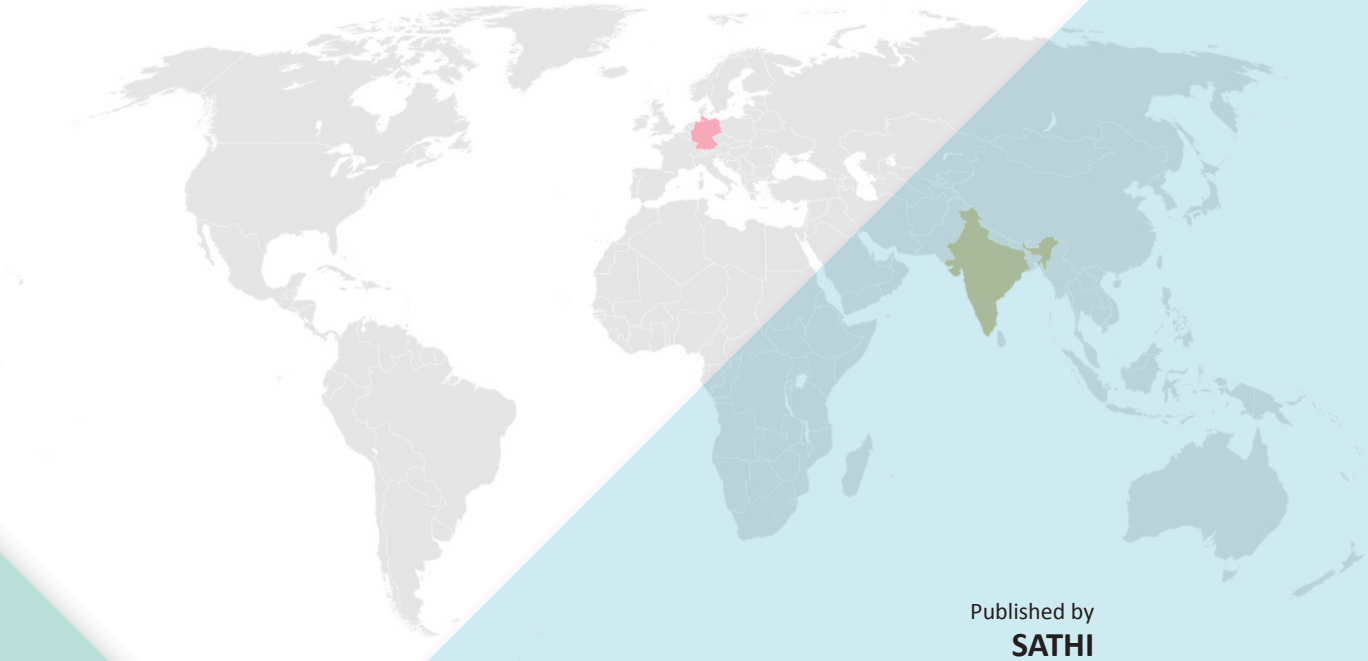

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SUPPORTING PATIENTS OR PROFITS

Analysing Engagement of German Developmental Agencies in the Indian Private Healthcare Sector

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INTRODUCTION

Development Finance Institutions display a significant underlying tension at the heart of their basic constitution and mandate – the contradiction between global market-driven imperatives for profit maximisation, and the claimed goal of expanding public good with equity. Official developmental agencies operate in a somewhat different mode, but when they support programmes in LMICs involving commercial healthcare providers on large scale, similar tensions arise between pursuit of conflicting goals. Here we discuss the broad observations and concerns regarding the involvement of German Development Finance Institutions and German Development Cooperation bodies with Indian private healthcare providers, as emerging from this study.

Development Finance Institutions (DFIs) are unique global investors in the healthcare sector. Despite being commercial entities, DFIs are supposed to have a developmental role in low- and middle-income countries, towards achieving Sustainable Development Goals (SDGs). A number of scholars and civil society experts have noted the potential negative effects of relying on private actors in healthcare to achieve public objectives. Transnational investments in the healthcare sector in India have experienced substantial growth in last two decades, contributing to increasing commercialisation of healthcare. German DFIs (GDFIs) have made significant investments in India's healthcare sector, similar to DFIs such as British International Investment (BII), International Finance Corporation (IFC), and the World Bank. It should be emphasised that in the health sector, making commercial investments in themselves do not necessarily contribute to UHC, and can even detract from the same, while increasing health inequities.

