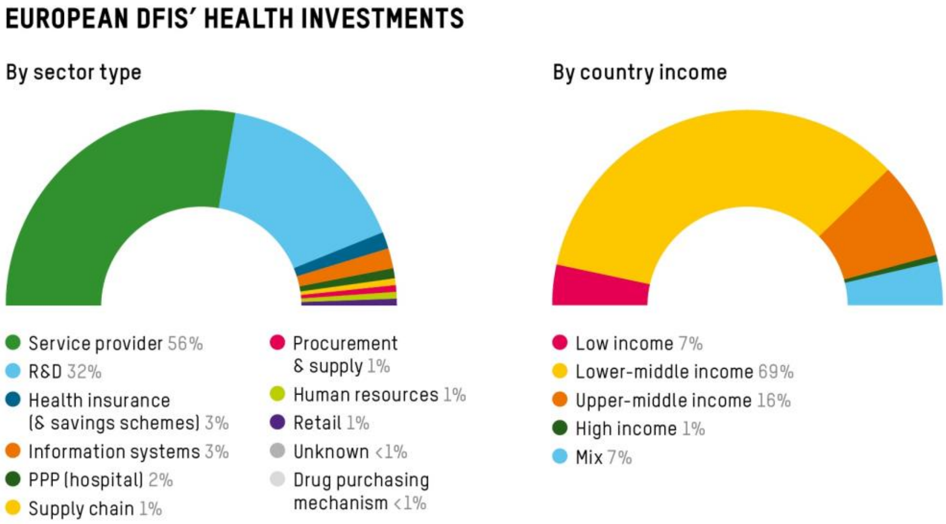
DFI	Number of multi-sector FIs investing in health	US$ invested in FIs	Number of ultimate health company beneficiaries
BII (formerly CDC)	72	US$2.5bn	117
DEG	15	US$174m*	35
EIB	9	US$158.83m	14
Proparco	26	US$427.73m	40
Total	**122**	**US$3.2bn****	**206**

*The US$ value of seven of the 15 investments could not be identified.
** This is the total invested in the financial intermediaries that invest in health as well as in other sectors. With the exception of Proparco, the proportion of this amount that goes to health is not known. In response to this report, Proparco told Oxfam that their investments in health via multi-sector financial intermediaries amount to $74m or 17% of the US$ 427.73.[283]

Figure 4 shows the breakdown of total direct and indirect health investments made by the four European DFIs by health sector type and country income. Of the 358 investments, 56% (202) were in private hospitals or other for-profit healthcare provider companies, while 32% (114) were in R&D companies.

Most investments (69%) went to private health companies operating in lower-middle-income countries, with 7% going to companies in low-income countries.

Figure 4.



Note: Percentages given of total number and not value of investments

Public–private partnerships (PPPs) constitute a small proportion of the total number of health investments identified but are significant in dollar value terms for DEG, EIB and Proparco (see Box 9).

Box 9: DFI-supported PPPs – for whose benefit?

Hospital public–private partnerships (PPPs) – public hospitals built by and using financing borrowed from the private sector – have been promoted by DFIs, especially IFC, as a solution for shortfalls in health financing. Far from being a winning formula, however, international evidence shows that PPP hospitals frequently end up burdening health ministries with higher than promised and unsustainable costs.

One PPP hospital in Lesotho advised by IFC has been mired in controversy and at one point cost over half the country's annual health budget.[284] The partnership has since collapsed.[285] England was the longest-running and largest testing ground for health PPPs but, due to their high cost, inherent inflexibility and multiple other failures, a parliamentary Treasury Select Committee concluded over a decade ago that they should be used as sparingly as possible.[286]

Despite this evidence, Oxfam's research finds that DEG, EIB, IFC and Proparco have collectively supported at least three hospital PPPs in Türkiye with nearly US$1bn in loans since 2014.[287] These hospitals formed part of an extensive government PPP expansion plan, but in 2021 the country's Ministry of Health (MoH) announced that there would be no further PPPs and that all future hospital construction would be financed from the government budget.[288] The decision was taken after it emerged that payments for just 10 operational hospital PPPs accounted for some 27.8% of the MoH budget.[289]

'Mistakes' contributing to unsustainable fiscal pressures for the Turkish government included the linking of PPP unitary payments to the value of the US dollar,[290] despite entirely predictable exchange rate volatility. The consequences of such mistakes will be borne by the country's taxpayers for years to come, while presumably benefiting investor DFIs in the form of higher returns.[291] Other national economic interests are likely also at play. For example, Proparco committed US$100m to the hospital PPPs and French company Meridiam stands to benefit significantly from those project contracts.[292]

OUT OF SIGHT, OUT OF MIND – INTERMEDIATED INVESTMENTS

Of the 358 European DFI health investments identified, at least 81% were made indirectly via financial intermediaries, primarily private equity funds.[293] The proportion ranges from 73% for DEG and Proparco to 91% for BII.[294] This is a major finding. To the best of Oxfam's knowledge, there has been no other equivalent attempt to systematically map DFI-intermediated investments in health, let alone assess their impact on patients and carers.

Only BII lists all intermediated health investments and in a way that can be searched.[295] It is unacceptable that other DFIs do not do this, especially because most of their health investments are made through this route.[296]

Because of this lack of transparency on the part of both DFIs and the private equity firms they invest in, it is impossible to say how many intermediaries or ultimate health company beneficiaries have been missed in this research. The number is likely to be substantial and the research has raised significant doubts that even some of the DFIs can fully account for all their intermediated funding to health.

It goes without saying that this is a huge accountability issue. If investments cannot even be traced, how can governments and citizens be sure that their development institutions are doing good, and at the very least not doing harm?

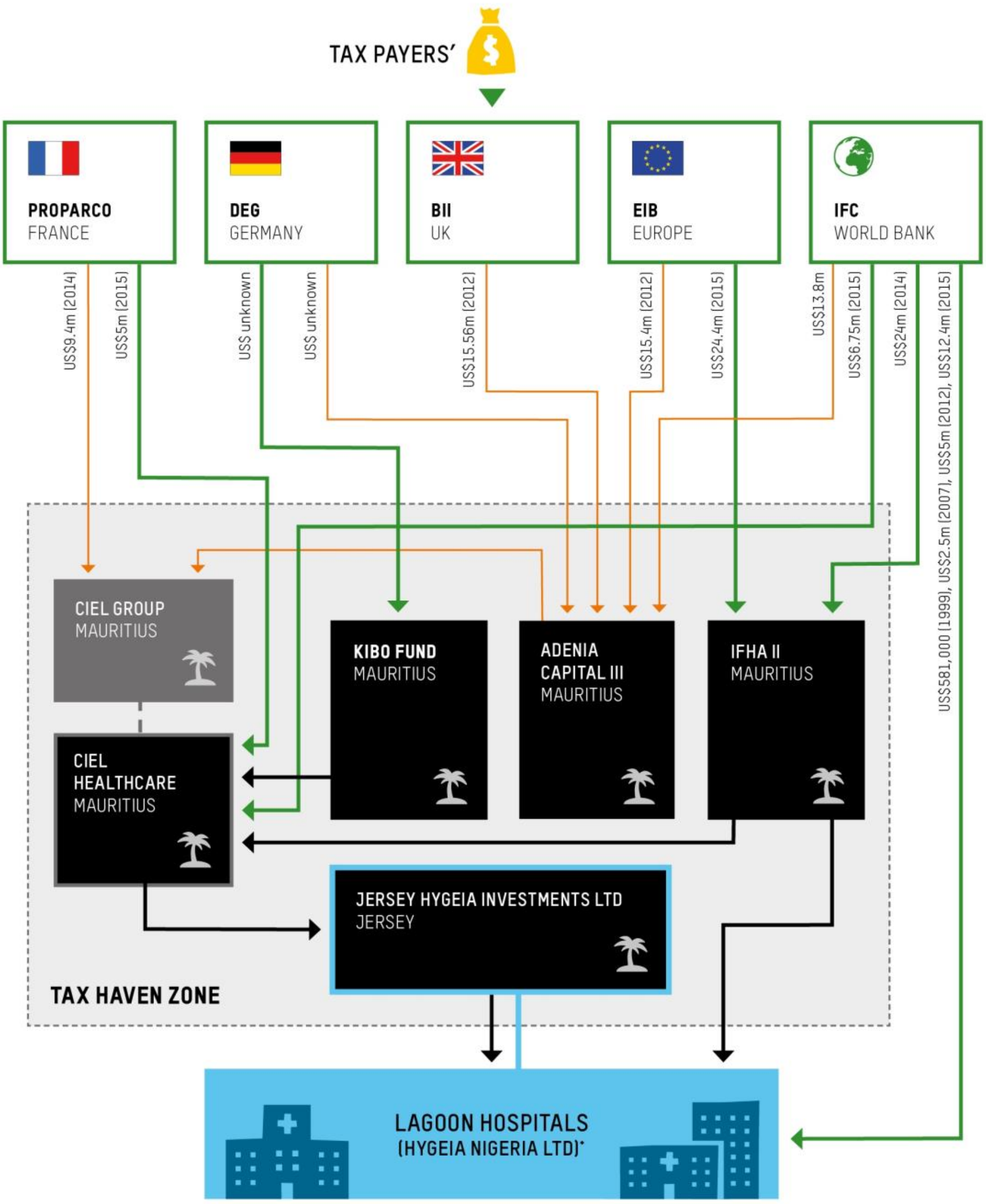
Some DFIs may try to dismiss the importance of their intermediated investments in health by, for example, stressing their smaller relative value in comparison with direct investments. However, with such a high number of investments this argument does not hold water. It would also be irresponsible in light of the confirmed and alleged harm perpetrated by private hospitals funded indirectly and would raise doubts about the attitude and level of commitment towards ensuring that resources entrusted to DFIs are always spent as effectively and as safely as possible. Ascertaining the value of these intermediated investments is in any case currently impossible due to a lack of transparency on the part of DFIs.

Oxfam's mapping has also revealed a complex, convoluted, unaccountable, and often invisible web of tax-avoiding financial intermediaries utilized by

DFIs to invest in health. Figure 5 illustrates this web for just one DFI-funded private healthcare provider – the Hygeia Group in Nigeria.

Figure 5.

DFI INVESTMENTS IN LAGOON HOSPITALS (HYGEIA)



→ Indicates indirect investment in CIEL Group which owns and manages CIEL Healthcare

*Hospitals managed by Hygeia, under the name Lagoon Hospitals, are located in some of the most exclusive commercial and residential districts of Lagos. The hospitals are unaffordable for most Nigerians.

Oxfam has counted a minimum of 11 direct and indirect investments in Hygeia by four of the DFIs since 1999, with a further five investments from all five DFIs in the group that manages a portfolio of investments including Hygeia. Together these involve a minimum of five financial intermediaries. This does not include other DFIs known to have invested but which are not included in this research, such as FMO in the Netherlands.[297]

One of the objectives that DFIs say they have when investing in financial intermediaries is to 'crowd in' additional private finance. Even if this was desirable, this level of duplicative and convoluted investment raises questions about whether DFIs are in fact acting together to 'crowd out' potential additional investors.

The financial intermediaries used to invest in Hygeia are all domiciled in the tax haven of Mauritius. At least one of these intermediaries has stated that its stake in Hygeia was held through Jersey Hygeia Investments Limited,[298] domiciled in the tax haven of Jersey.[299] The reasons for this are not clear, but they should be questioned. Iwosan Lagoon Hospitals Limited, formerly Hygeia Nigeria Limited, told Oxfam that it is fully compliant with its tax obligations at both state and federal levels.[300]

Hygeia is just one example. Oxfam's research shows that of the 140 financial intermediaries used by the European DFIs to invest in health, 80% are domiciled in tax havens, primarily Mauritius and the Cayman Islands.[301] This raises urgent questions as to whether and how the DFIs ensure that their investments in health are not complicit in tax avoidance schemes that deny governments the domestic revenues they urgently need to spend on health.[302]

Not only are some DFI health investments likely to bypass tax authorities; their complexity and frequent invisibility means that they certainly bypass public scrutiny and accountability too. This means that billions of dollars in development funding are entrusted entirely to the DFIs' own confidential due diligence and monitoring. This report has demonstrated the shortcomings of these in terms of protecting rights and preventing harm to patients. The scandalous collapse of one high-profile private equity firm supported by DFIs, Abraaj (see Box 10), raises serious doubts as to whether such mechanisms are fit for purpose to also prevent other forms of corruption and fraud.

Box 10: Abraaj – a 'capitalist fairy tale'

The Abraaj Group and its founder and chief executive Arif Naqvi were at the heart of the radical transformation of the development financing landscape that would see billions in public funds used to try and mobilize trillions in private finance. The UN, the World Economic Forum and leading development figures gave Naqvi a platform to deliver his mantra that, by investing in the likes of Abraaj's private equity funds, capitalism could be harnessed to make money for the rich while also 'ending the suffering of the poor'.[303] For Naqvi, healthcare was a key focus. The story of Abraaj's rise and fall is told in forensic detail in The Key Man, a 2021 book by journalists Simon Clark and Will Louch.[304]

The Abraaj fairy tale collapsed in 2018. In one of the largest corporate frauds in history, the unravelling of the group began when hundreds of millions of dollars went missing[305] from its US$1bn Global Markets Health Fund – a fund that Bill Gates had helped to initiate and had funded, together with the DFIs focused on in this report.[306, 307, 308]

Investigations allege that Naqvi had been plundering the health fund to pay for his billionaire lifestyle and to cover up fraud and corruption in other Abraaj funds in which many DFIs were also invested.[309] For the UK's BII alone, nearly US$700m of equity and debt was pledged to Abraaj's funds and companies in which the firm invested.[310] It is still unclear if and how much development funding was lost.[311] Abraaj's liquidators are still trying to claw back funds by suing the health fund for over US$100m on behalf of its creditors.[312]

Serious questions remain unanswered about the role played by the DFIs in this scandal, including why their due diligence processes failed so badly and why alarm bells were not ringing from the start when, for example, the Abraaj Africa Health Fund sold some of its private hospital investments, including Nairobi Women's Hospital, directly to the Abraaj Growth Health Markets Fund,[313] raising enormous potential conflicts of interest.

As discussed, even less scrutiny was given to the hospitals funded by Abraaj that imprison patients, or the fundamental flaws in the theory of change publicly promoted by Abraaj and the DFIs which held that fee-charging, profit-making hospitals can help to end health poverty. Emails between Abraaj executives cited in The Key Man reveal that even they did not believe that targeting services to the poorest citizens would make enough money.[314] 'Target market will be the lower half of the pyramid,' an Abraaj executive wrote to colleagues in 2017. 'Not the Bottom of the Pyramid which is unlikely to be economically sustainable.'[315]

Arif Naqvi is currently under house arrest in London, awaiting extradition to the US where he faces criminal charges that carry a potential sentence of 291 years in a high-security prison.[316] The DFIs who together entrusted hundreds of millions of dollars in public funds to Naqvi, including to advance healthcare access to people who Abraaj executives knew would not be reached, have not yet been held to account.

FAILING TO MEASURE WHAT MATTERS

Project descriptions for hundreds of millions of dollars of DFI investments in health are ludicrously limited – a few paragraphs at most. Project impact information can be as little as one or two sentences, and sometimes there is nothing at all. No objectives or expected impact are provided for the 80% of DFI health investments made indirectly. That DFIs are permitted to provide so little public information about how they are investing in health on behalf of governments and taxpayers is hard to fathom.

