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PRIVATE HEALTHCARE IN EMERGING MARKETS
An Investor’s Perspective

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I am excited to announce a bold new World Bank Group (WBG) initiative that will provide guidance to private health care providers and investors on how to embed ethics into their businesses. At the upcoming 8th IFC Global Private Healthcare Conference on March 27–28 in Miami, we will unveil the WBG’s 10 Ethical Principles in Health Care (EPIHC). These principles will unpack in an accessible, methodical way the issues that health care organizations need to pay attention to in this field.

With more than $2 billion in health care investments dispersed across dozens of clients across the globe, IFC is well placed to spearhead this initiative. Some of our more established clients may have already integrated these principles into their daily operations. However, other health care providers—even in the least developed markets—may not yet have thought through the issues these principles raise. We expect all the health care organizations that IFC supports to follow these principles, and we will encourage others to follow them too. As well as being the right thing to do, we believe it is in their long-term interest as businesses to implement these principles. Ultimately, the more ethically responsible you behave, the more patients you attract, the more high-quality staff you retain, and the better you perform as a business.

So what kinds of issues do the principles flag? To give just a couple of examples, EPIHC 3 underscores the value of promoting high-quality standards of care. It may surprise some to learn that poor quality health care kills more people each year than lack of access to care. And so, if you are a business operating in this space, ensuring high-quality care is an essential ingredient in transforming Universal Health Coverage from an aspirational goal to a clinical reality. After all, there is no point guaranteeing patients free access to care if that care is going to cause them harm. Another example is EPIHC 6, which focuses on upholding patients’ rights. When someone needs health care, they are often in a vulnerable state. That is why it is so important for care providers to ensure that the patient understands the proposed treatment, is informed of the alternatives, and is made aware of the right to refuse or discontinue a treatment at any time.

This is not the first initiative of its kind. Notably, back in 1999, there was a move in this direction by a group of individuals who, under the auspices of the British Medical Association (BMA), published the Tavistock principles, named after BMA’s headquarters in Tavistock Square, London. Two decades on, with more and more countries adopting Universal Health Coverage as a national goal and given the crucial role of the private sector in helping to reach this goal, a revived, reinvigorated push is timely. IFC has worked closely with the World Bank’s Human Development Practice Group and other thought leaders over the past year to develop the principles.

IFC’s health care conference in Miami is an ideal venue for the EPIHC rollout. We will be convening 400+ health care providers, investors, and thought leaders from more than 50 countries, 70 percent at executive level, for two days of top-quality discussions and facilitated networking. We are delighted that several of our clients have already agreed to become ‘Early Adopters’ of the principles, including Apollo Hospitals in India, Medicina clinics in Russia, Quadria Capital (an Asia-based fund), and Saudi-German Hospital Group. We hope that others—both IFC clients and non-clients—will follow their lead. It’s good for patients, good for business, good for staff, and, ultimately, the right thing to do.

For more information on EPIHC, go to www.ifc.org/EPIHC
Ten years ago, I came to Africa for what I thought would be a three-month stint, leading an impact investment fund in the region. A decade later, I am still here, having had the privilege of investing in and working alongside incredible entrepreneurs who have built enterprises that deliver critical services to millions of consumers in sectors ranging from education to renewable energy to health care. Of these, health care has provided me with the clearest view of the vast opportunities—and very real challenges—of operating in Sub-Saharan Africa. Having led $300 million of investments across nine companies in eight countries, it seems timely to reflect on these enriching experiences and pen some thoughts about this space.

The past decade, as I see it, has been defined by three big trends: the push for Universal Health Coverage (UHC), the consolidation of health care providers, and the arrival of large-scale private equity investors. A fourth trend—the deployment of emerging technologies—has enormous potential to shape the next.

EXPANDING HEALTH COVERAGE—A QUALIFIED SUCCESS

There is a growing consensus across Africa’s political leadership that government-sponsored health insurance is a critical tool for arriving at the holy grail of Universal Health Coverage. Ghana, Kenya, Nigeria, and Rwanda have joined South Africa—five countries with a combined population of 338 million—in declaring their intent to provide basic health insurance to every citizen through public health insurance schemes financed through a combination of government funding and individual contributions. It is estimated that more than 63 million people in these countries now have some form of health insurance, a number projected to grow exponentially over the next decade.

This change in the role governments see for themselves in health care—from being a provider of care to a financer—is a seismic shift. Smart implementation of these national insurance plans could reap numerous benefits such as equity in health care outcomes irrespective of ability to pay, more risk pooling, and increased ability to leverage private capital to build a much-needed health care delivery infrastructure. It also has the potential to lower overall health care system costs. Some of these benefits have begun to accrue. For example, in Kenya, the National Hospital Insurance Fund (NHIF) expanded by 70 percent between 2014 and 2018 to cover an estimated 25 million individuals—50 percent of the country’s population. The NHIF paid out close to $370 million in medical costs in 2018 compared with $100 million in 2014. While the veracity of some of these numbers have been questioned by critics, most actors in the Kenyan health care space agree that the NHIF is fast becoming a bulwark protecting Kenyans against catastrophic health events as well as a catalyst spurring growth in the sector. This emergence of a major government health insurance scheme, has in turn, spurred investments by private investors and entrepreneurs in health care infrastructure nationwide.

