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As we prepare to host our 7th Global Private Health Conference in Barcelona, I reflect on its remarkable evolution over the years. When IFC organized its first emerging markets health conference over a decade ago, there was debate over the legitimacy of private health services as part of the solution for growing healthcare needs in emerging markets. It was a modest affair, hosted in the IFC basement, with about 60 attendees—all IFC staff and clients—and an agenda focused on health services.

It has been exciting for me to watch the conference grow into a major global event in the health industry, growth that has mirrored increasing investment in emerging markets health. Milestones along the way include in 2010, the first time we opened up the conference to non-IFC clients and held it outside our headquarters in a nearby hotel. In 2013, we took the party beyond Washington to Istanbul. In 2015 in Prague, we expanded the agenda to include the pharmaceutical sector.

Later this month, we will host our biggest conference to date. We are expecting around 500 participants from all corners of the globe, 70 percent at executive level, with representation from 60 countries. We are looking forward to helping them to network and share thoughts on how to create value-focused health systems, this year’s conference theme.

As we cross the 10-year mark, I’d like to thank a few attendees who have been with us throughout the journey, including Hygeia, one of Nigeria’s largest integrated care providers; China-based United Family Healthcare, another integrated care provider; and Saudi German Hospital, which operates a network of hospitals across the Middle East.

We all know the challenges in healthcare in emerging markets: lack of funding, shortfalls in health infrastructure, the rise of non-communicable diseases, and the aging of populations. At Barcelona, we aim to create the magic formula that inspires innovative ideas, ones where private and public sectors come together to find effective, integrated solutions to the problems we face.

We hope this newsletter will serve as an appetizer to things to come. We have exclusive interviews with our keynote speakers Elizabeth Teisberg and Mark Britnell, newly published case studies from clients Medlife in Romania and Fybeca in Ecuador, and a guest column from conference lead sponsor, Johns Hopkins Medicine. We hope you enjoy!
In 2015, the IFC Global Private Health conference was held in Prague where nearly 400 delegates actively discussed the important long-term role the private health sector plays in emerging markets healthcare. The 2017 conference will take discussions even further. With a greater number of delegates registered and from a broader global geographical spread, the opportunity for active networking, sharing important lessons learned, and developing long-term partnerships has grown.

In addition to fostering partnerships and investment opportunities, the 2017 event is built around relevant and pertinent themes where the private health sector has a voice.

At a time when there is an increasing global focus on how to build sustainable health systems and a deeper understanding of the role the private sector plays in many emerging markets, the core theme for the 2017 conference is value. We are fortunate that a leading figure in the value-based healthcare strategy movement will be the keynote speaker. Elizabeth Teisberg is Full Professor at the Dell Medical School at the University of Texas at Austin.

Professor Teisberg, who is also a senior institute associate at Harvard’s Institute for Strategy and Competitiveness, centers her work on high-value care delivery and implementation of value-based strategy in healthcare by providers, employers, health plans, pharmaceutical and device companies, patient advocacy organizations, and policy makers.

With her deep background in strategy and innovation and special attention to the healthcare sector, she collaborated with Michael Porter to co-author *Redefining Health Care: Creating Value-Based Competition on Results* (Harvard Business Review Press, 2006).
To tie everything together, our closing keynote speaker is Mark Britnell, the Global Head of Health for KPMG. Mark is Chairman and Partner of the Global Health Practice at KPMG.

Since 2009, he has worked in over 60 countries, helping governments and public and private sector organizations with operations, strategy and policy. He has a pioneering and inspiring global vision for healthcare in both the developed and developing world and has written extensively on what works around the world including his first book, *In Search of the Perfect Health System*, published in October 2015.

Through a value-focused agenda, the private sector can actively support the achievement of Universal Health Coverage through smart investment decisions and demonstrating smart business models that efficiently utilize resources and make use of appropriate emerging digital health and medical technologies. The conference will provide multiple insights into how success can be realized through smart investment strategies.

Key themes and panel discussions are summarized below:

**THE IMPACT OF SOCIAL AND PRIVATE HEALTH INSURANCE**

Social and private health insurance in emerging markets will expand significantly in the next decade. How will spending priorities be defined and how will this alter market dynamics? Will there be a shift from fee-for-service to bundled payments? What does this mean for private providers of care and how can they provide insight and support? How can we ensure that low-income quintiles can fully participate in these insurance systems? Which payment systems will evolve as most effective and efficient? Given resource limitations, which services should remain out-of-pocket and what should be covered by insurance?

**THE FUTURE OF MEDICAL DEVICES IN BRICS**

Given the ever increasing demand for affordable health services and the importance of timely access to health services, what are we learning and where is the medical technology market heading in BRIC countries?

