

The Role of the International "pools of private capital" in the Investment in Health Systems in Low Income Countries.

Christopher Egerton-Warburton, Lion's Head Global Partners

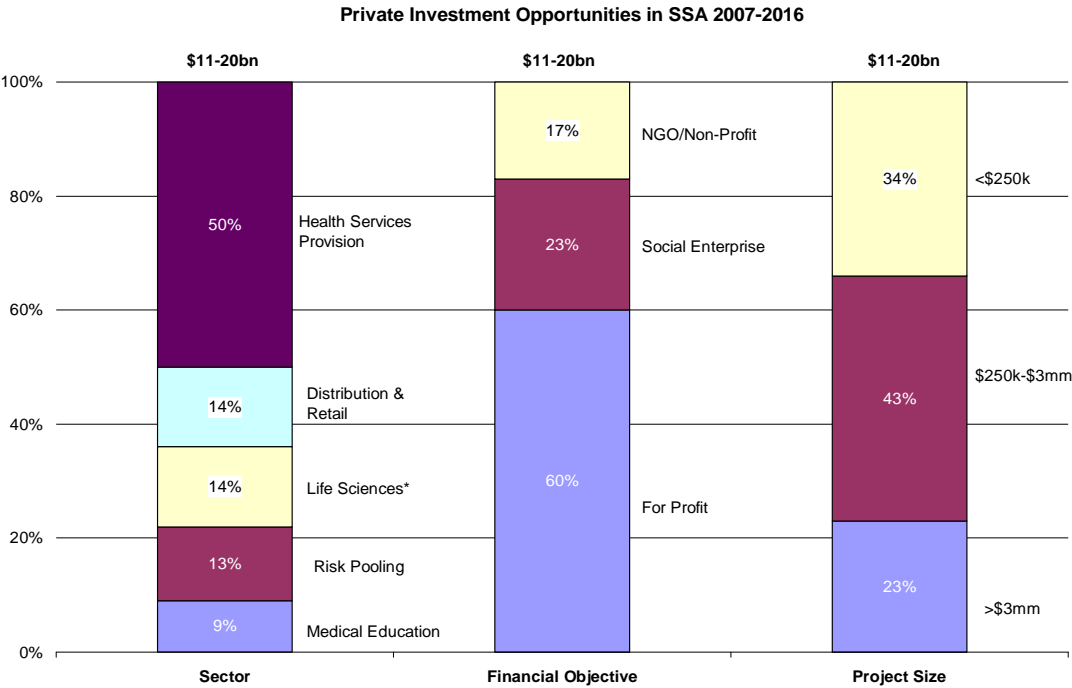
If one is to look at the quantum of purely international capital directly dedicated to health systems in low income countries either via a dedicated fund or indeed a listed stock, you could be forgiven for coming to the conclusion that it barely exists.

Whilst in a 2007 Thematic Investment Paper : Africa the Final Frontier, *Merrill Lynch* identified health investment as 4th on their list of attractive investment sectors, they identified only 5 significant sized listed firms, all in the pharmaceutical sector: From Egypt, *Amoun Pharmaceutical*, *Egyptian International Pharmaceutical*, *GlaxoSmithKline Egypt*, from Nigeria, *Glaxo SmithKline Nigeria*, and from South Africa *Aspen Pharmacare Holdings*. Had they identified 6 companies they would have also mentioned *Netcare Limited*, South Africa's largest private hospital company, who just missed the cut (see below). However, focusing on specific funds or firms misses the very substantial amounts of capital that are either indirectly invested in the Health Systems or are invested via some Social Investment vehicle. The purpose of this report is to review the private capital currently flowing into healthcare systems in Low Income Countries directly or indirectly, to consider ways to enhance such flows and if possible to create greater harmonisation.

There is nothing about Health Systems that makes them the exclusive domain of either the public or private sectors. Indeed in the developed countries, even those with deeply embedded and highly efficient public systems, Health remains an actively invested sector; healthcare represents 15.1% of the S&P500. The text book examples of "defensive stocks" are utilities, consumer staples and pharmaceuticals. For international capital looking to invest in an emerging market the criticality of a company or its sector to the economy is a key metric and as such were there greater opportunities to invest in health related opportunities in low income countries they would have no less strong capability to compete for international investment funds.

The private sector is already a key part of the Healthcare system in the majority of low income countries and continues to be so in model middle income countries such as India. Around 60% of all health care expenditure in Africa comes from private sources, with approximately 50% of services provided by private providers. But more significantly in the case of the region's poor, it is private provision and often crippling out of pocket expenditure that provides the majority of healthcare provision. For example in Nigeria, Uganda and Kenya the poorest quintile receive over 60% of their healthcare from private sources (*Africa Development Indicators World Bank 2006*). It is worth noting that of this expenditure the majority is the simple purchase of drugs (either licensed or unlicensed) from small retail outlets with limited value added in terms of medical advice or appropriate diagnosis.

In its 2006 report, *The Business of Health In Africa* prepared with McKinsey, IFC drew the conclusion that it was both financially impossible and impractical for the public sector (even with donor support) to fund all of the necessary investment in Health Systems in emerging economies. In their report they forecast a \$25-30bn investment need in the sector over the next 10 years of which \$11-20bn is likely to come from the private sector, divided between healthcare provision (50%) with the remainder divided between distribution and retail, product manufacturing, insurance and medical education. Approximately half of these investments are expected to be made by for-profit entities, with NGOs and social enterprises accounting for the rest. In summary it is the IFC/McKinsey forecast that \$5-10bn will be invested in Health Systems by the private sector over the next 10 years.



