
Supporting patients or profits?

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

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About Anusandhan Trust and SATHI



Anusandhan Trust was founded in 1991 by a group of socially motivated health professionals to run democratically managed institutions for undertaking research on health and allied themes; to provide education and training, and to participate in relevant advocacy efforts. SATHI, an action-research centre of Anusandhan Trust, is based in Pune. SATHI has nationally pioneered health rights approaches in India since 1998, fostering accountability of public health services, private healthcare and inter-sectoral community action through civil society partnerships.

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Abbreviations

AB-PM-JAY: Ayushman Bharat Pradhan Mantri - Jan Arogya Yojana or Prime Minister – People's Health Scheme.

BII: British International Investment

BMZ: Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (the German Federal Ministry for Economic Cooperation and Development)

CAGR: Compound Annual Growth Rate

CDC: Commonwealth Development Corporation

DEG: Deutsche Investitions- und Entwicklungsgesellschaft (German Investment Corporation)

DFI: Development Finance Institution

GDC: German Development Cooperation (BMZ, GIZ and KfW are known collectively known as GDC)

GIZ: Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (German Agency for International Cooperation GmbH)

HWC: Health and Wellness Centre

IBEF: India Brand Equity Foundation

IFC: International Finance Corporation

IGUHC: Indo-German Programme on Universal Health Coverage

KfW: Kreditanstalt für Wiederaufbau (Credit Institute for Reconstruction, Germany)

KPMG: Klynveld Peat Marwick Goerdeler

MoHFW: Ministry of Health and Family Welfare

NHA: National Health Authority

NHP: National Health Policy

NITI Aayog - National Institution for Transforming India

ODA: Official Development Assistance

PM-JAY: Pradhan Mantri- Jan Arogya Yojana

PPP: Public-Private Partnership

RSBY: Rashtriya Swasthya Bima Yojana

SDG: Sustainable Development Goal

UHC: Acronym used for Universal Health Coverage as well as Universal Health Care

Introduction

Healthcare has become a lucrative area for growth of investments globally. In contemporary India, this sector continues to be increasingly commercialised, supported by both international development institutions¹ and many domestic governments. Private development investments from international, bilateral, and multilateral Development Finance Institutions² (DFIs) have globally grown six-fold between 2000 and 2017³. As of 2021, the global DFI portfolio for healthcare investment reached USD 84 billion⁴, almost half of the world's Official Development Assistance (ODA)⁵. Private investment in healthcare provisioning and financing is often presented as the only viable solution to address disparities in healthcare provisioning and to reduce the financial burden of out-of-pocket expenditures. However, this argument overlooks the evidence from around the world which contradicts this perspective.

Promoting the private sector

The justification for promoting private investment in social sectors, including the health sector, comes from different levels. First, it is considered a necessary strategy to bridge the annual gap of

US\$ 2.5 trillion required to achieve the targets of Sustainable Development Goal-3⁶ globally, which aims towards 'ensuring healthy lives and promoting well-being'. It is argued that private sources of finance are instrumental in meeting this goal. Second, private healthcare providers are considered major contributors to expansion of access to healthcare for populations in LMICs, and private sector investments are regarded as essential for promoting growth of this sector. A recent report by KPMG and academic researchers on behalf of the World Innovation Summit for Health has suggested that achieving Universal Health Coverage (UHC)⁷ by 2030 will be challenging without utilising existing private capacity, investment, and innovation.⁸ Third, it is important to note that the National Health Policy (NHP) of 2017 encourages significant private investments in India's healthcare sector.⁹ Furthermore, reports published by National Institution for Transforming India (NITI) Aayog in 2021¹⁰ openly promote accelerated growth of the private healthcare sector, encouraging both transnational and domestic investments in the Indian healthcare industry¹¹.

1 Hunter B.M and Murray S.F, Deconstructing the Financialization of Healthcare, Development and Change 0(0): 1–25. DOI: 10.1111/dech.12517, 2019

2 DFIs are a subset of public development banks. They are specialised institutions set up to support public policy objectives, mainly private sector activities in developing countries. They are usually government-owned and controlled institutions that invest in private sector projects in developing countries.

3 Runde DF and Milner A. Development Finance Institutions: Plateaued Growth, Increasing Need. Center for Strategic and International Studies. February 2019. (cited 2023 Jan 20). Available from- [Development Finance Institutions: Plateaued Growth, Increasing Need \(csis.org\)](https://www.csis.org/development-finance-institutions-plateaued-growth-increasing-need)

4 Mohammad O. Money Matters: How development finance has grown and grown. Devex. November 2022 (cited 2023 Jan 20) Available from-<https://www.devex.com/news/money-matters-how-development-finance-has-grown-and-grown-104205>

5 Official development assistance (ODA). 2022. (cited 2023 Jan 20). Available from- Official development assistance (ODA) - OECD

6 Stenberg K. et al. 'Financing Transformative Health Systems towards Achievement of the Health Sustainable Development Goals: A Model for Projected Resource Needs in 67 Low-income and Middle-income Countries', The Lancet Global Health. 2017. 5(9): e875–e887.

7 See note at the end of the report for our position on UHC.

8 Roland J. et al. 'Healthy Returns: The Role of Private Providers in Delivering Universal Health Coverage'. Report of the WISH Role of the Private Sector in Healthcare Forum 2018. Doha: WISH.

9 Government of India. Situational Analysis: Backdrop to the National Health Policy. Ministry of Health and Family Welfare, New Delhi.2017

10 Sarwal R, U Prasad, K Madangopal, S Kalal, D Kaur, A Kumar, et al. Investment Opportunities in India's Healthcare Sector," NITI Aayog, 2021

11 Sarwal et al. Investment Opportunities in India's Healthcare Sector, NITI Aayog (2021)

The unique role of DFIs

DFIs are unique transnational investors. While they are commercial enterprises, DFIs also claim to play a developmental role in supporting private investments in Low- and Middle-Income Countries (LMICs) to realize Sustainable Development Goals (SDGs)¹². Most DFIs maintain multiple objectives and often include *“sustainable private sector projects; maximising impacts on development; remaining financially viable in the long term; and mobilising private sector capital in high-risk markets globally”*¹³. DFIs play a significant role in strengthening the private sector since this is their core mandate. They support commercial growth in developing countries by mobilising private investment through financing, risk-sharing, and support activities, making them vital contributors to this cause.¹⁴.

However in recent years, a number of scholars¹⁵ as well as civil society representatives¹² have noted the potential negative effects of relying on private actors in healthcare to achieve public objectives, including during the COVID pandemic. Various stakeholders and analysts have highlighted the potential risks associated with a for-profit private sector and market-focused international development approach, which may divert Official Development Assistance (ODA) from local priorities and can undermine the role of public goods and services in promoting economic development. This area requires further analytical attention and research to understand its impact fully.

Why this study?

International development agencies are investing in the private healthcare sector in India with a claim to promote universal, affordable, and high-quality healthcare. However, there is limited research on how these investments actually impact access to affordable healthcare and progress towards SDGs. German developmental agencies¹⁶ including German DFIs have made significant investments in India's private healthcare, similar to other DFIs such as British International Investment (BII), International Finance Corporation (IFC), and the World Bank. But public evidence regarding the impacts of German developmental agencies' financing and involvement with the private healthcare sector in India is scarce. During the COVID-19 pandemic, concerns related to affordability and access to healthcare¹⁷ have been further highlighted in context of commercial for-profit and corporate private hospitals¹⁸. Therefore, a concrete analysis is needed to assess the impact of these investments in the health sector, whether these are actually strengthening movement towards public health goals and ensuring universal and equitable access to healthcare. This study was conducted to understand the trajectory and current landscape of financial commitments and engagement by German developmental agencies in the Indian private healthcare sector. The study aims to identify key concerns from patient and community perspectives, and to examine the claims that these investments contribute to the development of UHC systems as articulated in various concerned documents¹⁹.

12 Danish Institute for Human Rights. Human Rights at Development Finance Institutions. 2021. (cited 2023 Jan 21). Available at: https://www.humanrights.dk/sites/humanrights.dk/files/media/document/Human_rights_at_development_finance_institutions_accessible.pdf

13 Kingombe C, Massa I, and te Velde D.W. Comparing Development Finance Institutions Literature Review. Overseas Development Institute. 2011.1-72.

14 Hunter B.M and Marriott A. 'Development Finance Institutions: The (in) coherence of their investments in private healthcare companies'. The Changing Faces of Development Aid and Cooperation: Encouraging Global Justice or Buttrressing Inequalities?. 2017. Available from- <https://www.realityofaid.org/wp-content/uploads/2018/12/2-Development-Finance-Institutions-The-incoherence-of-their-investments-in-private-healthcare-companies.pdf>

15 Chapman A. The Impact of Reliance on Private Sector Health Services on the Right to Health. Health Hum Rights.2012. 16.122.

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

17 Marathe S, Bhalerao S, Pawar K, Kakade D and Shukla A. Patients' voices during the pandemic: Stories and analysis of rights violations and overcharging by private hospitals. Compendium. 2022. SATHI, Pune

18 Chakravarthi I, Hunter BM, Marathe S, and Murray, S.F. Corporatisation in the private hospitals sector in India: case study from Maharashtra, India. Economic and political weekly. 2023. vol IVIII no 11

19 Rohregger B and Rudolph P. Achieving Universal Health Coverage: Contributions by German Financial Cooperation. KfW Development Bank – Perspectives on Development Financing, No. 3 July 2017. (cited 2023 Jan 25). Available from- https://www.kfw-entwicklungsbank.de/PDF/Download-Center/Standpunkte/2017_07_Nr.3_UHC_EN.pdf

The study critically analyses the engagement of German developmental agencies' financial commitments with private healthcare providers in India, and attempts to offer insights into their impacts on access to healthcare with an equity lens. While much of the current research on DFIs in LMICs is led by researchers from the global north, this study is somewhat unique since it has been conceptualised and implemented by researchers based in India, while consulting with colleagues

from various parts of the world. The findings aim to increase awareness and foster dialogue on this theme among various stakeholders, such as civil society activists, healthcare professionals, academics, and policymakers. Furthermore the study provides recommendations for both German and Indian government actors regarding orientation of GDFIs towards effectively promoting equitable and affordable access to healthcare in India.



Methodology

How was the study conducted?

This exploratory study involved both empirical data collection and desk review. We mapped the extent of German DFIs (i.e. DEG²⁰) and German Development Cooperation-GDC (i.e. KfW²¹, BMZ²² and GIZ²³ which are collectively known as GDC) commitments in India's healthcare sector, gathering data from a range of sources, including business intelligence reports, reports on DFIs in India, investment databases, websites, policy documents, annual reports of German developmental agencies (DEG, KfW, BMZ and GIZ), financial intermediaries, Indian hospitals supported by German institutions, press reports, and academic literature. We identified additional online sources through a snowballing approach and compiled details of German developmental agencies-supported projects, including the type of support, donor body, intermediary, recipient institution, size, and duration of financial or technical support. For recipient hospitals, we collected data on hospital profile, type, geographic location, number of beds, specialties, health services, transparency, medical tourism, and more.

It is important to clarify at the onset that this study primarily focuses on understanding the support provided by German developmental agencies to projects involving private healthcare providers in India. Therefore, we have not analysed their commitments related to public health services and related activities in detail, which has been significant and deserves separate analysis. Nonetheless, certain significant commitments made by them have been briefly mentioned in the findings section to provide contextual information.

We conducted two case studies with different institutions to develop an in-depth understanding of the practices and impact of GDFI (DEG) and GDC (BMZ/GIZ) supported projects in India, specifically those involving the private healthcare sector. One concerns the Indo-German Programme on Universal Health Coverage (IG-UHC) program supported by BMZ, and another focusses on ABC²⁴ private hospital which has been supported by DEG. We selected IG-UHC program from the several ongoing projects because it supports the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PM-JAY, Prime Minister – People's Health Scheme or PM-JAY, henceforth referred to as PM-JAY) scheme, a major nationally implemented health insurance scheme in India with large scale involvement of private hospitals. We selected ABC hospital from the list of four private hospitals currently financed by DEG in India, as it was the only hospital which has received financing from DEG on multiple occasions²⁵. The Institutional Ethics Committee of Anusandhan Trust has approved this study.

We conducted in-depth qualitative interviews with fourteen purposively selected respondents using a semi-structured interview guide. We identified respondents related to PM-JAY primarily through narrative literature. Additionally, for the PM-JAY case study, we interviewed one representative from the Indo-German social health security program, one state official who had worked on BMZ-supported state health programs, and two practitioner-researchers with extensive work on publicly funded health insurance schemes.

For the private hospital case study, a snowball sampling method was used to identify respondents

20 DEG -Deutsche Investitions- und Entwicklungsgesellschaft, German Development Financing Institution

21 KfW- Kreditanstalt für Wiederaufbau (Credit Institute for Reconstruction)

22 BMZ - Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (German Federal Ministry for Economic Cooperation and Development)

23 GIZ- Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (German Agency for International Cooperation)

24 The name of the private hospital has been encoded to ensure anonymity.

25 To safeguard the anonymity of the private hospital, we avoid elaborating on this point with factual data.

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associated with it. Ten individuals were interviewed for the ABC hospital case study, including five ex-staff and ex-consultants (medical and non-medical) associated with the hospital, one senior public health physician who was member of the state-level COVID task force, two patients with experience related to ABC hospital, and two health activists who have been dealing with patient complaints related to various private hospitals in the state. Despite repeated requests for interviews with the management of ABC hospital, including a request for a physical meeting, unfortunately we did not receive any response from the ABC hospital management.

All respondents were informed of the research aims and the interview purpose, and gave their informed consent to audio-record the qualitative interviews. Interviews were transcribed verbatim, anonymised, coded, and analysed thematically. We also thoroughly reviewed academic literature, policy documents, official reports, and media sources to supplement both case studies, particularly for the PM-JAY case.

Challenges in conducting the study

The following are certain major challenges encountered during this study.