**AN INVESTOR’S PERSPECTIVE—HEALTH PROVIDER CASE STUDIES**

Investment insights and case study stories from private health entities with whom IFC has partnered. What have been the secrets of success? How to work with investors and keep them happy? Key lessons learned and challenges faced.

**RIPE FOR DISRUPTION—THE FUTURE IS TECHNOLOGY**

An engaging look at how medical technology and digital trends are changing the shape of health service delivery. What does this mean in emerging markets not only for investors looking closely at the Medtech space, but also for those health service providers making medical technology investment decisions? Which non-health industries may enter the health market and cause disruption?

**WHAT PATIENTS WANT: VALUE THROUGH QUALITY**

A drill down into how a focus on quality benefits patient outcomes, experience, and overall care provision. The session will include case study examples of how quality not only adds value to the spectrum of care, but how it is feasible to implement sustainable quality management approaches that contribute to improved outcomes and at reduced cost.

**UNDERSTANDING REGULATORY AFFAIRS**

Using Africa and China as reference points, an interactive session to discuss the regulatory environment and approaches to improve the manufacturing as well as supply and distribution of drugs and medical consumables in emerging markets. What has worked? What are the challenges ahead? How is the regulatory environment developed over the years and what are the strategies to manage the changes? How to develop a better collaborative approach going forward? Specifically on pharmaceutical distribution, we will discuss the typology of countries looking to restructure their pharmaceutical supply chain, including for example—the level of private sector involvement, regulations and upcoming changes to the regulations, current level of fragmentation/concentration and trends toward consolidation, how the use of technologies such as track and trace can be beneficial,
wholesale and retail mark-ups for medicines (by comparing prices across regions), sharing of drugs that are imported vs domestically produced, and level of counterfeit drugs.

INNOVATIONS IN THE SUPPLY OF SKILLED HEALTH PERSONNEL

Most emerging markets face uncertainty on how to train and retain health professionals. Using case study examples of innovative practice, this session outlines workable solutions for the training and development of health professionals in emerging markets.

SUCCEEDING IN CHALLENGING MARKETS

A ‘lessons learned’ dive by experienced emerging markets health sector investors and operators into some of the common challenges to be considered when making investment decisions in these markets. What are the common risks to be considered pre investment? What problems often arise post investment? How does the investment experience differ between younger and mature entity types? Does the health sector present specific issues? Are some markets facing a valuation bubble in the health sector? How to manage investment hype vs market reality.

DISRUPTIVE MODELS IN PRIVATE AND PUBLIC COLLABORATION

An interactive and provocative session to explore various models of public and private collaboration and how they support sustainable health systems and improve service delivery. Panelists together with active audience input will look beyond traditional infrastructure Public Private Partnership (PPP) models and explore emerging and expected future trends in public private collaboration. What are the lessons not to be repeated from previous PPPs? How can more conducive participative environments be established? How can the private sector play a direct and expanded role?

For those of you coming to the conference, we look forward to seeing you in Barcelona. Stay tuned after the event for our conference eMagazine, where you can read summaries of all panel discussions and keynote speeches.

Charles Dalton
IFC Senior Health Specialist
As the co-creator of the “value-based health care” concept, are you heartened or disillusioned with how markets have evolved since you published your book a decade ago?

Value for patients is now recognized as a critical goal in healthcare delivery. This raises aspirations to achieve better outcomes for the money spent, and thus expands the opportunity to enable better health for more people. All of that is heartening.

Improving health outcomes is the goal of healthcare. Spending reduction is necessary, but not sufficient. People need appropriate, efficient, effective care.

Politeness and respect are critical, but should be the norm, not the stretch goals. People don’t seek healthcare for the experience of treatment, but the experience should nonetheless be caring and compassionate.

Improving value for patients—achieving better outcomes that are meaningful to patients and families, for the money spent over the full cycle of care—aligns the professional aspirations of clinicians with the goals of the individuals they serve. That alignment is an antidote to burnout. And this support for professionalism is also heartening.

What is the measure or measures of success in a healthcare market?

High value means improving the health outcomes achieved for the money spent on the full cycle of care. Health is individual, though people share health circumstances. Organization around the shared health circumstances that many people face can enable the success of effective, kind, efficient care for more people. To measure this success, the healthcare sector needs different outcome goals in different patient segments. For example, the outcomes that matter are largely similar among patients with the combination of hypertension and diabetes, and largely similar among children with asthma, or among frail elderly adults, but outcomes are different for those three examples.

As an American based in the U.S., what is your take on its heated debates around health policy—in particular, what lessons should the rest of the world draw from how the U.S. system is organized and from efforts to improve it?

The United States drives up spending by failing to provide universal access to effective early stage and preventive care. This is a mistake to avoid. Every nation in the world with some form of universal access to primary and preventive care has lower costs per capita than the U.S. does.

