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International Development Committee Inquiry - Investment for development: The UK's strategy towards Development Finance Institutions

Written submission by Oxfam GB

Oxfam's evidence on British International Investment's (BII) healthcare portfolio is drawn from extensive research and investigations over the last five years. The BII-specific information in this submission is complemented by and should be read in conjunction with Oxfam's publication 'Sick Development: How rich-country government funding to for-profit private hospitals causes harm and why it should be stopped'.[1] Unless otherwise indicated, references for all the evidence cited in this submission can be found in Oxfam's report 'Sick Development' or its accompanying methodology note.[2] It should be noted that the information provided in this submission is specific to BII, while the report 'Sick Development' presents evidence for BII plus four other DFIs.

Oxfam has also contributed to a second joint submission to the Inquiry on BII's role in education.

Summary

Oxfam has conducted extensive mapping and analysis of BII's (formerly CDC) healthcare portfolio between 2008 and 2022. Our findings indicate that BII's healthcare investments go to expensive hospitals that are either unaffordable to those most in need or risk bankrupting them and pushing them further into poverty. This means that instead of advancing universal health coverage and poverty reduction, BII's investments in healthcare provision risk doing the opposite. Not only this, Oxfam's body of evidence also indicates that BII's investments are unsafe, and in some cases are causing significant harm. The examples of patient and human rights violations shared in this written submission are of serious concern and warrant urgent independent investigation and response.

Recommendations:

- an immediate freeze of all BII future direct and indirect funding to private healthcare providers
- an independent and comprehensive inquiry into BII's healthcare investments
- the urgent establishment of an independent accountability mechanism to allow communities to raise human rights and environmental concerns related to BII's financing and that action is taken to remedy harms identified

Background on BII investments in health

1. Oxfam's research to map and analyse BII's health portfolio has identified that CDC/BII channelled a total of **$843 million** of UK development funding specifically to health between 2008 to August 2022. This is made up of:
    - $712.53m invested directly in 12 private health companies (this includes one investment of $200m in a non-profit drug purchasing mechanism).
    - $130.2m in four different health sector specific financial intermediaries or investment platforms which to date have invested in 12 disclosed for-profit health companies. However, this is a significant under-estimate of health company beneficiaries due to non-disclosure by BII of indirect investments made by two of the three health-specific financial intermediaries.[3]

2. In addition, Oxfam has identified that CDC/BII made a further 117 investments in for-profit health companies via 72 multi-sector equity funds or other multi-sector financial intermediaries. CDC/BII invested a total of $2.5bn in these multi-sector financial intermediaries but the proportion of this amount going to the 117 health investments is not disclosed by BII.

3. As reported by Publish What you Fund[4], there is a significant time lag in BII's investment reporting which means the above figures likely underestimate BII's funding to health. Incomplete and inconsistent reporting by BII is also a challenge in ascertaining accurate data. All the above investments have been confirmed to Oxfam by BII.

4. Oxfam has identified a minimum of 141 health companies in receipt of funding from BII. Of these companies:
    - 50% are healthcare providers and 42% are involved in research and development. The remaining health companies are focussed on supply chains, information systems and health insurance or savings schemes.
    - 91% of all health investee companies receive their BII funding indirectly at arms-length via financial intermediaries, mostly private equity funds. This is of major concern (see below).
    - Of the 76 health-specific and multi-sector financial intermediaries used by BII to invest in health, over 86% are domiciled in known tax havens, primarily Mauritius and Cayman Islands.

5. Of BII's 70 direct and indirect investments in for-profit healthcare provider companies:
    - Just 6% are in low-income countries; 81% are in lower middle-income countries and 10% are in upper middle-income countries
    - Countries with the highest number of healthcare investments are India (53%), followed by Egypt (7%) and Kenya (6%).
    - 87% of BII's investments in healthcare providers are made indirectly via financial intermediaries

The remainder of this submission focusses primarily on BII's funding to **healthcare providers**, constituting 50% of BII's health portfolio.