*Pharmaceuticals and medical products include South Africa. All other areas exclude South Africa

Source: Ministries of Health, National Health Accounts, Country Interviews: McKinsey analysis - *The Business of Health in Africa* IFC, McKinsey & Company 2007

Investment Sources

Local Capital

The IFC/McKinsey Report highlighted clearly much of this investment will come from local groups funded domestically or from other Low Income countries. This is logical for a number of reasons – investments are generally small, with less than 25% of transactions expected to have a size of over \$3mm. Healthcare is a hands-on activity requiring significant management skills, the recruiting of large numbers of local staff and is very sensitive to local policy – clearly a domain best understood by local groups.

Strategic Investors

The second largest investment group will come from strategic investors, whilst there is limited investment by groups from Europe or US, the same cannot be said from middle income countries where there is a greater familiarity with the provision of the relevant services. Expect Brazil, India and South Africa which each have dynamic players in the health space to increasingly look for opportunities in low income countries. As a recent example, *Apollo Hospitals*, one of the largest private hospital groups in India has recently made a \$12mm investment into a 300 bed hospital in Nigeria together with the largest Nigerian HMO group *Hygeia* (see below). It is also reviewing similar opportunities in Ethiopia and Tanzania.

While much of the private sector healthcare investment will be targeted at the high end market, which due to the recent economic growth in Africa is increasingly middle class Africans rather than foreign workers of multinational firms, such facilities have a significant catalytic effect on the entire health system. They provide increased demand for quality medical products, catalysing local entrepreneurs to service them, they have demand for diagnostic testing, they provide a need for higher qualified staff, encouraging the stronger personnel to remain in country, but perhaps most importantly, they pay tax. While it has been argued that such hospitals “pull” good staff away from the public sector hospitals, this is better than such personnel leaving the system entirely and there are many stories of good doctors providing pro-poor services “on the side”.

Pro-poor programmes can also support private providers. For example a government run programme that insures all of the 30 million people poorest in Andhra Pradesh – the *Aarogyasri Programme*, uses predominantly private facilities (160/180) and administrative services are provided by a third party administrator. Facilities include the *Apollo Hospitals* (see above). Indeed 33% of the *Apollo Hyderabad's* volumes are now made up of below the poverty-line Aarogyasri members. Such systems are not without their flaws and the logistical issues of providing coverage to the poorest in society, many of whom lack registration, should not be underestimated, however the achievements of the Indian states to-date in improving healthcare for their “Bottom of the Pyramid” groups provides a clear case study of what can be done.

Strategic investors also make valuable partners as operators of a government or quasi-government project. A good example of such a project is the new Lesotho National Referral Hospital project which is being co-funded by the IFC and Development Bank of South Africa. The winning consortium is run by *Netcare Limited*, the largest South African private healthcare provider, also is the largest outsourcing partner for the National Health Service in the UK. Netcare will design, build, co-invest and operate the 390 bed hospital under an 18 year concession. The PPP contract has ensured that the cost to the Lesotho Government of the new facility is comparable to the cost of the current aged QEII Hospital.

The Lesotho project demonstrates a key issue in the field of system strengthening being that of “technical assistance”. Few of the Low Income Countries have the technical skills to build manage and operate the health system resources that are needed even if funding was not an issue. In this regard it is only via a suitable PPP relationship that the necessary skills can be tapped into to project manage much of the necessary development. However, it should be noted that there are many issues in the design and development of a hospital in a Low Income Country that are not faced in a developed country and so the strategic firms active in this sector in the middle income countries have a very significant role to play. Clearly whether one is in the realm of public or private provision appropriate regulation and oversight is critical. As PPP projects in Europe and other developed economies have demonstrated failures in appropriate oversight can result in significant additional costs, assistance is therefore required in the construction of PPP contracts for developing nations to ensure that lessons from past projects are taken into consideration.

Multinationals Corporations

The next largest investor in the sector is the large multinational firms. It should be of no surprise that in countries like South Africa, it was the large mining firms that first commenced large scale ARV programmes to combat HIV/AIDS. Many form self sustaining communities of their own “at the mine”, with fully fledged health provision for both their workers and their families. Whether acting out of philanthropy or simple self interest – you need healthy workers. It demonstrates that corporate investment in health systems is very significant and is generally provided via the private sector. Healthcare provision is not limited to the mining community. In 2001 Heineken launched one of the first programmes to provide treatment to all its HIV+ employees and dependents in sub-Saharan Africa. Over time this was followed by other Dutch companies including Celtel, Shell and Unilever who came together in 2004 to pool their activities. This initiative has led to the development of the HIF programme (see below). With foreign direct investment into Low Income countries averaging \$9bn per annum (2000-2006) (source UNCTAD), the scope for foreign firms or foreign owned firms to take-up more of the burden of healthcare provision is clearly happening and is significant.

The Original Mission Related Investors

Some might say that the most recent arrival on the low income country health system scene is the “social investor”. Arguably however these were the first international groups to arrive on the development scene, the first examples being the mission hospitals established by faith groups during the 19th century. These have continued to this day, in many countries providing some of the most highly regarded healthcare services. The sector has suffered in recent years due to a decline in church numbers in developed countries, on which many relied, but the group is now going through something of a renaissance as providers of microinsurance schemes look for clinics to meet their growing needs (see *Jamii Bora* below).

The new advocates of “social investing” also miss that this has been a key pillar of the development architecture over the past 50 years either delivered by the investing arms of multilateral organisations such as IFC, AsDB, AfDB, IADB, EBRD and more recently EIB or the bilateral investment vehicles ranging from the Government Development Banks such as AFD, KfW, the regional development banks such as Development Bank of South Africa and East African Development Bank and the European Development Finance Institutions (DFIs) such as CDC/Actis, FMO, DEG, Norfund. These organisations remain active as true “investors” in health systems in low income countries.

Recently the World Bank Group has established a “Health In Africa” initiative to address the need of securing increased capital for private sector entrepreneurs in the region. This is a joint initiative between the World Bank and IFC. In addition to a financing package, the

initiative will provide technical assistance to governments to help address the major challenges faced by private sector providers in the region. The initiative is staffed with 6 members in Nairobi, 2 in Dakar and 3 in Washington DC. An initial \$100mm equity fund is being established to be managed by an existing Emerging Market SME investment group that is proposed to be funded by IFC, Gates Foundation, DEG and the African Development Bank. In addition the IFC will work with the region's banks to facilitate debt lending in the region of \$300-350mm to private sector Health System providers.