REACHING PEOPLE ON LOW INCOMES AND LIVING IN POVERTY

Oxfam searched project descriptions for direct investments in healthcare providers and in health sector-specific financial intermediaries for indications of DFI intent to benefit people on low incomes or in poverty, and women and girls, as patients or users of the healthcare services they fund.[317,318] The results were discouraging. Terms related to healthcare access to low- or lower-income people in some form[319] were found in only six of 13 cases for BII (46%); two of 17 for DEG (12%); one of two for EIB (50%);[320] and three of 22 for Proparco (14%).[321]

It is too generous to count any of these as having any meaningful intent to improve healthcare equity, due to the brevity and lack of definition of terms and the absence of any disclosed evidenced or well-considered theory of change, any relevant measurable goals or any credible indicators to assess whether or not such goals are achieved.[322]

BII told Oxfam that it has applied its health impact framework,[323] which includes pillars on accessibility and affordability, to every new direct health investment since 2017, but will not publish this information because of 'commercial confidentiality'. BII also made clear that the impact framework is a 'soft' tool to encourage the companies it invests in to move in the right direction and that making its investments conditional on improvements such as reducing fees, or even committing to not increasing them, was 'not realistic'.[324]

DEG told Oxfam that some of the companies it invests in undertake charitable activities and may provide some free services to people who cannot afford them. Such cases are not counted in the figures above, since charity is not core to the investments and is not a solution to otherwise unaffordable and inequitable healthcare provision.[325] Furthermore, health activists and representatives of community-based organizations interviewed as part of Oxfam's qualitative research in India raised significant concerns about 'free medical camps' and other charitable services being used by some private hospitals as a strategy to recruit more paying patients for potentially unnecessary treatments and services.[326]

REACHING WOMEN AND GIRLS AND TACKLING GENDER INEQUALITY

Searches of project descriptions produced even worse results for any stated intent to benefit women and girls as users of healthcare services. References to gender, women or girls, or to any services specifically benefiting them, such as sexual and reproductive health, were found in only three cases for BII (23%), one case for Proparco (5%) and in no cases for DEG or EIB.[327]

The DFIs, particularly BII and Proparco, frequently award their health projects the '2X' badge, indicating that they are part of a global initiative for 'gender lens' investing.[328] For the most part, this appears to be justified on the basis that women make up a significant proportion of the health company's workforce. This is unremarkable in healthcare, and women are largely concentrated in lower-status, low-paid and often unpaid roles in the sector.[329] With one or two exceptions, the lack of any DFI references to the quality of jobs done by women undermines confidence in their assessments.[330] There is no evidence that broader impacts of investments on women and girls are considered or measured.

WHAT IMPACT?

Shockingly, Oxfam also found no disclosed evidence of any comprehensive impact evaluation or even of any meaningful and substantiated impact data for the healthcare investments of the four European DFIs in relation to healthcare access for people on low incomes, or for women and girls.[331]

One partial exception was an evaluation of a Narayana Health facility in India as a pilot case study for BII's new health impact framework in 2017.[332] The case study[333] noted Narayana's participation in government insurance schemes; some potential but unclear cross-subsidization from richer to poorer patients; and some help to link up struggling patients with philanthropists who might help them to pay their healthcare bills. However, the authors noted the challenge for patients of having to pay out-of-pocket if their healthcare bills exceeded government insurance caps; found 'little evidence available to understand the real impact' of the various approaches to improve access to poorer patients 'and whether patients are avoiding catastrophic medical expenses'; and expressed thinly veiled criticism of the company's ad hoc charitable model, which might give preferential access to handpicked patients deemed 'most deserving'.

The evaluation also raised concerns that fee-for-service payment contracts for senior doctors at Narayana might incentivize unnecessary admissions, procedures and treatments. The authors concluded that many of Narayana's achievements had been supported only anecdotally and that 'data collection must improve so that it can back up its claims'.[334]

BII claims in a recent report that its investment in Narayana, which ended in March 2020, 'supported the delivery of quality care to more than 2 million low-income patients'.[335] However, Oxfam has been unable to find any further information to substantiate or expand upon this claim.

Narayana told Oxfam that as a for-profit company it has 'chosen the path of conscious capitalism to find a balance between building a sustainable business and serving the neediest of the society'. It said that its sustainable healthcare delivery model was 'attractive to CDC' and that the purpose of 'CDC's investment … was to make a return on their investment for the UK government'.[336]

Across the healthcare investments of all four European DFIs, Oxfam has found only two other references to numbers of low-income patients reached.

Quadria Capital – an Asian private equity firm funded by Proparco, DEG and IFC[337] – reports that 12% of patients (four million out of 34 million) treated via its portfolio companies are 'under-privileged'.[338] However, Quadria told Oxfam that it relies on self-reported impact data from companies and conceded that terms like 'under-privileged' and 'low-income' are ill-defined and context-specific. It explained that if a hospital is in an expensive residential area, 'low-income' would not necessarily mean low-income by national standards.[339]

An impact report by the Medical Credit Fund (MCF), funded by BII, EIB and IFC,[340] states that 56% of patients served by healthcare companies in its portfolio were from low- to very low-income groups and that 75% were women and children.[341] However, MCF told Oxfam that figures were based on self-reported estimates by clinics asked to group patients according to four undefined income groups.[342] MCF said that it does not collect information on fees charged by the clinics, but does encourage them to join national insurance schemes.

Without clear, stated and measurable intent to advance healthcare access for those in most urgent need, and in light of their desperately deficient impact reporting, DFIs' claims that their healthcare investments are helping to achieve UHC should be dismissed as disingenuous.

Box 11: How does IFC compare?

Unlike for the European DFIs, the World Bank Group has an Independent Evaluation Group (IEG) which has periodically reviewed the World Bank Group's overall health portfolio, which includes IFC.

Its latest review from 2018[343] found that the global health sector portfolio performed comparatively better than the rest of IFC's portfolio in terms of environmental and social effects, economic and social sustainability, and project business success. However, the evaluation also emphasized that the IFC rarely monitors all dimensions of the quality of its health interventions or captures the impact on marginalized communities. It found no evidence to assess affordability or indicate the main users of healthcare facilities supported by IFC. The IEG said that it was not possible to determine whether access figures reported by the hospitals contributed to expanding coverage or whether they improved availability for those who were already covered elsewhere. The IEG concluded that the distributional impact of IFC's health projects remains unknown.

A previous IEG review in 2009 stated that IFC health projects were found to have 'benefited primarily upper- and middle-income people at the top of the pyramid'.[344]

An independent mid-term review of IFC's Health in Africa Fund[345] reported that IFC had not analysed how to reach poor people effectively via the private sector; had not directed investments for the benefit of poor people; and had not measured whether poor people were being reached. It also judged that IFC had made no attempt to answer the question: 'Does strengthening the private health sector improve health outcomes for the poor?'[346]

Oxfam India's research found that IFC has not disclosed any results for its healthcare lending and investments in India since these first started over 25 years ago.[347]

FAILING TO PROTECT

PATIENTS

This report has spotlighted specific examples of alleged and confirmed unacceptable harm caused to patients and their relatives by specific DFI-funded healthcare providers that have exposed the inadequacy of DFI governance and oversight, especially when it comes to patient rights. Risks to patients are exacerbated further because DFIs are investing in contexts where regulation is woefully inadequate and often captured by vested interests; and further again because investments are mostly made at arm's length via financial intermediaries.

Recently the IFC supported the development of the Ethical Principles in Health Care (EPiHC).[348] Companies who are signatories of EPiHC voluntarily commit to follow the 10 EPiHC principles, which focus on ethical decision-making and responsible conduct, including respecting laws and regulations, maintaining quality standards, upholding patients' rights and preventing harm. However, EPiHC has major limitations: it is a voluntary initiative with no monitoring or enforcement mechanisms, and several hospital companies with reported patients' rights violations are signatories.[349]

A recent report by the UN Human Rights Office notes that while DFI environmental and social safeguard policies are increasingly aligned with human rights,[350] a major gap is the lack of attention paid to the human rights of users of products and services, including public services like health and education. The report criticizes DFIs for ignoring how the pricing of services can be unaffordable or discriminatory, and for their lack of standards for judging whether users are being treated fairly or being excluded from services. While DFIs were found at a minimum to require that the companies they invest in comply with national law, the report notes that national law may not cover consumer protection, or may be weak or limited in scope.[351]

Others have criticized DFIs for categorizing human rights only as part of a compliance or risk management agenda, as opposed to part of their intentional positive impact.[352] This seems particularly critical for DFI investment in a sector responsible for delivering the fundamental human right to health.

The right to effective remedy for harm is a core tenet of international human rights law, which holds that in addition to States' obligations, business enterprises have a responsibility to ensure that individuals and communities who have experienced human rights violations have access to remedy by providing for or cooperating in remedial action; DFIs share this same responsibility to provide remedy when their investments contribute to harm and should not exit a project before remedy has been provided. Some DFIs may seek to deflect criticism about specific investments by pointing out that they have divested when harm and negative impacts have occurred. However, their responsibility to provide remedy to affected communities remains even after exit.[353]

For patients who do suffer harm and want to seek remedy, to the best of Oxfam's knowledge there is no requirement for DFI-funded private healthcare providers to inform complainants about the DFI's respective independent accountability mechanisms. The UK's BII has a complaints mechanism but it is not independent of BII.

Of course, for any DFI grievance mechanism to be effective, impacted communities need to first be aware of the DFI's investment. None of the participants in Oxfam's primary research on two DFI funded hospital chains in India for example. were aware of this support.

PUBLIC HEALTH CARE SYSTEMS

DFIs like to evidence the necessity of their investments in for-profit health providers by pointing to weak and under-resourced government healthcare. Claims are made that private healthcare can relieve the burden placed on these services. But a bigger, better financed and more powerful for-profit private healthcare sector can have the opposite impact, diverting resources from publicly provided care with devastating impacts for those most reliant on it.

Risks are varied and complex and include a brain drain from already under-staffed hospitals and clinics[354] and the diversion of public funding through, for example, tax avoidance and evasion, or via tax breaks and other government subsidies lobbied for by powerful private health actors.[355] The push for government health insurance schemes that include for-profit providers can skew public spending to more expensive urban-based private hospitals to the detriment of rural and more locally accessible government provision (see Box 7).

Private providers can also corrupt government health services by co-opting government doctors to refer patients to private facilities.[356] A larger and better-equipped private healthcare sector can erode incentives for the better-off to pay their taxes or vote for more public funding to government services.[357]

There are signs that some DFIs are starting to understand such risks. Investors for Health, an initiative involving BII, IFC and DEG, acknowledges that private sector involvement in health might undermine UHC, including by 'diverting resources away from public health systems and the most underserved populations'.[358]

According to Investors for Health, to overcome these challenges 'requires substantial investor and public-private collaboration to provide care structures with the greatest positive impact'. What this means, however, is not explained. Nor is it made clear how such close collaboration can be achieved when over 80% of DFI healthcare investments are made indirectly.

Interestingly, even some private hospitals think public money should not be spent on them. The founder and chairman of BII-funded Narayana Health said himself in a note to investors in 2020 that 'privatising healthcare is not the solution for a country like India. No matter how much a private hospital reduces the treatment charges, they simply cannot treat a patient with no money in his pocket.'[359] He went on to explain that the solution in his view was to strengthen public hospitals to serve the majority of people. Narayana Health told Oxfam: 'In our opinion, public health spending should be kept within the public health system, and not be diverted to the private healthcare system. The public healthcare spend currently going to private operators could be better utilized to improve public hospital infrastructure, pay higher salaries, build more primary centres, convert district hospitals to medical colleges, and implement electronic medical records.'[360]

FINANCING THE FINANCIALIZATION OF HEALTHCARE – FOR WHAT AND FOR WHOM?

In the absence of any credible theory of change or evidence of impact, DFIs seem to be financing the financialization of healthcare as an end in itself, generating returns for investors while radically transforming the landscape of healthcare systems in the Global South, regardless of potential far-reaching and long-lasting structural consequences.

Oxfam's mapping of DFI healthcare investments shows that in many cases they are funding some of the largest, most well-established corporate hospital chains, which have objectives of further expansion and market dominance via mergers and acquisitions. Evidence shows how this corporatization of healthcare in countries like India involves swallowing up and eliminating competition, including from smaller and potentially lower-cost independent private and charitable healthcare providers.[361] Gaining greater command of the market helps to maximize returns but may squeeze out any hope or opportunity of building a genuinely universal and equitable public healthcare system.

The excessive use of private equity firms by DFIs is of particular concern in health, given mounting evidence that they use myriad techniques to siphon wealth out of social sectors for themselves, instead of investing for better services and care.[362] Women invariably pay the greatest price, as they make up the majority of workers and users of services in these sectors.[363]

Studies in the United States, France, Germany and the UK, for example, have found higher rates of mortality and lower staffing levels in care homes owned by private equity firms, and lower quality of care in for-profit homes, compared with their public or non-profit peers.[364] Evidence is growing in the USA that private equity's expansion into healthcare has led to higher prices and diminished quality of care.[365]

Oxfam's research for this report has focused on the losers in this process – the patients and carers paying exorbitant life-changing bills, paying with denial of their rights and paying with exclusion from care.

Some of the winners are also worth considering.

Rede D'Or is a Brazilian hospital chain funded by Proparco and IFC that is rapidly expanding.[366] The company's President Jorge Moll Filho is Brazil's tenth richest billionaire.[367]

IFC has repeatedly invested in three of India's biggest corporate hospital chains, including Fortis, which was founded by billionaire brothers Malvinder and Shivinder Singh.[368] Of note is that in 2022, the brothers were sentenced to six months in jail for crimes associated with the sale of Fortis to another IFC beneficiary[369] and investment partner,[370] IHH Healthcare.

BII has made multiple investments in and partnered with the Manipal Group in India, described by Forbes as a 'health and education empire'. Manipal is controlled by Ranjan Pai, whose wealth has grown in real terms by US$1.48bn in the last year alone.[371]

Far from providing UHC, a legacy of DFI investments in for-profit private healthcare is more likely a growing concentration of wealth and power in the hands of a small number of incredibly wealthy men.

CONCLUSION

This report is not an account of a few bad apples. It examines the fundamentally flawed and dangerous idea that spending precious development funds on expensive for-profit healthcare in contexts of extreme inequality and woefully inadequate regulation, and without robust safeguards, will help fight health poverty and inequality and advance healthcare for all. It is an approach that has been allowed by rich country governments to flourish unhindered by inconvenient counter-evidence or meaningful accountability. This in a context where half the world lacks access to even essential healthcare and 60 people every second are pushed into poverty through paying for healthcare out-of-pocket.[372]

For-profit healthcare providers are not going away and nor should their role be eliminated. The question here is whether DFIs should be investing aid and other public development finance in (and profiting from) such providers. Based on extensive research and investigation, Oxfam firmly believes that the answer is no.

Those arguing in favour of DFI funding to private healthcare are hardly impartial. Since IFC first laid out its arguments about the necessity of scaling up funding for the for-profit private healthcare sector in Africa in the late 2000s,[373] DFIs have been largely unchallenged in writing the script to justify their own role in healthcare.

What has emerged is an evidence-free, rich country bankers' guide to fixing healthcare in low- and middle-income countries. It is a guide that borrows from WHO's analysis of the problems but turns its back on its solutions.

Achieving healthcare for all requires designing and delivering universal health services free at the point of need, which first and foremost can meet the priority needs and rights of the poorest and most marginalized women, men and children. This has to be the priority, and the COVID-19 pandemic has shown the importance and urgency of it to everyone.

When aid and other forms of development funds are used to support country-owned, gender-transformative public health care systems, comprehensive primary healthcare, health workers and the removal of user fees, it works to save lives and advance the right to health for all.

At a time of increasing need and declining aid budgets, it is more crucial than ever that any public development funding for health is spent as effectively as possible.

It is not acceptable that rich country governments have instead given DFIs free rein to spend public resources on under-regulated, for-profit private healthcare providers through a complex web of unaccountable and tax-avoiding intermediaries, with no credible theory of change or impact indicators, no democratic oversight in recipient countries, and no publicly available evidence of impact on those most denied healthcare access or impoverished by it. All this comes with potentially profound and long-lasting negative impacts on already fragile and under-resourced healthcare systems.