-Opacity of German DFI data- Accessing and gathering data on German DFI commitments in India's healthcare sector presented significant challenges. The availability of data in a fragmented and partial manner with limited details in public domain, and difficulty in identifying appropriate sources made it particularly challenging to map DEG's investments in healthcare over the past decade. The lack of transparency in data was compounded by the fact that DEG's commitments are often channelled through financial intermediaries, making it challenging to track the details of their further investments to private companies. Furthermore, it was nearly impossible to correlate and trace the primary sources of financial

commitment in the case of indirect investments.

-Non-response from certain key stakeholders- Despite repeated attempts to contact top management personnel from ABC hospital, representatives of the German DFI and its Indian offices, and the IG-UHC program, many potential interviewees did not respond or declined to provide interviews. ABC hospital did not even respond to the request for specific data on free or subsidised care given to patients over the last few years. Consequently, primary data from the hospital on this aspect were unavailable for analysis.

-Maintaining anonymity - To strictly maintain the anonymity of the respondents and the private hospital selected for the case study, we cannot cite certain information collected and specific sources of information, as that could serve as direct or indirect identifiers of the hospital.

Structure of the report

We begin with an overview of DFI commitments in India's healthcare sector. Moving on to the focus of the study, we present a mapping of German developmental agencies' financial support to healthcare services in India. Subsequently, we present the findings from the two case studies, combining insights from empirical data and desk-based reviews. We then analyse the key concerns regarding German developmental agencies' including DFI investments in private healthcare sector in India, using the lenses of health systems approach; universality with equity; and social accountability with rights and solidarity. Finally, we provide recommendations for German developmental agencies' investments in the Indian healthcare sector, which has relevance for other LMICs.



Findings

What are our findings?

The findings are organised into the following four sub-sections-

- I. DFI commitments in India's healthcare sector.
- II. Mapping financial support by German developmental agencies to the healthcare sector in India
- III. Case study of DEG financed private hospital from India
- IV. Case study of BMZ-supported Indo German-Universal Health Coverage program for India's national health insurance scheme (PM-JAY)

I. Overview of Development Finance Institutions' Investments in India's healthcare sector

India is one of the leading destinations for international finance investments in commercial hospital chains. Lifting public restrictions on Foreign Development Investment (FDI) in the healthcare sector since 2000 majorly enlarged the scope for foreign investments in India. The World Bank's private equity investment arm, IFC, and private equity firms occupy a central role in investing in healthcare. Additionally, other multilateral development banks, DFIs, and government-owned institutions involved in bilateral financing invest significantly in India. According to

India Brand Equity Foundation (IBEF) reports²⁶, the Indian healthcare sector is expected to rise nearly four-fold, growing at a Compound Annual Growth Rate (CAGR) of 22% between 2016–22 to reach US\$ 372 billion in 2022 from US\$ 110 billion in 2016. By FY22, Indian healthcare infrastructure was expected to reach US\$ 349.1 billion. The analysis of DFI commitments in healthcare²⁷ shows that there were 14 commitments with a total cost of \$335.2 million from four major institutions viz- DEG, IFC, CDC and Swedfund directed at healthcare companies in India between 2013-2017.

World Bank and IFC investments

The World Bank and other multilateral development banks play key roles in shaping and promoting India's private healthcare system, providing ideological and financial support for its growth and development²⁸. The World Bank has played a major role in promoting privatisation of healthcare in the Global South, including in India, since the 1990s. Health was a prominent focus in both the World Bank's Country Partnership Strategy 2013-17²⁹ and the Country Partnership Framework 2018-22³⁰ for India. In these strategies, the World Bank notes the problems related to poor oversight of private health providers, lack of accessibility for the poorest, and high levels of Out-of-Pocket Expenditures (OOPEs), often resulting in debt and poverty. It proposes the standard prescriptions of expanding Public Private Partnerships (PPPs), despite the documented evidence of these approaches often failing to improve access to healthcare for the poor. In July

26 IBEF. Healthcare Industry Reports. 2022. (cited 2023 Jan 25). Available from-<https://www.ibef.org/industry/healthcare-india>

27 Hunter B.M, Marriott A. 2017

28 Engel S. The multilateral development banks, COVID-19 and health privatisation in India. Public Services International. 2021. Available from- https://pop-umbrella.s3.amazonaws.com/uploads/7325a923-df6f-4da5-a4bc-b2d047a41803_Engel_2021_MDBs_india_Engel.pdf

29 World Bank. Country Partnership Strategy for India for the period 2013-2017. Washington: World Bank Group. 2013. 91199. (Cited 2023 Jan 28). Available from-<https://documents.worldbank.org/en/publication/documents-reports/documentdetail/816871468258564439/country-partnership-strategy-for-india-for-the-period-2013-2017>

30 World Bank Group. "Country Partnership Framework for India." India: India Country Management Unit, World Bank Group, 2018.

2022, the World Bank approved a US\$ 1 billion loan³¹ towards India's Pradhan Mantri-Ayushman Bharat Health Infrastructure Mission, which relies heavily on private sector participation.

IFC is the World Bank's private equity investment arm and a multilateral DFI that started lending to the health sector in the late 1990s. Its first loan was in 1997 to establish a private hospital in Kolkata. Its lending in the health sector was predominately focused on private hospitals and the expansion of private pharmaceutical production. IFC's activity further expanded from 2005, with 13 loans provided in 2000s³². Companies receiving IFC investments had 142 million healthcare users by 2017, and the IFC aims to increase this eightfold by 2030³³. A recent article by a private equity specialist at the IFC noted the health sector as one of its best-performing sectors in terms of returns on investment³⁴. IFC aligns with the World Bank's strategy for promoting the private healthcare sector in India. They have prepared a guide for investors in private healthcare in emerging markets through their Health and Education Advisory Services.³⁵ The compilation of data³⁶ from 1999 to 2016 demonstrates that IFC has made equity investments and/or given loans to many healthcare companies in India. Many of those are either Pan-India or multinational hospital chains, for example, Max Healthcare, Apollo health enterprises, Fortis Healthcare, Portea Medical,

Healthcare Global (HCG) enterprise and Super Religare laboratories.

Other DFIs investments

While IFC is the largest investor in private healthcare companies including hospitals, other DFIs have become increasingly active in the healthcare sector. Bilateral DFIs³⁷ based in other countries supporting private health investments in India include: UK (Commonwealth Development Corporation or British International Investment), Germany (Deutsche Investitions- und Entwicklungsgesellschaft (DEG), Sweden (Swedfund) and the US Overseas Private Investment Corporation (OPIC).

United Kingdom's BII - until recently termed "Commonwealth Development Corporation (CDC)³⁸" - has invested heavily in several private health facilities in India. Compilation of data from 2007 to 2019³⁹ shows that the CDC group invested more than USD 150 million in India's private healthcare sector. CDC engages in partnerships with several private funds which have invested on a large scale in healthcare companies across India⁴⁰.

The Swedish development finance institution- Swedfund has invested in India in Medica Synergie in 2013. It has also invested through Quadria capital in the Indian Fund HealthQuad II (2020) to support early-stage private companies in the health sector⁴¹.

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- 31 Healthworld, from the Economic Times. India gets \$1.75 bn World Bank loan for health, private investment. 2022. (Cited 2023 Jan 28). Available [India gets \\$1.75 bn World Bank loan for health, private investment, ET HealthWorld \(indiatimes.com\)](https://www.indiatimes.com/HealthWorld/indiatimes.com)
- 32 Engel S. The multilateral development banks, COVID-19 and health privatisation in India. Public Services International. 2021.
- 33 IFC.Private Healthcare in Emerging Markets: An Investor's Perspective.2017. Issue 5. (Cited 2023 Jan 28). Available from- <http://documents.worldbank.org/curated/en/547661510751676837/pdf/121273-NEWS-IFC-HealthNewsletter-issue-5-PUBLIC.pdf>
- 34 Mirza, N. Analysis: Returns and Impact from Healthcare Investment in Emerging Markets. Health Investor Asia.2018. (Cited 2023 Jan 29). Available from- www.healthinvestorasia.com/Show Article.aspx?ID=3845
- 35 IFC International Health Conference 2011: Private Health Care Is Growing Rapidly in Emerging Market Countries, Says IFC. (Cited 2023 Jan 29). Available from- https://www.ifc.org/wps/wcm/connect/bec6d7804970befd9694d6336b93d75f/Health2011_FS.pdf?MOD=AJPERES, accessed on 6 November 2017.
- 36 Chakravarthi I, Roy B, Mukhopadhyay I and Barria S. Investing in Health: Healthcare Industry in India. Economic & Political Weekly.2017. 52(45): 50–56.
- 37 Bilateral DFIs are either independent institutions, such as the Netherlands Development Finance Company (FMO), or part of larger bilateral development banks, such as the German Investment and Development Company (DEG), which is part of the German development bank KfW. They are both among the largest DFIs worldwide.for example- CDC, DEG, Swedfund
- 38 CDC Group was originally named the Colonial Development Corporation, which was then changed to the Commonwealth Development Corporation. The organization is now known simply as CDC Group.
- 39 Hunter BM. Investor States: Global Health at the End of Aid. Cambridge: Cambridge University Press.2023 (Forthcoming)
- 40 Chakravarthi I, Roy B, Mukhopadhyay I and Barria S. Investing in Health: Healthcare Industry in India. Economic & Political Weekly.2017. 52(45): 50–56.
- 41 Swedfund. Swedfund's investment creates new opportunities for Indian healthcare.2020. (Cited 2023 Jan 29). Available from- <https://www.swedfund.se/en/about-swedfund/mynewsdesk/#/pressreleases/swedfunds-investment-creates-new-opportunities-for-indian-healthcare-3015940>

Details of German DFI are discussed at length in a separate section below.

DFI financing towards the COVID-19 pandemic in India

Four multilateral development banks, namely World Bank Group (WBG), Asian Development Bank (ADB), New Development Bank (NDB) and Asian Infrastructure Investment Bank (AIIB), provided large loans amounting to more than \$5.8 billion to support health system preparedness towards the COVID-19 pandemic in India, from the start of 2020 to the end of June 2021⁴². The ADB also provided \$300m for Strengthening Comprehensive Primary Health Care in Urban Areas⁴³.

Furthermore, the IFC was assigned a significant role in the World Bank's efforts to tackle COVID-19 through financing private health actors and promoting further privatisation of healthcare. IFIs approved 16 health loans, grants and technical assistance projects for health sector in India from 1st Jan 2020- 5th July 2022⁴⁴. However, as noted in a recent Oxfam report⁴⁵, a large portion of pandemic preparedness projects in India did not substantially contribute to the long-term strengthening of India's public health system through addressing staff shortages, working conditions, or treatment facilities, which was a matter of concern.

II. Mapping financial support by German developmental agencies to the healthcare sector in India

DEG investment portfolio

DEG (Deutsche Investitions- und Entwicklungsgesellschaft) is a German government-owned DFI and is responsible for working with private enterprises that invest in developing countries and emerging economies. DEG aims to contribute to achievement of various SDGs, including good health and well-being⁴⁶. DEG continues to invest in profitable and long-term private enterprises that contribute to sustainable development in line with the United Nations 2030 Sustainable Development Goals Agenda. For more than five decades, DEG operates as a subsidiary of KfW (Kreditanstalt für Wiederaufbau), and maintains itself as a "reliable partner to private-sector companies operating in developing and emerging countries"⁴⁷.

Globally DEG ranks as the third-largest bilateral DFI as of 2021⁴⁸, with a portfolio worth Euro 9.2 billion in 2022. It finances investments in nearly 80 countries, with a total of 336 active projects. In 2021, DEG made a new commitment of Euro 499 million in Asia, the second-highest among various regions, aiming for sustainable development impact⁴⁹. Despite the COVID pandemic, DEG committed more than Euro 1.4 billion in 2020 and Euro 1.5

42 Oxfam India. Overlooking the fundamentals: An analysis of international financial institutions' COVID-19 era health and education projects in India. 2022

43 Ibid. Oxfam India, 2022

44 Ibid. Oxfam India, 2022

45 Ibid. Oxfam India 2022

46 KfW-DEG. More than finance: We shape transformation DEG at a glance. 2022. (Cited 2023 Jan 29). Available from- https://www.deginvest.de/DEG-Dokumente/Download-Center/DEG_Imageflyer_2022_EN.pdf

47 Mann K. Development Finance Institutions as Tools For Foreign Aid Distribution: A Comparative Analysis of the Overseas Private Investment Corporation, FinDev Canada and Deutsche Investitions – und Entwicklungsgesellschaft. University of Windsor. 2019. Major Papers. 83. (cited 2023 Jan 20). Available from-<https://scholar.uwindsor.ca/major-papers/83>

48 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

49 KfW-DEG. More than finance: We shape transformation DEG at a glance. 2022.

billion in 2021, to finance private investments in developing and emerging countries. In 2021, via advisory and promotional programmes, DEG committed Euro 62 million for 179 projects, a high proportion of which is again related to Covid-19 response measures in healthcare and prevention. The geographic distribution of its 2021 portfolio shows that Asia has the highest share, with 30% of DEG's total investments⁵⁰.

DEG's healthcare commitments in India

DEG has been active in India since 1964 in various sectors, including healthcare sector. It has made direct and indirect commitments to a range of private healthcare companies including pharmaceutical, medical equipment, biotechnology, and big private hospitals (Annexure 1). Except for COVID response financing to Medica hospital in 2020-21 in the form of standard grant, all other financing was made as private equity funds. Since 2009, DEG has financed six large private hospitals in India, mostly as private equity or quasi-equity loans. Ivy Health and Life Sciences Pvt. Ltd, in Punjab was the first private hospital to receive direct investments from DEG over last two decades, aligning with DEG's goal of promoting private-sector investment in the healthcare sector. However, most commitments have been made through fund managers or financial intermediaries, with Quadria Capital being a significant funding vehicle⁵¹.

Role of fund managers and transparency issues

The limited transparency of DFIs has been widely recognised, and DEG is no exception^{52,53}. Transparency issues in DEG's functioning

are evident in different ways, including lack of disclosure of investment details and country-wise data, and insufficient reporting on social impacts of the development financing and their policies. These challenges have been noted by other researchers too⁵⁴. During this study we did not receive any substantial responses from DEG, despite specific queries for information made to them. Very limited information about GDFI investments in Indian private hospitals is available in the public domain, and concerned officials appear reluctant to share information even when requested. According to the DFI Transparency Index 2023, among non-sovereign DFIs DEG ranks 11th with a score of 27.7 out of 100, highlighting the significant need for enhancing transparency in their financing practices⁵⁵.

