PharmExec.com
COMMERCIAL INSIGHTS FOR THE C-SUITE

Investing in African Healthcare: Study, Share, Act — and Grow

Sep 18, 2014
By Pharmaceutical Executive Editors

Is sub-Saharan Africa a jewel box of untapped assets for a growth-obsessed big Pharma? Some of the majors apparently think so, with both GSK [see blog [1]], Sanofi and Astra-Zeneca recently announcing a significant upgrade in infrastructure investments and scientific partnering relationships dedicated to the region. Overall industry revenues in Africa are growing at a double digit annual clip, and IMS forecasts sales will skirt close to the pivotal $50 billion mark by 2020. And there is additional potential in simple demographics: the region can count on having the world's youngest population of working age for decades to come – what we call the "human energy advantage." To identify some benchmarks for best practices in building a viable drugs business in Africa, Pharm Exec *recently spoke with* ***Steven Adjei*** *(pictured above), a native Ghanaian and founding partner of BlueCloud Healthcare, an investment advisory firm and start-up business "incubator" focused on opportunities in the sub-Saharan region.*

PE: *Why is Africa the focus of so much positive investor sentiment today? On the surface, the region still appears mired in the same post-colonial patterns of poverty, flawed governance and simmering sectarian rivalries that cost lives and erode human potential. What has actually changed?*

Adjei: Perceptions tend to last longer than facts. At the turn of the millennium, Africa had yet to turn the corner on economic growth. Rural poverty was endemic. Urbanization – one of the key structural drivers of change over the past decade – was just taking root. Foreign investment outside the extractive sectors was almost nil. Civil unrest in some of the larger countries transcended national boundaries, with a destabilizing effect on business confidence due to frequent regime change and the refugee problems that accompanied it.

Today, we see a much more diverse picture. Africa's rate of return on FDI surpassed 12 per cent in 2007, and since then has consistently delivered similar returns, in the double digits. By comparison, the rate averaged only 2 to 4 per cent in the US, the EU and Japan. Stable governments are becoming the norm in Africa, with 30 instances of peaceful leadership transition through the ballot box in the last decade. Corruption and bribery are being brought under control, as evidenced by the latest Transparency International Corruption Perception Index [CPI], which ranks 35 African nations ahead of Russia and six ahead of Italy, in terms of clean business practices.

Perhaps the brightest indicator of progress is the latest forecast by the Africa Development Bank that the number of Africans with a middle class income will pass the 100 million mark by the end of next year. While the definition of middle class is somewhat judgmental, the point is the number of people with discretionary income is clearly on the rise. Many in this group are younger demographically than in other regions, with a strong desire to consume. The transition is having a simple but profound impact at the retail level: one of the most successful emerging franchise operations in West Africa today is the KFC chain of convenience foods, which benefits from the higher discretionary incomes of this emerging middle class. The trend also means people are prepared to invest in their own health, which over time means more opportunity for private clinics, hospitals, pharmacies and physicians.

PE: *With FDI on the upswing, which are the hottest areas for investors? How does health care figure in the mix?*

Adjei: Energy and natural resources are still the most attractive play, but financial services is surging along with transport, engineering, housing and other investments linked to infrastructure. Right now, health care is not a key area of interest, with only about one per cent of FDI taking place in this sector in 2012. Capital goes to the places where it can obtain the highest return; health care is currently perceived as not delivering as much on this score as other sectors, although we are seeing interest in investments in the supply chain, like retail pharmacies. It is also true that many of Africa's most persistent health conditions, led by HIV, other communicable infections and malaria, primarily affect populations at the low end of the income spectrum, making it difficult to stimulate consumer demand for all but the most basic medical services.

But there is a silver lining for health care providers: the combination of a growing middle class interested in health care provision and the rising incidence of non-communicable diseases like diabetes, cardiovascular conditions and respiratory ailments. Such conditions offer varied opportunities for profitable and scalable health care businesses because there is a small but growing consumer base with the income to pay for treatment. We are also seeing opportunities in the move of national health systems to focus on community-based prevention and lifestyle changes. Campaigns to control smoking, alcohol, unwanted pregnancies and obesity carry enormous reciprocal benefit to society when applied to the entire population. Private enterprise can play a strong role in making such programs scalable.