This report has shone a light on some of the human costs: the patients blocked from access or bankrupted by eyewatering hospital bills that should never have been charged; patients imprisoned in hospitals for being too poor to pay; urgently needed maternity services and lifesaving COVID-19 care far out of reach; emergency healthcare denied. These costs have been under-considered and under-investigated. This must not be allowed to continue.

The model of DFIs investing in for-profit healthcare in LMICs is fuelling the financialization of healthcare for the benefit of large and powerful corporations and their millionaire and billionaire CEOs and investors. The DFIs and the private equity firms in which they invest are reaping returns from profit maximization strategies in healthcare that are draining lower-income country health budgets and people's pockets, increasing health inequality and exposing patients to unacceptable risks of harm.

Guardrails are urgently needed to protect sectors responsible for the delivery of fundamental human rights from this colonial and extractive approach.

RECOMMENDATIONS

DEVELOPMENT FINANCE INSTITUTIONS SHOULD:

- Stop all future direct and indirect funding to for-profit healthcare providers.
- Take action to remedy any harms resulting from their investments including human and patient rights violations identified.
- Ensure full transparency for all investments and advisory services, including all investments made through financial intermediaries, and fully disclose data on impact.
- Conduct a transparent and participatory consultation, especially with governments and civil society from LMICs, to explore the potentially positive contribution that DFIs can make to redistributing and strengthening R&D and local manufacturing of medicines and medical technologies in the Global South to advance more equitable, affordable and timely access to lifesaving technologies.

GOVERNMENTS OF THE UK, FRANCE, GERMANY, EU MEMBER STATES AND WORLD BANK SHAREHOLDERS SHOULD:

- Stop promoting and financing the commercialization, financialization and privatization of healthcare including PPPs. Safeguard all public services from efforts to 'mobilize' and 'leverage' private finance using publicly funded or backed development finance.

- Exercise their duty to provide full oversight of the DFIs which they fund, including by demanding implementation of all the recommendations above – stopping future DFI funding to for-profit healthcare; the immediate disclosure of all direct and indirect DFI health investments and of impact evidence held; take urgent action to provide remedy for harm; and ensure the establishment of DFI independent accountability mechanisms where these do not exist.
- Urgently commission an independent and comprehensive evaluation of existing and historic DFI funding to for-profit healthcare providers, with priority focus on the impact of DFIs on advancing equitable effective healthcare access without financial hardship to those most denied it, and the protection and promotion of patient rights. The impact for those on low-incomes and living in poverty, women and girls, and other people who are marginalized in the societies and economies where DFIs invest should be comprehensively assessed. The evaluation should include analysis of wider health system and economic impacts on healthcare inequality and should include the full and transparent participation of healthcare equity and patient rights experts, including from civil society and academia. The evaluation should include the cases of alleged and confirmed harm identified by Oxfam's research.
- Fund and support government and social accountability capacities to regulate private providers with priority focus on upholding patient rights and ensuring grievance redress mechanisms for citizens utilizing private services.

ALL GOVERNMENTS SHOULD:

- Invest in strengthening public healthcare systems that are equitable, universally accessible, gender-transformative and free at the point of use. More priority should be given to supporting comprehensive primary healthcare; gender transformative health workforce strategies; removing user fees; and redressing inequality in access to sexual and reproductive health services and rising maternal death rates.
- Stop healthcare systems being commercialized and financialized and instead generate more funds for health and other public services by supporting greater progressive taxation including wealth taxes, the cancellation of debts and the mobilization of Special Drawing Rights.
- Ensure robust regulation of for-profit health providers and hold them accountable for violations of patients' rights including through legal means.
- Governments of countries where DFIs are investing in health should hold DFIs to account and insist they do no harm. They should scrutinize their investments and insist on democratic oversight, including by ensuring they are fully available for scrutiny by parliaments and regulatory bodies.

CIVIL SOCIETY SHOULD:

- Insist on full transparency and accountability of the role of DFIs in health, with full disclosure of impact evidence, especially on reducing healthcare poverty and inequality and advancing gender equity in health.

- Investigate and scrutinize DFI financing to for-profit healthcare providers in LMICs, including by utilizing Oxfam's mapping, and work with others to raise complaints with DFI Independent Accountability Mechanisms where exploitation and extortion are identified. Oxfam's research should be replicated for other DFIs.
- Build alliances and work together to develop effective social accountability mechanisms to hold DFIs and private healthcare providers to account.

UN HUMAN RIGHTS BODIES, INCLUDING THE HUMAN RIGHTS COUNCIL SHOULD:

- Strengthen the integration of patients' rights within human rights frameworks, ensure adherence to the same by DFIs and other development organizations, and develop guiding principles for private for-profit healthcare providers to protect against any human rights abuses.

NOTES

[1] Business Daily. (10 November 2016). Hospital CEO talks money, zeal, silence. https://www.businessdailyafrica.com/bd/lifestyle/hospital-ceo-talks-money-zeal-silence--2130932

[2] Email communication from TPG to Oxfam, 25 May 2023.

[3] The fees reportedly charged by both CARE Hospitals and Narayana Health to the people Oxfam talked to for this research ranged from INR 60,000 to INR 30 lakh (about US$730 to US$36,000). According to the World Inequality Lab, the average income in India is INR 211,000. https://inequalitylab.world/en

[4] Concern USA. (2022). The 10 Worst Countries to Be a Mother. https://www.concernusa.org/story/worst-countries-to-be-a-mother/#:~:text=1.,for%20every%20100%2C000%20live%20births

[5] WHO. Health Equity Assessment Toolkit (HEAT). https://whoequity.shinyapps.io/heat/

[6] Wherever the names Hygeia or Lagoon hospitals are used in this report they refer to the company Hygeia Nigeria Ltd now renamed Iwosan Lagoon Hospitals Ltd.

[7] According to information provided by the hospitals in 2020, at Lagoon's Ikeja and Ikoyi facilities, starting prices for unassisted childbirth range from NGN 280,000 to NGN 430,000 (US$728 to US$1,118), and for a caesarean birth they cost as much as NGN 790,000 (US$2,054). Income data from World Inequality Database. https://wid.world/. See methodology note for approach to calculating average incomes. Anna Marriott (2023) Sick development: Methodology note. Oxfam. http://policy-practice.oxfam.org.uk/publications/sick-development-how-rich-country-government-and-world-bank-funding-to-for-prof-621529

[8] The lowest-cost delivery identified at Evercare Hospital in Nigeria is NGN 575,000. A caesarean birth costs NGN 1,125,000. The average annual income for someone in the bottom 10% in Nigeria is NGN 47,342.50. Income data from World Inequality Database. https://wid.world/. See methodology note for approach to calculating average incomes. Anna Marriott (2023) Sick development: Methodology note. op. cit

[9] Nyaaya. (2022). Right to Emergency Medical Care. https://nyaaya.org/legal-explainer/right-to-emergency-medical-care/

[10] Email communication from TPG to Oxfam, 20 May 2023.

[11] E. Kiggundu. (18 June 2021). 20 days spent in ICU at IHK, Nakasero, Victoria, Case hospitals will cost you money worth a house in Gayaza, Kira. Nile Post. https://nilepost.co.ug/2021/06/18/20-days-spent-in-icu-at-ihk-nakasero-victoria-case-hospitals-will-cost-you-money-worth-a-house-in-gayaza-kira/

[12] The initial hospital bill was published by Eagle Online. (23 June 2021). Outrage as TMR Hospital asks Sh118m from a #Covid-19 patient. https://eagle.co.ug/2021/06/23/outrage-as-tmr-hospital-asks-shs118m-from-a-covid-19-patient.html; NewVision. (2021). Museveni bails out Kaaya's family with sh300m for his medical bills. https://www.newvision.co.ug/category/news/museveni-bails-out-kaayas-family-with-sh300m-111851

[13] Email communication from TPG to Oxfam, 20 May 2023.

[14] WHO. (2019). Primary Health Care on the Road to Universal Health Coverage: 2019 Monitoring Report. Geneva: WHO. https://www.who.int/publications/i/item/9789240029040

[15] Using the latest available data and avoiding double counting, the WHO and World Bank estimate the global number of people suffering catastrophic and impoverishing out-of-pocket health spending in 2017 was between 1.366 billion and 1.888 billion people in 2017, depending on the poverty line used to identify impoverishing health spending (the poverty line of extreme poverty or relative poverty, respectively). See WHO and World Bank. (2021). Tracking Universal Health Coverage: 2021 Global Monitoring Report. https://www.who.int/publications/i/item/9789240040618

[16] Ibid.

[17] R. Rannan-Eliya and A. Somantnan. (2005). Access of the Very Poor to Health Services in Asia: Evidence on the role of health systems from Equitap. UK: DFID Health Systems Resource Centre; D. Balabanova, M. McKee and A. Mills (eds). (2011). 'Good health at low cost' 25 years on. What makes a successful health system? London: London School of Hygiene and Tropical Medicine. https://ghlc.lshtm.ac.uk/; WHO Commission on the Social Determinants of Health. (2007). Challenging Inequity through Health Systems. Geneva: WHO

[18] Y. Assefa, W. Damme, O. Williams, et al. (2017). Successes and challenges of the millennium development goals in Ethiopia: lessons for the sustainable development goals. BMJ Global Health 2017;2: e000318. https://gh.bmj.com/content/2/2/e000318

[19] The Global Fund. (2022). Results Report 2022. The Global Fund to Fight AIDS, Tuberculosis and Malaria. https://www.theglobalfund.org/en/results/

[20] M. Lawson, et al. (2019). Public good or private wealth? Universal health, education and other public services reduce the gap between rich and poor, and between women and men. Fairer taxation of the wealthiest can help pay for them. Oxfam. https://www.oxfam.org/en/research/public-good-or-private-wealth

[21] Due to greater data availability for the UK, our analysis includes funding from BII since 2008. See: Anna Marriott (2023) Sick development: Methodology note. op. cit. For full list of DFI direct and indirect health investments see annex as separate download on the page for this publication.

[22] None of the DFIs systematically disclose the value of intermediated investments. In response to this report, Proparco told Oxfam that the value of its indirect investments in health via multi-sector financial intermediaries is US$ 74m. Email from Proparco to Oxfam 13th June 2023.

[23] Oxfam's research identified a total of 140 first recipient (primary) financial intermediaries used by the four European DFIs, of which 112 are domiciled in known tax havens. See Anna Marriott (2023) Sick development: Methodology note. op. cit.

[24] In meetings with Oxfam on 1 March 2023 and 13 March 2023, EIB and DEG respectively confirmed that they do not conduct this kind of impact monitoring. Proparco was unable to provide examples of improved access to low-income patients or to people living in poverty when asked in a meeting with Oxfam in January 2020. In response to requests for impact information, BII provided extensive responses on their approach to health; however, the materials referenced did not provide any substantive impact information on improved access or affordability for low-income patients or women and girls. BII told us that since 2022, investments are also assessed for inclusion. The information available on BII's impact scoring, however, does not reassure that any greater level of impact information will be available for external scrutiny. E.g. BII. (2022). Impact Score: 2022–26 Strategy Period. https://assets.bii.co.uk/wp-content/uploads/2022/02/02111950/BII-Impact-Score-2022-26.pdf

[25] For example: IFC. (2008). The business of health in Africa: partnering with the private sector to improve people's lives. Washington, D.C.: World Bank Group. http://documents1.worldbank.org/curated/en/878891468002994639/pdf/441430WP0ENGLI1an10110200801PUBLIC1.pdf; and Oxfam's response: A. Marriott. (2009). Blind Optimism: Challenging the myths about private health care in poor countries. Oxfam. https://www.oxfam.org/en/research/blind-optimism

[26] World Bank. (2018). World Bank Group Support to Health Services: Achievements and Challenges. Independent Evaluation Group. Washington, DC: World Bank. https://ieg.worldbankgroup.org/evaluations/world-bank-group-health-services

[27] Independent Evaluation Group (IEG), World Bank. (2009). 'Chapter 5 – IFC's Health Strategy and Operations', in Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population – An Evaluation of World Bank Group Support Since 1997. Washington DC: The International Bank for Reconstruction and Development/The World Bank, pp.82–83.

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[29] Taneja, A and A. Sarkar (2023) First, Do No Harm: Examining the impact of the IFC's support for private healthcare in India, Oxfam. https://www.oxfam.org/en/research/first-do-no-harm-examining-impact-ifcs-support-private-healthcare-india

[30] Ibid.

[31] J. Gabbani, S. Mazumdar, and M. Suhrcke. (2023). The effect of health financing systems on health system outcomes: A cross-country panel analysis. Health Economics, Vol. 32, Issue 3, March 2023, pp. 574–619. https://onlinelibrary.wiley.com/doi/10.1002/hec.4635?af=R; and A. Wagstaff and S. Neelsen. (2020). A comprehensive assessment of universal health coverage in 111 countries: A retrospective observational study. Lancet Global Health, 8(1), e39–e49. https://doi.org/10.1016/s2214-109x(19)30463-2

[32] S. Garg, K.K. Bebarta, and N. Tripathi. (2022). Role of publicly funded health insurance in financial protection of the elderly from hospitalisation expenditure in India – findings from the longitudinal aging study. BMC Geriatrics. 22, 572 (2022). https://doi.org/10.1186/s12877-022-03266-2; D. Dubey, S. Deshpande, L. Krishna and S. Zadey. (2023). Evolution of Government-funded health insurance for universal health coverage in India. The Lancet, Regional Health Southeast Asia. https://doi.org/10.1016/j.lansea.2023.100180; S. Nandi. (2020). PPPs in publicly funded health insurance schemes: The case of PMJAY in India, of how women bear the brunt while the private sector expands. https://www.bloomsburycollections.com/book/corporate-capture-of-development/ch6-ppps-in-publicly-funded-health-insurance-schemes-the-case-of-pmjay-in-india-or-how-women-bear-the-brunt-while-the-private-sector-expands; S. Nandi. and H. Schneider. (2020). When state-funded health insurance schemes fail to provide financial protection: An in-depth exploration of the experiences of patients from urban slums of Chhattisgarh, India. Global Public Health, 15:2, 220–235. 10.1080/17441692.2019.1651369.

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[34] WHO. (2020). Country assessment guide: the health financing progress matrix. https://www.who.int/publications/i/item/9789240017825/

[35] Data spanning 153 countries over a 14-year period from 1995 to 2008, after controlling for other factors. R. Moreno-Serra and P. Smith. (2011). The Effects of Health Coverage on Population Outcomes: A Country-Level Panel Data Analysis. Results for Development Institute Working Paper. https://www.r4d.org/resources/effects-health-coverage-population-outcomes/

[36] J. Assa and C. Calderon. (2020). Privatization and Pandemic: A Cross-Country Analysis of COVID-19 Rates and Health-Care Financing Structures. The New School for Social Research, Department of Economics Working Paper 08/2020 http://www.economicpolicyresearch.org/econ/2020/NSSR_WP_082020.pdf

[37] Ibid.

[38] OHCHR. (2023). Benchmarking Study of Development Finance Institutions' Safeguard Policies. https://www.ohchr.org/sites/default/files/documents/issues/development/dfi/OHCHR_Benchmarking_Study_HRDD.pdf

[39] N. Shaxson. (2021). Care Givers and Takers - How finance extracts wealth from the care sector. Public Services International. https://publicservices.international/resources/publications/care-givers-and-takers---how-finance-extracts-wealth-from-the-care-sector?id=12877&lang=enhttps://publicservices.international/resources/publications/care-givers-and-takers---how-finance-extracts-wealth-from-the-care-sector?id=12877&lang=en; F. Schulte. (2022). Sick Profit: Investigating Private Equity's Stealthy Takeover of Health Care Across Cities and Specialties. KFF Health News. https://khn.org/news/article/private-equity-takeover-health-care-cities-specialties/

[40] Forbes Billionaires List. Jorge Moll Filho & family. https://www.forbes.com/profile/jorge-moll-filho/?list=billionaires&sh=f731a2572504

[41] Forbes Billionaires List. Ranjan Pai. https://www.forbes.com/profile/ranjan-pai/?list=billionaires&sh=6812177ac5c4

[42] It has been confirmed that the hospital was registered as part of the government health insurance scheme for which the patient had an eligible card that could have covered at least some of the hospital costs, up to a value of INR 5 lakh. Hospital staff can check if a government health insurance card is genuine, but it is not their job to make a subjective judgment on whether a card holder can afford to pay out-of-pocket. In this case the interviewee told Oxfam that hospital staff only said that the family could afford to pay, without giving any further explanation.