In Europe a comparable fund has been launched The Investment Fund for Health for Health in Africa – IFHA. The fund was launched to compliment another Dutch Initiative to catalyse increased risk pooling in Africa (See Stitching Health Insurance Fund – HIF below). The fund is structured as a classic VC fund dedicated to small and medium sized equity investments in private healthcare companies in sub-Saharan Africa. Target sectors are pharmaceutical supplies, health insurance, private hospitals and laboratories. The fund's first investment was in the Hygeia Hospital Chain in Nigeria (see above). It has since invested in Vine Pharmaceuticals, a pharmacy chain in Uganda and Pyramid Pharma, a pharmaceutical distribution firm in Tanzania. Importantly IFHA secured investment from not only the official sector, but also a group of financial investors. The current LPs are FMO, Goldman Sachs International and a Dutch Foundation created by Achmea, Aegon, Heineken, Shell and SNS-Reaal. A further interesting feature of the IFHA fund is its return profile. In the event that investor returns exceed 10%, 50% of the additional return is paid to the Stitching Health Insurance Fund – see Box 7 below.

Box 1: IFHA Investment: Hygeia Nigeria Limited

Hygeia Nigeria Limited was incorporated in 1984 and is now the largest private sector HMO in Nigeria and one of the Top 10 in Sub-Saharan Africa. It has had annual revenue growth of greater than 50% annually since 2002. In 2007 IFHA invested \$1.0mm in Hygeia for a minority stake.

At the primary care level, Hygeia currently operates 27 worksite company clinics within its clients' premises. At the secondary and tertiary levels of care, the company operates its flagship hospital, Lagoon Hospitals/Clinic in Apapa, Ikeja and Victoria Island, Lagos and at the same time, has developed contractual relationships with nearly 200 other clinics and hospitals around the country to create a wide-reaching network.

In order to maximise its response to client's needs, Hygeia is currently developing an electronically managed Nurse Call System as well as Telemedicine Services linked with medical experts overseas.

In 2007 Hygeia was selected as the operational partner for the Stitching Health Insurance Fund in Nigeria, under the name **Hygeia Community Health Plan (HCHP)**. The program initially targeted potentially 115,000 families. This includes 40,000 market women and their families in Lagos and 75,000 farmers and their families of the rural Shonga community in Kwara State, around 500 kilometres north-east of Lagos. Patients pay 10% of the "fair value" premium cost, with the remainder covered by the HIF and other official payments. The scheme has been expanded to include 22,500 low income ICT workers in Lagos. The Kwara state has also announced its intention to co-fund a further 71,000 farmers and their dependants.

Out of the US, OPIC is supporting a third health focused investment fund (**Africa Healthcare Fund**) with insurance to cover 50% of an investors capital should the fund fail. The fund is being launched by a JV between a US based fund – *Seven Seas Capital Management*, and a South African group, *Indigo Venture Partners*. The fund was targeted to have a size of \$100mm, focusing on South Africa, Ghana, Kenya and Uganda. The fund is actively seeking LPs seeking a double bottom line return.

These three examples of donor/Government sponsored funds with non-government participation represent a growing trend towards the blending of the original "mission related investors" with the new players in the mix – the Philanthropic Foundations. This is a critical

development because it represents the stepping stone to the mainstream capital markets, where the amounts of available capital could rapidly swamp the current flow of donor originated funds.

Impact Investment, Social Investment

Invested funds all have some form of mission or investment criteria, selected by investors to create a blend of exposures that fit the purpose of the investment criteria. Few funds would flow to African Healthcare on a pure economic return model. The opportunities are very “local” and as such fully exposed to the local economy (unlike a mining investment for example), generally the investments are long term and finally the investments are currently small – although clearly there is the hope that companies will grow and develop into listed firms or firms that can be on-sold to international strategic buyers.

Fortunately, there is a growing class of investors who specifically look to sectors such as healthcare in their international investing – this concept is described by many names including “Impact Investment” or “Social Investment”. The concept was defined by the *Monitor Group* in their report on the sector (2008) - *“Using profit-seeking investment to generate social and environmental good is moving from a periphery of activist investors to the core of mainstream financial institutions.”*

It has been estimated that the volume of “blended” investments (seeking more than just a financial return) could rise to as much as \$500bn over the next 10 years. While this seems staggering, it is less surprising when it is noted that as much as \$1tr is invested in Socially Responsible Funds in the US. These have traditionally invested via an exclusion policy, avoiding companies believed to be “harmful” and by promoting good corporate governance. However, there is a growing trend towards a more “active” investment strategy that seeks to fund companies that are actively “doing good”. The largest proportion of such funds is US pension funds – for example *TIAA-CREF* and *Prudential* which run some of the largest SRI funds in America for US pension funds. For such funds retaining an ethically positive exposure to the mainstream equities will remain a pillar of their business, but increasing “experiments” with Impact Investing are occurring.

Unsurprisingly focus has started “at home” with **CleanTech** and **Community Based Lending** capturing the majority of funds. CleanTech has become so successful in its own right (and appeals to such a broad investor base) that it is almost hard to think of it as “social investing”. **Community Development** in the US is possibly the oldest social investment sector, but even this is benefiting from a wave of new developments such as the successful growth of community development banks such as *ShoreBank*. A similar initiative is being considered in UK with the Bangladesh based *Grameen Bank* starting *Grameen Glasgow* in the UK, to lend to the perceived unbankable some of whom have been on welfare for 3 generations.

