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Does the private sector help improve healthcare systems in developing countries?

There is no denying the healthcare progress made by developing countries. However, the sector needs additional financing to meet growing needs. What is the role for private investment?

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Healthcare in developing countries undeniably improved between 1990 and 2010, yet there is still much to be done, particularly in Africa, where the health-related Millennium Development Goals are not going to be achieved. The African continent represents 11% of the global population and 24% of total morbidity.

Improving the population's health means taking full account of the problem's social dimension. The general improvement in life expectancy and health masks the fact that a large portion of the population lacks access to these healthcare improvements, especially the poorest sections of the community. In sub-Saharan Africa and South Asia, only 5 to 10% of people are covered by formal social protection (*versus* 20 to 60% in middle-income countries). This goes some way towards explaining why it is the patients who bear almost half of all out-of-pocket health costs. Worldwide, 100 million people fall below the poverty line every year as a result of their healthcare costs.

To overcome these challenges, massive investment in healthcare systems is essential. In the 49 poorest countries, the sector's financing requirements for the period 2011–2015 are estimated at USD 169 billion. Although the health sector is receiving increased development assistance, governments in developing countries are still struggling to meet healthcare needs and put in place a healthcare system.

The private sector can and must participate in this crucial investment effort. Whether it is supplying drugs, providing outpatient care or even assisting with hospitalisation, innovative private-sector initiatives, sometimes in partnership with government funding bodies, can help develop affordable, quality healthcare services. However, relying on a wholly private strategy is not feasible. Governments must regulate and oversee private-sector practices and be involved in financing the healthcare costs of the poor sections of the population. For the health sector in particular, solutions must be sought through public-private partnerships so that all stakeholders can contribute, on the basis of their skills and resources, according to their goals and respective strengths. —

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Does the private sector help improve healthcare systems in developing countries?

Improving health outcomes by gearing health systems towards universal health coverage

While all countries face health challenges, the situation is most acute in the countries that are home to the "bottom billion". While still fighting against the major communicable diseases and maternal and child conditions, they also face the increasing burden of non-communicable diseases and injuries, with health systems that are often underfunded. Within this context, the notion of universal health coverage (UHC) has become the guiding vision for strengthening health systems.

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Today the world is less than thousand days from the 2015 deadline of the Millennium Development Goals (MDGs), which were established to guide global efforts at development, especially in the most vulnerable countries, using quantifiable targets against to which measure progress (United Nations, 2000). Health is one of the key focus areas of the MDG framework (Table 1). But health is also indirectly linked to the other goals such as the eradication of poverty and hunger (Goal # 1), since health interventions are increasingly seen as priority actions for equitable socio-economic development and for breaking the illness-poverty cycles both at an individual and at a country level (World Bank, 1993; WHO, 2001; Bloom et al., 2011).

Many of the most vulnerable countries have recently been moving towards better health outcomes. Between 1990 and 2011, the global under-five mortality rates had come down by 41%, and between 1990 and 2010 maternal mortality ratio had dropped by 47%, with the most striking achievements coming from the WHO Western Pacific region (Figure 1). Many countries have also been making demonstrable progress in controlling and treating some of the major diseases, such as HIV/AIDS, tuberculosis and malaria; for example, the number of people living with HIV and accessing antiretroviral treatment (ART) increased by 63% from 2009 to 2011 (UNAIDS, 2012). Globally, mortality rates for tuberculosis have fallen by 41% since 1990 (WHO, 2012).

Despite the recent impressive progress in health outcomes, the progress has been uneven between countries and within countries, and consequently, many of the most vulnerable countries will most probably not meet their targets for the health MDGs (United Nations, 2012A). Furthermore, these countries face health challenges not directly captured by the MDG framework, notably an increase in the burden of non-communicable diseases (NCDs) brought about by ongoing epidemiological and demographic transitions. It has been estimated that 80% of NCD-related deaths happen in low- and middle-income countries and that NCDs also kill at a younger age in these countries, where 29% of NCD deaths occur among people under the age of 60, compared with 13% in high-income countries (WHO, 2011).

"Many of the most vulnerable countries will most probably not meet their targets for the health MDGs."

Identifying health system needs

Several gaps exist in the health systems in vulnerable countries. In the area of health service delivery, many countries face important geographical limitations in making

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services available. This could be related to investment priorities (skewed resource allocation to specialised care instead of primary care) but also to the overall shortage of health workers and the failure to motivate them and/or retain them in remote areas. In 2006 it was estimated that there is a worldwide shortage of nearly 4.3 million health workers[1] (WHO, 2006). The quality of the health service provided is also one of the major health system challenges, especially in resource-constrained settings where there are structural quality constraints, such as poor infrastructure. Health information systems are often unable to provide data that would enable adjustment and reform in health policies. Affordability and availability of medicines, and their quality, are other challenges[2]. Besides these health system gaps, there are several problems that cut across the whole health system, notably inequity and inefficiency. Inequities can be found in the financing mechanisms: countries relying on out-of-pocket payments (OOP) impose an inequitable financial burden on households. Inequities in access to services (for financial or non-financial reasons) are also widely reported from many countries. Finally, there are numerous sources of inefficiencies[3], relating to low technical efficiency (for example the ratio of inputs/outputs at the hospital level) or low allocative efficiency, which is interpreted in terms of the mix of health interventions produced at the right time in the right place that would maximize population health for the available resources.

"There are several problems that cut across the whole health system, notably inequity and inefficiency"

THE RESOURCE AND HEALTH FINANCING GAPS

The resource and health financing gaps are one of the most crucial health system challenges. The continuous heavy burden of disease in the most vulnerable countries is further accentuated by the low levels of national income, the informal nature of the economies and a restricted domestic resource base that limits the possibility of countries' acting on the major health conditions and their risk factors. In 2009, the High Level Task Force for Innovative International Financing for Health Systems (HLTF) estimated that by 2015 the low-income countries would need to spend an annual average of USD 60 per capita on health in order to ensure coverage with a relatively limited set of key health services, while presently the average low-income country spends only USD 32 per capita on health[4] in 2010 (Figure 2).

The level of total health expenditure can be broken down into three major components: (i) out-of-pocket expenditure for accessing health services, (ii) pooled funds that rely on prepaid contributions (tax, general government revenue or insurance contributions), and (iii) external funds – in those countries where international support for health is channelled. When systems for prepayment and pooling are weak, people wishing to access health services are forced to pay for them out of their own pockets. ▶▶▶

[1] The same report identified 57 "crisis" countries (39 of which are in Africa) which have fewer than 23 health workers for every 10 000 people (WHO, 2006).
[2] In low-and middle-income countries over the period 2007-2011, despite the international initiatives that rely on public and private funding, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, and UNITAID, the available data shows that, on average, the availability of selected essential medicines was 51.8% in public sector health facilities and 68.5% in the private sector (United Nations, 2012B).
[3] The 2010 World Health Report enumerated the ten most common areas of inefficiencies and emphasised which each country would need to tailor their actions toward, depending on the context and available tools, and strategies for increasing efficiency of the health system (WHO, 2010).
[4] This included all domestic funding sources and financing provided by external donors, which averaged 28% of total health expenditure for these countries.

TABLE 1: HEALTH MDGS AND TARGETS

Health goals in the MDG framework	Targets linked to these goals
Goal 4: Reduce child mortality	Target 4.A: Reduce the under-five mortality rate by two-thirds between 1990 and 2015
Goal 5: Improve maternal health	Target 5.A: Reduce the maternal mortality ratio by three-quarters between 1990 and 2015
	Target 5.B: Achieve universal access to reproductive health by 2015
Goal 6: Combat HIV/AIDS, malaria and other diseases	Target 6.A: Have halted and begun to reverse the spread of HIV/AIDS by 2015
	Target 6.B: Achieve universal access to treatment for HIV/AIDS for all those who need it by 2010
	Target 6.C: Have halted and begun to reverse the incidence of malaria and other major diseases by 2015
Goal 8: Develop a global partnership for development	Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Source : UN, 2001/2002

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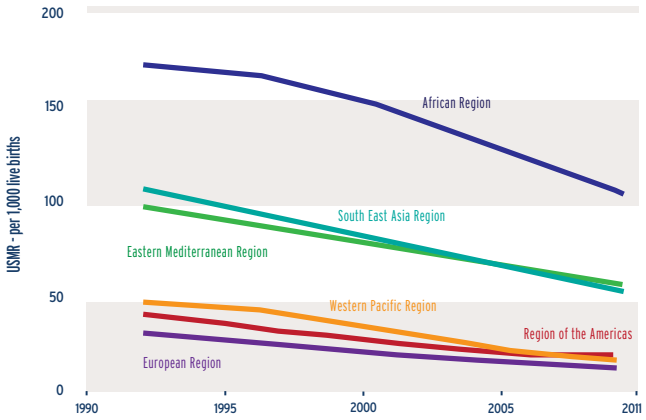
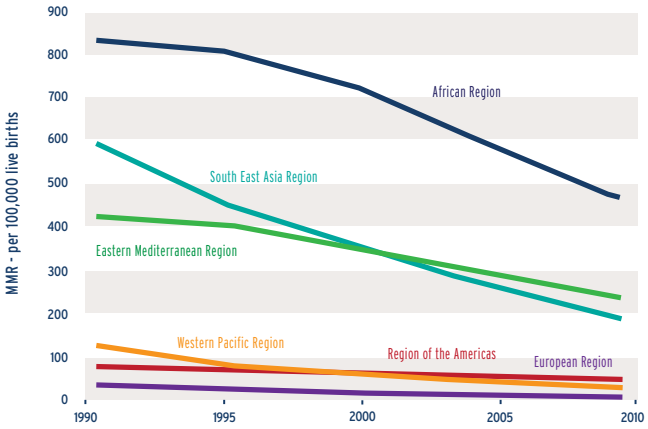
FIGURE 1 A & B. EVOLUTIONS IN HEALTH MDGS 4 & 5

Evolution in under-five mortality rate (u5mr) by who region, 1990-2011



Source : WHO, 2012

Evolution in maternal mortality ration (mmr), by who region, 1990-2010



Source : WHO, 2012

▶▶▶ This out-of-pocket spending on health leads to financial catastrophe and impoverishment for some people and deters others from seeking or continuing treatment. Due to the low level of government spending on health, the poorer countries rely the most on out-of-pocket payments, which represent almost 50% of total health expenditure in low-income countries, compared with 30-35% in middle-income countries and 20% in high-income countries.

In low-income countries[5], government spending on health, in absolute terms as well as in relation to GDP, varies among countries and is generally very low – on average, general government health expenditure (GGHE) is at 2.4% of GDP and USD 12 per capita in low-income countries, compared with 6.8% of GDP and USD 2,400 per capita in OECD countries. Very few African Union countries have reached 15% of GGHE over general government expenditure, as was pledged in the 2001 Abuja declaration (Organisation of African Unity, 2001).

"Basically all countries rely on a pluralistic health service provision model."

External funding from development partners has been and still is a crucial aspect of reducing the health funding gap. The level of external financing for health almost tripled between 2000 and 2011, from USD 11 billion to USD 28 billion. There is an urgent need to keep focusing on international efforts in supporting the most resource-constrained countries. However, looking at the long-term objectives, it is domestic health funding and domestic efforts to strengthen health systems that will determine the success or failure of reaching UHC and better health outcomes.