[43] Regardless of permissions granted, Oxfam has changed the names of all patients and family members interviewed for this research to protect their identities.

[44] Some noteworthy exceptions include the following: B. Hunter. (2023). Investor States: Global Health at the End of Aid. Cambridge: Cambridge University Press; Global Justice Now. (2021). Healthcare for all? How UK aid undermines universal public healthcare. https://www.globaljustice.org.uk/wp-content/uploads/2021/01/gjn_-_healthcare_for_all_-_2021.pdf; S. Attridge and M. Gouett. (2020.) DFI health investments as a Covid-19 response. ODI. https://cdn.odi.org/media/documents/200529_dfis_final_v3.pdf; Wemos. (2022). Improving healthcare but for whom? Studying the International Finance Corporation's investments in health. https://www.wemos.nl/en/improving-healthcare-but-for-whom/; A. Marriott and J. Hamer. (2014). Investing for the few: the IFC's Health in Africa initiative. Oxfam International. https://www.oxfam.org/en/research/investing-few; I. Chakravarthi, B. Roy, I. Mukhopadhyay and S. Barria. (2018). Investing in Health: Healthcare industry in India. Economic and Political Weekly, LII (45). https://www.epw.in/journal/2017/52/special-articles/investing-health.html

[45] M. Day. (29 March 2022). What development finance institutions don't want you to know. Devex. https://www.devex.com/news/opinion-what-development-finance-institutions-don-t-want-you-to-know-102880. See also: Oxfam. (10 June 2020). IFC found negligent of preventing harm to indigenous communities in Guatemala. Press release. https://www.oxfam.org/en/press-releases/ifc-found-negligent-preventing-harm-indigenous-communities-guatemala

[46] The UK's DFI was formerly called the Commonwealth Development Corporation (CDC). The name was changed to British International Investment (BII) in April 2022. BII is used throughout this report even if investments were made while the organization was known as CDC.

[47] Taneja, A and A. Sarkar (2023) First, Do No Harm op. cit

[48] A. Marriott and J. Hamer. (2014). Investing for the Few, op. cit.; see also: A. Marriott. (2014). A Dangerous Diversion: Will the IFC's flagship health public–private partnership bankrupt Lesotho's Ministry of Health? Oxfam International. https://www.oxfam.org/en/research/dangerous-diversion

[49] International Development Association. What is the IDA Private Sector Window? World Bank Group. https://ida.worldbank.org/en/financing/ida-private-sector-window/what-is-ida-private-sector-window

[50] S. Attridge and M. Gouett. (2021). Development finance institutions: the need for bold action to invest better. ODI. https://cdn.odi.org/media/documents/DPF_Blended_finance_report_tuMbRjW.pdf

[51] R. Rannan-Eliya and A. Somantnan. (2005). Access of the Very Poor to Health Services in Asia: Evidence on the role of health systems from Equitap, op, cit; D. Balabanova, M. McKee and A. Mills (eds). (2011). 'Good health at low cost' 25 years on. What makes a successful health system? Op. cit.; WHO Commission on the Social Determinants of Health. (2007). Challenging Inequity through Health Systems. Geneva: WHO

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[53] Oxfam. (2009). Blind Optimism: Challenging the myths about private healthcare in poor countries. https://www.oxfam.org/en/research/blind-optimism

[54] For example, the World Bank Group has formally adopted a private-finance-first approach with no guardrails to protect sectors like health and education, which are responsible for delivering fundamental human rights. Eurodad. (2022). Our future is public: Why the IMF and World Bank must support public services. https://www.eurodad.org/our_future_is_public_why_the_imf_and_world_bank_must_support_public_services

[55] B. Hunter. (2023). Investor States, op. cit.; B. Hunter and S. Murray. (2019). Deconstructing the financialization of healthcare. Development and Change, 50: 5. https://onlinelibrary.wiley.com/doi/full/10.1111/dech.12517; B. Hunter and S. Murray. (2015). "Beyond aid" investments in private healthcare in developing countries. BMJ, 2015 (351). http://sro.sussex.ac.uk/id/eprint/86070/1/bmj.h3012.full.pdf

[56] Examples include the following: 'At CDC we are committed to better understanding the impact of our investments and how best we can contribute to universal health coverage.' BII. (2019). Making an impact in healthcare. https://www.bii.co.uk/en/news-insight/news/making-an-impact-in-healthcare/; 'Our health impact framework was designed … to ensure investments contribute to Universal Health Coverage and UN SDG3.' BII email to Oxfam, 15 December 2022; 'IFC helps private providers meet the soaring demand for health care and supports governments in their goal of reaching Universal Health Coverage by 2030'. IFC. IFC's Work in Health. https://www.ifc.org/wps/wcm/connect/Industry_EXT_Content/IFC_External_Corporate_Site/Health. The EIB does not have a dedicated health strategy but confirmed in a meeting with Oxfam on 1 March 2023 that its health work is guided by EU development policy and by UHC and other WHO principles. DEG says that the companies it supports are driving forward the SDGs (https://www.deginvest.de/Our-impact/). It also told Oxfam that it works to deliver the SDGs, including in health, but considers its role too small to have a significant impact on UHC. Oxfam meeting with DEG on 1 March 2023.

[57] WHO. (2022). Universal health coverage (UHC): Key facts. https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

[58] Ibid.

[59] DEG's official communications do not make clear an explicit focus on patients living in poverty or on low incomes, despite its mandate to achieve the SDGs.

[60] Examples including BII (2019) op. cit.; BII email to Oxfam 15 December 2022; IFC https://www.ifc.org/wps/wcm/connect/Industry_EXT_Content/IFC_External_Corporate_Site/Health; EIB meeting with Oxfam March 2023; Oxfam meeting with DEG on 1 March 2023; Proparco. Investments driven by their contribution to development in Southern countries. https://www.proparco.fr/en/investments-driven-their-contribution-development-southern-countries; BII. (n.d.). Productive, Sustainable and Inclusive Investment: 2022–26 Technical Strategy. https://assets.bii.co.uk/wp-content/uploads/2022/01/06170001/2022-2026-technical-strategy-2.pdf

[61] See: https://www.legifrance.gouv.fr/jorf/id/JORFTEXT000043898536

[62] IFC. (n.d.). The Role of the Private Sector in Expanding Health Access to the Base of the Pyramid. https://www.ifc.org/wps/wcm/connect/3a4d636b-adaa-4724-8997-9a2714ae6175/60939_IFC_HealthReport_FINAL.pdf?MOD=AJPERES&CVID=lK6ZFwF

[63] The EIB also said that the threshold for the portion of these services delivered via public systems and/or to the benefit of specific categories of population is taken into account during appraisal of individual projects on a case-by-case basis. Email communication, 28 April 2023.

[64] H. Wadge, R. Roy, A. Sripathy, M. Prime, A. Carter, G. Fontana et al. (2017). Evaluating the Impact of Private Providers on Health and Health Systems. Imperial College London. https://assets.cdcgroup.com/wp-content/uploads/2017/06/25150846/Impact-of-private-providers-on-health-and-health-systems.pdf

[65] BII email to Oxfam, 15 December 2022.

[66] Investors for Health. https://www.investorsforhealth.com/

[67] R. Morgan, T. Ensor and H. Waters. (2016). Performance of private sector health care: implications for universal health coverage. The Lancet 2016; 388: 606–12; World Bank. (2014). Is that surgery really necessary? Ensuring the medical necessity of care. https://www.worldbank.org/en/news/feature/2014/07/30/is-that-surgery-really-necessary

[68] R. Morgan et al. (2016). Performance of private sector health care, op. cit. B. Hunter, S. Murray, S. Marathe, I. Chakravarthi. (2022). Decentred regulation: The case of private healthcare in India, World Development, Volume 155, 2022, https://doi.org/10.1016/j.worlddev.2022.105889.

[69] See, for example, Monitor. (2020). IFC acquires 54.23 Stake in AAR. https://www.monitor.co.ug/uganda/business/finance/ifc-acquires-54-23-per-cent-stake-in-aar--1873572; and IFC. (2008). The Business of Health in Africa: Partnering with the private sector to improve lives. https://www.unido.org/sites/default/files/2016-01/IFC_HealthinAfrica_Final_0.pdf

[70] WHO. (2019). Financing for Universal Health Coverage: Dos and Don'ts, op. cit.; J. Kutzin. (2012). Anything goes on the path to universal health coverage? No. Bulletin of the World Health Organization 2012 90(11): 867-868 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3506412/

[71] WHO. (2020). Country assessment guide: the health financing progress matrix, op. cit.

[72] Data spanning 153 countries over a 14-year period from 1995 to 2008, after controlling for other factors. R. Moreno-Serra and P. Smith. (2011). The Effects of Health Coverage on Population Outcomes: A Country-Level Panel Data Analysis, op. cit.

[73] J. Assa and C. Calderon. (2020). Privatization and Pandemic: A Cross-Country Analysis of COVID-19 Rates and Health-Care Financing Structures, op. cit.

[74] Ibid.

[75] Assefa, W. Damme, O. Williams, et al. (2017). 'Successes and challenges of the millennium development goals in Ethiopia: lessons for the sustainable development goals', op. cit.

[76] J. Burnley. (2010). 21st Century Aid: Recognising success and tackling failure. Oxfam International. https://policy-practice.oxfam.org/resources/21st-century-aid-recognising-success-and-tackling-failure-113995/

[77] The Global Fund. (2022). Results Report 2022, op. cit.

[78] Aid for health was 8%, 9% and 11% of French, German and UK bilateral aid, respectively, in 2021. Figures sourced from the OECD Creditor Reporting System: https://stats.oecd.org/Index.aspx?DataSetCode=crs1

[79] E. Seery and D. Jacobs. (2023). Financial wizardry won't pay the bill for a fair and sustainable future. Methodology note. Oxfam International. https://oi-files-d8-prod.s3.eu-west-2.amazonaws.com/s3fs-public/2023-04/Methodology%20Note%28English%29.pdf

[80] Searches of the DFIs' websites were carried out periodically over the period 2018 to 2022. The information presented on funding provided by the European DFIs was correct as of August 2022. Note that a small number of projects or investments identified early on in the research were no longer shown on the DFI websites in 2022 but have been included here. Note also that due to greater data availability for the UK, Oxfam's analysis includes funding from BII since 2008. Data sourced from the IFC project portal were correct as of February 2023.

[81] Research participants were anonymized to protect identifies, so companies were not asked to comment on specific patient cases but were given the opportunity to comment on the issues raised by them.

[82] Anna Marriott (2023) Sick development: Methodology note. op. cit.

[83] Oxfam's research found that the highest number and proportion of combined direct and indirect heath investments for the DFIs of France (19%), Germany (19%) and the UK (53%) are in India. IFC reported that 28% of its global health portfolio was in India in 2016 (https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=18159). Only the EU's DFI, the EIB, is not heavily invested in health in India, with only one investment (and this not in healthcare provision). Kenya also has the highest concentration of EIB health investments (16%). Kenya has the second or joint second highest concentration of total health investments for France (14%) and Germany (5%). For the UK's DFI BII, Kenya hosts the second highest number of healthcare investments (7%) and the third highest number of health investments overall (6%).

[84] The Nairobi Women's Hospital. https://nwh.co.ke/hospital/

[85] Cited below.

[86] P. Ogemba. (2018). It is illegal to detain patient in hospital over bills, court rules. The Standard. https://www.standardmedia.co.ke/article/2001297635/it-is-illegal-to-detain-patient-in-hospital-over-bills-court-rules

[87] T. Minney. (19 January 2010). Africa Health Fund makes first investment. African Capital Markets News. https://africancapitalmarketsnews.com/africa-health-fund-makes-first-investment/

[88] The Swedish DFI Swedfund also invested in NWH, buying 19% of the company in 2013. It sold its shares to Abraaj Growth Health Fund in 2017. https://www.mynewsdesk.com/se/swedfund/pressreleases/swedfund-saeljer-sin-andel-i-nairobi-womens-hospital-1951901

[89] Norfund. Africa Health Fund (Aureos). https://www.norfund.no/investment/africa-health-fund-aureos/

[90] IFC Project Information and Data Portal. Abraaj Global Health Fund. https://disclosures.ifc.org/project-detail/SII/33475/abraaj-global-health-fund

[91] Republic of Kenya. (2017). The Kenya Gazette. Vol. CXIX No 64, 19 May 2017. http://kenyalaw.org/kenya_gazette/gazette/download/Vol.CXIX-No_.64_.pdf; G.W. Leaper. (2017). Swedfund Sells Shares in Nairobi Women's Hospital. Nordsip. https://nordsip.com/2017/05/09/swedfund-sells-share-in-nwh-to-abraaj-ghf/

[92] The information on CDC/BII's investment in the Abraaj Growth Health Fund (AGHF) was first captured by Oxfam from CDC's website in 2018–19. Since then BII has removed all references to AGHF from its website and now incorrectly reports that its indirect investment in NWH took place in 2019. It also now reports an investment amount of US$50m rather than US$75m as originally reported.

[93] BII. Evercare Health Fund. https://www.bii.co.uk/en/our-impact/fund/evercare-health-fund-2/

[94] African Development Bank, Private Sector Operations. (2016). Abraaj Growth Markets Health Fund Africa. https://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/Project_Brief_ABRAAJ_GROWTH_MARKETS_HEALTH_FUND_Multinational_2016.pdf

[95] TPG. (20 June 2019). TPG Closes Transaction to Take Over the Abraaj Group's Growth Markets Health Fund. Press release. https://tpggloballlc.gcs-web.com/news-releases/news-release-details/tpg-closes-transaction-take-over-abraaj-groups-growth-markets

[96] Business Daily. (10 November 2016). Hospital CEO talks money, zeal, silence, op. cit.

[97] Gender Violence Recovery Centre. Our Major Activities. https://gvrc.or.ke/

[98] Thika Town Today. (2017). Family's agony as kin's body is held for 5 months over KES. 1 million bill. https://www.thikatowntoday.co.ke/2017/05/family-agony-as-kins-body-is-held-for-5.html?m=1

[99] Nation. (15 November 2017, updated 5 July 2020). Nairobi Women's Hospital detains 12 patients in Ongata Rongai (video). https://nation.africa/video/news/4146788-4188826-gxq8a4z/index.html

[100] Kahawa Tungu. (24 November 2017). Fida Demands Release Of 12 Patients Detained By Nairobi Women's Hospital. https://www.kahawatungu.com/fida-demanding-release-of-12-patients-detained-by-nairobi-womens-hospital/

[101] Nairobi News. (17 December 2017). Agony of Nairobi women detained in hospitals over bills. https://nairobinews.nation.africa/agony-of-nairobi-women-detained-in-hospitals-over-bills/

[102] P. Ogemba. (2018). op. cit. and P. Ogemba. (3 October 2018). Kenya: Court rules Nairobi Women's Hospital's detention of patient over unpaid medical bills is a violation of his rights. Standard Digital (Kenya), republished by Business & Human Rights Resource Centre. https://www.business-humanrights.org/de/neuste-meldungen/kenya-court-rules-nairobi-womens-hospitals-detention-of-patient-over-unpaid-medical-bills-is-a-violation-of-his-rights/

[103] D. Luchina. (23 April 2019). Burundi refugee held at Nairobi Women's Hospital over Sh1 million bill. The Star. https://www.the-star.co.ke/news/2019-04-23-burundi-refugee-held-at-nairobi-womens-hospital-over-sh1-million-bill/

[104] The Standard. (19 May 2019). Revealed: Shock of detained bodies and patients over unpaid billions. https://www.standardmedia.co.ke/health/article/2001326171/revealed-shock-of-detained-bodies-and-patients-over-unpaid-billions

[105] Citizen TV Kenya. (7 July 2019). Nairobi Women's 'prison' Hospital. YouTube video. https://www.youtube.com/watch?v=0zQl5nFh41U

[106] G. Aradi. (2019). Help me bury my mother who has been in morgue for 2 years. The Standard. https://www.standardmedia.co.ke/nairobi/article/2001348505/help-me-bury-my-mother-who-has-been-in-morgue-for-2-years

[107] A. Omondi. (25 October 2019). Woman pleads with Nairobi Women's Hospital to release mum's remains as Christmas gift. Tuko. https://www.tuko.co.ke/320939-woman-pleads-nairobi-womens-hospital-release-mums-remains-christmas-gift.html; Tuko. (2019). Give me my mother's body as Christmas gift. YouTube video. https://www.youtube.com/watch?v=v5ylgMYGR9g; G. Aradi. (2019). Ibid.

