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# FIRST, DO NO HARM

Examining the impact of the IFC's support to private healthcare in India

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## Acknowledgement

**Co-Authors:** Anjela Taneja and Amitabha Sarkar

**Research Support:** Akshay Tarfe

Designed by Akshay Tarfe

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## About the authors:

Anjela Taneja led the work on Public Services including health and education at Oxfam India. She authored a report "Overlooking the Fundamental" looking at the World Bank, ADB, AIIB and NDB lending in India's health and education sectors during and after the COVID-19 pandemic. She also co-authored reports on Patient Rights and the impact of the privatization of health on Dalits, Adivasis and Women in India.

Amitabha Sarkar has done his PhD from the Centre of Social Medicine and Community Health, Jawaharlal Nehru University (JNU). His PhD thesis is on the World Bank's Aid in Health Systems. He works on the interlinkages of international development and health policy. He is currently a Swiss Government Excellence Fellow at the Global Health Centre, The Graduate Institute of International and Development Studies (IHEID) in Geneva. He is also an Associate at the Transnational Institute (TNI), the Netherlands and a guest lecturer at the Global Health and Social Policy, Tampere University, Finland.

## Summary

This report examines the support to private healthcare provision in India by the World Bank's private sector arm, the International Finance Corporation (IFC). Despite supporting private healthcare in the country since 1997, no healthcare results for lending and investments have been disclosed since the start of these operations over twenty-five years ago. The IFC has overwhelmingly invested in high-end urban hospitals which are out of reach for the majority of Indians. Several have consistently failed to provide free healthcare to poor patients despite this being a condition under which free or subsidized public land was allotted to these hospitals. Supporting private healthcare in a context where 37% of Indians experience catastrophic health expenditures in private hospitals appears to run counter to the World Bank Group's focus on poverty reduction. These investments do not contribute to the building of stronger healthcare infrastructure or respond to unmet healthcare needs. Only 14% of IFC-financed hospitals are located in the 10 states ranked lowest in terms of the overall performance of the health system. Furthermore, we found many instances where regulators upheld complaints pertaining to violations of patients' rights by these hospitals including overcharging, denial of healthcare, price rigging, financial conflict of interest and medical negligence. The IFC does not acknowledge or engage with these recurring and systemic problems in its public disclosures. The report recommends that the IFC immediately stop all new investments in private hospitals and clinics in India until existing investments and operations in this sector are independently reviewed and a robust, transparent, and accountable framework is put in place to ensure that all projects and investments are equitable, geared towards meeting unmet healthcare needs, promote, and protect patients' rights and strengthen the public system.

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## EXECUTIVE SUMMARY

India is ranked fifth from the bottom in terms of public spending on health globally and ranks 155<sup>th</sup> out of 167 countries on hospital bed availability. It has one of the highest out-of-pocket spending levels on health in the world. Out-of-pocket spending as a proportion of total health spending is a leading cause of impoverishment in India. The hospital industry accounts for 80% of India's total healthcare market; it is expected to be valued at USD 132 billion by 2023. Despite its huge role, regulation of the private sector is weak.

### THE INTERNATIONAL FINANCE CORPORATION (IFC) IN HEALTH

The IFC, the private sector arm of the World Bank Group, has been financing corporate hospital chains in India since 1997 and the country has recently accounted for 28% of the IFC's global healthcare portfolio. This report tracks the IFC's financial and advisory support to private healthcare in India and assesses its development impact especially in relation to equity and patients' rights and in terms of adherence to regulatory standards. The IFC sees its role as supporting Universal Health Care (UHC) by investing in private healthcare, especially in emerging economies. Its investments also aim to contribute to poverty reduction, job creation and the creation of human capital. The IFC also uses knowledge for capital market creation and builds alliances in support of corporate engagement in health. It has developed guidelines to promote quality, standards and ethics in healthcare including the IQ – Improving Quality Healthcare tool and the Ethical Principles in health Care standards (EPIHC). However, the World Bank Group's Independent Evaluation Group (IEG) has highlighted that the IFC has failed to adequately prioritise quality and equity when investing and monitoring impact.

### IFC IN INDIA'S HEALTHCARE SECTOR

Our tracking of IFC activities in India's private healthcare since the inception of the IFC operations in India (1997-2022) has identified:

- 14 advisory projects (10 completed and four active) worth USD 7,624,377– for most, the IFC acts as transaction advisor for the establishment of hospital public-private partnerships (PPPs). Two additional advisory projects have been identified via IFC press releases.
- 18 direct investments of which eleven are in the hospitals and clinics sector. The historic hospital and clinic investments totalled USD 523 million of which equity financing is USD 331 million (63 %), and loan financing is USD 192 million (37%). These are dominated by some of India's biggest corporate hospital chains– Apollo, Fortis, and Max Groups. The Apollo group is the IFC's most prolific investee with four direct investments in India, an indirect investment via IHH Healthcare, and one direct investment in its Sri Lanka operations.
- 23 investments through financial intermediaries with specific healthcare sector investments in hospitals, clinics, and diagnostics. The IFC has made recent improvements in the transparency of its investments through financial intermediaries, however its lack of consistent and transparent reporting of its intermediated investments in health makes a comprehensive and accurate mapping of such projects was impossible. Of those IFC-financed financial intermediaries that invest in healthcare, 15 (68%) are domiciled in places that are considered tax havens by the Tax Justice Network including Mauritius, Singapore and the Cayman Islands.
- 67 million USD in private capital through Asset Management Companies (AMCs) from commercial banks to support private entities for Apollo Health and Lifestyle Limited.

### INADEQUATE TRACKING AND DISCLOSURE OF DEVELOPMENT IMPACT FOR IFC OPERATIONS IN INDIA

We have been unable to find any disclosed project evaluations for the IFC's healthcare advisory or financing projects in India. In July 2017, the IFC launched its Anticipated Impact Measurement and Monitoring (AIMM) system, however, a health sector specific AIMM framework has not been disclosed and the IFC does not otherwise disclose how it measures the impact of its support to the healthcare sector. Detailed assessments of these projects under the previous DOTS system are also not available.

The IFC's anticipated development impact across its support to the health sector in India is disclosed as follows:

- Advisory Services: All hospital PPP projects stated that they will enhance provision for patients. Seven of the eight PPPs also stated that the purpose was to increase private investment. The intended development results are either commercial or administrative; Seven of the eight projects' development

results were reported as 'bid conducted' or 'agreements signed.' Many of the PPP projects appear to have experienced significant project overruns or delays. Many of the IFC-supported PPPs entail locking the government into concessions or contracts with private players for long periods. The inflexibility of such an approach has proven problematic to accommodate inevitable changing health needs. Projects lack baseline information and do not appear to track long-term or systemic impacts on the healthcare system as a whole; many offer no information on development results even long after their completion. No evaluation reports of any of these projects are in the public domain.

- Direct investments: Stated anticipated development impacts include increased expansion of healthcare facilities (in 10 of 11 projects); job creation (in 6 of 11 projects) and improved management practices (in 5 of 11 projects). Only three projects focus on increasing the number of patients benefitting from services. No investment in India has disclosed detailed development results against the above.
- Indirect health investments via financial intermediaries: For those intermediaries we identified that make onward investments in health the anticipated impact is largely framed in commercial terms. Six of nine investments anticipated expansion or value creation for investees. Three aim to ensure job creation and only two (healthcare specific funds) explicitly focus on improving access, quality, and affordability of healthcare. The IFC considers its role as the source of financial resources (eight) while understanding of the health sectors are never mentioned. The intermediated investments or sub-projects in the health sector financed by intermediaries are not comprehensively and consistently listed and their anticipated impact is not disclosed. The IFC has not disclosed development results achieved by intermediary fund sub-projects, even against the very limited metrics.

### **PERFORMANCE STANDARDS AND RISK AND MITIGATION ASSESSMENT SYSTEMS**

- Advisory projects: The disclosures of Environmental and Social (E&S) risks for some older advisory projects are limited with four of nine projects not providing any information in the public domain. The remaining projects merely list applicable IFC frameworks. The mitigation measures disclosed merely state that advice will be provided to enable understanding of the IFC's Performance Standards.
- Direct investments - loans and equity: The quality of disclosures is better here with each project having a separate Environmental and Social Review Summary (ESRS) information page, although Annual Environmental and Social Monitoring reports are not disclosed. However, this information does not address the impact of the core business or the externalities in terms of the impact on the healthcare sector at large in India. None of the disclosures refer to the status of compliance with legal provisions like the Clinical Establishments Act or track adherence with the Patients' Rights Charter.
- Indirect investments via Intermediaries: No evidence could be found about how and to what extent ESS advice is issued or implemented in the private hospitals financed by the IFC via intermediaries.

### **POOR TRACK RECORD OF IFC HOSPITAL INVESTMENTS ON HEALTHCARE ACCESS, EQUITY AND PATIENTS' RIGHTS**

#### **Investing in high-end urban hospitals and clinics**

Poor rural populations suffer the greatest access gaps to healthcare but as is common for most private hospitals, IFC investees are concentrated in highly populated urban areas because this is where more income and therefore profit can be generated. 77.8% of the IFC direct investee chain hospitals are in Million Plus population cities. 60.4% of hospitals are in Tier 1 cities, 35.4% are in Tier 2 cities and only 4.2% are in smaller habitations. Of the 144 hospitals listed on the corporate websites of these chains, only one was described itself as being in a rural area. Only 13.9% of the hospitals are in the 10 states ranked lowest in terms of the overall performance of the health system based on the Annual Health Index 2021; not a single hospital operates in four of these 10 states.

#### **Investing in hospitals where a wide range of deeply concerning complaints have been upheld**

While the IFC has advocated for ethical principles in healthcare and its EPIHC reiterates the need to protect patients' rights. The report could not find a single project information window on the IFC portal that addresses patients' rights in India. In the absence of any information from the IFC we identified instances where regulators upheld complaints made against the hospitals. These revealed deeply concerning problems and rights violations. A range of problems emerged including overcharging, denial of healthcare, price rigging, financial conflict of interest, medical negligence, and refusal to provide free healthcare to patients living in poverty - the conditions under which free or subsidized land was allotted to these hospitals. The array of concerns points to a range of

recurring problems in investee hospitals that the IFC does not acknowledge or engage with in their public disclosures.

Some examples of the cases of medical negligence upheld by regulators include a patient being dropped on the floor leading to multiple fractures and death, a patient being left unattended in an ambulance, resulting in their death, and in one instance cotton wool was left in a patient's brain after brain surgery, again leading to their death. One patient had the wrong leg operated on, and a child in one hospital was left permanently disabled. One baby appeared to have been declared dead by doctors only to be discovered to be breathing as the last rites were performed. Regulators also upheld multiple complaints relating to overcharging and failure to treat patients, especially during the Covid-19 pandemic, and multiple complaints that these IFC supported hospitals were failing to provide free beds for poor patients, despite committing to do so.

### **Investing in hospitals priced out of reach for the majority of Indians**

Investee hospitals largely cater to India's elite and are unaffordable for most Indians. Supporting private healthcare in a context where 37% of Indians experience catastrophic health expenditures in private hospitals runs counter to the WBG's focus on poverty reduction. While the costs of hospitalizations are not disclosed by any hospitals, the costs of a two-day stay in a hospital in Delhi for a C-section would cost the equivalent of three to four months of Delhi's average wage in IFC-funded Apollo, Max, and Fortis hospitals. Even offerings that are packaged as being "affordable" mostly serve well off clients. Apollo has refused to join the national health insurance scheme, Ayushman Bharat in Tier I cities and has been actively lobbying the government to increase the rates of payment to private hospitals under the scheme.

The IFC's approach to the quality of healthcare does not adequately address patients' rights concerns, process, or outcome dimensions of quality (such as patient satisfaction in terms of care, hospitality, respect, and medical expenditure transparency) or adequately focus on serving the poor, women, marginalized communities, or underserved locations. Private investment-fuelled expansion of private healthcare provision risks the decline of healthcare systems as social institutions and raises troubling implications for health equity. The IFC must ensure that it does no harm by considering and addressing the impacts of its investments on the public health system in the country in the long run.

### **CONCLUSION AND RECOMMENDATIONS:**

The IFC must ensure that its investments in the private healthcare sector do not produce negative outcomes in terms of equity or damage the rights of India's patients, particularly the poor and vulnerable. The IFC should stop new investments in private hospitals and clinics in India until existing investments and operations in this sector are independently reviewed and a robust, transparent, and accountable framework is put in place to ensure that all projects and investments are equitable, geared towards meeting unmet healthcare needs, promote and protect patients' rights and strengthen the public system. More specific recommendations have also been made for the IFC, the World Bank Group, the UN system, the Indian Government, Civil Society and Patients' Rights Bodies.

## CHAPTER 1: INTRODUCTION

India is one of the biggest emerging economies yet ranks fifth from the bottom in terms of public health spending<sup>1</sup>. Consequently, it ranks 155 out of 167 countries on bed availability<sup>2</sup> and has 5 beds and 8.6 doctors per 10,000 of its population. This hits the poor hardest. Life expectancy at birth in India reveals persons born in the richest wealth quintile, on average live seven and a half years longer than the poorest<sup>3</sup>. The poor rely on the public health system. However, the private sector now accounts for 58% of hospitals and 81% of doctors in India<sup>4</sup>. Among ailments which were treated, 69.9% are treated by the private sector.<sup>5</sup> However, this comes at a cost with the average out of pocket expenditure on private hospitals being six times more than for government hospitals<sup>6</sup>.

The International Finance Corporation (IFC), the private sector investment and advisory arm of the World Bank Group (WBG), has been investing in the private healthcare sector, including hospitals in emerging and low-income economies, since 1956. It has a 2-billion-dollar portfolio in healthcare investments and claims it is supporting governments in their goal of reaching Universal Health Coverage by 2030.<sup>7</sup> India accounts for a significant portion of the IFC's global healthcare portfolio; in 2016 this was 28%<sup>8</sup>. Assessing the IFC's health performance in India is therefore not only important for the people of India but can offer important insights for its work in other developing countries.

This report maps the IFC's financial and advisory support to the private healthcare sector in India and assesses its impact especially in relation to equity and patients' rights and in terms of adherence to regulatory standards. This assessment is informed by the World Bank Independent Evaluation Group (IEG)'s evaluation of the World Bank Group's support to Health services undertaken in 2018<sup>9</sup> which highlighted that IFC investments seldom monitor and evaluate all dimensions of quality or capture the extent to which disadvantaged populations are identified as beneficiaries.

### THE GROWTH OF THE PRIVATE SECTOR IN HEALTHCARE IN INDIA

The healthcare market for products and services is growing across the world.<sup>10</sup> The global hospital services market was valued at USD 10 trillion in 2020 and is expected to grow at a rate of 8% to reach USD 16 trillion by 2027.<sup>11</sup> In India too, the private healthcare sector has been growing with the support of the government and private sector investors, many backed by the IFC. The hospital industry accounts for 80% of the total healthcare market; it was expected to be valued at USD 132 billion by 2023<sup>12</sup>. The value of the private hospital sector in India is projected to touch INR 18,3 trillion (approximately USD 236.14 billion) by 2025. In 2022, India had four Billionaires in the private hospital and diagnostic sector. These include Prathap C Reddy (Apollo Hospitals, 2.3 billion), Devi Shetty (Narayana Health, 1.1 billion US), Abhay Soi (Max Hospital, 1 billion USD) and Arvind Lal (Dr Lal Path Lab, 1.5 billion).<sup>13</sup> The Investment Information and Credit Rating Agency of India's (ICRA's) analysis of five big hospital chains- Apollo, Fortis, Narayana Hrudayalaya, Max India Limited and Healthcare Global Enterprises Limited points to an 80% increase in the revenue earned over five years between 2012-2017<sup>14,15</sup>. ICRA estimates a 15-17% revenue growth in the hospital sector in FY2023.<sup>16</sup>

Healthcare while being a basic right of citizens is also seen by the government as an integral part of the economy contributing to job and revenue generation.<sup>17</sup> In 2015, this sector became the fifth largest employer in India, employing 4.7 million people directly.<sup>18</sup> It is also a source of foreign exchange. The Foreign Direct Investment allocation to the private healthcare market in India leapfrogged 13.5 times between 2011 (USD 94 million) and 2016 (USD 1275 million). Despite the disruption caused by the pandemic, it is estimated that rising demand for domestic healthcare and medical tourism would cause the private hospital market in India to expand at a CAGR of 16.18% from 2020 to 2025.<sup>19</sup> Estimates suggest that 6.4% of all foreign tourists arriving in India in 2019, the year before international travel was disrupted by the pandemic, came for medical treatment.<sup>20</sup> The healthcare sector is growing; there were 619 medical



infrastructure-related projects (as of April 2022) with investment opportunities in the range of USD 26-27 million.<sup>21</sup> This role of private healthcare has meant that it has received extensive support from the government including facilitating land acquisition, viability gap funding and strategic purchase from the private sector through insurance schemes.<sup>22</sup>

Foreign investment has played a particular role in this respect. The private healthcare sector saw increases in both Foreign Direct and Venture Capital investment. It is estimated that \$2.4bn was invested across 31 healthcare deals in 2020, up from \$1.1bn invested across 24 deals in 2019<sup>23</sup>. This has driven a process of consolidation and concentration of ownership of India's private healthcare market<sup>24</sup> that is contributing to the expansion of healthcare corporate chains receiving international support, including from the IFC.

	Foreign Direct Investment Equity Inflow to India- Jan 2000 - Sept 2022 <sup>25</sup> (USD million)					
	2000 - 2018	2019	2020	2021	2022 (till Sept)	Cumulative FDI
Hospital & Diagnostic Centres	5,995.1380	630.3076	408.7288	694.4596	672.2712	8,400.9050

## THE IMPLICATIONS OF GROWING PRIVATIZATION

The growth of private healthcare in India is often projected as a route to improve access and quality, but the reality is far more complex. Out-of-pocket expenditure on health pushes 63 million Indians into poverty every year. The costs for patients at private hospitals are about twice as much as those in public hospitals<sup>26</sup>. This affects the poor, women, and people from marginalized communities the most since these are excluded from or discriminated against in private healthcare. Around 75% of women delivering in private institutions in Gujarat for example experienced catastrophic health expenditure.<sup>27</sup> 4% of Adivasis and 15% of Dalits utilize private facilities; Dalits and Adivasis<sup>1</sup> face discrimination in the private healthcare system including disparity in care, denial of entry into private clinics and longer waiting times.<sup>28</sup>

The introduction of government health insurance was intended to address the consequences of the high costs of seeking private healthcare. However, 59% of people across India lack government or private health insurance.<sup>29</sup> Additionally, only 1.6% and 4% of private hospital admissions under PMJAY, India's largest health insurance/assurance scheme, were from Dalits and Adivasis respectively compared to their projected eligible population share of 19.7% and 15.4% respectively<sup>30,31</sup>. Indeed, India's out-of-pocket expenditure as a percentage of current health spending is 48.8%, with the real figures potentially higher<sup>32</sup> and the government health insurance scheme has failed to reduce this<sup>33,34,35,36</sup>. There are gender impacts with almost two-thirds of all non-childbirth spending being on males under Rajasthan's health insurance scheme. Higher out-of-pocket costs of healthcare disproportionately deter female utilization, especially among elderly patients.<sup>37</sup> At the same time, the spread of private healthcare providers is not uniform. Rural India houses 70% of the population, while it has 40% of the beds<sup>38</sup>.

The impact of the growth of the private healthcare sector, furthermore, is not just on individuals but the health system. Information asymmetry and lack of coordination in healthcare management often result in under-provision and over-provision of services.<sup>39</sup> Furthermore, private healthcare providers and their supply chains (medicine to diagnostics) are typically based in urban areas leaving a vacuum in rural areas.<sup>40</sup>

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<sup>1</sup> Dalit also previously known as untouchable, is the lowest stratum of the caste system in India. Adivasis is a collective term used by the indigenous people of India. Scheduled Castes and Tribes is the official term applied to these communities in the Constitution of India.

The current cycle of acquisitions of private healthcare companies and the resulting greater concentration of ownership in healthcare provision suggests growing reliance on the resources of a small number of corporately owned chains with serious long-term implications for costs and regulation. Globally, corporatisation processes are triggering inflated costs, exacerbating medical malpractice and creating distrust in doctor-patient relationships in private healthcare provisioning.<sup>41</sup> In 2018 a study found that, 92.3% of respondents said that they did not trust healthcare in India; 74% said that they do not trust hospitals, followed by pharma and insurance firms (62.8%), medical clinics (52.6%), doctors (50.6%) and diagnostic labs (46.1%).<sup>42</sup> Therefore, while India's private healthcare sector has flourished on the back of increased government funding and foreign investment, India has seen the continued neglect of public health provision. 49.9% of Indian households do not generally use a government health facility; nearly 40% of these state that they do not use a public health facility because there is none nearby.<sup>43</sup>

India's obligation under international human rights law for delivering the right to health requires the state to actively monitor and 'oversee' the activities of the private players in healthcare. However, over time in the face of the thrust towards a stronger market economy, this role has often shrunk to 'silently observing', to the detriment of realizing health rights.<sup>44</sup> Several treaty bodies like CEDAW (2007), CESCR (2008) and UNCRC (2914) have raised concerns about the impact of the privatization of health services in India on the access and affordability of healthcare, particularly for the poor and women.<sup>45</sup> Similarly in 2018, the IEG undertook a review of the WBG's global healthcare portfolio<sup>46</sup> that noted this concern and recommended improvement in the measurement of the distributional effects of health service projects.

## REGULATION OF PRIVATE HEALTHCARE IN INDIA

Patients' Rights Violations are rampant in India's private healthcare sector and regulation is woefully inadequate. This should be of significant concern for those investing in India's private healthcare providers. A rapid survey was undertaken by Oxfam India in 2021 to assess the degree of adherence to patients' rights, as established in the Clinical Establishments Act. The findings included that 58% of patients or carers of patients hospitalized said that they were not provided with an estimated cost of treatment/procedure before the start of treatment/procedure. 8 in 10 respondents reported being forced to get tests/diagnostics from one place only, usually owned by or in an arrangement with the hospital. 19% of respondents whose close relatives were hospitalized said that they were denied the release of the dead body by the hospital.<sup>47</sup>

Private hospitals in India are frequently accused of overpricing, medical negligence and of advising unnecessary tests or surgeries. A recent analysis of the bills of four big hospitals in the Delhi-National Capital Region (NCR) by the National Pharmaceutical Pricing Authority found that profit margins ranged from 100% to 1,737% on drugs, consumables and diagnostics.<sup>48</sup> Partly in response to egregious fees charged by private hospitals during the pandemic, fifteen Indian states issued government directions to regulate the rates in private hospitals.<sup>49</sup>

The Clinical Establishments (Registration and Regulation) Act (CEA) was introduced in 2010. It lays down the standards for the registration, seeks to ensure that no clinical establishment functions without recognition and includes key provisions for patients' rights like transparency and standardization of rates<sup>50</sup>. However, as health is a state subject, the Act must be ratified and implemented at the state level. Only 13 States and 6 Union Territories (of 28 states and 8 UTs) have adopted the CEA and notified state rules<sup>51</sup>. Additionally, several states have state-specific legislation related to health including AP, Maharashtra, Gujarat, Delhi, MP, Manipur, Nagaland, Odisha, Punjab, and West Bengal.<sup>52</sup> Despite the existence of legislation, however, a significant number of establishments continue to be unregistered

and unrecognized. The National Register for Clinical Establishments had 27,030 clinical establishments provisionally registered from 5 UTs and 8 states in 2020. However, in 2019, 55% of clinical establishments in the Ambattur Zone in Tamil Nadu were unregistered<sup>53</sup>. The National Council for Clinical Establishments established under the CEA has not taken any specific steps to ensure transparency of rates.

