



**JOINT
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For Universal Health Coverage



Fundamentals of Harnessing Private Capital for Universal Health Coverage

Mini-Guide

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About this Mini-Guide

This Mini-Guide was produced by the Joint Learning Network on Universal Health Coverage's Virtual Learning Exchange on the Private Sector, which took place between March and June 2022. It distils the key lessons, frameworks and case studies that were co-produced during the course of the learning exchange. The primary aim is to build a foundational understanding among public officials as to the key concepts around harnessing private investment to achieve government's UHC agenda. The mini-guide addresses the following key questions:

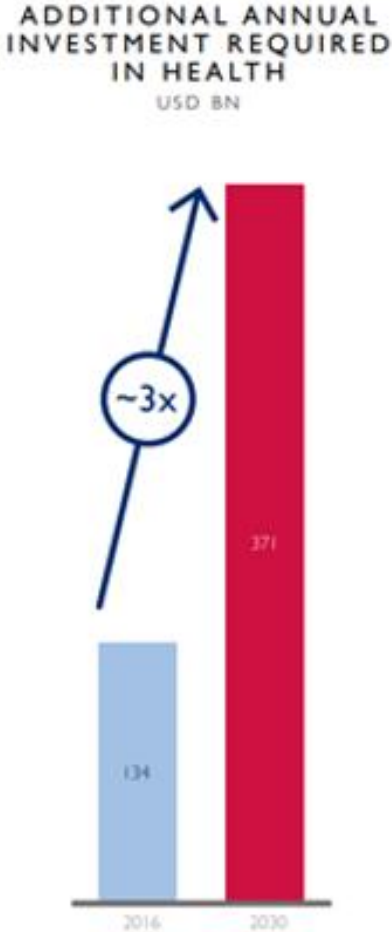
- Why should governments pursuing universal health coverage care about private investment?
- What is private healthcare investment and who controls it?
- Why doesn't private investment align with governments' visions for UHC?
- What levers can governments use to harness and direct private investment?
- How did one country (Republic of Georgia) manage to harness private investment as part of its healthcare reform story?

Why should governments pursuing universal health coverage care about private investment?

Public financing is the most equitable and sustainable model of funding Universal Health Coverage (UHC). However, as models such as national health insurance rollout they need to have the right services in the right place for their beneficiaries to seek care from (World Bank Group 2019). This is where private investment is critical to accelerating the journey towards ‘health for all’ – as it will determine how private providers can respond to the challenges and opportunities of UHC.

Annual investment in healthcare in emerging markets is currently nowhere near where it needs to be to build up a delivery system capable achieving the health-related Sustainable Development Goals (SDGs). An estimated gap of US\$134 billion in investment 2016 is projected to grow to US\$371 billion by 2030 (see Figure 1) (USAID 2019). Healthcare spending, likewise, exhibits an enormous gap – around US\$176 billion in additional spending is needed each year across 56 low- and middle-income countries alone to achieve UHC by 2030, according to the World Bank (World Bank Group 2019). In short: healthcare has an urgent need to secure more sources of funds.

Figure 1: Annual investment gap to achieve the health-related SDGs, 2016 and 2030 (USAID)