[108] S. Onzivua. (10 July 2021). Court rules on detention of a patient. The Monitor. https://allafrica.com/stories/202107120141.html; E. Karuti. (27 May 2021). Detention of patients over unpaid hospital bills: a constitutional perspective. DLA Piper Africa: Insights. https://www.dlapiperafrica.com/en/kenya/insights/2021/detention-of-patients-over-unpaid-hospital-bills-a-constitutional-perspective.html

[109] Owaahh. (6 February 2020). Customers, Not Patients: The Nairobi Women's Hospital Saga. The Elephant. https://www.theelephant.info/features/2020/02/06/customers-not-patients-the-nairobi-womens-hospital-saga/

[110] M. Kiruga. (7 February 2020). Kenya: Private healthcare requires intensive care and better regulation. The Africa Report. https://www.theafricareport.com/23096/kenya-private-healthcare-requires-intensive-care-and-better-regulation/

[111] M. Kiruga. (25 January 2020). How Nairobi Women's Hospital milked patients dry in crazy revenue game. Nation. https://nation.africa/kenya/nation-prime/how-nairobi-women-s-hospital-milked-patients-dry-in-crazy-revenue-game-244636

[112] N. Agatu. (6 February 2020). On the spot: Nairobi Women's Hospital dismiss 'inflation cost' claims. The Star. https://www.the-star.co.ke/news/2020-02-06-on-the-spot-nairobi-womens-hospital-dismiss-inflation-cost-claims/; P. Alushula. (13 February 2020). More private hospitals face probe over medical bills fraud. Business Daily. https://www.businessdailyafrica.com/corporate/health/More-private-hospitals-face-probe-over-medical-bills-fraud/4258458-5453854-pyy8t/index.html

[113] N. Kabale and A. Oketch. (27 January 2020, updated 15 July 2020). Working public hospitals are the remedy – KMPDU. Nation. https://www.nation.co.ke/nationprime/When-patients-lose-trust-in-hospitals/5279428-5434182-13vtdx8/index.html; J. Kisero. (11 February 2020, updated 4 July 2020). To ward off greedy investors, fund locals to put up private hospitals. Nation. https://www.nation.co.ke/oped/opinion/To-ward-off-greedy-investors--fund-locals-to-put-up-hospitals/440808-5452186-c7wus6z/index.html

[114] UK Parliament Committees. (2023). 25 April 2023 – Investment for development: The UK's strategy towards Development Finance Institutions – Oral evidence. https://committees.parliament.uk/event/17957/formal-meeting-oral-evidence-session/

[115] The measures include leadership changes, a new payment policy and a patients' charter. TPG told Oxfam that its various oversight mechanisms have not raised any concerns about improper detainment of patients.

[116] R. Yates, T. Brookes and E. Whitaker. (2017). Hospital Detentions for Non-payment of Fees: A Denial of Rights and Dignity. Centre on Global Health Security, Chatham House. https://www.chathamhouse.org/sites/default/files/publications/research/2017-12-06-hospital-detentions-non-payment-yates-brookes-whitaker.pdf

[117] A fifth of respondents to an Oxfam India survey on patient rights in 2021 whose close relatives had been hospitalized said that the patient was denied discharge or they were denied release of the dead body by the hospital. See Oxfam India. (2021). Securing Rights of Patients in India: Lessons from rapid surveys on people's experiences of Patient Rights Charter and the COVID-19 vaccination drive. https://www.oxfamindia.org/knowledgehub/oxfaminaction/securing-rights-patients-india; R. Nagarajan. (7 November 2020). Hospitals defy courts, hold patients hostage over bills. Times of India. https://timesofindia.indiatimes.com/india/hospitals-defy-courts-hold-patients-hostage-over-bills/articleshow/79094533.cms

[118] ISER. (2021). When Patient Becomes Prisoner: Detention in Health Facilities in Uganda. https://iser-uganda.org/wp-content/uploads/2022/07/When_Patient_Becomes_Prisoner.pdf; The Independent. (7 July 2021). MPs grill private hospitals for retaining dead bodies, exorbitant fees. https://www.independent.co.ug/mps-grill-private-hospitals-for-retaining-dead-bodies-exorbitant-fees/

[119] J. Ogundepo. (14 May 2023). Patients detained over hospital bills recount ordeals. Punch. https://punchng.com/patients-detained-over-hospital-bills-recount-ordeals/; C. Nwokeke. (2019). Hospital Detention For Non-Payment Of Bills And Its Community Legal Effect. The Nigeria Lawyer. https://thenigerialawyer.com/hospital-detention-for-non-payment-of-bills-and-its-community-legal-effect-by-chidera-nwokeke/

[120] International Hospital Kampala (IHK) is part of the International Medical Group in Uganda, which has been funded via at least seven overlapping investments made by DEG, EIB, Proparco and IFC – see Annex as a separate download for this publication for details. In 2016 the NGO Centre for Health, Human Rights and Development (CEHURD) requested that a court order the release of a patient detained at IHK for non-payment of a medical bill. Reported in Monitor. (2 September 2016, updated 17 January 2021). Patient sues IHK over detention. https://www.monitor.co.ug/uganda/news/national/patient-sues-ihk-over-detention-1664730

[121] On 12th June 2023 EIB told Oxfam that this hospital is not an EIB-financed project. On 16th June 2023 DEG told Oxfam that this hospital is 'not known as a DEG investment (neither direct nor indirect).Information available indicates DEG is invested in International Hospital Kampala which is part of the International Medical Group via its investment in the Kibo Fund and via CIEL Healthcare, and EIB is invested via its investment in IFHA II and CIEL Healthcare. See annex as separate download on the page for this publication.

[122] For example, see: Y. Balarajan, S. Selvaraj and S.V. Subramanian. (2011). India: Towards Universal Health Coverage 4 Health care and equity in India. The Lancet, 377(9764), 505–515; P.N. Prasad and P. Raghavendra. (2012). Healthcare Models in the Era of Medical Neoliberalism: A Study of Aarogyasri in Andhra Pradesh. Economic & Political Weekly, 47(43), 118–126; S. Selvaraj and A. Karan. (2012). Why Publicly-Financed Health Insurance Schemes Are Ineffective in Providing Financial Risk Protection. Economic and Political Weekly, 47(11), 60–68; K. Sen, S.G. Roy, S. Kumar, K. Narayana and A. Priyadarshi. (2018). Health Reforms and Utilization of Health Care in three states of India: Public health prospects. Social Medicine, 12(1), 108–121; I. Chakravarthi. (2018). Regulation of Private Health Care Providers in India: Current Status, Future Directions. Indian Journal of Public Administration, 64(4), 587–598; Oxfam India. (2021). Analysing Regulation of Private Healthcare in India. https://www.oxfamindia.org/knowledgehub/workingpaper/analysing-regulation-private-healthcare-india; S. Sangar, V. Dutt and R. Thakur. (2019). Burden of out-of-pocket health expenditure and its impoverishment impact in India: evidence from National Sample Survey. Journal of Asian Public Policy 15:1.

[123] Anna Marriott (2023) Sick development: Methodology note. op. cit.

[124] Further measures to protect the identity of interviewees have been taken, including, in some cases, not naming the state in which healthcare was sought and excluding identifiers such as dates or details of patient illnesses or conditions.

[125] D. Chaki. (8 May 2023). Blackstone signs binding pact for controlling stake in Care Hospitals. https://economictimes.indiatimes.com/news/india/blackstone-signs-binding-pact-for-controlling-stake-in-care-hospitals/articleshow/100057906.cms

[126] Ibid.; Trade Brains: Stock Market News. (10 March 2023). Healthcare company in talks to acquire Care Hospitals; Stock jumps 2%. https://in.investing.com/news/healthcare-company-in-talks-to-acquire-care-hospitals-stock-jumps-2-3555994

[127] Email to Oxfam, 25 May 2023.

[128] Narayana Health. Chairman's Message. https://www.narayanahealth.org/about-us

[129] Eligibility for government health insurance in Chhattisgarh is universal. Two-thirds of those enrolled are covered under the national scheme for 'the poor' (Ayushman Bharat Pradhan Mantri Jan Arogya Yojana - PMJAY), which provides annual coverage for families of up to INR 5 lakh. The scheme was introduced in the state in 2018, and was preceded by a similar scheme with lower-value coverage. The other third of enrolees are covered by a smaller scheme for the 'non-poor', formerly known as MSBY, which has annual coverage worth one-tenth of the former. Since January 2020 the Chhattisgarh government health insurance scheme has been known as DKBSSY (Dr. Khoobchand Bagher Swasthya Sahayata Yojana). S. Garg, K.K. Bebarta and N. Tripathi. (2020). Performance of India's national publicly funded health insurance scheme, Pradhan Mantri Jan Arogaya Yojana (PMJAY), in improving access and financial protection for hospital care: findings from household surveys in Chhattisgarh state. BMC Public Health 20, 949.

[130] Narayana Health confirmed to Oxfam that its hospital in Chhattisgarh has been empanelled in the national health insurance scheme PMJAY since its introduction in the state in 2019. Oxfam has also confirmed via state government records that prior to this the same hospital had been empanelled in the previous health insurance scheme, RSBY (Rashtriya Swasthya Bima Yojana), since at least 2014. Empanelment in RSBY and the scheme for the elderly, MSBY (Mukhyamantri Swasthya Bima Yojana), is also indicated on Narayana's website: https://www.narayanahealth.org/content/rsby-msby

[131] Enrolment in the Odisha government health insurance scheme (known as BSKY) is automatic for all residents registered as living below the poverty line (BPL) or in extreme poverty (AAY) and for those who were already registered as eligible for the state's previous government health insurance scheme BKKY. For those without any of these options but who are living on an annual income of less than INR 50,000 in rural areas and INR 60,000 in urban areas, an income certificate can be applied for and used as proof of eligibility for free cashless healthcare at any government-empanelled private hospital. See http://nhmodisha.gov.in/frmrbsyostfbkky.aspx

[132] In Odisha, proof of eligibility to be accepted by hospitals includes a BKSY card; any card from the previous BKKY health insurance scheme; official identification of living in poverty (BPL and AAY card) or a government-issued low-income certification. See: Biju Swasthya Kalyan Yojana (BSKY) Dashboard. https://bskydashboard.odisha.gov.in/About. In January 2020 the government of Chhattisgarh announced that any government ID card could be used from that point forward to claim government health insurance-funded healthcare. Enrolled patients interviewed by Oxfam all had government-issued health insurance cards at the time of seeking treatment and care. See Economic Times. (19 January 2020). Good Governance: Smart cards not mandatory for Chhattisgarh integrated health scheme. https://government.economictimes.indiatimes.com/news/digital-india/good-governance-smart-cards-not-mandatory-for-chhattisgarh-integrated-health-scheme/73371280?redirect=1

[133] S. Garg et al. (2020). Performance of India's national publicly funded health insurance scheme, op. cit.; BSKY Dashboard. https://bskydashboard.odisha.gov.in/About

[134] Government of India. Health benefit packages & empanelment criteria. https://www.pmjay.gov.in/sites/default/files/2018-07/HBP.pdf

[135] S. Garg et al. (2020). Performance of India's national publicly funded health insurance scheme, op. cit.

[136] BSKY Dashboard, op. cit.

[137] This point was confirmed in a communication from Narayana Health to Oxfam, 29 April 2023. To protect the identity of research participants, the specific injuries suffered by Ravi (not his real name) are not disclosed. However, several treatments relevant to Ravi's injuries are listed in the Chhattisgarh health insurance benefit package, including rehabilitation.

[138] The allowance for non-listed items in Chhattisgarh is INR 1 lakh. With pre-authorization, other interventions can be covered.

[139] The government of Odisha makes clear that the purpose of the government health insurance card is to provide free cashless treatment and care. To the best of Oxfam's knowledge and searches, there is no suggestion or indication that government health insurance cards are used only for survey purposes. This was the only reason given by the hospital staff as to why the card could not be used. See: http://nhmodisha.gov.in/frmrbsyostfbkky.aspx

[140] The rules say that insurance is provided for approximately 1,929 procedures, covering all costs related to treatment, including but not limited to drugs, supplies, diagnostic services, physician's fees, room charges, surgeon charges, OT and ICU charges, etc. https://nha.gov.in/PM-JAY

[141] R. Dasgupta, S. Nandi, K. Kanungo, M. Nundy and R. Neog. (2013). What the good doctor said: a critical examination of design issues of the RSBY through provider perspectives in Chhattisgarh, India. Social Change, 43(2):227–43; D. Maurya and M. Ramesh. (2019). Program design, implementation and performance: the case of social health insurance in India. Health Economics, Policy and Law 14:487–508; S. Nandi, R. Dasgupta, S. Garg et al. (2016). Uncovering coverage: utilisation of the universal health insurance scheme, Chhattisgarh by women in slums of Raipur. Indian Journal of Gender Studies, 23:43–68.

[142] Robert said that his loans were provided by Ujjivan Financial Services. This company received a direct investment of $8m from IFC in 2012. https://disclosures.ifc.org/project-detail/SII/30283/ujjivan-project

[143] For further details of each focus group as identified in the paper, see: Anna Marriott (2023) Sick development: Methodology note. op. cit.

[144] Research on government health insurance schemes consistently indicates disproportionately low utilization for tribal people and people from scheduled castes; for example: D. Dubey, S. Deshpande, L. Krishna and S. Zadey. (2023). Evolution of Government-funded health insurance for universal health coverage in India, op. cit.; R. Chintan. (16 August 2021). Failure to serve marginalised, private health sector under PMJAY burdens public systems. News Click. https://www.newsclick.in/Failing-to-Serve-the-Marginalised-Private-Health-Sector-Burdens-Public-Systems-Instead

[145] S. Nandi and H. Schneider. (2020). When state-funded health insurance schemes fail to provide financial protection: An in-depth exploration of the experiences of patients from urban slums of Chhattisgarh, India, op. cit.

[146] S. Garg et al. (2020). Performance of India's national publicly funded health insurance scheme, Pradhan Mantri Jan Arogaya Yojana (PMJAY), op. cit.; D. Dubey et al. (2023). Evolution of Government-funded health insurance for universal health coverage in India, op. cit.; A. Karan, W. Yip and A. Mahal. (2017). Extending health insurance to the poor in India: an impact evaluation of Rashtriya Swasthya Bima Yojana on out of pocket spending for healthcare. Social Science & Medicine, 2017; 181: 83-92; R.K. Sinha. (2018). Impact of publicly financed health insurance scheme (Rashtriya Swasthya Bima Yojana) from equity and efficiency perspectives. Vikalpa, 43: 191-206.

