

D6 | THE INTERNATIONAL FINANCE CORPORATION'S 'HEALTH IN AFRICA' INITIATIVE

In 2007 the International Finance Corporation¹ (IFC) launched a report sponsored by the Bill and Melinda Gates Foundation and researched by McKinsey & Co. (IFC 2011a; IEGWB 2009: 86). The report, *The Business of Health in Africa: Partnering with the Private Sector to Improve People's Lives*, outlined the IFC's laudable aim of developing and enforcing quality standards for private healthcare, but also made significant claims about the role of the private sector in healthcare in the continent. IFC states that the private sector already delivers half of all healthcare across sub-Saharan Africa and even more for the poorest people (IFC 2011a: vii), and that private healthcare is often more affordable for poor people than government provision (IFC 2010: 2; IFC 2011a: 26). The report asserts that private sector enterprises can 'stimulate higher efficiency and quality standards' through competition, and set national benchmarks for higher-quality healthcare. The report also says that up to two-thirds of needed investments to scale up and improve health services in sub-Saharan Africa may need to come from non-state actors.

IFC claims about the performance and potential of the for-profit private sector in health remain largely unsubstantiated, and have since been challenged (Oxfam International 2009; Basu et al. 2012). Yet in 2008, the IFC launched



Image D6.1 IFC is a part of the World Bank Group

the Health in Africa initiative – a \$1 billion investment project which aimed to ‘catalyse sustained improvements in access to quality health-related goods and services in Africa [and] financial protection against the impoverishing effects of illness’, with ‘an emphasis on the underserved’ (Investment Climate Advisory Services 2013: 1). Health in Africa would achieve these objectives by harnessing the potential of the private health sector, specifically by improving access to capital for private health companies, enabling them to grow and expand, and through assisting governments to incorporate the private sector into their overall healthcare system. Health in Africa would aim to ensure the private health sector became ‘an additional and powerful instrument to progress towards the Millennium Development Goals’ with ‘extra efforts to improve the availability of health care to Africa’s poor and rural population’ (Brad Herbert Associates 2012: 11).

Health in Africa enjoys the backing of many international actors, including the governments of France, Japan and the Netherlands, and the Bill and Melinda Gates Foundation (IFC and World Bank 2012: 1). Other partners include the African Development Bank and the German development finance institution DEG (IFC n.d. a). Within the Bank the initiative was characterized as ‘a new direction for the World Bank Group in health’, and formed part of the Bank’s larger health strategy (World Bank Group 2012: 1).

IFC’s track record in health

Until the early 1990s, IFC had only a few, sporadic health projects and no health department or specialized health staff (*ibid.*: 77). However, IFC’s operations have grown exponentially and its current investment commitments total \$50 billion, involving nearly 2,000 companies in 126 countries. (IFC (n.d. c). An assessment in 2009 found a number of IFC health projects implemented between 1997 and 2002, where operations resulted in abandonment of project construction, or complete failure of the business and bankruptcy of the sponsor company. Development outcomes were also low, with a number of hospital projects reporting significant underutilisation of facilities (World Bank Group 2012: 83). The IFC’s health operations showed some improvement in the following decade, but saw continuing low development outcomes in a number of its hospital projects. Only a third of its advisory services met or exceeded expected outcomes and the cost-effectiveness of projects was considered low. The IFC’s experience in health projects was assessed as limited, sporadic and predominantly based outside of Africa in low-risk middle-income countries. Far from benefiting the underserved, IFC health projects were found to have ‘benefited primarily upper- and middle-income people’, the so-called ‘top of the pyramid’ (*ibid.*: 90).

The pattern of low performance has continued with the Health in Africa initiative. The independent mid-term review of the initiative published in 2012 identified some limited areas of success, but overall found its performance had

been uneven with a failure to deliver across a number of key objectives (Brad Herbert Associates 2012: 11). The review commends the IFC for establishing a new equity fund that aims to incentivize health sector investments that will benefit people at the so-called 'base of the pyramid'. However, as discussed later, a closer look at this incentive mechanism reveals serious flaws that render it largely meaningless as an effective approach to ensure poor people benefit from the equity fund investments.

Poor progress on Health in Africa investments

It is clear that Health in Africa's activities have failed to deliver anywhere near the scale of healthcare investments and reforms they set out to achieve. The poor progress has led many stakeholders to label Health in Africa as merely 'talk and paper', and to suggest that the initiative should 'stop wasting everybody's time' (ibid.: 47, 50).