However, public evidence regarding the impacts of German developmental agencies[1] including GDFI on the healthcare sector in India is scarce. This exploratory study was conducted to understand the practices and impact of German DFIs (i.e. DEG[2]) and German Development Cooperation-GDC (i.e. KfW, BMZ and GIZ[3,4]) commitments in India, specifically those engaging with the private healthcare sector. The study encompassed two case studies, one focusing on the Indo-German Programme on Universal Health Coverage (IG-UHC) supported by BMZ, and another on ABC[5] private hospital which has been supported by DEG, a major German DFI.

1 The term German developmental agencies refer to German Development Cooperation which includes KfW, BMZ and GIZ, as well as the German DFI i.e. DEG

2 DEG - Deutsche Investitions und Entwicklungsgesellschaft

3 KfW- Kreditanstalt für Wiederaufbau (Credit Institute for Reconstruction), BMZ-Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (the German Federal Ministry for Economic Cooperation and Development), GIZ-Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (German Agency for International Cooperation GmbH)

4 Keeping with the focus of this study, we have not analysed GDC's commitments related to public health systems in India in detail, which has been significant and deserves a separate analysis.

5 The name of the private hospital is coded to maintain anonymity.

KEY FINDINGS

1. DEG's healthcare commitments in India

DEG is a German government-owned DFI which operates as a subsidiary of KfW, the German state-owned investment and development bank. DEG ranks as the third-largest bilateral DFI globally as of 2021, with a portfolio worth EUR 9.2 billion in 2022[6]. It finances investments in nearly 80 countries, with a total of 336 active projects. In 2021, DEG made a new commitment of EUR 499 million in Asia, the second-highest among regions, aiming for sustainable development impact[7].

In India, DEG has been active since 1964, supporting various sectors, including healthcare. It has invested in private healthcare companies such as pharmaceuticals, medical equipment, biotechnology, and large private hospitals. Since 2009, DEG has financed five large private hospitals in India, mostly as private equity or quasi-equity loans.

2. DEG operations through financial intermediaries and issues of transparency

Accessing data on German DFI commitments in India's healthcare sector presents a significant challenge. Detailed information related to GDFI commitments in India are not available in public domain. This challenge has been noted by other researchers also[8]. DEG does not have a dedicated disclosure and transparency policy in place and does not publicly provide a complete list with details of the projects receiving DEG support[9]. According to the DFI Transparency Index 2023, DEG ranks 11th among DFIs having a score of 27.7 out of 100, highlighting the significant need for enhancing transparency in their financing practices[10].

Financing by DEG is frequently routed through globally operating financial intermediaries, which presents further challenges related to transparency and accountability. A large part of DEG's financial commitments in the Indian healthcare sector have been made through financial intermediaries like Quadria Capital, which claims to be 'Asia's leading healthcare private equity fund'[11]. Currently, Quadria Capital's healthcare portfolio displays investments[12] in 17 healthcare companies from Asia, of which 11 are based in India. However, details of these investments made through Quadria Capital are not available publicly. Such mediated investments are likely to undermine the developmental goals of DFIs, since commercial intermediaries may prioritise their own business interests, leading to misaligned priorities and reduced effectiveness. Quadria Capital is based in Singapore which has been termed by many business commentators as a tax haven, known for enabling offshore businesses to minimise taxes and evade public accountability for their actions, while promising confidentiality regarding their funds[13]. Such major involvement in a commercial private equity fund based in a tax haven adds a further layer of complexity and opacity t o DEG's investment practices.

6 The growth of development finance. 2022. (cited 2023 May 30). Available from- https://pages.devex.com/rs/685-KBL-765/images/The_Growth_of_Development_Finance.pdf

7 KfW-DEG. 2022. (Cited 2023 Jan 29). Available from- https://www.deginvest.de/DEG-Dokumente/Download-Center/DEG_Imageflyer_2022_EN.pdf

8 Attridge, S. and Novak, C. (2022) An exploration of bilateral development finance institutions' business models. ODI Working paper. London: ODI (www.odi.org/en/publications/anexploration-of-bilateral-development-finance-institutions-business models).