DEVELOPING HEALTH SYSTEMS TOWARDS UHC – WHAT ROLE FOR THE PRIVATE SECTOR

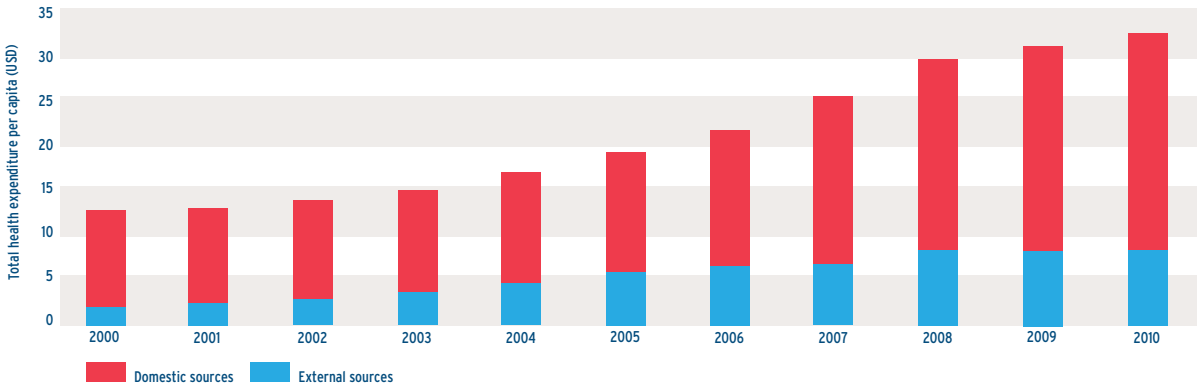
UHC is a goal that conceptualises the main objectives and values of health system strengthening. It is based on two overarching and interlinked objectives: that everyone has access to good quality health services they need – including treatment, prevention, promotion and rehabilitation; and that no one suffers financial hardship for paying for those health services. The role of mandatory funding mechanisms, based on the taxation power of governments is crucial for moving towards the UHC objective. It aims at distributing the financial burden equitably among the population and ensuring access to and the affordability of health care for all, and clearly remains a public sector function. In practice this means that public funding is the key to moving towards UHC. Voluntary funding mechanisms in the form of private health insurances (community-based health insurance, commercial health insurance, etc.) could be a supplementary strategy in some contexts for reducing out-of-pocket expenditure, but their impacts on the overall equity of the financing system could be negative if they hamper cross subsidies among different population groups. When it comes to service provision, the answers become much less obvious. The role of the state as a regulator of health service provision is one of the cornerstones of a well-functioning health system, but as basically all countries rely on a pluralistic health service provision model and as the current evidence shows that neither sector is intrinsically superior to the other, the main question is not whether to univocally favour one over the other, but rather to find the best mix of these two sectors in or-

[5] *The figures for government health expenditure here includes some funds from external sources that are disbursed through government channels.*

der to ensure the availability, accessibility, efficiency, equity and quality of services. How and whether private sector health service provision supports the objectives of health system strengthening towards UHC depends on the way it affects overall system performance components, such as equity, efficiency and quality. Private sector service provision has been sometimes seen as more efficient and of better quality than that of the public sector. It seems though that the evidence on this is rather inconclusive and varies highly according to the context (Basu et al., 2012; Montagu et al., 2011). From an allocative efficiency point of view, the interface between health financing and service provision is of crucial policy importance. Using public funding to contract service provision or intermediary services to the private sector is a strategy that has been used by many countries (Liu et al., 2007). This type of arrangement has been used, for example, in many sub-Saharan African countries (Benin, Ghana and Zambia, for example) for contracting service provision to private not-for profit providers that operate with subsidies from the government (for salaries, medicines and supplies) and assure health services in areas where publicly provided services are either unavailable or irregular. One of the arguments for resorting to this strategy is that it allows governments to allocate resources more flexibly and to circumvent some of the rigidities in the public system, and at the same time, it allows them to focus on their core functions of governance and regulation.

Moving towards UHC is a process that needs progress on several fronts. Ultimately what matters is how the different health system components align themselves with the overall objective of UHC in ensuring and promoting the utilisation of services, financial risk protection, the quality of services, equity, and efficiency. •

FIGURE 2: GROWTH IN AVERAGE TOTAL HEALTH EXPENDITURE PER CAPITA IN LOW-INCOME COUNTRIES BY SOURCE



Source : WHO, 2012

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Does the private sector help improve healthcare systems in developing countries?

The positive healthcare scenario in Brazil

Brazil's public health system covers all citizens. While it achieves excellent results in certain areas, it often fails to provide basic assistance to many due to a lack of financing. The private healthcare network is also challenged, with increasing numbers of people covered by health plans. In this context, Hospital Sírio-Libanês has developed expansion plans, while maintaining its participation to public-private initiatives.

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On promulgation of the 1988 Federal Constitution, the Brazilian state committed itself to guaranteeing access to health services as a right of all and a duty of the state. Since then, Brazil has been greatly challenged to structure and maintain, with the necessary financial and human resources, what is named the *Sistema Único de Saude* (SUS), a system ensuring full universal and free-of-charge access to care for the country's entire population. The SUS is one of the largest public health systems in the world. It includes simple assistance to outpatients, organ transplantations, and an ample network of units and services covering almost 200 million citizens, regardless of social or economic class. In addition to providing consultations, examinations, and hospitalisations, the system also undertakes vaccination campaigns and preventive and sanitary surveillance – such as food inspection and the registration of medicines – reaching all Brazilians. Such a major social inclusion project, created not long ago and in a country with well-known costing and public investment difficulties, encounters several challenges that reflect in a service of less-than-expected quality.

"Currently, 75% of Brazilians do not have a private health plan."

Currently, 75% of Brazilians do not have a private health plan and use the SUS. While it serves a greater number of people than the private sector, it relies on fewer resources. The reason for this is a lack of public resources. Healthcare spending in Brazil accounts for 8.4% of gross domestic product (GDP), which is in line with the global average of 8.5% per annum, according to a report issued by the World Health Organisation (WHO). Yet Brazil differs in terms of who is responsible for the expenditure. In Brazil, 55% of health spending is private (benefiting approximately 48.7 million health plan holders) and 45% is public – (benefiting all 190 million Brazilians). The public portion accounts for 3.7% of GDP, one third down on the international average of 5.5% of GDP (WHO, 2012). Compared with countries with similar health systems, Brazil fares even worse: it achieves excellent results in certain areas (vaccine coverage of practically its entire population, programs for transplantation, and combating diseases such as AIDS, among others), despite its unsatisfactory resources, yet due to a lack of financing, it often fails to provide basic

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Since 2008, **Paulo Chapchap** is corporate strategy superintendent at Hospital Sírio Libanês. He also coordinates the Institution's liver transplantation program, and chairs the board of the Sírio-Libanês Institute for Education and Research. He is graduated from the School of Medicine of the University of São Paulo and is now a research fellow and visiting assistant professor at the University of Pittsburgh. He also serves on the boards of the International Liver Transplantation Society.

assistance to a large number of people.
After many years of dealing with the issue of insufficient financing, in 2012 Constitutional Amendment n. 29 was promulgated. It stipulates that the states and municipalities are to allocate between 12% and 15% of their revenues to healthcare. The federal government, in turn, must invest the same volume of resources as the previous year, plus GDP variation. The specialists and the Brazilian authorities (federal, state and municipal) still wonder whether such a change to the rules will resolve the problem of funding the public healthcare network. The idea is that, little by little, the government's share of healthcare spending will return to levels registered in previous decades.
In the private sector, the challenges are no smaller. Since mid-2000, Brazil has been undergoing an economic development process that has improved the income and employment levels of a large portion of the population. It is estimated that 20 million Brazilians have been lifted above the poverty line. This scenario has led the number of patients with access to supplementary healthcare to rise. The National Agency of Complementary Health states that 47.8 million Brazilians hold some kind of health plan, 76% of which are through collective agreements offered mainly by companies. The revenue of companies in this sector grew 11% in 2011, to reach R$ 84 billion (approx USD 40 million).
This increased demand has put pressure on the private healthcare network, impacting on private hospitals (for-profit and not-for profit) that are at the limit of their capacity. Hence, private hospitals are experiencing a period of massive investment, seeking to expand their capacity and, thus, to maintain the quality of their services. The growth trend is expected to be maintained, and in 2012 alone, these institutions (approximately 60 hospitals) were expected to have invested approximately R$ 1 billion (USD 500 million) in expansion projects. According to Francisco Balestrin, president of the National Association of Private Hospitals (Anahp), by December, 35 out of its 45 members together had invested about R$ 600 million, twice that made the previous year. Currently at its height, the investments boom in the hospital area began about three years ago. This expansion is required as the current average rate of occupation in these hospitals stands at 77%. Above 80%, the assistance process becomes jeopardised.

"Private hospitals are experiencing a period of massive investment, seeking to expand their capacity."

The Hospital Sírio-Libanês case

A participant in this landscape is *Sociedade Beneficente de Senhoras Hospital Sírio-Libanês* (HSL), a Brazilian philanthropic institution founded more than 90 years ago. Given the new reality of the private healthcare sector, in 2005 the institution set off an important process of changes to its management, and implemented a new model of corporate governance and a new strategic plan. That landmark in the professionalisation process, among further initiatives, established the following: growth guidelines, new positioning, branding, and a consolidation project, all without negatively affecting the principles of human warmth and philanthropy, present since the hospital was founded.
Investments were intensified and, seeking to embrace its new profile, Hospital Sírio-Libanês expanded its relationship with the financial markets. First, a R$ 20 million (USD 9 million) credit line was approved in 2009 by the National Bank for Social and Economic Development (BNDES) and Banco do Brasil. Next, its search ensured support from important multilateral institutions (for USD 40 million), in addition to a further R$ 430,6 million (USD 200 million) of finance from the BNDES and Banco do Brasil. A business plan in line with the strategy had to be structured to allow for an ample long-term vision.
If all of the resources invested in the current structures and in the projects for capacity expansion are added, HSL is due to invest approximately R$ 1 billion (USD 500 million) in the period between 2009 and 2014. Investments should double its existing assistance capacity by 2017, when the institution will be offering 710 beds. And like HSL, most Brazilian private hospitals are undergoing transformation towards professionalisation.

Private growth associated with philanthropy and public health

In addition to expanding their structures to serve patients within their existing profile, the growth of institutions such as HSL is reverberating and strongly effect- ▶▶▶

FOCUS

A philanthropic institution founded in Sao Paulo over 90 years ago, the Hospital Sírio Libanês leads in providing inpatient services such as surgeries, and outpatient services such as oncology, rehabilitation, diagnoses and check-ups. With 4,700 collaborators – including 3,800 doctors – and 357 beds, it has the capacity to carry out more than 50 surgical procedures and around 2,000 diagnostic examinations daily. Its mission is also to develop integrated services in the areas of social assistance, health, tutoring and research.

ing the development of the public healthcare system. HSL is one of the six Brazilian healthcare institutions classified by the Ministry of Health as a 'Hospital of Excellence'. This classification, established by the federal government, sets the standard for the new model of investment of resources in philanthropic ventures. Thus, since 2009, 100% of the tax relief awarded has been fully returned to Brazilian society by means of projects that are part of the SUS Institutional Development Program PROADI-SUS (see box). Had it not been deemed a 'Strategic Hospital', HSL would have been considered a 'Philanthropic Hospital Institution' and would have had to either invest 20% of its assistance revenues in free-of-charge care or provide assistance to SUS patients. To this end, the relevant institutions' growth also ensures an increased volume of resources invested in projects.

The agreements entered into with the BNDES and Banco do Brasil stipulate an investment of 5% of total credit in projects of interest to the Ministry of Health. In the first triennium of operation of this new philanthropy regulation (2009-2011), HSL invested almost R$ 180 million (USD 85 million) in these projects, engaging approximately 50,000 professionals in the public health network from all over Brazil.

Investments in management-oriented courses and training aim to meet the large demand from the public sector. Yet integrating the healthcare networks and using the available human and financial resources more efficiently are major challenges. In this area, the public and private sectors can jointly make mutual gains and an important exchange of experiences aimed at improving the services provided to their patients. For this reason, in addition to the programs for the PROADI-SUS, the private sector has also sought to contribute to the public network by forming the body Social Health Organisations (OSSs), made up of private institutions of proven experience in the provision of healthcare services. The OSSs are institutions in charge of the management of public healthcare units and, for this, are paid an amount set out in an agreement entered into with the prefectures or states, who oversee meeting the pre-established targets. This model has shown that services can be improved by the private sector transferring its knowledge and contributing to resolving a major setback in improving quality for the public sector: labour management. Because they are private, the OSSs are able to handle staff employment and dismissal with greater agility, ensuring that targets are met and that quality services are provided to the population. This is a gain that can be seen in the units managed by HSL in São Paulo. Studies made by the Fernando Henrique Cardoso Foundation show that, on a budget only a little bigger than those of the hospitals directly administered (an 8.1% variance), their average cost was significantly lower (around 25%).

