SICK DEVELOPMENT

Methodology note

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1 KEY STATISTICS FROM SECONDARY RESEARCH

METHODOLOGY TO MAP FUNDING TO HEALTH SECTOR BY DEVELOPMENT FINANCE INSTITUTIONS

Development Finance Institution (DFI) funding to health companies was mapped for British International Investment (BII), Deutsche Investitions- und Entwicklungsgesellschaft (DEG), the European Investment Bank (EIB) and Proparco utilising desk (secondary) review and content analysis of key databases and any additional documentation.

Specifically, the mapping exercise extracted information from DFI databases to gather evidence related to modality of donor engagement, financial instrument used, private sector programme type, health focus, type of private sector engaged and the role of the private sector. Table 1 outlines the components against which information on projects were extracted where these were available. Due to transparency gaps, data on investments was cross-checked across all the DFI project portals. Investments were also identified from DFI press releases and online searches using the respective DFI names and search terms including 'health', 'healthcare', 'hospitals' etc.

Specific sources utilised for the mapping exercises (complemented by wider searches of DFI websites, annual reports and other online sources include the following project portals:

BII - https://www.bii.co.uk/en/our-impact/search-results/

DEG - https://deginvest-investments.de/

EIB - https://www.eib.org/en/projects/all/index.htm

Proparco - https://www.proparco.fr/en/page-thematique-axe/health

IFC - https://disclosures.ifc.org/

The Creditor Reporting System (CRS) was also used to identify any further projects and to cross-check others - https://stats.oecd.org/Index.aspx?DataSetCode=crs1

The websites of any financial intermediaries identified were also searched for any further information about their health investments on behalf of the DFIs.

This research was initially focused on the four European DFIs. However, during the research it was identified via information on DFI project portals and in press releases that the World Bank Group's International Finance Corporation (IFC) was a significant co-investor in many of the same financial intermediaries and ultimate health sector beneficiaries. The IFC project portal was then searched to identify only these overlapping investments and to identify date and volume of funds invested. A full IFC health portfolio review was beyond the scope of this project.

For the European DFIs, disclosed project information for direct investments in healthcare providers and in health specific financial intermediaries was then assessed for references related to healthcare equity and gender (further details below).

Table 1: Information extracted in mapping DFI funding to health

DFI	Investment name	Start date	Budget	Country
Project description	Financing instrument	Health type	Private sector beneficiary	Other development partners
Income equity as a stated objective	Gender equity as a stated objective	Dimensions of equity measured or addressed		

The following criteria was used to limit the scope of the mapping exercise:

Time period – only projects and funding from 2010 to 2022 were included for DEG, EIB and Proparco. Due to greater availability of data this time-period was extended for BII to include projects initiated in 2007-2008 that continued into the timeline of the main research focus.

Project modality – only projects where DFI engagement modality is finance are included. Advisory or other modalities were not mapped.

Health – the research sought to identify health sector beneficiaries of DFI funding whether directly or indirectly.

Private for-profit – focus for the research is for-profit[1] health sector beneficiaries including those funded via financial intermediaries. Due to their low number, non-profit recipients including one financial intermediary are included in the investments listed by Oxfam but are identified as such wherever included.

A note on financial intermediaries: The mapping of BII's role in health revealed significant funding to private for-profit health companies via financial intermediaries. BII discloses its sub-investments and categorises these clearly by sector. Financial intermediaries used are both health specific and sector agnostic (multi-sector). Due to lack of sub-investment reporting by the other DFIs, the same searches for intermediated investments could not be replicated via the other DFI project portals. Instead DFI portals and other DFI and financial intermediary sources were searched for financial intermediaries known to invest in health (using BII data). The names of financial intermediaries were also searched for any indication they invested in health. Lack of, and incomplete reporting of sub-investments, alongside extremely limited information, even when disclosed, was both a major limitation and finding of this research.

Limitations of the research were largely related to missing information, poor transparency, inconsistencies, and insufficient details at all levels of reporting by the DFIs. These challenges undermine a systematic and

comprehensive analysis of the role of DFIs in health that is necessary for assessing their impact and holding them to account. Given the scale of intermediated investing in health, the failure of DFIs other than BII to systematically report sub-investments in health is highly problematic and should be urgently rectified. Other challenges include significant time lags in reporting new investments and a failure to report when investments have been exited. The implications of this lack of transparency and easy to navigate reporting means that Oxfam's findings very likely under-estimate the number and value of health investments, and that it is impossible to say by how much.