9 Fact Sheet DEG (Germany) and private finance for development. (Cited 2023 June 1). Available from- DEG.pdf (d3n8a8pro7vhmx.cloudfront.net)

10 DFI transparency index 2023. (Cited 2023 May 29).Available from- DFI Transparency Index 2023 - Publish What You Fund

11 Quadria Capital. (Cited 2023 May 29). Available from https://quadriacapital.com

12 Quadria Capital. (Cited 2023 Jan 29). Available from- https://quadriacapital.com/portfolio/investments/

13 Vervynckt M. Going Offshore. Eurodad. 2014.

3. Case study: Operations of a DEG-financed private hospital

The Indian private hospital taken as case study in this research has received large scale support from DEG, both directly as well as through a financial intermediary. This hospital is a large corporate hospital with 500 beds, providing super speciality, tertiary level healthcare and offering high-end medical technology. Interviews with key informants suggest that operations of this private hospital are strongly commercially oriented. **Such practices with potential negative impacts on staff (such as altered working conditions and constrained autonomy), as well as on patients (such as unaffordable treatment and denial of healthcare to individuals covered by official health schemes or subsidies), have reportedly intensified since the hospital began receiving DEG investment.**

According to some respondents, initially the hospital had more patients who were subsidised by official schemes, but this has now shifted to an emphasis on private insurance-supported and corporate patients. Lack of regular provision of free or low-cost care to general patients is a reflection of the commercialised mode of operation of this GDFI-supported private hospital. While some services are provided under public health insurance schemes, here also denials of care are reported as exemplified by certain patient respondents in this study. Hence there is serious question about the DFI's claim of ensuring equitable and affordable access to healthcare through such investments. Numerous complaints have been filed by patients to the state's Clinical Establishment regulatory body[14] regarding ABC hospital over last five years; during 2017 to 2022, there were 36 such complaints regarding ABC Hospital. Out of these, 11 complaints were related to overcharging, 13 were related to medical negligence, and the remaining 12 were related to private insurance claims, state health insurance schemes, and treatment protocols.

Further, a strong focus by ABC hospital on catering to medical tourists is documented, and raises concerns about internal brain drain, as scarce specialised staff are utilised for treating high-revenue overseas patients, while local patients who seek affordable healthcare services through government schemes (considered less lucrative by the hospital) may be treated as lower priority.

4. Case study: Performance of BMZ-supported Indo-German-Universal Health Coverage15 program working with India's national health insurance scheme

The German Federal Ministry for Economic Cooperation and Development (BMZ) has been supporting the IG-UHC programme during 2020-2023. This programme of BMZ in partnership with the Ministry of Health and Family Welfare (MoHFW), Government of India involves financial commitment of USD 15,195,150 (Euro 12,65 Million) and is the largest among ongoing commitments by BMZ in the health sector in India. IG-UHC provides technical cooperation through around 63 consultants working with Health Authorities at national level and across different Indian states[16] , for the implementation of Pradhan Mantri - Jan Arogya Yojana (Prime Minister – People's Health Scheme or PM-JAY[17]), the flagship health insurance scheme of the Government of India.

IG-UHC aims to advance India's journey towards achieving Universal Health Coverage (UHC). However, our case study on PM-JAY shows serious concerns regarding provision of external technical support to this scheme which has a range of structural issues

14 The name of the state is not disclosed to maintain the anonymity of the hospital. Also, specific citations to media reports and commission have not been mentioned owing to the same reason. (The time of India, 2020, Indian Express, Feb, 2009; Statesman, April 2018.)

15 The term UHC mentioned in this entire section is with reference to the IG-UHC documents, which cites the World Health Organisation's definition of UHC, as- Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship' (WHO, 2019. Available at- https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc).

16 Project factsheet. IG-UHC. (Cited 2023 May 31). Available from- https://iguhc.in/wp-content/uploads/2022/02/IGUHC-project-factsheet_RFA.pdf

17 PM-JAY (Pradhan Pradhan Mantri Jan Arogya Yojna), launched in 2018, is a major health insurance scheme which aims at providing a health cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalisation to cover socioeconomically deprived 40% of the Indian population.

and inadequacies. The PM-JAY scheme is majorly based on the involvement of private hospitals, with large majority of claims, upto 75% of total claim value flowing to private hospitals as per data upto early 2019[18]. Until 2022, 54% of patients treated under the scheme have been hospitalised in private hospitals[19]. Keeping in view the highly commercialised and unregulated nature of private healthcare in India, the current mode of involving commercial private providers on a large scale in this scheme poses the risk of major distortions, with the continuation of inequities in access to healthcare.