Health in Africa aimed to generate \$1 billion via three main investment mechanisms: a \$300 million equity vehicle; a \$500 million debt facility mobilizing loans from local banks to private healthcare actors; and \$200 million in technical assistance (IFC 2010; IFC and World Bank 2012: 4). The equity and debt schemes aimed to provide capital for nascent small and medium enterprises (SMEs) by channelling smaller, more manageable investments than the average large endowments made directly to companies by the IFC (World Bank Group 2012: 1).

Health in Africa's equity vehicle comprises investments in two private equity funds: the Africa Health Fund managed by the Abraaj Group (IFC n.d. a), and the Investment Fund for Health in Africa (IFHA) established by the Dutch PharmAccess Foundation in February 2007 (IFC n.d. b). The two funds had collectively raised \$172 million at Health in Africa's mid-point in June 2011 (Brad Herbert Associates 2012: 6), with IFC contributing over \$26 million.² However, only \$24 million had actually been disbursed (ibid.: 32). The remainder sat unused in the equity funds but was still culled for hefty management fees.³ Moreover, this \$24 million constituted Health in Africa's total investment as of June 2011— just 2.8 per cent of the \$850 million target.⁴

In recent years, owing perhaps directly to the significant failure to make any real progress towards Health in Africa's \$1 billion target, the IFC has now begun marketing its own direct health investments in sub-Saharan Africa. The largest of these totalled more than \$93 million, almost four times Health in Africa's own investments (ibid.: 4).

Reaching the poorest: Health in Africa's commitment to 'the underserved' The IFC's literature has repeatedly emphasized the intention of Health in Africa to focus on benefiting 'underserved' populations in sub-Saharan Africa. Its plan presented to the World Bank board in 2007 emphasized improving the 'availability of health care to Africa's poor and rural population' (ibid.: 4). Despite

this, there is clear evidence of systematic failings across all work streams to impact on poor people. This includes failure to analyse how to reach poor people effectively via the private sector; failure to direct investments for the benefit of poor people; and failure to even measure whether poor people are being reached (*ibid.*: 4, 18, 41).

The independent mid-term review found Health in Africa's analytic work completely failed 'either by omission or design' to 'engage with the most single important global controversy with regard to the role of the private sector in health in Africa: the role – if any – that the private health sector can and should play in achieving development impacts'. Despite the stated focus on the 'underserved', the IFC had made no attempt to answer the question: 'does strengthening the private health sector improve health outcomes for the poor' (*ibid.*: 4, 18, 20). A further concern is the apparent lack of consideration of gender equity, both in terms of whether the initiative seeks to promote gender equity and, if so, how this will be measured. Given that women are disproportionately represented among poor and rural populations, this is a worrying oversight and is at odds with the World Bank Group's commitment to promote gender equity.

Publicly available information suggests Health in Africa's investments to date have in practice almost uniformly been in expensive, high-end, urban hospitals offering tertiary care to African countries' wealthiest citizens and expatriates. The intention to target the elite, including those rich enough to seek care overseas as health tourists, is made explicit in several investment decisions. Clinique La Providence in Chad was to receive an IFC loan of \$1.5 million to make available 'locally, health care services for which Chadians are currently travelling abroad' (IFC Projects Database 2014a). Togo's already well-established Clinique Biasa received a \$1.7 million investment and describes itself as 'one of Lomé's top three private hospitals' (Private Equity Africa 2012). And in Nigeria (a country bearing 14 per cent of the entire global maternal mortality burden) the Africa Health Fund has invested \$5 million in West Africa's first IVF centre with an objective, to quote Jacob Kholi, managing partner of the Africa Health fund, to 'provide world-class infertility treatments' (Abraaj Group 2012).

IFC's biggest Health in Africa investment to date has been in Life Healthcare – South Africa's second-largest multimillion-pound company with services spanning a network of sixty-three hospitals plus other facilities across the country (IFC Projects Database 2014b). Life Healthcare's services remain unaffordable even for many comparatively wealthy South Africans.⁵ Moreover, Life Healthcare is rapidly expanding, but predominantly outside African markets; its main growth since the \$93 million Health in Africa investment has been the 2011 acquisition of a 26 per cent stake in one of the largest hospital groups in India (Hasenfuss 2011).

Some Health in Africa investments have targeted smaller companies but

their hospitals still deliver the same kind of expensive, inaccessible services. At the Health in Africa-supported Nairobi Women's Hospital, even the most basic maternity package would cost an average Kenyan woman three to six months' worth of wages at \$463. This goes up by almost \$280 if an obstetrician is involved and by more again if a caesarean section is required. The hospital claims to cater for low- and middle-income Kenyan women and their families, yet their average reported inpatient cost was \$845 in 2011. Two thirds of Kenyans would have to forgo at least their entire income for well over a year to pay such a fee.⁶

Any genuine availability of services for poor people in Health in Africa's investment portfolio seems to be limited to tokenistic corporate social responsibility schemes on a tiny scale, such as the donation of 250 blankets; sponsorship of eight water pumps in schools; and two days of free eye screening for 200 people (Nakasero Hospital n.d.: 1, 4).