Financing by DEG is frequently routed through globally operating financial intermediaries, which presents further challenges related to transparency and accountability. Tracking of investments made through intermediary funds is more challenging than direct investments⁵⁶. Although DEG's annual reports include a list of direct investments in various companies, including fund management and intermediary companies, they do not provide details about the subsequent recipients of investments from these intermediary sub-projects or sub-granting. For example, although DEG's investment in Quadria Capital was reported in their annual reports, subsequent investments made by Quadria Capital in private hospitals such as Asian Institute of Gastroenterology or Krishna Institute of Medical Science were not mentioned. While these sub-project investments are displayed in the respective portfolios on Quadria Capital's website, it

50 KfW-DEG. Portfolio. 2022 (Cited 2023 Jan 29). Available from- <https://www.deginvest.de/Unsere-Investitionen/Portfolio/index-2.html>

51 Quadria Capital, headquartered in Singapore, is an independent healthcare focused private equity firm that specializes in growth capital investments in small cap and middle-market companies within the healthcare sector across South and Southeast Asia. It manages capital for some of the most prestigious and prominent institutions, including several state backed funds, global pension funds to influential multinational corporations and family offices. Its investor base is diverse globally and spread across the US, Europe and Asia.

52 DFI transparency index 2023. (Cited 2023 May 29). Available from- [DFI Transparency Index 2023 - Publish What You Fund](https://www.publishwhatyoufund.org/2023/01/2-trillion-in-public-assets-but-little-transparency/)

53 Publish what you fund. (Cited 2023 May 29). Available from- <https://www.publishwhatyoufund.org/2023/01/2-trillion-in-public-assets-but-little-transparency/>

54 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).

55 Ibid. DFI transparency index 2023.

56 Romero M. A Private Affair: Shining a light on the shadowy institutions giving public support to private companies and taking over the development agenda. 2014. Brussels: Eurodad

is difficult to establish a direct relationship between DEG investments and the sub-projects, since Quadria Capital receives investments from multiple investment companies. Currently, Quadria Capital's healthcare portfolio displays investments⁵⁷ in 17 healthcare companies from Asia, of which 11 are based in India. The primary sources of investments are not provided for any of these projects. Such mediated financial arrangements inherently make public investments non-transparent. As noted by some scholars, such practices obstruct effective monitoring of DFI activities by both civil society and governments and undermine country ownership⁵⁸. Additionally, DEG's involvement in providing support to the private healthcare sector in India through Quadria Capital, which is based in Singapore, raises certain concerns. Singapore 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 funds⁵⁹. DEG's major involvement in a commercial private equity fund based in a tax haven, adds a further layer of complexity and opacity to their investment practices which are supposed to be socially accountable.

DEG's support to India during the COVID pandemic

DEG made direct commitments to a major private hospital in India during the pandemic. In response to the pandemic, DEG pledged financial assistance of Euro 2.875 million to the Medica hospital chain in 2020 and 2021, primarily through the develoPPP program⁶⁰. These funds were used to help this hospital build necessary infrastructure and for purchasing equipment to treat COVID patients⁶¹.

DEG finances the fight against Covid-19 in eastern India⁶²

With DEG's support, Medica hospital undertook two major initiatives to respond to the COVID-19 crisis in Kolkata, India. Firstly, Medica refurbished a police hospital that had been unoccupied for 15 years, transforming it into a 300-bed treatment facility for moderate and severe COVID cases. The renovation was completed within a remarkably short period of two weeks. Additionally, Medica also converted the site of a sports stadium in Kolkata into a fully equipped temporary COVID hospital with a capacity of 300 patients

KfW's healthcare commitments in India

Besides DEG, other German government-owned institutions like KfW, BMZ and GIZ also make major financial commitments related to healthcare in India. Unlike DEG, these institutions make direct commitments (without involving intermediaries). These institutions have partnered with government departments, NGOs, private bodies, PPPs, and research institutes from developing countries.

KfW (Kreditanstalt für Wiederaufbau-Credit Institute for Reconstruction) is a German state-owned investment and development bank. As of 2014, it is the world's largest national development bank, and as of 2018 it was Germany's third largest bank by balance sheet. It supported healthcare projects through promotional and development loans amounting to Euro 845 million as of 2019, with more than half of the funds (55%) given to Asia/Oceania⁶³.

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

58 Hunter B.M, Marriott A. 2017

59 Vervynckt M. Going Offshore. Eurodad. 2014.

60 KfW. 2021. develoPPP program (Cited 2023 Jan 29). Available from- [develoPPP Program | DEG \(deginvest.de\)](#), [DEG finances the fight against Covid-19 in eastern India | KfW Stories](#).

61 Ibid. KfW. develoPPP program.2021

62 Ibid. KfW. develoPPP program.2021

63 KfW Development Bank.2019. (Cited 2023 Jan 29). Available from- <https://www.kfw-entwicklungsbank.de/International-financing/KfW-Development-Bank/Topics/Health/>

Although KfW primarily supports India to address climate change and achieve development goals⁶⁴, it has occasionally committed to the health sector in India. In 2014, it supported the Basic Health West Bengal project. During the COVID-19 pandemic in 2020, it committed Euro 490 million out of a total of Euro 1.1 billion for coronavirus emergency aid programs in Asian countries⁶⁵. KfW also provided Euro 300 million in funds to the Indian Ministry of Health and Family Welfare in 2020-21 for procuring medical supplies related to COVID-19 through UNICEF (United Nations International Children's Emergency Fund)⁶⁶.

Additionally, KfW supported the Indian government with a COVID-19 Social Protection Crisis Response Programme⁶⁷ in August 2020, which was a parallel financing with the World Bank, and included participation from other bilateral and multilateral donors. The program aimed to provide the Indian government with up to Euro 460 million for additional social security measures, the total cost of which was around USD 23 billion. KfW's support during the first phase was to provide additional food to 800 million people and cash transfers to 320 million affected individuals in an effort to cope with the coronavirus crisis quickly. However, no documentation is available in the public domain to evaluate the utilisation of this support against its objectives.

Healthcare commitments of BMZ and GIZ in India

BMZ (Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung), the German Federal Ministry for Economic Cooperation and Development, plays a leadership role in setting

Germany's development cooperation policies while GIZ (Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH), the German Agency for International Cooperation, is a state-owned company that implements the majority of BMZ's technical development cooperation. GIZ acts as a service provider in the field of international cooperation for sustainable development with focus on vocational training, energy and climate, health, infrastructure and construction, water, and good governance. BMZ and a few other ministries are the main commissioning parties of GIZ in India. India is one of the "global partners" of BMZ. As part of Indo-German cooperation formed in May 2022, Germany plans to invest at least ten billion euros for the period up to 2030⁶⁸.

The project database of BMZ and GIZ in India shows 29 projects from year 2010 to 2022 (Annexure 3). Most of these commitments were with either state or union governments, or in some cases with NGOs, and were in the form of standard grants or low-interest loans. Basic health program, basic health infrastructure program and social security programs seem to be long term programs supported by BMZ in various Indian states. BMZ has consistently supported health insurance programs under the rubric of improving social security and social health protection. The BMZ considers social protection a key element of the SDGs as it bridges the goals required for successfully implementing the 2030 Agenda and the Leave No One Behind principle⁶⁹ (BMZ, 2017).

Indo-German Social Security Programme (2011-2020)⁷⁰ and IG-UHC (2020-2023)⁷¹ are two prominent programs of BMZ in collaboration with the Ministry of Health and Family Welfare (MoHFW),

64 KfW. (Cited 2023 Jan 29). Available from- [KfW - Countries](#)

65 KfW. (Cited 2023 Jan 29). Available from- [Asia | KfW Development Bank \(kfw-entwicklungsbank.de\)](#)

66 Email communication from KfW official in May 2022 and KfW Development Bank news.2020 https://www.kfw-entwicklungsbank.de/International-financing/KfW-Development-Bank/About-us/News/News-Details_618496.html

67 KfW. 2022. (Cited 2023 Jan 29). Available from- https://www.kfw.de/About-KfW/Newsroom/Latest-News/Pressemitteilungen-Details_603008.html [Social security for India during the coronavirus pandemic](#)

68 BMZ. (Cited 2023 Jan 29). Available from- <https://www.bmz.de/en/countries/india>, https://www.bmz.de/en/countries/india#anc=id_49168_49168

69 BMZ. Social protection for equitable development. BMZ position paper. 2017. (cited 2023 Feb5). Available from- www.bmz.de/en/publications/type_of_publication/strategies/Strategiepapier420_09_2017.pdf

70 GIZ. (Cited 2023 Feb 1). Available from- <https://www.giz.de/en/worldwide/15859.html>

71 GIZ. (Cited 2023 Feb 1). Available from- <https://www.giz.de/en/worldwide/89546.html>

Government of India. It is notable that both these national programs are focussed on Health insurance schemes involving commercial private providers on large scale.

In the past, from 2008 to 2018, the Indo-German Social Security programme provided advisory support to MoHFW on the implementation of the Rashtriya Swasthya Bima Yojana (RSBY). The scheme aimed to provide publicly funded health protection to poor and informal workers and their families. RSBY was one of the world's largest health insurance schemes in terms of the number of beneficiaries with coverage to around 11.8 million hospitalisations in more than 10,000 registered hospitals⁷². Despite large numerical coverage, RSBY suffered from a wide range of structural problems which have been noted by numerous scholars^{73,74,75,76}. Certain large states like Maharashtra experienced very low effectiveness of the scheme⁷⁷ and decided to close down the programme. After discontinuation of RSBY, MoHFW and the newly established National Health Authority (NHA) supported designing of a new major health reform which entails setting up a national health insurance scheme called PM-JAY. The IG-UHC aims to advance India's journey towards achieving UHC. It provides technical cooperation to the ministry and the newly founded National Health Authority on implementation of PM-JAY. In a subsequent section, we probe into the role of the IG-UHC program linked with brief analysis of performance of PM-JAY.

III. Case study of DEG-financed private hospital from India

DEG claims that⁷⁸ *“The healthcare services co-financed by DEG are open to all sections of the population. The high financial outlay for medical equipment and specialist staff makes it necessary to charge for goods and services. **To ensure that these are also accessible to poorer sections of the population, DEG attaches great importance to enabling these people to benefit from healthcare. For this reason, DEG supports its customers in providing the poorer classes with cheaper or free treatments.** This happens, for example, within the framework of social plans for the treatment of children, the provision of free ambulances in the event of accidents in the vicinity of the hospitals or through treatment plans with local companies”.* (Emphasis added)

This case study aims to explore the practices of a corporate hospital which has received major financing from DEG, viewing this from a patients' perspective while examining whether the hospital ensures accessible healthcare for patients from economically deprived sections as claimed by DEG.

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. DEG, through Quadria Capital,

72 Birdsall K. Health insurance for India's poor. GiZ.2016. (Cited 2023 Feb 1). Available from [Health insurance for India's poor – Healthy DEvelopments \(bmz.de\)](https://www.giz.de/Projekte/Health_insurance_for_India's_poor_-_Healthy_Developments_(bmz.de))

73 Bandyopadhyay S, Sen K. Challenges of Rashtriya Swasthya Bima Yojana (RSBY) in West Bengal, India: An exploratory study. *International Journal of Health Planning and Management*.2017. 33(11)

74 Narayana D. Review of the Rashtriya Swasthya Bima Yojana, *Economic and Political Weekly*.201 Vol. 45, Issue No. 29

75 Das S, Naskar S, Das D, What Went Wrong with Rashtriya Swasthya Bima Yojana *CHRISMED. Journal of Health and Research*. 2021. 8(3), Jul-Sep 2021.

76 S Nandi, M Nundy, V Prasad, K Kanungo, H Khan, S Haripriya et al. The Implementation of RSBY in Chhattisgarh, India: A study of the Durg district, *Health, Culture and Society*.2012. Volume 2, No. 1

77 Ghosh S. Publicly-financed health insurance for the poor understanding RSBY in Maharashtra. *Economic & Political Weekly*. 2014;46(20), 93-99.

78 German parliament response. German Bundestag 19th electoral period. February 2020.

acquired a majority stake in ABC hospital⁷⁹ in 2013. The investment was meant to facilitate the growth of ABC hospital's network to over 1300 beds and to provide greater access to high-quality medical care in the region⁸⁰. Since the investment in 2013, the number of beds has quadrupled, and the hospital treated almost 500,000 patients a year as of 2019⁸¹. The ABC hospital is recognised as the largest integrated healthcare provider in the region. The hospital defines its goal as *"to serve patients from middle and low socio-economic backgrounds, thereby reducing the healthcare inequalities that exist in India – in both quantitative and qualitative terms"*⁸². It claims that the hospital has succeeded not only in substantially increasing its income but also in offering high quality, affordable healthcare for the numerous patients from the region who are economically disadvantaged. DEG provided large-scale financial assistance to this hospital for building infrastructure and purchasing equipment which was critical for COVID treatment.

The genesis

Until 2006, ABC hospital was a small 25-bedded ENT hospital. However after this, a group of like-minded doctors joined together to fulfil their idea of building a chain of hospitals in the region. An ex-minister played a significant role in securing the land for the hospital, who later became the primary owner of the hospital. A senior staff member who had been with the hospital since its inception shared that the hospital-acquired around 1,72,000 sq. ft of land from the municipal corporation on a lifetime lease agreement at a reduced price. In return, the hospital agreed to provide 35% subsidised care to poor people, which is still in effect today⁸³. The construction of the enlarged hospital was completed in 2008, and the 500-bedded super specialty hospital began its operations in 2010. Initially, the hospital took loans from Indian banks, and later (2013-14), DEG made a major investment.

According to study respondents, the hospital's top management was eager for investments, and funds came in from various sources. However, the staff was not informed about the investor details, and only a few respondents were aware of the funding from Quadria Capital. Some senior staff members who had been with ABC hospital since 2008 shared that different investors had come and gone over time, but they were never informed about any German investment.

