OHCHR PUBLIC SERVICES: OXFAM SUBMISSION
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Q 7-How is the participation of private actors in public service delivery regulated and monitored in your country/region? Please share challenges and good practices.

Public services are key for the enjoyment and fulfilment of economic, social, and cultural rights. Universal and free public services address essential needs, save people from paying out of pocket, and offer an escape route out of poverty for hundreds of millions of people. Yet, the SDG financing gap was estimated to be approximately USD 3.9 trillion in 2021 and since the pandemic, poverty has risen for the first in 25 years, and glaring inequality with it.[1] [2] This comes at a time when public systems are being impacted by policies that contribute to debt and austerity across low-income countries. [3]

Alongside this, we are observing a concerted push to expand private actor participation in development or to privatise public services, as supported by the World Bank, some regional development banks, corporate philanthropy, Development Finance Institutions (DFIs) and some bilateral donors. Market-based solutions have been positioned as central to addressing current and imminent crises and private-sector mobilization has now come to dominate the discourse around MDB reforms. Thus, the World Bank Group seeks to enhance the participation of the private sector in development by mobilizing, catalysing, or de-risking private finance, 'at scale' in order to meet development challenges. The World Bank Group, through their private sector arm, the International Financial Corporation, has played a major role in this. [4] For example, Oxfam conducted a review of the World Bank's funding to governments for primary and secondary education between 2013 and 2019 covering 116 projects and found that one-fifth (22 percent) of projects included elements of direct support for private provision of education across 14 countries.[4] This trend is likely to be enhanced over the coming period.

This submission will focus on the challenges in regulating the participation of private actors in the social sector, primarily health and education, particularly when their involvement is promoted by IFIs International Financial Institutions). We provide an overview of the impacts of private actor involvement in such settings, outline the key international laws and policies that apply to the regulation of private actors in the social sectors and provide a summary of the key challenges related to regulating private actors from both a global and local perspective.

CONTEXT FOR NEED FOR REGULATION OF PRIVATE ACTOR INVOLVEMENT IN THE PROVISION OF PUBLIC SERVICES IN THE CONTEXT OF SUPPORT BY DFIs

Rather than putting all efforts into addressing the many structural reasons holding back the public sector, several IFIs appear to see the increased involvement of the private sector as key to increased efficiency and quality of services and hope to enhance this through various means. This creates a range of regulatory challenges that need to be addressed by legal or policy regulatory frameworks. [5] We provide three examples below:

[1] OECD (2023), Private finance mobilised by official development finance interventions, Development Co-operation Directorate, OECD Publishing, Paris.
[2] J. Walker, M. Martin, E. Seery, N. Abdo, A. Kamande, M. Lawson, "The Commitment To Reducing Inequality Index 2022", (2022).[Link]
[3] R. Saalbrink, D. Archer (2023) Fifty Years Of Failure: The International Monetary Fund, Debt And Austerity In Africa[Link]; A. Kentikelenis, T. Stubbs (2023) IMF Social Spending floors: A fig leaf for austerity [Link]
[4] K. Malouf Bous (2019). False promises. Oxfam GB. [Link]
[5] B. Emmett (2006) In the public interest. Oxfam International. [Link]

i. Negative equity impact and unclear or poor development outcomes

There are mixed outcomes which have come with blended finance, indicating that these modalities often do not yield equitable outcomes that are pro-poor.[6] In education, impacts have included the negative or null effects on education outcomes, poor compliance to national regulations and negative impacts of exclusion on poor children and girls have been shown severally.[7] Recent academic studies and reviews have found mixed evidence on learning outcomes in education PPPs and no evidence that they consistently perform better than public schools.[8] A 17-country analysis found that "PPP schools appear to be outperforming public schools not through any superior or innovative practices, but rather by cream-skimming more capable students into the private sector. Enrolment in a PPP school is tied to powerful socioeconomic indicators such as student wealth and prior academic ability... In a majority of countries, [PPP schools] are reinforcing social disparities by disproportionately serving students in the upper-income quintiles.[9]

The 2018 review of the WBG's Healthcare portfolio[10] highlights that improved access has not been demonstrated and quality has not shown to have consistent improvement in the IFC portfolio. Similarly, improvement in equity and the distributional impact of IFC projects remain unknown. The report highlights that the IFC has failed to prioritize strengthening health systems and improving health outcomes in practice. While it 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 speciality chains supported by IFC investments continued to rely primarily on out-of-pocket payments. A similar IEG evaluation of the IFC investments in K-12 Private schools[11]highlights found no evidence that the IFC project investments were relevant for the local education systems in which schools operated. IFC's engagement with education quality in K–12 private schools was minimal and highlighted risks with respect to sorting of students and failure to serve impoverished or marginalized students.

Oxfam also looked into the impact of the Punjab PPP schools initiative, shedding light on the unintended consequences of a high stakes "reward and sanction" model in which schools' funding is tied to student performance on a standardized test. The approach created incentives for schools to exclude the poorest children, children with disabilities, and others who are likely to do poorly on tests. Schools in the sample sacrificed quality, failing to invest in qualified teachers, relevant training and support, and adequate facilities. Some schools relied on gender inequality in the labour market, by predominantly employing a low-paid female teaching workforce, with average reported salaries less than half the minimum wage. The study also found a clear democratic and social accountability deficit

[6] J. Pereira (2017) Blended Finance: What it is, how it works and how it is used. Research Report. Oxfam. [Link]

[7] M. Aslam, S. Rawal, S. Saeed. n.d. Public-Private Partnerships in Education in Developing Countries: A Rigorous Review of the Evidence [Link]; Mauricio Romero and Justin Sandefur, 2019. "Beyond Short-term Learning Gains: The Impact of Outsourcing Schools in Liberia after Three Years." CGD Working Paper 521. Washington, DC: Center for Global Development. [Link]

[8] See full discussion of the evidence in the main report, which includes Verger, A., and M. Moschetti (2017) Public-Private Partnerships as an Education Policy Approach: Multiple Meanings, Risks and Challenges. Education Research and Foresight Series, No. 19. Paris, UNESCO; Aslam, M., S. Rawal, and S. Saeed. (2017). Public-Private Partnerships in Education in Developing Countries: A Rigorous Review of the Evidence. Ark Education Partnerships Group; Baum, D. (2018) The Effectiveness and Equity of Public-Private Partnerships in Education: A Quasi-Experimental Evaluation of 17 Countries. Education Policy Analysis Archives Vol. 26, No. 105.