On the international stage the poster child of Impact Investing is **Microfinance** which following the success of groups like *Grameen* and *BRAC* in Bangladesh, groups like *Accion* in Latin America and groups that have now become fully fledged banks in Africa, Microfinance has moved from the domain of pure philanthropy to active investment. Private groups such as *Gray Ghost* have been active investors in the sector for over 10 years. Investment is becoming more mainstream, with groups such as *responsAbility* and *Blue Orchard* providing vehicles for private clients or other mainstream investors to participate in the microfinance market. This is significant in the Health space, because where there is microfinance,

microinsurance is following which offers a tool to significantly increase the penetration of risk-pooling in developing countries (see Risk Pooling below). Microinsurance will never cover the poorest, as by definition it requires people in some form of productive employment, however where systems develop they free resources from the centre that can theoretically be deployed as a safety net for the weakest in society. It challenge is to ensure that Governments do not use such schemes as an excuse to reduce their commitments.

Specialist social investment groups have also begun to appear. *The Acumen Fund* is a US headquartered non-profit fund whose objective is to build transformative businesses that strive to alleviate poverty. The fund started investing in 2001 and has now invested over \$35mm, in 26 enterprises, in 4 key portfolios – health, energy, housing and water. While the fund has relied on philanthropic donations to fund its investments to-date, it has launched a new debt fund that will give investors back their capital and a return commensurate with a risk free investment. Significantly \$22mm of Acumen’s investments is in its health portfolio. These include investments in a full cross section of all the health sectors from maternal healthcare clinics to urban ambulance services, to bed-net manufacturers. Interestingly Acumen does not promote itself on a specific health platform; the firm has the mandate to invest in commercial viable pro-poor businesses. However they have found that when this lens is used the health sector offers one of the deepest pools of potential transactions that reach the greatest number of people and are the most financially viable. Although *Acumen* is still small, the majority of its investments have co-investors generally targeting both a commercial and social return. As with Microfinance, it is hoped that as the number of successful case studies of social investments builds, more capital will be attracted to the sector. Many significant foundations have given grants to Acumen including the *Lundin Foundation* which is a Steward of the fund and holds a seat on its board.

Company	Objective	Company	Objective
A to Z Textile Mills	Long Lasting Anti-Malaria Bednets	Bio-Extracts EPZ ltd (BEEPZ)	Local Artemisinin Production to fight Malaria
Books of Hope	Speaking books for Healthcare education	BroadReach	Efficient Healthcare Distribution
Drishtee	Rural Distribution and Technology Kiosks	First Micro Insurance Agency	Micro Insurance for families in Pakistan
Insta Products	Micronutrient-rich breakfast for millions of Kenyans	AyurVAID	Comprehensive Care for Chronic Diseases
LifeSpring	Hospitals for Maternal and Paediatric Care	Medicine Shoppe India-SEHAT	High Quality, Low Cost Health Centres
Meridian	Affordable Healthcare Clinics across Kenya	Sehat First	E-Health Consulting through Franchised Centres
Sustainable Healthcare Foundation (SHF)	Micro-Franchise Drug Distribution	VisionSpring	Affordable Reading Glasses for the Poor
Voxviva	Remote Healthcare Communications	Ziqitza Healthcare	1298 Ambulances offering service to All
Source: acumenfund.org			

Organisations like the Calvert Giving Fund, Fidelity Charitable Gift Fund, KIVA, Schwab Charitable and the Vanguard Charitable Endowment are becoming increasingly attractive vehicles for investors to channel funds into social investments.

Not all investments of Social Investors need be for profit. Professor Yunus has been amongst others successfully promoting the role of Social Businesses where sponsors would receive their invested capital back, but would not “own” the equity in the established firms. His established entities such as Grameen Bank and Grameen Phone are some of the largest mutually owned firms that adhere to these principles. A Social Stock Market has been proposed. There are certainly an extraordinary number of non-profit organisations that would benefit from such support.

Box 2: R-Joland Hospital

The R-Joland Hospital started as a small clinic in 1982; it has since expanded to a 150 bed hospital. Patients are charged under a tiered structure that charges what clients can pay, sometimes as low as \$1 for a visit. Every day it serves over 200 patients. The hospital has had good years and bad, but has always been financially self-sustaining. However such models generally require a social entrepreneur, in this case Dr. Oladipo. When asked about expanding or opening a new facility he cites access to affordable financing as the barrier: “I don’t know where I would get it.” (The Business of Health in Africa – IFC)

Foundations and Mission Related Investment

For Foundations Impact Investing has also been around for longer than people think, with the creation of “Program Related Investments – PRI”. The legal definition of PRI was established in the Tax Reform Act of 1969 thanks to pioneering work by groups such as the *Ford Foundation*.

“To be program-related, the investments must significantly further the foundation's exempt activities. They must be investments that would not have been made except for their relationship to the exempt purposes. The investments include those made in functionally related activities that are carried on within a larger combination of similar activities related to the exempt purposes”.

Source IRS: US Department of the Treasury

Generally Foundations consider PRI investments as part of their 5% grant allocations. Most foundations do some PRI to complement their grant giving the range varies with some of the more recent foundations such as the *Shell Foundation and Skoll Foundation* having a greater percentage of PRI vs. grants. This can also include grants to groups who themselves are effectively acting in a PRI manner such as groups that support SME’s such as *Grofin and Business Partners International*.

However a number of foundations are realising that the social value of their foundations could be transformed if a part of the foundation endowment was also invested in pro-mission companies – hence the concept of “mission related investment”.

Box 3: Kellogg Foundation

The W.K. Kellogg Foundation has earmarked \$100 million of its endowment assets for a pilot program in mission-driven investing. Mission-driven investing (MDI) is a process whereby the Foundation invests its assets in a way that realizes both financial and social returns, also known as “double bottom line” investing. Of the \$100 million, \$25 million has been designated to mission-driven investments in southern Africa, while the balance – \$75 million – will be used for investments in the United States.