Another national milestone was the introduction of the Patients' Rights Charter. The National Human Rights Commission (NHRC) shared a draft Charter of Patients' Rights with the Ministry of Health and Family Welfare (MoHFW), Government of India for implementation in all States and UTs in all clinical establishments, whether public or private. In 2019, the Union Health Secretary wrote a letter to Chief Secretaries of all states and UTs, urging them to adopt it. However, its implementation has been lacklustre, with grievance redress mechanisms for violations being minimal. Without a reliable and affordable enforcement mechanism, "a patient charter is little more than a toothless tiger."<sup>54</sup>

Other regulatory responsibilities are created through the introduction of publicly financed medical insurance schemes like Ayushman Bharat. Pradhan Mantri Jan Arogya Yojana (PM-JAY). The Insurance Regulatory and Development Authority of India (IRDA) has directed all hospitals empanelled with it to enrol under the National Accreditation Board for Hospitals and Healthcare Providers (NABH) and comply with the norms laid down by them. However, the currently accredited hospital register lists only 955 hospitals which are significantly less than the numbers already registered under the CEA<sup>55</sup>. While the IRDA has attempted to address fraud and denial of claims,<sup>56,57</sup> much more needs to be done considering the scale of the problem.

At the same time, relying on standard-based quality control in healthcare organizations creates its own set of problems. As the response to a Right to Information request included in Annexure III shows, while the NABH says that its assessments take into consideration the quality of a hospitals' human resources, the background check to establish the authenticity of the medical qualification held by doctors is deemed to be the responsibility of the hospital itself. Other shortfalls include that the NABH does not make it mandatory for hospitals undergoing its assessment, to disclose the number of cases of medical malpractice and negligence pending against it.

The rapid growth and increasing dominance of the private healthcare sector in India, the evidence base about its potentially harmful impacts, especially on the poorest and most marginalised people, alongside woeful levels of government regulation, are of huge concern and make an assessment of the IFC's support to private healthcare in India and its approaches to monitoring impact and accountability important and urgent.

## THE STUDY:

This report tracks the IFC's investments and advisory support to the private healthcare sector in India. The IFC has been financing corporate hospital chains in India since 1997. This report builds on past research on the IFC's track record of health investments including research conducted by Oxfam in 2014 that found that IFC investments in Africa benefitted the wealthy by funding healthcare that was out of reach of people on low incomes.<sup>58</sup> It also draws from extensive research by Oxfam India as well as academics and other organisations on the practices and impact of private healthcare providers in India. This report seeks to provide a:

1. Summary of the policy advice by the IFC in healthcare with a focus on India particularly concerning affordability, quality, and non-discrimination.
2. Mapping of IFC's healthcare investments and advisory services in India.
3. Record of adherence to regulatory frameworks by IFC-supported hospital chains in India.

## METHODOLOGY:

Four data (qualitative and quantitative) collection tools were employed. They constituted a narrative review of relevant literature, document review, quantitative data collection from IFC and other data portals and discussion with key stakeholders related to the study. Documents examined on the website include Summary of Investment Information for projects, Summary of Advisory Services Project Information, Environment Documents, Documented case studies, tools, IFC press releases, IEG reports, other IFC reports, and other publications disclosed on the WGB and IFC websites. The report focuses on investments in the hospitals and clinics sector for the nearly 25-year period starting in 1997 and ending on 13 September 2022. This included a review of four forms of support as detailed below:

- IFC Advisory projects: These include projects where hospitals were the only area of focus and those including diagnostics, health insurance or other related healthcare dimensions.
- IFC Direct investments. These include those that were found using the IFC's coding of projects under 'health and education' The project cost, the IFC investment share in the same, the form of investment, the department/industry/sector classified by the IFC and the year of the signing of the contract were recorded.
- Investments through intermediaries. These include three levels of search on the IFC website.
  - Search one looked for IFC investments in 'private equity funds (in the menu on the IFC database) that invest in health in India and South Asia. These needed to be checked manually to understand whether they had investments in healthcare. The investee company names were then searched for. The disclosures made by the IFC, that of the individual Private Equity (PE) fund on their websites or disclosures made on other websites (e.g., the UK's CDC) were consulted to understand whether the project made any investment in India.
  - Search two involved looking at IFC investments in 'funds' (under 'Industry' on the IFC database) and then looking for 'world region,' South Asia and India.
  - Search three involved looking for IFC investments in Industry "others" category in India, South Asia, and World Regions.
  - For each of these, a record was maintained of the project ID, the site where the Fund is based (particularly comparing it against the Tax Justice Network 2021 Corporate Tax Haven Index<sup>59</sup>), the amount of IFC investment made, the Sector under which it was classified by the IFC and the list of investee hospitals.
- Four potential additional IFC investments in private healthcare were identified from other online searches but for which information is not available on the IFC's website.

For each investment, searches were conducted to find:

- Information on anticipated impact, role, and additionality of the IFC and any project results that may have been disclosed by the IFC.
- ESS risk assessments and mitigation mechanisms. This involved looking at both the Summary of Investment Information and the Environment Documents, where disclosed.

Due to time lags in reporting and lack of consistency it is often not possible to ascertain the status of IFC investments. While new investments are often announced publicly, it is unclear how often information about investment exits is disclosed, forcing one to rely upon third-party documents for information.

Given the limited impact data disclosed by the IFC, IFC website searches were supplemented by a review of literature, including published research and media reports, about the status of patients' rights in investee hospitals and PPP projects. An overview is provided of the instances where courts or other regulators in India have found these companies guilty of a range of violations. A content analysis has

been done of these reports to understand the nature of the violations. For direct investees, a search of their websites was undertaken to understand their geographic spread and the costs of healthcare in one city- Delhi. In the latter case, telephone calls were made to confirm the rates. Short fieldwork was also undertaken in Kolkata in the office of People for Better Treatment (PBT)<sup>60</sup> to understand the regulatory context in private healthcare provisioning.

## CHAPTER 2: IFC IN THE HEALTH SECTOR: THE POLICY FRAMEWORK

This chapter maps the IFC's policy on investing in healthcare at the global and Indian levels, particularly from the lens of affordability, quality, and non-discrimination.

### The IFC's strategy for the healthcare sector

The WBG adopted an organisation-wide strategy (One WBG Strategy) in 2013. The IFC sees the private sector as critical for economic development and market incentivisation to propel competition, productivity, innovation, specialisation and entrepreneurship and thus lower prices and contribute to the social good.<sup>61</sup> It considers the private sector as a solution to job creation, improvement of services and reduction of poverty<sup>62</sup> and looks at well-functioning markets as prerequisites for economic development in emerging economies.<sup>63,64</sup> It views the private sector as a driver of economic growth and a job creator, as serving development (such as minimising the healthcare service gap, especially among the poor and promoting social inclusion) and financial goals (like the return on investment for IFC and its partners and return of capital for IFC financiers), and supporting, leveraging, and accelerating private sector growth through collaborative approaches with businesses, governments, and financial institutions.

It has not disclosed a comprehensive dedicated policy for the healthcare sector. However, it states that it is committed to furthering the goal of UHC (SDG target 3.8), especially in emerging economies<sup>65</sup> and building human capital by influencing economic and social processes of development.<sup>66</sup> More specifically<sup>67</sup>, it aims to

1. Increase access to quality healthcare by financing integrated healthcare networks and providers that strive to deliver quality care to patients of all incomes.
2. Promoting access to affordable pharmaceuticals and medical products by working with generic pharmaceutical companies and global medical technology companies to bring the latest standard of care to emerging markets affordably.
3. Fostering transfer of knowledge and capital by conducting advisory and convening work to ensure replication of best practices in cost-efficient health delivery systems and adoption of viable innovations.

IFC has committed to taking on a greater role in spearheading private health sector investment.<sup>68</sup> It champions the cause of private capital in the healthcare market by investing in various private equity funds.<sup>69</sup> In 2009, it constituted a special-purpose vehicle called an Asset Management Company to mobilise capital from global and domestic markets and manage private equity investments in emerging economies.<sup>70</sup> The IFC's Strategy and Business Outlook Update for FY 2019 – 2021, stated the intention to not only strategically invest in private healthcare establishments but also develop capital markets.<sup>71</sup> The latest IFC Strategy and Business Outlook report for the period FY23-FY25<sup>72</sup> identifies supporting healthcare resilience and vaccine access as a priority area. This includes an emphasis on increasing developing countries' access to healthcare services and support for sustainable regional health value chains. It strategically focuses on emerging markets where the presence of competition (because of a sizable number of private healthcare providers and the existence of medical insurance markets), consumer choice and fewer regulatory barriers (and/or absence of bureaucratic regulations for being a market-friendly economy) define the investment context as promising.<sup>73</sup> Equity financing in the healthcare sector has fetched strong financial returns in comparison to other sectors<sup>74</sup>, a trend unbroken even at the height of the pandemic.<sup>75</sup>

In the context of India, the IFC's investments work in conjunction with other forms of WBG support for private healthcare in India. The World Bank's last Country Partnership Framework (CPF) (period 2018-

2022)<sup>76</sup> sought to expand support for the Government of India's initiatives in universal health coverage by prioritizing the improvement of the delivery of health insurance. It sees the role of the IFC as supplementing this by mobilizing private sector capital to expand "affordable, quality healthcare and create a mass market for lower-income populations" specifically. The sovereign lending of the WBG in health has also prioritized investment in the private sector over the period 2020-2022. Oxfam India's review of health investments by IFIs in India has shown that a significant share of the projects involve engagement with the private sector either through support for insurance schemes or entry into PPPs<sup>77</sup>. None of these explicitly emphasized the need for the regulation of the private healthcare sector, including compliance with existing regulatory frameworks like the Clinical Establishment Act<sup>78</sup> that may have enforced the commitment of the investee companies to uphold the right to health for all.

IFC operations are accompanied by 'knowledge production' to use as evidence to influence governments and the conduct of the capital markets.<sup>79,80</sup> It supports regular Global Private Health Conferences for which it teams up with market research agencies, like-minded foundations and government think tanks to develop policy/position papers that further its advocacy agenda. It also produces regular case studies highlighting and amplifying the work of its investees. It also prepares how-to documents to guide private sector engagement. For example, it developed a primer (jointly with the WHO) as a practical introduction for governments for contracting the private sector in national COVID-19 responses that recommend developing the capacity to contract with the private sector as a core function of health system functioning.<sup>81</sup> In India, the IFC has facilitated the framing of reports like the 2019 Tec Emerge report<sup>82</sup> which promotes the adoption of technologies in the healthcare sector. In 2014, in collaboration with the WISH Foundation and Deloitte, it released a report on the 'Landscape of Inclusive Business Model of Healthcare in India'.<sup>83</sup> It stressed channelizing development finance into the private sector, highlighted the need for active government participation through framing a favourable public policy architecture and advocated for public finance routes in creating a private sector ecosystem and fostering networks that promote the private healthcare market. While there is evidence of outreach to the private sector, no information is available about the outreach of the IFC to patients' rights groups, health worker unions or the public health movement.

### **IEG'S REVIEW OF IFC'S HEALTH OPERATIONS**

Given the above, it would be critical to examine the World Bank IEG's own assessment of the effectiveness of the IFC's health portfolio. The 2018 IEG review of the WBG health portfolio highlights several challenges with IFC operations, particularly in terms of the extent that enhancing access and improved equity and quality are ensured. The report recommended a strengthened focus on and measurement of the quality of health services and the distributional effects of health service projects. The present report seeks to build on these findings and examine the trends in the context of India.

#### **BOX 2.1: 2018 REVIEW OF THE WBG HEALTHCARE PORTFOLIO<sup>84</sup>**

- Improved access has not been demonstrated, because of the limitation of the monitoring frameworks it is not possible to determine whether access figures reported by hospitals contributed to expanding coverage or to improving availability and use among those who were already covered elsewhere. The review found no evidence to assess affordability or indicate the main users of the facilities.
- Quality has not shown consistent improvement. Only 46% of quality improvement objectives in evaluated WBG projects were rated positive (moderately satisfactory and above) and the emphasis on quality measures in IFC projects is declining over time. The metrics of quality prioritize structural (like licensing and accreditation standards, appropriateness of equipment and supplies) over processes (like patient satisfaction) and outcome dimensions (e.g.,

tuberculosis treatment success rate) of quality. Service monitoring was rarely included in projects.

- Improvement in equity and the distributional impact of World Bank and IFC projects remains unknown. All but one project evaluated were rated unsatisfactory in this area.
- Did not prioritize strengthening health systems and improving health outcomes in practice. The evaluation found only three evaluated IFC projects (one investment and two advisory services) that aimed to strengthen health systems and only 1% of IFC investments and advisory services comprise project development objectives aiming at improving health outcomes.
- While the IFC sought to integrate private provision with public financing, this did not happen due to challenges with PPPs including limited availability of public resources and capabilities; underdeveloped private markets for health services; and inadequate regulation and regulatory enforcement. Hospitals and specialty chains supported by IFC investments continued to rely primarily on out-of-pocket payments. IFC Advisory Services also shows insufficient information to assess the equity, efficiency, sustainability, and fiscal burden of the PPPs.

#### Conclusion:

The IFC's activities in health include market creation, knowledge production, development of business strategies and building a network of support that focuses on its institutional goal of creating and supporting markets to promote private healthcare. It not only leverages resources but creates a web of actors that work jointly with the IFC to expand markets for the private healthcare sector.<sup>85</sup> A recent IEG review of the WBG health portfolio highlights several challenges with IFC health operations, particularly weaknesses in the areas of enhancing access and improving equity and quality of healthcare.



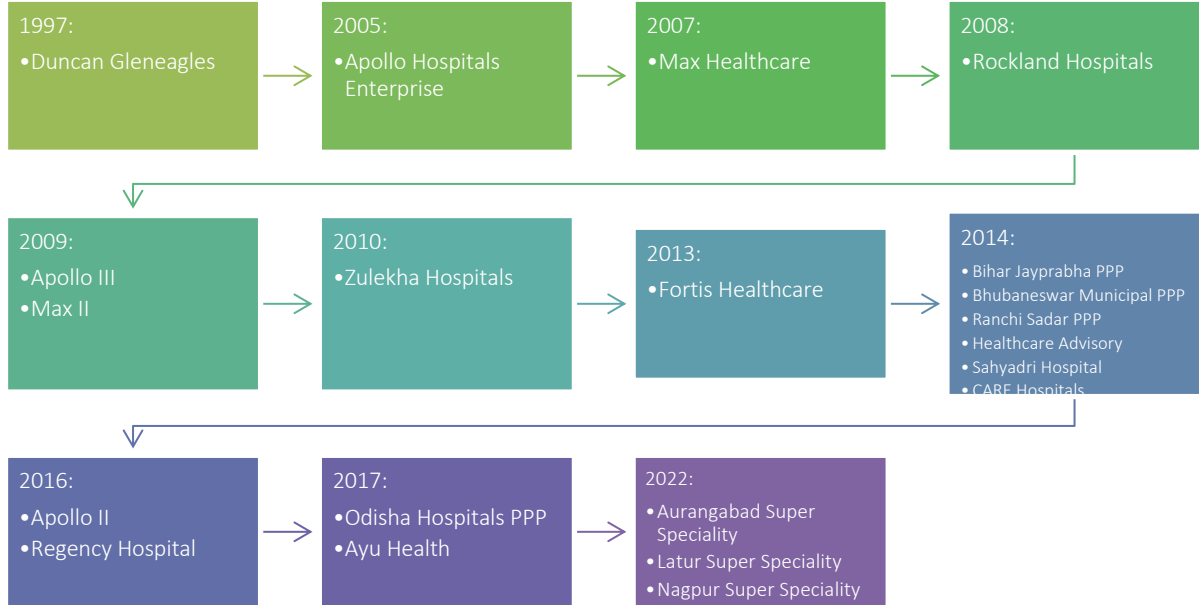
# CHAPTER 3: AN OVERVIEW OF THE IFC’S OPERATIONS IN THE HEALTH SECTOR IN INDIA

This chapter provides a snapshot of the IFC’s advisory and financing support to private healthcare providers in India for the past three decades.<sup>86</sup> The disclosed performance of these projects and investments is addressed in the next chapter.

## IFC global investments in the hospitals, clinics, and diagnostics sector

Globally, hospitals, clinics, and diagnostics as a sub-sector make up more than half (58%) of IFC’s total direct investments in the health sector between 1991 to March 2022, based on the portfolio of projects reviewed for this research. The pharmaceutical industry also received a sizable portion (33%), followed by other medical/health services such as medical education, medical insurance, and life science products (9%). Health and education were the smallest investment portfolio for the IFC between 2001 – 2012,<sup>87</sup> but grew six times between 2006 and 2010 relative to the previous period. The investment flow remained steady over the subsequent five years, only to decline slightly between 2016-19. The IFC made a USD 139.20 million investment commitment in the hospitals and clinics sub-sector between April 2020-March 2022 during the peak of the COVID-19 pandemic, as part of its Global Health Platform<sup>88</sup>, a \$4 billion initiative to provide financing to manufacturers of healthcare products, suppliers of critical raw materials, and healthcare service providers to expand capacity for products and services for developing countries during the pandemic. More broadly, the surge of IFC investment in the hospitals and clinics sub-sector since the late 2000s reflects the trend of seeing the private sector as a partner in the implementation of the Millennium Development Goals<sup>89</sup> and the SDGs.<sup>90</sup> The IFC contributed to market creation, mobilisation of private capital and facilitating development needs through the flow of private capital.

### 3.1 Timeline of IFC direct support to private hospital companies in India



## IFC ADVISORY SERVICES

The IFC provides advisory services to both the private sector (including financial institutions/funds and industry partners) and governments in developing and underdeveloped countries to facilitate the creation of markets for private healthcare.<sup>91</sup> Its advisory services help companies and institutions to expand their businesses, achieve sustainable financing and improve corporate practices. It offers advice to governments to implement public-private partnerships and implement reforms that would encourage private investment. It also works with financial institutions and funds to strengthen risk management and develop the private equity industry.<sup>92</sup> The IFC states that it is the only multilateral organization offering advisory services to governments on structuring PPP transactions and has over 20 years of experience structuring and implementing PPPs<sup>93</sup>.

The data for IFC's advisory service in India is listed from 2009 with no previous records available on the IFC data portal. A total of 76 advisory projects are reviewed, out of which 14 (10 completed and four active) are found to be related to the healthcare sector. Barring the two projects for which the information is not disclosed and/or unavailable, this amounts to USD 7,624,377 (all advisory services-related expenses are in budget amount). They include advisories for healthcare provision (eight projects) and other modes including support for medical insurance schemes (e.g., Meghalaya Project 1 & 2), diagnostics and other operations. Most of these involved the IFC as a transaction advisor.

The hospital sector has received the most advisory support. Diagnostics and publicly financed medical insurance are the next two most frequent intervention areas while engaging with the Union and State governments. This is in line with the IFCs general approach in which PPPs have been the central plank of their health advisory services activities globally. Between FY2005 and FY2016, health PPPs were found to account for 69% of the IFC's global portfolio of health sector advisory services (47 out of 67 projects).<sup>94</sup>

Table 3.2: IFC advisory services in India in the health sector (2009 – March 2022)

	Project Number	Project Name	Project Description adopted by IFC	Estimated End Date	Estimated total budget in USD	Status
Hospitals as the only area (eight projects)						
1	599671	Bihar Health Patna Jayprabha Hospital PPP	Public-Private Partnerships Transaction Advisory <sup>95</sup>	30-Jun-14	502,000	Completed
2	599572	Bhubaneswar Municipal Hospital PPP	Public-Private Partnerships Transaction Advisory	31-Aug-14	428,563	Completed
3	600946	Odisha Hospitals	Cross-Industry Advisory Services	30-Jun-17	810,928	Active
4	594228	Ranchi Sadar Hospital PPP Project, Jharkhand	Public-Private Partnerships Transaction Advisory	30-Jun-14	526,840	Completed
5	579727	Healthcare Advisory Program	Sustainable Business Advisory <sup>96</sup>	30-Jun-14	360,000	Completed

6	606823	Aurangabad Super Speciality Hospital	Transaction Advisory	Pending	Pending	Active
7	606822	Latur Super Speciality Hospital	Transaction Advisory	Pending	225,500	Active
8	606799	Nagpur Super Speciality Hospital	Transaction Advisory	Pending	900,000	Active
Having diagnostics, insurance, or other healthcare aspects as primary subject/area (six projects)						
1	605359	Covid-19 Health Sector Response Support to Madhya Pradesh	Transaction Advisory	Not Available	Not available	Completed
2	600972	TechEmerge	Cross-Industry Advisory Services	31-Mar-17	2,205,734	Completed
3	597087	Health for All_1 (Meghalaya Project 1)	Public-Private Partnerships Transaction Advisory	30-Sep-12	440,000	Completed
4	597027	Universal Health Insurance, Meghalaya Project 2	Public-Private Partnerships Transaction Advisory	31-Dec-13	620,602	Completed
5	599147	Jharkhand Diagnostic Imaging Services PPP	Public-Private Partnerships Transaction Advisory	31-Mar-14	302,105	Completed
6	599148	Jharkhand Diagnostic Pathology Services PPP	Public-Private Partnerships Transaction Advisory	31-Mar-14	302,105	Completed

Source: [https://disclosures.ifc.org/enterprise-search-results-home?f\\_type\\_description=Advisory%20Services](https://disclosures.ifc.org/enterprise-search-results-home?f_type_description=Advisory%20Services) (Accessed on 8 August 2022) NA: Not Available

Apart from hospital PPPs, there are two other projects (No. 599147 & 599148) in which the IFC offered advisory services to the Government of Jharkhand for setting up diagnostic pathology centres and radio imaging laboratories in all 24 District Headquarters and three state-run Medical Colleges under PPP mode. This was estimated to reach 3.5 million people and participate in the training for paramedical and technical staff of the states<sup>97</sup>. The IFC also partnered with the Medical Education and Drug Department (MEDD) in Maharashtra to strengthen medical education through PPP mode in the state<sup>98</sup>. The Medall and SRL (an IFC investee) private laboratories got the contract for pathology services through competitive bidding.<sup>99</sup> The radio imaging service contract was given to HealthMap Diagnostics Private Limited (a joint venture of a major Indian health player Manipal Health and Philips).<sup>100</sup> During the pandemic, the IFC advisory services (Project No. 605359) also helped to enhance the procurement systems of the Madhya Pradesh state government by leveraging private sector capacity.

Keeping in view the growing market for digital healthcare, the IFC also conducted industry-wide consultation (Project No. 600972, TechEmerge) for its clients to contribute to the emerging Indian digital technology market. The TechEmerge project information site notes that the pilot project was aimed at accelerating the “dissemination and commercial adoption of new innovative healthcare technologies.”<sup>101</sup> This advisory service project is a typical example of the IFC’s outreach to energise local actors in relevant sectors.

In addition to the above, two additional projects could only be tracked through media reports highlighting the limitations of IFC project disclosures. The IFC announced plans to work with the state of Andhra Pradesh to enable three public hospitals to offer diagnostic services such as dialysis to low and middle-income people in 2009.<sup>102</sup> A subsequent press release states that the contract was awarded to a consortium of Wipro-GE Healthcare Private Limited and Medall Healthcare Pvt Ltd.<sup>103</sup> No other information is available about the project. Another press release pertains to a project (undertaken jointly with the Gates Foundation and the World Bank) in 2011 aimed to streamline payments to health workers and beneficiaries to make the same more efficient, transparent, and timely<sup>104</sup>. No further information is disclosed.

## IFC Investments

The IFC's investments in health are in for-profit companies<sup>105</sup>. This report tracks all four types of investment products employed by it including direct loans, equity financing, Private Equity (PE) Funds and Asset Management Companies (AMCs) to map the IFC investment in India's private hospital sector.