'It was a fantastic management earlier, but slowly things started changing'

According to several respondents, there were gradual changes in management practices at ABC hospital, with notable changes occurring in the approach towards the staff post-2014-15. A senior doctor shared that, *'Initially, the top management was fantastic, and senior doctors were invited and consulted in management meetings. However, over time the management circle gradually became smaller with the exclusion of senior doctors who were earlier consulted. At the same time, the top management started including non-medical personnel in the hospital management.'*

These changes in management practices impacted upon the working conditions for doctors and other staff. Respondents reported that the management introduced mechanisms for monitoring doctors' work, such as placing CCTVs in their cabins, which were monitored by non-medical staff. Such interference by the management in doctors' work created dissatisfaction among many doctors. While some clinical targets always existed in ABC hospital, according to senior doctors, post-2016, the business model changed, and it became more target and incentive-oriented. The hospital had experienced sharp attrition of human resources, including doctors and nurses. Respondents explained that some senior doctors who had been

79 The hospital name as well as specific details which could serve as direct or indirect identifiers, are not disclosed.

80 News on project. 2013. The specific source of information and its citation is not given to maintain anonymity of the private hospital.

81 DEG report.2019. Specific citation is not given to maintain anonymity of the private hospital.

82 The specific source of information and its citation is not given to maintain anonymity of the private hospital.

83 Scrutiny of hospital website and annual reports for last five years make no mention of provision of free care as per the agreement with municipal corporation. Also, we could not obtain information from the hospital management (as emails from researchers were not responded to by the hospital management) regarding implementation of this conditionality in the present circumstances.

with the hospital since its founding years, were now unhappy with the changed working conditions and constrained autonomy and left. The same trend was reported among non-medical staff as well. One senior doctor reflected that no investor would ask the hospital to make such changes. However, it was a consciously adopted policy of the top management, aiming to bring in fresh people who would be amenable to the new policies. There were also examples of how many members of the earlier staff were shunted out by the management around 2014-2016.

'Subsidised or free care to poor people? Even horses will laugh!'

The hospital is supposed to provide subsidised or free care to a definite percentage of poor patients as part of their commitments linked with DEG investments and land lease agreement with the corporation. However, respondents have noted that the hospital's patient care approach has changed over time. A senior doctor shared that, *'Initially, the hospital management emphasised that no patient should leave without treatment. It was quite significant and we followed it'*. However, as the hospital became more business-oriented, its approach became business-oriented. When we asked one senior specialist doctor (who is a member of a state level official committee) about the provision of subsidised or free care to patients by ABC hospital, he exclaimed that *'...even horses will laugh at such question! It is a business hospital following the typical corporate approach, which does not provide free or subsidised care, except for some concessions on case-to-case basis mostly with some reference or recommendation'*.

According to many of our respondents, the public perception about this hospital is that only those who have a good private insurance package or sufficient money, should seek treatment there. According to respondents, initially the hospital had more patients who paid in cash, or patients who were subsidised by official schemes, but this has now shifted to emphasis on commercial insurance-supported and corporate patients. Many patients tend to shy away from ABC hospital, they might go there for

outpatient care but for more expensive operative care, would prefer to seek care elsewhere. A patient activist stated that, *'The ABC hospital is run like a hotel. We do not recommend it to anybody. It is kind of infamous. People do not have a positive view about it'*.

A senior doctor explained that earlier the hospital used to be very helpful with concessions granted by individual doctors to patients. However, after 2013-14, doctors were not allowed to give discounts to patients without management's approval. Also, the hospital took a 20% share of the doctor fees, which is double that of most hospitals in the region. The hospital increased charges only on those items where the revenue went to the hospital entirely, unlike doctor's fees which primarily went to the doctors. The hospital management took decisions regarding such matters unilaterally without taking doctors on board. According to another senior doctor, *"somewhere around 2013-14 things changed, and doctors' freedom was lost. The ability to give concession in one's personal fees charged to patients was also stopped, so those things were where we found our say went down."*

Respondents witnessed a striking change in patient profiles when the hospital shifted from an ENT (Ear-Nose-Throat) hospital to the current large multi-speciality hospital. The hospital used to actively take patients covered by various government schemes up to 2012, primarily to promote the hospital's functioning. However, from 2013 onwards, when the hospital started running well, their policies regarding such scheme patients changed. The State government health insurance scheme was officially launched in 2016 to provide healthcare coverage to the economically weaker section of the population. According to a non-medical staff member, *'the hospital only took this scheme because of government pressure. Many other big private hospitals in the region are similarly reluctant to take official scheme patients'*. According to some respondents, the hospital is reluctant to take state insurance scheme patients, and either refuses to take them, or charges them extra in various possible ways.

‘Money-minded hospital with unaffordable treatment’

After analysing online reviews from four prominent websites⁸⁴ spanning from 2017 to 2022, we found that out of 892 patient reviews, 68% (593) reviews for ABC hospital were negative, while only 32% (299) were positive. Among the 593 negative reviews, 111 complaints were related to non-transparent and excessive billing. Additionally, we examined complaints filed by patients to the state’s Clinical Establishment regulatory body^{85, 86} regarding ABC hospital. Over five years, from 2017 to 2022, there were 36 formal 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.

Respondents shared that in 2014-15, there was a big uproar about a kidney transplantation racket in the region, and ABC hospital was alleged to be involved in it. Consequently, its license was suspended by the state for kidney transplant procedures, which was widely reported in the media⁸⁷.

During the second wave of the COVID-19 pandemic, ABC hospital purchased a large number of ECMO (Extracorporeal Membrane Oxygenation) machines with assistance from DEG. However, some respondents opined that the hospital used these sophisticated machines as a medium to earn money from critically ill patients. Respondents reported that some patients admitted to the ICCU (Intensive Critical Care Unit) were charged up to INR 60,000 (around € 668) per day. A state COVID task force member opined that, *‘the decision to use an ECMO machine was not always based on scientific clinical decisions but was rather linked with the patient’s economic status and ability to pay. Clearly,*

it’s a money-minded hospital with unaffordable treatment’. Despite receiving financial assistance from DEG, there were reports of denial of care by ABC hospital to official scheme patients during the COVID-19 pandemic, with directly paying patients being given preference. The following cases also showcase how this hospital engaged certain agents, and decided on whether to give admission based on assessing the patient’s paying capacity (box 1). Various media reports have documented such incidents⁸⁸ where COVID patients were denied treatment by this hospital.

‘Giant player in medical tourism’

According to India Tourism statistics 2014⁸⁹, the region in which ABC hospital is situated is considered a popular medical tourism destination for cost-sensitive patients from lower and middle-income countries such as Bangladesh, Afghanistan, Nepal, Myanmar, Bhutan, Pakistan, and Nigeria. This demographic makes up a significant portion of India’s medical tourism demand, comprising roughly 40% in 2013.

We inquired about medical tourism at ABC hospital and learned that it is one of the major players in the industry, similar to other corporate hospitals in the area. A non-medical staff member mentioned that, *‘ABC hospital is a giant player in medical tourism in the region’*. ABC hospital has a separate cabin for international patients, and has a dedicated department for international marketing. It began offering medical tourism services from 2012-2013. They initially focused on countries such as Bangladesh, Bhutan, and Nepal. Furthermore, ABC hospital conducts camps and conferences in targeted countries to promote medical tourism, focusing on cardiac, orthopaedic, and neurosurgery specialities. Approximately 10% of the hospital’s

84 Following websites were accessed to see the patients’ review regarding the hospital- mouthshut.com, consumercomplaints.in, google.com and facebook.com.

85 The name of the state is not disclosed to maintain the anonymity of the hospital. Also, specific links to media reports and commission have not been mentioned owing to the same reason.

86 The Times of India, 2020. Specific citation is not given to maintain anonymity of the private hospital.

87 Indian Express, Feb, 2009; Statesman, April 2018. Specific citation is not given to maintain anonymity of the private hospital.

88 Millenium post, Dec 2020. Specific citation is not given to maintain anonymity of the private hospital.

89 India Tourism Statistics (2014) India tourism statistics. Ministry of Tourism, Government of India. 2013. (cited 2023 Feb5). Available from-www.tourism.gov.in



No entry to official scheme patients during the pandemic

Patient story 1

Patient Story 1: My father was diagnosed with COVID-19 and his doctor recommended that he should be admitted to a hospital. I wanted to admit him to ABC Hospital because he had undergone a successful operation there under the state employee scheme in 2018. We had been regularly visiting it every three months. I contacted ABC Hospital for admission, but they refused to admit my father after knowing that he was a state scheme cardholder, meaning that although entitled to care he would not be paying the higher, commercial rates paid by directly paying patients. Despite my repeated attempts to reach them, they would pick up the phone and hang up.

Patient Story 2

My mother was admitted to a hospital where the doctors advised us to shift her to a more advanced hospital for critical treatment. Since most hospitals in the area were running out of beds, I asked several people to check and inform me about the availability of beds. One day, I received a call from an agent claiming to be from ABC Hospital (I later found out that he was not a staff member but the hospital's agent), who asked me for my mother's medical details. The agent advised me not to disclose that I had a state scheme card for my mother, or else ABC Hospital staff would refuse admission. A few days later, three to four staff members, including a doctor from ABC Hospital, contacted me to discuss my financial capacity. They offered me a 10-day package for 4.5 lakhs (around € 5000), along with need to pay additional fees for longer stay, and specific services at an additional cost. They also clarified that even if the patient is discharged before the end of the package, the full amount must be paid. After my agreeing to this, another staff member from ABC Hospital called me the next day for more details. She asked me if I had a scheme card for any subsidised care, and I informed her that I had a scheme card with coverage of one lakh, but I was willing to pay in cash as well. She then requested me to send her the card's photo on WhatsApp, which I did immediately. However, all communication suddenly stopped after that. They never called me back or responded to my follow-up calls and messages. With all the call details and WhatsApp reports, we filed a complaint with the state commission. As a result, ABC Hospital was penalised one lakh for refusing to treat a patient with an official scheme card.



patients are foreigners⁹⁰. Interestingly, commercial facilities like several guest houses and flats for rent have emerged in the vicinity of ABC hospital in response to the demand for accommodations for international patients and their families.

IV. Case study of BMZ-supported Indo German-Universal Health Coverage⁹¹ program for India's national health insurance scheme (PM-JAY)

The German Federal Ministry for Economic Cooperation and Development (BMZ) has been supporting the Indo-German Universal Health Coverage (IG-UHC) programme during 2020-2023. This case study aims to explore the role of IG-UHC program in providing technical assistance for the implementation of PM-JAY, within the context of related health system issues, while briefly analysing the performance of PM-JAY based on existing literature that assesses various aspects of the scheme.

About the IG-UHC program

The IG-UHC programme of BMZ in partnership with the Ministry of Health and Family Welfare (MoHFW), Government of India involves financial commitment of USD 15,195,150⁹², and is the largest among ongoing commitments by BMZ in the health sector in India. The IG-UHC program's activities primarily focus⁹³ on the implementation of Ayushman Bharat PM-JAY, the Union government's flagship health insurance scheme. The program articulates its objective as follows- *Indo-German Programme*

*on Universal Health Coverage (IGUHC) aims to improve the conditions for achieving Universal Health Coverage in India by strengthening the implementation of the PM-JAY, in terms of quality, scope and availability of health services.*⁹⁴

IG-UHC program works closely with the National Health Authority (NHA) and selected state governments to provide policy advice and implementation support in UHC, Health Systems Strengthening, Social Health Insurance, and health security. The program also encourages the convergence of existing insurance schemes, especially at the state level, under the flagship of PM-JAY.

IG-UHC provides technical assistance to NHA and MoHFW through over 60 consultants working with Health Authorities at the national level and across different Indian states for the implementation of AB-PM-JAY. Their technical assistance includes training and capacity development, research, and evaluation, strengthening Information Technology and monitoring systems, IEC (Information, Education and Communication), and operational support.

About the PM-JAY scheme⁹⁵

PM-JAY is a flagship scheme of the Government of India that was launched in 2018 with the goal of achieving UHC. PM-JAY covers secondary and tertiary healthcare-related costs of up to 500,000 Indian rupees (about €6,300) per family per year. The scheme covers around 1330 medical procedures, and its objective is to cover the "bottom 40%" of India's population, which translates to approximately 500 million poor and vulnerable individuals.

90 A book published by Springer in 2019 gives details about medical tourism. Specific citation is not given to maintain anonymity of the private hospital.

91 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-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)). See end note for elaboration on our position regarding the term-UHC.

92 GIZ. (cited 2023 Feb5). Available from- <https://www.giz.de/en/worldwide/89546.html>

93 IG-UHC. (cited 2023 Feb5). Available from- <https://iguhc.in/policy-advise/>

94 Indo-German Programme on Universal Health Coverage. Available from - https://iguhc.in/wp-content/uploads/2022/02/IGUHC-project-factsheet_RFA.pdf

95 National Health Authority. (cited 2023 Feb). Available from- <https://nha.gov.in/PM-JAY>

When PM-JAY was launched in September 2018, it was under the oversight and management of the newly established National Health Agency, a body created by Cabinet decision, vested with full functional autonomy, though organizationally an “attached office” of the health ministry⁹⁶. In January 2019, the National Health Agency was converted into the National Health Authority. PM-JAY subsumed RSBY and the states were provided with considerable flexibility to converge their existing schemes with it. As of December 2021, 33 out of 36 states/union territories are implementing PM-JAY scheme,⁹⁷ which involves a total of 28,311 hospitals including private and government hospitals, of which 46% are private hospitals.

German government’s technical assistance to UHC-related reforms in India

Since over a decade, BMZ and GIZ have supported the development of social health insurance and health security schemes in India, with the stated objective of achieving UHC. While respondents acknowledged the positive impact of efforts of developed countries to advance UHC in developing countries, they also expressed concerns about how the support is rolled out between the donor and recipient entities.