KEY FACTS AND FIGURES DRAWN FROM DFI HEALTH INVESTMENT DATA

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. Oxfam identified:

- **67 direct investments in health sector companies, totalling US$2.2bn.**[2]
- **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).**

Values for direct investments and for investments in both health specific financial intermediaries and multi-sector financial intermediaries were taken, where disclosed, from the DFI's project portals or other sources such as press releases. Values are according to currency exchanges from year of investment and/or as reported by the DFIs themselves. The values of four direct health investments by DEG, and three investments in health specific financial intermediaries are not known and DEG staff told Oxfam they could not be provided.

The value of investment in multi-sector financial intermediaries that sub-invest in health, where identified, were also taken, where disclosed, from DFI project portals or other online sources such as press releases. Oxfam makes clear that the proportion of this total (US$3.2bn) that is spent on health is not known as this is not disclosed by the DFIs. An exception is that in response to this report, Proparco provided Oxfam with an estimate of the value of its health investments via these intermediaries (US$74m).

The value of seven DEG investments in multi-sector funds sub-investing in health is not known and DEG staff told Oxfam they could not be provided.

Except for BII, Oxfam is also not confident it has been able to identify every financial intermediary investing in health on behalf of the DFIs as these sub-investments are not systematically reported so this figure is likely an under-estimate of the true value.

- **Oxfam's searches identified 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.**

A full review of IFC's health portfolio was beyond the scope of the research for this paper but IFC's project portal was searched to assess where it has co-invested in health with any of the four European DFIs. This was done for direct investments and for investments in health-sector and multi-sector financial intermediaries that sub-invest in health. The search function on the IFC's project portal is not very effective and using other internet search engines frequently produced better results in identifying IFC co-investments. Recent changes in IFC policy do mean that sub-investments made by IFC funded financial intermediaries are now being disclosed but this is not true for all historical investments. These sub-investments are also not searchable (as they are for BII) which prevents a full IFC health portfolio review.

- **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. The remaining 12% are detailed below.**

Table 2 below provides a detailed breakdown of the number (not $ value) of DFI direct and indirect health investments by health sector type. Sector type was established via project descriptions and/or company searches on the internet.

Table 2: Health sector type of DFI direct and indirect health investments

	BII	DEG	EIB	Proparco	Total	% of total
Service provider	70	50	15	67	202	56
R&D	59	27	4	24	114	32
Health insurance (& savings schemes)	5	4		1	10	3
Supply chain	3		2		5	1
Information systems	3	2	1	4	10	3
Procurement and supply		4		1	5	1
Human resources		2			2	1
Retail		1		1	2	1

PPP (hospital)		3	3	3	9	2
Unknown	1				1	0
DPM	1				1	0
Total	**140**	**93**	**25**	**101**	**361**	**100**

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

Table 3 provides the full breakdown of the number (not $ value) of all direct and indirect health investments per country income. Where this information is not provided in DFI project portals it was found via online searches and cross referenced with investments made by the other DFIs where relevant.

Table 3: Country income for DFI direct and indirect health investments

Country income	BII	DEG	EIB	Proparco	Total	%
Low	9	5	4	6	24	7
Lower-middle	114	51	11	70	246	69
Upper-middle	14	25	4	16	59	16
High		3	1	1	5	1
Mix	4	7	5	8	24	7
Total	141	91	25	101	358	100

- **Kenya and India – two countries found by Oxfam to have the highest concentration of DFI healthcare investments.**

The number of direct and indirect investments in India and Kenya were added up and divided by the total number of health investments for each DFI. Table 4 provides a detailed breakdown of the figures. IFC reported that 28% of its global health portfolio was in India in 2016[3] however this is presented as a proportion of the total US$ value of investments and it is not made clear if the figure includes sub-investments. Oxfam could not calculate the proportion of total US$ value of investments due to lack of disclosure of this information for sub-investments.

Table 4: Number and proportion of DFI direct and indirect health investments in Kenya and India

	No. of investments in Kenya	% of total investments in Kenya	No. of investments in India	% of total investments in India
BII	8	6	75	53
DEG	5	5	17	19
EIB	4	16	1	4
Proparco	14	14	4	16

- **Of the 358 European DFI health investments identified, at least 81% were made indirectly via financial intermediaries, primarily private equity funds. The proportion ranges from 73% for DEG and Proparco to 91% for BII.**

Table 5 shows the number and percentage of direct and indirect investments identified by Oxfam for each of the European DFIs. The full list of investments for each DFI can be found in the annex on the same download page for the full report.

Note that the percentage of intermediated investments relates to the number rather than the US$ value of investments made. Again, the latter is impossible to calculate due to lack of disclosure on values of sub-investments.