### Direct Loan and equity investment

There are 18 listed direct investments in healthcare providers (hospitals, clinics, and diagnostics) on IFC's project portal. Of these, ten are equity investments, three are loans, two are mixed forms of investments comprising both equity and loan financing, and one is a mix of equity financing and AMC mobilisation of capital. To date, IFC's hospital and clinic investment portfolio for India totals USD 523 million of which equity financing is USD 331 million (63 %), and loan financing is USD 192 million (37%). The complete record of all the direct investments can be accessed in Annexure I. Of the 18 investments, 12 are clinics and hospitals (Fig 3.3). Duncan Gleneagles has since been taken over by the Apollo Group.

The IFC has shown a preference for investment in India's larger private hospital chains. It has invested in Apollo, Fortis, and Max Groups<sup>107</sup>. The first investment was in the Apollo Hospital Enterprise in 2005 followed by the Max Group in 2007. The latter was to expand hospitals in the National Capital Region (NCR) of Delhi and Mohali and Bhatinda (in Punjab as a PPP project). The project (No. 25805) intended to add 452 new beds.<sup>108</sup> The third Max Group investment came in 2009 (Project No. 27976) to expand its various existing facilities and construct two new hospitals, again in the NCR.<sup>109</sup> The IFC's investment in Fortis (Project No. 33057; USD 100 million) is so far its largest single investment in the healthcare sector in India.<sup>1103</sup>

IFC's most frequent and largest total investment has been in the Apollo Group (with up to five investments

Fig 3.3 IFC Direct Investment in Private Hospital Chains (in USD million)

Duncan Gleneagles	IFC Project number 8084	8
Apollo <sup>2</sup>	IFC Project number 24406	20
	IFC Project number 25969	50
	IFC Project number 31549	60
	IFC Project number 37895	68 <sup>106</sup>
	IFC Project number 32237 through IHH Healthcare Berhad (multi-location including India)	
	IFC Project number 7374 Apollo Sri Lanka Hospital (not India)	
	Apollo Total	206
Max	IFC Project number 25805	67.1
	IFC Project number 27976	42.4
	Max Total	109.5
Fortis	IFC Project number 33057	100
Regency Hospital	IFC Project number 35989	9.7
Zulekha Hospitals	IFC Project number 28873	20

<sup>2</sup> An additional investment of USD 67 million was done in the Apollo group through an AMC.

<sup>3</sup> IFC's project number 35836 for Ciel Healthcare Limited in Sub-Saharan Africa is for a project to be undertaken jointly with Fortis Healthcare Limited. This project is not analysed since the project lies outside India.

in India and six times overall) accounting for an overall investment of USD 198 million. In 2005 the IFC and the Apollo group came together to work on the company's corporate strategy for business expansion. The first allocation under the 'Apollo Equity' project (No. 24406) appears to have been in the Apollo hospital network more broadly.<sup>111</sup> The second investment (Project No. 25969) was to bolster the building of the Apollo Reach Hospitals network, which was claimed to be designed for poorer populations residing in peri-urban and rural parts of India.<sup>112</sup> In 2012 IFC again invested in the Apollo Hospitals Enterprise Limited (AHEL) for supporting Apollo's country-wide expansion of hospital infrastructure (Project No. 31549).<sup>113</sup> In the last case, IFC offered both equity financing and AMC mobilisation (No. 37895) to support Apollo Health and Lifestyle Limited (AHLL, a subsidiary of AHEL) for expanding its network of 151 small-scale healthcare units across the country.<sup>114</sup> Apollo Clinics, as these centres are popularly known, offer the primary level of care including diagnostics, pharmacy, small surgeries, maternity, dialysis and dental care treatment.<sup>115</sup> This investment seeks to expand Apollo's footprint to outpatient preventive and primary medical care. The IFC has also supported Apollo's expansion to Sri Lanka<sup>116</sup> and received funds from its investment in IHH Healthcare Berhad which holds a minority stake in the Apollo group<sup>117</sup>. Across the various investments, the IFC has supported the flagship chain of Apollo Hospitals, Apollo Reach hospitals, Apollo Clinics, and subsidiaries (Apollo Sugar Clinics, Apollo Dialysis, Alliance Dental Care, Apollo Cradle and Apollo Spectra) in India.

In addition to the big hospital chains, IFC's investment has also gone to companies involved in multi-speciality treatment (such as Regency, Rockland<sup>4</sup>, and Zulekha), except for Healthcare Global (HCG), which is a provider of cancer care. The IFC has also been diversifying its investment in private healthcare provisioning by financing a diagnostics chain (Super Religare Laboratories Limited/SRL) and super speciality services for kidney care and dialysis treatment (NephroPlus) and eye care (Eye-Q Vision). This diversification also includes home-based care (Portea Medical) for providing nursing aides, nurses, physiotherapists, and doctors. This marks a gradual move from the role of these companies in tertiary care to include secondary and primary healthcare.

No investment rationale has been provided for the repeated investments in the same companies or the decision to invest in some of the biggest chains in India. Instead of using its knowledge to diversify the healthcare sector in India and promote competition, the IFC appears to be using its resources to support the expansion of some of the biggest players in India's healthcare market. An investigation by the Competition Commission of India (CCI) has recently found several of these companies were abusing their dominance by overcharging patients in violation of India's competition laws.<sup>118</sup> While the matter is subjudice in the High Court, its earlier investigation found "abuse of dominant position by Max in charging supra-competitive prices from the locked-in patients for the products and/or services including but not limited to syringes in the aftermarket needs to be explored"<sup>119,120</sup>. An IEG review of IFC's approach to engaging clients for increasing development impact across sectors found little or no effect on repeat clients' environmental and social capacity beyond individual projects or influence the clients' poverty focus and base-of-the-pyramid orientation.<sup>121</sup>

It should be noted that the utilisation of project funds is not always limited to the countries where the investee companies are officially registered. For example, the funding for the Apollo project (24406) in 2005<sup>122</sup> was also used for the company's expansion outside of India. The IFC articles speak of the expansion of the NephroPlus network into Central Asia<sup>123</sup>. Similarly, the funding for building Alexis Hospital in the Indian city of Nagpur was given to the Zulekha group based out of the United Arab Emirates (UAE). As per the IFC data portal, the investment is registered under the UAE country portfolio.<sup>124</sup> We have included this in our review since funding was directed to hospitals in India.

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<sup>4</sup> Now called Medeor Hospitals

## PRIVATE EQUITY (PE) FUNDS THROUGH FINANCIAL INTERMEDIARIES

A private equity fund is a pooled investment vehicle where the manager pools together the money invested in the fund by all the investors and uses that money to make, usually long-term, investments on behalf of the fund<sup>125</sup>. This section examines the IFC investments in PE funds that go on to invest in private healthcare providers.<sup>5</sup> The search from the IFC investment data portal indicated that 22 PE funds' investments indicated or mentioned the healthcare sector (including hospitals) as existing/prospective sub-projects (Annex II).<sup>6</sup> The PE fund managing companies lend to various healthcare sector businesses including hospitals and clinics, pharmaceuticals, medical insurance, and digital healthcare. However, many of the investments pre-dating IFC's recent commitments to PE disclosure do not disclose the names of the companies in which investments have been made making it impossible to comprehensively track all sub-investments being made to the hospitals/clinics and diagnostics sectors. The table below lists where investments in specific hospitals and clinics could be traced. However, this list is likely incomplete.

Table 3.4: IFC investments in private equity Funds that invest in Private Hospitals and Clinics in India

Project ID	Company Name	Country of origin	Projected Board Date	IFC Investment amount (USD million)	Sector	Department / Industry	Investee Hospitals/ healthcare ventures financed by the IFC-supported PE funds	Status of investment	
1	39605	STELLARIS VENTURE PARTNERS INDIA I	India	12, Jun, 17	10	P-BB – Venture Capital Fund	Disruptive Technologies and funds/ Funds	Ayu health (hospitals & clinics)	Unknown
2	35855	EVERSTONE CAPITAL PARTNERS III LP – managed as IFC AMC	Singapore	03, Nov, 14	50 [AMC fund is not disclosed]	P-BA – Private Equity/Venture Cap Fund – Country	Disruptive Technologies and fund/ Infrastructure	Sahyadri Hospital (hospital chain in Maharashtra) <sup>126,127</sup>	Investment exit underway <sup>128</sup>
3	33475	Abraaj Global Health Fund (now Evercare Health Fund)	Cayman Islands	21, Jan, 14	150	Leveraged Buyout Fund	Disruptive Technologies and funds/ Funds	CARE Hospitals, India	Investment Exit underway <sup>129</sup>
4	41401	Multiples Private Equity Fund III Limited	India	2 April, 19	20	Growth Equity	Disruptive Technologies and funds/ Funds	Not specified but includes healthcare as one of the sectors. The Fund's website mentions Vikram Hospital, Bengaluru <sup>130,131, 132</sup> . Vikram Hospital	Exited. 2021

<sup>5</sup> A private equity fund is a pooled investment vehicle where the adviser pools the money invested in the fund by all the investors and uses that money to make investments on behalf of the fund.

<sup>6</sup> On-lending in financial transactions refer to the process wherein the capital intermediaries borrow funds from one/multiple entities (from anywhere in the world) and finance (or on-lend) the funds to another entity/ies.

								has since been acquired by the Manipal Group <sup>133</sup> .	
5	31707	Pragati Fund	Mauritius	23 Feb, 12	20	Private Equity/Venture Cap Fund-Country	Disruptive Technologies and Funds/Financial Institutions	Not specified, but disclosures suggest that one of the investments includes DCDC (Deep Chand Dialysis Centre) Health Services	Unknown
6	39362	IDG Ventures India Fund III LLC	Mauritius	27 Feb, 17	40	Venture Capital Fund	Disruptive Technologies and funds/Funds	Ovo Health (healthcare facilitator for cosmetic surgery, cancer, and fertility)	Unknown
7	42714	Chiratae Ventures International Fund IV LLC	Mauritius	30 Sept, 19	40	Venture Capital Fund	Disruptive Technologies and funds/Funds	OncoCancer Centres (centres in Telangana), Ovo Health	Unknown
8	30711	Aavishkaar India II Company Limited	Mauritius	30 May, 11	15	Private Equity/Venture Cap Fund-Country	Disruptive Technologies and funds/Infrastructure	GV Meditech- a group of hospitals in UP	Unknown
9	29593	Sarva Capital LLC (formerly Lok II)	New York, USA	3 Jun, 10	15	Micro-finance and small business - Non-commercial banking	Regional Industry- FIG Asia & Pac/Funds	Dr Mohan's Diabetes Specialities Centre (hospital chain in TN). Drishti Eye Care (Disha Medical Services) is a former investment	Lok exited Disha in 2019 <sup>134</sup> Dr Mohan's investment dates to 2017 <sup>135</sup>

Source: [https://disclosures.ifc.org/enterprise-search-results-home?f\\_type\\_description=Investment](https://disclosures.ifc.org/enterprise-search-results-home?f_type_description=Investment) (Accessed on 8 August 2022)

The transparency of financial intermediaries again emerges as a critical issue. Several projects do not fully disclose the sub-projects/companies in which the PE funds have invested. It is important to note there has been improvement in the transparency of disclosures over time with recent welcome commitments by IFC on PE fund disclosures<sup>136</sup>. However, it is essential to ensure that all investments disclose the names of investee companies, fund amounts and monitoring criteria for respective sub-activities/sub-projects. The UK's British International Investment (BII) calls for impact information for funds to be aggregated at the sector level providing the number of people employed by companies in each sector, the corporate taxes paid by companies in each portfolio and sector-specific metrics<sup>137</sup>. In contrast for the IFC, the status of the investments, particularly historic investments, and those through intermediaries, is often unknown. This makes it difficult to impossible to understand the true impact of the IFC's health portfolio or understand the extent to which environmental or social standards are being enforced. Opacity in investments, furthermore, makes it harder to ensure accountability, particularly by affected communities. In this regard, the IFC may learn from the UK's BII which discloses all sub-projects

both active and exited.<sup>138</sup> However, even Bill has also been recently criticised by Publish What you Fund for lengthy time lags in updating its investment information.<sup>139</sup>

Another critical dimension of transparency and accountability is the extensive use of tax havens by many of these financial intermediaries. 15 of the 22 (68%) PE Funds' companies/intermediaries used by the IFC that invest in healthcare are based in territories classified as tax havens by the Tax Justice Network<sup>140</sup>. These include Mauritius, Singapore, the Cayman Islands and Delaware, USA. Only seven of these funds are based in India. The IFC states that its investments in these instances are in line with its tax policy<sup>141</sup> and that it undertakes due diligence to ensure that the structure will not be used for tax evasion, tax avoidance or abuse tax planning and, furthermore, that companies are liable for taxes within India. Obviously, there can be legitimate reasons for a company to be incorporated in a tax haven. However, channelling investment through such tax aggressive jurisdictions is very often an indicative mechanism used by corporations to shift profits from countries where the company is operating to lower tax jurisdictions, and therefore minimize the company's tax bill.

Mauritius	10
India	7
Singapore	2
USA- Delaware	2
Cayman Islands	1
	22

The IMF's paper "The rise of Phantom investment"<sup>142</sup> estimated that close to 40% of total FDI (Foreign direct investment) is phantom investment. It is not meant to bring capital into productivity gains but most of it only passes through empty corporate shells to conduct some company intrafirm activities (financing or intangible assets management) to purely minimize the group tax bill.

International donors like IFC should play a role in contributing to distinguish when the use of tax havens is only intended to minimize tax bills or even a way to countervail more strict legislation. Complete transparency and access to the information could be a first step for IFC investment policy.

The IFC's failure to curb the use of tax havens has, furthermore, long contradicted the IFC's stated commitment to eliminating extreme poverty and risks making it complicit in companies' efforts to dodge taxes<sup>143</sup>. The financial loss through the use of tax havens is significant in countries like India. It is estimated that India loses over 10 billion dollars each year to tax avoidance by multinational corporations; this is equivalent to 44.7% of the health budget of India and holds the potential to pay for the yearly salaries of 4.23 million nurses.<sup>144</sup> A stronger commitment is required from the IFC to demonstrate that its clients including PE funds pay their fair share of taxes, by for instance ensuring that they publish country-by-country information on tax payments in each country where they operate, publish responsible corporate tax policy and publish all discretionary tax treatments<sup>145</sup>.

## MOBILISATION OF CAPITAL- THE AMC ROUTE

The IFC has also mobilised private capital through Asset Management Companies (AMCs) to boost private actors in many sectors including health. These are firms that invest pooled funds from clients, putting the capital to work through different investments including stocks, bonds, real estate, master limited partnerships and more.<sup>146</sup> The IFC thus also actively mobilises funds typically from commercial banks, insurance companies and sovereign wealth funds (like pension funds) to support private entities.<sup>147</sup> This acts as a further tool to grow the corporate healthcare sector in India, particularly prioritizing India's biggest healthcare chains. In India, Apollo Health and Lifestyle Limited and Tata 1MG Technologies Private Limited are the only corporate hospital chain (as a subsidiary of Apollo Hospitals Enterprise Limited) and digital healthcare platform (online pharmacy and healthcare products) respectively, in the IFC's AMC portfolio.<sup>148</sup> The IFC's Emerging Asia Fund, established in 2016 to support IFC-managed AMCs, invested USD 67 Million (combining equity investment and AMC fund mobilisation) in Apollo Health and Lifestyle



Limited (AHLL) to scale up Apollo’s clinic-based care centres (like fertility, dental, diagnostics, dialysis and others) across India.<sup>149</sup> This means that the IFC has invested in Apollo at least seven times, through various channels.<sup>150</sup>

**TABLE 3.6: HEALTHCARE INVESTMENTS BY OTHER DFIS IN INDIA**

The IFC is not the only Development Finance Institution (DFI) that has historically investing in healthcare in India. A list of investments made by some multilateral and bilateral development financing institutions including the IFC, ADB (non-sovereign lending), Proparco (France), DEG (Germany), BII (UK) and DFC (US) have been uploaded on the report page<sup>7</sup>. The quality of the disclosures, particularly through intermediaries, is patchy and the list may be significantly longer. At the same time, some investments are likely to no longer be active. A comprehensive investigation into the investments made by all the DFIs in India is needed.

**Hospitals:**

Apollo Group	IFC, ADB	Care Hospitals	Proparco, BII, IFC
Fortis	IFC	Manipal Hospitals /Global Health	BII, ADB
Max Healthcare	IFC	Sahyadri Hospitals	BII, IFC
Narayana	BII	Vikram Hospital	BII, ADB, IFC
HealthCare Global	ADB, IFC, DEG, Proparco	Krishna Institute of Medical Science	Proparco, DEG, ADB
Vaatsalya	BII, Proparco	GV Meditech	IFC, Proparco

**Others:**

Krsnaa Diagnostics	BII, ADB	Super Religare Laboratories	BII, IFC
Dr Mohan’s Diabetes Specialities Centre	IFC, BII, Proparco	DCDC Health Services	BII, ADB, IFC
Eye- Q	DFC, IFC	Drishti Eye Care	BII, DFC, IFC
Portea	BII, DFC, IFC	Healthcare at home	DEG, ADB, Proparco

**Conclusion:**

The IFC’s advisory services have promoted private sector-led service provisions within the public system by promoting PPPs and insurance models. Corporate hospital chains dominate the IFC’s direct investments in private healthcare in India. The IFC is also financing corporate expansion from tertiary health to primary and secondary levels of care and by doing so promoting the corporatization of healthcare. Disclosures related to the IFC’s investments through intermediaries in healthcare in India are improving but still weak and 65% of the intermediary companies were in tax havens. It has also mobilised funds to improve access to long-term capital markets by corporate hospitals to further expand private healthcare provisioning. It also plays the role of fund mobilizer to improve access to long-term capital markets by corporate hospitals to further expand private healthcare provisioning.

<sup>77</sup> <https://www.oxfam.org/en/research/first-do-no-harm-examining-impact-ifcs-support-private-healthcare-india>

## CHAPTER 4: DISCLOSED DEVELOPMENT OUTCOMES OF IFC HEALTH OPERATIONS IN INDIA

This section discusses the IFC's approach to measuring its contribution to development, providing an overview of the disclosed development performance by the IFC's supported hospitals and clinics in India. In so doing, the effort is to understand the extent to which these interventions contribute to the realization of the right to health in India.

### THE IFC'S APPROACH TO IMPACT ASSESSMENT

#### TRACKING DEVELOPMENTAL IMPACT: FROM DOTS TO AIMM

The IFC seeks to ensure that projects have an impact along two dimensions: project outcomes (its direct and indirect effects on stakeholders, the economy, and the environment) and market outcomes (increase market competitiveness, resilience, integration, inclusiveness, and sustainability).<sup>151</sup>

It professes to assess projects at the time of selection (impact potential and likelihood) and monitors performance throughout the project lifecycle<sup>152</sup>. This includes both sector-specific impact measurement and economic impact estimation frameworks. The IFC has so far disclosed 21 AIMM sector-specific frameworks, but the framework for health has not been disclosed, no consultations have been held on its content (unlike with other sectors) and there are no AIMM reports available in the public domain on any IFC health sector project as of March 2023. At the same time, global disclosures of overall AIMM effectiveness of interventions, do not disaggregate scores specifically for the health sector; scores are instead shared in terms of industry groupings. The health sector investments fall across industry groupings like Manufacturing, Agribusiness and Services and Disruptive Technologies and Funds. This makes it difficult to understand the application of the same to health.

Furthermore, the IFC first piloted and adopted the overall AIMM system in 2017<sup>153</sup> which means that many projects included in this report predate its introduction, especially as it is unclear when the AIMM health sector framework went into use. Prior to this, the IFC used the Development Outcomes Tracking System (DOTS) from 2005.<sup>154,155</sup> It also set targets for financial, economic, environmental, social, and broader private sector development impacts that included corporate standard indicators and departmental indicators (including healthcare<sup>156</sup>). Detailed DOTS assessments of individual projects are also not available. Consequently, for individual health projects, it is difficult to understand the IFC's actual impact globally and in India.

#### EVALUATIONS OF DEVELOPMENT PERFORMANCE

The IFC's website emphasises the role that its own evaluations play in demonstrating impact, ensuring accountability, and informing its operations. The IFC website lists development result information for only 15 projects in India from 2012, none of them related to health<sup>157</sup>. No reports on IFC health projects or investments in India are available on its website.

Regular IEG reports of the IFC's work are disaggregated by service area (such as advisory and investment services) and do not provide information for hospitals or other health sub-sector-specific analyses of development performance.<sup>158</sup> This makes the occasional IEG evaluations of the World Bank Group's health portfolio the only available source of accessible impact information. The 2018 evaluation found that the global health sector portfolio performed comparatively better than the rest of the IFC portfolio in terms of environmental and social effects, economic and social sustainability, and project business success.<sup>159</sup>

However, the evaluation also emphasised that the IFC rarely monitors all dimensions of the quality of its health interventions or captures the impact on marginalized communities; it describes the distributional impact of IFC health projects as unknown.

An earlier evaluation by the IEG at the global level in 2009 found several IFC health projects implemented between 1997 and 2002 where client operations resulted in the abandonment of project construction or complete failure of the business and bankruptcy of the sponsor company.<sup>160</sup> Development outcomes were also initially low, with several hospital projects reporting significant underutilization of facilities.<sup>161</sup> Far from benefiting the underserved, IFC health projects were found to have 'benefited primarily upper- and middle-income people at the 'top of the pyramid'.<sup>162</sup> With regards to its hospital projects, among 12 hospitals for which information was available, three were mainly targeted to expatriates and six were aimed at high- and middle-income populations.<sup>163</sup> Only a third of IFC advisory services met or exceeded expected outcomes and the cost-effectiveness of projects was considered low.<sup>164</sup>

## **IFC FRAMEWORKS ON ETHICS, RIGHTS, AND PATIENT SAFETY**

The IFC states that it seeks to foster best practices in healthcare, promote the deployment of innovative technologies and advance quality care. It provides a set of voluntary guidelines for their client/ investee hospitals and clinics to promote quality, standards, and ethics in service delivery. It has developed a set of guides for analysing and supporting healthcare providers to enable them to improve the quality of healthcare delivered and protect patient safety:

- a) Guide to Healthcare Quality Standards: Its Healthcare Standards cover five thematic areas, namely, clinical governance and leadership, ethics and patients' rights, quality measurement and improvement, patient safety, facility safety and emergency management. In collaboration with the Joint Commission International (JCI), the IFC affirms to use of these standards to undertake on-site assessments of the hospital environment.<sup>165</sup>
- b) The IFC Global Improving Quality (IQ) Healthcare tool is the newer set of standards. It has eight core areas- direct health service operations such as medication management and use, patient safety, infection control, improvement of operative practices related to ethics and family rights, governance and leadership, facilities management and safety, quality improvement and human resources.<sup>166</sup> It further specifies 150 specific measurable elements<sup>167</sup>. The process of administering the tool includes undertaking a facilities tour, interviews with key senior staff, and a documentation review. Inputs from third-party sources of information like court filings do not appear to be part of the process.<sup>168</sup> It also offers the application of the tool as an advisory service,<sup>169</sup> offers a self-paced course to help facilities develop standardized processes to minimize harm to patients,<sup>170</sup> holds regular webinars to take the agenda forward<sup>171</sup> and maintains a Facebook community of Practice on the issue.<sup>172</sup> The IFC also offers international and national benchmarking of hospitals drawing on the IQ standards.<sup>173</sup>

The IFC has also developed the EPIHC (Ethical Principles in Health Care) standards. These were designed to provide a platform to promote ethical conduct in healthcare. Healthcare providers are invited to commit to following the ten principles as a voluntary commitment without enforcement or complaint mechanisms. The principles of EPIHC include- respecting laws and regulations, making a positive contribution to society, maintaining high-quality standards, conducting business matters responsibly, respecting the environment, upholding patient's rights, safeguarding information and using data responsibly, preventing discrimination, harassment, and bullying, protecting and empowering staff, and supporting ethical practices and preventing harm.<sup>174</sup> Apollo Hospitals is one of the founding signatories of the framework<sup>175</sup> and Fortis and Regency Hospitals are signatories.<sup>176</sup>

The IFC's intention to promote the quality of healthcare is commendable. There is empirical evidence of the positive correlation between quality healthcare and health outcomes, and patients' choice of healthcare providers.<sup>177,178</sup> The experience of the IQ tool suggests that the domain of Ethics, Patients' & Family Rights is a domain where hospitals tend to fare less well with domains like patient confidentiality frequently compromised<sup>179</sup>. However, despite their existence, the IEG's review suggests that quality and equity in healthcare are not adequately prioritized while making and evaluating investments in the hospitals and diagnostics sectors. The extent to which these frameworks succeed in protecting patients' rights in weak regulatory contexts and without simultaneous efforts to strengthen the regulatory capacity of the state particularly forms a critical question.