Unfortunately, with universal access only to emergency rooms, the U.S. policy debates have had to remain focused on access questions. It is important to solve and get beyond access issues to the questions on how to transform care delivery and achieve better health results. Countries with universal access to early and preventive care can focus on transforming to high-value healthcare.

You will be joining us in Barcelona next month for our biannual conference on private health care in emerging markets. What parts of the agenda are you most excited about and why?

There are myriad opportunities in emerging markets to leapfrog current approaches and design effective, integrated care that achieves high-value care delivery. Transformation is difficult for most people to imagine, but the possibilities are huge. Think back to your phone service in the days of wired land line phones. No one complained that their phone didn’t take pictures of their children playing at the park—it was beyond imagination. Healthcare delivery could change that much in the coming years.
What are some innovative business models you are seeing emerge that take on board this notion of value-based health care?

Organizations that start from understanding the needs of individuals are creating exciting new models. Some provide “surround sound” support for lifestyle change, such as the new chronic headache care centers in Germany, which aim to improve exchange of information and coordination of treatment for better outcomes. Some organizations provide different approaches to communication that change the location, medium, or delivery of the message rather than just re-scripting what it said.

Organizations that measure meaningful outcomes during and after care drive the insight to achieve better and better health outcomes for the people they serve. Usually, this involves creating interdisciplinary care teams that integrate the needed care rather than layering on coordinators in systems of fractured care.

What are your predictions for how health systems and markets in the coming decade will evolve and what are the core challenges that need to be addressed?

I hope the world will see more healthcare value achieved for more people. This requires transforming systems to be about health, not just treatment. Organizations rarely improve what they don’t measure. Measuring meaningful health outcomes is a powerful lever for driving the needed transformation.
Q: What inspired you to write your book, ‘In Search of the Perfect Health System’?

Over the past eight years, I’ve had the privilege of working in 69 countries on over 300 occasions, and worked with a wide variety of public and private organizations. This has provided me with a unique opportunity to look closely at the strengths and weaknesses of health systems around the world. Over time, I’ve collected notes and ideas on my journeys. I wrote my book based on these experiences so that politicians, health professionals, patients, and the public can better understand that every country is facing pressures with their health service.

Q: How attainable is Universal Healthcare Coverage (UHC) for all countries?

The momentum behind UHC as a global priority is now unstoppable. Countries are increasingly appreciating that it provides not just a moral and social benefit, but also an economic and political advantage. These latter points are important, as politicians realize that investment in healthcare for all is a value and not just a cost. It has been estimated that a one-year increase in life expectancy can increase GDP per capita by 4 percent. The recent Lancet Commission noted that reductions in mortality in low and middle-income countries accounted for approximately 11 percent of recent economic growth. Given the ways in which healthcare has a direct gain on a country’s GDP, new global health funding streams have increased dramatically and remain an almost uniquely favored area of interest for international donors. KPMG’s new Center for UHC exists to help countries overcome these issues. We have developed an unmatched suite of tools, intelligence, insights, and experience to make UHC reforms a success.
What are the key ingredients to implementing UHC successfully?

How to achieve UHC will be one of this century’s greatest challenges of political will and technical skill. Part of this challenge stems from the lack of a clear threshold of when UHC has been achieved, and how to measure progress toward it. Experience from the Millennium Development Goals shows clearly that what gets measured matters, and the targets selected for health programs have a major impact on how those programs are designed. From our research on countries that have achieved UHC emerge three clear design elements that are important to include. Firstly, some element of mandatory inclusion or membership in the scheme. Secondly, it is highly beneficial to pursue a ‘breadth then depth’ strategy, meaning you first try to provide coverage to the entire population for basic primary healthcare, and then expand this coverage to include more complex primary healthcare as well as secondary and tertiary healthcare. Thirdly, include some form of public insurance or financing option, even if a private health insurance market is envisioned.

What country provides a good lesson to share with others on UHC?

Our recent work in the Bahamas provides an excellent case study of wholesale transformation of a country’s health system toward universal coverage. Several previous attempts at introducing a unified National Health Insurance (NHI) system, dating as far back as the early 1980s, had been obstructed by political turbulence, vested interests in the status quo, and implementation challenges. However, this cycle is finally being broken. After a renewed push by government—and with support from KPMG—the Bahamas is in the midst of implementing the most significant national development program in over a generation. In the initial phase to be rolled out in May 2017, primary care physician services will be provided for free at point of care at approved providers across the public and private systems, as well as many drugs and diagnostics.

KPMG’s team has been working since February 2016 to support NHI Bahamas in a range of areas. We are helping to draft guiding policies, define and cost the initial NHI benefits package, negotiate new physician fee schedules with options for capitated, bundled or fee-for-service models, and establish an integrated governance structure to direct the implementation of NHI and health system strengthening efforts. We are also assisting in procuring a private operator to run the new public insurer (BahamaCare), designing the IT architecture to support the scheme and supporting procurement of the IT solution, developing relevant legislation and regulations, providing health system strengthening support to bring public primary care clinics up to the required standards, and facilitating stakeholder consultations with key constituencies.