[9] Baum, D. (2018) The Effectiveness and Equity of Public-Private Partnerships in Education: A Quasi-Experimental Evaluation of 17 Countries. Education Policy Analysis Archives Vol. 26, No. 105. https://doi.org/10.14507/epaa.26.3436

[10] World Bank. 2018. World Bank Group Support to Health Services: Achievements and Challenges Independent Evaluation Group. Washington, DC: World Bank. https://ieg.worldbankgroup.org/evaluations/world-bank-group-health-services

[11] World Bank. 2022. An Evaluation of International Finance Corporation Investments in K–12 Private Schools. Independent Evaluation Group. Washington, DC: World Bank.

in the sampled PPP schools, with none of the schools studied having a school management committee or parent-teacher council.[12]

Another example is provided of yet another World Bank-supported Universal Secondary Education PPP scheme in Uganda which failed to reduce the significant obstacles impeding vulnerable and marginalized groups of students from accessing quality education, especially high non-fee costs. Despite explicit rules against fee-charging, many PPP schools were levying additional fees and pursuing other tactics to increase revenue. Additionally, when a number of PPP schools were found to be in contravention of their signed Memoranda of Understanding, there was little evidence of sanctions or penalties for breaches, and overall, the government was failing to regulate compliance. [13] Similar dynamics operate in the healthcare sector, for instance, the African Medical Equipment Facility, is a blended finance facility that aims to improve access to medical technologies by supporting private healthcare providers to purchase medical equipment through de-risking of loans from local financial institutions. Early assessments of the AMEF, show that despite project aims, it has so far ended up mainly catering to enhancing the market share of high-end, western manufacturers rather than the local SMEs it was claiming to target and is not likely to enhance access to care for poor or disadvantaged populations.[14] It is fairly evident that the introduction of commercial interests into public service delivery through PPPs, risks compromising the mission of education and health services.

We should also note that PPPs are not the only mode of IFI-promoted private sector participation in the education sector. Other models such as direct and indirect investments in low-fee private schools have yielded similar results. For instance, Bridge International Academies (also referred to as New Globe Schools, the name of its parent company) has received significant investments from DFIs such as the World Bank's IFC and the UK's BII. At its peak, Bridge was operating over 250 low-fee private schools across several countries including Kenya and Uganda.[15] Civil society provided evidence of the negative impacts of the school operations on pupils, teachers and staff, highlighting concerns about the quality of education, lack of transparency, poor labour conditions, high fees and lack of respect for the rule of law in host countries.[16] This aligns with the growing body of evidence which raises deep concerns about the negative impact of commercial and profit-oriented private schools in education.[17] Given these and other concerns, in 2022 IFC quietly divested from Bridge Academies/ New Globe[18] and froze any further direct or indirect investments in private fee-charging K-12 schools. 23

ii. Hidden and unsustainable transfer of risk

The discourse around de-risking the private sector has often left unacknowledged that the 'de-risking' private investment involves shifting the risks to the public sector. For example, in health, hospital public–private partnerships (PPPs) – public hospitals built by and using financing borrowed from the private sector – have been promoted by DFIs, especially IFC, as a solution for shortfalls in health financing. Evidence shows that these PPP hospitals frequently end up burdening health ministries with

[12] K. Malouf Bous (2019). False promises. Oxfam GB. [Link] ; J. Gideon, E. Unterhalter (2017) Exploring public private partnerships in health and education: a critique, Journal of International and Comparative Social Policy, 33:2, 136-141, DOI: 10.1080/21699763.2017.1330699

[13] K. Malouf Bous (2019). False promises. Oxfam GB. [Link]

[14] AMWA, Wemos (2023) The Africa Medical Equipment Facility (AMEF) in Kenya: Does this new blended finance facility contribute to equitable access to healthcare services? [Link]

[15] CAO (2019) Compliance Appraisal: Summary of Bridge International Academies (IFC Project #32171, #38733, #39170 and #39224) Kenya. [Link]

16 Open Letter: Calling attention of investors to concerning evidence regarding Bridge International Academies. [Link]

[17] Submission to UK IDC Parliamentary Inquiry Investment for development: The UK's strategy towards Development Finance Institutions.[Link]

[18] IFC Disclosure. https://disclosures.ifc.org/project-detail/SII/32171/bridge-international-academies

higher than promised and unsustainable costs. One PPP hospital in Lesotho, advised by IFC at one point cost over half the country's annual health budget.[19] The partnership has since collapsed.