<u>Funding unaffordable and inaccessible health care, especially for women and girls</u>

6. Half the world's population lack access to even the most essential healthcare. Out-of-pocket spending on health care is also a leading cause of financial hardship and impoverishment across low and middle-income countries and is a problem that is getting worse.[5] Achieving Universal Health Coverage, a Sustainable Development Goal committed to by the UK government, means advancing healthcare access and financial protection to the most underserved including those on low-incomes, women and girls, as well as people facing other forms of marginalisation and discrimination.

7. Oxfam has conducted systematic investigations and collected a large body of evidence indicating that BII funded private healthcare providers are unaffordable to people living on low-incomes, and in cases are exacerbating poverty and inequality, especially for women and girls.

Maternity fees

8. Maternal health is a long-stated priority for the UK government, but maternal death rates are rising in many regions of the world. Wherever we have been able to identify fees related to maternal health services provided by BII funded health care providers we find they are unaffordable. The following table provides illustrative examples and demonstrate that rather than helping to tackle unacceptably high maternal mortality rates in these countries, BII are investing in hospitals that are simply out of reach for most women. Table 1 shows the starting cost of childbirth (vaginal and caesarean births) presented as the number of months' total income for a person on national average income and a person on average income in the poorest 50% in the countries where the hospitals operate. In Novamed hospital for example, it would take a person on national average income in Burkina Faso five months to earn enough to pay for a vaginal birth, and for someone earning the average income of the bottom 50%, it would take 43 months (of over three and a half years) to pay for a caesarean birth.

Table 1. Cost of giving birth at sample BII funded private hospitals in months of income for average earners

Name and country of private hospital	**Months of income to pay for vaginal birth for:**		**Months of income to pay for caesarean birth for:**	
	Person on national average income	**Person on average income in bottom 50%**	**Person on national average income**	**Person on average income in bottom 50%**
Evercare, Bangladesh	3	8	8	22
Novamed, Burkina Faso	5	22	9	43
CARE Hospitals, India	5	17	6	22
Avenue, Kenya	2	8	6	23
TMR, Uganda	4	17	9	38

9. In reference to Rainbow Hospital that is directly funded by BII in India, BII staff told Oxfam that while the hospital might not be affordable to those living in extreme poverty, it would help to reach those living on around $5.50 a day. At that same hospital in 2022 a mother was reportedly charged a bill of INR 52 lakh ($63,000) for the treatment of her premature twins who both sadly died. The reported bill is the equivalent of 35 years' total income for someone living on $5.50 per day.[6]

10. Far from making healthcare more affordable, there is evidence that investments by BII make healthcare even further out of reach. Childbirth fees at TMR hospital in Uganda increased by an incredible 60% within four years of BII's investment.

11. The average starting price for a vaginal birth in private hospitals funded by BII (together with those funded by France's Proparco, Germany's DEG, the European Investment Bank and the World Bank's IFC) is the equivalent of one years' total income for an average earner in the bottom 40%. The average starting cost for a caesarean birth amounts to over two years' total income for the same people.

COVID-19

12. A global health emergency is perhaps the best test of BII's theory of change that investing in commercial health care providers can advance universal health coverage, increase access to the under-served and add capacity to compliment and relieve struggling public health systems. However, research across LMICs revealed alarming and widespread trends of unethical behaviour by private health care providers at the height of the COVID-19 pandemic including withdrawing health services and refusing to admit COVID-19 patients; filtering of patients based on ability to pay; gouging on price; and brinksmanship on price per patient to be paid by governments dependent on access to private hospital beds.[7] Furthermore, in many countries, including India where BII's private health investments are heavily concentrated, patients were left overwhelmingly dependent on public health care provision for COVID-19 treatment and care.

13. Oxfam found significant reported information about BII funded private hospitals allegedly charging exorbitant fees for COVID-19 treatment and care and/or engaging in other unethical practices. This evidence is published in detail in Oxfam's report 'Sick Development'. Examples include BII supported TMR hospital in Uganda which reportedly charged $32,000 for two weeks of COVID-19 treatment and care.[8] Avenues Clinic in Zimbabwe reportedly charged between $800 and $1000 a day for a COVID-19 ICU bed.[9] BII funded CARE Hospitals in the Indian state of Chhattisgarh was issued a court order by the state government stating that a patient had been forcibly evicted from the hospital in March 2020 after doctors suspected that she was infected with COVID-19. In Telengana state, the same hospital chain was ordered to refund over $8500 to COVID-19 patients who were overcharged above government COVID-19 price caps.[10] A director of Rainbow Hospitals in Bihar state was reportedly arrested for black market sales for COVID-19 treatment Remdesivir at prices up to 29 times the cap set by government.[11]