Table 5: Direct vs indirect health investments

	Direct	% direct	Indirect	% indirect
BII	12	9	129	91
DEG	25	27	66	73
EIB	3	12	22	88
Proparco	27	27	74	73
Total	67	19	291	81

- **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.**

Data on the health-specific and multi-sector financial intermediaries used by the DFIs to invest in health and where they are domiciled for tax purposes, was sourced primarily from DFI project portals and, where this information was not available, from other online searches including business news media outlets, business registry websites etc. Information could not be found for one financial intermediary for DEG.

Table 6 shows more details of the number of financial intermediaries and the proportion of these domiciled in tax havens for each of the four European DFIs.

Table 6: Financial intermediaries (FIs) investing in health that are domiciled in tax havens

DFI	**Number of FIs***	**Number of FIs in tax havens**	**% of FIs in tax havens**
BII	76	65	86%
DEG	21	13	62%
EIB	11	9	82%
Proparco	32	25	78%
Total	**140**	**112**	**80%**

*Does not include secondary financial intermediaries i.e. intermediaries financed by primary intermediaries

All but three of the 112 financial intermediaries domiciled in tax havens are domiciled in the top 15 corporate tax havens ranked by Oxfam.[4] The three remaining are domiciled in Guernsey and Malta, which are ranked 17th and 21st respectively in the Tax Justice Network's Corporate Tax Haven Index in 2021.[5]

- **Terms related to healthcare access to low- or lower-income people in some form were found in only six of 13 cases for BII (46%); two of 17 for DEG (12%); one of two for EIB (50%); and three of 22 for Proparco (14%).**
- **References to gender, women, or girls, or to any services specifically benefiting them such as sexual and reproductive health, were found in three cases for BII (23%), one case for Proparco (5%), and in no cases for DEG and EIB.**

Content analysis of project descriptions available on DFI project portals was conducted for the direct investments in healthcare providers and investments in health financial intermediaries made by the DFIs between 2010 and 2022. Hospital PPPs were excluded from the analysis since healthcare at these hospitals is delivered by government under government access policy. Previous searches of DFI project portals revealed no project descriptions for intermediated health investments so these were excluded. Investments in multi-sector financial intermediaries were also excluded from this analysis.

Search terms in relation to patients and/or users of services for the content analysis included 'low-income', 'poor', 'poverty', 'bottom of the pyramid', 'marginalised', 'gender', 'women', 'girls', 'mothers', 'sexual' and/or 'reproductive health'. However, project descriptions and project impact information were so brief or even non-existent as to make it possible to read all project documentation to check for relevant content.

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.

OTHER FACTS AND FIGURES

- **The average starting cost of an uncomplicated vaginal birth at DFI-funded private hospitals amounts to over one year's total income for an average earner in the bottom 40% of the population. The cost of a Caesarean birth amounts to over two years' total income for the same group.**
- **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.**

Oxfam identified 224 direct and indirect investments in private healthcare

providers made by the five DFIs. Only co-investments alongside the four European DFIs are included and analysed for IFC.

Maternity fees charged by these providers were found via hospital websites, direct communication with the hospitals, or other online sources such as local or national online fee information websites.

Maternity fee information was identified for half of the investments (110 or 49%). All fees provided are starting costs, with most hospitals detailing a long list of exclusions often including doctors' fees, pain relief, other interventions and any care and treatment for the newborn child.

Note that 52 investments in service provider companies that only provide diagnostics or pharmacy services are not included in the total (224). However, some other healthcare providers such as cancer or eye specialists that likely do not provide maternity services, were still included in the total thus artificially bringing down the proportion for which maternity fee information was identified.

Maternity fees were chosen as a focus for this research because of the urgency of tackling unacceptably high maternal mortality and morbidity in LMICs. In general Oxfam's research found low levels of transparency on fee information from most of the DFI funded private providers. Information on maternity fees was relatively more available than any other form of treatment or service but was still very limited. Lack of transparency on fees was both a significant challenge in terms of the research, but also indicative of significant transparency and accountability challenges faced by patients.

To calculate the time it would take for people in different income groups to earn enough to pay for the maternity fees, income data from the World Inequality Database[6] was used (Pre-tax national income, equal split adults, constant 2021).

The maternity costs (vaginal birth and Caesarean birth) for each hospital in each country were divided by the average monthly income from 2021 (most recent data) for people in various income brackets in the relevant country.

The number of months it would take people on average incomes from different income groups to pay for childbirth in each hospital in each country was averaged across the total number of DFI funded hospitals or healthcare providers for which maternity fee information was available. Table 7 provides the results of this in more detail.