According to an ex-consultant from India’s social security and health program, *‘the German government provides two types of support to India: investments and loans to support the state and central governments on specific themes, and technical assistance that does not involve investment. The German government provides technical advisory support to India based on requests from the Indian state or central governments. The support is sanctioned if the request aligns with the German government’s interests and both parties agree. The IG-UHC program is confined to demand-driven support, while policy decisions are always*

taken by the Indian government’. GIZ document on Sector Strategy on Social Protection, categorically mentions that, *‘the initiative for the establishment, extension or modification of social protection systems has to come from the respective partner country and Germany does not want to export European models of social protection’*.

Other respondents described the model of support as GIZ/BMZ hiring a cadre of consultants for the particular program who design its structure and provide technical inputs for implementation. As mentioned earlier, GDC has deployed more than 60 professional consultants to different states. At the national level, several GDC staff members have been embedded in the NHA and work as a part of its team. GDC also regularly responds to a wide range of short-term technical assistance requests from NHA⁹⁸. A senior health activist shared that *‘while these consultants may have valuable knowledge and experience, they are paid high salaries matching those in Germany and are expected to follow guidance from abroad. Instead of paying high salaries to these consultants, the government should consider using foreign support to increase the salaries of frontline health workers in India’*.

With regards to the consultants’ 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’⁹⁹”*.

Respondents also highlighted the issue of limited contextual understanding among German consultants, even if they consult with some experts from India, who are often not from within the public health system. It is important that people involved in designing health programs have

96 Report on evolution of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, India. New Delhi: World Health Organization, Country Office for India; 2022.

97 National Health Authority. Ayushman Bharat PM-JAY. Annual report. 2021-22. (cited 2023 June 3). Available from- https://abdm.gov.in:8081/uploads/PM-JAY_Annual_Report_25_1f47b3cfa5.pdf

98 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/goodpractices.

99 Trusted partners for Universal Health Coverage. 2020. GIZ

contextual understanding and ground level insights of the health system as well as experience with communities which access healthcare. Additionally, even while such funding is provided to international consultants, grassroots-level stakeholders should have the space to provide feedback based on ground level experiences concerning actual implementation of the program. Respondents emphasised the need for checks and balances to ensure accountability throughout the system regarding the utilization of such support in any form.

Analysing performance of PM-JAY

“Cashless, paperless and portable healthcare and treatment facility provided by Ayushman Bharat-PM-JAY scheme for poor and underserved families has substantially reduced their out-of-pocket expenditure and financial bankruptcy due to severe and prolonged illness, and expensive treatment” - Dr. Mansukh Mandaviya, Union Minister for Health & Family Welfare stated this on occasion of the celebration of completing four years of implementation of PM-JAY on 25th September 2022¹⁰⁰. Although the impacts of PM-JAY are presented as a giant leap towards UHC, existing evidence presents a mixed picture of PM-JAY’s implementation. Several reports and studies have documented both positive achievements as well as major gaps and challenges in the implementation of the scheme. There is a body of evidence on PM-JAY analysing its various aspects, including awareness, empanelment of hospitals, enrolment of patients, overall functioning, and performance in terms of expenditure etc.

The achievement of UHC is grouped as Target 3.8 under SDG 3 - ‘Ensuring healthy lives and promoting well-being for all at all ages.’ UHC is measured through two indicators:

- Indicator 3.8.1 - Coverage of essential health services

- Indicator 3.8.2 - Proportion of a country’s population with catastrophic spending on health, defined as significant household expenditure on health as a share of household total consumption or income.

We discuss below the evidence in relation to these two indicators and a few other key aspects of the scheme.

Coverage and utilisation of PM-JAY

The scheme has issued more than 190 million PM-JAY cards and has provided free treatment to over 20 million beneficiaries, with 54% of them treated in private hospitals and the remaining 46% in public hospitals. While these numbers paint a positive picture of the scheme, some studies have highlighted significant gaps in its coverage and utilisation. Existing research reveals significant disparities in distribution and utilisation of scheme in terms of geography, gender, age, social groups, and balance between public and private healthcare sectors.

Although the scheme is implemented in 33 states and union territories, in Delhi, Odisha, and West Bengal state governments are yet to take up the scheme. Of the total involved providers, 60% of the PM-JAY facilities are located in just five states: Karnataka, Gujarat, Uttar Pradesh, Tamil Nadu, and Rajasthan. Among the empanelled hospitals, 40% of the hospitals offer between two and five specialties while 14% offer 21–24 specialties¹⁰¹. Geographic access also plays a crucial role in the utilisation of the scheme. Uneven distribution of empanelled private hospitals across regions limits access to insured health services¹⁰². The skewed distribution of private hospitals in states with low per capita income is an area of concern, since a significant proportion of the eligible population under PM-JAY is concentrated in these states^{103, 104}. A study from Chhattisgarh highlighted the geographical inequity

100 Press Information Bureau. Government of India. Ministry of Health and Family Welfare. Sep 2022. (cited 2023 March 12) Available from-<https://pib.gov.in/Pressreleaseshare.aspx?PRID=1861792>

101 Joseph J, Sankar D,H, Nambiar D. Empanelment of health care facilities under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) in India. PLoS ONE. 2021. 16(5): e0251814.

102 Choudhury M and Datta P. Private Hospitals in Health Insurance Network in India: A Reflection for Implementation of Ayushman Bharat. National Institute of Public Finance and Policy New Delhi. Working paper No. 254 19-February-2019

103 Joseph J, Sankar D. H and Nambiar D (2021)

104 Wagle S and Shah N. Government Funded Health Insurance Scheme in Maharashtra: Study of Rajiv Gandhi Jeevandayee Arogya Yojana. Mumbai: CEHAT.2017

in the availability of hospital services under the state-funded universal health insurance scheme¹⁰⁵. Another study found that 44% of empanelled hospitals in Maharashtra were concentrated in just six urban centres¹⁰⁶.

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 relatively higher per capita incomes like Kerala and Himachal Pradesh¹⁰⁷.

It is also evident that those most vulnerable - whether in terms of states, gender or community - may not have been able to use the scheme as much as the relatively better off. Nationally, enrolment under the scheme is almost equal for males (50.8%) and females (49.2%). However, the total value of claims are higher for males (56.4%) as compared to females (43.6%), and average per-capita claim value for males is Rs. 16,715 (around €178) compared to Rs. 13,730 (around €144) for females. Overall, 68% of high-value claims are attributed to males, although sex-based utilisation varies from state-to-state¹⁰⁸. The analysis also shows that the most vulnerable communities have not been able to use the PM-JAY scheme as expected. For instance, while Scheduled Caste (SC) and Scheduled Tribe (ST) groups together comprise approximately 28%

of India's population, at the national level, SC and ST populations contribute to only 5% and 2% of private hospital admissions respectively, since the scheme's inception¹⁰⁹.

Awareness related to PM-JAY

Public awareness is crucial in determining the success or failure of various government schemes, including PM-JAY. Studies have documented varied levels of awareness about PM-JAY across geography and socio-economic status. A study in Chennai, Tamil Nadu¹¹⁰ involving 300 households revealed that 77.33% were aware of the scheme. This is primarily due to the pre-existing state health insurance scheme, which has helped raise awareness level. However, another study from six Indian states¹¹¹ found that the more marginalised (especially Scheduled castes and Scheduled tribes) remain less aware of PM-JAY. Also, awareness was lower among respondents from Meghalaya, Tamil Nadu and Chhattisgarh. Another study from Karnataka state¹¹² found that among 1027 households, 44% were cardholders. Among the cardholders, 65% were aware of the scheme, yet only 3% of the cardholders utilised the scheme indicating a need for greater awareness levels among potential beneficiaries. Similar studies on RSBY have also highlighted a lack of awareness as a critical gap leading to non-utilisation of the scheme. PM-JAY is supposedly an upgraded and comprehensive version of RSBY, yet this still falls short in critical areas like awareness among beneficiaries.

105 Nandi S, Schneider H & Garg S. Assessing geographical inequity in availability of hospital services under the state-funded universal health insurance scheme in Chhattisgarh state, India, using a composite vulnerability index, *Global Health Action*. 2018. 11:1, 1541220, DOI: 10.1080/16549716.2018.1541220

106 Wagle S and Shah N. (2017).

107 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>.

108 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>.

109 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>

110 Sree GV VP, Maiya GR. 2021.

111 Parisi D, Srivastava S, Parmar D, Strupat C, Brennat S, Walsh C et al. Awareness of India's national health insurance scheme (PM-JAY): a cross-sectional study across six states. *Health Policy and Planning*. 38, 2023, 289–300.

112 Girish B, Surendran J, Vishma BK, Jyothika V, Tahreem S. Study on awareness and utilization of Ayushman Bharat Arogya Karnataka scheme in Chamarajanagar taluk: a cross-sectional study. *Int J Res Med Sci* 2023;11:544-50.

High Out of Pocket Expenditure on Healthcare among users of PM-JAY

Although PM-JAY has officially claimed to have substantially reduced out-of-pocket expenditure (OOPE) for poor and underserved families¹¹³, the available evidence suggests otherwise. Many studies^{114,115,116,117} have suggested that health insurance schemes in the Indian context, including the PM-JAY, have been largely ineffective in providing much-needed relief in terms of substantially reducing OOP figures. For instance, a household survey from Chhattisgarh¹¹⁸ revealed that enrolment under PM-JAY or other PFHI schemes did not increase hospital care utilisation or reduce out-of-pocket expenditure.

Furthermore, during the COVID-19 pandemic, PM-JAY's contribution to providing much-needed care was sub-optimal¹¹⁹ and enrolment under the scheme did not effectively reduce out-of-pocket expenditure. According to media reports, COVID patients constituted only 5% of PM-JAY hospitalisations at the peak of pandemic¹²⁰. Also, less than 12% of hospitalised Covid-19 patients were treated for free under the Ayushman Bharat-PM-JAY scheme¹²¹. Another study conducted during the pandemic¹²²

in Chhattisgarh state strongly corroborates these findings. The mean OOPE per hospitalisation was INR 4,871 (around €50) in public hospitals and INR 169,504 (around €1900) in private hospitals. This study reveals that around 3% of hospitalisations in public hospitals and 59% in private hospitals resulted in catastrophic expenditure. Despite operation of PM-JAY in the state, this study also depicts the continuing huge scale of OOPE, which was significantly greater for private hospitalisation than public hospitals. A study on PM-JAY in two Indian states¹²³ finds that incidence and magnitude of OOPE were significantly high, with 63% of the patients from Madhya Pradesh who sought care in private hospitals having to spend Out-of-pocket while accessing care through the scheme. Since the primary objective of PM-JAY is to make healthcare accessible to individuals and communities without financial hardship, evidence of positive impact of the scheme in terms of reducing out-of-pocket healthcare expenditure is quite limited until now. The reasons for this limited impact of PM-JAY despite large scale public investment as well as significant scale of technical support through IG-UHC need critical examination.

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- 113 Business standard. AB-PM-JAY substantially reduced out-of-pocket expenditure of poor: Mandaviya March 2023. (cited 2023 March 14) Available from-https://www.business-standard.com/article/economy-policy/ab-PM-JAY-substantially-reduced-out-of-pocket-expenditure-of-poor-mandaviya-122092400015_1.html
 - 114 Garg S, Bebartta KK, Tripathi N. Performance of India's national publicly funded health insurance scheme, Pradhan Mantri Jan Arogya Yojana (PM-JAY), in improving access and financial protection for hospital care: findings from household surveys in Chhattisgarh state. *BMC Public Health*. 2020;20:949
 - 115 Ranjan A, Dixit P, Mukhopadhyay I, Sundararaman T. Effectiveness of government strategies for financial protection against costs of hospitalization care in India. *BMC Public Health*. 2018;18(1):501. <https://doi.org/10.1186/s12889-018-5431-8>
 - 116 Garg S, Chowdhury S, Sundararaman T. Utilisation and financial protection for hospital care under publicly funded health insurance in three states in Southern India. *BMC Health Serv Res*. 2019;19:1004.
 - 117 Nandi S, Schneider H, Dixit P. Hospital utilisation and out-of-pocket expenditure in public and private sectors under the universal government health insurance scheme in Chhattisgarh state, India: lessons for universal health coverage. *PLoS ONE*. 2017;12(11): e0187904.
 - 118 Garg S, Bebartta KK, Tripathi N. *BMC Public Health*. 2020;20:949
 - 119 Upadhyay, A. (2021, June 16). Under Ayushman Bharat, huge disparities among states where Covid patients availed scheme. *India today*. (cited 2023 March 12) Available from-<https://www.indiatoday.in/india/story/ayushman-bharat-huge-disparities-states-covid-patients-testing-treatment-1815303-2021-06-16>
 - 120 The Indian express. 2021. Cited 2023 May 31). Available from- <https://www.newindianexpress.com/thesundaystandard/2021/nov/14/at-peak-of-pandemic-only-five-per-cent-of-hospitalisations-under-PM-JAY-study-2383291.html>
 - 121 Barnagarwala T. Scroll.in. The pandemic's hidden cost: Much-hyped health insurance scheme failed to cover hospital bills. March 2022. (cited 2023 March 15) Available from-<https://scroll.in/article/1020201/the-pandemics-hidden-cost-much-hyped-health-insurance-scheme-failed-to-cover-hospital-bills>
 - 122 Garg S, Bebartta KK, Krishnendhu K. Catastrophic health expenditure due to hospitalisation for COVID-19 treatment in India: findings from a primary survey. *BMC Research Notes* (2022) 15:86 <https://doi.org/10.1186/s13104-022-05977-6>.
 - 123 Trivedi M, Saxena A, Shroff Z, Sharma M. *PLoS ONE*. 2022. 17(5): e0266798. <https://doi.org/10.1371/journal.pone.0266798>

One year into PM-JAY implementation- A study led by GIZ¹²⁴.

A study on PM-JAY led by GIZ (German Agency for International Cooperation) conducted in collaboration with India's National Health Authority, is the largest household-level study on this scheme to date. This study was carried out in seven Indian states, covering sixteen districts. The 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 (OOPE) related to hospitalisation. The average OOPE (pre + during + post hospitalisation) was quite high at Rs. 13,664 (around €144)¹²⁵. Among these, even those patients having any kind of social health insurance coverage (state or central scheme or private insurance) including PM-JAY had to bear OOPE in 76% of cases. On comparing the out-of-pocket expenditure (OOPE) with the annual per capita household expenditure, it was found that on average, individuals who incurred hospitalisation expenses spent around 26% of their annual per capita household expenditure on hospitalisation. This study confirms the observations of several other state-level or 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 care¹²⁶.