The goal of the Kellogg Foundation's mission-driven investment program is to understand how to better leverage the Foundation's assets for mission purposes. It hopes to recycle capital and preserve its endowment while driving mission impact and potentially extend upon this initial effort.

“Ultimately, we want to make a positive difference by improving opportunities for individuals, families and communities, and still meet our financial investment goals,” says Sterling Speirn, president and CEO. “Mission-driven investing is another tool that we can use to leverage our resources. Among other things, it allows us to preserve and grow our financial resources, while realizing greater social change by being able leverage our endowment to serve the public good.”

In the case of the giants of Global Healthcare philanthropy, including the *Bill & Melinda Gates Foundation* (“BMGF”), the *Clinton Foundation*, *Ford Foundation* and *Rockefeller Foundation*, program-related investments are no longer just a nice to have, or even a means to extend the life of the foundation, but rather a critical tool in the armoury to achieve the foundation’s mission. The Global Public goods of new medicines etc that any of the groups have enabled the creation of, or expansion of, will come to nothing if the infrastructure is not in place to ensure their effective delivery.

Both the *BMGF* and *Rockefeller Foundation* have made private sector health investment a key focus in the last two years, with the *BMFG* partnering with *IFC* for its new Health Fund and the *Rockefeller Foundation* funding a series of research pieces on the sector which will be published during the summer of 2009.

The investment need was clearly demonstrated by an interview given by Victoria Hale the founder and Board Chair of *OneWorld Health*, a California based non-profit pharmaceutical firm, where she cited a critical dependence upon the need for better pharmaceutical distribution and doctors to enable the drugs that her firm produces to achieve their true potential. These bottlenecks cannot be solved with grant dollars alone. *OneWorld Health* has developed Paromoycin, an antibiotic that tackles Black Fever, *Visceral Leishmaiasis*, a potentially fatal disease that kills over 500,000 per annum predominantly in some of the poorest states in India and has developed a synthetic version of the anti-malarial compound Artemisinin.

How to Ensure Greater Investment by International Investors into African Healthcare

One of the key issues limiting international financial investor’s direct participation in the African Health sector is the current size of transactions, where the execution costs can literally swamp the value of the investment. However the development of a group of dedicated funds with local investment personnel on the ground is happening and while the majority of the investors to date have been from official sources, the ground is being laid for institutional participation with every case study further breaking any myths surrounding the investment into Healthcare.

IFC/McKinsey looked into the key areas that would drive greater private sector investment into the sector and identified four.

1. Better regulation: both of products and services
2. Including as many people as possible into risk pooling mechanisms
3. Channelling a portion of public and donor funds through the private sector
4. Improving access to capital, including by increasing the ability of local institutions to support private healthcare enterprises

As discussed above Africa is not short of healthcare provision, every village in every district in every low income country will have someone offering to provide health advice or services. The tragedy is the quality of that service, generally provided by untrained professionals and offering drugs that prey on the desperation of a family for some solution to illness. The region is plagued by sub-standard drugs, with often the final sellers unable to identify between genuine and counterfeit products. Does this require Government to take over the entire drug distribution system or merely to provide better regulation?

An interesting example of the latter choice can be seen in Tanzania with the *ADDO programme* – The government decided that it would never be able to place a trained pharmacist in every rural village and that even if they could afford it, they would run into the traditional healers whose reputation in the villages remains pre-eminent. As an alternative they gave the traditional healers an opportunity to become regulated pharmacists. Each is required to attend a series of training programmes at the end of which they are provided with signage to indicate that they are a qualified health provider and they are brought into an official distribution network for real drugs. The traditional healers being highly commercial welcomed the opportunity to provide cures that actually work, demand for illegal drugs falls and regional health can improve significantly. Once inserted into a distribution network, the registered ADDOs have already started ordering other products to come “on the lorry” from Dar, with simple hygiene products high on the list. Examples of successful blending of traditional medicine and western medicine can be seen in both India and China. It is therefore encouraging to see an African government adopt a similar approach, where the only investment necessary has been one of training and regulation.

The need to provide better risk-pooling mechanisms is not controversial. In all developed health markets risk-pooling exists to prevent the catastrophic consequences that illness of a family member can have. Historically risk pooling has not occurred in the poorest countries either due to the perceived financial resources (lack thereof) of the market, the “risk” particularly in countries with high HIV/AIDS disease burdens and the administrative challenges. Fortunately this situation is changing with the number of insured in low income countries rising through a range of government and community based schemes. (see Appendix for a fuller analysis on Risk Pooling).

The remaining two challenges of directing a greater proportion of government and donor aid via the private sector and the provision of greater funding to the sector are by definition “works in progress”. Clearly there are an increasing number of examples where private sector entities are providing valuable services for which government is one or even a major customer, with the *Aarogyasri Programme* in India representing an excellent example providing coverage to 30 million.

However, Government actions will also be influenced by donor activities. If the donors promote and /or back the further development of state health provision, clearly the state will start to take up a greater proportion of the health care provision envelope. However, this runs the risk of simply creating greater AID dependency. If in contrast the donors actively encourage public-private partnership by the developing governments, not only will that build a sustainable players in the market, but it will also unlock the provision of greater (and lower cost) financial capital to the sector as lenders will have greater confidence in the safety of their capital.

Conclusion

The primary objective of health system strengthening must be for Governments of developing countries to ensure a sufficiently funded and functioning system. This does not mean that provision of all parts of the Health System value chain need to be, or indeed are best provided by the public sector. Some areas, such as oversight and governance must always be the domain of the national governments. Others such as provision of services to the poorest are generally best provided by public provision, but for almost all other parts of the system either a public and private model are possible.

