PharmAccess Group response to the EC Roadmap on the Communication *Strengthening the Role of the Private Sector in achieving Inclusive and Sustainable growth in Developing Countries*

PharmAccess Group

PharmAccess Group, a Dutch non-profit organization, has been dedicated for over ten years to making healthcare more affordable and accessible to all people in Sub-Saharan Africa, contributing to healthier populations and social and economic development. We are an international mission-driven, development innovator in healthcare and are currently active in more than ten African countries with country offices in Tanzania, Kenya, Namibia, Nigeria and Ghana. Together with our partners we implement programs in Africa to increase the total amount of money for health systems and to increase the efficiency and effectiveness of healthcare delivery. This requires higher quality of care, more skills, more private capital, better policies and more insight and knowledge.

By combining standards for quality improvement, loans for healthcare providers, health plans and in-depth impact research we simultaneously stimulate the demand for and supply of healthcare services. The expertise within the PharmAccess Group includes health plans, healthcare quality, healthcare financing and healthcare infrastructure as well as mobile health (mHealth). The consultancy team within the PharmAccess-Group are expert advisors on public private partnerships and HIV/AIDS workplace treatment programs in Africa. There is collaboration with the Amsterdam Institute for Global Health and Development (AIGHD) and the Amsterdam Institute for International Development (AIID), which conducts rigorous impact assessments into the health plan programs.

From our inception PharmAccess has focused on strengthening the private health sector contrary to the traditional approach of funneling aid for health through the public sector. To begin with, across the developing world healthcare services are most often delivered in the private sector through SME's and micro enterprises. Another important factor is that the laws of health economics implicate that donor funding applied through the state and the public system mainly crowds out local private expenses and substitutes for local government spending, limiting the net resources for the health sector[i].

Main pillars of our model are therefore: building on existing local institutions, leveraging the capacity of the private sector, empowering clients and local communities and balancing demand and supply. With the financial support of the Dutch Ministry of Foreign Affairs and other donors, we have been able to leverage our own investment into the health sector several times, mobilizing tens of millions of euros from third-party donors, local governments, investors, local banks, private clients and insurance premiums. Our approach has generated considerable international attention, including a G20 prize that President Obama presented to us for our innovative healthcare financing model.

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Our partners, donors, investors and clients include Dutch and African (local) governments, local health maintenance organizations and insurance companies such as Hygeia, AAR and MicroEnsure, international (donor) organizations such as World Bank/IFC, United States Agency for International Development (USAID), International Labour Organisation (ILO), Clinton Foundation, DFID, Marie Stopes International and PSI, international public and private investors, multinationals such as Heineken, Shell, Zain, Air France KLM and health accreditation organizations such as Council for Health Services Accreditation for Southern Africa (COHSASA) and Joint Commission International (JCI).

Health and inclusive development: the case for health as a key sector

Better health is critical for human development. It contributes to economic progress, as healthy populations live longer, are more productive, and save more. Health is directly related to quality of life and to social and economic development. Health concerns every citizen of the world, but many people lack the means to access affordable quality care. Globally, data suggest that more than 150 million people annually suffer financial catastrophe and 100 million are pushed into poverty due to out-of-pocket health expenditures[ii].

Healthcare policies and social protection therefore, are an important pillar of social policy and inclusive development in general[iii]. The WHO, Organization for Economic Co-operation and Development and United Nations Research Institute for Social Development have already taken up the issue of universal social protection and equity as paramount in enhancing the poverty reduction effects of economic growth[iv] . Financial access to affordable quality health is part of the World Health Organization's definition of Universal Health Coverage (UHC), while UHC is mooted as an important goal for the post-2015 development agenda[v].

Health is not just an important development issue, but also an important economic sector. The healthcare industry has become the largest industry in the world and one of the biggest employers, accounting for over 10% of gross domestic product (GDP) in high-income countries. Total health expenditure consists of public and private health expenditure, covering the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health. In developing countries as the middle classes are rising the burden of non-communicable diseases is also growing rapidly. Growing and ageing populations and continuing urbanization will add to that burden in the developing world.

Constraints of traditional aid in health: the case for private sector strengthening

In many developing countries governments fail to provide effective healthcare and education for all. If the state doesn't deliver, such services are provided through the private sector. This is exactly what you see for example in health in Africa, where healthcare delivery is

dominated by the health SMEs in the private sector. When care or schooling is private, it doesn't mean that it is for profit. Religious groups and other charitable organizations run many clinics.

Therefore, any policy that overlooks the private sector cannot effectively contribute to improvement or change of the healthcare sector in developing countries. Healthcare is because of its nature often approached from a medical and ethical point of view, paying less attention to economic fundamentals. However, the long-term viability of any healthcare system needs to be financially secured. The growing burden of healthcare costs in developing countries is an issue high up their political agenda, whereby governments are also looking at what role the private sector can play in ensuring the most efficient use of the resources for healthcare.