With regard to registration, the same study shows that only 35% of the 72,636 eligible individuals surveyed reported to be enrolled in any government or state health insurance scheme, including PM-JAY. This highlights the substantial gap that still exists in achieving required registration and coverage under the program.

Regarding, PM-JAY eligibility and targeting, 78% of rural households in the sample still met at least one eligibility criteria based on the 2011 Social Economic Caste Census. However 99% of the households had at least one member earning more than INR 10,000 (around €110) per month; applying the same criterion in 2019-20 (when the study was conducted) would exclude all these households from the program. This induces the researchers to question the applicability of the 2011 criteria as an exclusive basis for targeting, because according to the PM-JAY guidelines, only those households are eligible which do not meet even one of the exclusion criteria.

Other concerns regarding PM-JAY

PM-JAY is a huge health insurance scheme sponsored by the Indian government, yet it faces major structural challenges and concerns that need to be addressed to achieve even the limited objective of minimising out of pocket spending on hospitalisation care for certain sections of the Indian population. Achievement of the larger objective of ensuring universal access to healthcare– whether conceptualised as 'Universal Health Coverage' or 'Universal Health Care'- seems even more distant and unlikely through the medium of PM-JAY. Despite being built on the lessons learned from the implementation of RSBY, several gaps experienced during RSBY implementation remain unaddressed in PM-JAY¹²⁷. There is a large body of evidence^{128, 129, 130} on RSBY which points to the major gaps such as poor enrolment practices, distribution of roles and responsibilities, fixed package rates, weak monitoring and supervision, delays in settling claims, delayed reimbursement, and patients

124 One year into PM-JAY implementation- A household study across seven states in India. One year into PM-JAY implementation- A household study across seven states in India. (Cited 2023 May 31). GIZ.2022. Available from- https://iguhc.in/wp-content/uploads/2023/02/Demand-Side-Report_23.01.2023_Web-version.pdf

125 Ibid. One year into PM-JAY implementation- A household study across seven states in India. (Cited 2023 May 31).

126 Trivedi M, Saxena A, Shroff Z, Sharma M. PLoS ONE. 2022.

127 GIZ. Trusted partners for Universal Health Coverage Learning from support to large-scale reforms in India and Indonesia A publication in the German Health Practice Collection.2020. (cited 2023 March 15). Available from- https://health.bmz.de/wp-content/uploads/UHC_INDIA_INDO_shortFINAL-1.pdf

128 Ghosh S. 2014

129 Devadasan N, Seshadri T, Trivedi M, & Criel B. Promoting universal financial protection: Evidence from the Rashtriya Swasthya Bima Yojana (RSBY) in Gujarat, India. Health Research and Policy Systems. 2013. 11(29).

130 Nandi S, Nundy M, Prasad V, Kanungo K, Khan H, Haripriya S, et al. The implementation of RSBY in Chhattisgarh, India: A study of the Durg district. Health, Culture and Society. 2012. 2(1), 41-70.

incurring OOP expenditure^{131,132}. Unfortunately, these constraints and limitations appear to have continued in PM-JAY as well ^{133,134}.

The PM-JAY scheme has been criticised for promoting the role of the private healthcare sector as it majorly involves private hospitals. Until 2022, 54% of patients treated under the scheme were hospitalized in private hospitals¹³⁵. Initial data from the scheme's implementation period between September 2018 and February 2019 showed that private hospitals contributed 75% of the total claim value under PM-JAY, which is quite significant¹³⁶. Given the highly commercialized and unregulated nature of private healthcare in India¹³⁷, involving commercial private providers on such a large scale poses the risk of major distortions under the scheme, with risk of perpetuating existing inequities in access to healthcare. On the other hand, despite public hospitals constituting 52% of the empanelled hospitals, they accounted for only 36% of hospitalizations under PM-JAY. This indicating a relatively lower contribution of public hospitals to the scheme, reflecting the weakened state of the public health system¹³⁸. The comparison of trends for budget allocations for PM-JAY and the National Health Mission (NHM) over last few years reveals a disproportionate focus on insurance-based health programs, in preference to expansion of public health infrastructure. For example, the allocation for

NHM declined from INR 371.6 million in 2022-23 to INR 367.85 million in 2023-24, while the allocation for Pradhan Mantri Jan Arogya Yojana (PMJAY) was increased by 12 per cent in the same year (2023-24).¹³⁹. Additionally, the allocation for the Health and Wellness Centres (HWCs) under Ayushman Bharat's second component falls under the NHM head, implying that with constriction of the overall health budget, existing interventions under NHM¹⁴⁰ may suffer lower allocations to carve out funds for HWCs. Similarly, there are concerns that PM-JAY is diverting funds from other health budget sections including non-communicable diseases, communicable diseases, and family welfare¹⁴¹.

Although private sector engagement is considered necessary in PM-JAY-like schemes due to the predominance of the private sector in India, transferring public funds to largely unregulated private providers on such a large scale raises serious questions. There is little evidence¹⁴² that for-profit healthcare schemes improve healthcare outcomes, and strong evidence that they increase costs and reduce efficiency.

Existing evidence suggest that healthcare schemes based on for-profit providers increase costs and reduce efficiency, associated with denial of care, double charging, lack of effective grievance redressal, and unnecessary procedures by private

131 Khetrpal S and Acharya A. Expanding healthcare coverage: An experience from Rashtriya Swasthya Bima Yojna Indian J Med Res. 2019. 149. pp 369-375 DOI: 10.4103/ijmr.IJMR_1419_18

132 Ghosh, S. (2014)

133 Trivedi M, Saxena A, Shroff Z, Sharma M. PLOS ONE 2022

134 Angell BJ, Prinja S, Gupt A, Jha V, Jan S. The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and the path to universal health coverage in India: Overcoming the challenges of stewardship and governance. PLoS Med.2019. 16(3): e1002759. <https://doi.org/10.1371/journal.pmed.1002759>

135 National Health Authority annual report 2021-22 https://abdm.gov.in:8081/uploads/PM-JAY_Annual_Report_25_1f47b3cfa5.pdf

136 Rajiv Kumar. Financial express. Why 75% claim value goes to private hospitals? December 2020. (Cited 2023 June 1). Available from- <https://www.financialexpress.com/lifestyle/health/ayushman-bharat-pmjay-private-hospital-role-dr-vipul-aggarwal-deputy-ceo-nha-interview/2156858/>

137 Shukla A, Pawar K, More A. Analysing regulation of private healthcare in India. Oxfam India; 2021.

138 Ibid. Shukla A, Pawar K, More A. Analysing regulation of private healthcare in India. Oxfam India; 2021.

139 Centre for Budget and Governance Accountability, Walking the Tightrope - An Analysis of Union Budget 2023-24, February 2023

140 Business standard. 2023 April21. The euphoria around PM-JAY vs neglect of public health services. (Cited 202 March 10). Available from- https://www.business-standard.com/article/economy-policy/the-euphoria-around-PM-JAY-vs-neglect-of-public-health-schemes-119042000583_1.html

141 Sharma NC. Health budget focuses only on Ayushman Bharat, other schemes ignored. Mint. 2019. published online Feb.

142 Lister J. 2013. Health Policy Reform: Global Health Versus Private Profit. Farington, Oxfordshire: Libri Publishing.

providers^{143, 144, 145}. Lack of social accountability and effective regulation of private healthcare often results in unethical behaviour, medically inappropriate practices, substandard care and unaffordable costs^{146, 147, 148, 149} which results in a conflict between the public goals of the healthcare program and the profit maximisation goals of most for-profit healthcare providers. Going beyond these issues, a study analysing ethical aspects of the scheme has also pointed out the potential problems of profit-motivated supplier-induced demand by private healthcare providers, and corrupt practices that are possible ethical burdens of the scheme¹⁵⁰. Within wider neoliberal policies promoting private sector provisioning, negative consequences for health equity and access are well evident¹⁵¹. These concerns need urgent attention given the major role

of for-profit private hospitals in PM-JAY. Developing a comprehensive framework for regulation and oversight of private healthcare providers is critical to ensure their effective engagement in any public scheme in keeping with the public interest.

Ultimately, movement towards universal access to free, quality healthcare will primarily depend on a reformed and adequately resourced public health system that can lead implementation, delivery, and monitoring of health services throughout the larger health system. It is essential to adequately fund and strengthen the public healthcare system¹⁵² along with tackling issues related to private sector regulation, both critical areas which seem to be unaddressed by IG-UHC until now.

143 Wagle S and Shah N. (2017)

144 Reddy S and Mary I. Rajiv Aarogyasri Community Health Insurance Scheme in Andhra Pradesh, India. *Indian Journal of Public Health*. 2013. vol. 57, issue 4, 254-259. doi: 10.4103/0019-557X.123264.

145 Ghosh S. 2014.

146 Shukla A, More A and Marathe S. Making Private Health Care Accountable: Mobilising Civil Society and Ethical Doctors in India. *IDS bulletin*.2018; Vol. 49 No. 2

147 Sheikh K, Saligram PS, Hort K. What explains regulatory failure? Analysing the architecture of health care regulation in two Indian states. *Health Policy Plan*. 2015;30(1):39–55.

148 Phadke A, More A, Shukla S, Gadre A. Developing an approach towards Social Accountability of Private Healthcare Services. *SATHI & COPASAH*.2013

149 Shukla A, Kulkarni S. Harvest of Uteruses. *Economic & Political Weekly*.July 2019; vol.no 29

150 Gopichandran V. Ayushman Bharat national protection scheme- an ethical analysis. *Asian Bioethics Review*. 2019. 11:69–80. <https://doi.org/10.1007/s41649-019-00083-5>

151 Nandi and Schneider. Using equity-based framework for evaluating publically funded insurance programmes as an n=instrument of UHC in Chattisgarh state, India. *Health Research Policy and Systems*.2020 18:50 <https://doi.org/10.1186/s12961-020-00555-3>

152 Angell BJ, Prinja S, Gupt A, Jha V, Jan S.. *PLoS Med*. 2019. 16(3): e1002759.



Discussion and Recommendations

A contradiction at the heart of DFIs

Development finance institutions display a major, underlying tension at the heart of their basic constitution and mandate – the contradiction between global market-driven imperatives of profit maximisation, and the claimed goal of expanding public good with equity. Dominant narratives hold that both these goals are fully compatible, that increasing the profits of firms receiving DFI investments, and ensuring equitable benefits to service users in recipient countries, can proceed in harmony. In practice, can both of these often-divergent objectives be achieved simultaneously, or is one likely to overpower the other? While profit-fuelled market frameworks are highly developed and operate on global scale, are the various necessary regulatory, institutional and social accountability frameworks in place to ensure that the claimed social objectives are also effectively fulfilled? In this study we have attempted to ascertain which of these two tendencies has primacy regarding investments made by GDFIs as well as GDC in India's private healthcare sector. We discuss below the broad observations and concerns emerging from this study, followed by certain recommendations.

Using complementary lenses to scrutinise DFIs in the health sector

Capital everywhere is governed by global markets, but healthcare anywhere must always be governed by society.

Health systems are complex social institutions; investments in the health sector cannot be viewed or planned purely as market-driven

processes. Understanding the larger health system requirements and social context in any particular country is essential to assess whether certain kinds of investment or technical support will contribute, or would adversely affect, achievement of public health objectives in that country. ***In the health sector, making commercial investments in themselves do not necessarily contribute to UHC, and can even detract from the same and increase health inequities*** – this has been observed by WHO and a range of health sector experts¹⁵³.

To assess whether particular forms of development financing and support inserted into the health sector are enhancing or weakening achievement of public health and social equity goals, we will try to examine the degree to which such interventions embody three inter-related approaches:

- **Adopting a health systems approach, oriented towards public health goals**
- **Scrutinising measures to ensure equity and universality**
- **Examining mechanisms related to social accountability, linked with processes to claim rights and build solidarity**

➤ Lack of an essential health systems approach

In any country, different parts of the health system including - public and private healthcare sectors; primary, secondary and tertiary healthcare providers; service delivery, human power management, financing, regulation, governance and accountability arrangements - interact with each other in very complex ways. Changes in one

153 WEMOS, Improving healthcare, but for whom? Inventory study on the International Finance Corporation's investments in Healthcare, 2022

part of the system influence many other parts in significant manner; **isolated interventions which are not positioned and planned with a wider health systems approach can do more harm than good.**

Key aspects of a health systems approach oriented towards public health goals would include focus on strengthening of public health services, emphasis on primary health care, regulation of private healthcare providers to ensure their orientation to equity and public health goals, and mechanisms for participatory governance and accountability. These would be part of processes for making healthcare less of a commodity to be purchased by households from the market, while increasingly converting it into a publicly organised social good.

However as noted in previous sections of this report, DEG as a major German DFI has been financing the Indian healthcare system without any publicly articulated health sector strategy.

This is deeply problematic. India has one of the most privatised healthcare systems in the world, with total public health spending amounting to only 1.28% of the GDP, and household financing making up the largest part – nearly 60% of current healthcare expenditure¹⁵⁴. An estimated 70% of healthcare utilisation is from private healthcare providers, which are overwhelmingly for-profit¹⁵⁵. In this situation, it cannot be presumed that providing external financial support to promote commercial, for-profit healthcare providers in India, contributing to further privatisation of the healthcare system, will lead to fulfilment of public health goals.

Yet, 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. **Hence DEG appears to be contributing to further privatisation of the already highly privatised Indian healthcare system.** Support to expansion of largely unregulated private healthcare is taking

place through direct and indirect financial support by DEG to various commercial private hospitals in India. The present transactional arrangements between GDFI and recipient commercial healthcare entities appear to be almost entirely business centred, with targets and performance only focussed on numerical reach and scale of investments. Further as we discuss below, advisory support provided to PM-JAY scheme, where for-profit private providers play a major role, also needs in-depth scrutiny.