Successful examples of partnerships between public authorities and private administrators show how this mediation between the two sectors can contribute towards overcoming the challenges posed by healthcare in Brazil. The advances achieved so far are a great incentive for all government and private entities connected with healthcare to pursue the attainment of the goal of service universality and equity. In this picture, the private sector has a key role to play. Finally, if the private sector can contribute to its public sector counterpart, knowledge will be gained by private hospital managers, irrespective of how advanced their structures and technologies may be. •

BOX: PUBLIC-PRIVATE PARTNERSHIP FOR HEALTH

The PROADI-SUS (*Programa de Apoio ao Desenvolvimento Institucional do Sistema Único de Saúde*) is a partnership between the Ministry of Health (MS) and health entities holding a Certificate of Beneficiary Entity of Social Assistance in Health (CEBAS-SAUDE) and of Recognised Excellence, which is regulated by Federal Law n. 12.101, issued on 27 November 2009, for the development of projects within the following areas:

- Studies on technology assessment and incorporation;
- Empowerment of human resources;
- Research on health of public interest;
- Development of techniques and management operation in the health services.

The program contributes by developing, incorporating and transferring new technologies and experiences in management; generating new knowledge and practices, through partnerships between health entities of recognised excellence and the SUS managers; and acting jointly to overcome challenges to improve and define strategic areas in the management and provision of the public health service in the country.

The Ministry of Health defines and annually discloses the themes and priority objectives for projects supporting the institutional development of the SUS. The projects are presented by the health entities to the Ministry, which analyses them through its competent secretariats or associated entities. Once approved, they are accepted in terms of an Adjustment Instrument, which is effective for three years. The health entities execute these projects by using resources from the fiscal relief (social contributions) they are entitled to due to their CEBAS-SAUDE status.

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Partnering for quality healthcare delivery

Good policies for the private health sector are essential to improve the overall performance of the health systems, especially given scarce public resources. The private sector provides a large part of health services in many developing countries, to both rich and poor, but their quality varies greatly and is often too low. To improve access to quality services, governments must lead by engaging all actors in the sector, and encourage healthy competition and partnerships among them.

Connor Spreng

Senior Economist, World Bank

Patients, when they seek care, are not concerned about the institutional arrangements or the ownership of the providers in the health sector. They care only about having timely access to affordable, good quality care for their sick children and themselves. Whether the providers are public or private[1] matters little to patients. Their perspective should guide the development of appropriate policies in national health systems. Indeed, an 'effective private health sector policy' may be a misleading term: what is needed is not a separate policy for the private health sector, but rather a health sector policy that includes all important actors in the sector, regardless of ownership or brand of medicine practiced.

When considering government policies for the private health sector, we are talking about two sets of policies. Ideally, the private health sector should be subject to policies that (i) regulate the private sector, making all firms abide by a set of rules concerning, for example, company registration and paying taxes; and (ii) regulate the health sector, making all providers – public and private – abide by a set of rules concerning, for example, minimum quality standards and maximum prices for particular services. What characterises effective policies and regulations differs for these sectors. Instituting effective policies for private firms, regardless of sector, means making rules simple, fast and transparent to provide a good business environment. On the health side, it is more complicated. Governments are responsible to citizens for overseeing the sector and ensuring that services are of good quality, accessible, and affordable. Since the private sector is a big player in modern health systems, it is imperative that health policies address it explicitly, ensuring that it is an integral part of health system improvements. In the majority of developing countries, the private sector provides a significant portion of health services for rich and poor, rural and urban populations alike. In sub-Saharan Africa, for example, more than half of all healthcare spending comes from private parties, and private providers are responsible for delivering at least half the services (Figure 1). In other regions, such as South Asia and Southeast Asia, the private sector's share of total health services is estimated to be higher still. The absence of effective policies and practices in many developing countries has not hindered its growth. Rather, it has resulted in an untapped potential for improvement of the health systems' performance. Ignoring the private health sector in developing countries is not a realistic option and implies abandoning all the patients who seek services from private providers. That public health sectors will fully replace their private counterparts and provide high-quality services for free, to all is a utopian ideal, not a useful guide for policy.

So, what is needed?

Governments have to take the lead in engaging with the private health sector to encourage its contribution to achieving national health goals. The literature on maternal and child care shows that closer coordination ▶▶▶

[1] *'Private' means non-public and includes non-profit, such as faith-based (mission hospitals, etc.), and for-profit.*

CONNOR SPRENG

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Does the private sector help improve healthcare systems in developing countries?

FIGURE 1: SOURCE OF HEALTH CARE BY WEALTH QUINTILE AND TYPE OF SERVICE PROVIDER FOR HOUSEHOLDS IN SUB-SAHARAN AFRICA

Note : All data are drawn from the sum of all Population-Weighted Sub-Saharan Africa Demographic and Health Surveys conducted after 2000. Source of treatment is a summary of respondents with children under 5 years of age reporting treatment in the prior two weeks for diarrhea and fever/cough.
Source : Analysis of DHS surveys; latest survey year available included; Montagu, 2010

▸▸▸ between the public and private sectors has improved access to family planning and increased the participation of skilled attendants during childbirth, both of which have saved lives (World Bank-IFC, 2011)[2]. Contracting with, or purchasing from the private sector can also be effective. Here, too, the results from maternal and neonatal programs have been particularly impressive. But beyond public-private collaboration in individual interventions and programs, a broader engagement is needed through systematic collaboration to achieve national health priorities. While public-private collaboration is not new, the World Bank Group's recent Healthy Partnerships Report has, as a world first, offered a codification of the elements of good engagement with the private health sector. Five domains are identified: policy and dialogue, information exchange, regulation, financing, and public provision of services. A research team measured the level of engagement along the codified elements in 45 countries of sub-Saharan Africa. The findings of the report are relevant not only for the African countries, in which a veritable wave of important reforms has started, but also for other countries.

Policy and dialogue between the government and the private health sector should set out the roles and responsibilities of the actors. In sub-Saharan Africa, more than 85% of the countries have an official policy for working with the private health sector.[3] However, the majority of countries do not implement their policies[4], often because the ministries of health see their job primarily as supervising a system of public health providers, rather than as overseeing a mixed health system. Yet there are a growing number of countries where dialogue is being (re-)initiated as a first step towards improving engagement. In Ghana, for example, engagement between the government and the private health sector has greatly improved since the existing private health sector policy was revived through a new forum for dialogue. The private sector, in turn, has responded by forming an umbrella organisation of private providers, a critical step: self-organisation by the private sector is critical in establishing dialogue, but is lacking in most developing countries.

The information exchange domain concerns information flows between the public and private sectors, and private sector inclusion in national health management information systems and disease surveillance. Accurate information about the scale and scope of privately provided care is a key ingredient of engagement. This is especially pertinent if the private health sector is providing a large proportion of health services.

The regulation domain focuses on the ability of the government to design and implement a regulatory framework for the private health sector. Key elements of good practice in health sector regulation include (i) the government knowing who is providing services, and where; (ii) standardised rules for opening and operating private health facilities, including a transparent quality control or inspection process, and the implementation of these rules; and (iii) the inclusion of all important types of health service providers. In many developing countries, registration of private providers is poor (only 13% of the 45 countries analysed have a comprehensive

[2] See literature review in Healthy Partnerships Report, page 22.
[3] Since the level of engagement with non-profit providers – in Africa, mostly faith-based providers – is higher in all countries and across all domains, it is the larger for-profit sector that remains excluded. Only if it too is included in the health system can the government's policies and practices claim to include the whole health sector.
[4] Thirty-nine out of the forty-five sub-Saharan African countries covered by the study have a policy for the private health sector; but only twelve countries are implementing these.

registry of private health facilities), regulations are inappropriate or outdated, and enforcement of the regulations is weak. Private providers tend to dislike the lack of consistent oversight, which allows low-quality providers to continue operating.

The financing domain covers the revenues that are actually or potentially available to the private health sector and the government's influence over such funds through various mechanisms. The key to financing is to ensure that there is a mechanism that allows poor people to have access to services, and that public funds buy value for money from either public or private services, which compete on a level playing field. This principle of strategic purchasing (buying services from the best providers regardless of ownership) is especially important in countries where the private sector is large. The existence of financial incentives (tax exemptions, land grants for rural clinics, import duty exemptions, etc.) specific to private health sector facilities serve as a proxy for whether the government seeks to improve the investment climate for the private health sector. Finally, and perhaps most important, the level of coverage of private providers by health insurance is used as a proxy to assess whether a significant part of the population can access the private health sector without having to pay out-of-pocket. The Healthy Partnerships Report states that in sub-Saharan Africa the level of health insurance coverage that would allow reimbursement for treatment received in a private facility is low; in most countries, less than 15% of the population. But coverage is growing. In several countries - for example, Kenya, Nigeria, and Uganda - expanded (public) insurance schemes are at an advanced stage. In these countries, the private sector is increasingly an active participant in policy discussions. The prospect of including private providers in national health insurance schemes holds great promise for improving the sector overall - in addition to providing a mechanism to protect against risk and to channel subsidies for health services to the poor. Such schemes offer the opportunity to force public facilities to compete against private providers in terms of quality and how they treat patients. Private providers, in turn, are forced to meet accreditation standards in order to be eligible for reimbursement.

Finally, the public provision of services domain focuses on how governments can use public production to complement, crowd out, or build a supporting environment for private healthcare markets. This can take the form of including private providers in public health interventions – such as immunisation programs or for treating HIV/AIDS – or instituting cross-referrals, from public to private and *vice versa*. In addition, the public sector can ensure the availability of basic services and institutional support. In most countries, there is some evidence that governments and the private sector can collaborate relatively well on disease and immunisation programs. And there is typically some form of patient referral between the private and public sectors. These instances of collaboration – sometimes prompted by the requirements of donor programs – on narrow issues hold some promise for engagement at the systems level.

Meaningful reform is within reach

Having identified the key elements for effective engagement with the private health sector is a key ingredient for positive reforms. However, much remains to be done. Specifically, in order to go beyond individual partnerships or public health initiatives, defining broader policies, such as the reimbursement of private providers for services rendered under a national health insurance program, will be needed. In an environment of scarce public resources, the key for governments is to focus more on what they need to do, such as oversight over all providers to ensure a minimum level of quality, and less on what can be done by others, such as managing service provision (see Box). •

BOX: EXAMPLE OF ENGAGEMENT WITH THE PRIVATE HEALTH SECTOR IN A LOW-RESOURCE ENVIRONMENT

The scores along the five domains are generally not correlated with income. So, these are not a question of resources. When the government has very few resources, which is the case in many developing countries, the prioritisation of its activities or responsibilities toward the private health sector becomes especially important. For example, in Liberia the government has let associations and umbrella organisations carry out some of the oversight activities, such as attempting to ensure minimum levels of quality and consistency across providers. The under-resourced Liberian Medical Board mandated the Private Clinics Association of Liberia (established by physician assistants, certified midwives, and registered nurses) to register all private clinics, and to perform the initial inspection to ensure that the professionals are duly licensed and that the facilities are worthy of certification.

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Does the private sector help improve healthcare systems in developing countries?

Meeting the financing needs of healthcare providers

In developing countries, the health sector is poorly structured and poorly regulated, and health insurance is practically non-existent. This does not encourage risk-taking, yet the financing needs are considerable. Development institutions already involved in this sector need to put in place increasingly innovative financing solutions to meet these growing requirements.

Philippe Renault and Magali Rousselot

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The scarcity and cost of financing is one of the major problems faced by developing economies and is a problem that particularly affects the health sector. Although financial partners endeavour to offer a wide range of appropriate financing instruments – from loans to equity stakes – there are still a large number of obstacles to financing, both on the supply and the demand side. And yet there is a tremendous need for new investment. It is estimated that the 49 poorest countries will need USD 25 billion in private financing between 2011 and 2015. Development institutions have a key role to play in strengthening the private companies they work with, structuring demand, ensuring a steady supply of services within a framework regulated by public authorities, bringing together healthcare providers and financiers – and, finally, making healthcare accessible to as many people as possible.

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A FRAGMENTED, CAPITAL-INTENSIVE SECTOR WITH AVERAGE PROFITABILITY

Market risk in the health sector might appear relatively small: the demand levels are known and are globally stable and there are considerable growth prospects because of the demographic and epidemiological changes taking place in the world. Apart from epidemics, healthcare demand is not cyclical. Ageing populations and an increase in chronic diseases will inevitably lead to an increase in the need for hospital treatment. But the very low solvency levels on the demand side – linked to a lack of social security coverage (public or private, mandatory or voluntary) – generates a serious market risk, making hospital revenues uncertain and making it difficult to assess the true value of health services. In sub-Saharan Africa and southern Asia, where only 5% to 10% of the population is (partially) covered by a formal social protection, the vast majority of healthcare services are paid for directly by patients. While it is relatively easy to model certain assumptions for financial forecasts for hospitals (we know what skills and technologies need to be mobilised), it is often more difficult to evaluate the needs of a population base – and even more complicated to evaluate its ability to pay for services. Besides, healthcare is a sector with high capital requirements: to develop infrastructure, set up modern technical platforms and combine small structures to generate economies of scale. The quality and continuity of healthcare provision have to be improved all the time, particularly by mobilising spe-

"Healthcare is a sector with high capital requirements."

cialist teams. In addition, the companies in this sector have considerable working capital requirements. Recurrent overhead costs are high: staff costs, equipment maintenance, patient hygiene and safety, building maintenance, purchasing medicines, managing waste and various medical devices, etc. This need for cash is often exacerbated by long delays in receiving payments from public and private insurance companies.