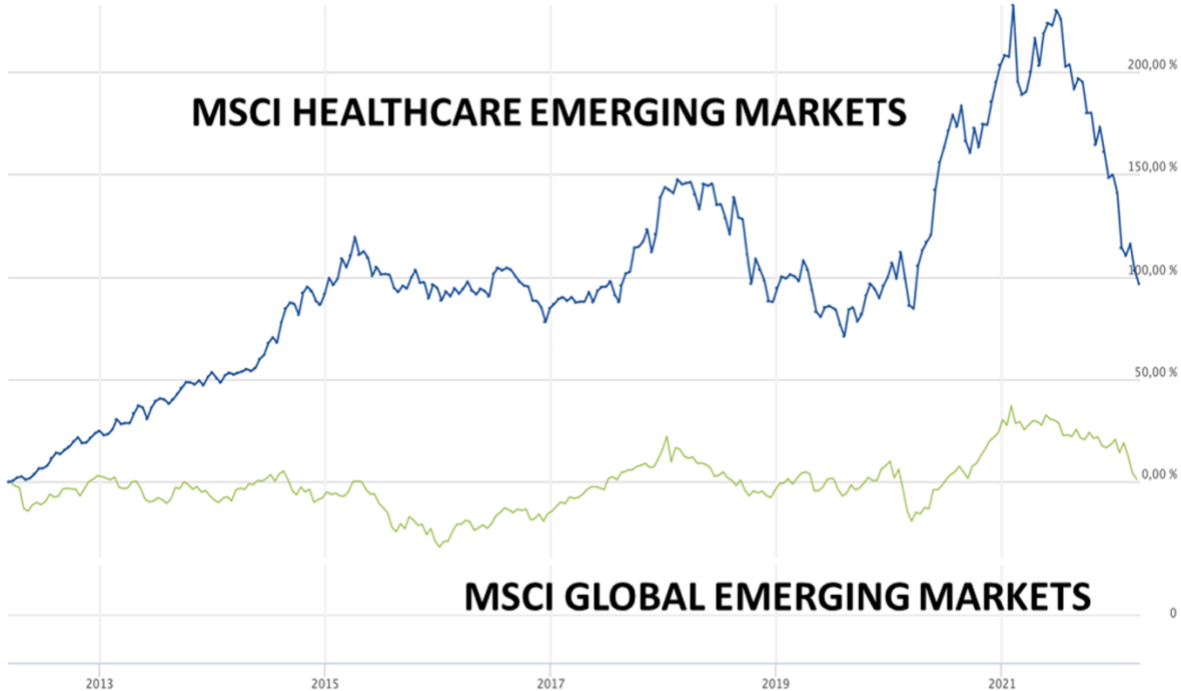


Source: USAID (2019) *Unleashing private capital for global health innovation*

Private capital is one part of the solution to this funding gap and shows tremendous potential for expansion. Global capital markets currently contain around US\$200 trillion across different forms of investments – less than half a percent of this figure would reduce the annual investment gap for UHC to zero (USAID 2019).

Furthermore, investments into emerging market healthcare businesses have proved very good bets over the past 10 years. While a typical all-sectors emerging markets fund will barely have grown over the past decade, an investment only in healthcare assets in the same countries over the same period would have doubled its value (See Figure 2). Added to this, healthcare investments tend to perform strongly on environmental, social and governance (ESG) criteria – the fastest growing sub-sector of investment finance globally.

Figure 2: Comparison of general emerging markets index fund versus healthcare-specific emerging markets index fund (2012 – 2022)



Source: Authors’ analysis using OnVista data

So, there is an urgent need for investment on the part of governments pursuing UHC, and a strong desire on the part of investors to find good healthcare opportunities in emerging markets. A perfect match? Not entirely, public officials report difficulties aligning private investment flows into the health system with the areas where they see the greatest need, and private investors report unease at betting on private providers that are too reliant on public payers and governments (Roland et al. 2019 and Wadge et al. 2017).

Participants on the JLN Virtual Learning Exchange on the Private Sector recognized the untapped potential of private capital to make their UHC reforms a success but shared a range of constraints in terms of their own understanding and skills, as well as those of private sector counterparts, which prevented effective partnership from happening (see Figure 3).

Figure 3: What do public officials say about harnessing private investment?



Source: Quotations from public official participants in the JLN Virtual Learning Exchange on the Private Sector

Properly harnessed, private capital can accelerate the pace of UHC reforms by:

- Funding the development of new service capacity and capability, which public payers can then contract with.
- Bringing innovation, new ways of working and new technologies into the provider sector – especially where existing private providers are not well equipped to adapt to the challenges of universal, comprehensive care.
- Targeting investment into gaps in service delivery, such as areas of the country with low provision, or inadequate primary or secondary care capacity.

