Development Finance Institutions: The (in)coherence of their investments in private healthcare companies

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Introduction

Development finance institutions (DFI) are playing an increasingly prominent role in the spending of official development assistance (ODA). They are at the forefront of attempts to 'leverage' private investment for development, with a particular focus on supporting the expansion of businesses and hence economies in the Global South. Interest in accommodating 'private sector instruments' to finance the Sustainable Development Goals is likely to encourage further growth of DFIs.

Some development agencies and their DFIs claim, in the absence of publicly financed universal access to healthcare, the private healthcare sector should become a priority area for their investment. Private investors are encouraged by the potential for rapid growth in the size and value of healthcare markets - people are willing to pay substantial amounts to try to achieve good health for themselves and others. The rising burden of chronic, non-communicable diseases globally is intensifying this demand for healthcare services.

Several DFIs have provided technical assistance and made large direct and indirect (through a financial intermediary) commitments to healthcare companies in recent years. The World Bank's International Finance Corporation (IFC) has made direct commitments totalling more than US$1.1 billion to healthcare companies since 2013. Three European DFIs – Germany's DEG, France's PROPARCO and the UK's CDC[1] – have together committed another US$425 million. (See the list of commitments in appendix). The wholescale transformation of Turkey's healthcare system through large private finance initiatives has attracted particularly large loans. DFIs such as DEG, PROPARCO and Canada's Export Development Corporation have backed the Turkish Ministry of Health's private finance initiatives with loans, but these have been dwarfed by loans from the USA's Overseas Private Investment Corporation (OPIC) and the European Bank for Reconstruction and Development (EBRD), totalling US$750 million and US$630 million respectively.

DFI health investments are often channelled via intermediary funds. These are more challenging to track than direct investments, but for some DFIs they can be significantly larger than their direct investments. There is a range of investment funds taking on greater roles in the healthcare sector (World Economic Forum, 2016), including some funds focused entirely on making investments in health-related companies. These funds include the Africa Health Fund (US$105 million), Investment Fund for Health in Africa (US$66 million) and follow-up Investment Fund for Health in Africa II (US$137 million). The largest to date is Abraaj Group's Growth Markets Health Fund, which aimed to attract US$1 billion for investment in health companies. It received investments from IFC, OPIC, PROPARCO, CDC, African Development Bank and the Bill and Melinda Gates Foundation, amongst others.

In some cases DFI investments have been accompanied by financing from private sources. Investment funds have attracted commitments from a range of commercial banks, pension funds

and pharmaceutical companies. The Turkish Ministry of Health's private finance initiatives have received loans from commercial banks and technology companies. The Abraaj Group has been a key private investor alongside DFIs, for example in Narayana Health in India (with CDC) and in North Africa Hospital Holdings (with the EBRD, DEG and PROPARCO).

The scale of DFI investment in private healthcare companies remains relatively small compared to overall development aid for health committed annually – estimated at $36 billion in 2015 (Dieleman et al., 2016). But it is a rapidly growing area and the vision for future expansion is grand. The IFC aims to reach 1.2 billion users through its healthcare investments by 2030 (IFC, 2017). Not all DFI investments are classified as ODA, however there is a growing trend whereby governments are using ODA to leverage private finance via DFIs. DFIs also have stated aims to promote poverty reduction and development. The remainder of this chapter examines some of the key concerns related to development policy coherence of these investments, including an illustrative case study. The chapter concludes with policy recommendations.

Concerns with policy coherence

Commitments by development finance institutions in private healthcare companies have seen an expansion of infrastructure that can be broadly categorised into two groups: 1) corporate chains and 2) private finance initiatives. DFI technical assistance can also play a key role. A series of concerns with the sustainable development policy coherence for these projects are outlined below.

Corporate healthcare, user fees and poverty reduction

A recent report by the World Bank Group and World Health Organization (2017) estimated that almost 100 million people were pushed into extreme poverty (US$1.90 a day) by out-of-pocket healthcare expenditure in 2010. At the $3.10 poverty line, the figure was over 120 million people. Healthcare user fees are one of the key drivers of descents into poverty (Krishna, 2010), and are widely acknowledged to be a regressive form of financing healthcare. Affordability remains a key reason why half the world's population still does not have full coverage of essential services (World Bank Group and World Health Organization, 2017).