Despite these commendable efforts and progress, however, Sub-Saharan Africa still has a long way to go to attain sustainable, universal health insurance. Two major hurdles need to be overcome. Firstly, there is much room for improvement when it comes to the quantity as well as the quality of health insurance penetration. Ghana, for instance, the first country in the region to legislatively mandate universal health insurance in 2003, only managed to attract 11 million subscribers in its scheme’s first decade, or about 30 percent of the population. Rwanda has, by comparison, achieved near universal penetration—92 percent—but the services the Rwandan scheme covers are confined mostly

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1. EY, Global analysis of health insurance in Sub-Saharan Africa, 2018
2. NHIF performance report, June 2018
3. NHIA annual report 2013
to primary health care. While primary health care coverage is important and has likely played a role in Rwanda, significantly improving on health indices such as lifespan, maternal mortality, and infant mortality, it is not enough. As the population ages, access to tertiary health care will become necessary and absence of it could result in catastrophic economic impacts and push families into destitution.

Secondly, several of these national insurance plans have become plagued by high overheads and medical costs, inefficiencies, and allegations of delayed payments and corruption, casting a long shadow over their financial and operational sustainability. Ghana’s scheme, for instance, took in $437 million in revenue from premiums in 2013 but doled out $484 million in medical costs and overheads the same year, creating a net operating deficit of $47 million. This precipitated a fiscal crisis and destabilized operations of health care providers who depended heavily on public insurance payments.

If governments are willing to learn the lessons of these growing pains and build on the progress that has been made, universal health insurance in Sub-Saharan Africa could be within reach. Technology and the private sector can and should lend a helping hand. For example, smart utilization of emerging technologies like data science, biometrics, mobile payments, and telemedicine by government health insurance schemes can significantly reduce inefficiencies and costs and dramatically improve patients’ experience. These technologies are already being deployed by several innovative private players, including CarePay in Kenya and Nigeria and Discovery Health in South Africa. Government-funded health insurance schemes should consider how best to deploy these innovations.

In addition, in the drive for better oversight and governance of public insurers, private sector efficiencies can be harnessed in an area that is increasingly being recognized as a public good. This can include exploring Public-Private Partnerships in which private health insurers support the management of public health schemes. For example, the Lagos State government in Nigeria recently launched a scheme covering 23 million people that use private health insurers such as Hygeia and innovators such as CarePay to support various aspects of the service, ranging from case management to pre-authorization. While it is still early days with that initiative, the synergies seem vast and exciting.

**CONSOLIDATION—THE NAME OF THE GAME**

Health care in Sub-Saharan Africa was traditionally dominated by fragmented mom-and-pop establishments. This created some market dysfunctions, notably poor economies, inconsistent quality, and some of the highest health care prices in the world paid by some of its poorest people. The last decade has seen the emergence of market consolidators in several countries. In Nairobi, hospitals such as Ladan, Metropolitan, Avenue, and Nairobi Women’s, each of which used to be a doctor or family-run establishment, have been consolidated by a private equity owner. The result is an emerging network of service providers encompassing eight hospitals and sixteen clinics across seven cities in Kenya. Ciel Healthcare Limited, a Mauritius-based health care platform originally set up as an operational partnership with Fortis, India’s second largest health care group, has acquired two hospitals in Mauritius and one in Uganda to become the first for-profit, multinational hospital network in the region.

We see this trend repeated in retail pharma with entities like Goodlife, the largest retail pharma network in East Africa, and HealthPlus, the largest pharma retailer in Nigeria. Both of these enterprises have scaled rapidly through organic and inorganic growth. The recent acquisition of Lancet’s diagnostic business in Africa by Cerba, a global network of medical laboratories owned by the Partners Group, suggests

4. Assuming an average GH¢ to US$ exchange rate of 2.07 in 2013
that a wave of consolidation continues to spread across the industry and continent. Ophthalmology, optical retail, and dialysis sectors could be next.

I believe this trend is here to stay, albeit with some additional characteristics. For example, having focused on acquisitive inorganic growth in recent years, market consolidators will likely begin investing in organic growth through brownfield and greenfield developments of hospitals as well as the expansion of existing hospitals into new specialties. This will potentially be done through partnerships with global players. These entities will also increasingly focus on operational excellence, cost efficiencies, and the buttressing of their clinical and managerial talent. While the first growth phase fueled by acquisitions was not easy by any stretch, this second phase will be even harder, faced with such stubborn structural problems as low insurance penetration, clinical and managerial talent shortages, and insufficient economies of scale in the absence of integration across economic blocks.