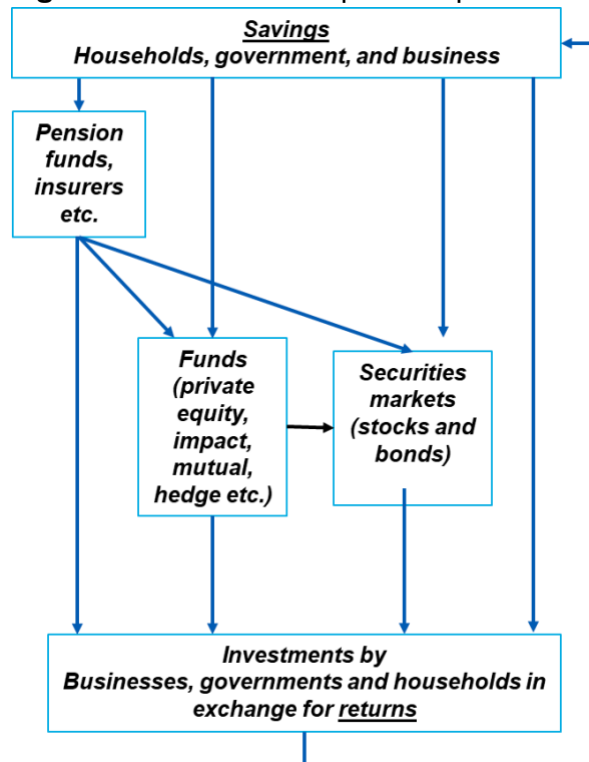
However, without proper direction, private investment can also impede UHC reforms. For example, if capital flows towards providers who duplicate capacity that already exists, do not meet the quality standards required by a payer, or induce demand for services where there is profit but little real health need. Private investors who fund providers that do not participate in UHC reforms may find that these organizations draw much needed health workers away from universal services, making the resource gap facing governments even worse.

What is private healthcare investment and who controls it?

Ultimately, all private capital is the accumulated savings of households, governments and businesses (see Figure 4), but how these are managed and deployed is key to understanding different types of investment. For social infrastructure and investment areas such as healthcare, the most relevant component of the global capital market is what is known as private capital, or investments that are not in listed public companies (i.e. publicly traded shares). This is worth around US\$7.8 trillion globally and is principally controlled by large institutional investors (such as pension funds and insurance companies) who are investing for the long-term and looking for stable, predictable returns. Other types of investors in this

category include private equity and venture capital, who have a higher tolerance for risk but also look for greater returns over a much shorter time period.

Figure 4: Overview of the private capital market



Source: Presentation to JLN VLE on the Private Sector by Andrew Myburg, Senior Economist, International Finance Corporation

There are two main ways that private capital is deployed. Firstly debt, in which the investor agrees a loan with a set interest rate and payback period which must be kept. This is secured against collateral (such as a building) which can be taken over if they fail to keep up repayments - but the investor does not take on any direct control of the asset. Secondly equity, in which the investor takes a direct ownership stake in the asset with no fixed endpoint and no set payback – but the borrower must cede some power and decision-making control to the investor. In general, equity is considered a better model for supporting innovation but is a more expensive means of businesses accessing capital. Over time, many companies will use a blend of both depending on what they are looking to achieve.

Returns are the key driver of all investments, with different levels of risk impacting how great a return is needed to attract sufficient investors. However, increasingly the raw profit on any given investment is not the only indicator that matters to many investors. Impact financing, or ‘ESG’ funds attempt to direct investment towards assets that can demonstrate both financial and social benefits (such as decarbonization, reducing inequalities, and improving human development indicators).

The types of assets that private capital is invested in are as varied as healthcare itself. However, Investors for Health, a group of investment players with interests in emerging market healthcare, have proposed 10

key archetypes for the most common types of investment ‘targets’ that they traditionally fund (See Box I).

