Private Sector & Development

A blog coordinated by Proparco

# Private Sector Opportunities in Developing Country Healthcare

*Jacob Kholi* *Senior team responsible – AFRICA HEALTH FUND*
*Ruth Wanjiru* *Analyst – AFRICA HEALTH FUND*

*August 12 2013*

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

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

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

**Abec Sanitas, a business case**

In 2011,the AHF invested in AbeC Sanitas, a Ghanaian holding company that owns two hospitals, five in-house clinics, a state-of-the-art diagnostic centre, a pharmaceutical distribution outlet and a managed healthcare unit. The investment was to support the establishment of a state-of-the-art diagnostic centre in one of the hospitals. The quality and level of technology used has transformed the facility into a pioneer in private and specialised healthcare delivery in Ghana. C&J, the business name for the two hospitals, grew from a small out-patient clinic in a poor neighbourhood into one of the leading providers of healthcare in Accra. The hospital offers a wide range of services, such as general and specialist clinics, radiology (x-ray), ECG, ultra-sonography, laboratory services, in-patient (39-beds) facilities, minor surgeries, a 24-hour pharmacy,

ambulatory services and phone-in services. Through the managed healthcare unit, C&J provides medical services for the employees and dependents of over 100 leading corporate clients, including on-site clinics for companies such as the Coca-Cola Bottling Company, Pioneer Food Cannery, PZ Cussons and Cargill Ghana Limited.
The Abraaj Group, through the AHF technical assistance facility, has supported C&J with US$ 250,000 to hire specialists and implement a hospital management information system. The specialists were hired to complement the investment in advanced technology at the diagnostic centre. The Abraaj Group is actively engaged in working with senior management to develop and implement value creation plans that will ensure the financial and operational sustainability of the holding company. Engagement is through regular discussions with senior management, continuous monitoring of financial and operational performance and representation in board meetings.
59% of patients served by Abec Sanitas were BoP 3000 (Dalberg Global Development Advisors, 2012).The highest BoP impact was achieved through the in-house clinics at the various companies.

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

**Multi-criteria investment decision-making**

Sustaining healthcare services in Africa will require the innovative approach of including the population at the BoP in the business model. In the absence of efficient, formal markets, the BoP pays more for products and services than those living at the top of the pyramid – a phenomenon known as the 'poverty penalty'. This market represents 70% of Africa's purchasing power. AHF was established on the belief that socially-motivated business practices enhance financial returns, while also adding positive value to society. On average, 60% of end users served in 2012 through six of AHF's partner companies were BoP 3,0002. The combined revenue from these six investments spread across East and West Africa in 2011 stood at USD 32.1 million, proving that BoP consumers have purchasing power. From work done with existing businesses in the health sector, three primary models have emerged on how companies can increase their reach and access into the base of the pyramid population.

The first model for accessing and reaching into the BoP population is through cross subsidisation. This involves using a portion of profits to subsidise costs for people who cannot afford services. For example, one of our portfolio companies with three hospital branches offers subsidised services in one of its branches located in a BoP-populated area. Footprint expansion is the second model for reaching into the BoP population. With this method, service lines or product distribution is expanded into territories and regions where there is a higher BoP population. This has worked well with medical centres and clinics in rural areas. The clinics, which are less capital intensive, provide basic healthcare, while specialised care and diagnostic services are referred to the main hospitals. The third model for accessing the BoP population involves process improvement manufacturing or

service delivery processes are reworked to reduce costs, and thereby prices, with the aim of increasing affordability; for example, one company invested in an energy audit of its manufacturing plant in 2012. The cost of energy in Kenya makes up one of the highest direct costs of production. The audit was aimed at identifying processes and equipment with the highest energy losses. It is expected that savings from energy efficiency will enable this company to continue providing affordable products.

From an investor perspective, deal selection involves identifying investments that inherently address BoP needs. This may include investments in specialised care for women and children, who make up the largest component of the population at risk3 ; and investing in manufacturing companies that manufacture essential drugs and medical products crucial for the BoP population. Revital Healthcare Limited has WHO-Good Manufacturing Practice and Conformite Europeene certification and exports over 50% of its production to other countries in Africa. It manufactures WHO-certified auto-disable syringes used by governments and NGOs (who primarily serve the BoP) in campaigns and programs against the spread of infectious diseases. Investments in public private partnerships (PPP) are another way of reaching BoP consumers. For example, The Bridge Clinic has partnered with the Lagos State Government to establish the Lagos State Institute for Fertility Medicine (IFM). The IFM provides affordable in vitro fertilisation services to patients in the mid and low socioeconomic classes who may not be able to afford the procedure at the current market rates. Through the PPP, 73% of patients served at the IFM were BoP 3000 (Dalberg Global Development Advisors, 2012).

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

**How to measure impact**

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

**Main challenges of the African private healthcare sector**

With the exception of South Africa and parts of North Africa, the most startling fact about the private healthcare space in the African market is how fragmented markets are. Most healthcare companies are run with weak governance and corporate institutionalisation, but will likely have high bed occupancy rates and potential for organic growth. Investing in these companies requires close

attention in the early days to ensure disciplined cash flow management, robust governance processes and effective implementation of systems. During this period, regular engagement is required to ensure the constitution of a professional board and board committees, a change in senior members of management where necessary, implementation of information systems to support expansion, and the re-education of the sponsor on how to scale the business.

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

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

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

**The role of SMEs in the african healthcare market**

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

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

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

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

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

**Footnotes**

[1] AHF defines the BoP as those who earn a net household member average income of less than USD 3000 in purchasing power parity (PPP) terms.
[2] Households with a net household member average income of less than USD 3,000 on a purchasing power parity basis
[3] As an example, 63% of patients treated at Nairobi Women's Hospital, a partner company of The Abraaj Group, are BoP.

**References** / **IFC, 2008**. The business of health in Africa. Partnering with the Private Sector to Improve People's Lives. World Bank Group. Available at http://www.unido.org/fileadmin/user_media/Services/PSD/BEP/IFC_HealthinAfrica_Final.pdf. / **Dalberg Global Development Advisors, 2012**. Review