Health economics

Private enterprise for public health

By many measures, the world today is a healthier place than ever before, yet a daunting set of deficits and disparities remains to be tackled. For various reasons, it is not clear that the traditional tandem of government and civil society are up to those challenges. This creates an opportunity for private enterprise to fill the breach. Indeed, evidence on the actual and potential contribution of private enterprise to public health is growing.

David E. Bloom, health economist, Harvard School of Public Health, and **Michael Chu,** senior lecturer, Harvard Business School

In recent decades, the world's population has enjoyed astonishing improvements in its health. Yet a daunting set of health deficits and disparities persist, particularly for the world's poor and vulnerable populations. In the developed countries, life expectancy is 78 years, while in developing countries it is only 67 – and in eight countries, principally in Africa, it is less than 50. In developed countries, infant mortality is only six per thousand, whereas in developing countries, it is 46 per thousand. Spending on health varies too: high-income countries spend more than 12 times as much per person as middle-income countries and more than 75 times as much as low-income countries. To make matters worse, in many of the world's low- and middle-income countries non-communicable diseases are on the rise, including diabetes, cancers, respiratory problems and heart-related conditions.

In development circles, these health issues are a grave concern: sick populations undermine the economic power, social fabric and political stability of society. They are also a source of frustration as interventions appropriate to preventing or directly tackling the biggest health risks already exist. The main challenge is getting those interventions to chronically underserved populations. Fortunately, a new source of hope is emerging – innovative and scalable private enterprises that pursue health interventions that help poor people, perhaps for humanitarian but also for business reasons. This raises the possibility that developing countries can increase their reliance on private enterprise and thereby benefit from its core expertise in delivering goods and services to secure a higher standard of health. Indeed, the interests of society are well served when both business and public sectors deploy side by side, each doing what it does best.

Profitable and investable: A real market

Traditionally, the responsibility for protecting and promoting public health has resided with governments, sometimes buttressed by civil society (such as international development organizations and domestic non-governmental organizations). Government has, in principle, great legitimacy to operate in this space, as well as the reach to realize scale economies, take proper account of positive and negative spillovers, and design efficient and stable health insurance pools to reduce financial risk.

In some countries, the public sector has performed well. In many others, it has been unable to marshal the resources and political wherewithal to do the job. Moreover, governments and civil society are typically strapped for resources, and frequently inefficient due to bureaucratic hurdles and corruption. These limitations of the public sector (and civil society) have created large gaps that can be filled by the private sector.

Already, private spending on health is significant in countries of all income levels. In absolute terms, global private spending on health in 2010 amounted to more than USD 2.4 trillion. While it varies signifi-

cantly across countries, generally the share of total health expenditure from private sources increases in inverse proportion to the wealth of the country. As a group, private sources in high-income countries account for 35% of all health expenditures (with the UK at just 16%, and the EU at 23%). But in low-income countries, the corresponding figure is 61%, with India at 71% **(see Figure 1)**.

The figures suggest that much of humanity frequently interacts with the healthcare system by engaging in market transactions, exchanging goods and services for payment. Low-income earners are significant participants in this space. A recent attempt to quantify healthcare markets for those with annual incomes below USD 3,000 (in local purchasing power) estimated the annual base-of-the-pyramid healthcare market at USD 42.4 billion in nominal dollars or USD 158.4 billion in purchasing-power-parity (PPP) adjusted dollars. The news here for the health sector investor world is that those earning PPP USD 3,000 or less can constitute a sizable investable opportunity **(see Figure 2)**.

New commercial models

Private enterprises for promoting public health are still in an infant state. But the early evidence is promising, in part because both individuals and governments are willing to pay for goods and services that the private sector produces in the healthcare arena. And all purchasers stand to enjoy the benefits expected from competition: lower prices, better service and improved value proposals. The private commercial sector is naturally attracted to opportunities with a potential for profit. The application of commercial principles promotes financial sustainability and provides incentives for continuous improvements in efficacy and efficiency.