Since IG-UHC is concerned with providing technical inputs on various aspects of ensuring UHC in India, the question also needs to be asked as to **why such technical assistance is currently mostly focussed on a health insurance scheme involving public-private partnerships, with less attention to other major fronts of urgently required health system reform in India.** GDC's Sector Strategy on Social Protection also mainly emphasises health insurance schemes and public private partnerships, within their priority area of health¹⁵⁶. However as per publicly available information, IG-UHC does not mention any role in providing technical inputs on **design of much-needed legal regulation of the entire Indian private healthcare sector for quality, costs and content of care.** Such regulation and a degree of standardisation of the entire private sector would be a logical precondition, or at least an important parallel intervention, while transferring large-scale public funds to significant numbers of private providers through insurance schemes. **Another related front of valid technical assistance would be strengthening of public regulatory capacity related to private healthcare providers.** Yet we could not find mention of any technical or other measures taken by German official developmental bodies to support implementation of the Clinical Establishments Act and similar overarching regulatory measures, related to the private healthcare sector in India.

154 National Health Systems Resource Centre. National Health Accounts Estimates for India (2018-19). New Delhi: Ministry of Health and Family Welfare, Government of India.2022

155 Key indicators of social consumption in India: Health, NSS 75th round; 2019; Ministry of Statistics and Programme Implementation, Govt. of India. 2019.

156 Sector Strategy on Social Protection. Strategies 195. Federal Ministry for economic Cooperation and Development. 2019

Overall, we would reiterate that the goal of developing an equitable, publicly organised UHC system in India, however it is conceived, cannot be limited to promoting certain for-profit private providers, and supporting a health insurance scheme which based on large scale engagement of largely unregulated commercial private providers.

➤ **Deficit of concrete measures to ensure equity and universality**

Concerning GDFI supported healthcare investments in India, we did not come across definite objectives and measurable indicators to ensure equitable access to healthcare. The KfW document on UHC¹⁵⁷ mentions in generic form the desirability of equity in service use, quality of services, and financial risk protection. However, 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 which need to be addressed while ensuring equitable access to healthcare. Similarly, there is no mention of regulatory provisions to ensure fair and affordable rates for care, and need for regulating prices of health-related services and goods which are provided by private bodies receiving investments from GDFIs.

Our case study on one GDFI supported large private hospital in this research reinforces these points. The operations of this corporate hospital appear clearly geared towards profit making, while commercially oriented practices with potentially negative impacts on staff as well as patients clearly appear to have intensified after the hospital began to receive DEG investment. Given the commercialised mode of operation of this GDFI supported private hospital, with lack of provision of free or low-cost care (aside from care provided under the public health insurance scheme, where also denials of care appear significant), there is serious question about the claim of ensuring equitable and affordable access to healthcare through such investments. The strong focus by ABC hospital on catering to medical tourists 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.

DEG appears to have selected certain large corporate or for-profit private hospitals for investment in India (Annexure 2), rather than less commercially oriented hospitals and healthcare organisations in rural and remote areas. Keeping all the above observations in view, effectively the main intention seems to be maximising return on capital investment rather than expanding equitable access to healthcare.

The case study on the publicly funded health insurance scheme in our research shows the limitations of GDC's external technical support to PM-JAY scheme which has a range of structural issues and inadequacies. Continued high out-of-pocket expenditure among beneficiaries, and low coverage of COVID hospitalisations by the scheme in most Indian states during the recent pandemic, are striking manifestations of these structural weaknesses. Since the scheme is indigenously designed and implemented, the related problems should not be ascribed to the external technical support agency alone. However, greater transparency is required to understand the nature of technical inputs provided by IG-UHC to the PM-JAY scheme, since the influence of this large-scale technical support is expected to be considerable, yet detailed information on this is not available in the public domain. It would be logical to examine the role played by the externally supported technical agency in providing advice to address the outstanding, well-known and serious problems of PM-JAY, many of which were further highlighted during the recent COVID pandemic.

One of the serious limitations of the PM-JAY scheme is its rigidly targeted nature, in contrast with the widely acknowledged need for universality in healthcare. Since its inception, the scheme has aimed to provide certain kinds of hospitalisation coverage to socio-economically deprived 40% households among the Indian

157 Rohregger B and Rudolph P. Achieving Universal Health Coverage: Contributions by German Financial Cooperation. KfW Development Bank – Perspectives on Development Financing, No. 3 July 2017.

population, while leaving out the remaining 60% households, among whom a large part are currently unable to access affordable healthcare. Ground level experiences underscore the manner in which the 'scheme cards' are provided to some and denied to many others within the same village or urban low-income community.

This lack of universality has very serious consequences, not only for the excluded 60% but even for the 40% households which are supposed to be included. To understand this core concern, we need to probe deeper into the dynamics which underlies genuinely universalistic healthcare systems, in contrast to schemes located on the periphery of health systems, which are limited to targeted provisioning of some services only for certain section of socio-economically deprived households.

... the first countries to move towards more universalistic principles in social policy were not industrial leaders such as the UK but industrial late comers such as Germany, Japan and Sweden, and universalistic social policy played a key role in their strategies of late industrialisation ... Indeed, it is misguided – at least from historical example – to state that poor countries cannot afford universal social policy given that successful industrialisers have always relied on it in various ways from very poor starting points.

... the universalistic principle is not simply that all people access a social good or service (e.g. education or health care), but that this access is provided through integrated systems, whereby all people access the service through the same organisational channels or entities, through which needs and standards can be assessed and managed collectively within the system along principles of equity. Hence, a universalistic health system implies that everyone accesses the same hospitals and

clinics, wherein the same quality of service is provided to all without discrimination ...
Universalism within such systems is determined by the degree to which private providers are regulated and/or managed as an integrated part of the system and are accessible to all on the same terms regardless of their private status. (emphasis added) ¹⁵⁸.

These core insights should be obvious to technical consultants with expertise drawn from a genuinely universal healthcare system, such as the German healthcare system. However, the complete lack of emphasis in IG-UHC on regulating private healthcare providers and reforming the healthcare sector towards creating “integrated systems, whereby all people access the service through the same organisational channels” is obvious. Because the practices of private healthcare providers on a broader scale have neither been effectively regulated nor rationalised, and they are not subjected to systematic social accountability, they continue their profit-driven mode of functioning and bring in a range of distortions, including double-charging and denials for patients even when formally brought under the ambit of PM-JAY.

To use a mainstream economics terminology, because health care and quality schooling are to a large degree demand-inelastic, they carry a huge potential for rent-seeking from the cartel-like activities of private profit-seeking actors. Conversely, a financially sustainable and affordable operation of a health insurance system, for instance, is predicated on a complementary control of costs within the associated health system. ... health insurance programmes in India (such as micro-insurance programmes) or in China (such as the rural health insurance system) are only able to make minor dents on large catastrophic health expenditures

158 Fischer A.M. Inequality and the Universalistic Principle in the Post-2015 Development Agenda, Institute of Social Studies (The Hague), Erasmus University Rotterdam, November, 2012

by households, partly **because of the inability to control costs within the actually or effectively privatised health care systems of both countries...**

(Emphasis added)¹⁵⁹.

Overall, the IG-UHC programme seems to have been unable to address the critical issues related to regulation of the private healthcare sector in India, as well as the targeted (not universal) nature of PM-JAY, and this raises serious questions regarding their ability to promote movement towards the goals of an equitable and universal healthcare system in India.

➤ **Missing social accountability, as well as processes to claim rights and promote solidarity**

We similarly need to examine whether the health sector reforms being promoted by IG-UHC are being designed in socially contextualised manner in India, with social accountability, collective participation and multi-stakeholder involvement being built into processes for planning as well as implementing activities. Let us see what a broader BMZ document on universal social protection, including universal health coverage, has to say in this regard:

Social accountability mechanisms, including civil society organisations, labour unions and individual citizens, are key when it comes to fostering civil society buy-in, ensuring that beneficiaries' changing needs are at the heart of USP (universal social protection) implementation. ...

*Rooted in a rights-based approach, the universality agenda not only institutionalises the right to social protection, but also gives citizens the tools to enforce their entitlement to social protection benefits.*¹⁶⁰

Although this policy position of BMZ is admirable, while advising the PMJAY programme has the IG-UHC attempted to ensure in practice involvement

of civil society and citizens groups in this process? As of now, besides an individual patient grievance redressal mechanism, **there are no social accountability, social audit or collective rights claiming mechanisms in place regarding the national PMJAY scheme, which involves over 500 million beneficiaries.** Panchayat representatives, civil society organisations, patients' groups, women's groups etc. are notably not included in governance structures of the scheme. **Ensuring a rights-based approach requires conscious creation of platforms, mechanisms and spaces (such as social audits or public hearings) whereby concerned people can come together and claim their rights;** occasional mention of rights in a few policy documents is not enough. To what extent has the central importance of social accountability mechanisms being given attention by the external consultants? Have they proposed 'giving citizens the tools to enforce their entitlement' as part of their ongoing and intensive advice to this major programme?

Overall GDFI-supported investments in the Indian private healthcare sector or Health insurance schemes do not appear to have any component of civil society involvement or participatory assessment of health system impact. In various concerned documents there does not seem to be mention of social accountability mechanisms involving civil society organisations and citizens, either at the end of BMZ in Germany, or at the end of the recipient country in India, to help monitor and ensure that all projects include and implement health equity and human rights requirements.

Further, we should keep in mind that the German social health insurance system itself has been developed over the last 140 years on basis of the defining principles of solidarity and self-governance¹⁶¹. Sickness funds, which historically have been at the base of the German health system, are collective forums which are jointly managed by employers and employees. **It would have been useful if IG-**

159 Ibid. Fischer A.M.

160 A systems perspective on Universal Social Protection, published by BMZ, edited by GlZ, 2019 - https://health.bmz.de/wp-content/uploads/GHPC_USP_Final-1.pdf

161 Busse R, Blümel M, Knieps F, Bärnighausen T. Statutory health insurance in Germany: a health system shaped by 135 years of solidarity, self-governance, and competition, Lancet 2017; 390: 882–97

UHC had provided a cross-learning platform to explore how social solidarity could be brought into strengthening governance of the health system in India, including various health insurance schemes¹⁶², for example building upon and expanding the role of Panchayats, women's self-help groups, cooperatives, unorganised sector workers' boards and other social collectives which are highly relevant in the Indian context. However, going by available public documents and interviews with key stakeholders, such critical discussions and recommendations on the role of social solidarity and bottom-up participatory governance seem to be missing from the priorities of IG-UHC. We are led to conclude that **while the evolution of social health insurance in Germany itself has historically been a deeply socially embedded process, in contrast the programme being promoted by German official technical agencies in India is contributing to a socially detached, individual beneficiary oriented healthcare coverage model**, where hardly any efforts have been made until now to systematically involve communities and collectives, or to promote much-needed social solidarity which is expected to be the essential basis for any genuine universal healthcare system.

➤ **Weak transparency, reliance on opaque, commercial intermediaries**

We have already discussed inadequate transparency in GDFI-related investments in the healthcare sector in India. Limited transparency in practice contradicts with the claimed social objectives written in policy documents. The inclusion of commercial financial intermediaries through tax havens may weaken the developmental goals of DEG, as intermediaries prioritise their own commercial interests over social goals, leading to misaligned priorities and reduced effectiveness. DEG does not have a dedicated disclosure and transparency policy in place, and does not provide a comprehensive listing with details of the projects receiving DEG support¹⁶³. Opacity in DFI-

intermediary arrangements reduces transparency regarding the scale, composition, and nature of investments. This practice of lack of transparency and limited access to information in the public domain about DFI-supported projects has been a major issue in holding the DFIs accountable. Therefore, it is crucial for governments to play a role in ensuring that DFI-backed projects adhere to widely agreed upon transparency principles.

To conclude, the current focus by GDFIs on providing financial support to certain large for-profit hospitals, along with BMZ's technical support to PM-JAY which is heavily based on private healthcare providers, seems to reflect more of private sector-oriented priorities than a wider, essential public health approach. This situation resonates with the concern that the banner of 'Universal health coverage' is frequently being used primarily as a platform for expanding investments in commercial private healthcare:

'universal health coverage' is a broad enough term to incorporate a range of publicly managed financing arrangements, but is in practice characterized by concerted efforts to promote models of healthcare financing based on 'affordable' user fees and health insurance, and on expansion of privately owned healthcare infrastructure ...

... there is an impetus for quick gains using technologies that bypass systemic problems such as under-resourced public healthcare systems, and for portrayal of these systemic problems as themselves requiring technical intervention, usually incorporating contracts for commercial actors. Private investment in healthcare provision and financing is now presented as the only solution for addressing geographic gaps in healthcare provision, high mortality and catastrophic out-of-pocket expenditures¹⁶⁴.

162 V.S. Saravanan, Social Solidarity in healthcare - Lessons for India from the German healthcare system, Governance Now, October 2016

163 Fact Sheet DEG (Germany) and private finance for development. (Cited 2023 June 1). Available from- [DEG.pdf \(d3n8a8pro7vhmx.cloudfront.net\)](#)

164 Hunter B.M and Murray S.F. 2019

Based on the available evidence, we are led to 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 private providers. Ensuring benefits to patients in terms of equitable access to free healthcare appears to be a peripheral objective, with very doubtful outcomes since the current interventions are not located in context of an overall public health strategy, they are not linked with comprehensive regulation of private healthcare providers, they lack adequate measures to ensure equity and universality, and are not subject to systematic rights claiming mechanisms, public scrutiny or accountability with participation of various social stakeholders.

Recommended changes in process and strategy

To allow the market mechanism to be sole director of the fate of human beings and their natural environment ... would result in the demolition of society. - Karl Polanyi¹⁶⁵.

From the preceding sections, it is clear that the present mode of intervention by German developmental agencies in India's health sector through various forms of engagement with private commercial providers raises deep concerns. There is no doubt that large-scale and basic changes are required, related to both the process of designing and monitoring such support and the actual strategy to be deployed while intervening in this sector. We base our suggestions in this direction by reiterating certain valuable principles proposed by STOPAIDS, a long-standing global network involved in international development and HIV-AIDS¹⁶⁶:

ODA-funded private sector engagement in global health must:

1. not undermine public healthcare provision
2. be driven by patient-centred needs and social accountability for health rather than commercial interests

3. have a demonstrated public health impact, be evidence-based and adhere to the principle of equitable access to services
4. have strong transparency and accountability mechanisms in place in line with principles of aid effectiveness
5. support and promote human rights, workers' rights, the rights of women and girls and all marginalised groups
6. not be used to promote private sector investment in health in countries which lack effective regulation of the private health sector.