Box I: Ten archetypes for private sector healthcare investing (from *Investors for Health, Private Capital’s role in Healthcare Delivery in Emerging Markets beyond COVID (2022)*)

TEN ARCHETYPES FOR PRIVATE SECTOR HEALTHCARE INVESTING

- ▶ **Diagnostic services and products:** Expanding access to early and accurate diagnosis, thereby contributing to better outcomes and overall system-level cost savings.
- ▶ **Clinics and hospitals:** Filling gaps in the public health system, improving quality of primary healthcare, and expanding access to and affordability of specialty care.
- ▶ **Pharmacy chains and e-pharmacy:** Expanding availability of authentic, low-priced medicines.
- ▶ **Supply chain solutions:** Strengthening local supply chains to enable movement of healthcare products.
- ▶ **Consumer health products:** Expanding access to low-cost over-the-counter medicines, supplements, and hygiene products.
- ▶ **Pharmaceuticals and biotech:** Improving access to generics and biosimilars to reduce cost of medicines, which accounts for a substantial proportion of out-of-pocket spending.
- ▶ **Medical devices:** Improving availability of devices for diagnosis and treatment at low-cost healthcare facilities (public and private) through low-cost innovation.
- ▶ **Insurance and financial products:** Extending insurance access to the uninsured.
- ▶ **Tele-medicine:** Expanding access to providers in remote areas, thus reducing distance barriers in urban areas and costs of consultations.
- ▶ **Tech-based hospital administration & EMR:** Improving facility and patient data management for better outcomes.

Why doesn't private investment align with governments' visions for UHC?

There is often a disconnect between how private investment flows into a health system and what governments pursuing UHC reforms would like it to do. Public officials might feel that their health agenda is creating major opportunities for private investors to put money into the gaps in service provision, upgrade infrastructure and create innovative new provider models. Investors, on the other hand, may see things very differently and stick to more traditional types of health asset, non-empaneled providers, or stay away entirely.

Part of understanding this disconnect is understanding how private investors find and appraise investment opportunities. Whereas an ideal investment has a predictable, steady income stream that will be resistant to shocks, scalable and be able to access international markets (in case of domestic downturns), healthcare investments have a number of inherent drawbacks: the industry is local, highly regulated, reputationally risky (e.g. if there is a patient safety scandal), uses a specialist workforce that are in short supply and take years to train, and – in systems pursuing UHC – often has a dominant public payer that controls the market and may change policies and prices at the whim of the political or economic cycle.

Long-term, institutional investors tend to be inherently conservative, and for a particular investment to be attractive virtually all of the six factors covered in Box 2 need to be met:

Box 2: Key factors private investors consider when assessing a healthcare investment opportunity

1. Macro-economic environment: Is the overall economy growing and showing strong fundamentals? Is the population increasing and are public finances and consumer spending habits sustainable? Is there a reliable legal system for protecting property rights and getting fair judgements in the case of any disputes arising.
2. Investment environment: For foreign investors and new ventures, is the process of getting licenses to operate and/or approval for the acquisition likely to be straight forward? Will it be easy to get the money out afterwards? Are there any tax incentives available for investors that will reduce this cost in early years?
3. Market dynamics: Is there a clear need for the provider in terms of un-met or under-met demand? Are there clear trends of sustained growth in healthcare spending and are these likely to continue? How highly regulated is the healthcare industry? What level of competition is there and what is the level of quality like?
4. Payer dynamics: How concentrated is the payer landscape in terms of numbers of payers? Do the main payers have a track record of paying on time? Do they tend to increase prices/tariffs in line with inflation? Are there payment models that offer additional rewards for higher quality care?
5. Characteristics of the investment 'target': Does the project or business have an experienced managed team running it? Does it (or will it) offer a range of services and treat a broad profile of patients? Does it have access to the clinical workforce it needs to expand? Does it have a differentiated value proposition compared to other providers? Does it have strong links with other local physicians who can recommend and refer to/from it?
6. Business fundamentals: Does it have different revenue streams to rely on (i.e. not just one payer)? If enrolled in government schemes? Is the business profitable (or has a compelling plan to become so)? Is there a clear expansion strategy and plan to deliver this? Are the financials of the business well managed?