Nonetheless, corporate chains that are being expanded with DFI support invariably use fee-based payment systems. These fees can be extremely high. Fees may be waived with chains that provide 'free' services to low-income households, cross-subsidised by fees paid by the less poor, but such packages are often limited to particular services, with limited follow-up, and are made at the discretion of the administering hospital. Health insurance to cover the costs of services at these private facilities is often either unavailable or unaffordable for much of the population. These user fee systems undermine the right to health and do little to assuage fears as to whether households are protected from both direct and indirect costs of care.

Segmented healthcare and inequality

There are important issues related to segmentation in healthcare systems. Corporate chains fit one of two models: 1) high-cost chains targeting wealthier groups and 2) high-throughput, 'affordable' chains targeting less wealthy groups – the so-called 'base of the pyramid'. In reality, the 'base of the pyramid' model is usually out of reach for the poorest groups, as noted in an IFC-commissioned report on 'inclusive' business models for healthcare (Deloitte, 2014). DFIs appear to be promoting a broadly three-tiered healthcare system whereby 1) the poorest rely on whatever informal,

charitable or public healthcare services are available; 2) those who can are expected to purchase healthcare from high-throughput chains; and 3) the wealthiest groups access care in private tertiary and specialty hospitals, often using private health insurance (see Health in Africa case study below).

This segmentation is exacerbated by growing interest in creating destinations for international medical tourism. Examples of hospitals that have received IFC support and compete in global healthcare markets include: Bumrungrad Hospital in Thailand; Asian Hospital and Medical Center in the Philippines; Saudi-German Hospitals in Middle-Eastern and North African countries; and Apollo Hospitals, Max Healthcare and Fortis Healthcare in India. Turkey's private finance initiative healthcare campuses, which are supported by loans from DFIs and private investors, were promoted by President Recep Tayyip Erdoğan as part of an effort to make Turkey 'one of the top five countries in the world for medical tourism' (Rosca, 2016).

This international approach to health infrastructure development does little to address the health needs of low-income groups and risks exacerbating inequality of access, especially if such private health investments lead to further brain drain from already under-staffed public health services.

Public funding and sustainability

Much of the healthcare infrastructure expansion that is taking place with DFI support is predicated on a future of public subsidies for private profit. Corporate healthcare chains are looking to secure revenue streams from the government insurance schemes being rolled out in the name of 'universal health coverage', but largely providing services for salaried workers, middle-classes and, in some cases, the informal sector. Commercial motivations within public healthcare are likely to provoke inflation, 'cream-skimming' and provider attrition. Public subsidies to commercial providers risk leaving governments rationing services and diverting funds from more progressive public health activities.

Private finance initiatives allow governments to transfer risk in hospital development to construction and management consortia. While the terms of payment are often generous and long-term, they lock current and future governments into significant and inflexible interest payments. Lesotho's IFC-brokered Queen Mamohato Hospital provides a clear warning of how these private finance initiatives can considerably distort public finances (Marriott, 2014). Because of these impacts, there are growing calls for development banks to stop promoting these models (Eurodad, 2017).

Fund managers, transparency and tax avoidance

The use of intermediary funds makes it difficult to track certain DFI investments (Romero, 2014). Although DFIs publish details of investments with external fund managers, they do not necessarily report the companies receiving investment from those funds (sub-projects). For example, investment by IFC in the Ambit Pragma Fund was reported in the IFC project database, but the Ambit Pragma Fund's subsequent investments in Beams Hospitals and Vidal Healthcare were not. This practice obstructs effective monitoring of DFI activities by both civil society and governments and undermines country ownership.

The IFC's Compliance Advisor Ombudsman (2012) found that, due to the lack of transparency and paucity of information, the IFC was unable to claim its investments via intermediary funds resulted in development benefits, or to provide assurance that these same investments caused no harm to poor people or the environment. In a positive step, IFC (also OPIC and CDC) now aims to report sub-projects of private equity funds that are categorized as high risk, based on environmental and social

risk. However, this reporting is patchy and does not appear to include supposedly lower risk sub-projects.