It is not unusual for promising projects to fail to materialise, or to fail to propose solutions suited to the market solely because of a lack of capital and funding. In transition countries, the mobilisation of finance (both debt and equity) is more complex and difficult. Because of this, the private health sector is taking a long time to modernise and is still fragmented and under-capitalised, with variable quality standards.

Obstacles to healthcare financing

The growth in demand presents a real asset for healthcare providers. But when it comes to obtaining financial resources from local banks, it is offset by a number of disadvantages. For instance, the revenue structure can be problematic. Payments in cash are particularly prevalent, there are a large number of collection points[1], and health insurance systems are rare and underdeveloped. In fact, healthcare institutions do not make much use of the banking system and their accounts only reflect a small part of their activity and the area they cover. They do not enable lenders to contemplate taking a reasonable, balanced risk in an unbiased manner. Most structures are small and not very specialised. In sub-Saharan Africa, the average size of investment projects ranges from USD 250,000 to USD 3 million. Still there are many investment opportunities (see Figure 1).

"The private health sector is (...) still fragmented and under-capitalised, with variable quality standards."

Even where development of healthcare providers is conceivable, it is hindered by the conditions for accessing loans. The debt structure of these establishments is complex. It is of course easy to back a loan by providing security[2] in the form of property, like a mortgage on land, buildings or equipment (hire-purchase, leasing). But enforcement is not simple, both for ethical and moral reasons and – in the case of certain types of equipment – for practical reasons. Some types of security pose fewer problems, such as assignment of receivables from health insurance companies. However, not enough hospitals generate sufficient revenues from these private insurance companies – and public social security systems are often short of cash. This means that in many low-income countries, the banks frequently refuse to take the risk of investing in the private health sector.

Where borrowing is possible, it has a serious impact on the profitability of the healthcare provider because of unfavourable financing terms (high interest rates and short maturities). In this case, only high tariffs can ensure a certain level of profitability. In most cases, hospitals fail to find the right balance between acceptable terms of finance and revenue prospects that are high enough to enable them to enter into a virtuous investment cycle – one that would eventually help them lower their tariffs. The establishments that succeed in financing themselves are often hospitals with more than 100 beds which are able to service their debts provided the maturities stretch to more than ten years.

The regulatory framework within which healthcare establishments develop also ▸▸▸

[1] *Patients can often pay doctors directly without having to go through the hospital.*

[2] *Security is a guarantee made to a creditor that enables him to obtain payment of the amount he is owed if the debtor fails to pay, either through allocation of goods (security in the form of property) or through a guarantee made by a third party.*

BOX: FINANCING A HOSPITAL NETWORK IN LEBANON

The Centre Hospitalier du Nord, a benchmark university hospital with 160 beds, was set up in Lebanon in 1996, primarily to respond to an urgent need to provide hospital treatment in this remote area of northern Lebanon. Its success inspired the creation of the Caremed group, an innovative hospital network model. Since 2012, Proparco has been assisting Caremed with its USD 51 million expansion programme, including the construction of two new health centres in the country (a day care centre and a hospital facility), the modernisation of the radiotherapy centre and the purchase of cutting-edge equipment for cancer treatment. Proparco has contributed USD 15 million to this programme, alongside local banks. The deferred repayment model proposed by Proparco means the repayment period will start once the structure is operational. Proparco's involvement in structuring the financing right from the start of the project enabled the local Lebanese banks to accept this long-term risk on a project involving the construction of additional facilities, which entails a greater risk than an extension to an existing hospital.

FOCUS

Between 2004 and 2011, the AFD invested €850.6 million in the health sector, 49% of which was in the form of loans. Among other things, this financing helped develop healthcare systems, mainly in sub-Saharan Africa (38% of the total). These funds were shared between public services, NGO-run projects and private healthcare operators (loans of €77.6 million from Proparco, the AFD's private-sector arm, and bank guarantees totalling €6.5 million).

Does the private sector help improve healthcare systems in developing countries?

▶▶▶ constitutes one of the major obstacles to financing. Governments struggle to regulate this sector and to define a framework to implement mandatory social security coverage – whether it is a public system or one that is delegated to the private sector. The 2010 WHO report describes setting up a social security system as a prerequisite for attracting investors. The public authorities' ability to oversee and monitor the quality of healthcare installations and providers, and to impose hygiene and safety standards is weak. The developers are not forced to modernise.

The solutions proposed by development institutions

The health sector is often at the boundary between strictly private-sector approaches and public-interest missions. To ensure the development of the sector while taking this specific aspect into account, development institutions are proposing a number of different financing mechanisms.

In the private health sector, these institutions are financing healthcare providers through customised loans, health insurance schemes and innovative projects. Development of the private health sector often comes about as a result of an incentive policy introduced by the public authorities – usually involving health insurance reform with the aim of expanding the solvent population. However, poor populations tend not to be inclined to set aside a part of their income for future, uncertain expenditure unless they have to. In addition, the 'micro-insurance' sector[3] is still very underdeveloped. The risk-pooling system appears to work when contributions are mandatory, which is usually only the case for salaried workers in the formal sector. Yet these salaried workers are by no means representative of the majority of the population. The financing of private or semi-private mutual health insurance companies makes it possible to bring in more stable revenues while reducing the costs paid directly by patients – it therefore promotes the development of healthcare provision. It is for these reasons that donors try to finance mutual health insurance companies.

"Donors (...) need to mobilise as many innovative financial solutions as possible."

Moreover, the high risk or innovative character of a project often means that some level of subsidy is required, or loans at preferential interest rates which development financial institutions can provide. But subsidies cannot always be considered on their own as a structuring financial product. In general, subsidies do not help improve the financial management and governance of the beneficiary organisation. Moreover, they do not always lead to other sources of finance – which would make it possible to improve the situation over the long term.

The development of the healthcare market also depends in part on the structuring presence of investment funds. Investment funds can meet the sector's need for equity capital and improve the governance of health institutions. Some private equity funds seem determined to penetrate the health sector. Initiated and supported by development institutions, these funds have built their model on risk diversification, by investing in several countries within a region and in several different sub-sectors. They are looking for profitability, but on a longer term than classic investment funds, and support the structures in terms of professionalisation and growth (*e.g.* the Africa Health Fund and the Investment Fund for Health in Africa).

Besides providing adapted financing with long maturities (10 to 15 years) and financial intermediation (support for local banking sectors and specialised investment funds), the development institutions can provide added value by encouraging and helping health structures to become more professional so as to improve the way they are managed and their economic model (see box). For this reason, development institutions offer a technical assistance service that can be used to improve corporate governance, internal management systems and training (a major issue for development in this sector).

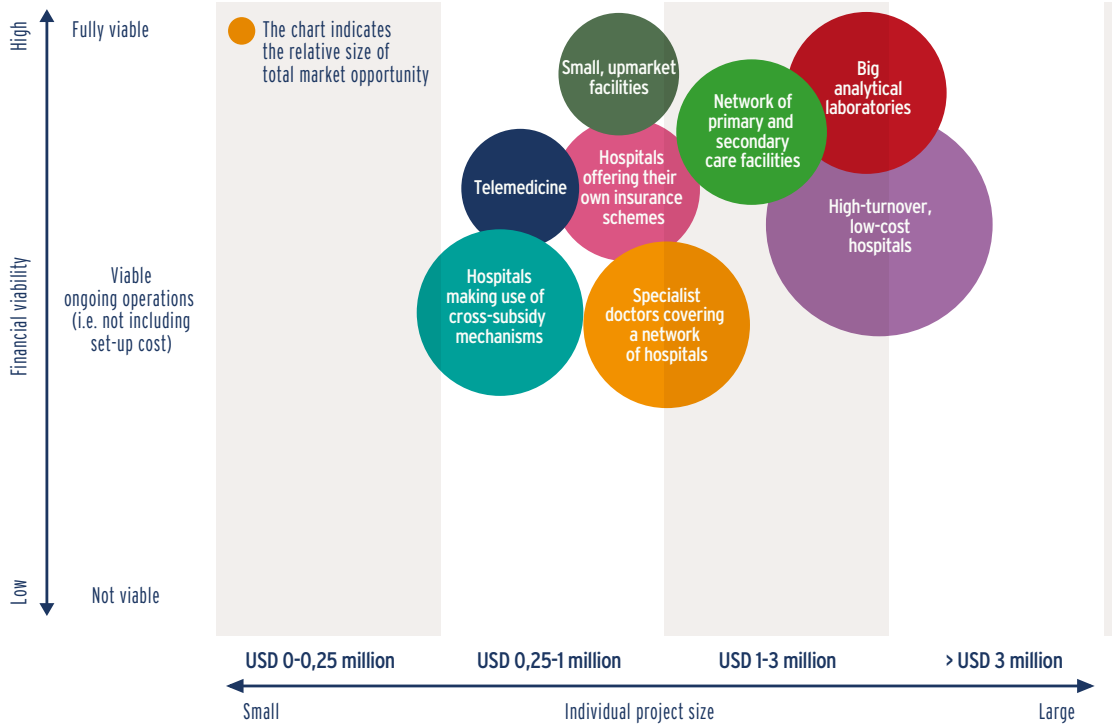
Finally, development institutions also use innovative financing to promote social impact by offering a decrease in interest rates on loans if the beneficiaries carry out social projects. These might take the form of funds dedicated to improving accessibility to free treatment for disadvantaged communities, the building of clinics in remote areas or the introduction of new technologies, like telemedicine.

The private health sector in developing countries will experience changes as a result of ongoing economic and social progress, and the rapid growth in chronic diseases. Donors therefore need to mobilise as many innovative financial solutions as possible. They need to support the development of

[3] *Micro-insurance describes an insurance system in which the beneficiaries are often people excluded from formal social security systems. Membership of the scheme is not mandatory and members contribute, at least in part, to the financing of health services.*

participants in this sector, whether they are small mutual organisations, private clinics or large private hospitals. As a result, more innovative tools will emerge alongside the traditional instruments (essentially subsidies and loans), including loan-grant combinations, the development of microfinance for health, and experiments with partially repayable subsidy systems. Moreover, development institutions must contribute to a better balancing of public and private policies and help provide a better structure for the sector. Here, more than in other sectors, development institutions need to act as a driving force, by serving as a role model – placing a focus not only on expected profitability, but also on improving health services and on human development as a factor of economic growth. •