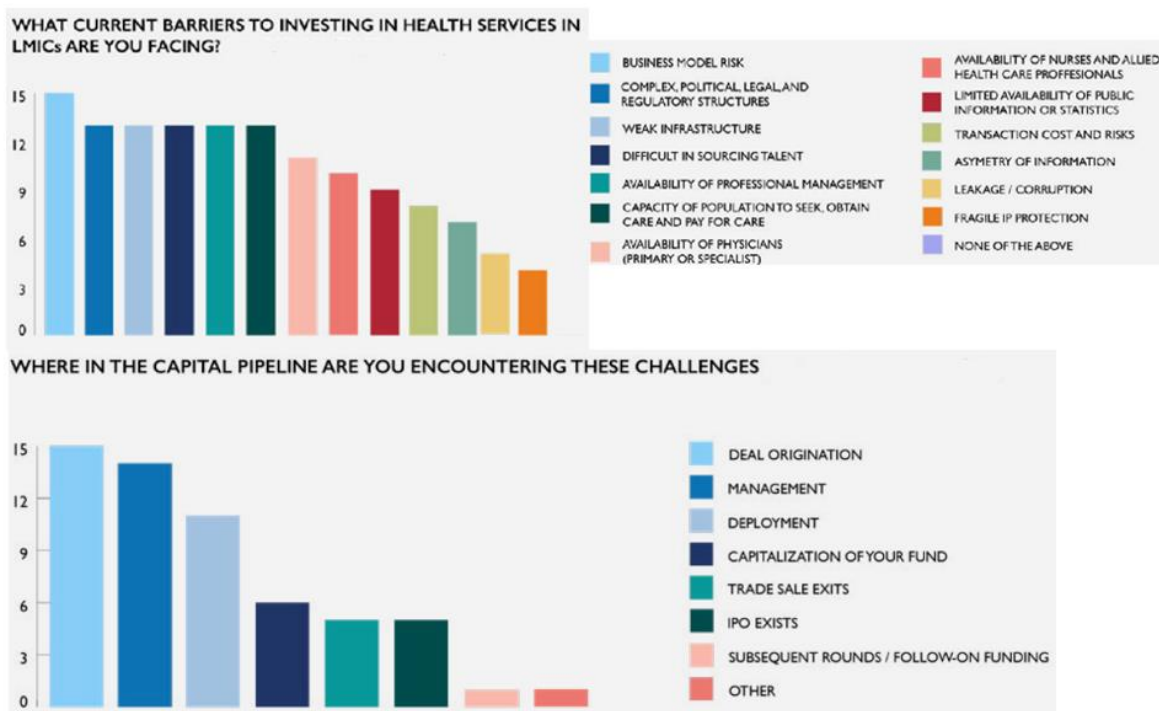
Long term investors tend to be conservative, and hence the six factors in Box 3 set a high bar. It is for this reason that private investors may tend towards 'tried and tested' investment types, such as private hospitals catering to privately-insured or out-of-pocket patients, even when a health system has a clear direction of travel set by the government towards universal insurance and greater emphasis on primary care.

It is also commonly the case that even where an investor sees this direction of travel, the level of specificity required to make a serious business case is not there: government policies may say that they have set a particular policy direction, but an investor often needs to know specific facts around demand, prices, regulatory environment etc. for the next five to ten years to reach the confidence they need to invest.

This while there are vast amounts of capital available, deploying it in a way that advances universal coverage is a major challenge. As recent survey data from 25 private investors who invest in emerging markets healthcare shows, the biggest hurdles to investment tend to be at the earlier stages of finding the right investment targets, and of systemic uncertainties and shortages in the wider health system (See Figures 5 and 6).

Figure 5: Survey responses by 25 private investment institutions to ‘What current barriers to investing in health services in low- and middle-income countries are you facing?’

Figure 6: Survey responses by 25 private investment institutions to ‘Where in the capital pipeline are you encountering these challenges?’



Source: Investors For Health, *Private Capital’s role in Healthcare Delivery in Emerging Markets beyond COVID (2022)*

What levers can governments use to harness and direct private investment?