In addition to transparency concerns, some external managed funds are registered in 'tax havens', which undermines domestic tax and resource mobilisation efforts in countries where they have their core business operations, weakening the funding base needed to achieve universal health coverage. For example, the two iterations of the Investment Fund for Health in Africa attracted US$200 million from DFIs and private investors, including the Bill and Melinda Gates Foundation, and the fund used Mauritius as a base for its investments. The Abraaj-managed (and IFC-backed[2]) US$100 million Africa Health Fund did likewise. Abraaj's US$1 billion Growth Markets Health Fund is registered in the Cayman Islands. Both Mauritius and the Cayman Islands utilise harmful preferential tax measures (Chardonnet and Langerock, 2017), depriving other countries of access to tax revenue from investment profits.

There have been some positive, but so far insufficient, steps to ensure responsible tax practices to increase the availability of public resources for critical investments, including healthcare. Of note is the European Union's recently agreed list of counter-measures against tax havens, both those which appear on its blacklist of tax havens, and potentially those on its 'greylist' (including Cayman Islands and Mauritius). Countermeasures include prohibiting European Investment Bank investments being routed through listed tax havens, and working with other development organisations to implement these measures more widely.

Health in Africa case study

In 2008, the IFC launched the Health in Africa initiative, a US$1 billion investment project whose objective was to 'catalyze sustained improvements in access to quality health-related goods and services in Africa [and] financial protection against the impoverishing effects of illness', with 'an emphasis on the underserved' (World Bank Group, 2013, p. 1). Health in Africa's strategy was to utilise three main investment mechanisms: 1) a US$300 million equity vehicle; 2) a US$500 million debt facility mobilising loans from local banks for private healthcare actors; and 3) US$200 million in technical assistance (IFC and World Bank, 2010). This initiative included the Africa Health Fund and Investment Fund for Health in Africa mentioned previously.

Health in Africa's official literature implied adherence to the World Bank Group's overarching goals to end extreme poverty and promote shared prosperity. There was repeated attention to Health in Africa's intended focus on benefiting 'underserved' populations in sub-Saharan Africa. The Health in Africa plan, presented to the World Bank board for approval in 2007, emphasised improving the 'availability of health care to Africa's poor and rural population' (Brad Herbert Associates, 2012, p. 11).

However, an independent mid-term review of Health in Africa, conducted by Brad Herbert Associates in 2012, found clear evidence of systematic failings to realise impacts for poor people across all Health in Africa's work streams (ibid.). The review documented failure to analyse how to reach poor people effectively via the private sector, failure to implement direct investments for the benefit of poor people and failure to measure whether poor people were being reached. Health in Africa's analytic work was found to have completely failed 'either by omission or design' to 'engage with the single most important global controversy with regard to the role of the private sector in health in Africa: the role – if any – that the private health sector can and should play in achieving

development impacts' (p. 18). The mid-term review concluded that the failure of the IFC to define or assess its anticipated results meant that it was 'difficult to assess the extent to which Health in Africa has had any real impact' (p. 4).

In 2014 Oxfam conducted a desk-based portfolio review of Health in Africa's investments (Marriott and Hamer, 2014). It found that a large proportion of these investments were made in expensive, high-end, urban hospitals offering tertiary care to African countries' wealthiest citizens and expatriates. For example, Health in Africa's largest direct investment was a US$150 million equity investment in South Africa-based corporate chain Life Healthcare. Corporate healthcare in South Africa is unaffordable, even for many comparatively wealthy South Africans with health insurance, let alone the 85% who lack insurance (McIntyre, 2010).