Similarly, Oxfam's research finds that DEG, EIB, IFC and Proparco have collectively supported at least three hospital PPPs in Türkiye with nearly US$1bn in loans since 2014. In 2021, Türkiye's Ministry of Health (MoH) announced that there would be no further PPPs and that all future hospital construction would be financed by the government. The decision was taken after it emerged that payments for just 10 operational hospital PPPs accounted for some 27.8% of the MoH budget. Various other 'mistakes' contributed to the unsustainable fiscal pressures for the Turkish government, including the linking of PPP unitary payments to the value of the US dollar, despite entirely predictable exchange rate volatility. The consequences of such mistakes will be borne by the country's taxpayers for years to come, while presumably benefiting investor DFIs in the form of higher returns.[20]

iii. Loss of State sovereignty

Various international agreements favour foreign corporate powers over poor countries or people's interests. For example, WTO Free Trade Agreements' and bilateral investment treaties have the potential to threaten public services by limiting how governments regulate foreign service providers. In these cases, big companies often dictate contractual terms, negotiating and 'cherry picking' the most profitable market segments, requiring guaranteed profit margins. Countries provide companies with special economic zones in which their own laws don't apply thereby eroding policy or State autonomy and their ability to attract more or appropriate investments. These arrangements are often denominated in dollars, putting low-income countries at a marked disadvantage. In other cases, governments are disabled from filing claims against investors or countries are forced to sign agreements that mean that if they try to terminate these contracts, they risk incurring heavy punitive costs. All the above extract crucial resources that could have been channelled towards the provision of education, health, and other key services. [21]

HOW ARE PRIVATE ACTORS CURRENTLY REGULATED IN THE PROVISION OF HEALTHCARE AND EDUCATION SERVICES?

Given the above, it is critical to put in place laws and regulations to govern the actions of private actors. These provide frameworks within which the private sector can enter a sector, operate, and participate in the creation and delivery of development services. They encompass everything from entry into the market to how a business should conduct itself, as well as legal protections and safeguards for all stakeholders involved. [22] The development and implementation of regulations around private actors' participation is guided by international, regional, national, or other applicable laws as well as local policies. Given the role that global institutions play in promoting private actor participation, we also highlight the role of DFI's own institutional policies and guidelines that guide their investments and client activities/ participation. We sample some of these below.

International, regional, and national law

[19] A. Marriott.(2014) A Dangerous Diversion. Oxfam International. [Link]
[20] A. Marriott, "Sick Development", Oxfam International, (2023) [Link]
[21] B. Emmett (2006) In the public interest. Oxfam International. [Link]; O. Abumbola (2020) Africa is a country, Regulatory chill [Link]; Institute for Economic Justice, Climate Finance for Equitable Transitions (2023) Submission to the Presidential Climate Commission on South Africa's Just Energy Transition - Investment Plan March 2023 Link]
[22] Devine, H., Peralta-Alva, A., Selim, H., Sharma, P., Wocken, L., & Eyraud, L. (2021). Private Finance for Development: Wishful Thinking or Thinking Out of the Box? *Departmental Papers*, *2021*(011), A001. [Link]

All financial institutions enterprises and private actors are bound by international laws, customary international law, as well as international treaties and conventions, and normative frameworks. IFIs are called on to respect international human rights law irrespective of their type of financial activity and going beyond only the areas where ESG approaches are applied.[23] Enterprises are required to respect international human rights obligations of the countries in which they operate, 'independently of States' abilities and/or willingness to fulfil their human rights obligations'.[24] Of particular significance are the Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, as well as the United Nations Guiding Principles on Business and Human Rights (UNGPs), the Guiding Principles on Human Rights Impact Assessments of Trade and Investment Agreements and the OECD Guidelines for Multinational Enterprises (OECD Guidelines). In addition, and of particular interest are also specific international principles that draw on international human rights law, such as the Abidjan Principles.[25] The principles touch on a broad range of issues including addressing: progressive realization of the right to education, the financing of education, quality, adequate regulation, (Principle 50 to 60), the requirement that states should effectively monitor and regulate private actor activity, using this information to make policy reforms and improvements(principles 84-87), and the right to effective remedy where harms or violations have occurred due to the involvement of private actors in education (Principles 88-90).[26]

Regional laws, regulations and standards also apply: regarding the enjoyment of economic and social rights for instance, we have seen these developed by the African Commission on Human and Peoples' Rights (ACHPR), the European Committee of Social Rights (ECSR), and the Inter-American Commission of Human Rights (IACHR).[27] The ACHPR recently provided general comment 7 on 'State Obligations to Regulate Private Actors Involved in the Provision of Social Services', given the growing realization that private actors were contributing to diminishing access to and the quality of social services and was a growing threat to the enjoyment of economic social and cultural rights.[28]

IFI institutional policies and guidelines

IFIs are also called on to respect international human rights law irrespective of their type of financial activity and this should go beyond the areas where ESG approaches are applied.[29] A variety of self-regulatory mechanisms have also been developed to mainstream human rights standards and sustainable practice into business operations, as well as to understand, manage and disclose environmental and social risks and business impacts. These include Environmental Social and Governance (ESG) frameworks which are developed by institutions or groups of institutions in order to meet the above obligations. In addition to ESG frameworks, various institutions also adopt additional standards and safeguards for the purpose of self -regulation: For example, the World Bank's private sector arm, the International Finance Corporation (IFC), developed the EPIHC (Ethical Principles in Health Care) standards which provide a platform to promote ethical conduct in healthcare. Healthcare providers are invited to make a voluntary commitment to following the ten principles and there are no penalties to non-compliance or related complaint mechanisms.[30] The extent to which

[23] OHCHR (2023) Investors, ESG and Human Rights.[Link]
[24] OECD Guidelines for Multinational Enterprises (OECD Guidelines) [Link]
[25] The Abidjan Principles: Guiding Principles on the human rights obligations of States to provide public education and to regulate private involvement in education [Link]
[26] The Abidjan Principles: Guiding Principles on the human rights obligations of States to provide public education and to regulate private involvement in education [Link]
[27] GIESCR (2022) States' Human Rights Obligations Regarding Public Services essential for the enjoyment of Economic, Social, and Cultural Rights - The regional perspective. [LINK]
[28] ACHPR (2022) General Comment 7 State Obligations Under the African Charter on Human and Peoples' Rights in The Context of Private Provision of Social Services. [Link]
[29] OHCHR (2023) Investors, ESG and Human Rights.[Link]
[30] EPiHC. The Principles [Link]

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.[31]

CHALLENGES IN EFFECTIVE REGULATION OF PRIVATE ACTORS

Some of the challenges experienced in the application of the above legal and policy provisions to blended finance modalities, such as PPPs, as well as direct and indirect investments made into private actors by DFIs in health and education service provision have been analysed below. This has been divided into challenges at the level of global and regional institutions and at the national level respectively.