## ANTICIPATED AND ACTUAL DEVELOPMENT IMPACT AND RESULTS OF INVESTMENTS IN INDIA

A content analysis of the development impact and results disclosed for IFC projects and investments is undertaken to understand the goals with which these were initiated, and the extent of progress achieved.

### ADVISORY SERVICES

The IFC discloses two levels of information under the tab of development results on the project website: expected development impact and development results. No evaluation reports for any of these advisory projects are in the public domain making it impossible to ascertain the extent to which they contributed to developmental impact.

In India, all eight of the IFC's hospital PPP projects stated or indicated that the expected development impact was an increase in the provision and/or enhancement of provision for patients. Seven of the eight also stated that the purpose was to increase private investment.<sup>180</sup> Two projects also expect to improve the provision of postgraduate medical education for specialists through the involvement of a private provider.<sup>181</sup> One project was a technical advisory focused on enhancing cost savings and improving the quality of the hospital.<sup>182</sup>

However, the reported development results identified were either commercial or administrative in nature. Seven of the projects' development results were reported as 'bid conducted' or 'agreements signed.'<sup>183</sup> Four of the projects' development results highlight that they received advice that will contribute to improved company procedures, improved performance, submission of reports and acceptance of the same by clients<sup>184</sup>. Four were aimed at increase in sales revenue or facilitating financing.<sup>185</sup> One project aimed to develop training modules which might presumably be considered as contributing to the capacity building of health personnel and hence contributing to healthcare.<sup>186</sup>

The table below illustrates some examples of the considerable and problematic mismatch between the intended impact as per the project description or expected impact and the development results reported.

Table 4.1: Example advisory project description, expected development impact and reported development results.

	Project Number	Project Name	Project description	Expected Development Impact	Estimated End Date	Development results
1	600946	Odisha Hospitals	Improve State's health infrastructure by structuring and implementing the rollout of low-cost hospitals in a PPP model. This will help the Government of Odisha to offer decent quality care at affordable prices to its citizens, including in rural areas.	Equitable, affordable, and good quality healthcare for the people of Odisha and promote private sector investment in the State's health sector.	30-Jun-17	1 bid conducted
2	594228	Ranchi Sadar Hospital PPP Project, Jharkhand	Development and operation of Sadar hospital campus at Ranchi under PPP mode. It will also involve setting up a Medical College if found feasible.	1. Increased access to healthcare services to around 15,000 to 20,000 in-patients and 100,000 to 200,000 out-patients per year 2. Mobilization of private investment worth USD 12 million (approximately) over 3 years post concession agreement signing.	30-Jun-14	1 bid conducted
3	599148	Jharkhand Diagnostic Pathology Services PPP	Structure the Public Private Partnership project for Pathology Diagnostic Services to improve the quality of services provided in the State's healthcare network.	Assist the Government to structure the PPP project for Pathology Diagnostic Services to improve the quality of services provided State's healthcare network. The project's objective is also to conduct a transparent and competitive tender process for the selection of private partners.	31-Mar-14	30 participants in a workshop, 2 agreements, 1 bid conducted

Some projects lack disclosure of results even a decade after the end date. Completed project 597087 (Health for All\_1 (Meghalaya Project 1) was due for a completion date in 2012. No results have been disclosed. Project 605359 (Covid-19 Health Sector Response Support to Madhya Pradesh) started in 2021 and is marked as completed. No developmental impact or results have been disclosed.

Some of the projects appear to be experiencing significant overruns or delays. Project 600946 (Odisha Hospitals) has an estimated end date of 2017 but is still marked as active. Little explanation or information, including on lessons to be learned is found either on the IFC portal or in media reports to

explain how this project is progressing or the reason for delays.<sup>187,188,189,190</sup> The only information on the IFC portal remains that the project is Active, 2017 is the estimated end date and that one bid was conducted by 2020.

The Ranchi Sadar Hospital PPP Project, Jharkhand (No. 594228),<sup>191</sup> is yet to start its operation due to a lack of consensus between the government and the private entities on the mode of contract. Fifteen years since the start of the project and despite the intervention of the Jharkhand High Court, work on the hospital remains incomplete.<sup>192</sup> Media reports allege that the state government found the initial PPP model unfeasible because of the high cost-sharing commitment in capital expenditure activities.<sup>193</sup> The project appears to have been resumed with different actors.<sup>194,195</sup> An audit of the district hospitals undertaken by the Comptroller and Auditor General of India for 2018-19 found that in Sadar Hospital Ranchi, Dental X-Ray purchased in 2017 remained unused till 2020 and laboratories in this hospital did not undergo NABL accreditation.<sup>196</sup>

The role of the IFC in many of these contracts is to offer transaction advisory services, making an examination of the contractual clauses particularly pertinent since transaction advisory processes can potentially have long-term impacts on project sustainability. Many of the IFC-supported PPPs entail locking the government into concessions or contracts with private players for long periods. The inflexibility of such an approach has proven problematic in accommodating inevitable changing health needs and presents significant and sometimes unsustainable fiscal risks to governments.<sup>197,198,199</sup> Key provisions that might relate to equity at the contract stage including the terms of concession agreements, private partner obligations and associated KPIs, and any other enforcement agreements concerning equity, are rarely made public and the IFC should ensure contracting contains obligations for regular reporting on these elements to key stakeholders.

In their response to Oxfam, the IFC has stated that their role as a transaction advisor ends with conducting a transparent bidding process. This raises the concern that the framing of the anticipated impact of interventions may be somewhat misleading, particularly in the absence of a disclosed and well-evidenced theory of change for individual projects that can explain how their transaction services result in the anticipated impact envisioned. The IEG's 2016 synthesis review of World Bank Group supported PPPs in health<sup>200</sup> also found that post-contract award "aftercare"<sup>9</sup> is rarely provided by the IFC despite its critical need. It also recommended that the IFC prepare post-completion reports after the PPPs have gone into operation given the long contractual life of PPPs. At the same time, the IFC should clearly and publicly acknowledge the limitations of their power in ongoing projects and put in place safeguards to ensure positive impact after the signing of the project.

The Bihar Health Patna Jayaprabha Hospital PPP project (No. 599671) was expected to facilitate the construction of a 500-bed super speciality hospital in Patna, Bihar via the design, build, finance, operate and transfer (DBFOT) model. The Global Health Patliputra Private Limited (GHP-PL), a unit of Medanta the Medicity, got the award in 2015 based on a concession period of 33 years. The project also suffers from inadequate disclosure. The concession agreement mandates the corporate hospital to reserve 25% of the operationalised beds for government-sponsored patients (mostly from the below poverty line (BPL) category) at a subsidised cost.<sup>201</sup> It is expected to eventually expand to 500 beds and increase access to 25,000-30,000 in-patients and 200,000 outpatients.<sup>202</sup> However, the only development result disclosed to date is that a bid was conducted, and an agreement signed. The absence of impact information especially on those most in need of healthcare is highly problematic.

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<sup>8</sup> This review excluded countries with decentralized health service delivery models including India.

<sup>9</sup> Investment aftercare services usually consist of administrative, operational, and strategic assistance to clients after the establishment of a project.

The Odisha Hospitals PPP project was packaged as India's Largest Public-Private Partnership Program. The Odisha Affordable Healthcare Project<sup>203</sup> was expected to develop up to a dozen hospitals with 50 to 200 beds each. At its full capacity of 2,400 beds, the project aims to "increase overall beds in the state by 8% and increase the availability of private beds by 15%."<sup>204</sup> It was expected to enhance access to equitable, affordable, and good-quality healthcare for the people of Odisha and promote private sector investment in the State's health sector.<sup>205</sup> However, the only declared development result is that a bid has been conducted.<sup>206</sup> (See table 4.1)

PPPs, including those in the health sector and those supported by the IFC, have proven extremely problematic, costly and controversial.<sup>207</sup> The failure of the IFC to disclose sufficient information about its supported health PPPs in India in order to understand progress (or lack of it) and examine development impact, including and especially related to the impact on the effectiveness and equity of the healthcare system, as well as financial sustainability, is unacceptable.

The lack of information or evidence on the impact of health PPPs in India reflects the findings of the IEG's 2016 synthesis review of World Bank Group supported PPPs in health<sup>208</sup> which highlighted that while IFC PPP projects often emphasized serving the poor and underserved population in their design, many lacked indicators, baselines and targets that would be necessary to track the access of poor populations. Critically, the IEG also found little evidence to show that the fiscal implications of PPPs had been considered, although many of the PPPs depended on the government for payment for services. Finally, the IEG recommended that "it should become Bank Group practice to ensure that the public option is at least considered and systematically assessed" before supporting PPP options. There is no evidence that these recommendations have been taken on board by the IFC's health PPP advisory work in India.

### **DIRECT LOAN AND EQUITY FINANCING:**

For the eleven cases of direct IFC financing to private healthcare in India, the reported anticipated development impact includes:

- Increased expansion of healthcare facilities in ten cases<sup>209</sup> with particular emphasis on expansion in Tier II/III cities or smaller towns<sup>210</sup> or underserved states.<sup>211</sup>
- Listed beneficiaries of expanded access also included government employees<sup>212</sup> and the middle class.<sup>213</sup> While three projects flagged enhancing affordability<sup>214</sup>, but none of the projects were aimed at improving healthcare for the poor.
- Disappointingly, only three projects explicitly anticipated increasing the number of patients benefitting from services.<sup>215</sup>
- Job creation in six cases<sup>216</sup> with only three projects disclosing the number of jobs to be created,<sup>217,218,219</sup> and only two explicitly prioritizing the career and professional development of women.<sup>220</sup>
- Improved management practices in five cases.<sup>221</sup>
- Two projects focus on the investee hospitals as a site of capacity building of personnel<sup>222</sup> (operating a nursing school or training dialysis technicians).
- Other impacts highlighted include the scope for greater south-south investments<sup>223</sup> and the green design of buildings constructed.<sup>224</sup>

The IFC considers its role to be to provide its market expertise<sup>225</sup> (six cases) and enhance governance, environmental, social, and business standards<sup>226</sup> (six cases). It also seeks to build long-term partnerships with clients to support expansion plans, especially south-south expansion.<sup>227</sup> Two projects disclose that the investment is being made to signal support to the health sector which is having difficulty raising funds.<sup>228</sup> More broadly, the IFC is presented as a provider of longer-term capital and as important in lending credibility to the company which can help leverage additional investments.<sup>229,230</sup>

The IFC's access to information policy suggests that it is expected to disclose results that are not commercially sensitive, as agreed with the client, and disclose them on the Summary of Investment Information as the project begins recording results. However, no disclosures of development impact are traceable on the IFC website in India for the education or health sector. It is understood that for ongoing projects it may not always be feasible to regularly update the development results because infrastructural expansion may still be in progress. However, the IFC's failure to report results also applies to health projects in India that closed long ago. This includes the first IFC investment in the Apollo group in 2005, Project No. 24406.<sup>231</sup> Indeed, the only documentation found of IFC's direct financing impact on health in India is a booklet on Apollo Hospitals<sup>232</sup> that provides an overview of the IFC's role in partnering with Apollo for over 20 years. Aside from an assertion that its investments were for 'the expansion of the network, purchase of equipment and expansion into smaller, less developed cities with Apollo Reach for low-income patients,' no impact data attributable to the IFC support is provided. No impact data is provided on Apollo's performance in expanding access to low-income populations<sup>233</sup> or its contribution to broader health systems strengthening.

## INVESTMENT THROUGH FINANCIAL INTERMEDIARIES (FIS)

Our searches have identified nine IFC investments in equity funds that go on to invest in specific private healthcare providers in India. Anticipated development impact or development results are not reported at all by the IFC for FIs or private equity sub-projects in health. For the equity funds themselves, the IFC does report both anticipated impact and what it sees as the IFC's 'additionality.' Anticipated impact is largely framed in commercial and business terms as opposed to social impact.

- Six of nine investments anticipate global expansion of local businesses and/or the creation of value for investees through improving governance, providing operational and financial expertise, and accelerating growth of portfolio companies.<sup>234</sup> Two anticipate demonstrating the viability of investing in healthcare businesses.<sup>235</sup> Four of nine investments expect an overall improvement in corporate governance, operational and E&S practices.<sup>236</sup>
- Supporting innovation and technology is an intended outcome of three investments.<sup>237</sup>
- Three investments aim to ensure job creation,<sup>238</sup> and two seek to ensure gender-inclusiveness in terms of female employment.<sup>239,240</sup>
- Only two investments report health-specific anticipated results. Both are health-specific funds that aim to improve access, quality, and affordability of healthcare.<sup>241</sup>
- Two investments anticipate the impact on low-income or 'base of the pyramid' households<sup>242</sup> and none specifically mention improving healthcare access or outcomes for women or socially marginalised communities.

The IFC's role and additionality for these financial intermediary investments are reported in terms of ensuring access to funds, including giving credibility to investees to help secure other sources of financing (8 of 9 projects).<sup>243</sup> In three cases the IFC is portrayed as playing a catalytic role in pioneering the setting up of a fund targeting social impact or innovation.<sup>244</sup> In six of the projects, the IFC highlights its contribution in terms of providing access to equity funds or knowledge gained from its investment portfolios, especially in technology, and experience in emerging markets.<sup>245</sup> Three investments reported the role of the IFC as one of ensuring that environmental and social sustainability practices were passed to investee companies<sup>246</sup> and one for improving governance standards.<sup>247</sup> The IFC's own expertise in the healthcare sector is not mentioned.

Even against these limited metrics and acknowledging that the IFC is gradually improving its reporting requirements, no development results are reported for the IFC's investments in equity funds. Across its



healthcare portfolio in India, the IFC consistently fails to demonstrate impact in terms of improving healthcare access, affordability, and equity and in measuring or reporting such impact.

## ENVIRONMENT AND SOCIAL ASSESSMENT SYSTEM

The IFC has had environmental and social risk and mitigation mechanisms for its projects since 1998.<sup>248</sup> The Environmental and Social (E&S) assessment system has undergone two reviews (2006 and 2012).<sup>249</sup> The environmental and social risks assessment and mitigation framework in project management are used to identify, mitigate and manage risks to enhance the development impacts of the projects.<sup>250</sup> The IFC has eight Performance Standards (PS) for its partners to comply with while implementing projects.<sup>251</sup> IFC-supported hospital projects (both investment and advisory services especially in hospital PPPs) are required to follow applicable standards. These have largely included PS 1 (Assessment and Management of Environmental and Social Risks and Impacts), PS 2 (Labor and working conditions), PS 3 (Resource Efficiency and Pollution Prevention) and PS 4 (Community Health, Safety and Security). PS 5: Land Acquisition and Involuntary Resettlement are applicable in a minority of projects<sup>252,253,254</sup>. PS 6: Biodiversity Conservation and Sustainable Natural Resource Management have been invoked in green hospital projects.<sup>255</sup> The following is an overview of the E&S risk disclosures provided:

### A. ADVISORY PROJECTS

The disclosures of E&S risks for some of the older projects are limited with four of nine projects not providing information in the public domain.<sup>256</sup> The remaining projects merely list the four frameworks above as applicable<sup>257</sup>. The mitigation measures state that advice will be provided to the partner to enable it to understand the IFC's Performance Standards. One currently active project states that an update on the mitigation measures is to be provided when the project is awarded and relevant contracts signed<sup>258</sup>; however, this information is not in the public domain. No promises of additional disclosures have been made in other projects.

### B. DIRECT LOAN AND EQUITY FINANCING INVESTMENTS

All IFC investments in this category fall under Environmental Category B<sup>10</sup>. Each investment has a separate Environment and Social Review Summary (ESRS) information page. The focus of the assessments appears to be on environmental assessments including an overview of waste disposal, power and water supply, hospital hygiene, fire protection, employee health and safety training and other safety standards. Social factors principally focus on labour and working conditions including the presence of relevant HR policies and training. Some investees have staff unions (e.g., Fortis and Apollo Hospitals) and the IFC states that it has provided a steer to enable the formation of staff associations in other companies. No updates on the plans have been disclosed that could help to ascertain the actions taken as per the plans shared.<sup>259</sup>

Environmental and Social Action plans disclosed suggest that considerable emphasis is given to minimising environmental damage and ensuring optimum working conditions, although the actual risks identified or progress in practice are not disclosed for the projects. Despite these suggested precautions, a recent study on reported fire incidents in major hospitals in India between 2010-2019 included two Apollo hospitals.<sup>260</sup> While the fires were minor, it is reported that two patients died after ICU patients were shifted to other hospitals.<sup>261</sup> Fortis Mohali was fined Rs 10 lakh for violating provisions of the Biomedical Waste Management Rules, 2016 for attempted disposal of untreated biomedical waste.<sup>262</sup>

Disclosures on stakeholder engagement highlight Corporate Social Responsibility (CSR) interventions undertaken by the hospitals, largely consisting of health check-up camps and health education and

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<sup>10</sup> Business activities with potential limited adverse environmental or social risks and/or impacts that are few, generally site-specific, largely reversible, and readily addressed through mitigation measures.

awareness activities<sup>263</sup> and construction impacts on the neighbouring community.<sup>264</sup> For example, Rockland Hospitals promised free/subsidized (outpatient and inpatient) medical services to low-income (below poverty line) patients from nearby communities and to provide training and outreach programs to secondary school students from nearby schools<sup>265</sup>. The disclosures, however, fail to meaningfully engage with the quality of stakeholder engagement or core business practices. CSR is not a replacement for ethical core practice.

Project disclosures highlight that appropriate grievance mechanisms and procedures are to be established, and maintained and that affected communities can access the IFC's complaint mechanism, the Compliance Advisory Ombudsman (CAO). Some projects state that grievance help desks have been established in hospitals<sup>266</sup> although the effectiveness of these is not reported. Investee companies are also required to commit to submitting an Annual Environmental and Social Monitoring Report (AMR) to the IFC. The IFC stated that the functioning of grievance redress mechanisms is undertaken as part of the reviews of the AMR. However, these reports are not disclosed for any of the projects.<sup>267,268</sup>

Critically, none of the disclosures reference the status of compliance with important national or state legal provisions in India such as the Clinical Establishments Act or track adherence to the Patients' Rights Charter, despite performance standards requiring explicit compliance with applicable national law. The IFC has responded to say that E&S requirement reviews include a review of applicable legal requirements. However, the ESRS is not updated to reflect levels of compliance or non-compliance.

### **C. FINANCIAL INTERMEDIARY DRIVEN IFC HEALTH SECTOR INVESTMENTS**

The adherence to IFC's E&S assessment system is more complicated. These projects are categorised as FI-2 or FI-3, which are designated as having no or minimal E&S risk.<sup>269</sup> All financial intermediaries are mandated to respect the IFC's Performance Standards of the E&S risk assessment and mitigation framework across their portfolios while investing in other companies or investment platforms. An Environmental and Social Review Summary is expected to be prepared by the IFC for each investment, and an Environmental and Social Action Plan (ESAP) is to be prepared if changes are recommended. For most investments, no ESAPs were deemed necessary<sup>270</sup> or they were not disclosed<sup>271,272</sup> making it difficult to understand the impacts of these investments. Two projects do include an ESAP which provides a timeline for the adoption of ESMS policy and procedures.<sup>273</sup>

The IFC's E&S systems fall short when applied to the healthcare sector in several ways. These include its inadequacies in terms of accounting for systemic factors, such as the significant risks of growing commercialization and privatization of healthcare provision, including potentially undermining the public health system and exacerbating health inequality. These constitute sector-wide risks, but they are also the consequence of individual investments and should be addressed accordingly. It would seem reasonable that all sector wide risks be identified and addressed alongside the risks and consequences of individual investments, given that these investments are ultimately meant to lead to stronger national health systems. Civil society has been critical of shortcomings in the IFC's E&S assessment in terms of its ability to address human rights.<sup>274</sup> The current E&S risk and mitigation assessment system of the IFC is not equipped to address both the systemic concerns arising from the growth of private financing and provisioning of healthcare and the specific concerns related to patients' rights violations in a context where regulatory mechanisms are weak. Yet gaps in the IFC's approach to due diligence and supervision are well documented, including by the IFC's independent accountability mechanism, the Compliance Advisor Ombudsman (CAO). For instance, in the education sector, the CAO raised questions about the adequacy of the IFC's oversight and supervision of client compliance with national laws, as well as their ability to ensure clients had the capacity and commitment to implement the Performance Standards.<sup>275</sup>

**CONCLUSION:**

The IFC claims that investing and advocating for healthcare businesses contributes to development, but the mechanisms do not exist to adequately capture the longer-term and holistic development impact of IFC operations in the healthcare sector. A clear conflict of interest exists between the accountability of the IFC to its commercial investees and the larger goal of ensuring a robust system of healthcare that is accessible to all without discrimination. While the absence of disclosures for some of the historic investments may be attributable to the limitations of the then-prevailing disclosure standards, the absence of critical information particularly the healthcare impact of the IFC's investments in even the more recent projects is concerning. The IFC's stance that they do not disclose commercially sensitive information pertaining to their investees cannot serve as a reason to not disclose any relevant information about the healthcare impact of their operations. In the absence of comprehensive external, independent evaluations of impact in the Indian context and often the absence of even self-declared information, the IFC's claim of enhancing development by supporting private healthcare in India remains unsubstantiated.

## CHAPTER 5: QUALITY, EQUITY AND PATIENTS' RIGHTS IN INVESTEE HOSPITALS IN INDIA

In the absence of adequate measurement systems and vague development impact outcomes of IFC investments highlighted previously, this chapter turns to other sources of information to understand the track record of IFC investee healthcare providers in addressing equity and in upholding patients' rights.

In so doing it looks at the extent to which the hospitals, and by extension, the IFC as their supporter, have been able to live up to the first principle of healthcare- doing no harm.

### ARE IFC INVESTEE HOSPITALS TRULY SERVING THE UNDERSERVED?

It is essential that development funding for health in India contributes to redressing the huge healthcare access gap and directly reducing catastrophic and impoverishing out-of-pocket health expenditures experienced by millions of people that are blocking progress towards achieving universal healthcare. Poor rural populations suffer the greatest access gaps to healthcare but as is common for most private hospitals, IFC investees are concentrated in highly populated urban areas because this is where more income and therefore profit can be generated. 77.8% of the IFC direct investee chain hospitals are in Million Plus population cities. 60.4% of hospitals are in Tier 1 cities<sup>11</sup>, 35% are in Tier 2 cities and only 4.2% are in smaller habitations. Of the 144 hospitals listed on the corporate websites of these chains, only one was described itself as being in a rural area.