[147] S. Garg, K.K. Bebarta and N. Tripathi. (2022). Role of publicly funded health insurance in financial protection of the elderly from hospitalisation expenditure in India – findings from the longitudinal aging study. BMC Geriatrics 22, 572; S. Nandi and H. Schneider. (2020). When state-funded health insurance schemes fail to provide financial protection, op. cit.; A. Ranjan, P. Dixit, I. Mukhopadhyay and S. Thiagarajan. (2018). Effectiveness of government strategies for financial protection against costs of hospitalization care in India. BMC Public Health, 16;18(1):501. DOI: 10.1186/s12889-018-5431-8; S. Nandi and H. Schneider. (2020). Using an equity-based framework for evaluating publicly funded health insurance programmes as an instrument of UHC in Chhattisgarh State, India. Health Research Policy and Systems 18, 50.

[148] Being hospitalized in a private healthcare facility increased the proportion of households pushed into poverty after making out-of-pocket payments from 1.3% if no member used such a facility, to 14.35% if at least one member in the household used a private facility. S. Sriram and A. Albadrani. (2022). Impoverishing effects of out-of-pocket healthcare expenditures in India. Journal of Family Medicine and Primary Care, Nov;11(11):7120-7128. DOI: 10.4103/jfmpc.jfmpc_590_22.

[149] According to the World Inequality Lab, the average income in India is INR 211,000. https://inequalitylab.world/en

[150] Ibid.

[151] It is not possible to conclude that the medicine bill necessarily exceeds what another private hospital would have charged, but the patient said that he thought it was exceptionally high. Medifee's website suggests that the average total cost of gallstone removal in Raipur, Chhattisgarh is INR 76,000. https://www.medifee.com/treatment/gallbladder-stone-operation-cost/

[152] The investigation was conducted by the government regulatory agency, the National Pharmaceutical Pricing Authority (NPPA), which said that the hospitals involved had requested anonymity. Sources told one journalist that the request was heeded because 'these practices are widely prevalent'. R. Nagarajan. (21 February 2018). Private hospitals making profits of up to 1,737% on drugs, consumables and diagnostics. Times of India. https://timesofindia.indiatimes.com/india/private-hospitals-making-over-1700-profit-on-drugs-consumables-and-diagnostics-study/articleshow/62997879.cms

[153] The three IFC-funded hospitals are Max Healthcare, Fortis and Apollo. See Taneja, A and A. Sarkar (2023) First, Do No Harm op. cit. and The Quint. (2 April 2022). CCI Pulls Up Three Large Hospital Chains Over Inflated Medicine Prices. https://www.thequint.com/fit/cci-notice-hospitals-drugs-medicines-medical-devices-prices

[154] The matter is still sub judice. Business Standard. (23 September 2022). Hospital chains abused their dominance to charge exorbitant prices: report. https://www.business-standard.com/article/current-affairs/hospital-chains-abused-their-dominance-to-charge-exorbitant-prices-report-122092300441_1.html [paywall]

[155] IFC has funded Fortis (see Taneja, A and A. Sarkar (2023) First, Do No Harm op. cit.) and BII has funded Sahyadri Hospital. Oxfam has found at least two indirect CDC investments in Sahyadri Hospitals, one in 2011 and one in 2012 (see Annex as separate download on the page for this publication). Information on investments in 2012 and before are now limited on the BII project portal and these two investments no longer appear.

[156] P. Kakodkar. (29 March 2018). Maharashtra govt files cases against seven hospitals for reusing medical devices. Times of India. https://timesofindia.indiatimes.com/city/mumbai/maharashtra-govt-files-cases-against-seven-hospitals-for-reusing-medical-devices/articleshow/63495584.cms; R. Khatun. (28 March 2018). Reusing Medical Devices: Maharashtra Govt files cases against top hospitals. Medical Dialogues. https://business.medicaldialogues.in/reusing-medical-devices-maharashtra-govt-files-cases-against-top-hospitals

[157] P. Kakodkar. (2018). Ibid.

[158] Nyaaya. (2022). Right to Emergency Medical Care, op. cit.

[159] The people Oxfam talked to could not clarify who had contracted the bulldozers and it is not implied here that the hospital was responsible for Kanaklata's injuries. It is understood that the residents were notified in some form in advance that the informal settlement was to be cleared.

[160] The suggested treatment cost of INR 1 lakh may have been a reasonable estimate of cost based on the hospital's fee schedule, but every government and private hospital in India is duty-bound to accept accident victims and patients who are in a critical condition. In this case the mother of the patient alleged that her son was unconscious and badly injured. If this was the case, the hospital could not have refused treatment even if the victim was not in a position to pay the fee or meet the expenses. Section 134(a), Motor Vehicles Act, 1988; Charter of Patient Rights, Ministry of Health and Family Welfare cited in Nyaaya. (2022). Right to Emergency Medical Care, op. cit.

[161] A healthcare assistant working at the same hospital for two years told Oxfam that she had witnessed similar cases of emergency patients being turned away, including a child with fractured bones in their arms and legs whose parents were in tears because they were refused admission and told to go to another hospital.

[162] One patient interviewed in Chhattisgarh said that before being taken over by Narayana, he thought that MMI hospital had been set up to 'help the needy people'. He said that since 'foreign investors got involved' he felt it had become more about 'making money' and that 'now they loot the people'. A different interviewee with long-term experience of patient care at CARE Hospitals for his parents said that since a 'Dubai firm' had taken over majority ownership of the hospital group he had heard that there was 'increased pressure' and 'direction' on 'how much profit must be made'. To the best of Oxfam's knowledge, these interviewees did not have direct knowledge or experience of the internal management policies and procedures of the hospitals concerned.

[163] As explained in the introduction, Eva told Oxfam that the hospital doctor assured her after her mother's surgery that the total hospital bill would not exceed INR 7-8 lakh and that this would cover all treatment and care already provided and any medicines and further diagnostics, including for up to two weeks after discharge.

[164] Communication to Oxfam, 19 May 2023.

[165] NH told Oxfam that in a few cases in the past some patients had omitted to disclose their status as beneficiaries of the schemes at the time of admission and hence were processed as regular cash patients.

[166] Communication to Oxfam 19th May 2023. CARE Hospitals was also given opportunity to comment directly but no response was received.

[167] For example: Y. Balarajan, S. Selvaraj and S.V. Subramanian. (2011). India: Towards Universal Health Coverage 4 Health care and equity in India, op. cit.; P.N. Prasad and P. Raghavendra. (2012). Healthcare Models in the Era of Medical Neoliberalism, op. cit.; S. Selvaraj and A. Karan. (2012). Why Publicly-Financed Health Insurance Schemes Are Ineffective in Providing Financial Risk Protection, op. cit.; K. Sen et al. (2018). Health Reforms and Utilization of Health Care in Three States of India, op. cit.; I. Chakravarthi. (2018). Regulation of Private Health Care Providers in India, op. cit.

[168] For example: R.K. Prusty, C. Choithani and G.S. Dutt. (2018). Predictors of hysterectomy among married women 15–49 years in India. Reproductive Health, 15:3; P. Chatterjee. (2019). Hysterectomies in Beed district raise questions for India. Lancet. 394(10194):202; S. Bhaumik. (8 February 2013). Oxfam calls for new regulations to reduce unnecessary hysterectomies in private hospitals. BMJ. https://www.bmj.com/content/346/bmj.f852.full; R. Srivastava. (8 May 2019). Missing wombs: the health scandal enslaving families in rural India. Reuters. https://www.reuters.com/article/us-india-health-slavery-idUSKCN1SE007; N. Sharma. (26 July 2019). Large volumes of hysterectomies in pvt hospitals under PMJAY, red flags raised. MediBulletin. https://medibulletin.com/large-volumes-of-hysterectomies-in-pvt-hospitals-under-pmjay-red-flags-raised/; Oxfam International. (6 February 2013). Unregulated and unaccountable: how the private health care sector in India is putting women's lives at risk. Press release. https://www.oxfam.org/es/node/10044

[169] In one Indian state, 95% of all hysterectomy claims were from private hospitals. Data from the same state show that 78% of all uncomplicated vaginal birth insurance claims came from the public sector, while 93% of all caesarean birth claims came from the private sector. Against WHO guidelines, the overall proportion of caesarean births performed under the government insurance scheme is already too high at 29%, but it rises to 63% of all childbirth insurance claims made by private facilities. S. Nandi. (2020) op. cit. 'PPPs in publicly funded health insurance schemes: The case of PMJAY in India, of how women bear the brunt while the private sector expands'. In C. Rodríguez Enríquez and M. Llavaneras Blanco (eds). Corporate Capture of Development. https://www.bloomsburycollections.com/book/corporate-capture-of-development/ch6-ppps-in-publicly-funded-health-insurance-schemes-the-case-of-pmjay-in-india-or-how-women-bear-the-brunt-while-the-private-sector-expands

[170] E. Suzuki, C. Kouame and S. Mills. (22 February 2023). Progress in reducing maternal mortality has stagnated and we are not on track to achieve the SDG target: new UN report. World Bank Blogs. https://blogs.worldbank.org/opendata/progress-reducing-maternal-mortality-has-stagnated-and-we-are-not-track-achieve-sdg-target

[171] For example: F.T. Bobo, A. Asante, M. Woldie, A. Dawson and A. Hayen. (2021). Spatial patterns and inequalities in skilled birth attendance and caesarean delivery in sub-Saharan Africa. BMJ Global Health, Oct;6(10). https://gh.bmj.com/content/6/10/e007074

[172] Note that 52 investments in companies providing only diagnostics or pharmacy services have not been included in this list. Some of the 224 companies do not provide maternity services.

[173] Including just the overlapping investments identified for IFC.

[174] Oxfam made corrections to information on fees provided by companies given the opportunity to comment. Some fee information was found through third party sources. Any inaccuracies are due to lack of transparency on fees charged. See Anna Marriott (2023) Sick development: Methodology note. op. cit.

[175] The statistics are the same whether using mean or median income for the bottom 40% of people in each country where the hospitals are located. See Anna Marriott (2023) Sick development: Methodology note. op. cit.

[176] Concern USA. (2022). The 10 Worst Countries to Be a Mother, op. cit.

[177] WHO. Health Equity Assessment Toolkit (HEAT), op. cit.

[178] National Population Commission, Nigeria. (2019). Nigeria Demographic and Health Survey 2018. https://www.dhsprogram.com/pubs/pdf/FR359/FR359.pdf

[179] Prices provided by the hospital in 2020.

[180] The average annual income for someone in the bottom 10% in Nigeria is NGN 47,342.50. Income data from World Inequality Database. https://wid.world/. For approach to calculating average incomes, see Anna Marriott (2023) Sick development: Methodology note. op. cit.

[181] Iwosan Lagoon Hospitals Limited (formerly Hygeia Nigeria Limited) told Oxfam that it caters to all classes of patients through different access points, lowering the entry barrier for low-income earners through the health insurance system. It also said that it catered for patients on the National Health Insurance Scheme. Email to Oxfam, 16 May 2023. The company did not respond to Oxfam's requests for more information about how, and by how much, access barriers are lowered or whether this impacts on access to maternity services.

[182] In 2022 membership also excluded informally employed and unemployed Nigerians. F. Magaji, J. Ali, W. Golit et al. (2022). National Health Insurance Scheme Coverage for Pregnant Women in Jos, Nigeria: Implications for SDG-3. Journal of Health Sciences and Practice, 1:1.

[183] The lowest-cost delivery identified at Evercare Hospital in Nigeria is NGN 575,000. A caesarean birth costs NGN 1,125,000. Income data from World Inequality Database. https://wid.world/. For approach to calculating average incomes, see Anna Marriott (2023) Sick development: Methodology note. op. cit.

[184] Using an average exchange rate of UGX to USD in 2018 of 3,669.99. PoundSterling Live. U.S. Dollar–Ugandan Shilling History: 2018. https://www.poundsterlinglive.com/history/USD-UGX-2018

[185] Information provided by TMR Hospital in response to email request, December 2019.

[186] Prices for an uncomplicated vaginal birth were reported on TMR's website in 2022 as UGX 2,430,000 and for a caesarean birth UGX 5,490,000. TMR International. Maternity Care. https://www.tmrinternational.org/delivery-packages

[187] BII. (13 August 2013). CDC and The Abraaj Group invest in Rainbow Hospitals. https://www.bii.co.uk/en/news-insight/news/cdc-and-the-abraaj-group-invest-in-rainbow-hospitals/

[188] Oxfam meeting with BII (then CDC), May 2019.

[189] Arrail. Arrail Dental. http://www.arrailgroup.com/en/business/tooth.html

[190] Proparco. (n.d). ODM Group: Strengthening Cancer Treatment Facilities in Morocco. https://www.proparco.fr/en/carte-des-projets/groupe-odm

[191] Examples include: Portea. (2015). Portea – Healing India at Home. YouTube video. https://www.youtube.com/watch?v=Yl_4r6wcJEE; and https://www.portea.com/testimonials/Nursing

[192] U.S. International Development Finance Corporation (DFC). (n.d.). Advancing accessible healthcare in India. https://www.dfc.gov/investment-story/advancing-accessible-healthcare-india

[193] The minimum wage in India peaked at INR 178 per day in 2022. https://www.statista.com/statistics/1284710/india-national-floor-level-minimum-wage/. US$133 = INR 11,000.

[194] Poder 360. (2018). Conhecido por atender políticos, Sírio-Libanês terá unidade em Brasília. https://www.poder360.com.br/brasil/conhecido-por-atender-politicos-sirio-libanes-tera-unidade-em-brasilia/ [Portuguese]

[195] M. Tarantino. (7 January 2011). O hospital do poder: Por que o Sírio-Libanês é tão requisitado por políticos e celebridades do Brasil e do Exterior. Istoé. https://istoe.com.br/118751_O+HOSPITAL+DO+PODER/ [Portuguese]

[196] N. Cuminale. (14 January 2011, updated 25 May 2016). A saúde da República, nas mãos do Hospital Sírio-Libanês. Veja. https://veja.abril.com.br/saude/a-saude-da-republica-nas-maos-do-hospital-sirio-libanes/ [Portuguese]

[197] Poder 360. (2018). Conhecido por atender políticos, Sírio-Libanês terá unidade em Brasília, op. cit.; and Sírio-Libanês. (n.d.). Projetos de Apoio ao SUS. https://hospitalsiriolibanes.org.br/quem-somos/compromisso-social/proadi-sus/#:~:text=O%20S%C3%ADrio-Liban%C3%AAs%20%C3%A9%20uma,%C3%9Anico%20de%20Sa%C3%BAde%20(SUS) [Portuguese]. DEG told Oxfam that the hospital does work in partnership with the Brazilian health authorities and 'offers certain programs that include free medical care for low-income families, including child health programs and breast cancer screening. No information was provided on the scale or impact of these initiatives. DEG communication to Oxfam 16th June 2023.

[198] These include the FV Hospital in Ho Chi Minh City, Vietnam, backed by DEG, Proparco and IFC; Rainbow Hospitals and Narayana Health in India, backed by BII; and Sahyadri Hospitals in India, backed by BII and IFC.

[199] Hospital Cima. (n.d.). Lifecycle Center. https://hospitalcima.com/en/lifecycle-center-2/

[200] See, for example, IFC and World Bank's work in the Indian state of Meghalaya to support the introduction of a new scheme with objectives to 'encourage choice for beneficiaries and foster greater entry of quality providers in the health-sector'. IFC. (2013). Public-Private Partnership Stories. India: Meghalaya Health Insurance. https://www.ifc.org/wps/wcm/connect/d8c01ea2-790a-42de-80b1-30792a80063f/PPPStories_India_MeghalayaHealthInsurance.pdf?MOD=AJPERES&CVID=lKbKixW

[201] B. Khawaja and R. Riddell. (20 May 2022). Stealth privatization: Kenya's approach to universal health coverage is a private sector giveaway. Open Global Rights. https://www.openglobalrights.org/stealth-privatization-kenyas-approach-to-universal-health-coverage-is-a-private-sector-giveaway/?lang=English;C. Averill and A. Marriott.. (2013). Universal Health Coverage: Why health insurance schemes are leaving the poor behind. Oxfam International. https://policy-practice.oxfam.org/resources/universal-health-coverage-why-health-insurance-schemes-are-leaving-the-poor-beh-302973/

[202] BII. (2022). Productive, Sustainable and Inclusive Investment: 2022–26 Technical Strategy, op. cit.