Consolidators are also well positioned to deploy emerging technologies in their platforms to dramatically magnify their reach, improve customer experience, enhance quality, better utilize scarce medical talent, and reduce costs. The applications could range from basic interventions such as better electronic medical records and virtual consultations to more cutting-edge innovations such as drone-based logistics, just-in-time inventory management across their platform, and data science-enabled personalized medicine. The health care platforms, which demonstrate vision and celerity in this regard, hold the potential to grow exponentially and dominate their respective markets.

LONG OVERDUE ARRIVAL OF PRIVATE EQUITY

For far too long, a major constraint to the growth of private health care in Sub-Saharan Africa was the scarcity of institutional equity capital—and the expertise that typically comes with it. The last decade has seen a significant shift for the better in this area, with vehicles like the Africa Health Fund (AHF) and Investment Fund for Health in Africa (IFHA) emerging as pioneers. AHF and IFHA together invested about $200 million in the region. More importantly, they generated the momentum and interest that enabled successor funds totaling $1.1 billion, approximately $400 million of which was directed to Africa.

Their success has encouraged other fund managers to raise health care focused capital and invest in health care companies through their generalist funds. Whereas in 2005 African health care focused funds raised a miniscule $0.1 million, by 2015, this amount had increased a whopping twenty thousand-fold to top $2 billion, ushering in an unprecedented opportunity for health care companies to access private equity capital. This development has had several positive spinoffs such as an improvement in financial management and governance and the attraction of high-quality management talent to the health care industry. It has also catalyzed the previously mentioned market consolidation wave.

So far, we are seeing a healthy track record of profitable exits in this space. Coupled with an increasing demand for health care fueled among other factors by the accelerating drive for universal health insurance by many countries, this should guarantee continued strong interest in the sector from the global private equity world. Recent transactional evidence of this includes The Carlyle Group’s acquisition from AfricInvest of Abacus, a large East African pharma manufacturer and distributor. It is especially heartening to see the platform companies that some of the early funds invested in returning to the market for secondary investment rounds, and generating interest from global players like TPG, Carlyle, and the Partners Group. This is, of course, great news for the industry as many of these General Partners come with significant experience in the health care sector and can pair this global expertise and networks with the local insights of African health entrepreneurs and management teams.

TECHNOLOGY—THE FOURTH ELEMENT

As I turn my gaze toward the next decade, I believe that all three trends—universal insurance coverage, market consolidation, and institutional equity—will continue to shape Africa’s fast-evolving health care systems. A fourth element likely to emerge and have an impact on the first three is technology. As mentioned earlier, health insurance can leverage technology to reduce costs, improve quality, and magnify reach. Market consolidators like Goodlife are well positioned to use technology to dramatically ramp up

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The accelerating development of disruptive technologies is making deployment more feasible than ever. Technology increasingly allows health care to be provided over a distance, leverages scarce human and physical capital, and enables continuous monitoring and analysis of vast amounts of data generated by consumers and providers, making medicine more personalized and preventive. These shifts are especially relevant and game changing in this relatively resource-poor region where there is only 1 doctor per 5,000 people, 1.2 hospital beds per 1,000 people, and $9 billion spent on health care, a small fraction of the estimated $37 billion needed.

The following three innovations will, I predict, have special relevance to Africa over the next decade:

**Big Data Analytics**

As the adoption of electronic health records by health care companies in the continent grows and an increasing array of biosensors starting with the humble mobile phone make themselves ubiquitous, a wealth of data related to health will be generated. According to Intel, 1.7 megabytes of data will be generated per person, per second by 2020. Mining this data will allow better analysis and early diagnosis of diseases and holds the potential to shift the spectrum of care toward the preventive end. This can not only reduce costs for the system but, more importantly, improve the health and life of the patient. A very simple example would be tracking the amount of exercise that a person does on a daily basis. Analysis of this dataset lends itself to myriad applications from managing chronic ailments such as diabetes and hypertension to setting health insurance premiums. Discovery Health—a South African health insurer—is a global pioneer of this approach through its widely feted Vitality initiative.

**Telemedicine**

While telemedicine in some shape or form has been available for decades, what’s new is the ubiquity of smartphones, the reduction in the cost of these phones and the data they generate, the emergence of 5G mobile technology, and the drastic improvement in augmented reality and virtual reality technologies. All of this makes it easier for the continent’s scarce medical talent to be projected across boundaries, creating the potential to greatly improve access to medical care and medical education, particularly in underserved and remote areas. Several health care providers and insurance companies could scale up exponentially by rolling out virtual consultation solutions.