At the same time, only 13.9% of the hospitals are in the ten states<sup>276</sup> ranked lowest in terms of the overall performance of the health system. This is based on the Annual Health Index 2021<sup>277</sup> prepared by Niti Aayog, the Ministry of Health and Family Welfare and the World Bank. Furthermore, parts of Uttar Pradesh, one of the lowest-ranked states, adjoins and overlaps with the National Capital Region of Delhi, one of the highest populated areas of the country. If one sets aside the hospitals from the NCR, the proportion of hospitals in these ten lowest-performing states slips to 9.72%. Not a single hospital operates in four of these ten states.

	Tier I	Tier II	Tier III +
Apollo	Delhi, Bengaluru, Chennai, Hyderabad, Kolkata, Mumbai, Ahmedabad	NOIDA, Bhubaneswar, Guwahati, Indore, Kakinada, Kochi, Lucknow, Madurai, Mysuru, Nashik, Nellore, Tiruchirappalli, Vishakhapatnam, Bilaspur	Aragonda (rural), Karur
Apollo Cradle	Bengaluru, Chennai, Delhi, Hyderabad	Gurugram, NOIDA, Amritsar, Ghaziabad	
Apollo Spectra	Bengaluru, Chennai, Delhi, Hyderabad, Mumbai, Pune	Gurugram, NOIDA, Gwalior, Jaipur, Kanpur, Patna	
Fortis	Delhi, Bengaluru, Chennai, Kolkata, Mumbai	Gurugram, Faridabad, Amritsar, Chandigarh, Ludhiana, Jaipur	Mohali, Kangra
Max	Delhi, Mumbai	Gurugram, NOIDA, Dehradun	Mohali, Bhatinda
Rockland/ Medeor	Delhi	Gurugram	
Regency		Kanpur, Lucknow	

<sup>11</sup> Tier 1 cities are eight metropolitan areas with high population and cost of living. The smallest city has a population of 3 million. The city with the lowest population in the Tier 2 list half a million. Cities in bold are in the 10 lowest performing states.

Thus, the IFC investee hospitals are largely not located in habitations with the greatest need of additional hospital infrastructure, but instead, provide additional options to populations with existing healthcare options in metropolitan cities. Underserved locations are ignored in favour of sites where greater profits could be made. An exception to this trend is the chain of franchisee Apollo clinics that have come up in smaller towns. These are addressed in Box 5.2. Having examined the challenges in physically accessing healthcare in the locations chosen for establishing private healthcare institutions, it is critical to look at the experiences of patients who can access healthcare in the same.

## WHAT IS THE TRACK RECORD OF IFC INVESTEE HOSPITALS WITH RESPECT TO ETHICS AND PATIENTS' RIGHTS?

The WHO defines patients' rights as those owed to the patient as a human being, by physicians and the state. Respecting that patients have basic rights that are not forfeited by entering a relationship with a doctor or healthcare facility is a fundamental responsibility of healthcare providers. A charter or list of patients' rights acts as a health promotion and protection tool by looking for systematic, rather than anecdotal, mistreatments by healthcare providers—mistreatments which are the product of either an active policy decision or of an undesirable common practice—which the health provider or the state has been neglecting to attend to.<sup>279</sup> The IFC has advocated for ethical principles in healthcare and its EPIHC reiterates the need to protect patients' rights to dignity, privacy and confidentiality and prevent discrimination, harassment, and bullying.<sup>280</sup> One of the domains of the IFC's IQ tool is to improve patient safety.<sup>281</sup>

Despite the IFC's stated emphasis on improving the quality of healthcare and ensuring patient safety<sup>282</sup>, the report could not find a single project information window on the IFC portal that addresses the status of patients' rights at its investee hospitals in India. This is a significant omission given that the issue of patients' rights is an important parameter for both equity and quality of healthcare.

In the absence of any information from the IFC itself, a search of media reports was undertaken to examine the track record of IFC's investee hospitals in terms of patients' rights, the adherence with the various E&S metrics of the IFC and the EPIHC principles. Only instances where regulators have upheld the complaints against the hospitals are included in the present analysis to ensure that the instances included are more than just allegations. The result is a list of over sixty reported patients' rights violations where the Indian authorities have upheld complaints against IFC-supported corporate hospitals in India and/or where some form of restitution has been done or penalties imposed (Table 5.2). Litigation in India is slow, and hospitals may have appealed some of these cases.<sup>283</sup> While the IFC has informed us that it is informed about newly filed court cases, it is not discernible what corrective action is taken and to what extent it recognizes these cases as a reflection of severe underlying systemic risks based on the reliance on commercial actors in healthcare.

The highest number of cases reported were from the Apollo, Max and Fortis groups which are repeated and direct investment clients in IFC's India health sector portfolio. A summary of these cases is provided in Table 5.2. These include 16 complaints related to Apollo, 16 for Max and 24 for Fortis Hospitals<sup>284</sup>. Most pertain to failure of overcharging and failure of governance, although are violations of other patients' rights and point to compromises made with the rights of patients in apparent contradiction with India's Patients Rights Charter and the IFC's EPIHC principles. In most instances, the action was taken by the State, National or District Consumer Disputes Redressal Commissions/ Forums. However, many instances also pertain to pending cases in the High or Supreme Court of India, the Competition Commission of India, SEBI, and the National Pharmaceutical Pricing Authority. Action was also taken by the concerned state or municipal administrations, State Medical Councils, State Clinical Establishment Regulatory Commissions, and the National Human Rights Commission.

Table 5.2: MEDIA REPORTS REGARDING ACTION BY REGULATORS ON PATIENTS' RIGHTS IN IFC-SUPPORTED CORPORATE HOSPITALS IN INDIA

	Hospital	State	District	Type of violation	Case
Direct Investments					
1	Apollo Gleneagles Hospital	West Bengal	Kolkata	Medical negligence	West Bengal Clinical Establishment Regulatory Commission fined doctors for negligence in treatment and awarded compensation to the patient's parents. <sup>285</sup> News reports suggest that the State Medical Council suspended the doctors involved for three months. <sup>286</sup>
2					West Bengal Clinical Establishment Regulatory Commission Patient orders compensation for patient being kept unattended in an ambulance for about 27 minutes despite reporting experiencing cardiac problems culminating in his death. <sup>287</sup>
3					West Bengal Clinical Establishment Regulatory Commission ordered compensation after a patient died after falling from bed while under treatment resulting in bone fractures and health injuries. <sup>288</sup>
4					Two doctors were suspended for six months on the grounds of negligence by West Bengal Medical Council. The Council also charged the hospital with delaying the shift of the patient to another hospital without first clearing the bill. The patient died. <sup>289</sup>
5				Overcharging for COVID treatment	West Bengal Clinical Establishment Regulatory Commission found the hospital guilty of not abiding by the COVID advisory capping rates and overbilling. <sup>290</sup>
6	Apollo Hospital	Karnataka	Bengaluru	Refusal to treat COVID-19 patients referred	District Health Officer is reported as shutting down the OPDs for 48 hours and threatened cancellation of license for hospital failing to treat patients referred by the government during the pandemic. <sup>291</sup>
7				Overcharging	The Medical Education Minister called for action against the hospital for charging patients above the prescribed price cap for COVID care despite past warnings. <sup>292</sup> The hospital claims that charges levied were as per insurance company tariff and not the government's price cap.
8		Tamil Nadu	Chennai	Medical negligence	Tamil Nadu Consumer Disputes Redressal Commission orders compensation for death caused due to medical negligence contributing to the death of patient. <sup>293</sup>
9		Maharashtra	Navi Mumbai	Overcharging	Municipal Corporation is reported as ordering refund for COVID patients <sup>294</sup> after a series of complaints against multiple hospitals. Two of the cases pertain to Apollo <sup>295</sup> . An audit of the billing and inspection by a team of doctors was ordered <sup>296</sup> .
10		Odisha	Bhubaneswar	Illegal organ trade	The National Human Rights Commission asked the Odisha government to suspend or cancel the registration of Bhubaneswar's Apollo Hospital for violating the Transplantation of Human Organs and Tissue Act and to pay compensation to victims. <sup>297,298</sup>
11		Telangana	Hyderabad	Medical Negligence	Telangana State Consumer Dispute Redressal Commission is reported to order compensation for death due to inadequate post-operation monitoring contributing to asphyxiation resulting in death of the patient. <sup>299</sup>
12					State Consumer Disputes Redressal Commission ordered compensation to family of deceased 22-year-old who suffered from sepsis contributing to complications resulting in death. The affidavits filed by treating doctors and discharge/death statement showed discrepancies; the case papers were reported to have been misplaced by the hospital despite obligation to retain them for three years <sup>300,301</sup> .

13				Not providing free beds	Media reports state that the State government reassured the Telangana High Court of action taken against Apollo for failure to treat patients for free in line with existing commitments <sup>302,303</sup> .	
14				Tax Avoidance and Illegal charges	The hospital is reported as being fined by tax authorities for charging registration fee without reflecting the same in the receipt. <sup>304</sup>	
15				Denial of care	Telangana High court is reported to have called for action by the government against the hospital for refusal to treat poor COVID patients. <sup>305</sup>	
16					Director of public health is reported to have issued notice to several hospitals in Hyderabad, including Apollo, for overcharging and refusing to treat COVID patients. <sup>306</sup>	
17	Max Hospital	Punjab	Bhatinda	Medical Negligence	Hospital was ordered to pay compensation by State Consumer Disputes Redressal Commission for death due to medical negligence through failing to address patient's problems with kidney and lungs in absence of specialists in these domains in the Branch. <sup>307,308</sup>	
18			Mohali	Over Pricing	Punjab State Consumer Dispute Redressal Commission ordered a refund and compensation for the hospital failing to adhere to the Central Government Health Scheme rates <sup>309</sup> .	
19				Failure to adhere to CGHS rate and unfair trade practice	State Consumer Disputes Redressal Commission, Punjab ordered refund with interest of the various charges worth 40 lakhs by the hospital despite deceased being entitled to cashless treatment in this empanelled CGHS hospital. <sup>310</sup>	
20				Transfusing HIV+ blood	Uttarakhand State Consumer Disputes Redressal Commission fined hospital for transfusing HIV positive blood; the patient later died from HIV <sup>311</sup> .	
21				Unfair trade practice	District Consumer Disputes Redressal Commission is reported to have held Max Hospital, Phase 6, guilty of unfair trade practices for carrying out unnecessary tests to issue medical fitness certification for immigration. <sup>312</sup>	
22				Medical Negligence	Punjab State Consumer Disputes Redressal Commission is reported to have ordered the hospital to pay compensation for medical negligence during treatment resulting in the amputation of fractured finger. <sup>313</sup>	
23			Delhi	Pitampura	Medical Negligence	State Consumer Commission asks the branch to pay compensation for negligence during delivery resulting in damage to the left arm of new-born resulting in his permanent disability. <sup>314</sup>
24					Surgery without consent	Delhi court asks police about steps taken on a complaint filed by deceased's brother regarding surgery on a hearing and speech-impaired patient without consent; no sign language interpretation appears to have been made available. <sup>315</sup>
25	Delhi	Medical Negligence		The hospital and surgeons were found guilty of negligence by the consumer court and directed to pay compensation for allegedly leaving cotton after brain surgery resulting in the patient's death. <sup>316</sup>		
26		Medical negligence and failing to release passport		Delhi High Court orders hospital to release passport of petitioner's wife and minor son who were Yemeni nationals following a dispute over medical bills. Commissioner of Police was also ordered to investigate the hospital and collect documents pertaining to the treatment which were not shared with parents <sup>317,318</sup> .		

27			Shalimar Bagh	Premature baby wrongly deemed dead	Delhi government probe found hospital guilty of failing to follow protocols in a case where a new-born boy was deemed dead; he was found to be breathing before his last rites. The hospital terminated the services of two doctors in the case. <sup>319</sup> The hospital states that the baby was never declared dead since he was not admitted to the hospital <sup>320</sup> .
28				Not providing free beds	License of hospital was cancelled for providing free beds; this order was subsequently stayed <sup>321</sup> .
29			All	Overcharging, Abusing dominant position	Investigation by Deputy Director General of the Competition Commission of India reportedly pointed out that hospital made 275%-525% profit on the sale of disposable syringes by abusing dominant position by forcing inpatients to buy products from its own pharmacy; data pertains to all 14 hospitals of the group. <sup>322</sup>
30				Overcharging	National Pharmaceutical Pricing Authority ordered hospitals to refund charges or face penalties; Max Hospital has stated that they have complied with the order <sup>323</sup> .
31			Saket	Not providing free beds	Notice issued by Delhi government to hospital for failing to offer free beds and out-patient care in line with court orders. <sup>324</sup>
32				Medical negligence	Delhi Medical Council suspended doctor from the medical register for a month for negligence resulting in the death of a patient; the operation was contraindicated for patients with active abdominal TB which status the doctor appears to have failed to ascertain <sup>325</sup> .
33	Fortis Hospital	Uttar Pradesh	NOIDA	Informed consent	The hospital was ordered by the National Consumer Disputes Redressal Commission to pay compensation to family of deceased for not taking informed consent before surgery. <sup>326</sup>
34		Punjab	Mohali	Informed consent	Ten lakh compensation awarded to patient for failure to obtain informed consent before undertaking colonoscopy; the procedure resulted in complications <sup>327</sup> .
35				Medical Negligence	National Commission orders the hospital to pay compensation for failing to treat a 96-year-old woman for bedsores and preventing infections acquired during treatment; patient was allegedly placed in hand restraints; no air mattress was provided, and inadequate attention was paid to maintaining hygiene. <sup>328</sup>
36					Consumer Redressal Commission, Punjab ordered the doctor to pay compensation in a case of a man who died due to negligence in the hospital due to failure to pay immediate emergency attention; there "appears to be deficiency in service" on part of laboratory section for not examining samples submitted. <sup>329</sup> The hospital denied wrongdoing <sup>330</sup> .
37				Ludhiana	State Consumer Disputes Redressal Commission ordered hospital to pay compensation for the death of a patient due to medical negligence in the use of pressure support ventilation. <sup>331</sup> The hospital denied wrongdoing <sup>332</sup> .
38				Improper waste disposal	Punjab Pollution Control Board is reported to have imposed a fine on Fortis Hospital after seizure of biomedical waste from a scrap dealer and directed management to deposit a bank guarantee of 25 lakhs as an assurance to ensure compliance with the Bio Medical Waste Management Rules. <sup>333</sup>
39		Haryana	Gurgaon	Overcharging	Health authorities sealed the lab of Fortis Hospital after information of overcharging for dengue tests. <sup>334</sup> Fortis spokesperson said that a refund was made to the complainant <sup>335</sup> .



40			Refusal of ambulance services and forgery	Government investigation showed overcharging and forgery of signatures of parents on key documents; withdrawal life support by hospital staff in the ambulance was done. <sup>336</sup> Parents had also alleged bribery by the hospital to settle the case <sup>337</sup> . Fortis was initially charged with culpable homicide <sup>338</sup> ; a ten-month investigation later chargesheet filed only against doctor who withdrew life support. <sup>339,340</sup>
			Overcharging	Overcharging of patients was reported. National Pharmaceutical Pricing Authority found that the hospital was making margins of over 1700 on medical consumables and medicines in the case. <sup>341</sup> Haryana Food and Drug Administration is reported to have issued a suspension notice to the blood bank and pharmacy at the hospital. <sup>342</sup>
41			Medical Negligence	Doctors were arrested for delay in administering emergency medicines. <sup>343</sup> Haryana's Food and Drug Administration is reported to have also suspended the license of Fortis Hospital's Blood Bank and IPD Pharmacy after government panel probed allegation of overcharging. <sup>344,345</sup>
42	Karnat aka	Bengaluru	Medical Negligence	Commissioner of health is reported to have ordered cancellation of transplantation licenses after the death of a patient after the hospital undertook a pancreas transplant without a license <sup>346</sup>
43				Three doctors were reportedly asked to pay compensation for negligence by the State Consumer Disputes Redressal Commission resulting in the death of the patient; the patient was allegedly operated upon ignoring the cardiac risk and no pace-maker facility was available in the hospital. <sup>347</sup>
44	West Bengal	Kolkata	Overcharging	West Bengal Clinical Establishment Regulatory Commission reportedly warned Fortis about overcharging and orders an audit of all the bills prepared by the hospital for a month. <sup>348</sup>
45			Overcharging	West Bengal Clinical Establishment Regulatory Commission is reported to have ordered a refund for excess charges <sup>349</sup>
46	Rajast han	Jaipur	Unfair business practice	National Commission ruled that insistence that patient purchase medicines from the hospital pharmacy imposed unjustified and unreasonable restrictions on consumers. Penalties were imposed on the hospital. <sup>350, 351</sup>
47	Mahara shtra	Mumbai	Overcharging	State Food and Drug Administration Minister informed the Legislative Council of the state that action has been taken against Fortis Hospital (Bhandup) for overcharging for stents. <sup>352</sup> It is alleged that the accused hospitals in the case charged for stents in the range of 1.05 - 1.9 lakh INR while procuring them at 50-90,000 INR.
48			Reusing catheters after sterilization	Cases filed in court against seven hospitals by Maharashtra (including Fortis Mulund and Sahyadri Hospital, Pune) after investigation for reusing catheters meant for one-time use after sterilization and charging multiple patients for the same. <sup>353,354</sup>
49			Overcharging	Navi Mumbai Municipal Corporation is reported to have ordered a refund for COVID patients <sup>355</sup> after a series of complaints. Two of the cases pertain to Fortis <sup>356</sup> . An audit of the billing and inspection by a team of doctors was ordered <sup>357</sup> .
50	Tamil Nadu	Chennai	Negligence	State Consumer Disputes Redressal Commission reportedly fined the company for falsely declaring applicant HIV positive on a pre-employment report resulting in the loss of a job offer and mental health costs. <sup>358</sup>

51		Delhi	Shalimar Bagh	Negligence	Five staff were reportedly sacked after doctors operate on the wrong leg; the hospital said that the expert committee probing the incident suggested that standard operating procedures were not followed in the case. <sup>359</sup>
52	Delhi Court directed police to file a First Information Report against Fortis Hospital for medical negligence resulting in disability involving a new-born; the brain injury was allegedly concealed by the hospital. <sup>360</sup>				
53			All	Fixation of costs	Allegations of collusion between manufacturers and hospitals to inflate costs resulted in an investigation by the National Pharmaceutical Pricing Authority which showed excess margins <sup>361</sup> . Competition Commission of India issued notice to the hospital chain to explain how it sets rates for medicines and medical devices or face penalties. <sup>362</sup>
54				Overcharging	National Pharmaceutical Pricing Authority issued show-cause notice for overcharging on coronary stents. <sup>363</sup> It took cognizance of reports from the "Paradise Papers" that the Chairman of Fortis Escorts Heart Institute held shares from a Singapore-based company that supplied coronary stents to the hospital chain. <sup>364</sup>
55				Diversion of funds	Capital markets regulator SEBI is reported as imposed penalties on Fortis Healthcare Holdings in case of diversion of funds by promoters in 2018. <sup>365</sup>
56			Fortis Escorts Heart Institute, Vasant Kunj	Not providing free beds	Notice issued by the Delhi government for failing to offer free beds and outpatient care in line with court orders. <sup>366</sup>

The penalties imposed have included a range of actions including hospitals or concerned doctors being fined, compensation demands and/or temporary suspension of operations by the competent authorities. In some instances, arrests have also been made.

It may be worth reiterating that the list above only includes instances where action is reported to have been taken by authorities. Numerous other concerns were unearthed during our exploration indicating that this is just the tip of the iceberg. In India, patient complaints are rarely successful given weak accountability mechanisms for the private sector.<sup>367</sup> Complainants fight cases individually whereas hospitals or doctors generally fight in unison under the umbrella of their professional bodies. Patients must approach different layers of institutional mechanisms to prove the merit of the complaints. Structural inequality (like the power of professional bodies) and system-wide inefficiency (in terms of the absence of a robust patient-friendly medico-legal framework) exacerbate victims' struggles. An overview of the issues highlighted is provided in the section below.

### **THE ROOT OF THE PROBLEM: OVERBILLING, PRICE RIGGING, REFUSING TO TREAT PATIENTS AND OTHER MODES OF EXTRACTING PROFITS.**

According to Dr Arun Gupta (president of the Delhi Medical Council), "the underlying cause of complaints is often overbilling."<sup>368</sup> The drive to meet targets and raise revenue for the employer has been known to trigger unwarranted treatment, false diagnoses, inflated bills, and medical negligence. This is a grave concern, especially about access and equity of healthcare– the development parameters that IFC is also aspiring to achieve. Some of the concerns that have emerged with respect to these hospitals include:

- **Collusion for Price Rigging:** The Competition Commission of India is undertaking an inquiry into inflated drug pricing in the Apollo, Max Healthcare and Fortis Healthcare hospitals.<sup>369</sup> A four-year investigation by the Competition Commission of India<sup>370</sup> concluded that hospital chains including IFC investee hospitals have been abusing their dominance in the market by overcharging for services and products. Higher prices were charged for medicines, tests, medical devices, and other consumables and they also do not allow patients to buy consumables, tests, devices, and medicines from outside, charging prices higher than from other makers.<sup>371</sup> Unfair trade practices like requiring patients to purchase medicines and clinical apparatus, accessories and implants from the hospital at rates significantly higher than market rates have been reported in other instances<sup>372</sup>.
- **Violating terms of the land lease:** The Delhi government has asked Fortis and Max Hospital<sup>373</sup> to deposit "unwarranted profits" for refusing free treatment of the poor, the prime condition for the land allotment lease under which land was granted for the establishment of the hospitals.<sup>374</sup> Similarly, the Telangana High Court had to intervene to ensure compliance with similar clauses in Hyderabad.<sup>375</sup> Box 5.1 covers some of the case law regarding this dimension in Delhi.
- **Refusal to treat referred patients and overcharging during the COVID period:** While many hospitals do provide free or subsidized healthcare through certain outreach programs,<sup>376</sup> action was taken against several private hospitals<sup>377,378</sup> for refusing to treat patients referred to them during the pandemic or exceeding the government cost caps for COVID testing and treatment.
- **Ongoing overcharging:** The National Pharmaceutical Pricing Authority reportedly issued a notification that Gurgaon Fortis made 300% margins on scheduled drugs which were under government price control<sup>379, 380</sup>. In another example, cases were filed in court against seven hospitals by Maharashtra including two IFC investees after an investigation for reusing catheters meant for one-time use after sterilization and charging multiple patients for the same<sup>381,382</sup>.
- **Financial Conflict of Interest:** National Pharmaceutical Pricing Authority issued a show-cause notice to Fortis for overcharging on coronary stents.<sup>383</sup> It took notice of reports from the "Paradise

Papers” that the Chairman of Fortis Escorts Heart Institute held shares in a Singapore-based company that supplied coronary stents to the hospital chain.<sup>384</sup>

These reports concern not only IFC investees but are reflective of the overall status of India’s private healthcare sector<sup>385</sup>. While price caps were introduced during the COVID-19 pandemic they were inadequately enforced.<sup>386</sup> Analysis of factor payments shows that 55% of GVA of unincorporated private hospitals is a gross operating surplus (or profit), followed by emoluments paid to employees and workers (42%). These factors potentially cause over-charging in the private sector<sup>387</sup>. Another research looked at over 1.6 million insurance claims and 20,000 patient respondent survey showed that private hospitals engage in coding manipulation to increase revenues at government expense and hospitals charge patients for care that should be free under program rules; raising rates reduces these charges significantly, but hospitals capture about half of the increase with the probability of passing on public subsidies higher in less concentrated markets, suggesting that hospitals exploit market power to capture public subsidies<sup>388</sup>.

