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Meeting the financing needs of healthcare providers

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

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

A fragmented, capital-intensive sector with average profitability

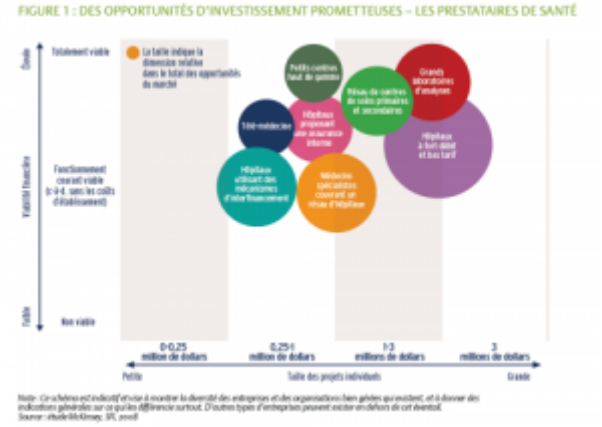
Market risk in the health sector might appear relatively small: the demand levels are known and are globally stable and there are considerable growth prospects because of the demographic and epidemiological changes taking place in the world. Apart from epidemics, healthcare demand is not cyclical. Ageing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

Besides, healthcare is a sector with high capital requirements: to develop infrastructure, set up modern technical platforms and combine small structures to generate economies of scale. The quality and continuity of healthcare provision have to be improved all the time, particularly by mobilising specialist teams. In addition, the companies in this sector have considerable working capital requirements. Recurrent overhead costs are high: staff costs, equipment maintenance, patient hygiene and safety, building maintenance, purchasing medicines, managing waste and various medical devices, etc. This need for cash is often exacerbated by long delays in receiving payments from public and private insurance companies.

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

Obstacles to healthcare financing

The growth in demand presents a real asset for healthcare providers. But when it comes to obtaining financial resources from local banks, it is offset by a number of disadvantages. For instance, the revenue structure can be problematic. Payments in cash are particularly prevalent, there are a large number of collection points1, and health insurance systems are rare and underdeveloped. In fact, healthcare institutions do not make much use of the banking system and their accounts only reflect a small part of their activity and the area they cover. They do not enable lenders to contemplate taking a reasonable, balanced risk in an unbiased manner. Most structures are small and not very specialised. In sub-Saharan Africa, the average size of investment projects ranges from USD 250,000 to USD 3 million. Still there are many investment opportunities (*see Figure 1*).



Even where development of healthcare providers is conceivable, it is hindered by the conditions for accessing loans. The debt structure of these establishments is complex. It is of course easy to back a loan by providing security2 in the form of property, like a mortgage on land, buildings or equipment (hire-purchase, leasing). But enforcement is not simple, both for ethical and moral reasons and – in the case of certain types of equipment – for practical reasons. Some types of security pose fewer problems, such as assignment of receivables from health insurance companies. However, not enough hospitals generate sufficient revenues from these private insurance companies – and public social security systems are often short of cash. This means that in many low-income countries, the banks frequently refuse to take the risk of investing in the private health sector.

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

The regulatory framework within which healthcare establishments develop also constitutes one of the major obstacles to financing. Governments struggle to regulate this sector and to define a framework to implement mandatory social security coverage – whether it is a public system or one that is delegated to the private sector. The 2010 WHO report describes setting up a social security system as a prerequisite for attracting investors. The public authorities' ability to oversee and

monitor the quality of healthcare installations and providers, and to impose hygiene and safety standards is weak. The developers are not forced to modernise.

The solutions proposed by development institutions

The health sector is often at the boundary between strictly private-sector approaches and public-interest missions. To ensure the development of the sector while taking this specific aspect into account, development institutions are proposing a number of different financing mechanisms.
In the private health sector, these institutions are financing healthcare providers through customised loans, health insurance schemes and innovative projects. Development of the private health sector often comes about as a result of an incentive policy introduced by the public authorities – usually involving health insurance reform with the aim of expanding the solvent population. However, poor populations tend not to be inclined to set aside a part of their income for future, uncertain expenditure unless they have to. In addition, the 'micro-insurance' sector3 is still very underdeveloped. The risk-pooling system appears to work when contributions are mandatory, which is usually only the case for salaried workers in the formal sector. Yet these salaried workers are by no means representative of the majority of the population. The financing of private or semi-private mutual health insurance companies makes it possible to bring in more stable revenues while reducing the costs paid directly by patients – it therefore promotes the development of healthcare provision. It is for these reasons that donors try to finance mutual health insurance companies.

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

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

Besides providing adapted financing with long maturities (10 to 15 years) and financial intermediation (support for local banking sectors and specialised investment funds), the development institutions can provide added value by encouraging and helping health structures to become more professional so as to improve the way they are managed and their economic model (see box). For this reason, development institutions offer a technical assistance service that can be used to improve corporate governance, internal management systems and training (a major issue for development in this sector).
Finally, development institutions also use innovative financing to promote social impact by offering a decrease in interest rates on loans if the beneficiaries carry out social projects. These might take the form of funds dedicated to improving accessibility to free treatment for disadvantaged communities, the building of clinics in remote areas or the introduction of new technologies, like telemedicine.

The private health sector in developing countries will experience changes as a result of ongoing economic and social progress, and the rapid growth in chronic diseases. Donors therefore need to mobilise as many innovative financial solutions as possible. They need to support the development of participants in this sector, whether they are small mutual organisations, private clinics or large private hospitals. As a result, more innovative tools will emerge alongside the traditional instruments (essentially subsidies and loans), including loan-grant combinations, the development of

microfinance for health, and experiments with partially repayable subsidy systems. Moreover, development institutions must contribute to a better balancing of public and private policies and help provide a better structure for the sector. Here, more than in other sectors, development institutions need to act as a driving force, by serving as a role model – placing a focus not only on expected profitability, but also on improving health services and on human development as a factor of economic growth.

Financing a hospital network in Lebanon

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

Footnotes

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

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

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

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