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.’ – Francisca 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.

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

For the average earner in the **BOTTOM 40%** of the population

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+ 1 YEAR’S INCOME

For the average earner in the **BOTTOM 10%** of the population

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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. A
caesarean birth at the even more expensive Evercare hospital, just a few
kilometres away, would cost 24 years’ income for the poorest 10%. 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
funded by BII, Proparco and IFC.

- **Emergency medical care denied**

In India, patients have a right to emergency care from all hospitals. 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.

- **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. The bill for
one patient who died from the virus at TMR Hospital came to an
extraordinary US$116,000. Oxfam’s research reveals numerous other
elements 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’.

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.\textsuperscript{14} Sixty people every second suffer catastrophic and impoverishing costs paying for healthcare out-of-pocket.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{18} The Global Fund to Fight AIDS, Tuberculosis and Malaria has saved more than 50 million lives since its creation.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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\textsuperscript{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”.\textsuperscript{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.  

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. 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.

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. 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.

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, and instead progress towards primarily publicly funded health care. 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, the greater the inequality in life expectancy between rich and poor people, and, during the pandemic, the higher the rate of COVID-19 infection and deaths (after controlling for other factors).

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. 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.\textsuperscript{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.\textsuperscript{40} Ranjan Pal, controller of BII-backed Manipal Group, saw his real-terms wealth grow by US$1.48bn in the last year alone.\textsuperscript{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.
NOTES


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


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.


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


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


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


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/9789240004081

16 Ibid.


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 USD 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 BI’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/2022/02/02111195/BII-Impact-Score-2022-26.pdf


30 Ibid.


37 Ibid.


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