Keeping in view our entire set of findings and analysis, certain recommendations emerging from this study are outlined below, which are applicable to the operations of German developmental agencies in India, but have relevance for other LMICs.

➤ Bilateral review and impact assessment of current projects, involving diverse stakeholders and based on complete transparency

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 this review process should include the 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.

➤ 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.

165 Karl Polanyi, *The Great Transformation*, Beacon Press, Boston 1944, 1957, 2001

166 STOPAIDS, *Principles for ODA-funded private sector engagement in global health*

➤ **Discontinuing involvement of commercial intermediaries**

GDFIs should phase out routing of 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.

➤ **Moratorium on financing of private hospitals**

Until completion of the comprehensive review process, no new agreements should be made for GDFIs providing financial support to private hospitals in India. In general, financial resources of German developmental agencies should be focused on strengthening of public health systems. Based on the findings emerging from the review, any decision to further invest in private healthcare providers must be made only after satisfying the pre-condition of effective regulation of this sector, while considering the implications on equitable access to care. Investing in high-end commercial private hospitals is not likely to contribute to equitable access to healthcare.

➤ **Major reorganisation of strategy in line with a public centred, health systems approach**

German developmental agencies should develop a comprehensive health sector strategy, which would spell out the role of German official developmental assistance in the health system in India. This should include integrated approaches related to strengthening of public health services, effective regulation of the private healthcare sector, implementation of social accountability, rights claiming and participatory governance mechanisms.

The health sector approach should explicitly aim to ensure greater equity in access to health care and strengthening of health rights, with well-

defined participatory mechanisms and monitoring frameworks to enable this. It must be recognised that fair and affordable pricing of services is central to ensuring health equity, hence financing and regulatory mechanisms must ensure this. Ensuring effective regulation of practices and rates of private healthcare providers should be an absolute pre-condition for making any further investments in private healthcare in the recipient country.

These measures need to be accompanied by transparency provisions covering all involved actors. As part of the reorganised approach, use of non-transparent, commercially driven financial intermediaries should be discontinued.

➤ **Recasting of technical support to PM-JAY, towards developing a genuine Universal Health Care system**

Based on the mentioned review, current technical support by IG-UHC which is limited to the PM-JAY scheme, needs to be reconsidered. In this process, all arrangements which include commercial insurance companies should be discouraged, and a comprehensive plan for regulation and rationalisation of private healthcare providers should be rolled out as the highest priority.

The current targeted health insurance programme needs to be majorly modified and recast into a time-bound process for operationalising a genuinely universal healthcare system, which is based on expanded public provisioning and is strongly embedded in equity and rights approaches.

The Employee State Insurance (ESI) scheme which has suffered from major policy neglect¹⁶⁷ and is now being pushed in direction of privatisation, needs to be reviewed regarding its potential for overhaul and expansion to include large masses of unorganised sector workers, with the possibility of becoming a vehicle for moving towards universal healthcare. Valuable lessons regarding social protection provided by various boards for unorganised sector workers in India (especially in states like Kerala and Tamil Nadu, and the Mathadi workers' board in Maharashtra) should be taken into account while

167 International Labour Organization. Accessing medical benefits under ESI Scheme A demand-side perspective. 2022.

designing solidarity based universal healthcare systems as a component of social security.

➤ **Ensuring social accountability and engagement, effective public accountability**

Regarding any healthcare agencies and arrangements which are supported by German developmental agencies, platforms and processes to ensure social accountability, which build upon and consolidate social solidarity need to be operationalised at the earliest. During the stage of design and initiation, all German developmental agencies - supported projects should ensure consultations with representative civil society networks and organisations. As may be appropriate, these should involve panchayats, women's groups, trade unions and associations of workers in the unorganised sector, patients' groups, and various civil society and community-based organisations, particularly organisations of marginalised communities.

To systematically continue such people's involvement, regular mechanisms like Social audit / Community-based monitoring, Participatory

planning (India), Health assemblies (Thailand) and Health councils (Brazil) should be considered and appropriately implemented in existing, diverse social contexts.

GDFI-supported investments in the Indian healthcare sector need to undergo periodic participatory assessment of health system impact. Such reviews need to be organised at the investor end in Germany, as well as the recipient country, India, to monitor and ensure that projects include and implement public health, health equity and human rights requirements.

There is also a need to ensure effective Parliamentary / Legislative oversight of all GDFI projects in India. Further, public accountability also includes an element of mutual accountability between partnering country governments. Generally, there is deficit of mechanisms for recipient country governments to hold DFIs accountable, regarding their adherence to agreed-upon principles. There is a need for defined frameworks to ensure that both donor and recipient country governments adhere to certain agreed-upon principles in the context of the operation of DFIs, in the larger public interest.



Note

Note on Universal Health Coverage

The framework of 'Universal Health Coverage', commonly abbreviated as UHC, is a widely used but somewhat ambiguous concept which has been interpreted in diverse ways¹⁶⁸. There is a degree of consensus regarding the ultimate goals of UHC - promoting access to quality health care for the entire population and providing households with protection from catastrophic consequences of out-of-pocket (OOP) health-related payments. However, there is significant range of opinion regarding the desirable policies, mechanisms and health system changes which need to be adopted to reach these goals. The discourse on UHC which is currently dominant among several global institutions has been critiqued as follows:

Unfortunately, in the name of UHC, some donors and developing country governments are promoting health insurance schemes that exclude the majority of people and leave the poor behind. ... Donors and governments should abandon unworkable insurance schemes and focus on financing that works to deliver universal and equitable health care for all¹⁶⁹.

And:

Moreover, the term coverage rather than care either suggests a limited scope of care or is being used to suggest enrolment in an insurance scheme. For many LMICs, this has meant operationalising UHC through government-funded health insurance schemes. The adverse implications are seen in countries such as India, where coverage by publicly funded health insurance has neither been equitable nor led to financial protection.

Involving the for-profit private sector in providing health care has allowed for funding imbalances and provider capture, with more funds from these public schemes going into the private health sector, thereby reinforcing existing health inequities. Insurance-based models of UHC risk being promoted at the expense of funding PHC and other public health programmes¹⁷⁰.

While elaborating on these debates is beyond the scope of this report, the authors note the manner in which the dominant discourse related to Universal Health Coverage has often been used by powerful global and national bodies to promote and justify a focus on government-supported insurance-based 'coverage' for sections of the population, often with prominent involvement of commercially operating private healthcare providers. In this report, we have examined the actual performance of GDFI-supported projects and activities, in some places taking reference to their own stated allegiance to achieving 'Universal Health Coverage', even in the limited sense in which this term is often used.

However, in our opinion this dominant version of Universal Health Coverage needs to be replaced by a much broader, deeper, and people-centred approach towards health system transformation, which is urgently required in India and other LMICs. Such a system for genuinely universal health care should be anchored in major strengthening and expansion of public health systems, effectively regulating private healthcare providers, ensuring broad-based social accountability and implementation of human rights, while being integrated with strengthened Primary Health Care and action on social determinants of health.

168 Abihiro and Allegri D. Universal health coverage from multiple perspectives: a synthesis of conceptual literature and global debates. BMC International Health and Human Rights. 2015. 15:17

169 Oxfam International. Universal Health Coverage: Why health insurance schemes are leaving the poor behind. 2013. Oxfam Briefing Paper, October 2013

170 Sanders, D., Nandi, S., Labonte, R., Vance, C. & Van Damme, W. Alma Ata to Astana: From Primary Health Care to Universal Health Coverage—One Step Forward and Two Steps Back. The Lancet. 2019. 394(10199):619–21.



ANNEXURES

Annexure 1: DEG investments in Indian healthcare

Year of investment	Recipient	Donor body/ Intermediary	Nature of investment	Health sector area	Size of investment
2009	Krishna Institute of Medical Science	Quadria capital	Private equity	Private healthcare provision	15-20 % share
2010	Health Care Global enterprises (HCG)	Quadria capital	Private equity	Private healthcare provision	Details not available
Not available	Ascent Meditech	Quadria capital	Private equity	Manufacturing and supply	Details not available
2013	Ivy Health and Life Sciences Pvt. Ltd (Ivy)	DEG	Quasi equity loan	Private healthcare provision	10 million Euros
2013	Medica Synergie	Quadria capital	Private equity	Private healthcare provision	Euros 17.6 million
2015	Asian Institute of Gastroenterology	Quadria capital	Private equity	Private healthcare provision	14% share worth US\$ 304 million
2016	Concord Biotech	Quadria capital	Equity shares	Manufacturing and supply	Euros 52.28 million
2017	Healthcare at Home	Quadria capital	Private equity	Private healthcare provision	Euros 40 million
2018	Strand life sciences	Quadria capital	Private equity	Manufacturing and supply	Euros 3 million
2019	AKUMS Drugs and Pharmaceuticals	Quadria capital	Private equity	Manufacturing and supply	Euros 70 million
2020-2021	Medica Synergie	DEG	Standard grant	Private healthcare provision	Euros 2.875 million

Source- The authors compiled this information using data from various sources, including media reports, press releases, annual reports, and the German parliamentary office.

Annexure 2: Profile of DEG-financed private hospitals in India

Name of the hospital group	Location of the hospital	Number of hospital branches	Hospital bed size	Specialty
Medica Synergie	Kolkata, Odisha, Ranchi, Siliguri, Patna	7 hospitals	1000 plus beds	Multispecialty
Healthcare at Home (HCAH)	Noida, Uttar Pradesh	Centres in 3 cities	1500 beds	Home based transition care, long term critical care etc
Krishna Institute of Medical Science	Hyderabad Andhra Pradesh and Telangana	2 multi-specialty hospitals	3600 beds	Multi-specialty
Healthcare global enterprises	Over 26 centres PAN India	26 plus hospitals	2000 plus beds	India's largest provider of cancer care
Ivy Health and Life Sciences Pvt. Ltd (Ivy)	Punjab Mohali	6 hospitals	180 beds	Multispecialty
Asian Institute of Gastroenterology	Hyderabad, Telangana	One hospital	800 beds	One of the largest centres in Asia for Gastroenterology.

Annexure 3: BMZ supported healthcare projects in India (2010-2022)

	Project name	FINANCE TYPE	Total Commitment	Recipient
	ONGOING PROJECTS			
1	Enabling psycho-social wellness of poor people with mental illness and disabilities in India	Standard grant	179,879 USD	Government of India
2	Amplifying community-based health care in Kandhamal and Sundargarh Districts of Odisha	Standard grant	USD 169,626	Government of India
3	Strengthening healthcare facilities to treat Corona-infected people in India	Not mentioned	USD 1,473,354	Government of India
4	Rehabilitation of homeless persons with psychosocial problems in and around Kolkata		USD 64,477	West Bengal Government
5	Health Care and Natural Medicine for Casteless and Marginalised Villages in Tamil Nadu	Not mentioned	USD 341775	Tamil Nadu
6	Enhancing access to holistic palliative and end-of-life care for the marginalised population across India	Standard grant	USD 850,410	Government of India
7	Indo-German Programme on Universal Health Coverage (IG-UHC)	Standard grant	USD15,195,150	Ministry of Health and Family Welfare, India
8	Community health promotion in the disease of Berhampur, Odisha	Standard grant	USD 114,459	Not mentioned
9	Care and support to people suffering from cancer in the district of Aurangabad, Maharashtra	Standard grant	USD 107,791	Not mentioned
10	Increase vaccination preparedness and free education efforts to combat irrational vaccination resistance	Not mentioned	USD 287,511	Not mentioned
11	Improved access to health and rehabilitation services as well as inclusion for persons with disabilities in Chhattisgarh, India	Not mentioned	USD 602,218	Not mentioned
12	Women-led traditional health cultures for resilience to climate-change-induced disasters in North Bihar, India	Not mentioned	USD 450, 125	Not mentioned
13	Medical education of religious sister doctors in India in order to improve female health care in rural areas in India	Not mentioned	USD 110,706	Not mentioned

14	Basic health care for tribal and rural poor communities in North-eastern Chhattisgarh	Not mentioned	USD 357, 667	Not mentioned
15	Enhancing Rural Resilience through Appropriate Development Actions – ERADA	Standard grant	USD 3,469, 999	Ministry of Rural development
16	Access to essential medicine and promotion of rational use of medicine in Odisha	Not mentioned	USD 69, 333	Not mentioned
17	Promoting the right to public health care in India with a focus on Karnataka, Madhya Pradesh and Tamil Nadu	Not mentioned	USD 369, 493	Not mentioned
18	Enhancing community-based health care services in India	Not mentioned	USD 9, 62,991	Not mentioned
19	Promoting community-based health work in fourteen districts of Odisha, India	Not mentioned	USD 214,767	Not mentioned
20	Comprehensive social security programme	low-interest loan	Euro 460 million	Indian government
ENDED PROJECTS				
21	Setting up Community-Based Health Insurance for the Tibetan refugee community in India	Standard grant	USD 344,937	Government of India
22	Pulse Polio Immunisation Programme IV	Standard grant	USD 9,425,953	Government of India
23	Improvement of public health through construction of out-patient department and diagnostic section in Baramulla district, Kashmir, India	Standard grant	USD 337,356	Government of India
24	Upgradation of Secondary Level Health Care Facilities in Karnataka	Standard grant	USD 17, 713, 630	Government of India
25	Basic Health Programme, West Bengal	Standard grant	USD 29, 687, 392	Government of India
26	Rural Dispensary in Acharapakkam	Standard grant	USD 114,924	Government of India
27	Handicapped accessible means of transportation to improve inclusion of concerned children and youth	Standard grant	USD 31,818	Government of India
28	Basic Health Programme	Not mentioned	USD 12,787,332	Government of India
29	Improving social security in India	Not mentioned	not mentioned	Ministry of Health and Family Welfare

Source- BMZ related website-d-portal.com



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