The other key reason to stress the importance of supporting private sector development in health in developing countries is that health reforms through the public sector have had a checkered history. Many public sector health reforms fail to deliver despite extra funding. Although improvements have been made on some indicators, many of the Millennium Development Goals will most likely not be reached by 2015. This is enough reason to revisit the approach to development aid in health, all the more urgent given the global economic crisis and increasing pressures on aid budgets[vi]. Africa's population is currently just over 1 billion, but forecast to double in the next decades.

Africa has about 15% of the world's population but why does it still bear approximately 44% of the world's burden of communicable disease and 25% of the total global disease burden? Why does it still account for less than 1% of global health expenditure? Why are in many countries more than 50% of private health expenses paid out of pocket, and why do most people not have access to affordable and qualitatively good health care?

In our view, many aid efforts fail to deliver meaningful results because it is funneling aid for health through the public sector assuming that the public sector is functioning properly. Most developing countries however, are ruled by some power elite that maintains a state that is designed to serve a limited elite as opposed to overall society. By ignoring this, donors have failed to acknowledge that institutions, formal and informal, and incentives in countries with limited state capabilities often work against their best efforts, making it harder for aid to reach the people who need it. Research shows that it's mostly the rich and people who work in the formal sector who benefit from public healthcare, while the overwhelming majority of the population belongs to the informal sector and is excluded from many basic public services because they are too poor to access them.

In these countries, GDP per capita is low, while health systems are severely underfunded. When there is an influx of donor money into the health sector, this doesn't raise the total amount of money in that sector. This is because in low-income countries there is a tight relation between GDP per capita and healthcare expenditures (first law of health economics)[vii]. Instead of increasing the amount of resources for health the donor money crowds out private funds or substitute for existing local public expenditures (the third law of health economics). In such countries, out-of-pocket payments will be high, pushing people into poverty (the second law of health economics).

Through their monopoly on power the elites in these developing countries can perpetuate the situation where they exclude large sections of the population from sharing the benefits from any economic growth. Nobel Laureate Douglas North and the school of so-called New Institutional Economics has long documented this problem. This exclusion creates various problems that put a break on economic development, foremost because it dampens people's willingness to invest and hence limits economic exchange.

A different approach: focus on exchange and incentives

It is from this perspective, people's attitude towards risk and central to corporate finance, that PharmAccess has developed a paradigm for a different approach to development problems, supported by New Institutional Economics and Behavourial Economics. This approach was first set out in the essay A New Paradigm for Increased Access to Healthcare in Africa that won a second prize in the annual IFC/Financial Times essay competition of 2007. The critical questions for policymakers are how to structure their initiatives to set in motion a virtuous cycle where the level of trust between supply, demand, local and state institutions goes up, lowering risks. More trust and lower risks will spark economic development.

An economy is built in essence by people making transactions, i.e. exchanging. Low-income countries are characterized by underdevelopment, which is largely determined by low levels of economic exchange or transactions. This is a result of high transaction costs. These are high because in countries where government institutions do not function properly risks in trade and investment are higher, and trust lower. Institutions are not only formal laws and government regulators setting and maintaining for example quality standards or ensuring transparent and enforceable property rights, but also cultural norms, reliable press, product information, technical, standards etc. In short, any formal or informal rule that reduces the opportunities to cheat and increases structurally the amount of trust. Lower risk and high trust, two sides of the same coin, translate into lower interest rates and discount rates (the return investors demand for their investment).

Our starting point is to build on existing local public and private institutions and informal networks in public private partnerships (PPPs). Where trust in the public sector is low, people have more faith in their own community and leaders. Successful institutions depend on their evolving from the bottom up. In a public-private partnership focused on private sector development crowding out of public money by an influx of donor money is being avoided.

Secondly, we leverage donor money that can reduce investment risks to mobilize private capital. In public private partnerships donor money can buy down the risk premium, while the alliance itself will also help to nurture trust. This will help to establish the confidence, expressed in lower interest rates, needed to spur the economic multiplier, boosting investments and demand. That will reinforce institutional growth – the same way more regional and global trade in the developed world forced the creation of institutions to support it[viii]. Tools available to donors include providing soft/subordinated loans or loss-insurance, issuing risk capital, or guaranteeing a certain level of demand.

Thirdly, we empower local clients and communities by giving consumers a voice in the services they need and by creating more transparency. Fourthly, we simultaneously invest in the supply and demand for healthcare. Fifthly, we introduce independent quality standards, support clinics with technical assistance to improve their business plans and the running of the clinic. The introduction of standards aims to increase trust and reduce risk in the healthcare system.

The Medical Credit Fund (MCF), part of the PharmAccess Group, is a good example how with the help of donor money a new market can be developed and how donor money can be leveraged several times. MCF that provides loans to small and medium-sized healthcare facilities in Africa has been set up as a hybrid fund that leverages public and private donor funds with private international and local investment capital. The hybrid status of the MCF makes it a Public-Private Partnership (PPP) in its own right.

In the MCF approach public and private donors contribute to finance healthcare assets (including first-loss assistance and guarantees to banks and working capital and skills to clinics) for the lower-end of the healthcare market by mitigating credit risks for investors and supporting the program costs. As a result the risk of financing these assets is reduced, which subsequently will trigger and leverage both international and local private investments. This way the total amount of capital is multiplied and the lower-end of the market becomes financeable and scalable. Through this 'layered capital structure' the MCF is able to significantly increase the development impact of public funding, which has attracted a lot of international attention.