FIGURE 1: PROMISING INVESTMENT OPPORTUNITIES – HEALTHCARE SERVICES



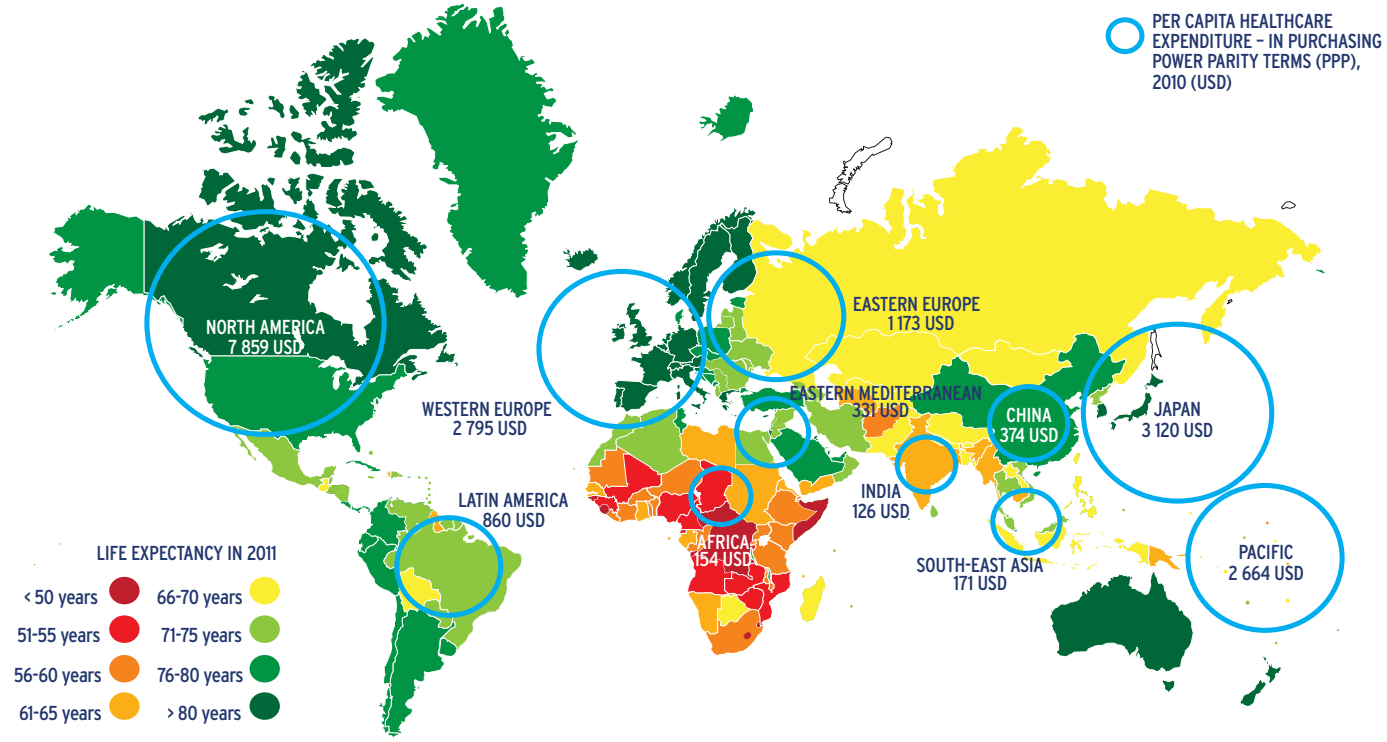
Note : The chart is illustrative and intended to provide an indication of the variety of well-operated businesses and organisations that exist, and an idea of the main differences between them. Individual enterprises may fall outside the ranges shown.
Source : McKinsey analysis, IFC, 2008

REFERENCES / **IFC, 2008.** / The business of health in Africa. Partnering with the Private Sector to Improve People's Lives. World Bank Group. Available at http://www.unido.org/fileadmin/user_media/Services/PSD/BEP/IFC_HealthinAfrica_Final.pdf. / **World Health Organization, 2010.** / The World Health Report 2010. Health systems financing: the path to universal coverage, Geneva.

Does the private sector help improve healthcare systems in developing countries?

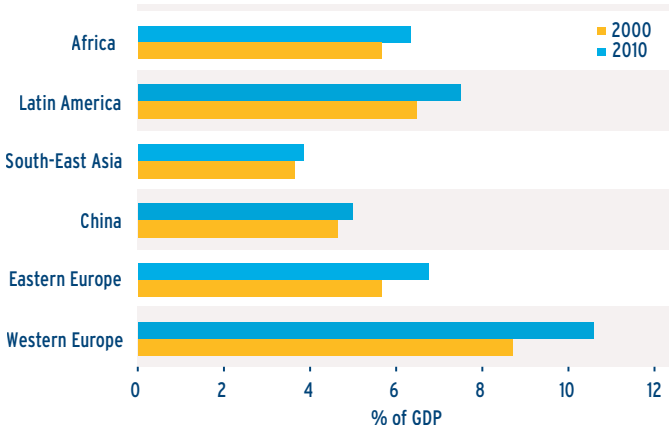
Despite the improvement of main mortality and morbidity indicators, healthcare problems remain a key issue in developing countries in particular. Demand for healthcare services is already increasing here – and is set to grow rapidly in the coming decades. The private sector has an important role to play in helping to deliver appropriate solutions.

Global overview of healthcare expenditure, 2012



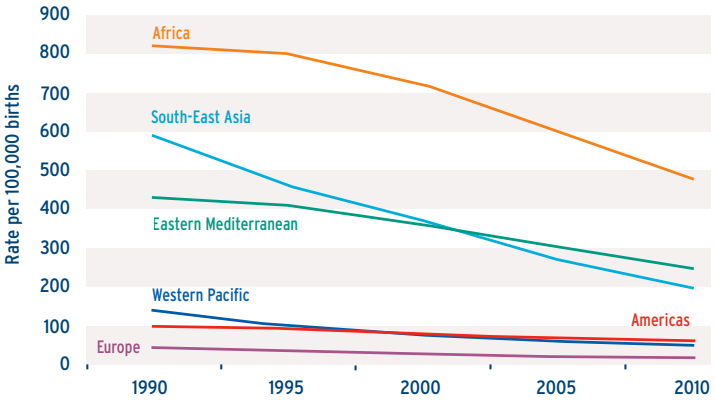
Note: Total healthcare expenditure includes both public and private expenditure.
Source: OMS, 2012

Healthcare expenditure, 2000–2010



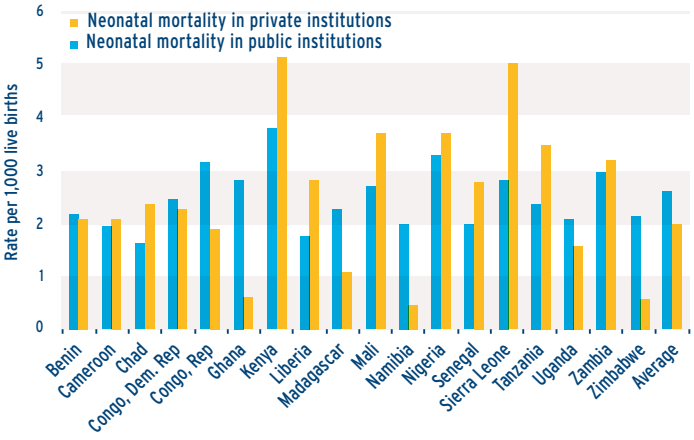
Source: Editors' calculations based on WHO data, 2012

Maternal mortality by region, 1990–2010



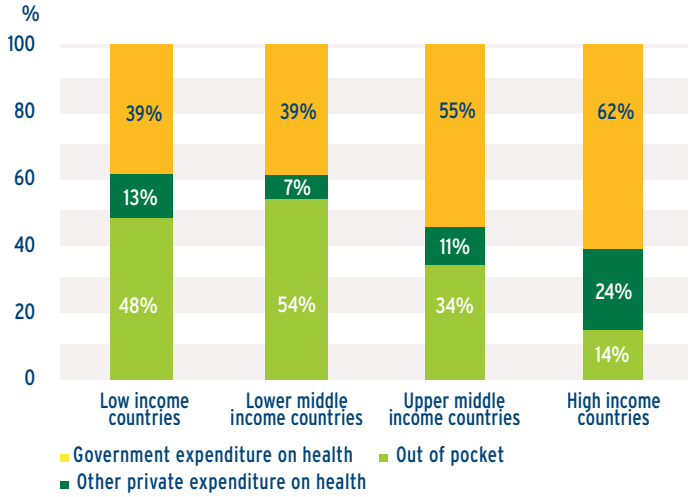
Source: OMS, 2012

Neonatal mortality in Africa by institution type



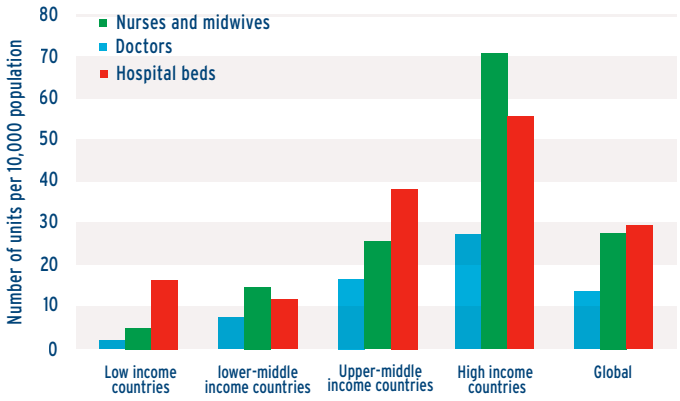
Note: Data from IFC, statistics gathered between 2006 and 2008.
Source: SFI, 2006 / 2008

Public and private expenditure as a % of total healthcare expenditure by income group, 2009



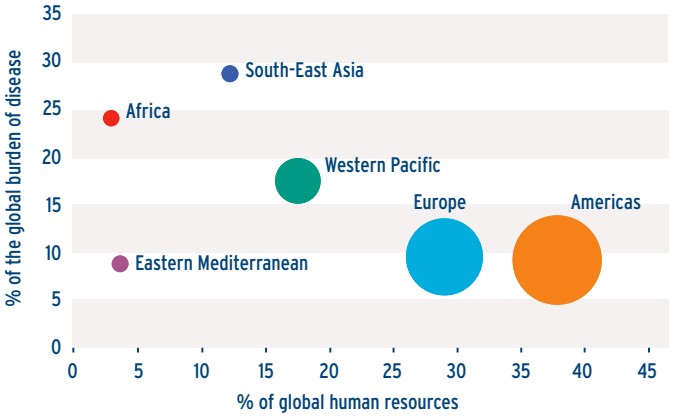
Source: WHO, 2009

Healthcare personnel and infrastructures by income group, 2009



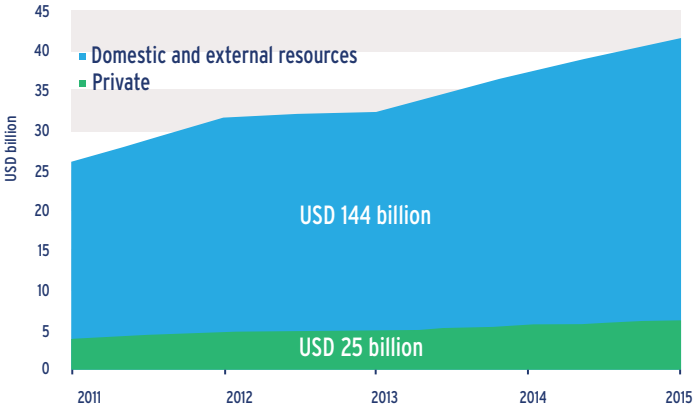
Source: WHO, 2012

Human resources for health by region, 2006



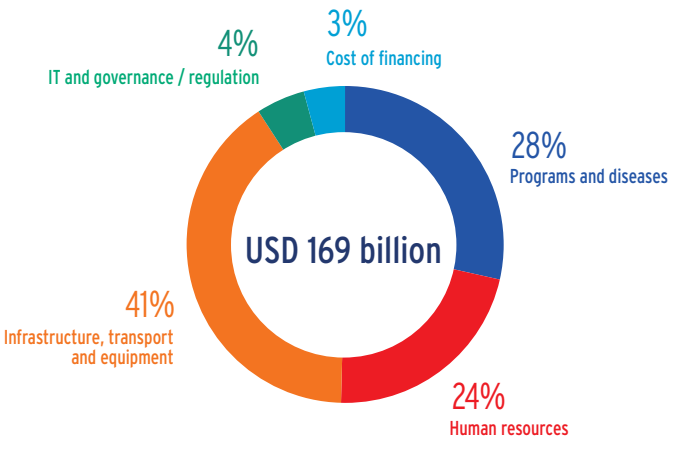
Note: Africa accounts for 24% of the global burden of disease but has access to only 3% of global healthcare personnel and less than 1% of global healthcare resources (including international donations or loans).
The size of the circles is proportional to total healthcare expenditure.
Source: McKinsey report, 2009

Estimated health financing needs for the 49 poorest countries, 2011–2015



Source: Editors' calculations based on data from the WHO, 2009, and FWG, 2010

Health financing needs of the 49 poorest countries, 2011–2015



Source: WHO, 2009 and FWG, 2010

Does the private sector help improve healthcare systems in developing countries?

Making the private health care sector deliver for the poorest: common sense or blind optimism?

Many international donors propagate the belief that Universal Health Coverage (UHC) can be achieved by enlarging the private health-care sector in low-income countries. Oxfam suggests that there are serious failings inherent in private provision, and that fixing the public sector might be the most efficient and effective route to achieving UHC.