Continued high out-of-pocket expenditure (OOPE) among beneficiaries, and low coverage of COVID hospitalisations by the scheme in most Indian states during the recent pandemic, are striking manifestations of such distortions arising from underlying structural problems. During the COVID-19 pandemic, PM-JAY's contribution to providing much-needed care was sub-optimal with only 5% of PM-JAY hospitalisations being for COVID patients at the peak of pandemic[20]. According to another media report[21], less than 12% of hospitalised COVID-19 patients across the country were able to access free treatment under the PM-JAY scheme. Further, a study conducted during the pandemic in Chhattisgarh state[22] found that the OOPE per hospitalisation was INR 4,871 (around 50€) in public hospitals and INR 169,504 (around 1900€) in private hospitals. Additionally, it revealed that catastrophic expenditure occurred in 3% of public hospitalisations and 59% of private hospitalisations. **Such significant OOPE associated with the COVID treatment, especially in private hospitals has made it unaffordable for large section of society in India.**

With respect to geographic disparity, states with higher poverty headcounts and disease burdens are considered to have a higher need for PM-JAY. However, the utilisation of PM-JAY in terms of claim volume and value has been found to be lower in states with high levels of poverty and healthcare needs, for example Bihar, Madhya Pradesh, Uttar Pradesh, and Assam, compared to states with higher per capita incomes like Kerala and Himachal Pradesh[23]. The PMJAY scheme analysis reveals gender disparities, with males (56.4%) having higher claim values and per-capita claim values than females (43.6%)[24]. Additionally, vulnerable communities like Scheduled Castes and Scheduled Tribes have low representation in private hospital admissions through the scheme (5% and 2% respectively) despite their comprising together 28% of India's population[25].

A study on PM-JAY led by GIZ[26] (German Agency for International Cooperation) conducted in collaboration with India's National Health Authority, which is the largest household-level study on this scheme and was conducted in seven Indian states, reveals striking findings. This study reports that in the sample of 5,364 hospitalised individuals who were eligible for being covered by the scheme, 84% experienced out-of-pocket expenses[27] (OOPE) related to hospitalisation. The average OOPE (pre + during + post hospitalisation) was quite high at Rs. 13,664 (around 150€). Among these, even those patients having any kind of social health insurance coverage including PM-JAY had to bear OOPE in 76% of cases. This study confirms the observations of several other

18 Dubey S, Deshpande S, Krishna L and Zadey S. Evolution of Government-funded health insurance for universal health coverage in India. The Lancet Regional Health - Southeast Asia 2023;13: 100180. xxx https://www.thelancet.com/journals/lansea/article/PIIS2772-3682(23)00040-9/fulltext

19 National Health Authority annual report 2021-22 https://abdm.gov.in:8081/uploads/PMJAY_Annual_Report_25_1f47b3cfa5.pdf

20 Garg S, Bebarta KK. Krishnendhu K. Catastrophic health expenditure due to hospitalisation for COVID-19 treatment in India: fndings from a primary survey. BMC Research Notes (2022) 15:86 https://doi.org/10.1186/s13104-022-05977-6.

21 Dubey S, Deshpande S, Krishna L and Zadey S. Evolution of Government-funded health insurance for universal health coverage in India. The Lancet Regional Health - Southeast Asia 2023;13: 100180. xxx https://doi.org/10. 1016/j.lansea.2023. 100180.

22 Ibid. Dubey S, Deshpande S, Krishna L and Zadey S. The Lancet Regional Health - Southeast Asia 2023

23 Trivedi M, Saxena A, Shroff Z, Sharma M. Experiences and challenges in accessing hospitalization in a government-funded health insurance scheme: Evidence from early implementation of Pradhan Mantri Jan Aarogya Yojana (PM-JAY) in India. PLoS ONE. 2022. 17(5): e0266798. https://doi.org/10.1371/journal. pone.0266798

24 Ibid. Dubey S, Deshpande S, Krishna L and Zadey S. The Lancet Regional Health - Southeast Asia 2023

25 Trivedi M, Saxena A, Shroff Z, Sharma M. Experiences and challenges in accessing hospitalization in a government-funded health insurance scheme: Evidence from early implementation of Pradhan Mantri Jan Aarogya Yojana (PM-JAY) in India. PLoS ONE. 2022. 17(5): e0266798. https://doi.org/10.1371/journal. pone.0266798

26 One year into PM-JAY implementation- A household study across seven states in India. (Cited 2023 May 31). Available from- https://iguhc.in/wp-content/uploads/2023/02/Demand-Side-Report_23.01.2023_Web-version.pdf

27 Out-of-Pocket Expenditures on Healthcare OOPE are payments made by an individual at the point of receiving healthcare services. his occurs when services are neither provided free of cost through a government health facility, nor is the individual covered under any public or private insurance or social protection scheme.

state-level and local studies which have reported that OOPE for patients covered under this scheme have remained quite high, representing an important barrier to access free hospitalisation care.