Participants in the Virtual Learning Exchange discussed three different stages of work to better attract and direct private investment into their healthcare systems:

Stage 1: Set clear objectives

Before deciding which levers and approaches to use, governments must first be clear about what they want private capital to achieve. There are many possible responses, including:

- To accelerate the pace of delivery system expansion
- To create new providers and expand capacity (without increasing national debt)

- To reform, rebuild or expand existing providers
- To inject new ideas, innovations and ways of working into the health system
- To limit direct financial and other risks to government
- To direct resources towards services and locations where there are gaps that the public sector cannot fill
- To introduce independent project valuation and management skills

For each of these, it is important to consider why this is not already happening and what role private capital can realistically play. For example, if there are no public sector providers in an area because there are no healthcare workers to staff them, how is that private investment is going to be able to do this? Or, if existing private providers are unable to make a profit on the prices paid by government for healthcare, why would new providers be interested in entering the market?

Stage 2: Develop a supportive macro-level environment for private investors

Many of the barriers identified by investors are broader than any specific project and are concerned with the wider environment for private investment and in the healthcare system at large. The following interventions are all supportive to increasing the overall volume of investment, as well as to some extent directing where it is deployed as well:

- Ensure there is a supportive legal and policy environment for foreign and domestic investors to engage in the healthcare sector, including supportive banking sector and a straightforward process for being granted any necessary approvals.
- Ensure a level playing field between different types of providers with clear standards as to what is expected.
- If contracting private providers directly, ensure that prices are fair and payment is timely.
- Develop mechanisms to measure and incentivise quality care, so that new entrants do not fear getting undercut by poor quality providers.
- Include the private sector provision within workforce planning, so that the needs of public and private providers are factored in. Private providers should also play their part in training health workers so that they are not a net drain on human resources for health.
- Create facilities for responsive communication between government and private players, including mechanisms to guarantee consultation in future health system changes. This might take the form of a dedicated private investment office within the Ministry of Health or national health insurance agency.
- Enact transparency measures so that future decisions are clear and investors have access to a broad and detailed range of data that they need to assess market opportunities as broad and detailed a range of data that investors might need available.
- Publish the main areas where you wish to encourage private investment and conduct a campaign to promote these among investors.
- Support downstream domestic innovators (e.g. start-ups and promising new providers) to develop (e.g. through grants, awards and coaching) so that they can grow to become the sought-after investment targets of the future.
- In systems with large numbers of small, fragmented private providers, supporting these to aggregate so that they are collectively a more attractive target for private investors.

- Ensure universal coverage, so that there is viable demand for healthcare from all income groups.

Stage 3: Develop specific partnership models

For some systems, addressing the macro-level environment for health policy will be insufficient, as investment may start flowing but still be misaligned with what government would like to achieve. In these cases, more specific models of public-private partnership (PPP) may help to directly steer investment where it is most needed. These have a much higher administrative and technical requirement on the part of government but do give a more powerful level of control - less of a 'guiding hand' and more of a 'hand on the tiller'.

PPPs can take various forms, but at their root are a way of the public and private sector agreeing to bundle specific aspects of a certain project of provider into an agreement whereby the private sector will source investment and execute various activities, with the promise of payment over a longer-term time period (often as much as 30 years).

Among the key forms of healthcare PPP identified by Wright et al. (2019) in their typology are:

- **Managed lease PPPs:** Typically, the private partners construct a new facility and then take responsibility for managing the building and some of its functions (e.g. laundry, catering, security or, in some cases, medical equipment) for a 15-35 year period, during which the government makes monthly payments (minus any deductions for failures or extra payments for work on top of what is stated in the contract). Clinical operations remain the responsibility of the government. Managed lease PPPs are a popular method of quickly expanding healthcare infrastructure globally, but don't allow private innovation into much bigger area of healthcare service delivery (e.g. to have the introduce new models of care).
- **Hospital infrastructure and clinical joint ventures:** These are hospital-wide JVs that typically involve government agreeing a 'managed lease' type contract with one company and a second contract for clinical operations with a (usually) separate company. The former is paid monthly instalments and the second payments based on healthcare activity provided. This PPP model opens up the scope for private investment and innovation into service delivery but has proved complex for system to administer – especially in areas where it is unclear which of the two private sector entities is responsible for a given problem.
- **Franchised hospital concession:** A single private sector partner (or consortium) takes over the full operations of either an existing provider with a licence to operate (e.g. an old municipal hospital) or builds a new one that aligns with the government's hospital plan. Rather than a unique contract to them, the hospital then operates on the same terms as other providers in the system – they are paid the same tariffs and cannot cream skim patients, although in some cases the government may guarantee income up to the equivalent of a certain number of patients.
- **Franchised population full-service:** This is the same model as the franchised concession hospital above, but with the addition of other providers in the local health system (e.g. primary care clinics, specialist hospitals, community care services). Payment is capitated (per population covered), which enables the private partner to unlock the full scale of potential service innovation and create new models of care that will be as efficient as possible.