Anna Marriott and Marame Ndour

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Universal Health Coverage (UHC) is gaining momentum worldwide. UHC means access for everyone to good quality, effective health services regardless of their ability to pay. Realising UHC depends on expanding services and drastic cuts to out-of-pocket payments. Growing research affirms that despite their serious problems in many countries, public health services dominate in higher performing, equitable health systems, and the poor are better reached when systems emphasise universalism, rather than targeting. Successful systems have eliminated financial and geographic barriers for rural populations by providing many facilities (Rannan-Eliya, R., Somantnan, A. 2005).
Yet many international donors would have us believe that UHC can best be achieved by an established, growing private sector. The IFC's report 'The Business of Health in Africa' states that as a major provider and financier of health care for the poor, the private sector should play a central role in scaling up (IFC. 2008). It also claims the private sector can save public money by bringing in resources and improving efficiency and quality. The IFC's 'Healthy Partnerships' report asserts that 'to achieve necessary improvements, governments will need to rely more heavily on the private sector' (IFC, World Bank. 2011). But do the arguments stack up? In 2009, Oxfam published what proved to be a highly controversial report concluding that the evidence available failed to support the case for a greater private sector role in health care in low-income countries (Marriott, A. 2009). On the contrary, there is considerable and increasing evidence that there are serious failings inherent in private provision, which makes it a risky and costly path to take. Unsurprisingly, some private sector advocates accused Oxfam of being ideological and selective with the evidence (Harding, A., 2011). Recently, however, a number of peer-reviewed cross-country studies have affirmed many of Oxfam's findings.

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MARAME NDOUR

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THE PRIVATE SECTOR OFFERS NO ESCAPE ROUTE TO THE PROBLEMS FACING PUBLIC HEALTH SYSTEMS

The fact that the private sector is the main provider in many countries does not mean that it should drive scale-up. . While in many developing countries it provides a significant proportion of outpatient care, in Africa 40% of this is informal shops selling drugs of unknown quality – this would not be labelled

'health care' in the rich world. When comparisons between the sectors is limited to licensed and certified health care personnel, the public sector dominates in all but 3 of 22 low- and middle-income countries where data is available (Gwatkin, D.R., 2000). Besides, the proportion of existing care provided by the private sector is not an indicator of whether the right to health is being fulfilled. In India the private sector provides over 80% of outpatient care, yet half of all women are denied medical care during childbirth. Despite the fact that out-of-pocket payments push 100 million people into poverty each year, (WHO. 2010), the large portion of private expenditure on health is sometimes seen as a signal of profit-making potential for private companies in low-income countries.

The idea that greater private health-care provision can complement and relieve governments is unsubstantiated. Attracting private providers to low-income, risky health markets requires significant public subsidy. Tax relief for private medical scheme contributions in South Africa cost the government the equivalent of nearly 30% of its health budget in 2001. During the same period, the government spent 12 times more on private health insurance for its civil servants than it spent on per-person funding of public sector health services for those reliant on them (McIntyre, D., Thiede, M., 2004). In many countries, rather than adding capacity, private sector growth has had a 'crowding out' effect on public services. In Ghana, South Africa, Uganda and Brazil, new private services were found to have reduced revenues available for public sector health facilities that also provided care to the poorer populations (Basu, S., Andrews, J., Kishore, S., Panjabi, R., Stuckler, D., 2012). Private sector growth in Thailand and India has pulled qualified personnel away from rural public facilities (Wibulpolprasert, S., Pengpaibon, P., 2003) (De Costa, A., Diwan, V.K., 2007).

Contrary to the argument that the private sector achieves better results at lower costs, in fact it is associated with higher expenditure. Research across multiple countries including India, Tanzania, Bangladesh, Malaysia and South Africa found significantly higher prescription drug charges in the private health care sector (Basu et *al.*, 2012). Costs increase when private providers pursue profitable treatments rather than those dictated by medical need. Chile's health-care system has wide-scale private-sector participation, and as a result, one of the world's highest rates of births by costly and often unnecessary Caesarean sections (Murray, S.F., 2000). Health-care costs in Colombia rose significantly following privatisation reform in 1993, and 52% of capitation fees were spent on administration (De Groote, T., De Paepe, P., Unger J.P., 2005). Private sector expansion has been associated with escalating costs across East and Southern Africa, even where private sector initiatives have been designed to cut costs (Doherty, J, 2011). Even generic drugs were five times more costly in Tanzania's private facilities compared with the public sector (Makuch, M.Y., Petta, C.A., Osis, M.J., Bahamondes, L., 2010). In China, privatisation has led to a decline of less-profitable preventative health care: immunisation coverage dropped by half in the five years following reforms. Prevalence rates of tuberculosis (TB), measles and polio are now rising and could cost the economy millions in lost productivity and unnecessary treatment, in addition to unnecessary suffering (Huong, D.B., Phuong, N.K. et al., 2007).

Difficulties in managing and regulating private providers creates inefficiencies, especially where government capacity is weak and there are too few private providers to ensure price competition. In Cambodia, private providers were found to have lower operating costs in only 20% of contracting programmes for which data were available (Bhushan, I., Bloom, E., et *al.*, 2007). In Madagascar and Senegal, the transaction costs of contracting private providers were found to have increased overall costs by 13% and 17% respectively (Basu et *al.*, 2012). Replacing the main public hospital with a privately built and operated one in Lesotho induced a payment by the government of a USD 32.6 million index-linked annual 'unitary charge' to Netcare for the hospital and services. Given that the annual budget for the previous hospital was less than USD 17 million, this represents a massive 100% increase in costs (Lister, J., 2011).

The private sector usually does not raise the quality and effectiveness of health services. Nine comparative studies found diagnostic accuracy and adherence to medical standards were worse among private than public providers (Basu, S., Andrews, J., Kishore, S., Panjabi, R., Stuckler, D., 2012). Outcome data from 24 countries showed that children with di- ▶▶▶

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Oxfam is an international confederation of 17 organisations working in more than 90 countries. As well as becoming a world leader in the delivery of emergency relief, Oxfam International implements long-term development programs in vulnerable communities. Oxfam is part of a global movement, campaigning to end unfair trade rules, demand better health and education services for all, and to combat climate change.

Does the private sector help improve healthcare systems in developing countries?

▶▶▶arrhoea were less likely to receive appropriate oral rehydration salts and more likely to receive unnecessary antibiotics when seeing private providers than when seeing public providers. Market incentives to make profits by lowering quality are at their worst in the informal private health-care sector. The inability to pay and low levels of education mean that most people in poor countries become dependent on unqualified drug peddlers, fake doctors, and other providers, who present a serious threat to their health.

There is also no evidence that private healthcare providers are any more responsive or any less corrupt than the public sector. Regulating private providers is difficult even in rich countries. The World Bank argument that contracting private health providers will drive up responsiveness and accountability remains theoretical. In reality, contracting has significant potential for corruption both in the awarding of contracts and in the provision of services. A report commissioned by the Government of India found that hospitals contracted and subsidised by the state to provide free treatment to poor patients were simply failing to do so (Qureshi, A.S., 2001)[1]. Oxfam's own research into the private health-care sector in poor countries has hit many hurdles because of the lack of transparency of private health care companies. We are repeatedly told that data on private sector spending of public funds is unavailable due to commercial confidentiality.

"Rather than help reach the poor, private provision can increase inequity of access."

Finally, rather than improving access for the poor, private provision can increase inequity of access because it favours those who can afford treatment and have less need. Research reviewed by Basu et al. suggested a systematic bias against indigent patients in terms of both quality and access (Basu, S. et *al*., 2012). Exclusion of low-income patients by private providers was found in South Africa and Paraguay. Several studies suggest the process of privatising public health services increased inequities in the distribution of services in countries including Tanzania and Chile. Privatisation in China was statistically related to a rise in out-of-pocket expenditure, such that by 2001, half of the Chinese surveyed reported they had foregone health care in the previous year due to costs (Basu et al., 2012).

Achieving health care for all

The private for-profit sector plays an incredibly important role in some aspects of health care, including the production and supply of affordable medicines and medical supplies. Its role and potential added value in the delivery of services for poor people at scale is however still unclear. The private sector brings with it serious and inherent market failures that constitute an additional significant barrier to improving the quality and effectiveness of health services, especially for poor people.

Still, the evidence on the poor performance of the private sector should not be used to play down the problems of many public healthcare systems in developing countries. These are real, and addressing them will require resources and skilled leadership.

What can be learnt from the higher performing low- and middle-income countries, including Thailand, is that little progress will be made towards universal and equitable coverage of health services until the best brains and resources are committed to making the public sector work as the main provider. Indeed, the experiences of some more successful low-income countries, such as Sri Lanka, suggest that fixing the public sector might also be the most efficient and effective route to improving the standards of private health care providers. The option for patients of free universal and accessible quality services from the public sector acts as an effective regulator of the private sector, which has no choice but to improve and provide something even better to attract paying patients. •

[1] *The research undertaken by Justice Quereshi concluded India's corporate hospitals were 'money minting machines'.*

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Private Sector Opportunities in Developing Country Healthcare

Healthcare demand in Africa cannot be fully met by the public sector. Substantial investment will be needed to meet the growing demand – largely from low and middle-income households, which comprise 70% of Africa's purchasing power. For private sector investors, diversification will ensure financial returns, while meeting social impact targets. Hence, business models that address this group's needs will be a key driver in delivering quality healthcare services in developing countries.

Jacob Kholi and Ruth Wanjiru

Partner of The Abraaj Group and managing partner of the Africa Health Fund
Analyst with The Abraaj Group

Healthcare in Africa faces a fundamental mismatch in terms of disproportionate disease burden, inadequate health infrastructure and insufficient and overly burdensome regulation. While this has resulted in large-scale health inequalities and fragmented delivery of healthcare from the public sector, it has also created opportunities for the private sector to play a role in delivering accessible and high-quality healthcare services. USD 25-30 billion in new investments will be needed in healthcare assets, including hospitals, clinics, and distribution warehouses, to meet the growing healthcare demands of sub-Saharan Africa. 50% of the investment opportunity would be concentrated in health services provision followed by distribution and retail (14%), life sciences (14%), risk pooling (13%) and medical education (9%).

As a private equity investor operating in Africa, The Abraaj Group is committed to improving and sustaining healthcare services through the Africa Health Fund (AHF or the Fund). Target businesses fall into one of the Fund's identified sectors, namely, health services provision, distribution and retail, life sciences, risk pooling and medical education. Estimates by the World Resource Institute indicate that Africa's measured base of the pyramid (BoP)[1] health market is USD 8.1 billion, comprising the annual spending of 258 million people. Therefore, investments in the health sector in Africa cannot disregard the potential of the BoP market. To address the health needs of this market, investments made by the AHF have the objective of helping low-income Africans gain access to affordable, high-quality health products and services. This is achieved through targeted investments in private health companies to scale up sustainable businesses, take proven business models into new regions, and identify and grow businesses in areas where ▸▸▸

"USD 25-30 billion in new investments will be needed in healthcare asset (...) in sub-Saharan Africa."

JACOB KHOLI AND RUTH WANJIRU

Jacob Kholi is a member of the senior team responsible for The Abraaj Group's investments and activities in Africa. He has brought 17 years of venture capital and private equity experience to The Abraaj Group, which he gained in West Africa with the CDC Group. He is a member of the Institute of Chartered Accountants Ghana, having trained with KPMG in Ghana and holds an executive MBA in international business from the Paris Graduate School of Management as well as an MSc in Finance and Financial Law from the University of London.

Ruth Wanjiru is an analyst with The Abraaj Group and coordinates The Africa Health Fund's base of the pyramid (BoP) impact assessments.

[1] *AHF defines the BoP as those who earn a net household member average income of less than USD 3000 in purchasing power parity (PPP) terms.*

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▶▶▶ there are critical gaps (see box 1). The Fund has invested in companies which serve the BoP directly or indirectly through the organisations to which the companies provide goods or services. Health services provision makes up 58% of AHF's deal pipeline. The demand for investment in health services provision (which for AHF's purposes would include hospitals, clinics and diagnostic centres) is driven by the need to upgrade and develop health infrastructure in the region. Risk pooling in the health sector is challenging due to the high rates of provider and user fraud, inability to control costs, and the high cost of health insurance for a majority of the population. Estimates indicate that with the exception of South Africa, insurance penetration in Africa is roughly 1%. In East Africa, 4% of the 126 million people have a modicum of medical insurance cover for themselves and members of their families. In most countries, national health insurance plans are not in line with the current medical inflation rates, making them less attractive to private healthcare providers. However, risk pooling becomes an attractive investment prospect when combined with health services provision through managed healthcare plans. This finding is supported by two of The Abraaj Group's investments, C&J Medicare Limited in Ghana and Avenue Group in Kenya. The two companies run Provider-based Managed Healthcare plans eliminating the need for costly middle men, such as insurance companies and have become a repository for the pooled funds.