The alternatives for private sector investment in Low Income Country healthcare are broad and can appeal to the full range of investors from donor backed funds, through foundations, individuals and more recently some of the socially motivated funds. Fortunately there are a

growing number of successful case studies of such investments that are serving as a beacon to attract greater funding into the sector. Furthermore as the sector expands and transaction sizes increase, the interest from the international investment community will grow. The IFC/McKinsey report provided a valuable tool in not only identifying the areas where greater investment could flow, but also the steps that recipient countries could take to ensure greater investment. Few would call their proposals controversial and as such they serve a roadmap for donors to play a catalytic role in ensuring greater private sector participation in a sector.

Appendix

Risk Pooling

In 1987 with the backing of the WHO and UNICEF, African Health Ministers signed what has come to be known as the Bamako Initiative, which was subsequently adopted in 35 African countries. One of the key principles of the initiative was increased involvement of the community – including financial participation – and decentralisation of health decision-making and management, especially in terms of primary healthcare. Communities were encouraged to set up a “drug revolving fund” where by a stock of essential medicines were provided. These would be “sold” with a margin, which together with user fees would allow the clinics to purchase more drugs and fund their operating expenses. The resources generated are managed at a local level by the community. One of the core features of the Bamako Initiative was a recognition that the poorest would struggle to pay user fees and it was proposed that those who cannot afford to pay should benefit from subsidies or exemptions.

While in many respects the aims of the initiative were laudable and there has been movement on the ground with UNICEF reporting that in its 1st 10 years it had led to the revitalisation of 6,000 community based healthcare clinics, the initiative alone is clearly not sufficient to meet the basic healthcare needs of low income countries. In practice the equity component of the Bamako Initiative has been widely neglected, with central government seeing the schemes as an excuse to reduce regional funding. In certain cases this has led to increased levels of exclusion and impoverishment. In a detailed study from 2003-2006 in DRC, Burundi, Mali, Chad, Sierra Leone and Haiti, *Médecines sans Frontières* has repeatedly demonstrated that in high poverty regions, the Bamako policy of charging user fees leads to reduced clinic visits and ultimately a failure of the system, as too frequently patients are only brought to doctors when it is already too late. *MSF* argues compellingly for a “Free at Source” health system in low income countries.

While clearly an equitable structure that ensures those who can pay do and those for whom free healthcare should be a basic human right should be a primary objective, local communities are often simply not able to meet their communities needs due to lack of sufficient funding from the centre.

One tool that could help meet the financing needs of the communities and ensure a “Free at Source” health system is **Risk Pooling**. Risk pooling is central to the health systems of all developed and middle income countries. It is only Low Income Countries where widespread risk pooling is notably absent. This is particularly striking when one considers that the majority of the most vulnerable people in the LICs live in rural communities with a very seasonal cash flow. Furthermore, many of the worst diseases are counter cyclical to their community’s cash flow i.e. they are most acute during the rainy seasons or winter periods when rural incomes are at their most stretched. It would seem therefore that there was seldom a more clear-cut case arguing for the need for risk pooling mechanisms to enable farmers to “sell/barter” a portion of their produce at the time of harvest in exchange for free access to a functioning clinic throughout the year.

The poor are well known to perform group insurance through family members, the village or other such informal mechanisms. These can often cope with acute conditions, a broken bone etc where the patient once cured returns to the community and can repay any debt incurred. It is much more challenging for chronic illness, of which the scourge of HIV/AIDS is perhaps one of the greatest, but there are many other examples such as diabetes, heart conditions etc. Even in rural parts of China which would rank as high undeveloped countries if they were indeed separate countries, such challenges have become increasingly the norm as basic

healthcare provision has been catered for. For this reason health insurance becomes a critical building block to any successful health system.

Once again the question can be asked should government be the provider of the insurance or the facilitator. Whilst a centrally managed national health system will always be able to provide the lowest cost provision, it requires a functioning tax system. In low income economies where often over 50% of the population is in the informal economy this is simply impractical. But this does not mean that the demand for participation in an insurance scheme is not there. African leaders appear to be voting with their feet. Nigeria has mandated that every worker in the formal sector must participate in an insurance scheme, but significantly the schemes are being administered by private sector groups. Similar policies are being adopted in Uganda and Rwanda with initial success. Such opportunities lead to the private sector investment that the countries so need either attracting new foreign players into the market or enabling existing groups to make the case to foreign investors for additional capital.

The fact that the private sector is already performing many of the functions that could have been played by Government in for example a UK system can complicate change. For example, when the Ugandan Government announced its intention to establish a social health insurance scheme, a variety of employer associations, insurance companies and private health providers lobbied against the government’s proposal that it administer the plan. The Ugandan Government is now working with the private sector to ensure their participation in the plan. Kenya has faced similar issues with formal workers uncomfortable that their health insurance be managed by the State.

Risk pooling does not have to be the domain of those in the formal sector alone. Some middle income countries such as China, Colombia, Chile, the Philippines, Thailand, and some countries of Eastern Europe have implemented risk-pooling at a national level with some success. So far only in Rwanda and to a lesser extent Ghana have national programmes been attempted. Securing coverage of the formal sector is becoming more common. The challenge is now to secure coverage of the poorest in the respective communities. Fortunately some promising models are developing but the scale of the challenge should also not be underestimated.

Box 4: The Global Micro Insurance Landscape

It is estimated that only eighty million out of the world's 2.5 billion poor are now covered by some form of micro insurance. Most remain without access to this critical financial service. In India and China, where organizations are estimated to serve nearly 30 million micro insurance clients each, the percentage of poor lives insured hovers below 3%. In Africa this figure is much lower – just 0.3% of the continent’s poor are insured. According to recent data, in 23 of the poorest 100 countries in the world, there is currently no identified micro insurance activity, representing an unserved population of 370 million. (*Micro Insurance Agency*)

In their April 2007 study “*The Landscape of Microinsurance in the World's 100 Poorest Countries*” – *Jim Roth, Michael J. McCord, Dominic Liber* found that the highest demand was for **Health Products** and **Life Products** followed by **Property Insurance** and **Accidental Death and Disability (AD&D)** cover. Their researchers identified coverage of 78.5 million people divided between the following categories. N.B. Many providers cover more than one sector therefore the total number of lives covered is less than the totals of the different sectors. E.g. in China alone one product provided by the *All China Federation of Trade Unions* provides limited coverage in all 4 sectors for 28.3 million people.