The MCF offers access to affordable loans in local currency, through local financial institutions, to private primary healthcare providers that serve low-income groups. Hitherto, local banks were reluctant to lend their capital to these clinics and charged unaffordable interest rates. Clinics needed these loans to improve and expand their services. MCF unlocked this banking market by providing the local banks with bank guarantees and first-loss assistance, while it supported the clinics through technical assistance with developing their business plan and advice on improving the running of their clinics.

Part of the MCF program is that the health facilities enter the quality certification program of SafeCare that has developed internationally recognized clinical standards and a stepwise quality improvement process tailored to small and medium-sized healthcare providers in low-income countries. In 2011, SafeCare was formed by three partners: PharmAccess, the Council for Health Services Accreditation of South Africa (Cohsasa) and the Joint Commission International (JCI). Quality improvements are recognized through formal certification of healthcare providers. It enables healthcare facilities to measure and improve the quality, safety and efficiency of their services and provides banks with insight in their credit risk. The certification aims to reduce the unknown risks of debt financing to primary healthcare providers through increased transparency, thereby enhancing trust in the segment among financial institutions. As a result, the lower end of the healthcare market becomes financeable in a sustainable manner.

In Nigeria's Kwara State the publicly funded Health Insurance Fund (HIF), also part of the PharmAccess Group, used donor money in various ways. It initially subsidized the insurance premium for the community-based health plan it set up for a group of low-income farmers through the Nigerian private health insurer Hygeia. These long-term donor commitments were made with the solvency of the insurance funds serving as collateral, which lowers the investment risk and makes investments in the health care supply chain feasible. Donor money triggered private sector investment in Hygeia, while HIF's resources were also used to upgrade medical and administrative capacity of the insurer and health providers contracted under the program. HIF has worked closely with the local state government which has gradually taken over the payment of the premium subsidy and has now committed itself to scaling up the program to cover 600,000 people within the next five years. The program would then reach 60 percent of the rural population in Kwara State.

Recommendations to donors

Donors should acknowledge the limitations of the public sector in many developing countries, as well as the complementary opportunities of engaging the private sector with their goals. We have the following recommendations:

1. Focus not just on the role of the private sector for the implementation of donor programs, but also engage the private sector in formulating development policies and targets, harnessing the strengths of the private sector, the sector's ambitions and incentives.
2. Concentrate on how donor funding can be leveraged through mobilizing private capital. Public development agencies could set explicit targets for leveraging private capital.
3. Focus on creating the conditions needed for the private sector to flourish, such as the rule of law, sound regulatory regimes and macroeconomic policies. Donors should support local governments in building institutions and infrastructure that are key conditions for developing inclusive markets such as setting and enforcing regulations (banking, insurance, employment, accounting etc.) and standards (quality/technical standards and controls, public registers, etc.) allowing markets to work better and to grow.
4. Further reduce investment risks by using blended financial instruments such as providing soft/subordinated loans or loss-insurance, or issuing risk capital. The article Public-Private Partnership and Development from the Bottom Up: From Failing to Scaling by John Simon (former ambassador of the USA to the Africa Union, former Executive Vice President of OPIC) and Onno Schellekens (PharmAccess) - published in Global Policy Journal in January - provides a table of instruments. The article has been included as an annex to our contribution to this consultation.
5. Be catalysts for opening up new markets for investments by investing in funds that provide access to capital to small and medium-sized entrepreneurs who are excluded from bank loans. This simply cannot be done without donor money. Their funding is essential to lower investment risk, which paves the way for private investment.
6. Invest in companies, often start-ups, and initiatives that create a market that did not exist previously or choose to commercialize services for the bottom of the market that traditionally are just in the realm of NGOs, such as many health and education services.
7. Develop and embed local institutions by aligning with existing non-state actors in public private partnerships (PPP). In PPPs donor money can buy down the risk premium, while the alliance itself will also help to nurture trust. There are many problems in developing countries –education, health, public transport and power infrastructure- where PPPs can start solving a development problem through the creation of a market.

8. Engage in supporting further public-private dialogue on supporting policies, programs and partnerships to ensure a level-playing field is being created for private investors. The EU has vast experience in developing regulations to unify markets and regulations that even create new markets.
9. Target holistic interventions at both the supply side as well as the demand side, addressing business sectors as a whole.
10. Contribute to the field of developing independent impact measurements and support often expensive, scientific impact evaluations of their aid initiatives and investments.
11. Concentrate on knowledge transfer of the long European historical experience in institution building. The development of the rule of law; benefit systems for health insurance, education, pensions, insurance, unemployment, incapacity; banking and financial regulation, accountancy standards, consumer protection, data protection and management, transparent pubic registers, tax collection etc.; these are all important market conditions in which the EU has strong competencies.
12. Coordinate aid policies and programs at country level where the EU and the Member States align with local ownership and engage in participatory decision-making with the stakeholders concerned.

Amsterdam, 24 February, 2014

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