Other evidence of expensive out-of-reach healthcare

14. Arrail Dental in China, which is funded by BII, describes itself as 'the leading premium dental services brand in China and targets affluent patients with high purchasing power, primarily in Tier-1 cities'.[12] BII supported Portea reports that its home-based ICU care costs in India start at US$133 per day, or 62 times the minimum daily wage in India.[13] The Pacific Plaza in Costa Rica, funded by BII via the Emerge Central America Growth Fund, is a 22-hectare continuing care retirement community development with an integrated medical complex, including a hospital. It is marketed to expats, tourists and those seeking an alternative to the US healthcare system. Health diagnostic packages cost US$1,040 for seniors.[14]

Failing to do no harm

Oxfam's research identified multiple cases of alleged and confirmed human rights and patient rights abuses by private hospitals funded by BII.

Denial and selective use of government health insurance cards exacerbating poverty and inequality

15. BII's 2022-2026 strategy states that going forward *"any investment we make in a hospital will ensure the hospital supports a significant proportion of users who are on government payment schemes or on low incomes."* [15]

16. While this statement from BII is welcome, in practice it is making an unsafe and unevidenced assumption that government payment schemes (primarily government health insurance

schemes) work to provide fair and equitable access to health care in private hospitals, and that BII funded private hospitals that are part of such schemes adhere to their rules. It is also making assertions that its more recent investments reach people on low-incomes but as discussed below, it fails to disclose any evidence at all to support this.

17. India, where BII's health care investments are concentrated, has a government health insurance scheme that entitles members to free cashless care in empanelled private hospitals. Evidence indicates that a number of BII funded hospital chains are empanelled providers. But widespread evidence indicates that by encouraging and enabling greater use of India's under-regulated private health facilities, the health insurance scheme has exposed the poorest and most marginalised people to even more, not less, risk of financial hardship as well as other forms of abuse and exploitation.

18. For India's elderly population, national data shows out-of-pocket costs of hospitalisation are six times higher in private facilities than in the public sector, regardless of health insurance enrolment.[16] In one state, median out-of-pocket costs for government insured patients are eight times higher in private facilities than public ones, but the figure rises to 25 times higher for women.[17] The insurance scheme has failed to improve financial protection for hospitalisation.[18] Any BII assumption that involvement of its funded private hospitals in a government payment scheme solves the access and financial protection problem for low-income patients is therefore not supported by the evidence.

19. Oxfam's primary research found that at least some BII funded hospitals in India are exploiting and excluding government insured patients who are entitled to free healthcare. Of the patients and caregivers interviewed by Oxfam who sought care at BII funded CARE Hospitals and Narayana Health hospitals in India five were entitled to cashless hospital care at these hospitals under the government health insurance scheme. All were unjustifiably either blocked from using their cards or their cards were used only selectively. In all cases the patients or caregivers suffered catastrophic or impoverishing financial consequences due to the hospital fees they should not have been charged. The fees charged by these two hospitals for patients interviewed by Oxfam ranged from between three-and-a-half months to 14 years' worth of wages for an average earner in India.

20. In Kenya, another popular country for BII healthcare investments, informal workers are largely excluded from the government health insurance scheme, and a national survey found households with at least one person covered by health insurance were more likely to suffer catastrophic healthcare payments. Most Kenyans, and especially those on low incomes, continue to rely on public provision, but government funding to for-profit providers has skyrocketed under the government insurance schemes – rising 30-fold between 2010 and 2021. Sixty-four per cent of government health insurance expenditure now goes to private providers, compared with just 20% to public facilities. This constitutes a huge diversion of public resources to private providers via these insurance schemes while continuing to exclude those on low incomes from both membership and financial protection. Private providers in Kenya also get significantly higher reimbursement rates and, astonishingly, the most expensive private hospitals get to negotiate bespoke rates, which the government health insurance scheme does not disclose. All of the BII funded private hospitals in Kenya that Oxfam has information for, fall into this most expensive insurance category. This means that not only does the Kenyan government pay a

higher amount to these BII funded hospitals, but the amount paid by insurance only covers a fraction of the hospital bill resulting in higher out-of-pocket expenditure for the patient.