Five hurdles to the home stretch

PE: *What will be necessary to redirect the agenda to focus more intensively on building the health sector in Africa?*

Adjei: I see five obstacles that must be overcome to raise health standards in Africa and improve the climate for investments in medical innovation. The first is what I have

already mentioned: bridging the **perception gap**. Last year, the big four consultancy EY conducted a survey on Africa's potential for growth that polled business executives based in the region along with HQ management who had no business interests there. In the latter group, Africa ranked dead last in terms of its attractiveness as a place to invest, while in the former case Africa placed second, just marginally behind Asia. In other words, those on the front line realize how great the potential is.

Second is the inadequacy of much current **infrastructure** – the poor condition of roads and rails, lack of good port facilities, non-competitive transport services and a sub-standard electricity, water and sewage grid. Communications, on the other hand, is considered excellent in most places, largely because cell phone technology has allowed Africa to leapfrog an entire cycle of product innovation beyond the land line.

The third factor is **political instability**, which, happily, is no longer a region-wide issue but rather concentrated in a few marginal geographic areas like the Sahel. It just happens that these conflict zones can be strategically important, shaping government policy and civil order in key countries like Nigeria. The threat to Nigeria posed by the insurgent terrorist group Boko Haram is a case in point, accentuating the sectarian divide between Christians and Muslims and diverting attention, involving both local and international interests, from the vital task of nation building and attracting optimal FDI. Because many Africans see health care as a public good – a right – government instability can affect the industry disproportionately compared to other sectors. It can serve as a disincentive to FDI. Perhaps the most striking case is the current Ebola crisis in Sierra Leone and Liberia, where the local response has been hampered by an overall record of inadequate governance.

Fourth is **bribery and corruption.** Even though the record is improving in many countries, this tends to go hand in hand with political instability. One big spin-off is counterfeiting, a particular challenge in medicines, with upwards of 60 per cent of the drugs for human use imported to Nigeria found to be sub-standard. There are numerous initiatives underway within Africa to "self-police" and single out for public scrutiny those cases where corruption is tolerated. Economic growth is also shrinking the size of the unregulated informal economy, which tends to perpetuate corrupt practices.

The fifth and last challenge is **regulatory risk**. This can range from lax enforcement – or the total absence – of intellectual property rules due to the inexperience, low pay [an incentive to corruption] and recognition, and poor resources of the regulatory bodies charged with acting in the public interest. Another, related aspect of this challenge is the reluctance of creditors to offer financing for new business ventures – what we might refer to as exposure risk. Contrary to prevailing wisdom, there is significant capital available in Africa to support new investment. The real issue is the absence of good projects with a sustainable business plan to invest in. Although Africa leads the world in new business start-ups, most of these are not sufficiently scalable or structurally viable to attract substantial capital. Most investment deals in private equity are for relatively small sums; that has to change because larger investments have a spillover effect in making the entire economy more efficient. What you have is this big disconnect between small businesses that need capital but don't have the bona fides or record of expertise that will raise the confidence of investors that their money will be well spent. It's a catch-22 situation.

PE: *Is there anything that can be done to bridge this gap and upgrade the competence of African entrepreneurs in obtaining the support they need to grow?*

Adjei: Private equity groups and debt consultancies like my own are advancing funds around what we call "latent projects:" smaller business opportunities likely to deliver scalable results only after five years or more. We serve as "incubators" for good ideas backed up by a solid business plan. It's an alternative to having to deal with the local commercial banks and their 25 per cent plus interest rates on loans. In addition to the factors above, one of the most important aspect to addressing investor concerns about the quality of business ventures is reversing Africa's endemic brain drain. The region's best and brightest still face strong incentives to leave – and once that happens, it is hard to get them back. Some foreign governments have started to create disincentives to slow the diaspora – the UK, for example, now requires pharmacists from accredited universities in Africa to take a one-year course costing some £7,000 to obtain the right to practice in Britain. We've seen fewer pharmacists leaving Africa for the UK; some Africans are actually returning home.