Naturally all the deficiencies in this Indian healthcare scheme should not be attributed solely to the IG-UHC advisers. However, it should be noted that the involvement of this German officially supported body in PM-JAY through a large team of consultants has been quite intensive. This involvement might have sometimes even overstepped the bounds of remaining in an advisory role. A report by GIZ mentions that, "the GDC team has become such an integral part of NHA and the running of PM¬JAY that some development partners who were interviewed for this case study, while appreciating GDC's flexible support in the setup phase of PM¬JAY, cautioned against the risk of 'substitution instead of enablement'[28]". ●

[28] Trusted partners for Universal Health Coverage. 2020. GIZ. (Cited 2023 May 31). Available from- German Health Practice Collection ghpc@giz.de www.health.bmz.de/good¬practices.

ANALYSIS AND MAJOR CONCERNS

We have focussed on three dimensions during our analysis – adoption of a health systems approach; universality with equity; and social accountability with rights and solidarity.

Lack of essential health systems approach

▸ DEG does not have a sectoral policy on health, which is essential to scrutinise the larger health system landscape, and to position any investments in such a broader public health context. ***Through its direct and indirect investments to commercial private hospitals, DEG appears to be contributing to further privatisation of the already highly privatised Indian healthcare system.*** The present transactional arrangements between GDFIs and recipient commercial healthcare entities appear to be almost entirely business centred, with targets and performance focussed solely on numerical reach and scale of investments.

It is also relevant to ask why DEG support and IG-UHC technical assistance is currently mostly focussed on public-private partnerships, with less attention to other major fronts of reform, such as the implementation of much-needed legal regulation of the entire Indian private healthcare sector for quality, costs and content of care.

It is crucial to note that the process of developing an equitable, publicly organised UHC system in India, however, it is conceived, should not be primarily focussed on promoting certain for-profit private providers, and supporting a health insurance scheme which based on large-scale engagement of commercial private providers.

Deficit of concrete measures to ensure equity and universality

▸ Various DEG policy documents related to healthcare investments in the private sector in India lack mention of specific dimensions of inequity such as class, caste and gender. These dimensions need to be addressed while ensuring equitable access to healthcare and regulatory provisions for private bodies receiving investments from GDFIs. Both case studies in this research reinforce these points. In the case of the GDFI-supported private hospital, its commercialised mode of operation coupled with lack of provision of free care, raises serious questions about the claim of ensuring equitable and affordable access to healthcare through such investments. Regarding PM-JAY, its rigidly targeted approach appears to be one of the serious limitations, which leads to major exclusions, and contrasts with the widely acknowledged need for universality in healthcare. Continued geographical and gender related inequities concerning access to healthcare delivered through the PM-JAY scheme, along with high out-of-pocket expenditures which adversely impact upon the poor, raise serious questions regarding the currently designed scheme's performance to ensure movement towards the goals of an equitable and universal healthcare system in India. ●

Missing social accountability, processes to claim rights and promotion of solidarity

As of now, besides an individual patient grievance redressal mechanism, no social accountability, social audit or other collective rights-claiming mechanisms are operational regarding the national PM-JAY scheme, which involves over 500 million beneficiaries. In various concerned documents, social accountability mechanisms do not seem to be mentioned either at the BMZ's end in Germany, or at the end of the recipient country in India. Overall, the collective rights-based approach, linked with social mobilisation for healthcare, is barely mentioned or implemented in context of this scheme. Further, in contrast to the German social health insurance system which has been developed over the last 140 years based on solidarity and self-governance, PM-JAY in India appears to be contributing to an individual beneficiary-oriented programme, which is detached from social organisations and participatory processes. So far it has hardly ensured any systematic involvement of communities and grassroots collectives, or processes for promoting health solidarity, which would be an essential basis for any genuine universal healthcare system.

The involvement of intermediary private equity funds in GDFI-related investments is likely to weaken the developmental goals of these DFIs, since such commercial intermediaries are likely to prioritise their own commercial interests over social objectives. Opacity in GDFI-intermediary arrangements reduces transparency regarding the scale, composition, and nature of investments, and increases the likelihood of profit maximising processes overpowering the achievement of social objectives, since public oversight becomes extremely difficult.