CHALLENGES AT THE INSTITUTIONAL LEVEL- GLOBAL

Challenges with institutional policies and approaches to development

A true commitment to adopting human rights standards across ESG frameworks across the private sector seems to be a long way off. The level of alignment of ESG frameworks with human rights, and their level of operationalization and application varies considerably across entities: there is often a disjuncture between ESG rhetoric or recognition of responsibilities and their translation into practice, with some enterprises doing the bare minimum or only applying a limited interpretation of core aspects in exceptional or extremely high-risk circumstances, rather than as part of their routine operations. In addition, communities, end users or vulnerable populations often fail to be considered when E&S risks or issues materialize. Similarly, with remedy concerns being translated into a 'blame game between DFI and client'. [32]

Secondly, value addition and impact are difficult to determine: For example, concerns have been raised about the poor transparency and accountability of blended finance projects and the challenges that come with stakeholder participation, local ownership, and alignment with national priorities. There is a paucity of evidence around project additionality and development impacts.[33] Contributing to this are factors such as: there is still a lack of common agreement on the definition of additionality across stakeholders i.e., no harmonized definitions, approaches, or methodologies to measure additionality which hampers monitoring and evaluation efforts and makes it challenging to compare projects or to draw lessons from across different institutions. There are also difficulties in measuring and tracking the development results of specific instruments, such as guarantees.[34] For development additionality, a narrow set of indicators is usually chosen that focus more on job creation, enhanced access to finance, improvements in project design, improvement in the projects' social and environmental standards or operational aspects, rather than how equitable a project is, its contribution to development goals or its catalytic impact across sectors.[35] There are also challenges around the transparency or quality of impact: The quality of reporting varies considerably with different and inconsistent levels of aggregation and different evaluation approaches used. [36] Various initiatives have

[31] A. Taneja, and A. Sarkar, "First, Do No Harm", Oxfam India. (2023) [Link]

[32] OHCHR (2023) Benchmarking Study of Development Finance Institutions' Safeguard Policies [Link]; OHCHR (2021) Taking stock of investor implementation of the UN Guiding Principles on Business and Human Rights. UN Working Group on Business and Human Rights [Link]; Amnesty International USA (2021) Risky Business: Top 10 Leading Venture Capital Firms Failing in their Responsibility to Respect Human Rights. [Link]; P. Muñoz. Bridging the Human Rights Gap in ESG. BSR blog, March 22, 2022 [Link]

[33] J. Pereira (2017) Blended Finance: What it is, how it works and how it is used. Research Report. Oxfam. [Link]

[34] H. Jeune (2019) Faith is not enough: Ensuring that aid donor-private sector partnerships contribute to sustainable development. Oxfam GB [Link]

[35] J. Pereira (2017) Blended Finance: What it is, how it works and how it is used. Research Report. Oxfam. [Link]

[36] P. James, R. Anderton (2023) DFI Transparency Index 2023 [Link]

been launched to address this, such as the Joint Impact Modelling tool, but their efficacy remains to be seen. [37]

Thirdly, non-transparency is rampant and appears to be accepted industry practice. A key area of complaint associated with E&S systems is information disclosures around ESG risks and accountability. Despite having policies in place, institutions rarely report about their implementation. In regard to transparency, both the UNGP and OECD guidelines require businesses to effectively communicate any risks or potentially adverse impacts on people, environment, or society, and how they plan to address them. [38] [39] Instead, what we find are opaque processes and extremely limited or absent disclosures. One particular study found that 106 of 120 complaints at the WB inspection panel were about consultation, participation, and information disclosure.[40] In another example, Oxfam experienced marked difficulty in attempting to identify the full portfolio of DFI health investments in health: DFI websites and databases were inconsistent and difficult to navigate and several of the investments identified were not reported in the DFIs' databases. Many were simply stumbled upon by chance. For example, finding information on Germany's DFI, DEG's health investments was especially opaque- There was no means of searching for health-specific investments, and staff told Oxfam that they were unable to confirm any of the organization's health investments made prior to 2015, due to confidentiality issues. DEG reported some important improvements in disclosure from 2022 but available information is still very limited.[41] While the UK's British International Investment's (BII's) project portal is more comprehensive and better structured, we still find an unacceptable time lag in its disclosure of new investments as well as exits.

Similarly, a study into IFC investments in India found that despite having Performance Standards and risk and mitigation assessment systems in place, the disclosures of Environmental and Social (E&S) risks need significant improvement. For instance, no evidence could be found about how and to what extent E&S advice is issued or implemented in private hospitals financed by the IFC via intermediaries. Annual Environmental and Social Monitoring reports are similarly not disclosed and information that is disclosed does not address externalities in terms of the impact on the healthcare sector at large in India or refer to the status of compliance with national law.[42] An additional concern lies with the Financial Intermediary (FI) based investments made, which have exhibited gaps in due diligence, monitoring and supervision, transparency, and accountability. The IFC, unlike other DFIs, has taken steps to improve disclosure of FI sub-projects. However, significant gaps still remain in regard to how FI clients adopt and perform across these dimensions, particularly in high-risk investments. [43]

Lastly, despite access to information being increasingly recognized as a human right under international, regional and (increasingly) domestic law,[44] commercial sensitivity is often used as an inappropriate defence to enhance accountability. DFIs also often raise 'business sensitivity' or 'commercial confidentiality' as a defence to transparency or demands for disclosure. Yet research shows that disclosures are possible despite clauses or exemptions that speak to this, including with client consent. It has also been noted that there are many private actors that are opting for improved