**Point-of-care imaging and diagnostics**

Most African countries are hampered by a scarcity of laboratory capacity, imaging tools, and pathologists and radiologists. New techniques in molecular diagnostics and microfluidics, successful convergence of high-quality imaging into small devices including smartphones, and the emergence of artificial intelligence tools for analysis of pathological specimen and diagnostic images are creating point-of-care diagnostic solutions. These can be used to test patients where they are and provide rapid results of comparable quality to tests conducted using large instrumentation in a centralized lab system. Dr Eric Topol in his seminal work, The Patient Will See You Now, writes about applications that digitize a person’s breath received through the microphone of a mobile phone to detect certain cancers, a task that would otherwise require numerous visits to specialists and expensive tests using sophisticated and expensive machines. While this is a particularly innovative idea and possibly still early in clinical application, there are numerous other simpler and more pervasive applications that are beginning to make a mark in POC diagnostics. Again, consolidated networks are best placed to deploy these exciting, emerging innovations.

**CONCLUSION**

Overall, while there is much to be done over the next decade to achieve the goal of equitable health care across Sub-Saharan Africa, I am cautiously optimistic. The building blocks are being laid as we speak of health systems, funded primarily by the continent’s governments and people through universal health insurance schemes, supported where necessary by international and local private institutional capital and in selective areas, by development aid. This is a long way from where we were a decade ago when I first arrived, a time when health care in Africa was still primarily funded by development aid and out-of-pocket payments of individuals. We are admittedly still a fair distance away from fully reaching the goal. But, if the governments, private sector, and international actors continue to work together, and public health policy keeps pace with private capital flows and technological innovations, it is only a matter of time before we get there.
On March 27–28, 2019 in Miami Beach, Florida, IFC hosts our 8th Global Private Healthcare Conference. The evolution of this conference has been remarkable. From its genesis as a small gathering of 50 delegates, mostly IFC staff, meeting at IFC headquarters in Washington, DC, to a major networking event hosted by different cities around the world every two years, the conference has become a kind of mini Davos for emerging market health care. At Miami, we will welcome more than 400 delegates from over 50 countries, more than 70 percent at C-Suite level, along with several government ministers.

The theme of this year’s conference is “Disrupting the Present, Building the Future—Embracing Innovation to Deliver Results.” We will have keynote speeches, plenary panels, think-tank sessions, showcases, and facilitated networking on:

- How the private sector can help governments reach Universal Health Coverage (UHC)
- Innovative business models for serving lower-income populations
- Expanding the use of technology and digital health care in service delivery
- Bio-pharma, complex generics, and specialty pharma
- Harnessing Big Data to better plan and monitor care

What makes IFC’s health conference so special? Firstly, it’s not a sales event. While we encourage and facilitate networking, this is a platform to share experiences and knowledge. Through my years of involvement in organizing the event, I’ve come to learn that many countries and stakeholders face similar challenges in health care but the markets in which they operate often are at different stages of maturity. That means that a solution which works well in one market may not necessarily work if carbon copied in a different market—but it can be tailored. Moreover, the sharing of knowledge about these experiences is very useful for businesses and investors as they seek out sustainable ways to evolve and expand.

With each conference iteration, we try new approaches. This year, we have decided to view the topics through the lens of embracing innovation and disruption. At each conference session, we will consider how innovation is shaping various markets. We interpret ‘innovation’ in a broad sense, covering both the many exciting technological breakthroughs affecting the market and innovation from a people and process management perspective.

Furthermore—and this is an exciting new element to the conference—we will have a mini showcase of innovative technologies from across the globe, some of which IFC has played a role in deploying to emerging markets through our TechEmerge initiative. TechEmerge is a matchmaking program through which IFC helps to connect health tech innovators with major health care providers in developing countries. We first rolled it out in India back in 2016, expanded to Brazil in 2018, and later in 2019, we will extend it to Africa.
Below is a summary of the themes from each conference session:

**PLENARY KEYNOTE AND PANEL: EMBRACING INNOVATION AND DISRUPTION TO CREATE HEALTH SYSTEMS OF THE FUTURE**

Demand for health care services is growing. Many health care systems are struggling to keep pace with demand and must evolve. This keynote session explores how embracing innovation and new thinking can build more effective health care systems with active private sector participation.

**PLENARY PANEL: DIGITAL HEALTH AND BIG DATA—UNLOCKING SOLUTIONS FOR BETTER OUTCOMES AND ACCESS**

Technology innovation is a broad concept and one that can bring many benefits to the health sector (for example, Blockchain). This interactive panel narrows the focus by providing some demonstrations and explores the emerging applications for digital health care and Big Data and their potential for opening new pathways to better health systems.

**PARALLEL SESSION: INNOVATIVE DELIVERY MODELS CREATING VALUE FOR PATIENTS**

This session will look at emerging models that are helping patients gain better access to care and are better coordinating that care. How can we expand these models to new markets? How can innovators enter new markets? What are the roadblocks they face? What makes expansion sustainable?