#### **BOX: 5.1. FAILING TO ADHERE TO TERMS OF LAND LEASE AGREEMENTS BY PRIVATE HOSPITALS IN DELHI**

Indraprastha Apollo, a part of the Apollo group which has been a repeated investee of the IFC<sup>11</sup> was allotted 15 acres of land on rent of Rs 1 per month in 1994 and received equity from the government to construct the hospital in exchange of a commitment to provide free treatment to low-income patients on one-third of its inpatient beds and 40% of outpatient services after it became fully operational. Nearly forty different hospitals across various chains were similarly sanctioned land at a concessional rate by the government during this period.<sup>389</sup>

In 2002, the legal activist group Social Jurist filed a petition in the Delhi High Court against the poor implementation of this quota. A High Court-appointed committee submitted a report in 2007 that found that the average free treatment provided by Apollo hospital in the previous five years was 2.46% of inpatient care and 0.27% of outpatient against the mandatory 33% and 40% respectively.<sup>390</sup> In 2007, the Delhi High Court imposed a fine on the hospital for not providing free treatment<sup>391</sup> and ordered the state government to ensure that it and other private hospitals comply with providing the free service.<sup>392</sup>

In the subsequent years, other hospitals were added to the list of hospitals responsible for providing free beds. In 2012, the Central Government notification said that all hospitals allotted land by the Land and Development Office should extend free services<sup>393</sup>. In another case, in 2018, the Supreme Court ordered that all private hospitals that availed land at concessional rates must provide free treatment for those under the poverty line with no cap on costs.<sup>394</sup>

However, the 2021 report of the Comptroller and Auditor General of India examining the functioning of the Land and Development Office in Delhi highlights that monitoring of this provision has been ineffective<sup>395</sup>. In 2022, 64% of beds reserved for Economically Weaker Section patients in Delhi’s private hospitals continued to lie vacant<sup>396</sup>. 47% were reported to be vacant in March 2023 in a survey of 27 hospitals including some IFC direct investees<sup>397</sup>. Reports suggest that private hospitals have been concealing the actual bed strength<sup>398</sup> and turning eligible patients away despite beds being available.<sup>399</sup> At the same time, inadequate efforts have been made to publicise the provision and put in place systems for redressal.<sup>400</sup> Another bone of contention is the refusal by several hospitals to provide consumables which contribute to a significant share of out-of-pocket expenditure.<sup>401</sup>

Similar provisions pertaining to the land lease exist on the books in other states including Maharashtra, Telangana and Haryana and similar incidents of free beds not being set aside for poor patients despite hospitals’ contractual obligations to do so continue to be reported. Apollo admits that its lease agreements in Kolkata, Hyderabad and Bilaspur also provide free or subsidized healthcare to a section of patients.<sup>402</sup>

The twelfth report of the Public Accounts Committee 2004-2005 (Fourteenth Lok Sabha) which deals with the allotment of land in Delhi at concessional rates to hospitals, observed, “Ultimately, what was started with a grand

idea of benefiting the poor turned out to be a hunting ground for the rich in the garb of public charitable institutions.<sup>403</sup>

### Failure of corporate governance

Despite the IFC's focus on corporate governance and the emphasis on respecting national laws and regulations and conducting business matters in the EPIHC principles, there have been several allegations against senior employees of their investee hospitals. This points towards the failure of corporate leaders in the investee hospitals to live up to the high ethical standards that they claim to subscribe to and raises questions about the IFC's due diligence of some of its investments. Issues raised include:

- **Financial Fraud:** The Supreme Court awarded a six months jail term to the former promoters of Fortis healthcare in a case related to the sale of Fortis shares to IHH Healthcare.<sup>404</sup> Loans worth INR 494 crore were allegedly sanctioned to companies linked to the former CEO and CFO of Fortis Healthcare.<sup>405</sup> The deals are under investigation by India's Serious Fraud Investigation Office (SFIO).<sup>406</sup> In 2019, Fortis Healthcare itself called for its founders' arrest<sup>407</sup>. Rs 4.34 crore was paid to the market regulator SEBI in settlement charges in a case of diversion of funds by its promoters.<sup>408</sup>
- **Illegal organ trade:** In 2016, five of Apollo's employees were reportedly arrested for involvement in a Kidney Racket in Delhi.<sup>409</sup> In 2019 some of those involved in the above case were again arrested in connection with another similar racket in Fortis Hospital, Faridabad while they were out on bail.<sup>410</sup> In the second case, the transplant coordinator was arrested for allegedly falsifying documents related to organ donation<sup>411</sup>. In the Delhi case, Apollo Hospital cooperated with the authorities and reported having been misled.<sup>412</sup> In Odisha, the NHRC ordered the Odisha government to suspend or cancel the registration of Bhubaneswar's Apollo Hospital<sup>413</sup> for cheating a patient into illegal transplantation of a kidney. The organ transplant license of Fortis hospital in Bengaluru was cancelled for several years for undertaking pancreas transplant without authorization.<sup>414,415</sup> Incidents of this nature point to flaws in due diligence processes by the hospitals.

Regulation in a marketized social sector like healthcare in India tends to be partial, disjointed and decentred to multiple loci, actively representing differing interests.<sup>416</sup> Many of the regulatory actions taken by industry-level actors and public insurers have been motivated by the desire to protect their own bottom line and not to ensure social equity and accountability.<sup>417</sup> An analysis of the regulatory processes calls for a much stronger focus on regulation that places the rights of patients at the heart of the process.<sup>418</sup> Official processes of monitoring and enforcement of regulatory measures have tended to be weak due to inadequacy of legal and organizational frameworks for regulation, deficient capacity including insufficient budgets and human resources, lack of transparency and accountability of regulatory organizations, weak bureaucratic and judicial systems, lack of political will and information asymmetries and unequal power relationships between providers and users.<sup>419</sup> It is unclear how the IFC is dealing with these challenges.

### DISREGARDING PATIENTS' RIGHTS AND DIGNITY

Many incidents highlighted instances when the rights of patients were compromised in direct contravention of the Rights Charter and the IFC's EPIHC principles. These include failure to obtain consent while undertaking medical procedures, failure to supervise patients and abusing their dominant position with patients to maximize profits. A survey by the White Ribbon Alliance India found that 23% of women aspired to dignity and respect and another 18% sought respectful behaviour from the healthcare providers in maternal healthcare.<sup>420</sup> The cases marked "informed consent" and many of the cases related to medical negligence are the result of a healthcare system that is stacked against patients, particularly

those that are poor, in the country. This is also a reflection that the mechanisms for patient complaints in India were limited in scope and effectiveness.<sup>421</sup>

## ARE THEY ADDRESSING HEALTH INEQUALITY?

IFC investee hospitals have won several corporate awards for clinical effectiveness and delivering quality healthcare in their specialities.<sup>422,423,424</sup> Claims have been made they obtain good health outcomes at a fraction of the cost delivered in the global north.<sup>425</sup> However, some of their facilities have also been compared to five-star luxury hotels.<sup>426</sup> India's Competition Commission is quoted as saying that room rates in these hospitals were comparable with that of three- and four-star hotels.<sup>427</sup> No wonder then that they cater to India's elite, including former Prime Ministers<sup>428</sup>, state Chief Ministers<sup>429</sup>, sports stars<sup>430</sup>, film directors<sup>431</sup> and actors.<sup>432,433</sup> Rather than being known for their affordability, many of these hospitals are marketed as premium products for those that can afford to pay.

Table 5.3 provides indicative costs for different procedures adopted in All India Institute of Medical Sciences (AIIMS) and the Central Government Health Scheme (CGHS) compared to three hospital chains directly financed by the IFC.<sup>434,435</sup> We have been unable to find publicly disclosed information from any of the directly IFC-supported hospitals on the costs they charge for treatment and care. Accordingly, costs have been derived from aggregator platforms and confirmed through calls to the hospitals themselves in NCR Delhi; the rates quoted during the calls were higher than those given on the platform. These rates are compared with those in AIIMS Delhi which is the city's premier public hospital offering a comparable standard of medical care to the IFC investee hospitals. It was ranked first among medical colleges in India by the National Institutional Framework in 2022<sup>436</sup> and was ranked among the top 100 hospitals in the world by Newsweek in 2020.<sup>437</sup> However, it is a publicly financed medical institute by the government, making the CGHS rate a better comparison of the rates that private sector hospitals in the city tend to still find economical. This is a rate reimbursed for the treatment of central government employees.

Starting fees for a two-day stay in intensive care in the IFC-financed hospitals are at least eleven times the cost of the equivalent in AIIMS. An uncomplicated 'normal' delivery in the IFC investee hospitals is 40-75 times that of the rates in AIIMS and is 7-19 times that of the reimbursement offered to private hospitals for central government employees in the city. Thus, most IFC-supported private hospitals appear to be financially out of reach for most people in India without suffering significant financial hardship.

Table 5.3: Cost of admission in selected hospitals in Delhi (all figures are in INR)			
	Normal delivery <sup>438,439</sup>	C- Section (package)	ICU charges
Apollo	78,804	91,362	12,800 <sup>440</sup>
Max <sup>441</sup>	77,548-145,000	100,152-145,000	11,000 <sup>442</sup>
Fortis	96,000- 150,000	96,000- 150,000	Not available <sup>443</sup>
AIIMS <sup>444</sup>	2,000	Not available	1000 <sup>445</sup>
CGHS Rate (Delhi) <sup>446</sup>	9,200	16,158	

The Apollo chain has attempted to expand its operations to Tier III cities through its Apollo Clinics and Reach hospitals for which it has sought support from the IFC. However, as Box 5.2 shows, these continue to serve the financially better off in these locations. One could have expected some of the costs of healthcare for patients to be addressed by insurance. However, 59% of Indians are currently not covered by health insurance.<sup>447</sup> At the same time, as the earlier section on patients' rights shows, corporate hospital chains have been reluctant to participate in publicly financed health insurance schemes and offer healthcare at a moderate cost. Thus, Apollo has said that the scheme does not cover the full costs of its hospitals<sup>448</sup> and has been influencing the government for an increase in the rates of payment under the CGHS<sup>449</sup> and Ayushman Bharat.<sup>450,451</sup>

The IFC's theory of change in terms of how supporting some of the most expensive private hospitals in India can provide a model for improving healthcare for its underserved majority remains unclear. The IFC, in its response to the report, has not addressed these concerns but expressed the hope that improvements in universal insurance coverage in India will lead, over time, to new contracting models for public and private services that will help make health coverage more accessible.

#### **BOX 5.2: APOLLO REACH HOSPITALS AND CLINICS: A MODEL OF "AFFORDABLE" HEALTHCARE FOR INDIA'S TOWNS AND VILLAGES?**

The IFC has marketed the Apollo Reach Network as one that can bring affordable services to the poor.<sup>452</sup> It reported that the network's facilities are largely in Tier II and III cities and costs to patients are 20-30% less than that of other hospitals in the Apollo network.<sup>453</sup> The only data point dates to 2011 that people when the hospital claimed that the 'Base of the Pyramid' (BOP) made up 38% of Reach Network clients. However, this definition of BOP was meaningless – BOP customers were defined as those who spend less than US\$70 per month on goods and services or 3264 INR per month.<sup>454,455</sup> At the time, 60% of rural households lived on just half this expenditure per month or less.<sup>456</sup> Moreover, it is also not clear how many of these 38 % availed in-patient service in comparison to outpatient and telemedicine services, where the cost to treatment is obviously onerous. There is no more updated data on this over the last decade. The IEG's 2018 evaluation highlights that the Reach hospitals have been less successful than planned in reaching the poor.<sup>457</sup>

The IFC support also went to Apollo Clinics. This is a franchisee model where the Apollo chain does not make any financial investment in the franchisees that put in the costs for establishing the clinics but receive a share of the revenue; such a clinic can expect to generate between Rs. 15-20 million, depending upon the facilities provided<sup>458</sup>. The model is profitable; in 2017, 31% of AHLL's revenues came from Apollo Clinics<sup>459</sup>. However, the analysis of the Apollo Clinics business model suggests that it again specifically targets patients belonging to the 'middle and upper class.'<sup>460</sup> A report by the German development agency GIZ also found that consultation fees were often too high for patients coming to its clinics.<sup>461</sup>

No information about the number of patients reached or the quality of healthcare delivered by these hospitals is available. Some of the early experiences suggest that hospitals may be experiencing a faster than anticipated turnover among the franchisees running the hospitals<sup>462,463</sup>. No evidence exists in the public domain that these hospitals serve underserved populations and are geared to anything other than middle class populations.

The IFC in its response to the report has stated that it is shifting its priority in its investments towards "out of hospital" services in clinics in India. It feels that these are easier to access, serve the provision of primary healthcare better and are more efficient contributing to improved overall health. It felt that this market shift will take time and increased private and public insurance penetration will benefit health service coordination and drive better value for money as the system moves away from fee for service. No explanation was provided to understand how expanding into primary and secondary healthcare without addressing the underlying challenges of regulatory failure of the state and the current track record of denial of coverage by insurance companies in India.

## **Need for regulatory intervention to ensure equity and quality and protect patients' rights**

As detailed above, IFC direct investee hospitals are not located in areas with the highest healthcare needs, provide expensive care and have been implicated in unethical practices. It is true that some of the companies covered in the section above may no longer be current IFC investees. However, it would be important to understand the impact that IFC's support and advice have on corporate behaviour including beyond the lifecycle of the investment or active project period. The array of concerns listed

above points to a range of recurring problems in investee hospitals that the IFC does not acknowledge or engage with in their public disclosures. No process is discernible by which the IFC either considers these issues in their development assessments or public information on how they are addressing these issues. In its response to the draft report the IFC acknowledged that it will take time and capacity building, regulatory reform, funding, and alignment of many stakeholders to create a health system that works for all. At the heart of the problem is that the IFC is investing in profit maximising healthcare providers in a context of woefully inadequate regulation. A recent study looking at private healthcare in India found that ‘a state of regulatory inefficiencies and private capture persists and evades correction, highlighting broad-based failures of governance and accountability in the health administration.’<sup>464</sup>

The IFC’s approach to ensuring quality healthcare appears to focus on the structural side of quality – ensuring that providers adhere to parameters like facility infrastructure, financing, human resources, and organisational anatomy. The IEG 2018 health evaluation confirmed that IFC hospital projects mostly contributed to the structural aspects of the quality of healthcare.<sup>465</sup> In contrast, process and outcome dimensions of quality have been relatively ignored. These include aspects like patient-provider interactions in terms of how the treatment is offered and received and patient satisfaction in terms of care, hospitality, and medical expenditure transparency. The IFC’s focus on investing in healthcare business models without ensuring patients’ rights is problematic.

The impact of the growth of healthcare investments, furthermore, goes beyond the impact on individual patients. Private investment-fuelled expansion of private healthcare provision risks the decline of healthcare systems as social institutions and raises troubling implications for health equity. The expansion of privately financed projects as commercial ventures creates health and financial risks, inequality, and social segmentation<sup>466</sup> and jeopardizes the delivery of affordable, rational, and equitable care for most of India’s population.<sup>467</sup> Investments do not respond to barriers to access and no steps are discernible to address the catastrophic impact of user fees and other out-of-pocket payments in the private sector in a country where it is estimated that 2.5 million households are pushed below the poverty line each year by the costs of inpatient care.<sup>468</sup> India has the highest complaint rate when compared with other common law jurisdictions like Canada, Australia, UK and California (USA) and several health insurance providers have alarmingly low claims ratios;<sup>469</sup> the health insurance system in India has been documented to suffer from weak regulatory oversight and enforcement of existing regulations and poor functioning of insurance ombudsmen.<sup>470</sup> Supporting private providers in the face of ineffective regulation is reckless and dangerous, especially without addressing underlying governance failures or putting in place social accountability frameworks and participatory processes.<sup>471</sup>

The IEG’s evaluation of the IFC’s investment in private schools (Box 5.3) has clear lessons for the healthcare sector. The IFC’s progress on improving access, quality, and equity of healthcare should be assessed including capturing the trade-offs between financial sustainability, ensuring equitable access, quality, and broader health system effects. This will not only bring clarity in evaluating the health sector projects against the mentioned yardsticks but also substantiate the IFC’s claim of investing in human capital for economic development.

**BOX 5.3: LESSONS FOR THE HEALTH SECTOR FROM THE IFC EVALUATION OF INVESTMENTS IN K-12 PRIVATE SCHOOLS IN MEETING THE GOAL OF QUALITY EDUCATION FOR ALL**<sup>472</sup>

The recent IEG’s evaluation of IFC investments in K-12 Private schools<sup>473</sup> examined the challenges of supporting private schools in low and middle-income countries contributing to the decision to cease investments.<sup>474</sup> The IEG evaluation highlighted six lessons for education provision that holds a striking potential to be generalized to the healthcare sector and other public services, which face identical concerns.



- **Impact on equity:** Improving overall access through expanding private provision can lead to the one-way movement of more privileged students from public to private schools, and leave behind more marginalized students, such as children with disabilities and out-of-school children.
- **Engagement with stakeholders:** Investors should consult not only with the client or owner but with a broad range of stakeholders. The aim should be to build an extensive coalition that includes a full range of groups with a stake in the education system, such as civil society organizations, local governments, regulators at the national level, parent organizations, and teacher unions.
- **Private-public collaboration:** More strategic collaboration and cooperation between private and public sector schools may support planned, positive spill overs from innovations. Private schools alone cannot be expected to promote positive spill overs as they have little incentive to create systemwide demonstration effects, but rather a combination of government regulations and strong implementation support is needed to catalyse public and private collaboration.
- **An education rationale:** Along with a focus on the financial viability of specific schools, investors should also consider the development impact in decisions and require investing in schools that are committed to links with a full range of beneficiaries and stakeholders in the local education system—such as school administrators, parent associations, and teachers.
- **Longer term investment horizons:** Investors will need to consider the trade-offs between ensuring the financial sustainability of investments in private schools and supporting equitable access, education quality, and broader education system effects.
- **Monitoring and evaluation.** Effective systems are needed to monitor the impacts of investments in private schools and to learn from them. This requires going beyond business indicators to include an assessment of access and equity of access, quality, and effects on other schools and local education systems. This should also include monitoring of factors such as accommodations for children with disabilities, the effect of initiatives such as scholarships to support access for low-income or out-of-school children, and constant learning to address potential negative effects on the education system.

#### **Conclusion:**

The “do no harm” principle is the ethical cornerstone for medical professionals across the world. The IFC is failing to live up to this principle given the track record of its investees in the highly under-regulated Indian context. The IFC’s approach in India appears to demonstrate a reckless disregard for such risks, first by promoting private healthcare giants in a dangerously unregulated context, and then by failing to design and uphold adequate impact and accountability mechanisms. The investments fail to address prevailing health inequality in India by continuing to prioritize urban areas (particularly million-plus cities) and focusing on rich patients at a time when rural areas and the poor are in dire need of improved health services. The IFC fails to adequately track patient experiences, the impact on the poor, marginalized and women and the impact of the private healthcare system’s expansion on the public system. It has facilitated the expansion of chains of corporate hospitals despite extensive case law and widespread coverage in the mainstream Indian media of overbilling, price rigging, refusing to treat patients and multiple failures of corporate governance in these chains. Its stated intention of ensuring ‘quality of care’ and ‘protection of ethics’ is compromised when it supports hospitals that stand accused of fraud and medical negligence.

## CHAPTER 6: RECOMMENDATIONS

This report once again highlights the Blind Optimism of international financial institutions which have continued to promote private healthcare resulting in the expansion of corporate medicine that fails to benefit marginalized populations.<sup>475</sup> The IFC's support for healthcare in India is failing on many levels most notably by ignoring the prevailing crises of regulation and effective governance of private healthcare resulting in widespread patients' rights violations. Its quest for expansion of the healthcare markets has come at the cost of its mandate to tackle poverty and inequality.

Despite almost 30 years of investing in healthcare provision in India, the IFC has provided no evidence of its impact on advancing access to healthcare or improving services. The IFC's method of reporting and measuring development effectiveness in the private healthcare market appears to be woefully inadequate, with minimal transparency and it seems, weak accountability. Not only does the IFC fund primarily expensive and out-of-reach corporate hospitals and other facilities, but there is also evidence that those hospitals cause harm.

The IFC needs to uphold the rights of patients and the right to health in its operations. It needs to strengthen accountability and prevent and mitigate patients' rights violations in its operations as a matter of urgency. It should address the issues raised in this report and focus on strengthening the national health systems by prioritizing improving access, quality, and equity of healthcare, and enhancing service delivery efficiency.

Given the evidence provided in the report, the IFC should stop making any new direct or indirect investments in private healthcare provision in India until existing investments and operations in this sector are fully and independently reviewed and a robust, transparent, and accountable framework is put in place to ensure that all projects and investments are equitable, geared towards meeting unmet healthcare needs, promote, and protect patients' rights and strengthen the public system. Priority attention must be given to its impact on access to quality healthcare without financial hardship for people living in poverty and on low incomes, especially women and girls. Its record on preventing and responding to patients' rights violations should be especially reviewed as well as the impact of its financing, advice, and underlying theory of change on the broader public healthcare system. The IFC must investigate reports of harm identified in this paper and take immediate action to ensure the rights of patients are being upheld in all its existing healthcare investments. In addition, the IFC should

- Strengthen accountability mechanisms, grievance redress and monitoring of its portfolio by:
  - Ensuring that all existing projects and investments have a clear healthcare rationale and include disaggregated targets, indicators, and baselines to track project differential impact based on gender, patient socio-economic status, disability status and membership of marginalized communities like Dalits, Adivasis and other minorities.
  - Ensuring full disclosure of the AIMM impact tracking assessments and ongoing monitoring for all investments; and ensuring all investments provide a regular and publicly available assessment of their compliance with existing domestic regulations. Ensuring all indirect investments through financial intermediaries are disclosed, with investment and monitoring information.
  - Undertaking rigorous E&S and impact assessments of private healthcare investments' impacts, especially on access to health, patients' rights, and the public healthcare system.
  - Proactively monitoring, responding, and disclosing any cases where healthcare investees are charged with criminal or civil wrongdoing by national or state regulators or other

authorities whether or not raised via the formal CAO complaint process. Effective remedy should be ensured for all negatively affected parties and the action taken disclosed.

- Including or supporting service delivery monitoring (such as prescription audits) and quality impact assessments (like assessing patient satisfaction) of its investee hospitals and enhance scrutiny by making these available in the public domain. The IFC should provide financial support to independent third parties such as patients' rights groups and enhance scrutiny by making these available in the public domain.
  - Involving all relevant stakeholders including governments and civil society prior to project inception and discussing project progress and outcomes periodically. There should be regular consultations to discuss the projects and commercial investments and their development impacts. Civil society engagement should be mandatory in policy consultations, evaluation exercises and stakeholder meetings.
  - Ensuring that all hospital investments and PPP advisory projects are available for third-party monitoring and evaluation under the leadership of respective local governments.
  - Providing a response to the issues raised in the present report including those pertaining to each investee.
  - Involving, in all projects in India, all relevant stakeholders including governments and civil society prior to project inception and discussing project progress and outcomes periodically. There should be regular consultations to discuss the projects and commercial investments and their development impacts. Civil society engagement should be mandatory in policy consultations, evaluation exercises and stakeholder meetings.
- Explicitly recognize and address the risks arising from commercialization of healthcare and the potential for profiteering in the IFC's Ethical Principles in Health Care.
  - IFC advisory projects must examine the long-term fiscal and wider structural consequences of its investments; the public option must at least be considered and systematically and transparently assessed before supporting PPP options in line with IEG recommendations. Concrete steps to avoid the use of tax havens should be taken.
  - While the IFC should halt its investments in private healthcare delivery in India, there are opportunities for it to provide positive support in other areas of the health sector including research and development and local manufacturing of medicines, vaccines, and equipment. However, the IFC should shift its approach and conduct a considered, open, and transparent consultation process involving wide-ranging stakeholders including from academia, civil society, patient groups and the well-established access to medicines movement in order to inform a progressive and impactful strategy for the future that strengthens India's public health system and advances equitable and universal access to medicines and other medical technologies.