Q: What are the common challenges in achieving UHC?

To date, only 60 of the world’s 192 countries are thought to have achieved universal coverage, leaving many of the rest with at best partial coverage.
Other questions we have worked through with governments include—what is the role of the State? How will the system be regulated? What will the benefit package comprise? Who will be covered and for what? How will the system be governed? How will the doctors be paid and managed? How will the provision of care be monitored and evaluated?

Q: **What about spending—How do you get “better value for money” when striving for UHC?**

UHC is about far more than spending more on healthcare—the design, performance, and equity of the system arguably have a much greater impact on progress than spending. This is evidenced by low-spending nations such as Israel, Singapore, and Brazil that have nonetheless achieved UHC, and high-spending ones such as the United States and Russia that have not. In many developing countries the instinct to replicate and imitate the health systems of developed economies is strong, but new entrants are challenging such thinking and introducing frugal innovation to meet local needs with better value.

We recently convened a conference in Africa where more than 50 public and private sector health leaders from across the continent discussed the provision of low-cost, high-quality healthcare. Key aspects of frugal healthcare innovation included use of asset-light and fit-for-use facilities that avoid over-specification, centralization of diagnostics and support services and lean supply chains, and carer or supported services delivered in conjunction with patients and families.

Q: **What are the basic options for funding UHC and what are their pros and cons?**

Different countries have taken different approaches to paying for UHC systems and these can broadly be split into three groups: single, public payer; multiple payers including both public and private options; and multiple private payers. Each of these approaches has been used in multiple countries and have demonstrated advantages and disadvantages to date. Single payers provide a large scope for raising resources and a potential administrative efficiency, but may lack choice and innovation and introduce potential inefficiencies due to lack of competition. A mixed multiple payer model can provide more individual choice and competition but can fragment care and increase complexity, while tending to escalate costs. Private multi-payer models, such as through mandated insurance with no ‘public option’, can help finance health services not funded publicly but can be associated with higher administrative and health system costs, and may tend to create a less equitable and slower path to UHC. There is not necessarily a clear “best practice” for funding healthcare and the funding approach choice should be based on the needs, capabilities, and political situation of an individual country.

Q: **Which parts of the Barcelona conference are you most excited about?**

The Barcelona conference is a truly global event bringing together private and public sector healthcare players from around the world. I think it will be a great learning experience, with renowned thought leaders and innovators whose work and ideas influence our industry. I’m looking forward to a global exchange of ideas, knowledge, and best practices, and sharing the exciting work we are delivering through KPMG’s new Center for Universal Health Coverage.

Dr. Mark Britnell is the author of ‘In Search of the Perfect Health System’ published by Palgrave (ISBN 9781137496614) and Global Healthcare Practice Chairman and Senior Partner at KPMG. For further information, please visit the KPMG Center for Universal Health Coverage.
Hospitals in about half of the world’s nations are operating with subpar numbers of essential healthcare personnel. The World Health Organization recommends a minimum ratio of 23 healthcare workers per 10,000 people, yet a global shortage makes reaching this ratio a significant challenge—and a barrier to better patient outcomes.

The overall shortage is exacerbated when aspiring doctors from countries without robust academic centers pursue their medical studies in the United States, Canada, Australia or Europe—search of better economic opportunities.

Johns Hopkins Medicine, a leading academic health system in the United States whose mission is to improve the health of the community and the world, helps to address this shortage by enhancing nurses’ clinical skills and education globally.

“In countries facing a lack of resources in healthcare delivery, nurses are a natural choice to increase those resources,” says Mohan Chellappa, M.D., president of global ventures and executive vice president of Johns Hopkins Medicine International. “Hospital administrators are now seeing nurses as instrumental to augment capacity, standardize care, and reduce costs.”

THE CASE FOR NURSE PRACTITIONERS

In the United States, one of the most successful capacity extenders is nurse practitioners—nurses with the academic preparation (master’s or doctorate level) and training to diagnose and treat health conditions, while emphasizing disease prevention and health management.

“Nurse practitioner students enjoy the academic preparation, which builds upon their clinical backgrounds, allows them to develop in a specialty practice, and expands their skills in pharmacology, pathophysiology, and physical assessment,” says Karen Haller, vice president of nursing and clinical affairs for Johns Hopkins Medicine International.

The American Association of Nurse Practitioners states that there are more than 222,000 licensed nurse practitioners in the United States. Their clinical focus areas cover the range from primary care to acute care, and from pediatrics to gerontology, as governed by national and state-by-state laws.