[37] OECD (2023), Private finance mobilised by official development finance interventions, Development Co-operation Directorate, OECD Publishing, Paris
[38] OECD Guidelines for Multinational Enterprises (OECD Guidelines) [Link]
[39] OHCHR (2011) "Guiding Principles on Business and Human Rights: Implementing the United Nations 'Protect, Respect and Remedy' Framework".
[40] OHCHR (2023) Benchmarking Study of Development Finance Institutions' Safeguard Policies [Link]
[41] A. Marriott, "Sick Development", Oxfam International, (2023) [Link]
[42] A. Taneja, and A. Sarkar, "First, Do No Harm", Oxfam India. (2023) [Link]
[43] A. Marriott, "Sick Development", Oxfam International, (2023) [Link]; Review team, CAO (2020) External Review of IFC/MIGA E&S Accountability, including CAO's Role and Effectiveness Report and Recommendations. [Link]
[44] OHCHR (2023) Benchmarking Study of Development Finance Institutions' Safeguard Policies [Link]

disclosure arrangements. Secondly, information often described as commercially confidential is often already available or accessible through various public sources or subscription databases. [45]

Poor inconsistent donor practices

There are also challenges with how donor governments engage in enabling private sector participation. For example, there is a lack of a standard definition of what donor support to the enabling environment for private sector development entails, and a lack of clarity around the variety of interventions captured under this type of support, and where these may result in the most impact – including on the poorest and most vulnerable people.[46] Similarly, it is expected that donors will institute checks and balances so that their investments or partnerships 'do no harm.' However, Oxfam reviewed nine donors and 20 partnerships, finding that donors often fail to sufficiently integrate development, human rights and environmental principles and standards. Additionally, they inconsistently implement due diligence and risk management requirements and development impact assessments are inadequate.[47]

CHALLENGES OF REGULATING PRIVATE ACTORS: A NATIONAL PERSPECTIVE

The following section takes a closer look at the challenges of regulating private actors in health and education that are experienced at the national level, largely relying on the regulation practices of one country- India. This country has been considered here given its size (in terms of the size of its education and health systems) and complexity (being a federal system) and at the same time, as a Lower Middle-Income Country, it experiences some of the same risks as many other national contexts at similar levels of economic development. At the same time, the country was selected given both its regulatory context and DFI support to India having been extensively researched. This section of our submission is based on research and analysis we have undertaken on the Indian regulatory context as regards the provision of health and education services. [48]

In India, education is part of the Concurrent List of the Constitution of India which means both the centre and the states have a role in the regulation of private schools. However, private school administration is largely governed by State law, with most states having a web of regulatory legislation for the regulation of private schools.[49] Healthcare, on the other hand, is a state function. Despite this, the Clinical Establishments (Registration and Regulation) Act, 2010 (henceforth referred to in this document as CEA 2010) has been drafted as a national legislation but is applicable to states which pass an Act or resolution to adopt the same.[50] This was adopted by 13 States and 6 Union Territories in 2022 (of 28 States and 8 UTs). The CEA is accompanied by a range of state specific legislation to regulate clinical establishments. Decades of under investment in both sectors, has led to an under-resourced and overstretched public system, which is struggling to cope with demand for quality healthcare. The gap in provision in health care for instance, is filled by India's burgeoning private healthcare sector, which has grown steadily in size and strength from the 1990s, aided by the liberalization and privatization process. Among ailments which were treated, 69.9% are treated by the private sector which has come at a cost with the average out of pocket expenditure on private hospitals being six

[45] P. James, R. Anderton (2023) DFI Transparency Index 2023 [Link]
[46] H. Jeune (2019) Faith is not enough: Ensuring that aid donor-private sector partnerships contribute to sustainable development. Oxfam GB [Link]
[47] H. Jeune (2019) Faith is not enough: Ensuring that aid donor-private sector partnerships contribute to sustainable development. Oxfam GB [Link]
[48] OECD MNE Guidelines [Link]
[49] A. Vyas, A. Taneja, Noopur (2023) Building Blocks for a Comprehensive Model Regulatory Framework for Private Schools in India. Oxfam India. [Link]
[50] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

times more than for government hospitals.[51] Similarly, nearly 49% of students at the elementary level in India[52] attend private schools The proportion of private schools in elementary education rose from 19.49% in 2007-08 to 22.74% in 2014-15.[53]

This creates the following challenges with regulating private actors in the education and health sectors in India.

i. Fragmented or complex regulatory landscapes

The regulatory landscape is extremely complex and layered, particularly given its federal character. For example, India lacks a singular, comprehensive private school regulatory framework and the regulatory landscape is also extremely complex and full of contradictions. For instance, the Uttar Pradesh Right to Education (RTE) Rules clearly state that recognition will be given to schools under the condition that they are not run for profit by any individual, group or association of individuals or any other persons. However, the Uttar Pradesh Self-Financed Independent Schools (Fee Regulation) Act, 2018 allows commercial activity on the premises of the school, and such income is to be deposited into the account of the school. Most states have a multiplicity of applicable legislation which has not been abolished while new layers are added creating a complex policy landscape. Additionally, many pieces of legislation referred to additional delegated legislation which has changed over time, without efforts to ensure consistency and uniformity.[54] A content analysis of over 100 legislations in place identified some of the domains of regulation as including provisions related to admission, regulation of fees, standards for the establishment, recognition and affiliation of schools, provisions regarding the process for obtaining and renewing recognition of private schools, provisions regarding human resources, child protection and child participation, parent participation and other provisions regarding the administration of schools. [56]

Similarly, the healthcare sector is regulated through a range of contradictory legislation, which governs various aspects of hospital management such as commissioning of a hospital, regulation of its business aspects, the sales and storage of drugs and safe medications, the qualifications, practice and conduct of healthcare professionals, environmental protection and safety, employment of human power, safety of patients, public and staff within the hospital premises, medico-legal aspects, professional training and research and biomedical research.[55]

This complex regulatory context provides the backdrop for the IFIs' support for the private sector. Thus, the preceding World Bank's Country Partnership Framework in India sought to promote delivery models that leverage the private sector to deliver services. Four of five World Bank-funded projects in India during the period 2020-2022 included some role for non-state actors in the delivery of core functions of education in line with its stated strategy and included a strong strand of promoting Universal Health Coverage (UHC), by prioritizing the improvement of healthcare delivery through the delivery of health insurance. The IFC sought to supplement this by mobilizing private sector capital to expand "affordable, quality healthcare and create a mass market for lower-income populations".[56] Clear strategies or understanding of the nuances of regulation is not discernible in donor documents.