<i>Millions Covered</i>	Life	Health	AD&D	Property
Americas	7.5	0.45	0.1	0.06
Africa	2.0	3.0	1.6	1.6
Asia	54.2	31.7	39.2	34.6
Total	63.7	35.2	40.9	36.2

Jim Roth, Michael J. McCord, Dominic Liber: 2007

Of the Low Income Countries, Micro Health Insurance was found in Asia (China, India, Laos, Thailand and Vietnam) in Latam (Bolivia, Ecuador and Peru) and SSA (Burkina Faso, Cameroon, DRC, Ghana, Mali, Mauritania, Rwanda, Senegal, Tanzania and Uganda).

Scaling Up Health Risk Pooling

Leveraging Trusted Community Organisations:

Mutuelles de Santé: These are locally-organised groups formed by community members in cooperation with local stakeholders, such as village chiefs and public administrators, healthcare providers and their communities. These groups pool risk and resources to provide health insurance for themselves. It is generally agreed that small scale community systems are not the panacea for health insurance in poor countries and that success can only be achieved if such systems are scaled up and integrated within a national system. To-date only Rwanda has achieved a full scaling up of its Mutuelles de Santé to a national programme, now covering more than 75% of the population. However, Mutuelles de Santé are common in Ghana, Mali and Senegal and each is undertaking programmes to further scale up their programmes.

Microfinance Institutions: Just as microfinance has proven that banking the unbankable represents a viable business model, microinsurance is growing as a parallel industry to insure the uninsurable. As with much in microfinance the leaders in the field are the Grameen group with established Grameen Kalyan which was followed by BRAC. In India traditional MFIs such as Uplift have also layered health insurance onto its microfinance offerings.

It is ironic that funeral insurance is where most African based insurance starts, rather than health insurance! But that is changing and some early demonstration models are proving encouraging. It has long been recognised that the greatest credit risk in microfinance is a health incident. This is particularly true in the case of African microfinance, where HIV/AIDS has impacted such a high percentage of the very customers microfinance seeks to serve.

The significance of microinsurance and a risk-pooling mechanism is that microfinance continues to be the recipient of very significant international investment flows, but while the broad concepts of microfinance are applicable in Africa as Asia, the differential health prospects in the two regions has been one of the primary reasons for the more muted growth in Africa. As such joint microfinance and microinsurance is arguably even more critical in Africa.

A well developed example of such a programme is provided by **Jamii Bora** in Kenya. For 1,200 shillings per year (£1 per month) (see box 5 below).

Thanks to a \$24.2mm grant from the Bill & Melinda Gates Foundation, the Micro Insurance Agency is also expanding its insurance product offerings with the target of covering 2.4 million people by 2012 (see box 6 below).

Box 5: Jamii Bora Health

In the year 2000 we identified hospital costs for members and their close relatives as the most common cause of default in loan repayments. With the health and life benefit in place it has been possible to keep the default rate very low.

Jamii Bora Health provides coverage for one adult and a maximum of 4 dependent children. The health benefit covers all in-patient costs in 43 partner hospitals which include both the faith based hospitals and several Government hospitals. The main hospital used in Nairobi is St Mary's Mission Hospital in Langata. Complicated heart surgeries and advanced cancer treatment as well as ICU patients are treated at Kenyatta National Hospital.

The Jamii Bora Health benefit for members covers all in-patient treatment including maternity and does not exclude members affected by HIV and AIDS. There is no upper limit to the cost at our partner hospitals. Yet the programme has been self-sustaining from the beginning and Jamii Bora has never requested for any subsidy from any donor or partner hospital.

The Jamii Bora health programme has benefited many members and has saved many, many lives. When we save the life of a poor mother we have saved five to eight children from becoming orphans and street children. (*Jamii Bora*)

Box 6: Micro Insurance Agency

In February 2008, the Bill & Melinda Gates Foundation provided the Micro Insurance Agency with a \$24.2 million grant. The funding will help Opportunity International's subsidiary, the Micro Insurance Agency, greatly expand its insurance products to the poor in Africa, Asia and Latin America and will enable the world's first stand-alone microinsurance agency to enter 11 new countries and provide life, health and crop insurance to 21 million poor people by 2012.

Opportunity International began offering microinsurance in 2002 and established the Micro Insurance Agency in 2005. Currently, the organization has 675,000 life, credit or crop insurance policies covering 3.3 million poor people in 10 African and Asian countries. Among its early innovations, the microinsurance pioneer developed a viable life insurance product in Uganda that includes coverage for persons with HIV/AIDS. In Malawi, a crop insurance program protects farmers from severe drought that caused starvation in their villages only a few years ago.

The Micro Insurance Agency has developed innovations and technology to create affordable insurance products for individuals and groups of the poor. A typical life insurance policy costs about \$1.50 per month and pays a death benefit for the head of household, spouse or child. "This keeps the economic shock of losing a family member from sending a working family back into poverty," Leftley explained. The life insurance product is so popular that about 40,000 new clients are signing up per month in the Philippines and 12,000 per month in Ghana.

In Malawi, the agency has successfully tested crop insurance for farmers in a country that frequently experiences drought. The insurance is combined with a loan that enables farmers to obtain higher quality, drought-resistant seed and fertilizer. The two-year pilot has been so successful that the World Bank, which provided initial funding, has selected the Micro Insurance Agency to expand crop insurance throughout Sub-Saharan Africa in the coming years.

The Bill & Melinda Gates Foundation grant also will enable the agency to expand into health insurance. "Health insurance is the most critical need of the poor and the most limited today. Few products exist and most are prohibitively expensive or are based on complicated models used in the developed world," Leftley said. "Our plan is to develop affordable and easy-to-use health insurance, and to enable 2.4 million people to gain access to healthcare services as we test, refine and roll out new products over the life of this grant."