Overall, this model has helped reach patients in rural areas and improved the overall access to clinical care.

SOLID RESULTS

In 1986, an analysis by the Office of Technology Assessment (OTA) indicated that nurse practitioners can safely and effectively provide more than 90 percent of pediatric primary care and 75 percent of general primary care services. Since then, multiple reports have confirmed these findings.

“Specialized nurses provide care that is at least as good as that provided by physicians,” says Chellappa, a surgeon by profession. “Nurses are the first line of contact with the patients and therefore have the trust of the patients.”

Patients’ trust—along with an increased use of technology in healthcare diagnosis and delivery—helps nurses offer the same quality of care as offered by physicians, in a standardized manner.

A GLOBALLY REPLICABLE CONCEPT

In many parts of the world, nurse training, education, and the practice environment have not yet evolved to the point where advanced practice nurses can be developed and incorporated. Addressing policy and licensing, access to education programs and the culture of how nursing roles are used and perceived is still needed to gain the benefits of using nursing to extend limited resources.
For nearly 20 years, Johns Hopkins Medicine International has collaborated with organizations around the world in the public and private healthcare sectors to help address these issues, including program development related to advancing nursing practice that is customized to the local region.

“There is a global demand to elevate nurses’ practice,” says Haller, who holds a doctorate in nursing. “Depending on the location, this is driven by the need to enhance quality and safety, become more cost-effective, or leverage physicians for more complex care.”

Between 2015 and 2016, some 300 nurses and nurse leaders from nine countries participated in nurse leadership development sessions in Baltimore, USA, sponsored by Johns Hopkins Medicine International, the Johns Hopkins University School of Nursing and the Institute for Johns Hopkins Nursing. Through interactive workshops, they built skills ranging from establishing budgets to navigating difficult conversations with staff members.

In Colombia, nurse leaders at Fundación Santa Fe de Bogotá (FSFB) are building on the training they have received as part of a long-term collaboration with Johns Hopkins Medicine International. The development of a Department of Nursing, a new nursing practice model and the creation of a chief nursing officer position are among the successes.

In the Kingdom of Saudi Arabia, Johns Hopkins Aramco Healthcare—a healthcare joint venture between Saudi Aramco, a world leader in energy, and Johns Hopkins Medicine—and the Johns Hopkins School of Nursing established the first Doctorate of Nursing Practice (D.N.P.) program in the Kingdom as a way to address the local physician shortage.

To earn a D.N.P.—the highest degree possible in the profession—students must complete two years of academic, clinical, management and leadership studies, culminating in an independent project. The program enhances nurses’ clinical skills, develops their leadership skills, and solidifies their role as an essential complement to physicians in delivering healthcare.

“This program is my dream,” says D.N.P. student Leena Al-Mansour. “I want to improve my leadership skills and my clinical practice. This is a golden opportunity.”

D.N.P. students at Johns Hopkins Aramco Healthcare recently launched a palliative care nurse-led consultation service to standardize the process to foresee and address the needs of patients at the end of life, including outpatient services and home health care follow-up. The consultation service is estimated to save over $2,500,000 a year in admission costs—but the true value of the program is reducing the pain and emotional suffering of patients and families.

THE ROAD AHEAD

For decades, trained nurses have assisted with care, mainly taking part in non-interventional clinical care delivery, such as monitoring and recording vital signs. This approach does not leverage their clinical training and fuels the notion among patients that doctors are the only ones with the knowledge to treat a condition and provide care.

There remains a need to fully educate local communities—and physicians—in emerging nations to provide the evidence that healthcare delivery requires a team approach between nurses and physicians.

“Sometimes there is reluctance from physicians and patients to rely on nurses as care providers. But when they see the benefits—more access, longer visits, more empathy—they are more likely to adopt the system,” Chellappa says. “We’ve seen it in the Kingdom of Saudi Arabia: The initial hesitancy from the patients and families now has been reversed.”

Physicians themselves can be a powerful ally in—and beneficiary of—paving the way for advancing nurse practice, especially those who return to their home countries after training abroad and experiencing firsthand the advantages of working as part of a highly trained healthcare team.

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Photo above: A group of 13 Doctor of Nursing Practice program students visit the Johns Hopkins Hospital to fulfill part of their nurse leadership coursework. Also in the photo are Johns Hopkins Aramco Healthcare nurses, school of nursing instructors and Johns Hopkins Medicine supporters of the program.
IFC is investing in Seniority Chile S.A., a provider of quality senior healthcare services in Latin America that operates under the brand name of Acalis. The investment, which is IFC’s first transaction in senior healthcare services, will support the creation of a network of professional-quality nursing homes in Chile and Colombia, responding to the needs of the rapidly aging population in Latin America. Acalis is part of the Belgian group Senior Assist International, which operates nursing homes in Europe, Asia and Latin America.