### **The World Bank Group must**

- Task the IEG with evaluating the IFC's role in the healthcare sector including in India, with a priority focus on how its healthcare sector operations, especially in hospitals and clinics, and healthcare chains, contribute to realizing the right to health, deliver improvement of the quality and equity in healthcare systems and uphold patients' rights.
- Prioritize supporting India's public health system through its financing and policy advice to ensure free, universal quality and public healthcare provision.
- Develop a 'white paper' to articulate its approach to the issue of patients' rights violations in private hospitals.
- Ensure robust civil society engagement in all health projects including all concerned stakeholders (especially patient right's bodies and affected communities).
- Invest in strengthening the regulation of private healthcare, protection of patients' rights and grievance redress in corporate hospitals in India.

- Support and fund independent social accountability organizations through the Global Partnership for Social Accountability (GPSA) to play a watchdog role on private providers.

#### **UN human rights bodies, including the Human Rights Council, must**

- Strengthen the integration of patients' rights within human rights frameworks, ensure adherence to the same by multilateral and bilateral organisations and develop guiding principles for corporate businesses active in direct patient services to protect against any human rights abuse.
- UN HR bodies must review WBG operations in health and make recommendations to strengthen the impact of its investments on the right to health.

#### **Indian Governments must**

- Scale up funding for public healthcare facilities to ensure universal access to free, publicly provided quality healthcare for all.
- Ensure that investments made by the IFC and other similar IFIs in health and education are available for scrutiny by Parliament, state Assemblies and bodies like the Comptroller and Auditor General of India.
- Strengthen the regulation of corporate hospitals including registration of all healthcare centres under the Clinical Establishments Act.
- Ensure the adoption and display of the PRC and strengthen grievance redress for patients.
- Urgently create a national registry for continuously documenting all patients' rights violation cases and devise a quick response mechanism to offer victims information and support to enable timely and effective grievance redress.
- Demand the submission of independent project evaluations of all DFI investments in health in India, to the Ministry of Health and Family Welfare and all relevant regulators.
- Demand that all DFIs demonstrate that robust grievance mechanisms and remedy frameworks are in place for investments and that necessary processes are undertaken to orient stakeholders and affected communities in the use of these mechanisms. They must also demand that the IFC address and provide a response concerning all past identified violations.
- Support patients' rights groups/bodies to conduct consultative workshops and participate in national/state-level regulatory meetings.

#### **Civil Society should**

- Sensitize Health for All movement members, health activists and grass-root health workers to the IFC's investments in corporate hospitals.
- Create IFI watch groups at the national and state levels to monitor investment and advisory activities in the health sector and generate more evidence.
- Engage with law-making bodies at various levels (including treaty bodies, parliaments, and state legislatures) to demand the recognition of patients' rights in human rights frameworks.
- Support the formation of national and state-level patients' rights bodies by mobilising survivors of patients' rights violations, health activists, academics, and other social and human rights activists. They should strategize for long-term campaigns for the implementation of a charter for patients' rights in corporate hospitals.

#### **Patients' Rights Bodies should:**

- Identify and document cases of patients' rights violations in corporate hospitals.
- Sensitize relevant stakeholders on the Patient Rights Charter and other key policy documents through social and mainstream media.
- Organize annual consultations or campaigns with the support of larger civil society networks and government bodies to sensitize citizens at large and the mainstream media on patients' rights.

## ANNEXURE I: IFC DIRECT INVESTMENTS IN PRIVATE HOSPITALS AND CLINICS IN INDIA

(1991 to September 2022)

Sl No.	Name of the corporate hospital	Project ID	Total project cost (USD in million)	IFC investment USD million (% of IFC's contribution to total project cost)	Form of investment (model of financing)	Year of signing contract	Department/ Industry/ Sector
Private Hospitals							
1	Duncan Gleneagles Hospitals Limited <sup>476,477</sup>	8084	29.4	8 (24%)	Equity (USD 1 million) Loan (USD 7 million)	1997	Regional Industry - MAS Asia & Pac/ Other/Hospital and Clinics/
2	Zulekha Hospitals UAE/Alexis Hospital, Nagpur*	28873	52	20 (38%)	Loan	2010	Regional Industry - MAS Asia & Pac/ Health & Education/ Hospitals and Clinics
3	Fortis Healthcare Limited	33057	NA	100	Equity (USD 45 million) & Loan (USD 55 million)	2013	Regional Industry - MAS Asia & Pac/ Health & Education/ Medical and Diagnostic Services
4	Apollo Hospitals Enterprise Limited	24406	70	20 (29%)	Equity	2005	Gbl Ind, Manufact, Agribus & amp; Services/ Health & Education/ Hospitals and Clinics
5	Apollo Hospitals Enterprise Limited	25969	200	50 (25%)	Loan	2009	Regional Industry - MAS Asia & Pac/ Health and Education/ Hospital and Clinics/
6	Apollo Hospitals Enterprise Limited (AHEL)	31549	394	60 (15%)	Loan	2012	
7	IHH Healthcare Berhad <sup>12</sup>	32237	NA	NA	Equity	2012	Regional Industry - MAS Asia & Pac/ Health and Education/ Medical and Diagnostics
8	Apollo Health and Lifestyle Limited (AHL)	37895	135	68 (50%)	Equity (USD 34 million) AMC (USD 34 million)	2016	Regional Industry - MAS Asia & Pac/ Health and Education/ Medical and Diagnostic Services
9	Regency Hospital Limited, Kanpur	35989	24.6	9.7 (39%)	Equity	2016	

<sup>12</sup> This is an investment in the IHH group in multiple countries. IHH has a minority investment in Apollo Hospitals in India. Its website suggests that it also invests in Gleneagles International Hospitals and Fortis.

10	Max Healthcare Institute Limited (MHIL)	25805	90	67.14 (74%)	Equity	2007	Gbl Ind, Manufact, Agribus & Services/ Health and Education/ Hospitals and Clinics
11	Max Healthcare 3	27976	93	42.39 (46 %)	Equity	2009	
12	Rockland Hospitals Limited	26248	76	13.71 (18 %)	Equity	2008	Regional Industry - MAS Asia & Pac/ Health and Education/ Hospitals and Clinics
Diagnostics and other medical care							
13	Healthcare Global Enterprises Ltd (HCG)	37903	NA	19.90	Equity	2016	Regional Industry - MAS Asia & Pac/ Health and Education/ Medical and Diagnostic Services
14	Eye-Q Vision Private Limited	35512	10	5.36 (53%)	Equity (VC/TMT)	2015	TMT, Venture Capital & Funds, Health & Education/ Medical and Diagnostic Services
15	Health Vista India Private Limited (Portea Medical)	37150	37	7 (19%)	Equity	2015	Gbl Ind, Manufact, Agribus & Services/ Health and Education/ Other Health Services
16	Nephrocare Health Services Pvt. Ltd. (NephroPlus)	34679	10	7 (70%)	Equity	2014	Gbl Ind, Manufact, Agribus & Services/ Health and Education/ Medical & Diagnostic Services
17	Super Religare Laboratories Limited (SRL)	31463	105	24.53 (23%)	Equity	2012	Regional Industry - MAS Asia & Pac/ Health and Education/ Hospitals and Clinics
18	Medgenome Inc	45102	31	16.5	Equity	2021	Disruptive Technologies & Funds/other/other <sup>478</sup>

\*Zulekha Hospitals is a business healthcare entity registered in the UAE. IFC invested in it to expand its Sharjah hospital in the UAE (brownfield project) and set up a greenfield tertiary care hospital in India (known as Alexis Multispecialty Hospital in Nagpur, India).<sup>479</sup>

Source: [https://disclosures.ifc.org/enterprise-search-results-home?f\\_type\\_description=Investment](https://disclosures.ifc.org/enterprise-search-results-home?f_type_description=Investment), Accessed on 2 April 2022

## ANNEXURE II: IFC INVESTMENT THROUGH FINANCIAL INTERMEDIARIES IN HEALTH SECTOR BUSINESSES IN INDIA (2007- September 2022)

Sl No.	Project ID	Company Name	Country of origin	Projected Board Date <sup>13</sup>	IFC Investment (USD million)	Sector	Investee Hospitals/healthcare ventures financed by the IFC-supported PE funds
1	40680	LIGHTHOUSE INDIA FUND III, LIMITED (managed as AMC by IFC)	Mauritius	9 Jan 2018	20 [AMC investment: 25]	P-BA – Growth Equity Fund	- Poly Medicure Limited (Medical devices manufacturers) - Tynor Orthotics (Medical equipment & supplies manufacturing).
2	39605	STELLARIS VENTURE PARTNERS INDIA I	India	12 Jun 2017	10	P-BB – Venture Capital Fund	-Ayu health (hospitals & clinics) -mFine (digital health intermediary)
3	39362	IDG VENTURES INDIA FUND III LLC	Mauritius	27 Feb 2017	40	P-BB – Venture Capital Fund	-Netdox (involved in digitisation of patient records) -Ovo Health (healthcare facilitator to arrange treatment for fertility, cosmetics, and cancer.) Healthplix (digitalization of healthcare), Sigtuple (microscopy).
4	37348	PLENTY PRIVATE EQUITY FUND I LIMITED (managed as AMC by IFC)	Mauritius	27 Apr 2016	40.6 [AMC fund is not disclosed]	P-BA – Growth Equity Fund	-Encube (Pharmaceuticals) -Natco Pharma (Pharmaceuticals and Medicine)
5	35855	EVERSTONE CAPITAL PARTNERS III LP (Managed as AMC by IFC)	Singapore	03 Nov 2014	50 [AMC fund is not disclosed]	P-BA – Private Equity/Venture Cap Fund – Country	-Ascent Health & Wellness (Wellness and Pharma) -Everlife Holdings (Singapore-based consulting firm for clinical diagnostics, scientific laboratory in Asia) -Slayback Pharma LLC (US-based pharmaceutical manufacturer) - Translumnia (medical devices for cardiovascular care-related products and services)

<sup>13</sup> This is the date when the investment was approved by the IFC Board.

							- Sahyadri Hospital (hospital chain in Maharashtra).
6	45049	Everstone Fund IV	Singapore	31 May 2021	60	Growth Equity Fund	Information not available on the IFC website which only states that it will primarily focus on healthcare/pharma.
7	33540	INDIA BUSINESS EXCELLENCE FUND-IIA	Mauritius	16 May 2013	25	P-BA – Private Equity/ Venture Cap Fund – Country	Arinna Lifesciences (pharmaceutical company)
8	32838	INDIA 2020 FUND II LIMITED	Mauritius	11 Feb 2013	25	P-BA – Private Equity/ Venture Cap Fund – Country	Indian Herbs (herbal animal healthcare products manufacturer).
9	45228	Prime IV/SEABRIGHT IV, LP	Delaware, USA	31 May 2021	30	Venture Capital Fund	Information is not available on the IFC website which only lists that healthcare as one of the priority areas. Prime’s website links the following investments in healthcare: Dozee, (remote health monitoring) mfine (online healthcare platform to connect to doctors) and affordplan (health savings solution). <sup>480</sup>
10	43399	Creagis Investment Fund-II (CIF-II)	India	17 Jun 2022	500	Growth Equity Fund	Information is not available on the IFC website which lists healthcare (e-pharma, tech-enabled delivery & diagnostics, device technology, pharma research & services) as priority. One investment appears to be Medikabazaar (a B2B marketplace for medical supplies). <sup>481</sup>
11	33475	Abraaj Global Health Fund	Cayman Islands	21 Jan 2014	150	Leveraged Buyout Fund	CARE Hospitals, India
12	39431	Leapfrog Emerging Consumer Fund III LP	Mauritius	15 May 2017		Growth Equity Fund	Investments are not disclosed on the IFC website. The fund’s website <sup>482</sup> lists Redcliffe Lifetech (diagnostic service), HealthifyMe (mobile health and fitness app), medgenome (genetic diagnostics, research, and data company) and Ascent Meditech (orthopaedic healthcare products manufacturer, distributor) as investments.



13	33006	Global Health Investment Fund- I, LLC	Delaware, USA	7 Dec 2012	10	Pharmaceuticals and Medicine Manufacturing	Information is not disclosed on the IFC website. However, the fund's website <sup>483</sup> lists Serum Institute of India (Pharma and Medicine) as one of their investments.
14	44026	Gaja Capital India Fund 2020 LLP	India	18 Feb 2021	50	Growth Equity Fund	Information is not available on the IFC website. However, it seeks to invest in mid-sized companies in healthcare.
15	41401	Multiples Private Equity Fund III	India	2 April 2019	20	Growth Equity Fund	Information is not available. However, it seeks to invest in healthcare (diagnostics, delivery, and devices) and pharma (formulation, distribution, etc). The Multiples website lists Vikram Hospital Bengaluru as an investment. <sup>484</sup>
16	42714	Chiratae Ventures International Fund IV LLC	Mauritius	30 Sept 2019	40	Venture Capital Fund	Information is not disclosed on the IFC website. The Fund's website <sup>485</sup> lists HealthifyMe (health and fitness app), Forus Health (ophthalmic technology), HexaHealth (portal to find the right doctor), HealthPlix (EMR software for doctors), OncoCancer Centres (centres in Telangana), Redcliffe genetics (genetics testing), Perfint (medical robotics) and Ovo as investments.
17	37348	Plenty Private Equity Fund I Limited	Mauritius	27 April 2016	25.4	Growth Equity Fund	Encube and, Natco Pharma (Pharma and Medicine).
18	29593	Sarva Capital LLC (formerly Lok II)	Mauritius	3 Jun 2010	15	Micro-finance and small business- Non-commercial banking	Not specified on the IFC website but includes investment in the micro-finance ecosystem including healthcare. The fund's website <sup>486</sup> lists Affordplan (financial planning for healthcare) and Dr Mohan's Diabetes Specialities Centre (hospital chain in TN). Drishti Eye Care (Disha Medical Services) is a former investment.
19	20711	Aavishkaar India II Company Limited	Mauritius	30 May 2011	15	Private Equity/Venture Cap Fund- Country	GV Meditech group of hospitals in UP. <sup>487</sup>
20	25576	VenturEast Proactive Fund	India	14 May 2007	15	Private Equity/Venture Cap Fund- Country	The IFC website does not list the investments made.

21	26237	India Infrastructure Fund	India	27 Sep 2007	100	Private Equity/Venture Cap Fund- Country	Healthcare is included as one of the areas under infrastructure.
22	47137	LightHouse India Fund IV AIF	India	Pending Board Approval	Up to 50 million	Growth Equity Fund/Disruptive Technologies and Funds <sup>488</sup>	Not available.

Source: [https://disclosures.ifc.org/enterprise-search-results-home?f\\_type\\_description=Investment](https://disclosures.ifc.org/enterprise-search-results-home?f_type_description=Investment) (Accessed on 13 September 2022)

## ANNEX III: RIGHT TO INFORMATION REQUEST TO NATIONAL ACCREDITATION BOARD FOR HOSPITALS & HEALTHCARE PROVIDERS (NABH)

Right to Information Application filed by Mr Shishir Chand New Delhi, India) dated 29th July 2020 seeking information under RTE Act, 2005

S N	Query	Reply
1	<p>What are the various criteria, benchmarks and metrics devised by NABH as part of its Pre-Assessment, Final Assessment and Verification Assessment of an HCO?</p> <p>Does the evaluation/ assessment of a HCO by NABH take into consideration past history of a HCO insofar as cases of medical malpractice and medical negligence are concerned?</p>	<p>NABH progressive level accreditation program has been stopped. Presently there are no criteria, benchmarks and metrics by NABH as part of its Pre Assessment, Final Assessment and Verification Assessment of an HCO for progressive level accreditation program.</p> <p>Assessment is based on evaluation against the set and pre-defined standards. Medical Malpractice and Medical Negligence cases are not directly evaluated but if there are related process and policies as per standards then they are assessed. Assessments are based on random sample audits.</p>
3	<p>Does the evaluation/ assessment of a HCO by NABH takes into consideration the quality of manpower of a HCO in terms of educational qualification held by its surgeons and the background check to establish the authenticity of the said qualification thereof?</p>	<p>Yes. The assessment of a HCO by NABH takes into consideration the quality of manpower of a HCO in terms of educational qualification but the background check to establish the authenticity of the said qualification thereof is the responsibility of the HCO.</p>
4	<p>Did Tata Main Hospital, Jamshedpur, a HCO disclose the number of cases of medical malpractices and medical negligence pending against it or decided by various courts all over India before progressive level accreditation was granted to the HCO for 2 years w.e.f 16th April 2016.</p>	<p>No comments can be made on cases already sub-judice. Secondly, it does not affect the decision of accreditation/ certification which is based on compliance of standards.</p>
5	<p>Did Tata Main Hospital, Jamshedpur, a HCO disclose the number of cases of medical malpractices and medical negligence pending against it or decided by various courts all over India before progressive level accreditation was granted to the HCO for 2 years w.e.f 16th April 2016.</p>	<p>No comments can be made on cases already sub-judice. Secondly, it does not affect the decision of accreditation/ certification which is based on compliance of standards.</p>

Source: RTI NO. QCIND/R/E/20/00027 dated 24th August 2020

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- <sup>94</sup> <https://openknowledge.worldbank.org/handle/10986/31042> (pp.178)
- <sup>95</sup> Transaction advisory services are third-party services obtained from professional or investment banking firms to handle the tasks associated with the transactions. Thus, under PPP transaction advisories, it prepares, structures, and implements transactions necessary for setting up PPPs.
- <sup>96</sup> Advisory services that help clients connect with the communities where they operate.
- <sup>97</sup> <https://ifc-org.medium.com/creating-a-sustainable-health-diagnostics-network-for-low-income-populations-in-india-through-48b098351a93>
- <sup>98</sup> <https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=26948>
- <sup>99</sup> <https://documents1.worldbank.org/curated/en/743601542222919945/pdf/132057-BRI-PUBLIC-PPPStoriesJharkhandPathology-Services.pdf>
- <sup>100</sup> <https://documents1.worldbank.org/curated/en/756011542223098198/pdf/132049-BRI-PUBLIC-PPPStories-Jharkhand-Radiology-Services.pdf>
- <sup>101</sup> <https://disclosures.ifc.org/project-detail/AS/600972/techemerge>

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- <sup>102</sup> <https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=24005>
- <sup>103</sup> <https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=23782>
- <sup>104</sup> <https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=25665>
- <sup>105</sup> [https://www.ifc.org/wps/wcm/connect/corp\\_ext\\_content/ifc\\_external\\_corporate\\_site/solutions/products+and+services/investment-proserv](https://www.ifc.org/wps/wcm/connect/corp_ext_content/ifc_external_corporate_site/solutions/products+and+services/investment-proserv)
- <sup>106</sup> Half of the investment amount is for IFC's own account and half for IFC Asset Management Company (AMC)
- <sup>107</sup> The first investment was in the Duncan Gleneagles Hospital which has since been taken over by the Apollo group.
- <sup>108</sup> <https://disclosures.ifc.org/project-detail/SPI/25805/max-phase-ii>
- <sup>109</sup> <https://disclosures.ifc.org/project-detail/SPI/27976/max-healthcarehealthcare-3>
- <sup>110</sup> <https://disclosures.ifc.org/project-detail/SII/33057/fortis-healthcare-ltd>
- <sup>111</sup> <https://disclosures.ifc.org/project-detail/SPI/24406/apollo-equity>
- <sup>112</sup> <https://disclosures.ifc.org/project-detail/SPI/25969/apollo-loan>
- <sup>113</sup> <https://disclosures.ifc.org/project-detail/SPI/31549/apollo-hosp>
- <sup>114</sup> <https://disclosures.ifc.org/project-detail/SII/37895/apollo-specialty>
- <sup>115</sup> <https://www.apolloclinic.com/about-apollo-clinic>
- <sup>116</sup> <https://disclosures.ifc.org/project-detail/SPI/7374/apollo-sri-lanka-hospital>
- <sup>117</sup> <https://disclosures.ifc.org/project-detail/SII/32237/ihh-healthcare-berhad>
- <sup>118</sup> [https://www.business-standard.com/article/current-affairs/hospital-chains-abused-their-dominance-to-charge-exorbitant-prices-report-122092300441\\_1.html](https://www.business-standard.com/article/current-affairs/hospital-chains-abused-their-dominance-to-charge-exorbitant-prices-report-122092300441_1.html)
- <sup>119</sup> <https://www.competitionlawyer.in/ccl-widens-the-scope-of-investigation-into-unfair-pricing-by-private-hospitals-in-delhi-based-on-current-investigation-against-max-super-specialty-hospital-for-overcharging-for-consumables-t/>
- <sup>120</sup> Max Healthcare in its response to the report stated it did not sell any drugs above the maximum retail price. It also stated that they are contractually bound to provide cashless treatment which rules out purchasing drugs from outside; at the same time they provide .medicines since “~20% of drugs in India are counterfeit”
- <sup>121</sup> <https://ieg.worldbankgroup.org/sites/default/files/Data/Evaluation/files/IFCClientEngagement.pdf>
- <sup>122</sup> <https://disclosures.ifc.org/project-detail/SPI/24406/apollo-equity>
- <sup>123</sup> <https://ifc-org.medium.com/lets-tackle-the-cause-of-disease-not-just-the-symptoms-53907880bed2>
- <sup>124</sup> <https://disclosures.ifc.org/project-detail/SPI/24406/apollo-equity>
- <sup>125</sup> <https://www.investor.gov/introduction-investing/investing-basics/investment-products/private-investment-funds/private-equity>
- <sup>126</sup> Reports suggest that a sell off process of the chain is underway. Max Healthcare, another of the IFC investee companies is one of the leading contenders.
- <sup>127</sup> <https://economictimes.indiatimes.com/industry/healthcare/biotech/healthcare/canadas-otpp-max-healthcare-lead-the-race-for-sahyadri-hospitals/articleshow/91774500.cms>
- <sup>128</sup> <https://www.moneycontrol.com/news/business/race-for-everstone-backed-sahyadri-hospitals-canadian-pension-fund-otppb-may-be-lead-suitor-8817851.html>
- <sup>129</sup> <https://www.moneycontrol.com/news/business/companies/tpg-backed-evercare-looking-to-exit-care-hospitals-8004861.html>
- <sup>130</sup> <https://www.multiplesequity.com/portfolio/vikram-hospital.html>
- <sup>131</sup> Manipal Hospitals acquired a 100% stake in Vikram Hospital in 2021 from Multiples
- <sup>132</sup> <https://www.moneycontrol.com/news/business/companies/manipal-hospitals-buys-out-bengaluru-based-vikram-hospital-from-multiples-private-equity-fund-6982361.html>
- <sup>133</sup> <https://www.thehindubusinessline.com/companies/manipal-healthcare-to-build-400-crore-multi-specialty-facility-in-raipur/article66131605.ece>
- <sup>134</sup> <https://impactalpha.com/lok-exits-as-affordable-eyecare-company-disha-raises-4-Million/>
- <sup>135</sup> <https://economictimes.indiatimes.com/industry/healthcare/biotech/dr-mohans-raises-rs-66-crore-from-lok-capital-evolve/articleshow/58161679.cms?from=mdr>
- <sup>136</sup> <https://ifc-org.medium.com/sustainable-practices-for-private-equity-funds-business-5d841850f7c5>
- <sup>137</sup> <https://assets.cdcgroup.com/wp-content/uploads/2018/06/25150838/Disclosure-and-Access-to-Information-Policy.pdf>
- <sup>138</sup> <https://assets.cdcgroup.com/wp-content/uploads/2018/06/25150838/Disclosure-and-Access-to-Information-Policy.pdf>