**PARALLEL SESSION: EMERGING TRENDS IN LIFE SCIENCES—BIO-PHARMA, COMPLEX GENERICS, AND SPECIALTY PHARMA**

This panel will explore various emerging models in the life sciences subsector and how traditional pharmaceutical companies are shifting significantly from producing plain vanilla generics to more complex ones with a view to positioning themselves for where the market is headed. Until recently, most pharmaceutical companies relied on basic generics for their core business. However, now they are having to build capacity in other areas such as biosimilars, complex generics, and specialty generics, where the rules of the game are very different, and in some cases, are still evolving.

**PLENARY PANEL: AN INVESTORS’ PERSPECTIVE**

What are the latest trends for investment in private health care, innovative health care technology, and life sciences in emerging markets? This panel will explore the outlook for health care investment for the next five years.

**PLENARY PANEL: PARTNERING WITH THE PUBLIC SECTOR—EXPECTATIONS OF PRIVATE SECTOR**

We will have a discussion with Health Ministers that will address the following questions:

- What are the common challenges facing their health care systems?
- What role does the private sector play?
- What role could the private sector play?
- What type of innovation is required?
- What immediate reforms are in the pipeline and how could the private sector support them?
- From a technology perspective, what are their specific expectations?
- How important is Big Data and how can the private sector support public sector initiatives?

**PLENARY PANEL: EMBRACING MEDICAL TECHNOLOGY INNOVATION—GETTING BEYOND THE HYPE**

The main aim of this panel, which will include some form of technology demonstration, will be to highlight the ever-changing world of medical technology.

**IFC CASE STUDIES**

Each year, IFC publishes a series of in-depth case studies of interesting and innovative clients active in the subsectors of health services, medtech, and life sciences. We are bringing some of these clients to our conference for follow-up discussions regarding their businesses.
PLENARY SESSION: INNOVATIVE BUSINESS MODELS SERVING LOWER-INCOME POPULATIONS

The core aim of this panel is to highlight the need for private sector business models that can deliver services to lower-income populations and to demonstrate how they can scale up. There is a growing need for low-cost, value-based care models capable of delivering both high-volume and high-quality care.

PLENARY SESSION: PHARMA SUPPLY CHAINS—FORGING BETTER LINKAGES

The panel will explore how prescription drug supply management can evolve to meet increasing demand and the emerging trends and success stories that will improve patients’ access to medicines and create better value.

CLOSING PLENARY PANEL: BUILDING THE FUTURE HEALTH CARE SYSTEM PIECE BY PIECE

Underpinning the final discussion panel will be the following assumptions:

- All health care systems must adapt and embrace efficiency. For most countries, it cannot be business as usual.
- Innovations—people, process, and technology—will play a key role in the evolution of systems.
- The private sector has a key role to play in all subsectors: services, pharmaceuticals, consumables, medical equipment, and digital health care.

ETHICAL PRINCIPLES IN HEALTH CARE (EPIHC)

We are delighted to launch at Miami the Ethical Principles In Health Care (EPIHC) initiative, to be unveiled by IFC COO Stephanie von Friedeburg. Developed by IFC in close collaboration with the World Bank’s Human Development Practice Group, EPIHC aims to give detailed guidance to private health care providers and investors on how to do business ethically. The World Bank Group expects health care organizations that receive IFC support to follow these principles and will encourage others to voluntarily adopt them.

THIRD DAY WORKSHOP: HOW CAN THE PRIVATE SECTOR IMPLEMENT UHC?

In addition to the two core days of the conference, we will hold an additional optional day, in partnership with the Health Care Management Department of the Wharton School, University of Pennsylvania. Wharton senior faculty members and IFC health care team principals will lead a workshop on the private sector’s role in implementing UHC. Adoption of UHC as an aspirational goal is spreading across the developing world, particularly African and Asian countries with limited or no safety net for their societies, but who affirm that UHC is a right of their citizens. There are four basic pillars where the private sector can play a role in implementing UHC: efficient, quality-driven clinical systems; patient-centric care; current, accurate, and accessible health records; and ‘precision medicine’ and ‘precision public health.’ The workshop will focus on the first and second of these pillars.

For more information and to register go to: www.ifc.org/health-conference
In Andhra Pradesh, a state on the southeastern coast of India, access to lifesaving diagnostic services was limited. Few government hospitals outside the metropolitan areas could offer specialized services like CT or MRI scans and access to tertiary healthcare and advanced diagnostic services, including laboratory services, was particularly skewed toward urban centers. In an effort to solve this problem, the state had introduced an insurance program to cover catastrophic health expenditures for families living below the poverty line. However, few public hospitals had enough funds to purchase modern diagnostic equipment or attract specialist technicians to manage the equipment and administer complex scans.

A GAP IN HEALTH CARE SERVICES

While diagnostic services were available in private facilities, they were unaffordable for low-income people, particularly the 20 percent of the state’s population who lived below poverty line. As the government was considering the idea of purchasing these services at a premium from private hospitals, the idea emerged of inviting the private sector to operate and manage imaging centers in government hospitals in partnership with the state. The government decided to test the idea with a pilot project in four public hospitals under a public-private partnership model. To support this initiative, the state government of Andhra Pradesh engaged IFC as advisors. Following a competitive tender process, the project was awarded to a consortium composed of General Electric, an international equipment manufacturer, and Medall, an established operator of diagnostic centers across India.