Exploitation and abuse

21. Oxfam's research into BII's healthcare portfolio has also identified extremely serious cases of exploitative, abusive and illegal behaviour and practice on the part of BII hospitals. The case of Nairobi Women's Hospital outlined in box 1 is one example drawn from Oxfam's report 'Sick Development'.

Box 1. Timeline of alleged and confirmed human rights abuses at Nairobi Women's Hospital

Nairobi Women's Hospital

The following evidence of both alleged and confirmed abuses of patients does not, to the best of our knowledge, apply to the hospital's non-profit charitable trust - the Gender Violence Recovery Centre[19] - which provides crucially needed free medical and psychosocial support to survivors and their families.

Nairobi Women's Hospital (NWH) was established in 2001 and today operates nine for-profit private hospitals and facilities across Kenya.[20] BII (then CDC) invested $75m in the Abraaj Growth Health Markets Fund (AGHF) in 2016. In 2017 AGHF bought a 75% stake in NWH.[21]

Following the liquidation of scandal hit Abraaj (see note below), management of AGHF was transferred to TPG Growth in 2019 and the fund was renamed 'The Evercare Health Fund'. The above information on CDC's investment in AGHF was first captured by Oxfam from CDC's website in 2018-19. Since then BII has removed all references to AGHF on its website and now incorrectly reports that its indirect investment in NWH took place in 2019. It also now reports an investment amount of $50m rather than $75m as originally reported.

Since 2017 there have been frequent media reports about patients being held hostage in NWH due to inability to pay medical bills. Such cases are alleged to have continued even after a court ruling in October 2018 that NWH acted unlawfully and in violation of the Kenyan Constitution.[22]

Published and broadcasted alleged human rights violations by NWH include:

16th May 2017: Family of George Mwenje Mwangi make public appeal to raise funds to pay for the release of his body reportedly detained by NWH for five months due to non-payment of $9700 bill.[23]

15th Nov 2017: A TV news report that 12 patients were detained at NWH facilities due to non-payment of bills. Detainees reportedly included one secondary school student detained for 11 months for an unpaid bill of $27,721.[24] The Federation of Women Lawyers and Center for Reproductive Rights called for their release.[25]

17th Dec 2017: A woman who lost one of her babies during childbirth reports that her surviving twin has been detained at NWH for over three months because she cannot afford the nearly $3000 bill. The mother told reporters of her psychological stress of having to commute daily to breastfeed her son before leaving him under the care of nurses.[26]

3rd October 2018: Court ruling that patient was illegally held at NWH for non-payment of a

$10,900 bill. Judge Lady Justice Wilfrida Okwany declared that even though this was a private facility, continued detention of the client was arbitrary, unlawful and in breach of the 2010 Constitution of Kenya.[27]

23rd April 2019: Refugee from Burundi detained for non-payment of $9,000 bill for his treatment following accident in Sept 2018 in which his ten-year old daughter was killed. His family of 7 who were reportedly on route to the UN refugee offices when the accident occurred had no means of paying the bill. NWH reported to have been in discussions to resolve.[28]

19th May 2019: Special report by Ministry of Health finds 15 bodies held at NWH over outstanding bills with 12 discharged patients detained for the same.[29]

July 2019: Undercover journalist interviews four patients detained at NWH for non-payment of bills. Cases include a single mother of two, first discharged on 22nd November 2018 but detained for 226 days for non-payment of her bill of $989. The bill escalated to $19,790 during her detention. All four patients were freed following TV coverage. The founder of NWH contacted the TV station to say: *'In cases where people are unable to pay, they reach an agreement with the hospital. For dire cases the hospital receives funding from donors.*'[30]

19th Sept 2019: Rebecca, 39 and mother of two, died from meningitis after five days in intensive care at NWH. Despite her husband offering to pay the $13,000 outstanding bill in instalments, NWH refused to release Rebecca's body for burial until payment made in full.[31]