High-cost, low-impact investments

Health in Africa has failed across its investment portfolio to prove claims of superior efficiency and cost-effectiveness in the private healthcare sector. Instead there are numerous examples of high-cost, low-impact investments which make a negligible contribution to the overall scale of health coverage. Health in Africa's investment in Chad's Clinique La Providence translates to a cost of \$50,000 per additional bed. The lack of transparent and accurate information makes it impossible to investigate why the costs are so high. Similarly, Health in Africa invested in Tanzania's so-called leading health insurance provider, Strategis Insurance (IFHA n.d.), which had just 30,000 people enrolled. The East Africa-wide health maintenance organization, AAR Health Care Holdings, has benefited twice from IFC investments⁷ yet currently provides outpatient services for only 500,000 people per year across the region (IFC 2013). AAR's growth target of serving an additional 600,000 outpatients per year by 2018 (ibid.) would see it reaching a mere 1.9 per cent of the total population of the three countries in which it operates by this date.

Turning a blind eye to measuring impact

The IFC's approach to Health in Africa is at odds with World Bank Group president Jim Kim's emphasis on evidence-based approaches and the 'science of delivery' (Kim 2012). The independent mid-term review states that 'the topic of the private health sector is controversial, and this should have led Health in Africa to be more engaged with defining its anticipated results and then assessing them. This has not happened, and as a result it is now difficult to assess the extent to which HiA has had any real impact' (Brad Herbert Associates 2012: 4).

The particular failure of the IFC to measure the extent to which Health in Africa impacts on people living in poverty is nothing less than surprising.

Box D6.1 IT workers' health insurance scheme

A series of schemes partnering the IFC-supported company Hygeia (IFC and World Bank 2012) in Nigeria have been celebrated for extending health coverage to low-income Nigerian communities. One Health in Africa scheme, receiving \$6.1 million from IFC, set out to subsidize health insurance for 22,500 low-income IT workers in Lagos over five years starting in 2008 (GBOPA n.d.). The pilot scheme automatically excludes the poorest and most vulnerable Nigerians as enrollees are required to be in formal employment and earning 300,000 naira a year or less (the equivalent of approximately \$5 per day, while 68 per cent of Nigerians live on \$1.25 or less per day).

Such exclusion is even clearer when looking at the costs of the scheme. In the first year enrollees pay \$10 to join. By year five, as the IFC subsidy is reduced, the cost rises to \$53. Beyond the project's five-year term it can only be assumed that the full cost of the \$93 insurance premium will fall to individual members unless the government can be persuaded to take it on. To achieve the latter on a country-wide scale would require tripling the current government per capita health expenditure.⁸

Even at this unaffordable cost the insurance scheme excludes a number of key healthcare services, including cancer treatment, intensive care, family planning, any major surgery, as well as several other essential health services.⁹

According to the project information available, the scheme has failed to reach its target number of enrollees. Today, a year after the project was supposed to close, fewer than 40 per cent of the planned beneficiaries have been reached and only 54 per cent of the IFC funding has been disbursed.¹⁰

The performance indicators outlined in the business plan for Health in Africa are inadequate to measure any impact on the underserved (*ibid.*: 32). Health in Africa equity funds are tasked with 'serving underserved and low-income people' through their investments but neither do so, nor measure their attempts to do so. The investment fund for Health in Africa simply requests its portfolio companies to complete a questionnaire on environmental, social and development impact and makes a series of assumptions, including that extension of insurance, tele-medicine and other products and services will increase equitable access to healthcare impact (IFHA 2012). The tele-medicine provider supported by the fund (a South African company called 'Hello Doctor') has since been branded unethical by the Health Professions Council

of South Africa, forcing the organization to withhold its services (Umar and Rondganger 2011).

The mid-term review notes that a results framework has 'finally been developed' for Health in Africa but despite the authors' requests to date, the IFC has not yet made this available for us to review (ibid.: 4).