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- <sup>139</sup> <https://www.publishwhatyoufund.org/dfi-index/2023/>
- <sup>140</sup> <https://cthi.taxjustice.net/en/>
- <sup>141</sup> <https://ppfddocuments.azureedge.net/c8ba2636-ea26-4bed-a6b5-a4cc5395293b.pdf>
- <sup>142</sup> <https://www.imf.org/en/Publications/fandd/issues/2019/09/the-rise-of-phantom-FDI-in-tax-havens-damgaar>
- <sup>143</sup> <https://policy-practice.oxfam.org/resources/the-ifc-and-tax-havens-the-need-to-support-more-responsible-corporate-tax-behav-604842/>
- <sup>144</sup> <https://taxjustice.net/country-profiles/india/>
- <sup>145</sup> <https://policy-practice.oxfam.org/resources/the-ifc-and-tax-havens-the-need-to-support-more-responsible-corporate-tax-behav-604842/>
- <sup>146</sup> [https://www.investopedia.com/terms/a/asset\\_management\\_company.asp](https://www.investopedia.com/terms/a/asset_management_company.asp)
- <sup>147</sup> [https://www.ifc.org/wps/wcm/connect/corp\\_ext\\_content/ifc\\_external\\_corporate\\_site/solutions/products+and+services/mobilization-proserv](https://www.ifc.org/wps/wcm/connect/corp_ext_content/ifc_external_corporate_site/solutions/products+and+services/mobilization-proserv)
- <sup>148</sup> <https://www.ifcamc.org/portfolio>
- <sup>149</sup> <https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=18159>
- <sup>150</sup> <https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=18159>
- <sup>151</sup> [https://www.ifc.org/wps/wcm/connect/topics\\_ext\\_content/ifc\\_external\\_corporate\\_site/development+impact/aimm](https://www.ifc.org/wps/wcm/connect/topics_ext_content/ifc_external_corporate_site/development+impact/aimm)
- <sup>152</sup> <https://www.brettonwoodsproject.org/2017/10/measuring-impact-overview-ifcs-new-approach-measuring-development-impact/>
- <sup>153</sup> <https://www.ifc.org/wps/wcm/connect/0d16e9f4-8f28-4422-9477-22c7c318856e/IFC-AR20-Measuring-Up.pdf?MOD=AJPERES&CVID=nInjoQJ>
- <sup>154</sup> <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/287171468326410253/development-outcome-tracking-system-dots-indicator-framework>
- <sup>155</sup> <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/287171468326410253/development-outcome-tracking-system-dots-indicator-framework>
- <sup>156</sup> [https://www.ifc.org/wps/wcm/connect/ba38541c-59b5-43a4-af50-3779921a84ab/IFC\\_AR16\\_Section\\_5\\_Our\\_People\\_and\\_Practices.pdf?MOD=AJPERES&CVID=ntu-GpD](https://www.ifc.org/wps/wcm/connect/ba38541c-59b5-43a4-af50-3779921a84ab/IFC_AR16_Section_5_Our_People_and_Practices.pdf?MOD=AJPERES&CVID=ntu-GpD)
- <sup>157</sup> [https://disclosures.ifc.org/enterprise-search-results-home?f\\_result=Development%20Results](https://disclosures.ifc.org/enterprise-search-results-home?f_result=Development%20Results)
- <sup>158</sup> <https://openknowledge.worldbank.org/handle/10986/2674>
- <sup>159</sup> World Bank. 2018. World Bank Group Support to Health Services: Achievements and Challenges Independent Evaluation Group. Washington, DC: World Bank.
- <sup>160</sup> Independent Evaluation Group (IEG) World Bank (2009) 'Chapter 5 – IFC's Health Strategy and Operations', in Improving Effectiveness and Outcomes for the Poor in Health, Nutrition, and Population – An Evaluation of World Bank Group Support Since 1997, Washington DC: The International Bank for Reconstruction and Development/ The World Bank. pp.82–83.
- <sup>161</sup> Ibid. pp.82–83
- <sup>162</sup> Ibid. p.90
- <sup>163</sup> Ibid. p. 90
- <sup>164</sup> Ibid. p. 86
- <sup>165</sup> <https://openknowledge.worldbank.org/handle/10986/22975?show=full>
- <sup>166</sup> [https://www.ifc.org/wps/wcm/connect/industry\\_ext\\_content/ifc\\_external\\_corporate\\_site/health/ifc+hospital+quality+tool](https://www.ifc.org/wps/wcm/connect/industry_ext_content/ifc_external_corporate_site/health/ifc+hospital+quality+tool)
- <sup>167</sup> [https://www.ifc.org/wps/wcm/connect/industry\\_ext\\_content/ifc\\_external\\_corporate\\_site/health/publications/hospital+quality+tool\\_casestudy](https://www.ifc.org/wps/wcm/connect/industry_ext_content/ifc_external_corporate_site/health/publications/hospital+quality+tool_casestudy)
- <sup>168</sup> [https://www.ifc.org/wps/wcm/connect/industry\\_ext\\_content/ifc\\_external\\_corporate\\_site/health/publications/hospital+quality+tool\\_casestudy](https://www.ifc.org/wps/wcm/connect/industry_ext_content/ifc_external_corporate_site/health/publications/hospital+quality+tool_casestudy)
- <sup>169</sup> [https://www.ifc.org/wps/wcm/connect/8042396f-e3c6-47e1-824b-34a3be180257/Health+Advisory+leaflet\\_Dec+2018+final.pdf?MOD=AJPERES&CVID=nORTg.F](https://www.ifc.org/wps/wcm/connect/8042396f-e3c6-47e1-824b-34a3be180257/Health+Advisory+leaflet_Dec+2018+final.pdf?MOD=AJPERES&CVID=nORTg.F)
- <sup>170</sup> [https://www.ifc.org/wps/wcm/connect/industry\\_ext\\_content/ifc\\_external\\_corporate\\_site/health/news/newsletter/health\\_newsletter\\_nov\\_2022](https://www.ifc.org/wps/wcm/connect/industry_ext_content/ifc_external_corporate_site/health/news/newsletter/health_newsletter_nov_2022)
- <sup>171</sup> [https://www.ifc.org/wps/wcm/connect/industry\\_ext\\_content/ifc\\_external\\_corporate\\_site/health/ifc+hospital+quality+tool](https://www.ifc.org/wps/wcm/connect/industry_ext_content/ifc_external_corporate_site/health/ifc+hospital+quality+tool)
- <sup>172</sup> <https://www.facebook.com/groups/190501062905137/>



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- <sup>173</sup> <https://www.worldbank.org/en/topic/health/publication/external-assessment-of-quality-of-care-in-the-health-sector-in-colombia>
- <sup>174</sup> [https://www.ifc.org/wps/wcm/connect/ae698423-c213-4d28-8f18-a392cb45b6ff/EPIHC\\_draft\\_3-15-19\\_web.pdf?MOD=AJPERES](https://www.ifc.org/wps/wcm/connect/ae698423-c213-4d28-8f18-a392cb45b6ff/EPIHC_draft_3-15-19_web.pdf?MOD=AJPERES)
- <sup>175</sup> <https://www.epihc.org/about>
- <sup>176</sup> <https://www.epihc.org/signatories>
- <sup>177</sup> Das, J., A. Holla, A. Mohpal, and K. Muralidharan. 2016. "Quality and Accountability in Healthcare Delivery: Audit-Study Evidence from Primary Care in India." *American Economic Review*, 106 (12): 3765–3799.
- <sup>178</sup> Das, J., J. Hammer, and K. Leonard. 2008. "The Quality of Medical Advice in Low-Income Countries." *Journal of Economic Perspectives* 22 (2): 93–114.
- <sup>179</sup> [https://www.ifc.org/wps/wcm/connect/3a57880a-f34e-418e-9943-7450058b90ba/IFC+quality+health\\_3-18-19\\_web.pdf?MOD=AJPERES&CVID=mGekQEc](https://www.ifc.org/wps/wcm/connect/3a57880a-f34e-418e-9943-7450058b90ba/IFC+quality+health_3-18-19_web.pdf?MOD=AJPERES&CVID=mGekQEc)
- <sup>180</sup> IFC Project numbers 594228, 599572, 600946, 599671, 606823, 606822, 606799
- <sup>181</sup> IFC Project numbers 606822, and 606823
- <sup>182</sup> IFC Project number 579727
- <sup>183</sup> IFC Project numbers 594228, 599572, 600946, 599671, 606799, 606822, and 606823
- <sup>184</sup> IFC Project numbers 579727, 606799, 606822 and, 606823
- <sup>185</sup> IFC Project numbers 579727, 606799, 606822 and 606823
- <sup>186</sup> IFC Project number 579727
- <sup>187</sup> [https://www.business-standard.com/article/news-ians/odisha-to-set-up-20-hospitals-in-ppp-mode-118062200696\\_1.html](https://www.business-standard.com/article/news-ians/odisha-to-set-up-20-hospitals-in-ppp-mode-118062200696_1.html)
- <sup>188</sup> [https://health.odisha.gov.in/OAHP/2018/Odisha%20AHP%20PIM\\_01102018.pdf](https://health.odisha.gov.in/OAHP/2018/Odisha%20AHP%20PIM_01102018.pdf)
- <sup>189</sup> <https://www.businesstoday.in/latest/economy-politics/story/centre-ayushman-bharat-in-planning-stage-odisha-one-step-ahead-110597-2018-09-13>
- <sup>190</sup> <https://www.newindianexpress.com/states/odisha/2018/sep/27/states-health-project-gets-encouraging-response-1877735.html>
- <sup>191</sup> <https://disclosures.ifc.org/project-detail/AS/594228/ranchi-sadar-hospital-ppp-project-jharkhand>
- <sup>192</sup> <https://lagatar24.com/15-years-on-sadar-hospital-ranchi-project-still-in-limbo-may-take-one-year-more-to-complete/95431/>
- <sup>193</sup> <https://timesofindia.indiatimes.com/city/ranchi/soaring-costs-cast-shadow-on-ranchi-sadar-hospital-revamp/articleshow/55108012.cms>
- <sup>194</sup> <https://timesofindia.indiatimes.com/city/ranchi/sadar-hospitals-super-specialty-wing-begins-work-after-6-years/articleshow/59925473.cms>
- <sup>195</sup> <https://khabarinfra.com/ranchis-sadar-hospital-to-become-super-specialty-centre/>
- <sup>196</sup> <https://cag.gov.in/ag/jharkhand/en/audit-report/details/115562>
- <sup>197</sup> <https://www.brettonwoodsproject.org/wp-content/uploads/2017/04/At-Issue-health-PDF.pdf>
- <sup>198</sup> <https://decidehealth.world/en/hellowell-PPP>
- <sup>199</sup> <https://www.oxfam.org/en/research/dangerous-diversion>
- <sup>200</sup> <https://documents1.worldbank.org/curated/en/672561478540044927/pdf/Public-Private-Partnerships-in-Health-World-Bank-Group-Engagement-in-Health-PPP-An-IEG-Synthesis-Report.pdf>
- <sup>201</sup> [https://www.ifc.org/wps/wcm/connect/aafadea6-0afc-4adf-a867-3472aba91b95/PPPStories\\_PatnaHospitals.pdf?MOD=AJPERES&CVID=IHoN1.c](https://www.ifc.org/wps/wcm/connect/aafadea6-0afc-4adf-a867-3472aba91b95/PPPStories_PatnaHospitals.pdf?MOD=AJPERES&CVID=IHoN1.c)
- <sup>202</sup> [https://www.ifc.org/wps/wcm/connect/aafadea6-0afc-4adf-a867-3472aba91b95/PPPStories\\_PatnaHospitals.pdf?MOD=AJPERES&CVID=IHoN1.c](https://www.ifc.org/wps/wcm/connect/aafadea6-0afc-4adf-a867-3472aba91b95/PPPStories_PatnaHospitals.pdf?MOD=AJPERES&CVID=IHoN1.c)
- <sup>203</sup> [https://health.odisha.gov.in/OAHP/2018/AHP\\_Brochure.pdf](https://health.odisha.gov.in/OAHP/2018/AHP_Brochure.pdf)
- <sup>204</sup> <https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=17283>
- <sup>205</sup> <https://disclosures.ifc.org/project-detail/AS/600946/odisha-hospitals>
- <sup>206</sup> <https://disclosures.ifc.org/project-detail/AS/600946/odisha-hospitals>
- <sup>207</sup> For example <https://www.oxfam.org/en/research/dangerous-diversion>; <https://www.eurodad.org/historyrepeated2>; <https://www.eurodad.org/historyrepeated2>; [https://www.eurodad.org/what\\_lies\\_beneath](https://www.eurodad.org/what_lies_beneath); <https://decidehealth.world/en/hellowell-PPP>

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- <sup>208</sup> <https://documents1.worldbank.org/curated/en/672561478540044927/pdf/Public-Private-Partnerships-in-Health-World-Bank-Group-Engagement-in-Health-PPP-An-IEG-Synthesis-Report.pdf>
- <sup>209</sup> IFC Project numbers 33057, 28873, 26248, 35989, 25805, 27976, 24406, 25969, 31549 and 37895
- <sup>210</sup> IFC Project numbers 33057, 28873, 24406, 25969 and 31549
- <sup>211</sup> IFC Project numbers 35989 and 31549
- <sup>212</sup> IFC Project numbers 26248 and 25805.
- <sup>213</sup> IFC Projects numbers 24406 and 32237
- <sup>214</sup> IFC Project numbers 27976, 31549, and 25969
- <sup>215</sup> IFC Project numbers 33057, 35989, and 8084. Regency Hospital aims to double the number of beds.
- <sup>216</sup> IFC Project numbers 33057, 28873, 35989, 25805, 31549, and 37895
- <sup>217</sup> 9,000 people in healthcare sector, apart from generating indirect employment.
- <sup>218</sup> Max II- 4500 jobs (medical industry and during the construction phase)
- <sup>219</sup> 1,500 jobs for new nurses and doctors for Rockland Hospitals
- <sup>220</sup> IFC Project numbers 33057, and 28873
- <sup>221</sup> IFC Project numbers 33057, 28873, 26248, 27976, and 24406
- <sup>222</sup> IFC Project numbers 35989, and 37895
- <sup>223</sup> IFC Project number 28873
- <sup>224</sup> IFC Project number 31549
- <sup>225</sup> IFC Project numbers 33057, 28873, 26248, 25805, 35989, and 27976
- <sup>226</sup> IFC Project numbers 28873, 26248, 35989, 25805, 31549, and 37895
- <sup>227</sup> IFC Project number 35989, 24406, 31549, and 37895
- <sup>228</sup> IFC Project number 25969, and 31549
- <sup>229</sup> IFC Project number 33057, 26248, 25805, 27976, and 31549
- <sup>230</sup> IFC Project number 25969, and 31549
- <sup>231</sup> <https://disclosures.ifc.org/project-detail/SPI/24406/apollo-equity>
- <sup>232</sup> <https://documents.worldbank.org/curated/en/415241500628213684/pdf/115719-WP-IN-Apollo-Case-Study-PUBLIC.pdf>
- <sup>233</sup> <https://documents1.worldbank.org/curated/en/415241500628213684/pdf/Apollo-Better-Care-through-an-Integrated-Network-in-India.pdf>
- <sup>234</sup> IFC Project number 39605, 35855, 41401, 31707, 42714, and 30711
- <sup>235</sup> IFC Project number 33475, and 30711
- <sup>236</sup> IFC Project numbers 39605, 35855, 41401, and 31707
- <sup>237</sup> IFC Project numbers 39605, 33475, and 42714
- <sup>238</sup> IFC Project numbers 39605, 35855, and 31707
- <sup>239</sup> IFC Project numbers 41401, and 3588
- <sup>240</sup> Multiples Private Equity Fund III is claimed to be the only woman-led PE fund manager in India.
- <sup>241</sup> IFC Project numbers 33475, and 30711
- <sup>242</sup> IFC Project numbers 33475, and 29593
- <sup>243</sup> IFC Project numbers 39605, 35855, 33475, 41401, 31707, 42714, 29593, and 39362
- <sup>244</sup> IFC Project numbers 33475, 31707, and 30711
- <sup>245</sup> IFC Project numbers 39605, 31707, 33475, 42714, 39362, and 30711

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- <sup>246</sup> IFC Project numbers 33475, 31707, and 30711
- <sup>247</sup> IFC Project number 29593
- <sup>248</sup> <https://web.worldbank.org/archive/website00346F/WEB/PDF/ANNEXG.PDF>
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- <sup>270</sup> IFC project numbers 33475, and 41401
- <sup>271</sup> IFC project number 39605. 317077, 30711 and 29593. Additionally, the table with the ESAP is blank for project 35855
- <sup>272</sup> The indicators for the ESAP for the Everstone investment suggest this may be limited to nomination of officers for compliance, establishment of SEMS and staff training.
- <sup>273</sup> Project number 42714, and 39362
- <sup>274</sup> <https://www.brettonwoodsproject.org/2009/09/art-565337/>
- <sup>275</sup> [https://www.cao-ombudsman.org/sites/default/files/downloads/CAOAppraisalReport\\_BridgeInternationalAcademies\\_English.pdf](https://www.cao-ombudsman.org/sites/default/files/downloads/CAOAppraisalReport_BridgeInternationalAcademies_English.pdf)
- <sup>276</sup> These includes both large and small population States including Nagaland (score of 27), Uttar Pradesh (30.57), Bihar (31). Arunachal Pradesh (33.91), Manipur (34.26), Madhya Pradesh (36.72), Rajasthan (41.33), Meghalaya (43.05), Uttarakhand (44.21) and Odisha (44.31).
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<sup>289</sup> <https://timesofindia.indiatimes.com/city/kolkata/2-apollo-docs-suspended-over-negligence-death/articleshow/63538950.cms>

<sup>290</sup> The WBCERC's website does not maintain records for 2021. <http://www.millenniumpost.in/kolkata/apollo-hosp-asked-to-revise-bills-in-3-separate-cases-450210>

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- <sup>433</sup> <https://indianexpress.com/article/entertainment/malayalam/actor-filmmaker-sreenivasan-undergoes-bypass-surgery-7858091/>
- <sup>434</sup> <https://www.parentlane.com/hospitals/best-maternity-hospitals-in-delhi>
- <sup>435</sup> Private room, including surgery, doctor fees, OT charges, drugs and investigations, room rent and nursing and administrative charges.
- <sup>436</sup> <https://www.nirfindia.org/2022/MEDICALRanking.html>
- <sup>437</sup> <https://www.newsweek.com/best-hospitals-2020>
- <sup>438</sup> The delivery package for Apollo-Fortis is for two days and is for three days under the CGHS rates. AIIMS does not specify the number of days.
- <sup>439</sup> The rates provided during the calls to the hospitals in March 2023 were as follows. The rates for Apollo Hospitals: Vaginal Delivery: 1 lakh general ward, semiprivate 1.5 lakh, private 2 lakh and C-section Delivery: 2 lakh general ward, 2.5 lakh semi-private and 3 lakh private. Fortis provided the following rate- Vaginal Delivery (2 days): 85,000, 4 bed: 1,02,000, twin: 1,25,000 and C-section (3 days package): 93,000 4 bed, twin 1,10,000, single 1,33,000. No call could be made to Max Healthcare.
- <sup>440</sup> <https://www.medifee.com/hospital/1530-indraprastha-apollo-hospitals/>
- <sup>441</sup> Max Healthcare in a response to the report stated that their rate in Delhi as sourced from one of the hospitals in the city was 70,000 for Normal and C-Section delivery and 15.500 for ICU charges. Pharmacy cost is charged extra which ranges between Rs 3.000-12,000.
- <sup>442</sup> [https://www.medifee.com/hospital/1541-max-super-speciality-hospital-\(saket\)/](https://www.medifee.com/hospital/1541-max-super-speciality-hospital-(saket)/)
- <sup>443</sup> For the Anandpur Kolkata- 9500 MICU for bed
- <sup>444</sup> <https://www.aiims.edu/aiims/hosp-serv/revise-rate-list.htm>
- <sup>445</sup> This is based on the cited rate of 375-18,200 for 10 days which has been converted into the charges for two days.
- <sup>446</sup> [https://mowr.nic.in/core/Circulars/2022/GA\\_08-07-2022\\_30.pdf](https://mowr.nic.in/core/Circulars/2022/GA_08-07-2022_30.pdf) The NABH rates have been used for the comparison with the IFC hospitals. ICU charges are included in the package rates for individual illnesses instead of being reported separately. At the same time, the delivery package is for three (and not two) days.
- <sup>447</sup> [https://www.business-standard.com/article/current-affairs/health-insurance-coverage-up-in-india-but-not-robust-yet-says-nfhs-122051301517\\_1.html](https://www.business-standard.com/article/current-affairs/health-insurance-coverage-up-in-india-but-not-robust-yet-says-nfhs-122051301517_1.html)
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- <sup>449</sup> [https://www.business-standard.com/article/economy-policy/hospitals-flag-concern-about-new-cghs-rates-for-patient-admissions-122092300461\\_1.html](https://www.business-standard.com/article/economy-policy/hospitals-flag-concern-about-new-cghs-rates-for-patient-admissions-122092300461_1.html)
- <sup>450</sup> <https://www.cnbctv18.com/healthcare/ayushman-bharat-apollo-hospitals-health-insurance-scheme-artificial-intelligence-non-communicable-diseases-15930491.htm>
- <sup>451</sup> <https://economictimes.indiatimes.com/markets/stocks/news/private-hospitals-want-government-to-review-rates-of-insurance-scheme/articleshow/64410117.cms?from=mdr>
- <sup>452</sup> <https://www.ifc.org/wps/wcm/connect/eb29cb28-e52a-4979-8fa7-82d33076b33f/Apollo.pdf?MOD=AJPERES&CVID=lv2hqsj>
- <sup>453</sup> <https://www.ifc.org/wps/wcm/connect/eb29cb28-e52a-4979-8fa7-82d33076b33f/Apollo.pdf?MOD=AJPERES&CVID=lv2hqsj>
- <sup>454</sup> [https://www.inclusivebusiness.net/sites/default/files/2020-01/Apollo\\_Hospitals.pdf](https://www.inclusivebusiness.net/sites/default/files/2020-01/Apollo_Hospitals.pdf)
- <sup>455</sup> <https://www.exchangerates.org.uk/USD-INR-spot-exchange-rates-history-2011.html>
- <sup>456</sup> According to the NSSO consumer expenditure on goods and services for 60% of rural households in 2011-12 was INR 1281.45 or less.  
<https://www.downtoearth.org.in/news/rural-expenditure-up-by-33-per-cent-nss-38844>
- <sup>457</sup> [https://ieg.worldbankgroup.org/sites/default/files/Data/Evaluation/files/WBG\\_Support\\_Essential\\_Health\\_Services.pdf](https://ieg.worldbankgroup.org/sites/default/files/Data/Evaluation/files/WBG_Support_Essential_Health_Services.pdf)
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- <sup>459</sup> <https://documents1.worldbank.org/curated/en/415241500628213684/pdf/115719-WP-IN-Apollo-Case-Study-PUBLIC.pdf>
- <sup>460</sup> <https://journals.openedition.org/cybergeo/26756>
- <sup>461</sup> <https://gita.org.in/Attachments/Reports/giz2013-en-healthcare-india.pdf>
- <sup>462</sup> <https://journals.sagepub.com/doi/pdf/10.1177/0256090920090208>
- <sup>463</sup> <https://gita.org.in/Attachments/Reports/giz2013-en-healthcare-india.pdf>



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- <sup>474</sup> <https://ieg.worldbankgroup.org/evaluations/evaluation-international-finance-corporation-investments-k-12-private-schools-7#:~:text=As%20a%20result,K%E2%80%939312%20investments>.
- <sup>475</sup> <https://oxfamlibrary.openrepository.com/bitstream/handle/10546/114093/bp125-blind-optimism-010209-en.pdf?sequence=1>
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