Based on the available evidence, ***we conclude that the primary focus of German DFIs in the private healthcare sector in India, especially their financial support to private hospitals, is to promote commercial growth of profit-oriented private providers.*** Ensuring benefits to patients in terms of equitable access to care appears to be a secondary objective, with doubtful outcomes since the current DFI interventions are not located in the context of an overall public health strategy, they are not linked with comprehensive regulation of private healthcare providers, and the measures to ensure equity and universality are very weak. These arrangements are not subject to systematic rights claiming mechanisms, public scrutiny or accountability with the participation of diverse social stakeholders.

RECOMMENDATIONS

Keeping in view our entire set of findings and analysis, main recommendations emerging from this study can be outlined as follows. These are applicable to the operations of GDFIs and official developmental agencies in the Indian healthcare sector, but have relevance for other LMICs.

1 **Bilateral review and impact assessment of current projects:** Comprehensive review of ongoing projects should be conducted, involving diverse stakeholders and ensuring complete transparency. The details of all current investments should be made public, and the review process should include participation of public health and social stakeholders, civil society networks, and organisations. Complementary review processes should be organised in India as well as Germany, enabling communication and sharing of information between these two sets of stakeholders.

2 **Transparency and access to information:** GDFIs and their recipient bodies should make available in the public domain comprehensive information about their projects, including details on scale, composition, and nature. This transparency is essential for enhancing monitoring, ensuring accountability, and evaluating project commitments. Governments of the respective countries should play a vital role in ensuring adherence to transparency principles.

3 **Discontinuing involvement of commercial intermediaries:** GDFIs should avoid routing their development-oriented investments in India and other LMICs through commercial intermediaries such as international private equity funds. All investments having developmental objectives should be provided directly, while ensuring associated public accountability mechanisms and transparency at the end of both donor and recipient countries.

4 **Moratorium on financing private hospitals:** Until the completion of the comprehensive review process and elaboration of an appropriate health sector strategy, GDFIs should refrain from providing direct or indirect financial support to commercial private hospitals in India. The focus of German developmental agencies' financial resources should be on strengthening public health systems, and any decision to invest in private healthcare providers should only be made after satisfying the pre-condition of effective regulation of the private healthcare sector,

while considering in depth the implications of such support in context of the essential requirement of equitable access to care.

5 **Major reorganisation of strategy:** German developmental agencies should develop a comprehensive health sector strategy that focuses on a public health systems approach. This strategy should include strengthening of public health services, regulating the private healthcare sector effectively, and implementing social accountability, rights claiming, and participatory governance mechanisms. The aim should be to promote genuine universality with equity in access to healthcare, and the strengthening of collective and individual health rights. Promoting fair and affordable pricing of services should be central to this strategy, with financing and regulatory mechanisms in place to implement this.

6 **Recasting technical support to PMJAY:** The current technical support provided by the IG-UHC limited to the PMJAY scheme should be reviewed keeping in view the significant structural deficiencies related to this scheme. A comprehensive plan for regulating and rationalising private healthcare providers should be prioritised, and arrangements involving commercial insurance companies should be discouraged. The PMJAY scheme should be modified, recast and dovetailed into a time-bound process for operationalising a genuinely universal healthcare system covering the entire Indian population. This should be focussed on expanded public healthcare provisioning and rationalised involvement of regulated private providers, which is strongly embedded in collective health rights and social accountability approaches.

7 **Ensuring social accountability and engagement:** Platforms and processes should be established to ensure systematic social accountability and engagement in all healthcare agencies and arrangements that are supported by German developmental agencies. Consultations with representative civil society networks and organisations, including panchayats, women's groups, trade unions, associations of workers in the unorganised sector, and groups of marginalised communities should be an integral part of project design and ongoing review. Mechanisms like social audits, community-based monitoring, participatory planning, health assemblies, and health councils should be considered and implemented to facilitate people's central and active involvement.

8 **Parliamentary oversight and mutual accountability:** Effective parliamentary and legislative oversight should be established for all GDFI-supported projects in India. Additionally, mechanisms should be developed to ensure mutual accountability between partnering country governments, addressing the deficit of accountability frameworks for recipient country governments to hold DFIs accountable to agreed-upon principles.

This research brief is based on the detailed report of a study undertaken by SATHI in 2022-23. The full report is available at **www.sathicehat.org**

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