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[51] National Statistical Office (2019) Key Indicators of Social Consumption in India: Health. [Link]

[52] http://udise.in/Downloads/Publications/Documents/ElementaryFlash2014-15.pdf

[53] Abhiijeet Singh (2015) What can the private sector offer Indian education? Ideas for India. [Link].

[54] A. Vyas, A. Taneja, Noopur (2023) Building Blocks for a Comprehensive Model Regulatory Framework for Private Schools in India. Oxfam India. [Link]

[55] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

[56] A. Taneja, A. Phillips,V. Wankhede (2022) Overlooking the Fundamentals: An Analysis of International Financial Institutions' Covid-19 Era Health and Education Projects in India. Oxfam India. [Link]

ii. Poor enforcement of policy and regulations

Legal and regulatory enforcement is often poor, uneven, and unpredictable given weak or inadequate capacity within implementing institutions and agencies at both the national and local levels. This contributes to regulations not being upheld or creates perverse incentives for the misapplication of existing rules. Contracting out makes further unrealistic demands of weak governments for regulation and the management of contracts and corruption to further limits government capacity for oversight and the enforcement of regulations or contracts. [57] [58] Poor enforcement of regulations concerning the registration of schools and clinical establishments in India highlights some of the factors that impact enforcement. For example, unrecognized schools are schools that run without government licenses most often because they are unable to fulfil the prerequisites for recognition. The admission of students into unrecognized institutions is prohibited. However, according to official sources, 17% of rural students enrolled in private schools are studying in unrecognized institutions.[59]

School recognition/ registration processes are often delayed due to inadequate capacity: In Delhi, the mandated time to obtain the essentiality and recognition certificates is eight months. However, research suggests that the process can take over 73 months in practice. Contributing to this is limited monitoring or schools and inadequate school inspections: In a study of school inspections in 11 states, massive shortfalls, and an inability of the state departments to cover even the minimum mandated number of inspections of schools was observed. However, in terms of coverage, one inspector is responsible for inspecting 205 schools in Delhi. It is apparent that national and state-level regulatory structures are seriously understaffed. It is therefore unsurprising that in one study in 2022, 84% of private school parents reported that state governments had been ineffective in regulating private schools. [60]

This situation is mirrored in the health sector: Despite the existence of legislation, 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. The CEA does not articulate any specific structures and mechanisms, such as additional budget and staff at the central and state levels for implementation of the CEA. The Act is meant to be implemented through the District Health Officer's office, which is already overwhelmed with the responsibility of running the Public Health System in that district and would find it very challenging to take on such additional major duties without dedicated staff. Research involving Interviews with the district health administration revealed challenges at their end including a lot of extra unpaid work and uncoordinated action.[61]

Another reason provided for poor implementation is poor policy planning or design, and poor coordination between different levels and arms of government. For example, the minimum standards still not having been notified to date: In the absence of notified standards, the regulation of clinical establishments (which includes implementation of minimum standards and standard treatment guidelines, transparency in charges and standardisation of rates, monitoring of adherence etc.) effectively remains on paper. [62] A variety of explanations have been provided: For instance, the process

[57] B. Emmett (2006) In the public interest. Oxfam International. [Link]
[58] M. Lawson, M. Chan, F. Rhode et al (2019) Public good or private wealth. Oxfam gb. [Link]
[59] A. Vyas, A. Taneja, Noopur (2023) Building Blocks for a Comprehensive Model Regulatory Framework for Private Schools in India. Oxfam India. [Link]
[60] A. Vyas, A. Taneja, Noopur (2023) Building Blocks for a Comprehensive Model Regulatory Framework for Private Schools in India. Oxfam India. [Link]
[61] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]
[62] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

of standards formulation is highly centralised at national level, which makes it difficult to customize for local conditions. State governments have therefore taken to drafting their own Acts, rather than adopting the CEA 2010. However, most of these state legislations only have provisions for registration, leaving out provisions for regulating quality and rates of care, increasing transparency, standardization, grievance redressal and so on. These laws are also often implemented in fragmented manner through multiple agencies, with execution varying from state to state. [63]

The WB and ADB support in India during this period sought to strengthen the design of national and state health insurance schemes (PMJAY nationally and Mizoram and Meghalaya for example) and support enrolment in insurance programmes, state capacity for implementation of India's flagship health insurance program (PMJAY) and enhance project management capacities. T However, this narrow focus is misplaced given the large-scale under-reach and limited access to the PMJAY. The strategy fails to critique the policy that insurance mechanisms may not be best placed for a country like India, especially in the absence of robust, free, publicly provided services. Insurance mechanisms tend to spend scarce public resources on private provision of very specific health services instead of focussing on easy access to publicly provided primary care which may stop the escalation of many illnesses currently using PMJAY. Early evaluation of the implementation of PMJAY in Chhattisgarh found neither an increase in the utilization of hospital care nor a reduction of catastrophic health expenditure post-enrolment in the scheme. Many empanelled private hospitals used these government-funded insurance schemes to enhance profits.[64] Furthermore, projects appear to support the expansion of these schemes, including in areas with limited penetration of the private sector. Thus, the WB Mizoram project seeks to promote it despite the project assessment document highlighting that 86% of all ailments in rural areas are treated in government hospitals (compared to a national average of 32%).[65]

iii. Non-compliance, regulatory capture and limited or no accountability.