Other examples of Health in Africa-linked investments that appear to disproportionately benefit elite groups rather than providing healthcare for people living in poverty include:

- A US$1.5 million loan to Clinique La Providence in Chad to make available 'locally, health care services for which Chadians are currently travelling abroad' (IFC, 2014);
- A US$1.7 million investment in Clinique Biasa in Togo, which described itself as 'one of Lomé's top three private hospitals' (Private Equity Africa, 2012);
- A US$2.7 million investment in Nairobi Women's Hospital, which had an average reported in-patient cost of US$845 in 2011, equivalent to the entire annual income for two-thirds of Kenyans (World Bank Group, 2012);
- A US$5 million investment in West Africa's first IVF centre in Nigeria that aimed to 'provide world-class infertility treatments' (Abraaj, 2012), at a cost of over US$4,600 for one cycle of IVF (Bridge Clinic, 2014); and
- At least US$7.7 million in loans and investments for Hygeia's Lagoon Hospitals in Nigeria which offer 'luxury accommodation' and claim to perform operations 'using techniques that are only possible at very few specialised hospitals in the United Kingdom and USA' (Lagoon Hospitals, 2014).

Health in Africa has also contributed to the expansion of health insurance models that disproportionately benefit the non-poor, but which can provide users and revenue for the types of private hospitals and clinics being expanded with Health in Africa support. Investments made by the Investment Fund for Health in Africa in Tanzanian private health insurer, Strategis Insurance, or in Nigerian health maintenance organisation, Hygeia, are unlikely to contribute meaningfully to the achievement of equitable universal health coverage (Averill, 2013).

Private health insurance is a notoriously regressive form of healthcare financing as it excludes the poor through high premiums and co-payments. One Hygeia pilot scheme in Lagos, for example, explicitly set out to target low-income workers, but ended up excluding approximately 80% of the working population as it required enrolees to work in the formal sector (Marriott and Hamer, 2014). With a US$93 premium per person, an expansion of this scheme into the informal sector could be expected to exclude people living in poverty unless there was a very high level of government or donor subsidy.

The use of intermediary funds to manage Health in Africa investments complicates the task of examining development impact. The two Health in Africa equity funds that were operational in 2014 – Africa Health Fund and Investment Fund for Health in Africa – were assigned the job of 'investing

in socially responsible private health companies serving underserved and low-income people' (IFC and World Bank Group, 2011). However, the Oxfam study found no evidence that either fund targeted low-income users in practice or measured their attempts to do so.

Managers for the Africa Health Fund reportedly claimed to have developed an innovative incentive framework to reward portfolio companies for reaching patients at the 'base of the pyramid' (Kholi and Wanjiro, 2013). However, the income threshold used as a ceiling for the 'base of the pyramid' was set so high that it included up to 95% of earners in sub-Saharan Africa.

The Investment Fund for Health in Africa requested that its portfolio companies voluntarily complete a questionnaire on environmental, social and development impact. On the basis of this data, fund managers made a series of unsubstantiated claims, notably that extension of insurance, telemedicine and other products and services would automatically lead to increased, equitable access to healthcare.

Concerns with Health in Africa's impact on poverty have never been sufficiently addressed. Health in Africa's 2012 mid-term review noted that a results framework had 'finally been developed.' However, this framework has not been made publicly available and there is no evidence available in the public domain to confirm it has been put into practice (Marriott and Hamer, 2014; author communication with IFC, 2018).

The IFC recently developed a new Anticipated Impact Measurement and Monitoring system (AIMM) to define and measure the development impact of its direct investments, financial intermediary investments and advisory services. The IFC's efforts in this direction are a welcome development. But it remains to be seen if this new system will consider who ultimately benefits from IFC investments and who is left out. A second question is whether it will go far enough to monitor health and health care system outcomes to ensure the IFC is meeting its obligation to reduce poverty and promote shared prosperity. Furthermore, unless the IFC improves transparency and disclosure practices for intermediary fund investments it will be almost impossible to verify impact claims using publicly available information.

Conclusions and recommendations

While DFIs claim to be motivated by poverty reduction, their investments in healthcare projects suggest significant policy incoherence. User fee models have been widely acknowledged as inequitable and poverty-causing. Yet they continue to be rolled out with DFI support. Many healthcare corporates backed by DFI investment do not attempt to provide services to the poor, or do so only on an *ad hoc* basis. The lack of a clear framework in attempts to evaluate Health in Africa's developmental impact is symptomatic of a policy myopia in DFIs.