"Sustaining healthcare services in Africa will require the innovative approach."

Multi-criteria investment decision-making

Sustaining healthcare services in Africa will require the innovative approach of including the population at the BoP in the business model. In the absence of efficient, formal markets, the BoP pays more for products and services than those living at the top of the pyramid - a phenomenon known as the 'poverty penalty'. This market represents 70% of Africa's purchasing power. AHF was established on the belief that socially-motivated business practices enhance financial returns, while also adding positive value to society. On average, 60% of end users served in 2012 through six of AHF's partner companies were BoP 3,000[2]. The combined revenue from these six investments spread across East and West Africa in 2011 stood at USD 32.1 million, proving that BoP consumers have purchasing power. From work done with existing businesses in the health sector, three primary models have emerged on how companies can increase their reach and access into the base of the pyramid population.

The first model for accessing and reaching into the BoP population is through cross subsidisation. This involves using a portion of profits to subsidise costs for people who cannot afford services. For example, one of our portfolio companies with three hospital branches offers subsidised services in one of its branches located in a BoP-populated area. Footprint expansion is the second model for reaching into the BoP population. With this method, service lines or product distribution is expanded into territories and regions where there is a higher BoP population. This has worked well with medical centres and clinics in rural areas. The clinics, which are less capital intensive, provide basic healthcare, while specialised care and diagnostic services are referred to the main hospitals. The third model for accessing the BoP population involves process improvement manufacturing or service delivery processes are reworked to reduce costs, and thereby prices, with the aim of increasing affordability; for example, one company invested in an energy audit of its manufacturing plant in 2012. The cost of energy in Kenya makes up one of the highest direct costs of production. The audit was aimed at identifying processes and equipment with the highest energy losses. It is expected that savings from energy efficiency will enable this company to continue providing affordable products.

From an investor perspective, deal selection involves identifying investments that inherently address BoP needs. This may include investments in specialised care for women and children, who make up the largest component of the population at risk[3] ; and investing in manufacturing companies that manufacture essential drugs and medical products crucial for the BoP population. Revital Healthcare Limited has WHO-Good Manufacturing Practice and Conformite Europeene certification and exports over 50% of its production to other countries in Africa. It ma-

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The Africa Health Fund (AHF) a USD 105.4 million fund, was established in 2009 with the backing of the African Development Bank, ASN Bank, the Bill and Melinda Gates Foundation, the Development Bank of Southern Africa, DEG, the Elma Foundation, the IFC, the Maria Wrigley Trust, Norfund and Proparco. Today, 43% of AHF's investments have been made in health services provision, 29% in retail, 14% in manufacturing, and 14% in risk pooling.

[2] *Households with a net household member average income of less than USD 3,000 on a purchasing power parity basis*
[3] *As an example, 63% of patients treated at Nairobi Women's Hospital, a partner company of The Abraaj Group, are BoP.*

nufactures WHO-certified auto-disable syringes used by governments and NGOs (who primarily serve the BoP) in campaigns and programs against the spread of infectious diseases. Investments in public private partnerships (PPP) are another way of reaching BoP consumers. For example, The Bridge Clinic has partnered with the Lagos State Government to establish the Lagos State Institute for Fertility Medicine (IFM). The IFM provides affordable in vitro fertilisation services to patients in the mid and low socioeconomic classes who may not be able to afford the procedure at the current market rates. Through the PPP, 73% of patients served at the IFM were BoP 3000 (Dalberg Global Development Advisors, 2012).

Most healthcare companies in Africa are owner-managed and small (typically less than USD 0.5 million in profits). These companies face profitability drags induced by their target customer base. Consequently, standard private equity structures may not work in these businesses. To protect investor capital, a number of investments are made with convertible, quasi-equity instruments that provide a degree of self-liquidation and downside protection. Carefully supervised sustainable expansion plans can provide a strong foundation for further capital deployment and scaling-up of the business. This requires taking a strategic outlook of the business, initially deploying smaller amounts of capital (USD 0.25- USD 3 million), establishing a foundation on which inorganic growth can supplement the growth objectives of the promoters, and subsequently deploying more capital as growth opportunities become available. The average tenor of AFH's investments is five years, while target gross IRR is 15% per annum. The main exit strategies include trade sale, buyback, and IPO.

How to measure impact

AHF has the unique mandate of achieving social and commercial returns. Each investment is assessed against the following three targets: Target A: 50% of end users served directly or indirectly by the portfolio company are "BoP 3000"; Target B: 70% of end users served directly or indirectly by the portfolio company are "BoP 3000"; Target C: 15% of end users served directly or indirectly by the portfolio company are "BoP 1000". Impact measurement is conducted by an independent consultant contracted by the Fund. The assessment is conducted through interviews with end users to obtain data on their income range, household size and socio-economic status (SES). The SES questions address the level of education, mode of transport used and characteristics of the type of dwelling. Impact measurement becomes more complex the further the investment is from the end user. In this case, reliance on secondary data such as household budget surveys and expenditure surveys becomes a key reference point to understanding the purchasing power of consumers in a given country and region. Out of six companies reviewed in 2012 by Dalberg ▶▶▶

BOX 1: ABEC SANITAS, A BUSINESS CASE

In 2011,the AHF invested in AbeC Sanitas, a Ghanaian holding company that owns two hospitals, five in-house clinics, a state-of-the-art diagnostic centre, a pharmaceutical distribution outlet and a managed healthcare unit. The investment was to support the establishment of a state-of-the-art diagnostic centre in one of the hospitals. The quality and level of technology used has transformed the facility into a pioneer in private and specialised healthcare delivery in Ghana. C&J, the business name for the two hospitals, grew from a small out-patient clinic in a poor neighbourhood into one of the leading providers of healthcare in Accra. The hospital offers a wide range of services, such as general and specialist clinics, radiology (x-ray), ECG, ultra-sonography, laboratory services, in-patient (39-beds) facilities, minor surgeries, a 24-hour pharmacy, ambulatory services and phone-in services. Through the managed healthcare unit, C&J provides medical services for the employees and dependents of over 100 leading corporate clients, including on-site clinics for companies such as the Coca-Cola Bottling Company, Pioneer Food Cannery, PZ Cussons and Cargill Ghana Limited.

The Abraaj Group, through the AHF technical assistance facility, has supported C&J with US$ 250,000 to hire specialists and implement a hospital management information system. The specialists were hired to complement the investment in advanced technology at the diagnostic centre. The Abraaj Group is actively engaged in working with senior management to develop and implement value creation plans that will ensure the financial and operational sustainability of the holding company. Engagement is through regular discussions with senior management, continuous monitoring of financial and operational performance and representation in board meetings.

59% of patients served by Abec Sanitas were BoP 3000 (Dalberg Global Development Advisors, 2012). The highest BoP impact was achieved through the in-house clinics at the various companies.

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▶▶▶ Global Development Advisors, six achieved target C, while five achieved target A.

Main challenges of the African private healthcare sector

With the exception of South Africa and parts of North Africa, the most startling fact about the private healthcare space in the African market is how fragmented markets are. Most healthcare companies are run with weak governance and corporate institutionalisation, but will likely have high bed occupancy rates and potential for organic growth. Investing in these companies requires close attention in the early days to ensure disciplined cash flow management, robust governance processes and effective implementation of systems. During this period, regular engagement is required to ensure the constitution of a professional board and board committees, a change in senior members of management where necessary, implementation of information systems to support expansion, and the re-education of the sponsor on how to scale the business.

The private healthcare space in Africa has multiple players, including governments, faith-based organisations, NGOs, trusts and private companies. Consequently, there is a market distortion in pricing and quality, as most of the players offer similar yet highly subsidised healthcare products and services. In this case, regulation to standardise healthcare provision is required.

"There is a market distortion in pricing and quality"

Estimates by the Medical Credit Fund indicate that 90% of healthcare providers in Africa have no access to capital, due to limited collateral and credit history, high credit risk associated with the health sector, and subsequent high interest rates. In addition, most of the companies are in the early growth stage and are too small to qualify for private equity investment. The provision of long-term capital to private healthcare providers is critical to improving and sustaining healthcare services in developing countries. One way of addressing this challenge is through facilitating mergers among specialists in the healthcare space. This will help to scale the businesses and create operational and financial benefits for both the entrepreneurs and investors.

For businesses that cannot access PE funding, options exist among angel investors and micro-finance institutions. Development finance institutions are an alternative for providing long-term and affordable financing. Governments should also encourage the role of SMEs in bridging the gap in healthcare, through policies that encourage banks to invest in SMEs and increased public-private partnerships (see Box 2). Most capital pools in Africa target the 'big three' infectious diseases: malaria, tuberculosis and HIV/AIDS. Yet substantial opportunities exist across the entire spectrum of healthcare businesses. Diversification through investing in multiple sub-sectors will help to ensure financial returns while meeting social impact targets.

Investments in the health sector need to be cognisant of the health inequalities that exist in developing countries, and the 'poverty penalty' imposed on the majority of the population who cannot afford high-cost healthcare. Therefore, working with private healthcare providers to develop sustainable business models that address the needs of the BoP (who make up over 60% of the population) will be a key driver in sustaining accessible, affordable and high-quality healthcare services in developing countries. ●

BOX 2: THE ROLE OF SMES IN THE AFRICAN HEALTHCARE MARKET

There is a rising middle class, with demands for better-quality healthcare. SMEs are bridging this gap through better-quality healthcare services and the provision of a wider range of basic laboratory and imaging services. Further, SMEs are progressively taking the leading role as innovators of low-cost, high-volume delivery models, driven by increased competition for the same customer base. However, SMEs are facing several challenges.

The quality of healthcare provision by most SMEs is compromised by a lack of strict regulatory standards to which healthcare providers must adhere. In addition, most SMEs cannot afford international accreditation standards, due to the high cost of implementation and the small size of the facilities. While quality is recognised as an integral part of business, it is superseded by other operational priorities, and in most cases, is viewed as the responsibility of one function rather than the responsibility of all employees. To address this weakness, there is need for training of employees on the linkage of quality across all levels of the organisation. On the upside, there is an increase in demand for quality by the rising middle class. Consequently, quality is now viewed as a differentiator in pricing and in the development of customer retention strategies.

SMEs are faced with competition from NGOs and faith-based organisations providing similar but highly subsidised services. This creates a market distortion in pricing due to competition for the same client base. Fortunately, the opportunity to provide affordable healthcare services is complemented by insurance companies targeting the rising middle class with innovative micro-insurance medical products.

SMEs lack the resources to hire professionals with skills to manage the operational inefficiencies associated with the profitability drag of most SMEs. Therefore, capacity building is necessary to address the skills gap of the management teams.

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Providing low-cost, high-quality healthcare for India's poor

LifeSpring provides prenatal care throughout a woman's pregnancy. Its core customer base is those who have a household income of USD 2-5 USD/day. A for-profit organisation - although not profit-maximising - its hospitals offer an alternative to resource-constrained public hospitals and higher-priced private hospitals. Financial self-sustainability is key to its model (centred on high quality, low cost, and customer focus).

Anant Kumar

CEO and Founder of LifeSpring

India, with a population of more than 1.2 billion, which is constantly growing, estimated its maternal mortality ratio (MMR) at 254 (per 100,000 births) in 2011, down from 400 in 1990. This is almost 15 times higher than the MMR in developed countries, although India's target is to reduce its MMR to 109 by 2015, in line with the United Nations' millennium development goal of improving maternal health. A recent report by the National Institute of Medical Statistics points out that India has failed to reach its goal of reducing the infant mortality rate to 28 per 1,000 live births by 2012. The report adds that the country is unlikely to achieve this target until the end of 2016. Currently, 25% of global maternal deaths are contributed by India. Only 19% of mothers of lowest wealk quintile get skilled birth assistance in India, compared with 53% of all mothers (for more detail on India's health system, see the box, below).

ANANT KUMAR

Anant Kumar launched the first LifeSpring Hospital in December 2005. Before this, he worked in social and rural marketing and social franchising. He continues to serve on high-level expert forums and committees to strengthen healthcare provision. He has been recognised as a TED India fellow and has won prestigious entrepreneurial and social entrepreneurship awards. HE is a management graduate from IRMA, and has a diploma in Health Care and Hospital Management from Symbiosis Institute, Pune, as well as certification in social entrepreneurship from INSEAD, Singapore.