[203] Oxfam. (2013). Universal Health Coverage: Why health insurance schemes are leaving the poor behind, op. cit.

[204] Ibid.

[205] A recent analysis of 36 sub-Saharan African countries found that only four had health insurance coverage rates above 20% (Rwanda, Ghana, Gabon and Burundi) and that insurance coverage was highly skewed towards higher-income households and those in the formal economy. E. Barasa, J. Kazungu, P. Nguhiu and N. Ravishankar. (2021). Examining the level and inequality in health insurance coverage in 36 sub-Saharan African countries. BMJ Global Health, 2021;6(4). https://doi.org/10.1136/bmjgh-2020-004712

[206] African Health Markets for Equity and University of California San Francisco. (n.d.). Gender Disparities in NHIF Access and Use: A barrier to achieving UHC in Kenya. https://globalhealthsciences.ucsf.edu/sites/globalhealthsciences.ucsf.edu/files/pub/policy-brief-nhif-gender-equity-june-2019.pdf

[207] J. Gabbani, S. Mazumdar and M. Suhrcke. (2023). The effect of health financing systems on health system outcomes: A cross-country panel analysis, op. cit.; A. Wagstaff and S. Neelsen. (2020). A comprehensive assessment of universal health coverage in 111 countries: A retrospective observational study, op. cit.

[208] Gabbani et al. found that there was no outcome for which SHI transitions showed significantly better outcomes than government financing. J. Gabbani et al. (2023). The effect of health financing systems on health system outcomes, op. cit.

[209] Ibid.

[210] B. Khawaja and R. Riddell, (2022). Stealth privatization, op. cit.; S. Nandi, A. Vračar and C. Pachauli. (2020). Resisting privatization and marketization of health care: People's Health Movement's experiences from India, Philippines and Europe. https://www.scielosp.org/article/sdeb/2020.v44nspe1/37-50/

[211] S. Garg et al. (2020) Performance of India's national publicly funded health insurance scheme, op. cit.; D. Dubey et al. (2023). Evolution of Government-funded health insurance for universal health coverage in India, op. cit.; A. Karan et al. (2017). Extending health insurance to the poor in India, op. cit.; R.K. Sinha. (2018). Impact of publicly financed health insurance scheme (Rashtriya Swasthya Bima Yojana) from equity and efficiency perspectives., op. cit.; Hooda, 2015; Karan, Yip, & Mahal, 2017; Prinja, Bahuguna, Gupta, Chowdhury, & Trivedi, 2019; Prinja et al., 2017; Ranjan et al., 2018; Selvaraj & Karan, 2012) in S. Nandi and H. Schneider. (2020). When state-funded health insurance schemes fail to provide financial protection, op. cit.

[212] D. Dubey et al. (2023). Evolution of Government-funded health insurance for universal health coverage in India, op. cit.; S. Nandi. (2020) op. cit.

[213] S. Garg, K.K. Bebarta and N. Tripathi. Role of publicly funded health insurance in financial protection of the elderly from hospitalisation expenditure in India, op. cit.

[214] S. Nandi and H. Schneider. (2020). When state-funded health insurance schemes fail to provide financial protection, op. cit.

[215] For enrolled women, the OOP expenditure was INR 10,000 (US$133) in the private sector and INR 400 (US$5) in the public sector. S. Nandi. (2020). 'PPPs in publicly funded health insurance schemes', op. cit.

[216] D. Dubey et al. (2023). Evolution of Government-funded health insurance for universal health coverage in India, op. cit.

[217] S. Prinja, A.S. Chauhan, A. Karan, G. Kaur and R. Kumar. (2017). Impact of Publicly Financed Health Insurance Schemes on Healthcare Utilization and Financial Risk Protection in India: A Systematic Review. PLOS One, 12(2), e0170996. https://doi.org/10.1371/journal.pone.0170996; A. Ranjan, P. Dixit, I. Mukhopadhyay and S. Thiagarajan. (2018). Effectiveness of government strategies for financial protection against costs of hospitalization Care in India, op. cit.

[218] S. Nandi and H. Schneider. (2020). Using an equity-based framework for evaluating publicly funded health insurance programmes as an instrument of UHC in Chhattisgarh State, India. Health Resource Policy and Systems 18, 50. https://doi.org/10.1186/s12961-020-00555-3

[219] Increased government spending on insurance is diverting expenditure away from other health sector needs, including communicable and non-communicable diseases and family welfare. Ibid.; D. Dubey, et al. (2023). Evolution of Government-funded health insurance for universal health coverage in India, op. cit.

[220] World Bank Group. (2022). Staying ahead of the curve: challenges and opportunities for future spending on health in Kenya. Kenya Public Expenditure Review for the Health Sector – FY2014/15-FY2019/20. https://documents1.worldbank.org/curated/en/099150006242224188/pdf/P175146046aa000170926707583dac4738d.pdf

[221] E. Barasa, K. Rogo, N. Mwaura and J. Chuma. (2018). Kenya national hospital insurance fund reforms: Implications and lessons for universal health coverage. Health Systems & Reform;4(4):346–61. https://doi.org/10.1080/23288604.2018.1513267

[222] E. Barasa, K. Rogo, N. Mwaura and J. Chuma. (2018). Kenya National Hospital Insurance Fund Reforms: Implications and Lessons for Universal Health Coverage Health Systems Reform. 2018 Jan 1; 4(4): 346–361. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7116659/

[223] African Markets for Health Equity and University of California San Francisco. (2019). Gender Disparities in NHIF Access and Use: A Barrier to Achieving UHC in Kenya, op. cit.

[224] Salari, et al. 'The Catastrophic and Impoverishing Effects of Out-of-Pocket Healthcare Payments', in: The Economic and Social Rights Centre-Hakijamii and the Center for Human Rights and Global Justice at New York University School of Law. (2021). Wrong Prescription: The Impact of Privatizing Healthcare in Kenya. https://chrgj.org/wp-content/uploads/2021/11/Report_Wrong-Prescription_Eng_.pdf

[225] B. Khawaja and R. Riddell. (2022). Stealth privatization, op. cit.

[226] Ibid.

[227] A. Owino. (2019). NHIF Hospitals: List of All Accredited Inpatient Kenyan Hospitals. Kenyans.co.ke. https://www.kenyans.co.ke/news/37324-nhif-hospitals-list-all-accredited-inpatient-kenyan-hospitals

[228] Scribd. (n.d.) Vaatsalya Hospitals: Affordable Health Care in Proximity. https://www.scribd.com/presentation/116007744/Vaatsalya-Hospitals

[229] Medifee. (2015). Vaatsalya Hospital. https://www.medifee.com/hospital/2979-vaatsalya-hospital/

[230] Information on fees obtained via Facebook queries.

[231] Such as this video by EIB on Penda Health: EIB. (2021). Supporting affordable healthcare in Africa. https://www.eib.org/en/videos/supporting-affordable-healthcare-in-africa

[232] A. Marriott and C. Green. (2009). Your Money or Your Life. Joint agency publication. https://www.oxfam.org/en/research/your-money-or-your-life

[233] World Bank Group President Jim Yong Kim's Speech at World Health Assembly: Poverty, Health and the Human Future, 21 May 2013. https://www.worldbank.org/en/news/speech/2013/05/21/world-bank-group-president-jim-yong-kim-speech-at-world-health-assembly

[234] E. Barış, R. Silverman, H. Wang, F. Zhao and M.A. Pate. (2021). Walking the Talk: Reimagining Primary Health Care After COVID-19. World Bank, Washington, DC. https://openknowledge.worldbank.org/server/api/core/bitstreams/36005695-0123-5ecf-88c9-043559c21479/content

[235] D. Wellings and J. Appleby. (30 March 2022). Public satisfaction with the NHS falls to a 25-year low. The King's Fund blog. https://www.kingsfund.org.uk/blog/2022/03/public-satisfaction-nhs-falls-25-year-low

[236] O.D. Williams, K.C. Yung and K.A. Grépin. (2021). The failure of private health services: COVID-19 induced crises in low- and middle-income country (LMIC) health systems. Global Public Health, 16:8-9, 1320-1333. DOI: 10.1080/17441692.2021.1874470

[237] Ibid.

[238] J. Frede. (2015). Closing gaps in health care. D+C. https://www.dandc.eu/en/article/private-hospital-mozambique-enhances-public-health-care; EDFI. EFP. https://www.edfi.eu/facility/efp/. DEG told Oxfam that it has not been involved in this hospital for 'several years' but did not specify the exit date. DEG communication to Oxfam on 16th June 2023.

[239] M. Afonso. (2021). Covid-19: A glance at prices in Maputo private hospitals – Carta. Club of Mozambique. https://clubofmozambique.com/news/covid-19-a-glance-at-prices-in-maputo-private-hospitals-carta-183402/

[240] IFC's investment in Lenmed, the hospital group that owns and manages Maputo Private Hospital, was approved in February 2023. IFC Project Information and Data Portal. (2023). Lenmed II. https://disclosures.ifc.org/project-detail/ESRS/44636/lenmed-ii

[241] E. Kiggundu. (18 June 2021). 20 days spent in ICU at IHK, Nakasero, Victoria, Case hospitals will cost you money worth a house in Gayaza, Kira, op. cit.

[242] See Annex as separate download on page for this publication for details of investments identified. As previously mentioned, in response to this report EIB and DEG have questioned their investments in this hospital. Available information indicates both are invested indirectly in the hospital via private equity funds.

[243] E. Kiggundu. (18 June 2021). 20 days spent in ICU at IHK, Nakasero, Victoria, op. cit.

[244] IFC Project Information and Data Portal. (2023). RSE COVID CIEL Healthcare Limited. https://disclosures.ifc.org/project-detail/SII/44074/rse-covid-ciel-healthcare-limited

[245] Comment on social media in response to reported COVID-19 fees in TMR hospital. Eagle Online. (23 June 2021). Outrage as TMR Hospital asks Sh118m from a #Covid-19 patient, op. cit.

[246] E. Oluka and D. Mukhaye. (16 June 2021). Covid-19: The situation in our health facilities. Monitor. https://www.monitor.co.ug/uganda/news/national/covid-19-the-situation-in-our-health-facilities-3439390

[247] E. Kiggundu. (18 June 2021). 20 days spent in ICU at IHK, Nakasero, Victoria, op. cit.

[248] The hospital bill was published by Eagle Online. (23 June 2021). Outrage as TMR Hospital asks Sh118m from a #Covid-19 patient, op. cit.

[249] NewVision. (2021). Museveni bails out Kaaya's family with sh300m for his medical bills, op. cit.

[250] E. Kafe. (8 August 2021). Shocking bills for Covid-19 patients. The Sunday Mail. https://www.sundaymail.co.zw/shocking-bills-for-covid-19-patients

[251] Community Working Group on Health. http://www.cwgh.co.zw/

[252] E. Kafe. (8 August 2021). Shocking bills for Covid-19 patients, op. cit.

[253] L. Igadwah. (7 April 2021). AAR to shut Tanzania clinics on rising financial woes. The East African. https://www.theeastafrican.co.ke/tea/business/aar-clinics-tanzania-3352532

[254] Exchange rates as of May 2023. https://www.evercarehospitallahore.com/covid19

255 S. Thevar. (11 July 2021). Pvt hospitals audited: ₹17.21 lakh over charged in seven days. Hindustan Times. https://www.hindustantimes.com/cities/others/pvt-hospital-bills-audited-rs-17-21-lakh-over-charged-in-seven-days-101626025599169.html

[256] Punekar News. (4 June 2021). Pune: PMC Issues Notices to 172 Hospitals for Overcharging Covid-19 Treatment. https://www.punekarnews.in/pune-pmc-issues-notice-to-172-hospitals-for-overcharging-covid-19-treatment/

[257] S. Roy. (23 December 2021). Medica hospital told to pay Rs 5 lakh for Kolkata woman's death. The Telegraph Online. https://www.telegraphindia.com/my-kolkata/news/medica-hospital-told-to-pay-rs-5-lakh-for-kolkata-womans-death/cid/1844437

[258] The Telegraph Online. (6 June 2020). Medica denies allegations, says ICMR guidelines followed. https://www.telegraphindia.com/jharkhand/medica-denies-allegations-says-icmr-guidelines-followed/cid/1778990

[259] For example, searches of the West Bengal Clinical Establishment Regulatory Commission portal found six other cases since 2018 where the Commission upheld complaints against Medica in the same state for overcharging patients. Refunds were ordered in five of the cases. http://wbcerc.gov.in/cms/order

[260] KfW. (6 August 2021).DEG finances the fight against Covid-19 in eastern India. https://www.kfw.de/stories/kfw/stories/society/health/medica/

[261] The hospital denied the allegation and said that the patient left of her own accord, against medical advice. The documentation required for discharge in such circumstances, however, was reportedly not signed by the patient. A. Saikia. (20 March 2020). Private hospital evicted suspected coronavirus patient, alleges Chhattisgarh government. Scroll.in. https://scroll.in/article/956672/private-hospital-evicted-suspected-coronavirus-patient-alleges-chhattisgarh-government

[262] The Telangana Public Health and Family Welfare Department ordered a total of 44 private hospitals to issue refunds to overcharged COVID-19 patients. P. Oommen. (24 May 2022). Full List: Hyderabad hospitals forced to refund patients after hefty Covid-19 bills. The News Minute. https://www.thenewsminute.com/article/full-list-hyderabad-hospitals-forced-refund-patients-after-hefty-covid-19-bills-164312

[263] A. Pandey. (28 June 2020). Hospitals in Telangana overcharging coronavirus patients, why is TRS silent: MBT's Amjed Ullah Khan. India Today. https://www.indiatoday.in/india/story/hospitals-in-telangana-overcharging-coronavirus-patients-why-is-trs-silent-mbt-s-amjed-ullah-khan-1694902-2020-06-28

[264] A. Didyala. (2 June 2021). Six more hospitals barred from treating Covid-19 patients. The Times of India. https://timesofindia.indiatimes.com/city/hyderabad/six-more-hospitals-barred-from-treating-covid-19-patients/articleshow/83156503.cms

[265] The Times of India. (8 May 2021). Hospital director among three held for selling Remdesivir on black market. https://timesofindia.indiatimes.com/city/patna/hosp-director-among-three-held-for-selling-remdesivir-on-black-market/articleshow/82464274.cms; D. Karmakar. (19 May 2021). Exorbitant drug prices: Few arrested after raids in Patna. The Times of India. https://timesofindia.indiatimes.com/city/patna/exorbitant-drug-prices-few-arrested-after-raids/articleshow/82748156.cms

[266] O.D. Williams, K.C. Yung and K.A. Grépin. (2021). The failure of private health services: COVID-19 induced crises in low- and middle-income country (LMIC) health systems, op. cit.

[267] The research was undertaken by the organization Support for Advocacy and Training to Health Initiative (SATHI) (https://sathicehat.org/) and was reported on by J. Shelar. (29 September 2021). 75% Covid patients overcharged by private hospitals in Maharashtra despite price cap: Survey. Hindustan Times. https://www.hindustantimes.com/cities/mumbai-news/75-covid-patients-overcharged-by-private-hospitals-in-maharashtra-despite-price-cap-survey-101632923241696.html

[268] S. Marathe. (2023). Overcharging during the Pandemic: Private Hospitals in Maharashtra. The India Forum. https://www.theindiaforum.in/forum/overcharging-during-pandemic-private-hospitals-maharashtra

[269] EIB. (8 June 2022). South Africa: EIB to support increased vaccine production by Biovac https://www.eib.org/en/press/all/2022-263-eib-to-support-increased-vaccine-production-in-south-africa-by-biovac

[270] Medicines Patent Pool mRNA technology transfer programme. https://medicinespatentpool.org/what-we-do/mrna-technology-transfer-programme

[271] This is something for which BII came in for particular criticism from Publish What You Fund in its recent DFI Transparency Index. Publish What You Fund. (2023). DFI Transparency Index 2023. https://www.publishwhatyoufund.org/dfi-index/2023/

[272] DEG told Oxfam that since 2015 information is available on its website for a period of five years and for investments committed from 2022 onwards, the investment-related summary information is available online for the entire period of the contractual relationship. From 2022 onwards, investment-related information about newly committed fund investments includes additional information about investee companies. This information is provided on the respective customer's website, to which DEG provides a link. Oxfam's research found that private equity fund websites do not consistently disclose investments or information about them.