Comments emphasising the profitability of the healthcare sector do little to assuage these concerns. For example, in a recent article, an IFC principal equity specialist highlighted healthcare as a lucrative area for its investments. But there was just one mention of poverty, which suggested that health services would improve 'human capital' and thereby reduce poverty (Mirza, 2018).

DFIs operating in the commercial healthcare sector frequently fail to reach the poor or even measure poverty reduction impact. Moreover, their activities risk widening social segmentation and inequalities. Their investments allow the expansion of healthcare models that exclude the poorest and legitimise a separation of the 'base of the pyramid' from wealthier groups. Widespread use of

'tax havens' for DFI investments weakens the domestic resource mobilisation needed to support equitable models of universal access to healthcare. A lack of transparency and accountability undermines development effectiveness principles. Urgent changes in the practices of DFIs are needed to address these concerns. Development organisations should certainly refrain from directing valuable ODA through this route until and unless DFIs:

- Undertake a full, transparent and accountable review of the pro-poor impact of current and historic health investments via DFIs. Such a review should include an analysis of the broader impact of increased private sector healthcare activity on health inequalities and the right to health;
- Introduce robust, transparent and accountable frameworks to ensure their healthcare investments benefit, rather than exclude, the poor and do no harm;[3]
- Enhance transparency and accountability in reporting healthcare investments and their impacts via intermediary funds;
- Demonstrate a strengthening rather than undermining of the public healthcare sector due to investments in private healthcare; and
- Support efforts to prevent tax avoidance and mobilise domestic resources for universal health coverage. This should be applied to existing as well as new investments.

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Appendix: A list of direct DFI commitments for healthcare companies, 2013-2017, in US$

Year	Company	Country	DFI	Amount ($ m)	Source
2013	Rainbow Hospitals	India	CDC	17.5	Annual report
2013	AAR Clinics	Kenya	Swedfund	3.0	Media
2013	Ivy Health and Life Sciences	India	DEG	13.0	Press release
2013	Medica Synergie	India	Swedfund	N/D	Media
2013	Medica Synergie	India	DEG	N/D	Media
2013	Concord Medical	China	IFC	50.0	DFI website
2013	Hospital Metropolitano de Santiago	Dominican Rep.	PROPARCO	10.0	DFI website
2013	Fortis Health	India	IFC	100.0	DFI website
2013	Bilkent Health Campus	Turkey	OPIC	250.0	DFI website
2013	STS Holdings Limited	Bangladesh	IFC	28.5	DFI website
2014	Intermed	Mongolia	IFC	10.0	DFI website
2014	AAR Holdings	East Africa	IFC	4.0	DFI website
2014	SalaUno	Mexico	IFC	2.2	DFI website
2014	Nephroplus	India	IFC	7.0	DFI website
2014	AIDS Healthcare Foundation	Sub-Saharan Africa	OPIC	7.5	DFI website
2014	Hospital Metropolitano	Nicaragua	IFC	4.4	DFI website
2014	Adana Health	Turkey	IFC	48.7	DFI website
2014	Adana Health	Turkey	EBRD	121	DFI website
2014	Adana Health	Turkey	DEG	36.3	Media
2014	Adana Health	Turkey	PROPARCO	36.3	Press release
2014	Kayseri Health (YDA Group)	Turkey	IFC	45.7	DFI website
2014	Centro Hospitalario Serena del Mar	Colombia	IFC	20.0	DFI website
2014	Rede D'Or	Brazil	IFC	50.0	DFI website
2014	Rede D'Or	Brazil	PROPARCO	62.2	DFI website
2014	Asia Heart	China	IFC	35.0	DFI website
2015	ESIP EyeQ	India	IFC	5.4	DFI website
2015	Conclina SA	Ecuador	IFC	15.0	DFI website
2015	Clinique La Providence	Chad	IFC	1.4	DFI website
2015	Etlik Health (Astaldi)	Turkey	IFC	88.0	DFI website
2015	Etlik Health (Astaldi)	Turkey	BSTDB[4]	67.2	DFI website
2015	Etlik Health (Astaldi)	Turkey	EBRD	140.0	Media
2015	Etlik Health (Astaldi)	Turkey	DEG	33.6	DFI website
2015	Konya Hospital PPP	Turkey	EBRD	72.7	Press release
2015	Konya Hospital PPP	Turkey	BSTDB	53.8	Press release
2015	Konya Hospital PPP	Turkey	IDB[5]	72.7	Press release
2015	North Africa Hospital Holdings	North Africa	PROPARCO	15.0	Media
2015	North Africa Hospital Holdings	North Africa	EBRD	25.0	DFI website
2015	North Africa Hospital Holdings	North Africa	DEG	15.0	Media
2015	Narayana	India	CDC	48.0	Media
2015	Eagle Eye Echo-Scan	Nigeria	IFC	11.6	DFI website
2015	Hygeia Nigeria	Nigeria	IFC	12.4	DFI website