This is only a partial solution. What really has to take place is the generation of better job opportunities in Africa so skilled people have no incentive to leave. That requires investment. One solid example is Kenya's Healthstore/CFW clinics, a franchise operation that has created a national network of community health delivery centers all linked by a brand name that has earned high levels of satisfaction and awareness among patients. From a societal standpoint, the company gives nurses and other health professionals the chance to directly influence clinically appropriate health care choices of patients across the country, providing good employment and the chance to earn a profit from their work. In Ghana, the Diagnostic Center, a private facility offering state of the art medical diagnostics in Accra, is succeeding by "making its equipment sweat" – i.e. using its equipment to its maximum capacity, and offering better quality and competitive pricing compared to the competition. Both of these examples share common features that can be considered essential to success in any market: economies of scale, affordability, knowledge of the customer, and a brand associated with quality service. Hundreds of new jobs have been created and the investments are yielding strong returns in what can be a difficult environment to launch new ventures.

Only connect

PE: *Is there a specific set of business imperatives that investors must apply to achieve success in the African environment? In short, is there an "African model" that will work in shorthand to overcome the challenges you have outlined?*

Adjei: There is one overriding imperative – business is not conducted according to rules, but to relationships. These relationships must be given time to form. It is not unusual for this process to extend out five to 10 years. And the outreach has to be broad, involving not just government and your business partners but also among your competitors as well as influential stakeholders like NGOs. It is not necessarily a Western model, in which all business relationships are essentially transactional. It is not sufficient in Africa to limit your reach only to those who are going to give you something. Pharmaceutical investors should take a page from the oil and gas sector, where the most successful investors have a legacy of preceding every big investment with a large dose of charity. Before they start drilling, they build schools and clinics and create job opportunities, thus building bridges to local communities and adding to the investor's base of in-country support. It is an essential element in creating familiarity

and trust.

While no one will blanch at the need to form relationships, the special African context comes from the importance of casting your net of contacts widely. That's because there is a thin line in Africa between relationships and corruption: if you depend too much on a few chosen "friends," the prospect of this tie morphing into something potentially illegal is increased. Diversity in relationships is a protective device, which is also why many first-time foreign investors in Africa favor joint ventures among a series of local partners to test the landscape and lower their risk.

PE: *What are the potential tripwires facing foreign investors in health care?*

Adjei: The health care sector is at a particular stage of development that can pose problems for companies seeking a profit. There is a lot of free money circulating in many countries due to the funding of basic health services by foreign aid donors. It is less true now, but a history of donated drugs from aid agencies has created a disincentive to local, profit-seeking manufacture of medicines. In some countries like Rwanda and Uganda, foreign aid agencies subsidize a large portion of the annual public health and medicines budget. This essentially free funding competes with private equity interests and it also reinforces a mindset in the population at large that no one should pay for health care. This can have unforeseen effects on development, growth and employment. I recall a case in Ghana where we had two local pharmaceutical manufacturers producing HIV anti-viral drugs at a very competitive generic price, only to be undercut by a foreign agency manufacturing under government contract whose even lower prices nearly put the two local firms out of business, with a potential loss of several hundred jobs. My recommendation is to avoid moving forward on an investment until you can answer this very simple two-part question: how many people are willing to pay out-of-pocket for your service or technology? Do you have an alternative method to generate income, such as customers who have access to health insurance?