The company offers a host of integrated medical services to individuals and corporate clients, catering to the middle-income segment of the country’s population. This is IFC’s fourth transaction with company and will help to further increase the national coverage of its services through expansion into second- and third-tier cities and the broadening of its service offerings.

A privately held group engaged in pharmaceutical manufacturing, distribution and retail, healthcare services, and health insurance. It is one of the largest pharmaceutical retailers and distributors in the country and it positions itself as an affordable and convenient pharmacy for the low- and middle- income population. IFC will finance the construction of an advanced oncology center in Tbilisi and an outpatient clinic in Telavi, East Georgia. IFC will also support the acquisition of state-of-the-art medical equipment for both clinics. Many of those services are scarce in Georgia, especially in the country’s outlying regions.

A subsidiary of Bank of Georgia Holding, Georgia Healthcare Group Holding (GHG) is the largest healthcare company in the country, owning operating companies that are market leaders in health services, health insurance and pharmaceuticals retail and distribution. IFC is supporting the expansion of Evex Healthcare services, the largest chain of hospitals country-wide, currently represented with 76 hospitals and clinics in six regions of Georgia serving patients from all segments of the population covered by Georgia’s universal health insurance scheme. The expansion financed by IFC includes the renovation of two recently acquired referral hospitals, a major expansion of its ambulatory clinic network and diagnostic laboratories, potential acquisitions, and expansion of its services in existing hospitals.

A healthcare service provider which owns and operates a healthcare network in the Indian state of Uttar Pradesh. Regency’s network currently includes two tertiary care hospitals, a healthcare clinic providing outpatient and diagnostic services, and dialysis treatment centers operated under a joint venture with Fresenius Medical Care—the world’s largest provider of products and services to people with chronic kidney failure. IFC is helping to finance the completion and opening of operations for a new oncology hospital, which will be Uttar Pradesh’s first oncology specialty care facility and operated under a joint venture with Healthcare Global Enterprises, also an IFC investee, as well as a new secondary care hospital. IFC’s investment will also support Regency’s planned expansion to cities in Uttar Pradesh, which lack quality health infrastructure.
ESSEX BIO (CHINA)

A research and development-driven pharmaceutical company and a leader in the development, production, and sale of biopharmaceutical drugs for certain niche eye treatments in China. Its drugs are used in the treatment of surface wounds and a variety of eye diseases and are based on basic fibroblast growth factor technology. IFC is supporting the company’s plans to continue investing in research and development, increase its sales-force, and improve its working capital management.

APOLLO SPECIALTY (INDIA)

Apollo Health & Lifestyle Limited (AHLL) is a subsidiary of Apollo Hospitals Enterprise Limited, a leading Indian healthcare group and a longtime IFC client. AHLL runs a network of multispecialty clinics including diagnostic centers, maternity clinics, planned surgery formats, and diabetes management clinics. IFC, together with its Asset Management Company (AMC), has invested in AHLL to help finance the opening of nearly 1,000 medical facilities, laboratories and collection centers. The investment will create over 4,000 new jobs across India for healthcare professionals, including doctors, nurses, and technicians.

UFH (CHINA)

Chindex is a major private healthcare company which provides premium quality healthcare services in China and operates under the newly incorporated Healthy Harmony through the operations of United Family Healthcare. IFC is again investing in Healthy Harmony, through United Family Healthcare to support the construction of a greenfield 150-bed general hospital in Guangzhou.

MEET IFC’S NEW HEALTH ECONOMIST

Meet IFC’s New Health Economist, Andrew Myburgh, who recently joined IFC as a senior health economist. He is going to be working on a number of initiatives over the coming year. Two of these are to help clients improve the quality of care they provide, and to help determine the important contribution that the private sector brings to several countries’ healthcare systems.

Improving and sustaining the quality of healthcare delivered is important for all healthcare organizations. Andrew is designing an advisory program to help organizations improve systems’ diagnostics, structures, and policies. The diagnostic will determine which areas are not performing effectively, and will inform the development of a “treatment plan.” The team will be available to help implement the plan through the provision of ongoing support. This approach has helped healthcare organizations achieve substantial improvements in the quality of care they provide, and Andrew is looking forward to helping IFC’s clients achieve the same.