Where fee information relies on third party sources such as online fee information websites, efforts were taken to triangulate this data wherever possible using multiple sources including media reports and other online fee databases. There may be some inaccuracies. Fund Manager TPG corrected down the fee we had for childbirth at its Evercare Hospital in Nigeria for example and told Oxfam that the fee we had for CARE Hospitals did not reflect the variance across their network of facilities. However, they did not provide corrected fee information for the latter or for any of their other hospitals. Oxfam has incorporated corrected fee information where such responses have been received. All maternity fee data is referenced.

Remaining inaccuracies are due to lack of transparency on fees from both the DFIs and the private facilities they fund. This undermines public scrutiny and accountability.

Table 7: Mean and Median time in months and years to pay for starting prices for childbirth (vaginal and Caesarean) at DFI funded hospitals for people on average incomes in different income groups.

	Bottom 10% to pay for vaginal birth	Bottom 40% to pay for vaginal birth	Bottom 50% to pay for vaginal birth	National average to pay for vaginal birth	Bottom 10% to pay for Caesarean birth	Bottom 40% to pay for Caesarean birth	Bottom 50% to pay for Caesarean birth	National average to pay Caesarean birth
Mean months	119.8	15.6	9.8	2.5	220.4	27.7	17.9	4.7
Median months	113.7	14.6	9.9	2.6	199.9	26.3	15.9	4.4
Mean years	10.0	1.3	0.8	0.2	18.4	2.3	1.5	0.4
Median years	9.5	1.2	0.8	0.2	16.7	2.2	1.3	0.4

Table 8 provides the data for Figure 3 in the report: The cost of giving birth at selected DFI-funded hospitals.

Table 8: Maternity fees for select DFI funded hospitals and date and source of fee information.

Company and country	DFIs fund direct	DFIs fund indirect	Starting price for vaginal birth	Starting price for Caesarean birth	Date of fee information	Source of fee information
Nakasero Hospital, Uganda		EIB, IFC, Proparco	UGX 2,210,000	UGX 3,650,000	2022	Email response from hospital
Evercare Bangladesh	BII, IFC	BII, IFC, Proparco,	BDT 63,000	BDT 185,000	2023	Phone call to hospital
Novamed, Burkina Faso		BII, DEG*, EIB, IFC, Proparco	XOF 390,100	XOF 742,100	2022	Direct communication with hospital over skype
AAR Healthcare Group, Kenya		EIB, IFC, Proparco	KES 98,700	KES 210,000	2022	https://nairobiwire.com/2022/05/aar-hospital-maternity-charges-in-2022.html
Medica, India	DEG	DEG, IFC, Proparco	INR 30,000	INR 62,000	2022	Facebook enquiry for vaginal birth and unverified online review for Caesarean birth https://www.youtube.com/watch?v=U2rSbOoln0w

Note that DEG told Oxfam that the investment in Novamed was 'not known' to them as either a direct or indirect investment. Information available

indicates that DEG is invested in Novamed indirectly via private equity fund Euromena III.

2. PRIMARY RESEARCH METHODOLOGY

Qualitative research was undertaken to explore whether DFI funded private hospitals uphold and protect patient rights and advance poor and marginalized people's access to quality healthcare without financial hardship. Data was collected in two Indian cities, Bhubaneswar, state capital of Odisha, and Raipur, state capital of Chhattisgarh in February and March 2020.

Ten semi-structured interviews with patients and/or their relatives were conducted across the two cities. Purposive sampling was used as it is an efficient technique for this research and it enabled the researchers to choose respondents that would be best suited to the research objectives. Experienced local community health workers played a key role in identifying patients and or families of patients who had sought or attempted to seek care from Narayana and CARE hospitals in each locality. Cases of patient rights violations and/or behaviour on the part of the private hospitals that had undermined patient access to quality healthcare and financial protection were identified and included in the study (see Table 9 for further details).

A further ten semi-structured interviews were conducted with a range of key informants including state legislators, health workers and union representatives, medical sales representatives, and a local health rights activist and journalist. The purpose was to collect information on direct and indirect experiences, informed perspectives and experts with first-hand knowledge and understanding of either the hospitals and/or the healthcare seeking challenges and experiences of local community members.

Focus groups were also conducted in each state to gather further information relevant to the research questions from those working directly as healthcare workers or health advocates in specific localities close to the hospitals. These focus groups are a particularly important and efficient means of understanding whether issues and experiences raised in individual interviews were reflective of broader community experiences.