ALLOCATING RISKS TO DELIVER LIFESAVING SERVICES

Under the project structure, the private partner was given responsibility for building facilities, staffing, and providing services to all patients referred by doctors from the respective hospitals, in compliance with Indian quality accreditations. Though no volume guarantees were given, the public hospitals agreed to refer all imaging services exclusively to the PPP facilities, with the operator given the right to use any unutilized capacity to provide services to private patients. The private operator retained qualified staff to manage the equipment and conduct diagnostics while sharing some civil infrastructure with the existing teaching hospitals.

As part of the PPP agreement, the government pays a predetermined tariff for scans provided to public patients. It is estimated that over 100,000 patients per year are receiving quality diagnostics services through this project, around 85 percent of which are lower-income families. With an average price per scan nearly 50 percent lower than the market rate, the government has been able to provide critical diagnostic services to a larger number of underserved patients within their allocated budget.

A SCALABLE FRAMEWORK

After a few years of successful operations, the government of Andhra Pradesh replicated the project across the state. The model served as an example for other states in India to ensure public patients had access to diagnostics services, including both imaging and laboratory services.
Often very complex, laboratory services PPPs leverage a hub-and-spoke model, with some tests performed at the main point of collection (for example, a government hospital), while other samples are collected in more remote facilities and transferred to testing facilities through a logistic system. This puts the diagnostic infrastructure closer to patients, reducing wait times and costs, especially in rural areas where patients used to have to travel long distances to have tests done.

In Jharkhand, a state in eastern India where 40 percent of the population lacks access to basic health care, IFC helped the state government set up a network of laboratory and imaging PPPs, which have transformed access to health care in the state and helped more than 3.5 million people each year.

**A GLOBAL SOLUTION TO IMPROVING HEALTHCARE**

Diagnostics PPPs have been adopted by many countries—including Albania, Brazil, Cambodia, Liberia, Moldova, Philippines, Cambodia, Timor-Leste, Sierra Leone, and Saudi Arabia—as a way to bridge gaps in infrastructure and services and increase access to lifesaving tests. Economies of scale, shared civil infrastructure, and, in some cases, utilities costs provided by governments under a PPP agreement, enable private partners to quote tariffs that are affordable for governments and patients and expand the availability of services to underserved communities at levels that are less than prevailing market rates, while being financially viable for the project.

The examples of diagnostics PPPs in Andhra Pradesh and Jharkhand show that public-private partnerships can be very effective in strengthening public health services and improving access to affordable and high-quality health services.
Imagine this nightmare scenario. You are diagnosed with renal cancer. The recommended treatment is removal of a kidney. You check into the hospital, have the operation. You wake up assuming you’re cured, only to be told that the surgeon mistakenly removed the healthy kidney and left the diseased one inside. This may sound like something out of a horror movie, but it can and does happen. In the United States alone, so-called wrong-site surgery was occurring about 40 times a week as recently as 2011, according to Becker’s Hospital Review. Most instances—71 percent—had fatal consequences for the patient. In developing countries, reliable figures are harder to find but the rate is likely much higher.

A recent Lancet study found that poor quality healthcare causes 5.7 million deaths a year in low- and middle-income countries, making it a bigger barrier to lowering mortality rates than lack of access to healthcare, which causes 2.9 million deaths a year. In high-income countries, about one in ten patients is harmed while receiving hospital care. In the United States, for example, medical errors cause more deaths annually than road accidents (40,000) and breast cancer (40,000) combined.

One cause of these alarmingly high figures is surgical site infections, where failure to follow sanitary protocols results in a patient getting an infection during surgery. The surgical site infection rate for low- and middle-income countries, at 6.1 percent, is seven times the rate of U.S. healthcare facilities. One in ten patients die in surgery in Africa and one in five develop a surgery-derived complication, Lancet has reported. The figures for maternal mortality are just as shocking: a mother undergoing a C-section in a low or middle-income country is ten times more likely to die than in the Netherlands.

With quality key to attaining Universal Healthcare (UHC), the International Finance Corporation (IFC), the arm of the World Bank that invests in the private sectors in emerging markets, has developed an easy-to-use Quality Assessment Tool for healthcare organisations in emerging markets. The Tool has been refined over the past year as we assessed the quality of care provided by healthcare organisations in Africa, Asia, Europe, and Latin America.
We have piloted the Tool in a diverse array of developing countries, including Georgia, Mexico, Nepal, and Uganda. We make recommendations for improvements, promoting the most effective measures, while recognising the budget constraints that healthcare providers in poorer countries face. These partnerships are starting to show positive results, with some organisations advancing to international accreditation.