A key problem with regulation is failure of private schools to adhere with legislation or other regulatory frameworks laid down.

A key example of regulatory failure that has impacted education equity and access is the regulation of fees. Fee regulation is most highly contested issue about private school regulation as well as the one that has the most provisions. The implementation of existing provisions has been largely ineffective, with the National Education Policy acknowledging the failure of current regimes in preventing "commercialization and economic exploitation of parents by many for-profit private schools".[66] Educational institutions are allowed to make a 'reasonable surplus', and this surplus should be used for the growth and better facilities of said institution and finally, that this surplus could not be used for profiteering by the school management. However, what constitutes "reasonable surplus" is ill-defined and the lack of basic financial transparency by schools makes it difficult to verify whether funds were used appropriate. In addition, there is lack of transparency in school fees: Private schools are often not transparent and key information about their functioning is often not available in the public domain. This includes audit information, enrolment, and other information. Fees are also enhanced arbitrarily, and it is not clear how fees are fixed or whom one can complain to if wrongdoing by the school is suspected. As such, several instances of financial irregularities in private institutions have been

[63] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

[64] A. Taneja, A. Phillips,V. Wankhede (2022) Overlooking the Fundamentals: An Analysis of International Financial Institutions' Covid-19 Era Health and Education Projects in India. Oxfam India. [Link]

[65] A.Taneja, A. Phillips,V. Wankhede (2022) Overlooking the Fundamentals: An Analysis of International Financial Institutions' Covid-19 Era Health and Education Projects in India. Oxfam India. [Link]

[66] A. Vyas, A. Taneja, Noopur (2023) Building Blocks for a Comprehensive Model Regulatory Framework for Private Schools in India. Oxfam India. [Link]

reported which involve malpractice and the misuse of subsidies, including land, provided by the government. To illustrate this further, 57% of parents reported having to pay additional charges that were not part of the declared official break-up of fees. As such, private schools which are expected to be not for profit, are reporting making margins of 25%. A similar study in Telangana found that many private schools were taking fees under ineligible heads; none of the schools submitted the Annual Administrative and Audit Report. Despite all this, penalties for violations by private schools are unclear and grievance redress mechanisms available to parents are weak. [67]

Similar to education, price regulation remains a critical and politically contentious aspect of the regulation of clinical establishments and as an example reflects how poor policy implementation and non-compliance are related. Rule 9 of Clinical Establishment (Central Government) Rules, 2012 prescribes an establishment to "charge the rates for each type of procedures and services within the range of rates determined and issued by the Central Government from time to time, in consultation with the State Governments". Except for West Bengal, all other existing state level legislations contain no provisions to regulate health care charges. [68] the National Council has not undertaken any specific steps to ensure transparency in rates.

Further, it has dissolved its sub-committee on rate standardization and shifted the responsibility for rate standardization to the concerned 11 states and 6 UTs who have adopted CEA 2010 by 202. On 30th July 2018, it was decided that the states/Union Territories would develop standard costs of procedures and services referring to a list of more than 3500 procedures / services and standard template of costing as approved and shared by the National Council. States and UTs would define such costs for common procedures as applicable to their states taking into other local factors into account and submit the first list of costs of procedures within 2 months. However, only Chandigarh and Dadra and Nagar Haveli; Andaman and Nicobar Island, Daman and Diu responded by 18th February 2019.[69]Unsurprisingly, an analysis of bills from four reputed private hospitals in the Delhi and NCR region by the National Pharmaceutical Pricing Authority (NPPA), Government of India revealed that they make profit margins from 100 % to 1,737% on drugs, consumables and diagnostics and these three components account for about 46% of a patient's bill. These malpractices and profit driven functioning are leading to increased out of pocket expenditure on healthcare and impoverishment of vast and vulnerable population in India. [70]

Other aspects of non-compliance within education in the Indian context include:[71]

- A large number of teachers in private schools are not qualified. Most also do not receive adequate in-service training.
- Most private school teachers lack job security and access to social protection measures, particularly female teachers. Lack of a decent teacher wage and poor and unsafe learning environments continue to plague private schools, particularly low-fee private (LFP) schools.
- In regard to access and equity, the admission process has received a lot of attention over the years due to allegations of private schools continuing to charge capitation fees and screening students, in violation of existing regulations. Interviews with children and parents, admission

[67] A. Vyas, A. Taneja, Noopur (2023) Building Blocks for a Comprehensive Model Regulatory Framework for Private Schools in India. Oxfam India. [Link]

[68] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

[69] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

[70] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

[71] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

tests and admissions have continued to remain rampant in private schools and children are admitted before the official age of admission and before they are ready for formal schooling.

Influencing both policy formulation and enforcement is the reality that private interests participate and sometimes dominate or capture policy making spaces in India. Most state governments have failed to take up adopting the CEA or developing robust regulations on clinical establishments as a political priority. With 70% of healthcare being provided in the private sector, the powerful private medical lobby is often in a position to dictate terms to the government, as has been observed repeatedly over the past 10 years through their actions to veto the implementation of the CEA 2010. At the state level, political will is greatly influenced by the vested interests of politicians who often have stakes in private hospitals and medical colleges and may have links with the powerful lobby of the medical industrial complex.[72] Core aspects of regulation of private healthcare services such as rates, quality, rationality of care, and patients' rights – which impinge upon the main operations and profitability of private providers – have remained persistently unaddressed in the Indian context.[73]