Four focus group discussions were conducted with a total of 76 women community health workers and other women of lower-middle income and low-income status; and two focus group discussions were conducted with a total of 32 health rights activists and representatives of community-based organisations (see Table 10 for further details).

A desk review of relevant literature (government, academic, company data/publicly available information etc.) and any relevant media coverage was undertaken in each state.

Data was analysed for recurring themes as well as pre-determined themes, such as financial impact of hospital payments and experience of using government health insurance cards.

All interview data was anonymised, and names changed to protect identities. In cases where patients feared the information provided would make them identifiable it was agreed to only disclose the hospital company and not the state in which they sought their healthcare.

Table 9: Patient and/or relative semi-structured interviews in the states of Odisha and Chhattisgarh, India

Patient name	Gender	Income	Age of patient	Respondent	Condition	Government insurance card?
CARE Hospitals						
Ravi	Man	Lower-middle	Teenager	Santosh (older brother)	Traffic accident	Yes
Rajesh	Man	Middle	80s	Rajesh and his sons	Gallstones	No
Suki	Woman	Middle	60s	Daanesh (son)	Cancer	No
Hammond	Man	Lower-middle	70s	Hammond (and Gietta, his wife)	Breathing difficulties	Yes
Eva's mother	Woman	Lower-middle	60s	Eva	Heart problems	Yes
Sagarika's father	Man	Upper-middle	60s	Sagarika	TB	No
Robert	Man	Low	30s	Robert	Heart problems	Yes
Narayana – MMI-NH						
Sanjit	Man	Lower-middle	60	Aabharan (son of)	Liver, kidney and lung problems	No
Joshi	Man	Lower-middle	64	Joshi	Heart condition and diabetes	Yes

Table 10: Focus group discussions

	Location	Participants	Number
FG1	Bhubaneswar, Odisha	Representatives of health rights and community-based organisations, individual health activists	12
FG2	Bhubaneswar, Odisha	Mostly women with children or grandchildren displaced by building works associated with hospital	Approx. 30
FG3	Bhubaneswar, Odisha	Social jurists, medical	Approx. 20

		professionals and activists, community health workers	
FG4	Raipur, Chhattisgarh	Women community health workers	7
FG5	Raipur, Chhattisgarh	Women community health workers and other women living and working in settlement close to MMI-NH hospital	25
FG6	Raipur, Chhattisgarh	Women community health workers and other lower-middle class and poor women in settlement on outskirts of city	14

Ethical considerations in the collection of data

Primary data was collected between February and March 2020. Informed and voluntary consent was obtained from participants at the start of every interview and focus group. Participants were given the option to make any comments they wished off the record or opt out at any point. All of the data recorded was treated as confidential and anonymized. Oxfam's Guidelines for Research Ethics were fully adhered to.[7] The research team included local facilitators who had previously worked in or were from the same community and spoke the local language. This was key to establish greater trust with participants.

As all information was anonymised to protect the identities of patients and their relatives it was not possible to provide the private hospitals or the DFIs with the specific information necessary for them to be able to comment or respond to individual cases and allegations.

The companies were provided opportunity to comment on the broad issues and challenges raised by research respondents in relation to their hospitals. Oxfam received a direct response from Narayana Hrudayalaya and where relevant their comments are included in the report. No direct response was received from CARE Hospitals but was received from its shareholder TPG. Comments from the latter are incorporated in the report.

With few exceptions due to lack of contact information available, all healthcare companies named in the report were given opportunity to comment and any relevant comments received are incorporated in the report.

NOTES

1 Organizations that engage in profit-seeking activities and have a majority private ownership (i.e. not owned or operated by a government). This term includes financial institutions and intermediaries, multinational companies, micro, small and medium-sized enterprises, co-operatives, and individual entrepreneurs who operate in the formal and informal sectors. It excludes actors with a non-profit focus, such as private foundations and civil society organizations.

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

3 IFC. (1 December 2016). *IFC invests in India's Apollo Health to Increase Access to Quality Healthcare*. Press release. https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=18159

4 E. Berkhout. (2016). *Tax battles: the dangerous race to the bottom on corporate tax* . Oxfam. https://www.oxfam.org/en/research/tax-battles-dangerous-global-race-bottom-corporate-tax

5 Tax Justice Network. (n.d.). *Corporate Tax Haven Index - 2021 Results*. https://cthi.taxjustice.net/en/

6 World Inequality Database https://wid.world/

7 S. Galandini and F. Mager. (2020). *Research Ethics: A practical guide*. Oxfam. https://policy-practice.oxfam.org/resources/research-ethics-a-practical-guide-621092/

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

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