While the final model is the only one to explicitly involve non-hospital provision (reflecting the reality that PPPs have high transaction costs and so typically only make sense for large-scale deals) there is no reason why they cannot be applied to chains of smaller providers (e.g. diagnostic centres, primary care clinics, or pharmacies).

There is much more to say on the proper use of PPPs in health system development, but they can be a very useful model to directly ensure private investment is used in ways that align with government's UHC agenda. Just remember that in the end with all PPP models it is the government that ultimately ends up paying (albeit over a longer time period), and the cost of building up healthcare infrastructure is typically just a small fraction of the cost of running these facilities over their lifetime.

Case Study: How did the Republic of Georgia manage to harness private investment as part of its healthcare reform story?

Source: *With grateful thanks to Alexander Kvitashvili, former Minister of Health for Georgia*

In the mid-2000s the Republic of Georgia was undergoing a transformation across its public sector, with major reforms to the tax system, social programs, policing and government administration – many designed to combat corruption and increase the government’s spending power. Healthcare was included in this package, as the system suffered from ageing infrastructure, a geographic distribution that didn’t match needs, and a host of other access and quality challenges inherited from a largely un-reformed, Soviet-era Semashko health system.

A system-wide renewal of the country’s hospitals and clinics was required, and needed private capital to finance it, as the government had neither the technical capacity nor fiscal space to undertake this transformation. However, the invasion by Russia of regions of the country in 2008 had investors concerned that the country was too unstable to be an attractive prospect. Yet within a few years the country had raised as much as US\$400 million private investment into the health delivery system from local and international investors, and substantially expanded and renewed healthcare provision. How was this accomplished?

The first stage was wider changes to the country’s investment environment: enabling foreign ownership of land and businesses, simplifying the visa system, and creating a more secure and safe banking system. These created an enabling environment across the economy for private investors to have the confidence necessary to seriously consider opportunities in the health sector when they came along.

The next stage was to offer some immediate payback and incentive to those who invested in new healthcare infrastructure. The government surveyed its existing healthcare land and assets that were either underutilized or of poor quality – many had little value as health facilities but great potential as hotels and other real estate in prime locations of Georgia’s historic urban centres. Deals were therefore established whereby an investor would be given a valuable old healthcare asset to develop into something new if they built a new facility at a different location specified by the government, agreed to operate it for 10 years and employ the former facilities’ staff. The government would also help to connect roads, power and other utilities to any facilities created in more rural locations.

Recognising that offsetting the building cost of hospitals was just one part of the equation for investors, the government also executed a parallel reform to health financing to create a multi-payer social health insurance system. A nationwide census of the poor and vulnerable was conducted and the 25 percent of the population found to be classified as poor and vulnerable were given entitlements to choose from one of 11 participating health insurers and have their premiums paid by government. Over time, civil servants would also be added to this group. This expansion in coverage gave investors the guaranteed future revenue streams they would need to plan for the future business model of any new hospitals they created.

The reforms created immediate interest, and as many as five new hospitals opened their doors within the policy’s first 18 months. Georgia has subsequently had a thriving private provider sector, including some

vertical integration to create HMOs, one of which, the Georgia Healthcare Group, now operates 16 hospitals, 34 clinics, over 200 pharmacies and one of the country's largest health insurers.

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