What kind of things should practitioners pay attention to? Firstly, the imperative of adhering to internationally-recognised, clinical protocols. Studies of primary care clinics in developing countries show, for example, that only 33–54 percent follow the clinical guidelines for treating childhood conditions. In hospitals in Nairobi, Kenya, only half of all sick and underweight newborn babies receive evidence-based treatment. With the rapid uptake of the internet and mobile technologies across developing countries, practitioners usually have all this guidance at their fingertips.

Many organisations spend large amounts of money on expensive facilities and equipment and ‘hiring the best doctors’ while neglecting basic practices on quality and patient safety. Quality does not need to be complicated or costly. It can be something as simple and low cost as healthcare workers uniformly washing their hands to kill all microbes. Conservative estimates indicate that at any given time, there are over 1.4 million patients suffering from an infection they picked up during treatment, most of them in developing countries. Hospital-acquired infections of the bloodstream, urinary tract, chest/respiratory system, and intestines are far too common and poor hand hygiene is often the culprit. Compliance with protocols is frustratingly weak—as low as 2 percent, according to surveys of some Kenyan primary care facilities.

The stakes are high but the rewards to be reaped from compliance are even higher. According to the Lancet Commission, improved quality of healthcare could prevent 2.5 million deaths from heart disease per year, one million newborn deaths, 900,000 tuberculosis deaths, and half of all maternal deaths.

For billions of people, UHC will be an empty vessel unless and until all nations make improving the quality of care as high a priority as attaining universal coverage. You can extend access to healthcare to billions of people who have never had it before but if that healthcare is of low quality, it will not help them, and indeed often it will harm them.

Finding innovative ways to expand access to high quality care will be front and center at the 8th Global Private Healthcare Conference which IFC is organising in Miami, Florida on March 27–28, 2019. The conference will convene some 400 delegates from more than 50 countries and 200 companies, 70 percent at C-Suite level, for great networking and discussions. To learn more and to register, go to: www.ifc.org/health-conference

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Millions of low-income Kenyans rely on informal pharmacies for medicine. Informal pharmacies—constituting around 66 percent of the estimated 12,000 private pharmacies in Kenya—dwarf the number of formal ones and pose critical health risks to Kenyan consumers. Many informal pharmacies offer a narrow selection of products, carry low-quality substitutes, or sell expired and even fake medicine. While Kenya’s Pharmacy & Poisons Board (PPB) is actively involved in regulating and enhancing the sector from a quality perspective, in 2011, for example, an estimated 20 to 25 percent of drugs sold in the country were counterfeit. Because they contain few or no key active ingredients, counterfeit medicine can cause treatment failure, adverse reactions, and even death.

Lower-income consumers, who do not have the disposable income to purchase high-quality medicine from reputable pharmacies, are particularly vulnerable to these risks. High-quality medicine is often expensive in Kenya because of the highly fragmented pharmaceutical distribution system in the country. Given the lack of coordinated distribution, numerous distributors and sub-distributors mark up prices, adding to the final price paid by consumers. Even the lowest-priced generic medicines in Kenya are estimated to be two to five times higher than their international reference prices.

Against this backdrop, Goodlife Pharmacy was founded in 2014 to meet the need for a trustworthy, customer-centric, branded pharmacy retail chain that offers safe, high-quality medicine to all Kenyans. Ultimately, Goodlife aims to become a health hub—a one-stop-shop to meet basic primary health care needs through pharmaceuticals and services throughout East Africa.

In only four years, Goodlife has become East Africa’s largest pharmacy chain, doubling its revenues since launch. In 2017 alone, Goodlife’s annual sales increased by 30 percent. Its 50-plus pharmacies in Kenya and Uganda—including more than 25 stores that target “emerging consumers,” that is, low- to lower-middle-income population segments—can be found in diverse locations such as malls, gas stations, and near bus stops. As of September 2018, Goodlife had reached around 1.1 million people during the previous twelve months with approximately 50 percent classified as emerging consumers.
The timing was right to enter the Kenyan retail pharmacy market. The country’s pharmaceutical market was the fastest-growing in Sub-Saharan Africa, driven by factors such as a growing population combined with an increase in chronic diseases—an estimated 27 percent of deaths in Kenya are attributable to chronic noncommunicable diseases. Also, over-the-counter medicine was (and remains) popular in Kenya with nearly 60 percent of the population self-medicating.

At the same time, there was a clear opportunity to disrupt and consolidate the Kenyan retail pharmacy market. Less than six percent of private, licensed pharmacies were part of a multi-outlet chain. Most private pharmacies were mom-and-pop enterprises; few had the ambition and capacity to grow beyond a handful of locations. Hardly any had more than 10 stores at the time. The co-founders knew that a multi-outlet chain could offer a larger selection of products and services of better quality, at higher standards, and often at lower prices.