25th Oct 2019: Two years after the death of her mother, Wanjiru makes a public plea to NWH to release her mother's remains as a Christmas present as she cannot afford the $43,000 hospital bill.[32]

March 2021: Kenya's High Court ordered NWH to pay Emmah Muthoni Njeri Ksh 3 million (over $27,000) in compensation for illegally detaining her at the hospital for over five months because of an unpaid bill. The judge declared the detention *'a violation of the right to liberty'* and *'an affront to human dignity'.*[33]

On a different issue, in January 2020, alleged internal NWH communications were leaked exposing the hourly pressure exerted by hospital senior managers on staff to increase admissions and delay discharges to ensure income targets were met, apparently regardless of clinical considerations.[34] In response, members of the public in large numbers shared personal experiences of alleged unethical practices including overcharging, over-testing and over-treating at NWH and other private hospitals in Kenya.[35] The situation escalated quickly – by February 5th 2020 the Association of Kenyan Insurers blacklisted NWH and extended their investigations to other hospitals owned by the donor backed Evercare Health Fund.[36] The Kenyan Medical Practitioners and Dentist Council sent in their inspectors and the Evercare Health Fund temporarily took over direct management of the hospital.[37]

A number of commentators covering the scandal at the time blamed the rapid and largescale injection of global finance via private equity firms in Kenya's private health care market as directly responsible for widescale unethical practices.[38] Some claimed the intensified drive for profits had translated to hospital managers being pushed to "*make money from patients by any means necessary"*.[39] Even in the midst of the scandal, another Evercare owned hospital, Avenue Group, announced the launch of a new $15.8m expansion plan, and Evercare disclosed plans to acquire even more medium sized hospitals in Kenya beyond the $99m already invested.[40]

22. These cases of alleged as well as confirmed human rights abuses require independent investigation and response. The case of NWH is particularly illustrative of the dangerous inadequacy of BII's due diligence, oversight and monitoring mechanisms. Patient detentions at NWH have received widespread coverage in the Kenyan media over the years and all the information presented above is sourced from freely available and easily found publicly reported and online sources. Further, the hospital policy of detaining patients was publicly confirmed by the hospital director <u>a year before</u> BII's investment in the hospital was made.[41] This raises serious questions over BII's due diligence, monitoring and reporting mechanisms, and whether they have simply failed to identify these well reported crimes. Further questions must be raised if these crimes were known and reported and no or insufficient action was not taken to stop them.

23. In response to a direct question in a UK IDC parliamentary evidence session in April 2023 about what action BII had taken in response to patient detentions at NWH, BII's CEO said: 'We fired Abraaj as the manager of the fund and replaced them with TPG. TPG, in turn, fired the entire management team at the Nairobi Women's Hospital. They put in place a whistleblowing mechanism in 2021, and, to my knowledge, there have been no incidents reported since then.'[42] But BII's response mischaracterizes what happened. Management of the Abraaj health fund was changed because of identified financial mismanagement by Abraaj and because Abraaj filed for liquidation in June 2018 (see Box 1 above and Box 10 in Oxfam's report Sick Development). BII and the other DFIs first appointed forensic auditors to investigate this in December 2017. However, patient detentions happened before and continued beyond this point and for at least another two years. There is no evidence that these human rights violations formed part of DFI investigations into Abraaj. The change in management at the hospital appears to have taken place in response to allegations of over-charging and unnecessary admissions. No mention of patient detentions were made at the time.

24. Oxfam's evidence strongly indicates that the NW H case is not an isolated example of abusive, exploitative, harmful or potentially illegal behaviour on the part of BII's health care portfolio companies and we have no confidence that BII's model of investment and accountability mechanisms provide sufficient safeguards against this practice happening in other hospitals that it funds today.

25. Oxfam's own primary research in India of patients seeking care and treatment at BII funded hospitals Narayana Health and CARE Hospitals uncovered multiple other cases of alleged rights violations including repeated denial of emergency care, including for a child and a woman left unconscious and badly injured in accidents as well as a stab victim. Patients also alleged being pressured to have unnecessary surgery. Oxfam also documented allegations of exploitative labour practices.