Of particular interest are new commercial models in healthcare that meet the true test of business: revenues exceed costs – yielding a surplus, the surplus is sustainable over time, and the surplus is equal to or greater than the yield obtainable in activities of similar type and risk. In other words, they are organizations that deliver high-impact health interventions to otherwise underserved populations, while being enterprises that are profitable and investable thanks to four characteristics:

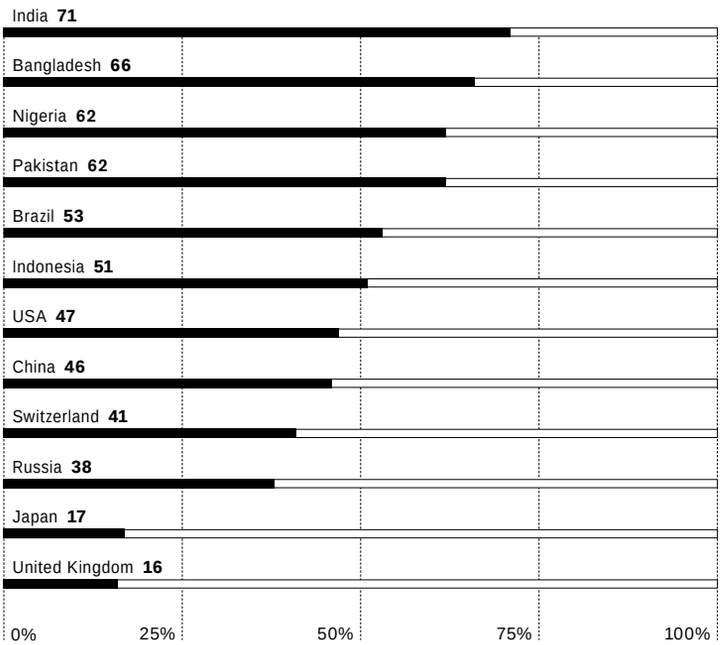
Reach. Many thousands of villages globally are without the most basic primary healthcare services, but there are hardly any that private companies cannot reach via marketing and distribution channels. In South Africa, BroadReach, a for-profit enterprise, has organized a large network of primary healthcare providers that it supports with training, clinical decision assistance and management systems. As a result, providers can deliver advanced HIV/AIDS care and antiretroviral therapy to patients who previously lacked access.

Rapid and efficient scale-up. Take the case of penicillin, discovered by Alexander Fleming in 1928. Ten years after the discovery, British scientists Florey and Chain confirmed the drug's therapeutic benefits, but it was difficult to mass produce. Eventually the government recruited the private sector to develop and implement efficient production methods. Thanks to the efforts of pharmaceutical companies, sufficient quantities of the drug traveled with the Allied soldiers to the D-day invasion at Normandy. Shortly after World War II, penicillin reached the commercial market to meet civilian demand – stopping people from dying of strep, staph, syphilis and even tiny scratches.

Innovativeness in designing and delivering health products and services. In India, Sulabh International invented a toilet system that is inexpensive, environmentally safe and made with local materials. There are now 15 million users of its public toilets and another 1.2 million >

01_Private spending on health is higher in poorer countries

Share of health expenditure from private sources, as a share of total health expenditure. **Source: World Bank, 2012; data are for 2010**



02_Low earners represent a major healthcare market

Lower prices, better service and improved value proposals benefit all.
Source: World Resources Institute and International Finance Corporation, 2007. Dollar figures refer to 2005.