TRANSFORMING A VISION INTO REALITY

Goodlife Pharmacy was formally launched in 2014. The three co-founders used their own funds, tapped into a few other private investors, and obtained an equity investment from Catalyst Principal Partners, a regional private equity firm. The co-founders then brought in senior executives who had experience with pharmacies, such as the Alliance Boots Retail Pharmacy chain in the United Kingdom, to help build the foundation for the business.

Over the next four years, Goodlife took a methodical approach to eventually reaching lower-income customers and expanding its offerings. The company would undergo three major phases of development:

1. Establish Infrastructure: It first established its pharmacy infrastructure and developed its business model through stores that served middle- and high-income customers.
2. Optimize Operations: It then worked on optimizing operations by increasing efficiencies and reducing costs.
3. Expand and Diversify: It finally turned its focus to expansion and diversification, including building its presence in East Africa, expanding its target customer market to include emerging consumers, and transforming into a “health-hub” by delivering basic primary health care services.

A LOAN FROM IFC

In 2015, IFC provided a $4.5 million loan to Goodlife. IFC wanted to build the market of high-quality retail pharmacies in East Africa. Goodlife had already grown to four stores and IFC believed that the pharmacy chain had a scalable model that could introduce international standards to the region. Goodlife also had the potential to bring in lower prices for consumers and significantly improve the quality of products. Goodlife’s plans to extend to emerging consumers was also important to IFC.

For Goodlife, a capital infusion from IFC—on terms not readily available in the local market—was essential for growth. It came at a critical time as its largest store had incurred significant losses due to the 2013 terrorist attack at the Westgate Mall, where it was located. IFC’s loan enabled Goodlife to grow to approximately 20 locations, thereby attracting interest for an equity investment from LeapFrog, a private investment firm focused on purpose-drive businesses.

IFC provided a second loan to Goodlife in 2018 to continue to support the company’s expansion.

Read the full case study at [www.ifc.org/health](http://www.ifc.org/health)
Founded in Singapore, Fullerton, a provider of integrated health care services across Asia Pacific has expanded to China, Indonesia, and Australia. Fullerton’s HMO services are complemented by its own network of health care facilities including laboratories, diagnostics, primary care, and specialist clinics. Fullerton’s long-term goal is to be an integrated pan-Asian health care provider that is affordable and of high quality in all of its markets. IFC’s investment in this company will help it to provide greater access to affordable quality health care in the Philippines.

Pyramid Healthcare is a leading medical consumables and equipment distributor with established operations in Tanzania. Over the past seven years, it has expanded into Kenya, Uganda, Ethiopia, Rwanda, Mozambique, Nigeria and Ghana. IFC’s investment in the company will support its expansion into new markets, such as Côte d’Ivoire and Senegal, as well as strengthen its existing operations. This Project will help improve access to high-quality medical consumables and equipment and allow the company to scale up the equally essential world-class training and servicing in these markets.

Based in Mexico, Genomma is one of the fastest-growing pharmaceutical and personal care products companies in the Latin America and Caribbean region. The company targets the middle- to low-income population through a multi-channel distribution platform that provides extensive geographic reach and a fast and efficient delivery of its products to the end consumer. IFC is supporting Genomma’s expansion plan, including the construction of its first manufacturing facility in Mexico, to promote greater market competitiveness and lower prices for consumers for over-the-counter and personal care products.

UCL is a pharmaceutical manufacturing company based in the outskirts of Nairobi, Kenya, producing over 100 formulations, including tablets, capsules, syrups, suspensions, ointments, and creams. The company is one of the few lowest-cost and high-quality pharmaceutical manufacturers serving some of the world’s developing pharmaceutical markets. IFC is supporting UCL to provide quality medication and to help develop East Africa’s pharmaceutical sector.
BRAZIL: FARMOQUIMICA (FQM)

The FQM Group is one of the most diversified pharmaceutical groups in Brazil, focused on branded prescription drugs, OTC medicines and dermatology products. IFC’s investment supported the business combination of two companies—Farmoquímica S.A., a subsidiary of Laboratorios Roemmers from Argentina, and Divcom S.A., a Brazilian specialist of over-the-counter products based in Recife. Through this investment, IFC is contributing to the consolidation of two national pharmaceutical players to promote a stronger more efficient company and help expand accessible quality health care. In addition, patients will benefit from a wider distribution of FQM/Divcom’s pharmaceutical products and from the introduction of new ones.

AFRICA REGION: TRIVITRON HEALTHCARE AFRICA

IFC is investing in Trivitron Healthcare Africa, a medical consumables and equipment distribution company, to support its growth in Kenya, Nigeria, Uganda, and later into other countries in Africa. IFC’s investment will help the company distribute high-quality medical consumables and equipment, provide comprehensive after-sales services at affordable prices, and hence improve access and affordability of medical consumables and equipment across the continent.
PRIVATE HEALTHCARE
IN EMERGING MARKETS
An Investor’s Perspective

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