Potential harm to weak and under-resourced public health care systems

26. BII invests in countries with enormous unmet health needs and under-resourced public healthcare systems on which the poorest and most marginalised people depend. BII's new strategy itself explicitly acknowledges the potential harm to public healthcare systems of investing in private healthcare, and states that it "*will not support activities that undermine*

public facilities".[43] However, it can be seen that BII does not have the appropriate investment model, nor the tools, to deliver on this commitment.

27. The potential risks to public health systems of a larger, better financed, and more powerful commercial healthcare sector are well evidenced but also very complex, especially in contexts of under-resourced and under-regulated public health care systems. Such risks include brain drain from already under-staffed government health services; diversion of public resources to less equitable private care in the form of tax breaks, subsidised or free land and utilities, lobbied for by powerful private actors; diversion of public resources to less accessible private providers through the government health insurance scheme; diversion of public resources via private providers exploiting government health insurance schemes including by cherry picking and gaming the system; undue pressure by ever more powerful private sector providers on governments for deregulation, removal or inappropriately high price caps and other measures important to safeguard patient safety and care, including their financial protection; undermining the case for universal health care; and corrupting government health services by co-opting and incentivising government doctors to refer patients to private facilities.

28. Nearly 90% of BII's healthcare provider investments are made at arms-length via financial intermediaries, meaning BII has minimal, if any, significant influence or control to analyse or safeguard its investments against these serious risks. BII staff have confirmed that for every new **direct** health investment since 2017 it conducts a health impact evaluation.[44] However, BII staff have also indicated that it does not disclose these evaluations on the grounds of commercial confidentiality.[45] It is therefore impossible to know how independent or comprehensive these evaluations are and how the very complex risks of undermining public healthcare systems are understood, measured or mitigated, if at all. These evaluations do not take place for the overwhelming majority of BII's healthcare investments which are intermediated.

29. BII is also part of and takes a leading role in an initiative called Investors for Health[46] whose flagship report acknowledges that private sector involvement in health might undermine Universal Health Coverage, including by "*diverting resources away from public health systems and the most underserved populations"*.[47] The report states that to overcome these challenges "*requires substantial investor and public-private collaboration to provide care structures with the greatest positive impact"*. Such close collaboration does not characterise BII's approach as nearly 90% of healthcare provider investments are made indirectly and at arms-length. Further, Oxfam's research in India found that even in the case of direct investments, local decision makers and stakeholders in the communities in which BII funded hospitals operate are simply unaware of BII's role in these hospitals, let alone collaborating with it.

30. Furthermore, with over 80% of the financial intermediaries used by BII to invest in health domiciled in known tax havens, predominantly Mauritius and the Cayman Islands, questions should be asked of BII as to how it ensures its investments in health are not complicit in tax avoidance schemes that deny governments the domestic revenues urgently needed to invest in and strengthen public health care systems.

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

the United States, France, Germany and the UK, for example, have found higher rates of mortality and lower staffing levels in care homes owned by private equity firms, and lower quality of care in for-profit homes, compared with their public or non-profit peers. Evidence is growing in the USA that private equity's expansion into healthcare has led to higher prices and diminished quality of care.[48]

32. The broader more foundational question of the need for and desirability of increased private financing for healthcare in LMICs should also be considered. The World Health Organisation (WHO) guidance on health financing for Universal Health Coverage recommends reducing reliance on private financing[49] and to progress towards a system that relies primarily on public financing.[50] Evidence also shows that in countries across the world, the higher the share of private financing for health the higher the rate of premature deaths;[51] the greater the inequality in life expectancy between rich and poor;[52] and, during the pandemic, the higher the rate of Covid-19 infection and deaths (after controlling for other factors).[53] BII's theory of change to encourage and increase a greater role for private financing in healthcare is not in line with WHO's international guidance and seems to fail to account for the evidence that a greater proportion of health financing from private sources exacerbates inequality and produces worse health outcomes, especially for women.

<u>Impact, transparency, governance, and accountability</u>

Insufficient poverty and gender impact reporting in healthcare

33. The most vital measure of impact for any development spending on health, including that which finances private health care actors, must be whether it advances health care access and outcomes for those most excluded and who suffer the worst health outcomes, and that it does this without causing financial hardship. Oxfam's research indicates that BII's investments go to expensive hospitals that are unaffordable to people on low-incomes and living in poverty. Oxfam's research to date also strongly indicates that BII's monitoring of impact on improving access to those most denied health care, including for women and girls is woefully inadequate.