[273] See Annex as a separate download on the page for this publication. Value of investment is unavailable from DEG for four direct health investments and ten investments in intermediaries.

[274] Proparco and BII staff were helpful in responding in detail to Oxfam's questions on their investments and provided more information on request. However, some of the information they provided is not systematically disclosed, which is problematic. DEG staff reviewed Oxfam's data and provided corrections where they were able to do so. The EIB said that it was unable to review Oxfam's list of health investments for accuracy, but said that requests for specific intermediated investments could be put to the relevant team.

[275] The mapping exercise extracted information from DFI databases. Due to poor disclosure and data gaps, searches of DFI websites and press releases, as well as broader online searches, were conducted. For methodology note see Anna Marriott (2023) Sick development: Methodology note. op. cit.

[276] Due to greater data availability for the UK, Oxfam's analysis includes funding from BII since 2008. See Anna Marriott (2023) Sick development: Methodology note. op. cit. and for full list of DFI direct and indirect health investments see the Annex as a separate download on page for this publication.

[277] Note that this figure includes US$200m from BII to MedAccess, a non-profit drug purchasing mechanism.

[278] Overlapping investments made by IFC can be found in the Annex as a separate download on the page for this publication.

[279] Wemos. (2022). Improving healthcare but for whom? op. cit.

[280] Includes one investment in a non-profit drug purchasing mechanism.

[281] In slides provided by DEG to Oxfam, DEG had 21 active direct investments in 2022. Oxfam's data cover the period 2010–22.

[282] This includes one investment called MEMG Manipal which BII told Oxfam is a direct investment. However, in order to capture the sub-investments made via this investment it is categorised here as a health intermediary, while noting BII's guidance to the contrary. This also includes two investments to the Medical Credit Fund which BII clarified is a loan facility and not a private equity fund. Email communication from BII to Oxfam 23rd May 2023.

[283] Email from Proparco to Oxfam on 13th June 2023.

[284] A. Marriott. (2014). A Dangerous Diversion, op. cit.

[285] M. Hellowell. (2023). How might PPPs enable service delivery reconfiguration in middle-income countries? Decide Health Decision Hub. https://decidehealth.world/en/hellowell-PPP

[286] House of Commons Treasury Committee (2011). Private Finance Initiative: Seventeenth Report of Session 2010–12. London: The Stationary Office Ltd. https://publications.parliament.uk/pa/cm201012/cmselect/cmtreasy/1146/1146.pdf

[287] DEG US$92.3m, EIB US$357.16m; IFC US$379.25m and Proparco US$100.95m. See Annex as a separate download on the page for this publication for details.

[288] WHO. (2023). Public–private partnerships for health care infrastructure and services: policy considerations for middle-income countries in Europe. https://www.who.int/europe/publications/i/item/9789289058605

[289] Ibid.

290 M. Hellowell. (2023). How might PPPs enable service delivery reconfiguration in middle-income countries?, op. cit.

291 It was confirmed by DEG in a meeting with Oxfam on 1 March 2023 that these same currency exchange mistakes were made in the DFI-supported PPPs.

292 B. Hunter. (2023). Investor States: Global Health at the End of Aid. Cambridge: Cambridge University Press.

293 Note that the percentage relates to the number rather than the value of investments made. The latter is impossible to calculate due to lack of disclosure on values of intermediated investments. For further details see Anna Marriott (2023) Sick development: Methodology note. op. cit.

294 IFC is not included in this analysis as Oxfam has only mapped IFC investments that overlap with the four European DFIs, and therefore does not know if the proportions of direct and indirect investments made by IFC would be proportional to its overall health portfolio.

295 IFC is the only DFI in Oxfam's research other than BII that lists sub-investments via intermediaries, but its agreement to do so is only recent and implementation is inconsistent. Sub-investments are not searchable on IFC's project portal.

296 EIB confirmed to Oxfam that it publishes project summaries for intermediated investments, but only if they exceed a value of €50m. Email communication, 28 April 2023.

297 FMO. (n.d). IFHA-II Cooperatief U.A. https://www.fmo.nl/project-detail/43060

298 CIEL confirms in its 2022 annual report that its investment in Hygeia Nigeria Limited was held through Jersey Hygeia Investment Limited and that this was disposed of during the year ending June 2022. CIEL Group. (2022). Go Beyond: Annual Integrated Report 2022. https://www.cielgroup.com/media/n23brtxi/ciel-integrated-annual-report_2022.pdf

299 OpenCorporates. (n.d.). Jersey Hygeia Investments Limited. https://opencorporates.com/companies/je/EXTUID_132321

300 Email to Oxfam, 16 May 2023.

301 Oxfam's research identified a total of 140 first recipient (primary) financial intermediaries used by the four European DFIs, of which 112 are domiciled in known tax havens. See Anna Marriott (2023) Sick development: Methodology note. op. cit.

302 On 13th June 2023, BII told Oxfam that its tax policy requires that: investee companies should comply with all applicable tax laws in the countries where they operate; investee companies do not engage in base erosion and profit shifting; and investee companies should not engage in other forms of egregious tax planning to deplete local tax bases. For reference: BII (2022) Tax strategy and policy on the payment of taxes and the use of offshore financial centres https://assets.bii.co.uk/wp-content/uploads/2022/09/22174048/Tax-Policy-2022-1.pdf. DEG told Oxfam that it 'does not use any structures that are set up to avoid tax [and].. expressly avoid[s] such structures.' It said 'for every transaction – whether a loan or an investment – the company to be co-financed and the relevant partners such as customers or suppliers undergo checks' and 'regular assessments.' DEG communication to Oxfam 16th June 2023.

303 S. Clark and W. Louch. (2021). The Key Man: How the Global Elite was Duped by a Capitalist Fairy Tale. UK: Penguin Books.

304 Ibid.

305 As explained in the BBC documentary Billion Dollar Downfall: The Dealmaker (https://www.bbc.co.uk/programmes/m001h1nd) and in the book The Key Man, an investment manager at the Gates Foundation was the first to spot anomalies in the health fund accounts in September 2017.

306 S. Clark and W. Louch. (2021). The Key Man, op. cit.

307 D. Bank. (16 June 2018). What went wrong in Gates Foundation investment in $1 billion healthcare fund for 21st-century megacities? https://medium.com/@davidmbank/abraaj-group-liquidation-tests-champions-of-sustainable-development-goal-3-73ea53728669

308 It should be noted that funding by the US DFI and others was not subject to the same methodology, approach and review by Oxfam as for the four European DFIs and the World Bank Group.

[309] Ibid.

[310] S. Clark. (2022). Written Evidence for the House of Commons International Development Committee Inquiry into Extreme Poverty and the Sustainable Development Goals. https://committees.parliament.uk/writtenevidence/106305/pdf/

[311] For the health fund alone, BII's CEO estimates losses of a minimum of US$25m. House of Commons, International Development Committee. (2023). Oral evidence: Investment for development: The UK's strategy towards Development Finance Institutions. 25 April 2023. https://committees.parliament.uk/oralevidence/13066/pdf/

[312] S. Clark and W. Louch. (16 July 2020). Abraaj Liquidators Sue Fund Backed by Gates Foundation. The Wall Street Journal. https://www.wsj.com/articles/abraaj-liquidators-sue-fund-backed-by-gates-foundation-11594922921 (paywall)

[313] S. Clark and W. Louch. (2021). The Key Man, op. cit.

[314] S. Clark. (2022). Written Evidence for the House of Commons International Development Committee Inquiry, op. cit.

[315] Ibid.

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[317] An assessment of IFC's project intentions was beyond the scope of this research and would have been unrepresentative, since only overlapping investments were included.

[318] Note that hospital PPPs were not included in this analysis since they are operated by governments as public hospitals.

[319] Note that general terms such as 'affordable', 'low-cost' or 'accessible' were not counted in this analysis as they are never defined, leaving the door open to hugely varied interpretations.

[320] EIB told Oxfam that its ex-ante assessments included looking at what services a hospital provides, to whom and who pays. It said that its criteria to ensure positive contributions to the public healthcare system and healthcare equity mean that it refuses more potential investments than it accepts. These criteria are not disclosed. Except for PPP financing, all of EIB's healthcare investments in LMICs are made indirectly. The above criteria are only applied to indirect investments above €50m. Oxfam meeting with EIB, 1 March 2023.

[321] Terms such as 'low-cost' or 'affordable care' or care in 'under-served areas' are not counted as references to access or affordability for low-income patients, as these terms remain vague and undefined.

[322] For example, a description of DEG's most recent funding to Medica in India simply states that 'Medica's long-term goal is to serve patients from middle and low socio-economic backgrounds'. KfW. (6 August 2021). DEG finances the fight against COVID-19 in Eastern India, op. cit. Proparco states that its beneficiary Lablink 'provides the poorest populations with access to its services', but nothing is added on how or on what scale. BII's 2019 US$45m investment in Chemistry Holdings Ltd for a hospital in Bangladesh simply states that patients are: 'Middle-income (inpatient care); Low-income (outpatient care) with c. 45 per cent of the patients from outside Dhaka.' BBI. (n.d.). Chemistry Holdings Limited. https://www.bii.co.uk/en/our-impact/investment/chemistry-holdings-limited/

[323] H. Wadge, R. Roy, et al (2017). op.cit.

[324] Oxfam meeting with BII (then CDC) staff, May 2019.

[325] For DEG, three project descriptions for direct healthcare investments mentioned charitable free services for disadvantaged patients but no further information (including on scale) was provided.

[326] This issue was raised by six different participants in Focus Groups 1 and 3. Examples provided did not refer specifically to DFI-funded hospitals. For details of focus groups see Anna Marriott (2023) Sick development: Methodology note. op. cit.

[327] The small number of relevant EIB investments is a significant limitation in this assessment.

[328] The 2X Challenge was launched at the G7 Summit 2018 to encourage DFIs/IFIs and the broader private sector to invest in the world's women. 2X Challenge. (2022). Invest in women. Invest in the world. https://www.2xchallenge.org/home

[329] WHO. (n.d.). Value gender and equity in the global health workforce. https://www.who.int/activities/value-gender-and-equity-in-the-global-health-workforce

[330] A full analysis of gender and jobs was beyond the scope of this research.

[331] In meetings with Oxfam on 1 March 2023 and 13 March 2023, EIB and DEG respectively confirmed that they did not conduct this kind of impact monitoring. Proparco was unable to provide examples of improved access to low-income patients or to people living in poverty when asked in a meeting with Oxfam in January 2020. In response to requests for information on impact, BII provided extensive responses on its approach to health; however, materials referenced did not provide any substantive impact information on improved access or affordability for low-income patients or for women and girls. BII told Oxfam that since 2022 investments had also been assessed for inclusion. Information available on BII's impact scoring, however, does not give any reassurance that any greater level of impact information will be available for external scrutiny. For example, see: BII. (n.d.). Impact Score 2022-26 Strategy Period. https://assets.bii.co.uk/wp-content/uploads/2022/02/02111950/BII-Impact-Score-2022-26.pdf

[332] H. Wadge, R, Roy, A. Sripathy, M. Prime, A. Carter, G. Fontana, J. Marti, and K. Chalkidou. (2017). Evaluating the impact of private providers on health and health systems, op. cit.

[333] See annex of Ibid.

[334] Ibid.

[335] BII. (2023). Insight: Investing for Impact in India. https://assets.bii.co.uk/wp-content/uploads/2023/01/06212044/Investing-for-impact-in-India_BII.pdf

[336] Communication to Oxfam from Narayana Hrudayalaya Limited, received 29 April 2023.

[337] Proparco invested US$15m in Quadria Capital in 2015 and US$20m in Quadria Capital II Fund in 2019. IFC invested US$25m in Quadria Capital in 2013 and US$50m in Quadria Capital II Fund in 2019. DEG invested US$30m in Quadria Capital II Fund in 2018.

[338] Quadria Capital. (2022). Quadria Capital Annual Review 2022/2023. https://www.quadriacapital.com/wp-content/uploads/2022/09/Quadria-Annual-2022-23.pdf

[339] Oxfam meeting with Quadria, 18 December 2019.

[340] Medical Credit Fund is also funded by France's development agency AFD, which part-owns Proparco.

[341] Medical Credit Fund. (2020). Medical Credit Fund Annual Report 2019. https://www.medicalcreditfund.org/wp-content/uploads/sites/4/2020/05/MCF_annual_report_2019.pdf

[342] Undefined income groups are 'very low income, low income, middle income, high income'. Email communication, 14 December 2022.

[343] World Bank. (2018). World Bank Group Support to Health Services: Achievements and Challenges, op. cit.

[344] World Bank IEG. (2009). 'Chapter 5 – IFC's Health Strategy and Operations'. In: Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population – An Evaluation of World Bank Group Support Since 1997, pp.82–83. Washington DC: The International Bank for Reconstruction and Development/ The World Bank.

[345] Health in Africa Fund. https://www.afdb.org/en/topics-and-sectors/initiatives-partnerships/health-in-africa-fund

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[347] Taneja, A and A. Sarkar (2023) First, Do No Harm op. cit

[348] Ethical Principles in Health Care (EPIHC). https://www.epihc.org/

[349] Taneja, A and A. Sarkar (2023) First, Do No Harm op. cit

[350] United Nations Human Rights. (2023). Benchmarking Study of Development Finance Institutions' Safeguard Policies, op. cit.

[351] Ibid.

[352] The Danish Institute for Human Rights. (2021). Human rights at development finance institutions: Connecting the dots between environmental and social risk management and development impact. https://www.humanrights.dk/sites/humanrights.dk/files/media/document/Human_rights_at_development_finance_institutions_accessible.pdf

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[354] IFC. (2008). The Business of Health in Africa op. cit.; Wibulpolprasert, S. and Pengpaibon, P. (2003). 'Integrated strategies to tackle the inequitable distribution of doctors in Thailand: four decades of experience'. Human Resources for Health 1(12).; H. Wadge, et al (2017) op. cit.

[355] For example: Corporate Watch. (2012.) An unhealthy business: major healthcare companies use tax havens to avoid millions in UK tax, https://corporatewatch.org/an-unhealthy-business-major-healthcare-companies-use-tax-havens-to-avoid-millions-in-uk-tax/; The Economic and Social Rights Centre-Hakijamii and the Center for Human Rights and Global Justice at New York University School of Law (2021) op. cit.; P. Ubel. (9 April 2021). Why Is Healthcare So Expensive? Blame The Lobbyists. https://www.forbes.com/sites/peterubel/2021/04/09/why-is-healthcare-so-expensive-blame-the-lobbyists/

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[357] R. Kumar. (2015). Lack of Social or Political Demand for Good Health Care in India: Impact on Unfolding Universal Health Coverage. Journal of Family Med Prim Care. 2015 Jan-Mar; 4(1): 1–2. DOI: 10.4103/2249-4863.152234. For description of how inequalities in healthcare can become structural see M. Mackintosh, A. Channon, A. Karan, S. Selvaraj, H. Zhao, E. Cavagnero. (2016). What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. Lancet 2016; 388: 596-605; B. Welham. (2014). Governance for Development. The World Bank. http://blogs.worldbank.org/governance/politics-service-delivery-0

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[363] Ibid.

[364] Ibid.

[365] F. Schulte. (14 November 2022). Sick Profit: Investigating Private Equity's Stealthy Takeover of Health Care Across Cities and Specialties, op. cit.

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