PE: *How extensive is government involvement in health care – would you say overall the impact has been positive for investors?*

Adjei: The record is mixed. No country has yet devised a way to balance the social responsibility to expand basic cover to those who need it while offering incentives to encourage more private options for those willing and able to pay for quality care. Rwanda is making progress toward a universal insurance program that requires most citizens to contribute, leaving those who cannot pay anything to the care of aid donors and NGOs. This is slowly creating the infrastructure necessary to boost public health outcomes while also envisioning a role for private enterprise in service delivery. Ghana is moving toward the same destination of universal basic coverage but with a different model that relies on financing through a dedicated VAT and deductions from salaries for those with jobs in the formal sector of the economy. Implementation of the program is still a question mark. Nigeria, in contrast, is struggling with the phase in of a National Health Insurance Scheme [NHIS] that is focusing on only a tiny portion of the population. Private insurers [about 50 to 60 are in business in Nigeria] have stepped in to try to fill the void, particularly focusing on elite and upper middle class Nigerians. It is little more than a patchwork approach.

What is missing in the region is an integrated, population-based approach to health services that emphasizes prevention and primary care. Delivery is still geared toward acute care around a few full service hospitals in urban settings. What is needed is a reliance on a wider base of providers; instead of physicians, governments should invest in small clinics and the training of nurses and community health practitioners who can be deployed outside the urban core, as the franchise model of CFW clinics are doing in Kenya. Governments should also come to a consensus on the form of insurance. Continued reliance on fee for service is a drag on economic growth due to the impact that a health emergency can have on the assets of an aspiring middle class. Health costs force many members of this group back into poverty until they can resolve their debts. Allowing insurance to shoulder the burden of health care will give consumers more confidence and thus help stabilize economic growth.

Another key area where government has failed is regulation. It is important that government gets it right because of the impact regulation has on medical practice, and hence on FDI, where keeping the public's trust is essential. Patients must feel protected, but unfortunately professional standards for physicians and other health care professionals lag behind expectations.

PE: *Is patent protection for medicines part of this unfinished regulatory agenda?*

Adjei: Patents in most African countries are recognized but the protections offered to inventors are poorly enforced, with distinct local variations in practice. It is bad for entrepreneurial initiative because everyone knows there is very little deterrent to copying medicines – certainly the large fines for infringement common in the US and Europe don't exist in this region. Unfortunately, it is hard to anticipate much change because African governments haven't yet seen the value of a patent. There is not going to be a strong political constituency for IP until such value becomes evident. One mechanism that can be leveraged to promote a broader perspective about patents is the Africa Medicines Regulatory Harmonization group [AMRH], which as a regional body working to harmonize medicines registration and related rules across the continent. This is a tool to address IP issues in a less politicized and more scalable context. Western governments also could do more to articulate the merits of an enforceable patent regime as part of their ongoing bilateral dialogue with African governments. Right now, what Africans hear about patenting tends to be one-sided.

PE: *How confident are you about the prospects that Africa will eventually emerge as a contributor to new medicines innovation?*

Adjei: Despite the constraints, I am confident that we will see more home grown African health care innovations in the years ahead. Governments are beginning to invest public funds in local science. The brain drain of medical talent has slowed. Partnerships with drug companies and foreign medical institutions are taking root, especially in looking at new ways to repurpose old drugs. There is the application of plant- or soil-based traditional medicine to the search for new treatments against prevalent local conditions like malaria. And we are also seeing a trend away from importing APIs used in local production, toward developing original APIs indigenous to the continent.

We fail to understand how important patient education and cultural changes to medical practice are in accelerating this transition. Just getting a patient in front of a physician for diagnosis poses serious hurdles for the vast majority of Africans. The cost of treatment is a barrier as well. How to use local health resources more intensively, with

increased efficiency, must be placed higher on the policy agenda. Africans have more capabilities at hand than is commonly realized – again, it's the perception gap.

William Looney is Editor in Chief of Pharm Exec. He can be reached at wlooney@advanstar.com [2]. Steven Adjei is Founding Partner of BlueCloud Healthcare. He can be reached at stevenadjei@bluecloudhealth.com [3]

Links:
[1] http://blog.pharmexec.com/2014/09/18/gsk-joins-uksouth-african-effort-to-target-non-communicable-diseases/
[2] mailto:wlooney@advanstar.com
[3] mailto:stevenadjei@bluecloudhealth.com