34. For the 90% of BII's health care investments that are made indirectly, Oxfam could not find any information regarding BII's anticipated or intended impact in terms of reaching people living on low-incomes or in poverty, or on women and girls. This is unacceptable.

35. In seven out of thirteen of BII's direct investments in healthcare providers or in health-specific financial intermediaries, Oxfam found no anticipated or intended impact references to access for low or lower-income people. In six cases[54] the brief project descriptions refer to the fact or infer that some low-income patients are reached by the healthcare providers, but 'low-income' is undefined, and numbers or proportions not provided. For example, BII's 2019 $45 million investment in Chemistry Holdings Ltd for a hospital in Bangladesh simply states that patients are: "*Middle-income (inpatient care); Low-income (outpatient care) with c. 45 per cent of the patients from outside Dhaka."* [55] There is also no clarity for any of the investments whether it is the intention of BII to further increase access to low-income patients via these investments.

36. Only three of thirteen project descriptions for BII's direct investments in healthcare providers or in health-specific financial intermediaries make reference to women and girls as users of health care services, or to any services specifically benefiting women and girls.

37. Oxfam has also found no comprehensive ongoing or ex-post impact monitoring data from BII about impact on low-income patients, women and girls or other marginalised groups.

38. In one partial exception, BII's direct health care investment in Narayana Health was evaluated as a pilot case-study for the then CDC's newly developed health impact framework in 2017.[56] In relation to access and affordability, the evaluation made note of the hospital chain's participation in government health insurance schemes that aim to increase access to poorer patients; some potential but unclear cross-subsidisation from richer to poorer patients; and some help to link up struggling patients to potential 'donors' who might help pay their healthcare bills. However, the evaluation also highlighted the challenge of patients at the hospitals having to pay out-of-pocket if their healthcare bills exceeded government health insurance caps and said little evidence was available to assess real impact in terms of reaching poorer patients or whether patients were avoiding catastrophic medical expenses. The authors also critiqued the company's ad hoc charitable model which they said might give preferential access to handpicked patients deemed 'most deserving' by philanthropic donors.[57]

39. Other relevant affordability concerns in the evaluation included the risk that fee-for-service payment contracts for senior doctors at Narayana may incentivise unnecessary admissions, procedures and treatments; and the absence of a formal and systematic approach to ensure treatments are cost-effective and appropriate. The authors concluded that many of Narayana's achievements have been supported only anecdotally or through basic data collection and that 'data collection must improve so that it can back up its claims'.[58]

40. DFIs including BII place emphasis on job creation as a key pillar of their positive impact on development and poverty reduction.[59] However, job creation should not be used as a replacement or alternative for positive development impact elsewhere, or as a defence for negative impact. This is especially important in key essential sectors such as health and education that are fundamental for upholding rights and tackling poverty and inequality.

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

Transparency and accountability

42. BII's reported information about its healthcare investment are often delayed, and not sufficient for accountability purposes. While BII does report its indirect investments, which is not the norm for all DFIs, the information provided on these investments is minimal. The level of information published has been reduced since Oxfam first started mapping CDC's health investments in 2018.

43. Financial intermediaries, primarily equity funds, are responsible for nearly 90% of BII's healthcare investments, and these intermediaries are not transparent about where they invest their funds or their impacts. For every BII indirect investment the project blurb reads the same

as follows: "*We do not hold direct relationships with the companies that investment funds invest in. Instead, we hold relationships directly with the fund. When investing through investment funds, British International Investment takes an active role as a limited partner to the fund, working with the fund manager to ensure best practices, including in environment, social and governance matters, and investment management oversight.*" [60] Oxfam has not found any reported evidence of BII's successes or failures in this regard in reference to health.

44. Some of BII's health investments are made through very complex overlapping financial channels, with intermediaries investing in other intermediaries, where the trail for information can be difficult to follow, and/or overlap with other BII investments as well as those of other DFIs. This not only raises further questions about the level of control and understanding BII has about the use of its development funding and who is benefitting from it, but also of whether these investments are serving one of their primary objectives of 'crowding in' other private investors.