It is not clear how this failure to adhere with legislation has been addressed by IFIs through their support to the sectors. Influx of significant pools of money into sectors suffering from significant failures of regulation carries considerable risk. Thus, the IFC's investments into the hospital and clinic sectors between 1997-2022 (the period of its healthcare investments in the country) totalled USD 523 million.[74]

iv. Rights violations and harm

Lastly, due to extremely weak and ineffective mechanisms for accountability and regulation, the private healthcare sector's quest for profit maximization often results in rights violations and/or harm. Thus in healthcare, despite a Charter of Patient's Rights being in effect, we find that the impersonal and profit-driven corporate management style in multi-specialty hospitals, with doctors being set performance targets and incentivised for achieving numbers, has had far reaching consequences on the practice of medicine – from hyperinflation in costs of healthcare, increasing instances of malpractice and corruption to a growing trust deficit between doctors and patients and incidents of unwarranted treatments, exorbitant or arbitrary healthcare bills, and violence against hospitals and healthcare workers. In addition, there has been a growing lack of transparency in diagnosis, treatment, and billing; gross deficiencies in services provided to the patients; absence of adherence to standard treatment protocols leading to unnecessary investigations, procedures, surgeries, and medications among others. [75]

It should be emphasised that women are affected disproportionately here: a key example is related to the PMJAY which is a Public Private Partnership insurance scheme where large amounts of public funds are handed over to empanelled private hospitals at predefined package rates for specified 1350 procedures in India. However, in 2019, there were reports of large-scale unwarranted hysterectomies in women working as sugarcane cutters in Beed, Maharashtra. Across states like Andhra Pradesh, Karnataka, Rajasthan, Chhattisgarh and Bihar, women especially from rural areas and poor households have been subjected to unnecessary hysterectomies in the private sector, often to avail insurance

[72] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

[73] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

[74] A. Taneja, and A. Sarkar, "First, Do No Harm", Oxfam India. (2023) [Link]

[75] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]; A. Taneja, and A. Sarkar, "First, Do No Harm", Oxfam India. (2023) [Link]

benefits under state-sponsored insurance schemes. Along with hysterectomies, Research has shown that caesarean section births are nearly three times more in the private sector as compared to the public sector21 in India. With 17% of all institutional deliveries being conducted through caesarean section in 2015-16, India has already crossed the World Health Organization's threshold of 15%. [76]

The Government of India has received many complaints regarding the above in clinical establishments, particularly large multi-specialty hospitals and corporate establishments and regulators have also upheld multiple complaints relating to overcharging and failure to treat patients, especially during the Covid-19 pandemic. However, investments into these same institutions persist without being sufficiently addressed by their DFI investors, enhancing the risk and potential of human and patients' rights violations in the health care sector.[77]

Similarly, in education, parents report having little voice and agency in schools. In an Oxfam India study, 51% of parents say they have no voice and agency around key decisions taken in the school; and less than 5% of those who filed complaints were satisfied by the action taken by the school. In the same survey, 78% of parents want the complaint processes to be made easier and complainants' children to be protected from harassment. In various states, legislation view parental participation through the narrow prism of setting up Parent-Teacher Associations, rather than defining clear processes to ensure parents are involved in key decisions taken by the school, that concern children and parents. In the previously mentioned Oxfam India survey, under 20% of parents report that their school has a parent-teacher association. Where a PTA existed, four in five parents were not consulted over decisions taken by the school. More concrete steps are needed to ensure that private schools are run in a manner that is more transparent and more accountable concerning their obligation to realize the right to education of their pupils. As part of the regulatory mechanisms, private unaided schools are required to submit an Annual Administrative Report (AAR) and annual reports every financial year, however, most fail to do so. [80]

None of the projects supported by DFIs disclosed prioritizing these dimensions in their operations in India.

CONCLUSION

Only 7% of mobilised private finance is currently going towards the social sectors, given their low rates of commercial viability and return profiles, and the challenging economic and political environments in which they exist. [78] [79]However, the impacts of even these few investments or projects are proving to be far reaching, leading to rising inequalities, high costs and acute exclusion of those who need these services the most. [80]

An approach that prioritizes private provision assumes private providers will start behaving rationally, ethically and will start providing standard quality of care just by joining publicly funded programmes, without the need to ensure acceptance of essential public standards and regulation as a norm by the

[76] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

[77] A. Taneja, and A. Sarkar, "First, Do No Harm", Oxfam India. (2023) [Link]

[78] S. Attridge (2019)Blended finance in the poorest countries: the need for a better approach. [Link]

[79] OECD (2023), Private finance mobilised by official development finance interventions, Development Co-operation Directorate, OECD Publishing, Paris.

[80]B. Emmett (2006) In the public interest. Oxfam International. [Link] ; CSO Joint paper (2023) Civil Society calls for rethink of World Bank's Evolution Roadmap as part of wider reforms to highly unequal global financial architecture CSO joint paper [Link]

entire sector.[81] Private sector provision can neither effectively work in the public interest or be equitable unless these conditions are set within the appropriate policy design. Therefore, while the private actors make important contributions to the economy and public life, their participation requires extensive monitoring and regulation and integration into strong public systems.[82] [83]

Attaining the highest level of human rights and realizing the Sustainable Development Goals cannot be achieved without conscious efforts to strengthen the regulation of private actors, including through the support provided by IFIs and DFIs. There should be stronger considerations given to the contexts in which private actor participation is being proposed – in weak regulatory contexts, capacities to implement existing regulations must be taken into consideration and where these are weak, development actors should be extremely cautious in encouraging or enhancing private actor participation and should rather direct any public funds towards strengthening public systems.

[81] A. Shukla, K. Pawar (2021) Health in India: Analysing Regulation of Private Healthcare in India, With focus on Clinical Establishments Acts. Current status, challenges and recommendations [Link]

[82] Devine, H., Peralta-Alva, A., Selim, H., Sharma, P., Wocken, L., & Eyraud, L. (2021). Private Finance for Development: Wishful Thinking or Thinking Out of the Box? *Departmental Papers*, *2021*(011), A001. [Link]

[83] B. Emmett (2006) In the public interest. Oxfam International. [Link] ; Public good or private wealth. Oxfam. [Link]