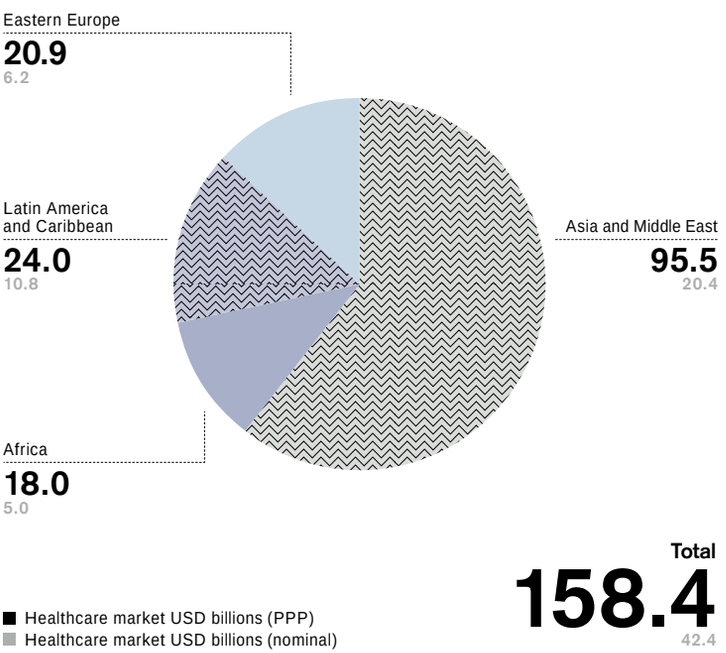


Photo: David Carmack

David E. Bloom is Clarence James Gamble Professor of Economics and Demography at the Harvard School of Public Health.

Michael Chu is Senior Lecturer at Harvard Business School and Managing Director and co-founder of the IGNIA Fund. President and CEO of ACCION International, he participated in the establishment and governance of leading microfinance banks in Latin America. Bloom and Chu lead Antares, a collaboration between their respective schools focused on high-impact public health interventions delivered through commercial models.

in private homes. This initiative has helped to make other enterprises commercially sustainable by creating 60,000 jobs in masonry and maintenance. Similar undertakings exist in other countries.

Responsiveness to incentives and the potential for financial self-sustainability. In Mexico, free medical care and medicines are a constitutional right. Roughly 55 million Mexicans (half of the population) depend on the public health system. But the public health pharmacies charged with providing free medicines supply them only 18% of the time. In 1997, an entrepreneur established Farmacias Similares – a chain of pharmacies with medicines priced at least 30% (and sometimes 75%) lower than at traditional retail drugstores, with a doctor's clinic attached, charging about USD 2 per visit. Today, the chain has over 3,900 stores. Every month, 12 million Mexicans use the chain to buy medicines, and 3.5 million use it to see their doctor. After a seed investment of USD 2 million, the chain now has annual revenues of over USD 1 billion, with a net income in excess of USD 150 million.

In India, Aravind Eye Hospital has driven the break-even cost of cataract operations to about USD 18, and Narayana Hrudayalaya Hospital has achieved break-even costs for open heart surgery of approximately USD 2,000 – thanks to world-class business processes and cost accounting systems. Both institutions match or exceed the quality levels of the leading US and European hospitals in their specialties. These reduced costs suggest considerable opportunity for expansion and replication because they permit these institutions to earn substantial margins at the prevailing prices. For example, the price charged by private clinics for equivalent open heart surgeries is around USD 5,000 or more. In fact, Aravind and Narayana both choose to use the surplus earned from their full-paying customers to cross-subsidize lower-income patients. At Narayana, a total of 63% of open heart surgeries are above break-even prices, while the remainder are at or below break-even, including some absolutely free of charge.

A complementary approach

Exciting as the entry of the business sector into public health may be, we are not suggesting that private enterprise can or should take over. Whenever commercial healthcare models are developed, business can scale rapidly and extend its reach at the lowest price to the consumer, so long as competition remains open and intense. Simultaneously, the public sector must continue to seek universal access to all those high-impact health interventions for which no commercial models exist yet. The government must also monitor and regulate to implement best practices, and prevent abuse and fraud.

There are also certain needs that the private sector is not best suited to address on its own, often necessitating a public-private partnership. A good example of such collaboration is social marketing designed to encourage adoption of a product or service by a target population. In Tanzania, the Kilombero and Ulanga Insecticide-Treated Net Project, implemented from 1996 to 2000, successfully used social marketing to promote adoption of insecticide-treated bed nets. Studies show that the donor-supported social marketing accomplished more than commercial distribution alone might have.

The bottom line is that healthcare for all is an urgent global priority. In this race to allow every human being to live up to their potential, the new business models hold the promise that the glaring gap between knowledge and action in healthcare may be significantly narrowed by the financial might of private investors and entrepreneurs – working closely with the public sector and the other major healthcare actors. ■