There is a growing recognition of the contribution that private healthcare organizations make to countries’ healthcare systems. That said, understanding the role that the private sector plays has been held back by lack of analysis and data that could clarify, and quantify the role of the private sector. This is changing. New data sets are becoming available on countries’ disease burden and the provision of services by the private sector. Using this data, Andrew will be working to provide more clarity on the role of the private sector and provide advice on how governments can work more effectively with the private sector to further strengthen the contribution of the private sector.
All of a sudden, Aneliss rolled her eyes to one side, as if she didn’t know where she was, and began to vomit. She started to cry and then went into a strange state, she was just staring aimlessly,” explained her mother, Diana U. Her frail daughter, just barely 13 months old, went on to have a seizure. Her mother had suspected that something was not right with her daughter since she was born. Early on, she had bags under her eyes and when she was nine months old, small veins appeared above the bridge of her nose and her eyes had swollen significantly. Blood tests did not reveal any particular issue but her mother was worried that the veins might burst, so they were very careful when handling her.

The parents had planned on taking Aneliss to be seen in Bucharest, where there is better quality care, but after this seizure they called 112 and took her to the emergency room in Constanta. A CT scan showed that there was a brain hemorrhage which could not be treated locally. The neurosurgeon referred them to a public hospital in Bucharest. At 4:00 a.m., they arrived and the doctor told them to “enjoy it while it lasts; we don’t know what could happen later.” Those words were very jarring to the parents, and the mother responded by saying, “Doctor, I have no intention to bury my child.” That doctor ultimately referred them to Dr. Stefanita Dima at MedLife.

In addition to the MRIs and CT scans that had been done, Dr. Dima ordered an angiogram, which provided a very clear view of what was happening. Dr. Dima told the parents that they were dealing with a very rare condition—pial paragalenic arteriovenous fistula—a type of venous aneurysm, which compressed the nerves and reversed the blood flow. This caused the epileptic seizures and the eyes to bulge. This was the first case in Romania and there had only been six such cases in the world.

Aneliss needed brain surgery. The father cried for two days in a row fearing that they would lose their little girl, but the mother told him she did not accept that—whatever happened, she must live. It was an emotional roller coaster for them given the complicated nature of the surgery. The medical team inserted metallic spirals (coils) that corrected the aberrant communication of the vessels at the site of fistula and a resin consolidated the entire structure, allowing the blood to resume its normal flow.

The surgery, which was done in September 2016, was a success. It was the first of its kind in Romania and Aneliss’ case was the seventh in the world to be treated with modern techniques since 2010. Aneliss woke up without any complications, was much livelier than prior to the surgery, and had a big appetite. Reflecting on the experience, Diana said, “We found a team of consummate professionals at MedLife, who helped my daughter become a normal child. She is laughing again and wants to get up and walk—she had started to walk right before her first seizure. I’m happy and can’t wait to take her home! We are forever thankful to the people at MedLife!”

Twenty years ago, such a complex surgery would not have been possible in Romania. Mr. Mihai Marcu, Chairman of the MedLife Board, explains, “MedLife was able to successfully address this case because of the high level of quality of our medical team and the state-of-the-art technology in which we are always investing in. This positions us to manage an increasing number of high complexity interventions, which are comparable to the procedures performed in high-ranking hospitals abroad.”

MedLife, S.A. is the leading private, for-profit healthcare provider in Romania, serving over 2 million patients annually with 3,300 employees, of which nearly 2,000 are doctors and 1,000 are nurses. MedLife has achieved such market penetration by offering “a one-stop shop” approach for patients through a network that integrates 37 outpatient clinics, 8 hospitals, 3-day care units, 26 laboratories with 143 sample collection points, 10 pharmacies, and 8 dental clinics. Its corporate subscriptions, pre-paid employer provided healthcare packages for employees, have reached over 500,000 individuals. Most of its patients are seen on an outpatient basis.
In 20 years, MedLife dramatically elevated the availability of quality healthcare, bringing it out of a communist era mentality and infrastructure and putting its services on par with several of its European neighbors. It has demonstrated that the private sector can be trusted to provide effective medical solutions. MedLife has become the leading healthcare provider in Romania by offering innovative, effective, affordable, and good quality healthcare.

The company has established a geographic footprint in about half of Romania and it has reached 80 percent of inhabitants in the areas where MedLife has a presence. Over a period of 20 years, it has provided medical services to over 5 million unique patients—this accounts for about 25 percent of the overall Romanian population. It is quite rare for a single private health service company to have treated such a large share of the country’s population. In addition, 70 percent of its patients are women.

IFC played an important role in MedLife’s growth and expansion through different stages of its development. In 2005, IFC took an equity stake in the company with a $5 million investment and a EUR 5 million ($6.23 million) loan. This was later followed by two separate loans over the next decade totaling EUR 20 million ($24.3 million) from IFC’s own account. In addition, in 2011, IFC mobilized a EUR 40 million ($53.6 million) syndicated loan. In December 2016, IFC supported MedLife in going public. It was the first healthcare company to be successfully listed on the Bucharest Stock Exchange. In 13 years, the company’s revenues have skyrocketed. In 2003, the company’s revenues were $1.5 million and as of December 2016, they rose to an estimated EUR 116 million, ($128.3 million).