2015	Ciel Healthcare	SSA	IFC	6.8	DFI website
2015	Portea Medical	India	IFC	7.0	DFI website
2015	UFH Guangzhou Loan	China	IFC	60.0	DFI website
2015	ADK Hospital	Maldives	DEG	12.0	DFI website
2016	Apollo Speciality	India	IFC	33.3	DFI website
2016	Kocaeli Hospital	Turkey	OPIC	250.0	DFI website
2016	Kocaeli Hospital	Turkey	EBRD	22.4	Press release
2016	Kocaeli Hospital	Turkey	EDC	58.0	Media
2016	Izmir Bayrakli Hospital	Turkey	EDC	69.0	Media
2016	Izmir Bayrakli Hosptial	Turkey	EBRD	96.3	DFI website
2016	Izmir Bayrakli Hospital	Turkey	OPIC	250.0	DFI website
2016	Elazig Hospital	Turkey	PROPARCO	42.9	DFI website
2016	Elazig Hospital	Turkey	IFC	87.6	DFI website
2016	Gaziantep Hospital	Turkey	EBRD	90.0	DFI website
2016	Gaziantep Hospital	Turkey	EIB	134.8	Press release
2016	Medlife	Romania	IFC	11.1	DFI website
2016	Iso Health Ltd	Kenya	IFC	5.7	DFI website
2016	STS Hospital Chittagong Limited	Bangladesh	DEG	17.5	DFI website
2016	Evex	Georgia	PROPARCO	25.0	DFI website
2016	Evex	Georgia	IFC	25.0	DFI website
2016	HCG	India	IFC	19.9	DFI website
2016	Care	India	CDC	N/D	DFI website
2016	Regency Hospital	India	IFC	9.1	DFI website
2017	Max Healthcare	India	IFC	75.0	DFI website
2017	Rede D'Or	Brazil	IFC	130.0	DFI website
2017	Intermedica	Brazil	IFC	75.0	DFI website
2017	AHG Bulgaria	Bulgaria	IFC	16.1	DFI website
2017	Cameroon Cataract Loan	Cameroon	OPIC	2.0	DFI website
2017	Axa Hospital	Nigeria	IFC	8.5	DFI website
2017	Bursa	Turkey	DEG	23.3	Press release
2017	Bursa	Turkey	PROPARCO	17.5	Press release
2017	Bursa	Turkey	EBRD	64.2	Press release
2017	Bursa	Turkey	EIB	174.8	Press release

Note. Non-US$ values have been converted into US$ using historical conversion rate on xe.com for date of investment. N/D – not disclosed

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[1] Deutsche Investitions-und Entwicklungsgesellschaft (DEG), Société de Promotion et de Participation pour la Coopération Economique (PROPARCO) and CDC Group (formerly the Colonial Development Corporation).

[2] An Oxfam analysis revealed that 51 of the 68 companies in sub-Saharan Africa that the IFC invested in used tax havens (Jespersen, 2016). Together these companies, whose use of tax havens has no apparent link to their core business, received 84 percent of the IFC's investments in the region. 2

[3] The UK's CDC recently commissioned impact assessment of private providers on health and health systems is a welcome first step in this regard. It is not yet clear however, whether CDC will conduct such impact assessments for investments *ex ante* and/or whether it will use assessment outcomes as a condition for investment.

[4] Black Sea Trade and Development Bank.

[5] Islamic Development Bank.