Unaccountable and opaque: use of financial intermediaries

The absence of any genuine attempts to measure development impact through Health in Africa is compounded by the initiative's use of financial intermediaries (FIs) to invest on its behalf. In 2011, over half of IFC's total portfolio was made up of lending through this route and research by Oxfam has identified several worrying associated problems (Oxfam 2012: 1). These include opacity, complexity, focus on financial returns over development impact, focus on financial risk over environmental and social risk, lack of oversight or ability to influence the business practices of investee companies, and remoteness from the projects ultimately financed and the impacts they have on poor people (ibid.: 3–6; Nash 2013).

A 2012 report from the Compliance Advisor Ombudsman (IFC's watchdog) found that IFC is unable to track whether or not its investments via FIs are causing harm to poor people and the environment, let alone measure whether they bring development benefits (CAO 2012: 24–5). This dearth of information can make it impossible for communities to find out whether the IFC is even involved in a project, much less know that they could access grievance and redress mechanisms through the CAO (Nash 2013).

The World Bank's response to Health in Africa's mid-term evaluation

The official World Bank Group response (World Bank Group 2012) to the critical findings of Health in Africa's mid-term evaluation was largely to emphasize the pilot nature of the initiative and that the IFC team were committed to an approach of 'learning by doing'. This defence is later undermined by their admission that monitoring and evaluation, a prerequisite for learning by doing, did not receive sufficient attention in the first year. In fact, Health in Africa did not have an overarching results framework until 2011. Further emphasizing the IFC's poor understanding of the purpose of monitoring and evaluation, the response commits to defining a verifiable criterion for judging the success of Health in Africa 'by the time it concludes' (ibid.: 6).

In response to the lack of focus on the underserved the World Bank management response appears at odds with the Health in Africa literature in claiming that the initiative 'did not intend to have a direct focus on the underserved in everything that it did, especially its policy work'. It goes on to assert that its work has indirect benefit by, among other things, improving the operating environment for the private sector. The response throughout reasserts IFC's ongoing and unsubstantiated assumption and expectation that the improvement

and growth of the private sector in the lowest-income countries will automatically benefit poor people (ibid.: 4–6).

Conclusion

The evidence available suggests that IFC's Health in Africa initiative works at odds with the commitment from the World Bank Group leadership to universal and equitable health coverage. While the failure of the initiative to mobilize its target level of investment is of interest, of significant concern is the lack of focus on poor people, and particularly women. The absence of any robust and comprehensive framework to measure impact, particularly on poor people, undermines IFC claims that it has taken a 'learning by doing' approach and has done nothing to challenge the weight of evidence demonstrating the risks and inequity of healthcare commercialization. There is little, if anything, in the official World Bank response to the mid-term evaluation to reassure critics that the IFC is committed to a pro-poor, evidence-based approach. The World Bank leadership should fully review the IFC's operations in health and question how they fit with, and are accountable to, the overarching goals to end extreme poverty and promote shared prosperity.

Notes

1 IFC is a member of the World Bank Group. On its website (www.ifc.org), IFC claims that it is 'the largest global development institution focused exclusively on the private sector in developing countries'.

2 IFC invested \$6.79 million in IFHA (IFC n.d. b).

3 For example, Aureos Capital takes 2.25 per cent from the Africa Health Fund as 'management fees'. See Lister (2013).

4 The \$850 million target comprised \$500 million for equity, \$300 million for debt and \$50 million for associated technical assistance (Brad Herbert Associates 2012: 32).

5 See Life Healthcare's website for examples of the additional costs of private doctors (outside of medical aid schemes) at Life Hospitals: Life Westville Hospital, www.lifehealthcare.co.za/Hospitals/DisplayHospital.aspx?nHospitalId=61; Life East London Private Hospital, www.lifehealthcare.co.za/Hospitals/DisplayHospital.aspx?nHospitalId=14; Life Faerie Glen Hospital, www.lifehealthcare.co.za/Hospitals/DisplayHospital.aspx?nHospitalId=20, accessed 11 May 2014.

6 Nairobi Women's Hospital's 'shortmat' maternity package costs KSh40,000 (confirmed in correspondence with Nairobi Women's Hos-

pital, February 2014, and converted at xe.com March 2014).

7 A \$4 million equity investment due to be disbursed (IFC Projects Database 2014c) and an additional purchase of a 20 per cent stake by the Investment Fund for Health in Africa (Private Equity Africa 2010).

8 According to WHO figures the Nigerian government spent \$29.6 per capita in 2011 (WHO Global Health Expenditure Database n.d.).

9 Including high-technology services (CT scans, MRI, etc.); epidemics affecting more than 10 per cent of the population; injuries resulting from natural disaster, war or riots; dialysis; congenital abnormalities; provision of spectacles, hearing aids or dental care; and drug abuse.

10 The scheme had 8,862 enrollees out of a target of 22,500 as of May 2013.

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