45. Citadel Holdings in Uganda is one example. This is an intermediated investment made via the Africa Rivers Fund and is tagged as a health investment by BII.[61] Oxfam's searches have been unsuccessful in finding out anything about what this company or financial vehicle is or what it does.

46. The lack of control, oversight and accountability of financial intermediaries could lead to risk of financial mismanagement, fraud and corruption. Fraudulent activity identified in the Abraaj Growth Health Markets Fund used by BII to invest in Nairobi Women's Hospital and other hospitals across Africa and Asia, led to the high-profile collapse and liquidation of Abraaj and put millions of development funds at risk.[62] There remains a lack of transparency about any due diligence and monitoring failings on the part of BII and other DFI investors in Abraaj that had partnered with Abraaj for many years before its collapse.

47. Independent accountability mechanisms (IAMs) are important governance tools that allow communities to raise human rights and environmental concerns to the institutions' financing projects. BII does not have such a mechanism, whilst DFIs such as the IFC, Proparco and DEG do.[63] This means that for communities and individuals alleged to have been adversely impacted by BII's health investments have no independent route to raise their concerns or complaints and hold BII to account.

Governance and oversight

48. On the basis of the evidence Oxfam has collected to date, it can be seen that BII's oversight and governance of its health care portfolio are inadequate. BII has evidently underestimated the true extent and nature of risks related to its healthcare investments to patients and caregivers and BII's business model and approach is not fit-for-purpose to safeguard against such risks. These shortcomings already apply to BII's direct healthcare investments but are amplified for the nearly 90% of health care investments it makes indirectly via financial intermediaries.

49. The insufficiency of BII's governance and oversight of its healthcare investments are further compounded by minimal or no effective government regulation of private healthcare providers in the countries in which it invests. For example, BII has made over half of all its healthcare investments in India and is contributing to the rapid commercialisation and corporatisation of the healthcare market. But government regulation and enforcement of private providers is weak in India and, in many cases, compromised.[64] In this context, evidence points to large scale

patient rights violations by private health care providers including price gouging and collusion; denial of free treatment to entitled patients; exorbitant bills; discrimination; and unnecessary admissions, procedures and treatments.[65] An example of the latter is tens of thousands of young women forced into debt and even slavery following entirely unnecessary hysterectomies carried out for profit by private health care providers.[66] Alarmingly, in one state of India, 95% of all hysterectomy claims were from private hospitals. Data from the same state shows that 78% of all normal childbirth claims come from the public sector, while 93% of all C-section claims came from the private sector.[67]

50. It is challenging to see how any arms-length investing in private healthcare could be deemed free of risk of doing harm in this under-regulated context. It is particularly troubling that despite the vast evidence base of large-scale patients' rights violations in India's private healthcare sector, we have found no significant public acknowledgement of such risks by BII.

Conclusion and recommendations

51. Oxfam's extensive research on BII's health care portfolio strongly indicates that rather than contributing to the goals of universal health coverage and poverty reduction, BII risks doing the opposite by investing in expensive, unaffordable hospitals that either block those most in need or risk bankrupting them, and pushing them into poverty. The weight of evidence is clear that BII's model of investing in healthcare lacks adequate safeguards and that some of its investments are doing significant harm. The examples of patient rights violations shared in this written submission and in Oxfam's report 'Sick Development' are of significant concern and warrant independent investigation and response.

52. On this basis Oxfam recommends:
    - an immediate freeze of all BII future direct and indirect funding to private health care providers
    - an independent and comprehensive inquiry into BIIs current and historic healthcare investments
    - the urgent establishment of an independent accountability mechanism to allow communities to raise human rights and environmental concerns related to BII's financing

53. *Please note:* Oxfam's recommendation to freeze future BII funding to health applies only to the 50% of BII's health investments that go to health care providers. We have not examined in greater depth the second largest area of BII's health investment portfolio – that of research and development (R&D). Investments in R&D and in local manufacturing of vaccines and treatments hold real potential for positive change if done with strong conditionality for fair and affordable access. However, this is an area that requires further investigation to understand the impact of BII's investing in this area.

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