**TOP 3 SUCCESS FACTORS**

Becoming the largest private healthcare provider in Romania was made possible in large measure because of its hyperclinics, its focus on the patient experience, and its pioneering attitude.

**HYPERCLINICS**

MedLife introduced the “hyperclinic” concept to the Romanian market. A hyperclinic is a very large clinic that treats a number of medical issues on an outpatient basis. This concept was revolutionary in Romania at that time. Romanians had believed that the hospital was the only place to get problems solved, because communist medical systems were typically hospital-centric.

The hyperclinic brings together a number of medical specialties under one roof and compliments high medical quality with state-of-the-art diagnostic and treatment equipment, labs and pharmacies. With its “one-stop shop” model, MedLife helped change the culture in Romania toward a greater acceptance of medical solutions that can be done on an outpatient basis. The hyperclinic is the gateway and referral coordination hub for its other health services.

**PATIENT EXPERIENCE**

MedLife fosters a medical culture that is focused on the best care experience for the patient. For many Romanians, this begins through employer-based corporate subscriptions that provide access to MedLife doctors for annual exams and basic care. If issues are identified, care is escalated to the next tier, typically an outpatient clinic. Across its network,
it improved the patient experience by standardizing care and covering a large number of specialties—ten of which are specialized niches.2

It attracts qualified doctors and is constantly increasing capabilities. It provides a clean medical environment and has a very low infection rate. It eliminated the “grey envelope,” a widespread practice in public hospitals where patients are expected to make informal payments to doctors prior to receiving treatment. It eliminated this practice by hiring doctors directly and paying them well. Unlike at public institutions, everything the patient needs for treatment is provided by MedLife on site, without the need for the patient to provide medications and medical consumables in order to be treated. It has gained patient trust in a country grappling with corruption and has built a strong brand based on its good reputation.

PIONEERING ATTITUDE

MedLife was convinced that they could do better than the status quo in the post-communist era and they introduced a number of firsts in Romania. They were the first to introduce the hyperclinic concept, the first to offer a fully integrated solution for patients on site, the first to open a private hospital for Romanians, not just expatriates, the first to hire their own doctors as employees, the first to offer transparency in pricing for patients, the first to introduce the day surgery model in Romania, and the first healthcare company to successfully publically list on the Bucharest Stock Exchange.

While some of these features may have already existed in other parts of the world, MedLife was the first to introduce them to the Romanian market and did so successfully. These efforts helped to change the culture of healthcare in the country. It shattered stereotypes and redefined patient expectations. It proved that the private sector has the power to safely resolve medical problems from the simple to the complex—with quality care.

Ann Casanova
IFC Health and Education Consultant

Twenty years ago, the brain surgery that saved Aneliss’ life would not have been possible in Romania but MedLife successfully cured the little girl’s rare condition.
The mid-1990s were a challenging time for low-income Ecuadorians that needed to access affordable, quality medicines. Because of political turmoil and a severe financial crisis, urban poverty increased from 35 percent to 65 percent between 1998 and mid-1999 in Ecuador. The lack of universal public insurance meant that private spending on health was almost entirely out-of-pocket, with an estimated 61 percent on pharmaceuticals.

Both the rural and urban poor were equally impacted by the crisis. At the time, about 45 percent of Ecuador’s population resided in rural areas. The rural poor had limited or no access to public health facilities and experienced medicine shortages because pharmacies were concentrated in cities with high population densities. Instead they turned to traditional healers, travelled great distances to purchase medicines they could barely afford, or went without medicines. In cities, pharmacies were plentiful, but they catered to middle and high-income customers, neglecting the urban poor.

Against this backdrop, Corporación Grupo Fybeca S.A. (GPF), a pharmaceutical retailer with a history of innovation, saw an opportunity to complement its high-end pharmacy chain, Fybeca, with a down market chain so that customers could access quality medicines at economical prices. In 2000, GPF launched SanaSana—its first pharmacy for low-income customers. GPF is a private holding company that dates back to 1930 with third and fourth generation family members still involved in management. The company employs 4,500 people and is committed to promoting gender equality — 65 percent of its staff are women—and the values of trust, transparency, and a desire to serve others.

Today, there are 510 SanaSana pharmacies across 120 cities and towns in all 24 of Ecuador’s provinces. Around 218 SanaSana pharmacies are located in rural areas, smaller cities, and towns. SanaSana is now the country’s largest pharmaceutical chain of company-owned and managed stores and the second largest in market share. The brand has become prominent for selling prescription and non-prescription medicines, personal care products, general merchandise, and mobile phone airtime along with handling utility bill payments. In 2016, SanaSana pharmacies contributed to more than 50 percent of GPF’s revenues.
PRIVATE HEALTHCARE IN EMERGING MARKETS
An Investor’s Perspective

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