The Micro Insurance Agency acts as an insurance broker and is working with many large international insurance companies that underwrite the policies. The organization has developed breakthrough efficiencies in its back-end administration that make the insurance affordable and enable payment of claims in an average of six days.

Subsidised Schemes

One of the most successful recent subsidized schemes is the Stitching Health Insurance Fund (HIF) established by Kees Storm (a former CEO of the Dutch Insurance group AEGON). The fund's objective is to catalyse insurance of the currently uninsured via subsidy payments. It represents a powerful example of private sector and donor collaboration, a private sector initiative created by the support of *Shell, CelTel, Unilever* and *Heineken*, in 2006 it secured a \$100mm pledge from the Dutch Government. While the HIF will continue to require donor funds to expand each project is designed to become self funding as the number of insured members becomes sufficiently large and the start-up costs of the programme are amortised. Furthermore, it is anticipated that premiums will be able to rise over time as the users see the benefit of the services provided.

In Uganda, *MicroCare* has also launched a partially subsidized scheme. *MicroCare* is a for-profit insurer that seeks to leverage its proprietary IT system, delivery network and technical expertise to bring health insurance to the poor. Currently *MicroCare*'s insured base is 70% formal sector 30% informal sector, but it is targeting a switching of these percentages over the next 5 years. Currently informal sector premiums are subsidized (25%) but *MicroCare* plants to transfer the full premium cost to consumers after the product gains credibility.

Box 7: Stitching Health Insurance Fund

In June 2006, the Dutch Ministry of Foreign Affairs provided the Health Insurance Fund with a €100 million grant for the development and implementation of insurance schemes for a period of six years.

Nigeria: the Community Health Plan

The first Health Insurance Fund program was started in Nigeria in early 2007 under the name Hygeia Community Health Plan (HCHP). The program initially targeted potentially 115,000 families. This includes 40,000 market women and their families in Lagos and 75,000 farmers and their families of the rural Shonga community in Kwara State, around 500 kilometres north-east of Lagos. Patients pay 10% of the "fair value" premium cost, with the remainder covered by the HIF and other official payments. For example the Government of Kwara match funds the HIF payments for the programmes in Kwara state.

Whilst 10% participation is modest, for the Government this represents in many cases the first time these families have been brought into the formal economy. The families are willing to pay as the benefit is immediately visible, unlike a tax payment to the centre where there is no guarantee even if the Kwara state had wanted, that the funds would have returned to fund the clinics.

In October 2008 the World Bank joined as a major donor, signing a \$6mm contract to establish prepaid health insurance for 22,500 low income ICT workers in Lagos. The Kwara state has also announced its intention to co-fund a further 71,000 farmers and their dependants.

The benefit package provides coverage for the most common medical problems that are found among the target groups and consists of primary care, limited secondary care and medication, including HIV/AIDS treatment.

Executing partner

The local executing partner of the program is Hygeia, the largest Health Maintenance Organization (HMO) in Nigeria (see below). Hygeia has contracted 19 clinics and hospitals for the Health Insurance Fund program where the scheme beneficiaries can obtain their medical services. Thirteen in Lagos and six in Kwara State. The clinics are selected on the basis of a medical due diligence of clinics carried out by PharmAccess and Hygeia.

Of the selected clinics thirteen are private and six are public. Eight of the clinics provide only primary health care, and eleven are referral centres providing primary and secondary care.

Upgrading programs

In November 2006, prior to the start of the program, Hygeia and the providers, with assistance from PharmAccess, developed upgrading plans for the clinics. Thirteen of these providers, ten in Lagos and three in Kwara State, are currently being upgraded. Of these facilities three are public and ten are private providers. Within the program funding is also allocated for improvement of the physical infrastructure. In Kwara State the Governor has allocated funds from the State budget for two clinics, amounting to \$ 75,000 per clinic, to rehabilitate them up to the required standards. Hygeia has provided training for the medical directors, nurses, pharmacists, laboratory technicians and administrative staff of all health facilities involved in the program.

Enrolment in the program is voluntary; registration is done per family. Special Hygeia 'marketing teams' go out into the field and assist people in the process of signing up for the scheme. The teams use laptops to register beneficiaries of the program on the spot. After a person has paid, a photograph of him/her is taken, personal identification data are entered into the computer, and within a few minutes the portable printer produces the insurance ID card. With this card the person can obtain access to health services in the designated health facilities nearby. By the end of 2008, more than 45,000 people had enrolled. The 19 clinics have, since the enrolment started in 2007, noticed a great increase in the number of patients.

The Lagos and Kwara programmes have achieved international acclaim with Margaret Chan President of the World Health Organisation (WHO) proclaiming the Kwara project to be one of the most successful community health insurance schemes in the world.

Tanzania: Health Insurance Fund proposal

In December 2006 a scoping study was carried out in Tanzania as a first step to determine whether this country is suitable for

implementation of a Health Insurance Fund program. The scoping study demonstrated that Tanzania offers the right environment and opportunities for a Health Insurance Fund program. Mainly for the following four factors: (1) The health insurance market is growing. (2) The Tanzanian government explicitly welcomes involvement of private actors in health care. (3) Tanzania already has a national health insurance program (NHIS) targeting civil servants, which currently covers around 2.3 million people and is growing. (4) The country has local HMOs or insurance companies that potentially qualify as executing partner of the program.

HIF has appointed a local insurer, Strategis Insurance Limited, as the executing partner for the program. Several potential target groups have been identified. These include workers at the Dar es Salaam fish market (fishermen, auction workers, cooks); people with a micro credit in Dar es Salaam and Arusha/Moshi; and coffee farmers involved in organic coffee farming in Northern Tanzania.

The implementation of the program is expected to start in the second quarter of 2009.