With rapid urbanisation, India has seen a concomitant rapid growth of the urban poor, with more than 20% of the entire urban population estimated to be poor. In terms of access to maternal and child healthcare services, the urban poor do not have much choice among the existing options. These are (1) government hospitals, which suffer from limited resources; (2) large private hospitals, whose high prices keep their services beyond the reach of many low-income women; (3) small private maternity homes, which lack transparency in pricing and quality (hospital facilities with fewer than 30 beds account for nearly 84% of the private for-profit sector, which is also the most unorganised, with most of the facilities managed by individual doctors); and (4) home births.

"Only 19% of poor mothers get skilled birth assistance in India."

Through its market-based approach, LifeSpring fills the gap in quality maternal health care at affordable rates for India's low-income population. It offers an alternative to resource-constrained government hospitals and higher-priced private hospitals. With 80% of health care expenditure in India being out-of-pocket, LifeSpring will significantly lessen the burden of rising health costs on the nation's low-income communities. LifeSpring's core customer base is the bottom 60% of the Indian population income segment (B60), who have a household income of Rs 3,000 to Rs 7,000 per month (approximately USD 2-5 USD/day). Many are employed in the informal sector (*e.g.* micro-entrepreneurs) or are day labourers. Eighty percent of LifeSpring's customers have an educational level of 10th grade or below. LifeSpring offers prenatal care, postnatal care, normal and caesarean deliveries, family planning services, immunisations, paediatric consultations, diagnostic services, pharmaceutics, and health care education to surrounding communities. Its hospitals have not utilised donations or grants for ▸▸▸

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▶▶▶ core operations, strongly believing that financial self-sustainability is key to its model and potential for scale.

An innovative private model

LifeSpring's three pillars are high quality, low cost, and customer focus. Its first hospital began as a proof-of-concept in 2005, and became operationally profitable in less than two years. On a unit level, each LifeSpring hospital is set up to be operationally profitable within 18-24 months of operation. LifeSpring is a for-profit organisation, although not profit-maximising. It prices its services at 30-50% of prevailing market rates: the price of a normal delivery is Rs 5,000 (USD 90), while a caesarean section is Rs 12,000 (USD 218) for a two- and five-day hospital stay (all-inclusive), respectively, although a mid-sized hospital typically charges around USD 200 for a normal delivery and USD 280 to USD 500 for a C-section.

"Lifespring (...) became operationally profitable in less than two years."

Additionally, LifeSpring provides prenatal care throughout the duration of a woman's pregnancy; the price of an antenatal checkup with a gynaecologist is Rs 100 (USD 1.50) for each visit. These lower tariffs do not prevent LifeSpring from being profitable, as has been proven across its 12 hospitals in Hyderabad.

At the core of LifeSpring's business model is its focus on maintaining low costs. Through regular activity-based costing analyses, it has been able to keep a close eye on costs per service, and to implement any necessary changes. There are four primary means through which LifeSpring is able to maintain its low costs, and each is dealt with below.

The first is service specialisation and high asset utilisation. Unlike a multi-specialty hospital, LifeSpring's focus on maternal health obviates the need to purchase a broad range of expensive medical equipment. This narrow focus also allows for improved efficiencies and high asset utilisation. It has refrained from making investments in building specialised infrastructure as births requiring intensive care account for just about 2% to 3% of all of its deliveries. Therefore, instead of creating the in-house infrastructure to address this need, LifeSpring has worked with paediatric hospitals to provide this care. This has helped not only in keeping the initial capital costs low, but also in reducing operating expenses related to hiring full-time paediatricians and paediatric nurses.

The second way of maintaining low costs is its low-capital expenditure model, which for new hospitals, entails entering into long-term leases with site owners. In the future, LifeSpring is also considering public-private partnerships with the government for sites. Adopting a cluster approach of having multiple hospitals in the city has also enabled expensive resources, such as ambulances and back-end operations, to be shared easily between the different facilities. Moreover, without compromising clinical quality, it offers no-frills hospitals, for instance, utilising fans instead of air conditioners in the general ward.

The third means of keeping costs low is the innovative structuring of partnerships. For instance, LifeSpring outsources its hospital laboratories, and has structured a revenue-sharing model with its partners. Additionally, it outsources its pharmacies, and buys in-patient medicines at cost, which avoids managing stocks, procurement and old medicines. To improve clinical quality within its hospitals, LifeSpring had partnered with the Institute for Healthcare Improvement (IHI) for two years.

LifeSpring's fourth way of maintaining low costs is through effective marketing. The BOP is the primary customer base in its model. The majority of women come to LifeSpring through word-of-mouth. Moreover, prior to adopting a hospital integrated management system across its hospitals, LifeSpring's marketing team utilised SalesForce to help track pregnant women in communities and to support the efforts of community outreach workers. Through SalesForce analyses its marketing team was better able to identify key decision makers in each household, and the specific aspects they care about. A big insight gained was that the real decision makers (and thus, 'customers') are often the pregnant woman's mother, mother-in-law, or husband. This led to the development of new campaigns to reach these decision makers, LifeSpring has also developed a unique protocol for customer care[1].

Impacts and learning

By October 2012, LifeSpring had delivered over 20,000 healthy babies across its 12 hos-

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LifeSpring Hospitals is an expanding chain of low-cost maternity hospitals that serves low-income women and newborns in India. It is a 50-50 joint venture between HLL Lifecare Limited (an Indian government enterprise) and Acumen Fund (a venture philanthropy organisation based in New York), a partnership which began in early 2008. LifeSpring currently has twelve 20-25–bed hospitals in Hyderabad, does 500 deliveries a month, and has done 20,000 to date.

[1] *LifeSpring CARES's protocol (courteous, attentive, respectful, enthusiastic, and safe), which all hospital employees are required to observe.*

pitals and had provided over 250,000 antenatal and postnatal checkups. It plans to scale across India, targeting urban slums. The main impact LifeSpring has recorded so far is that most of the private players have reduced prices in its vicinity, serving as a catalyst to improve the quality of healthcare offered by other providers.

Several key success factors have been identified. First, LifeSpring has a very narrow focus on maternal health, which has allowed it to achieve the level of operational efficiency it has. From the outset, LifeSpring has been focused on sustainability and scale. This led to the development of over 150 processes across clinical, operational, and marketing functions, allowing for the opening of new hospitals in an efficient and standardised manner. Early on, LifeSpring invested in a hospital integrated management system (HIMS) to improve efficiency at the hospitals and allow digital customer records to follow a woman, regardless of whether she goes for antenatal visits in one LifeSpring Hospital and delivers in another.

It has also managed to ensure alignment between social and financial metrics. In its initial proof-of-concept hospital, LifeSpring followed a cross-subsidy model, whereby customers in the semi-private and private wards would subsidise customers in the general ward. As the general ward comprised 70% of hospital beds and was the social focus of the hospital, there was, however, a disconnect when LifeSpring needed to ensure that its semi-private and private wards were filled. In a sense, there became two segments of customers: one to meet LifeSpring's financial goals, and one to meet LifeSpring's social goals. In order to more closely align its social and financial goals, LifeSpring discontinued its cross-subsidy model in 2009 and revised its business model such that each unit would be profitable solely through its general ward. This alignment brought unity to its financial goals and social mission. It has also developed strong marketing and community outreach efforts in order to reach its customer base.

Finally, LifeSpring has managed to face the human resource challenges, now centring less on hiring doctors than on finding and hiring hospital administrators to run the hospitals as 'unit-level CEOs'.

But can it be repeated?

The aspect of LifeSpring's business model dealing with entering new geographical areas strongly depends on government intervention to ensure that regulatory frameworks support a level playing field. But expansion to new countries also poses business viability challenges. The provision of innovative financing and smarter capital flows to take viable business models to scale and build markets is essential. By their nature, foundations have the funds and are in a position to take higher risks in their investments *e.g.* in R&D, innovation, pilots, etc. that LifeSpring would not be willing to embrace in newer markets. Also, foundations can play the key role of a broker between government-civil societies and the private sector in countries where that relationship is currently weak.

The LifeSpring model can be successfully scaled up via an integrated, genuine partnership model including all actors in society. While scale is important, it is necessary to focus on achieving operational excellence and profitability within existing hospitals before scaling up. Although LifeSpring was initially geared to open 30 hospitals by 2010, it re-evaluated its expansion goals, wanting to ensure that the model was set and finalised. This re-evaluation led to the development of a 'cluster strategy' approach, whereby it would have 10-20 hospitals in a given urban area. LifeSpring opened six more hospitals in Hyderabad in the summer of 2011, and now operates 12 hospitals in this cluster. •

BOX: HEALTHCARE IN POST-INDEPENDENCE INDIA

Since India's independence, public financing and the provision of healthcare services have been the main foundation of its healthcare policy. However, the public sector has well recognised problems, such as inadequate access by the most vulnerable groups, poor quality and coverage of primary and secondary facilities, and – until recently – excessive focus on sterilisation and inadequate focus on maternal and child health. The private sector has filled the gaps. At independence, it accounted for just 8% of healthcare facilities. According to the National Family Health Survey-3, the private medical sector is now the primary source of healthcare for the majority of households in both the urban (70%) and rural areas (63%) of India. Evidence is mounting that the private sector provides an increasing share of primary health care and that large segments of the poor use the private sector. The majority of private sector institutions are single-doctor institutions, with very little infrastructure or paramedical support. Many of these private practitioners do not have access to updated standard protocols for the management of common ailments; hence, the quality of treatment they provide is often suboptimal. Some private hospitals have also been found to be using inappropriate, unnecessary diagnostic tests and therapeutic procedures, as well as inappropriate and unethical treatment practices. Other problems reported in private sector include the use of unqualified service providers and the overuse of diagnostics and therapeutic measures, leading to exorbitant costs.

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Lessons learned from this issue

BY JULIEN LEFILLEUR, EDITOR IN CHIEF

The private sector is a key player in the healthcare systems of developing countries. Private operators – generally more efficient and flexible than public services – are often the leading providers of healthcare services in low-income countries. They account for more than half of healthcare provision in sub-Saharan Africa. With its flexibility and its greater freedom of action, the private sector is able to develop innovative models appropriate to the needs and resources of the poorest populations, while at the same time ensuring that its operations remain financially viable.

Nonetheless, guaranteeing fair access to quality healthcare remains a public service mission that cannot be delegated to the private sector without oversight. In developing countries where the health environment is sub-standard and the majority of the population is very vulnerable, the risks are higher than elsewhere: exclusion of low income population from access to healthcare, deterioration of healthcare quality and non-observance of standards in the sector, crowding out of public operators supposed to fulfil remits which the private sector is not interested in, etc. Besides, overseeing a private healthcare system – and thus ensuring that the public funds that finance most of the sector are traceable – is a particularly tricky task in low-income countries. Supervisory authorities often lack resources and are confronted with a multitude of small-scale players – sometimes informal operations, frequently working in difficult conditions and not always delivering quality services. Developing countries do not offer the ideal environment for the private sector to prosper sustainably: this is a market limited by low income, inadequate regulation, unfair competition from subsidised healthcare systems, etc. In these circumstances private operators find it difficult to get financed, and to build an organisation capable of attaining critical mass and achieving returns to scale.

Yet with respect to their needs, low-income countries are clearly among the most attractive markets for private investors. Their investments – if effective cooperation is developed with the public sector – can sustainably improve healthcare provision. To do this the private sector must innovate and adapt its models to these countries' specific needs – in particular by seeking to operate profitably in the 'bottom of the pyramid' (BoP) segment which constitutes the major part of the potential market. For this to happen, entry costs in this segment need to be reduced – for example by sharing resources with other players and scaling down structural costs. Cross-financing systems can also be put in place, so that wealthy patients indirectly 'subsidise' the poorest patients. Yet the social impact needs to progress beyond merely operating profitably in these most challenging segments. Private operators can also have a ripple effect across the entire sector, helping to support the public healthcare systems to which they are indebted: after all, the sector is still to a very large extent financed by public funds. Several kinds of support might be envisaged here: free healthcare for the poorest patients, supporting public operators through training initiatives and staff exchange programmes, structuring the network of private operators to complement public provision, disseminating expertise, helping to finance public health programmes, etc. In this context, development financial institutions have a fundamental role to play, by encouraging this cooperation, and by putting in place innovative financing solutions to meet the growing requirements of the sector.

In our next issue

Private electricity generation in sub-Saharan Africa

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