

Health is Wealth: Indian Private Sector Investments in African Healthcare

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ABSTRACT The increasing range of cross-boundary health issues has prompted the integration of health into the discipline of diplomacy, and this trend is reflected in India-Africa partnership. India's development partnerships are, however, predicated on the idea of development effectiveness, which requires active private sector engagement. By focusing on four opportunity sectors – medical tourism, tele-health, frugal innovations, and the pharmaceutical industry – this paper examines the nature of Indian private sector investments in African healthcare. It analyses their effectiveness in dealing with the issues around equity of access, the establishment of comprehensive 'prevention-based' health systems, and the creation of mutual benefit. There is significant Indian commercial presence in Africa's health systems; however, optimal engagement demands a broader conception of the 'private sector' to include traditional healers and social entrepreneurs engaged in frugal innovation for healthcare. Given their common health challenges, India and Africa must work towards crafting innovative low-cost healthcare models, and invest in the production and research of pharmaceutical products especially for neglected diseases.

INTRODUCTION

Health efforts can no longer be restricted to national jurisdictions, and the increasing range of trans-national health-related concerns calls for a more collaborative approach to addressing these challenges.¹ For one, the spread of infectious diseases has global implications: the recent outbreak of the Zika virus, for example, has caused widespread panic especially as global mobility has increased and the risks of a contagion have become starker. The absence of an effective treatment and—particularly for new mutations such as Zika—the lack of knowledge on even the

modes of transmission, highlight the need for collective action on both prevention and cure.² In addition to inter-governmental bodies like the World Health Organization (WHO), various philanthropic and non-state actors have also developed multi-country strategies to arrest the spread of these 'global epidemics'. For instance, the Bill and Melinda Gates Foundation works with national governments and grassroots organisations in more than 100 countries to reduce HIV prevalence.³ The Global Fund, another trans-national partly-private institution, is one of

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the largest financial contributors to the fight against HIV/AIDS, malaria and tuberculosis. Global Fund-supported programmes across developing countries save more than two million lives every year.⁴

Another prevalent phenomenon responsible for the globalisation of health issues is the rising mobility of both patients and medical professionals. Low costs, coupled with high-quality services offered in developing economies like India and Thailand, have transformed these countries into popular destinations for what has come to be known as 'medical tourism'.⁵ Increasing cross-border movement of health professionals has also expanded the scope and complexity of international trade in health services. While this trend has the potential to streamline the international health labour market, the unidirectional large-scale migration of health workers from developing countries to more lucrative destinations has caused significant health-workforce crises in the former.

Global and regional agreements on trade and intellectual property also have considerable implications for the provision of health services, especially regarding access to essential drugs.⁶ Mandatory patenting of medicines for all World Trade Organization (WTO) members, under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), has left several countries with no choice but to restructure their respective intellectual property rights (IPR) policies.

All these strands put together prompt a qualitative shift in the manner in which health is currently understood, and explains the emerging practice of integrating the subject into the discipline of diplomacy.

Health also figures prominently in India-Africa development partnership. The Pan Africa e-Network Project, for example, was set up to provide telemedicine and tele-education in 53 African countries, and the project has already been commissioned in 48 countries.⁷ At the third India-Africa Summit, held in October 2015, the Indian prime minister announced a grant of US\$

10 million specifically for the India-Africa Health Fund; many African countries also sought closer cooperation with India for setting up primary healthcare centres and other healthcare infrastructure, and training paramedics and technicians.⁸ This paper examines how Indian private sector investments can contribute to African healthcare—the nature of existing investments and the challenges they pose, and the opportunities and potential for forging new partnerships.

While the private sector is undoubtedly driven by the profit-motive to a large extent, this paper considers its investments in African healthcare in terms of the possible development gains. The private sector is increasingly being viewed as a key development partner. The Sustainable Development Goals, for example, accord a central role to private sector investments and public-private partnerships, in meeting the agreed-upon goals and targets. There is also a growing consensus that foreign aid is an inadequate driver of global development; rather, it should be used as a catalyst for improving the developmental outcomes of trade, private sector investments, philanthropy, and migration.⁹

In the Indian context, New Delhi has been steadily increasing its development partnership investments since the mid-2000s. Its development partnership programs blend commercial interests and development instruments. Indian lines of credit, for example, provide concessional loans for development projects to other developing states, but these are tied to the use of Indian companies for goods and services. The very nature of Indian development partnership is thus built around active private sector participation. In Africa in particular, most of India's outreach is led by the private sector.¹⁰ Moreover, India's development partnerships are predicated on the idea of a 'development compact', which brings together various non-aid instruments for development outcomes.¹¹ As the private sector is increasingly being considered a critical development partner, both globally and in India, it is necessary to examine the exact nature and implications of its contributions.

Private sector investments have tremendous potential to improve the provision of health services, both through trade and investments as well as partnerships with African governments. Indian companies have been a steady source of low-cost pharmaceuticals for African patients, and social gains from the Pan African e-Network Project would have been extremely limited without the participation of large Indian private hospitals such as Apollo Hospitals, Fortis, and the Moolchand Hospital.¹² However, considering private sector investments from a development effectiveness perspective also flags three areas of concern. First, privatisation can raise the cost of healthcare and create a fragmented health market that mainly caters to elite interests; drawing on India's example, the high cost of private healthcare is a critical factor in driving the poor further into poverty. Issues of equity in access and care thus have to be given high priority when considering private sector investments. Second, the privatisation of healthcare is better attuned to providing secondary and tertiary health services, and not the broader creation of health systems based on prevention through, for example, investments in sanitation and education. Third, from the perspective of India's development partnerships, the challenge is to create the conditions and opportunities through which the private sector can contribute to mutually beneficial gains, for India and its partners, in healthcare.

Section I of the paper situates the role of the private sector in the context of shared health challenges in India and Africa. Section II explores ways to maximise positive spillovers of trade and investment in four key sectors related to health: medical tourism; tele-health; frugal innovations; and the pharmaceutical industry. Section III concludes with a set of concrete recommendations to optimise private sector contributions in light of the three challenges earlier mentioned: equity of access and care, prevention and health systems, and mutual benefit.

INDIA AND AFRICA: SHARED CHALLENGES

The African continent ranks among the most health-poor regions in the world. On average, Africans live much shorter lives than others around the world: 13 years less than the average world citizen, and a decade less than the average Southeast Asian.¹³ A closer look at the mortality profile shows that traditional communicable diseases remain the leading cause of death in the region, accounting for almost 60 percent of total deaths. Chronic non-communicable diseases (NCDs) are also emerging as a major killer — the WHO estimates that, by 2030, NCDs will be responsible for almost half of all deaths in Africa.¹⁴ The region's health systems are ill equipped to address this dual disease burden.

Access continues to remain a primary challenge. The current in-patient bed density stands at nine per 10,000 individuals, against the global average of 27;¹⁵ availability of essential drugs remains limited in both public (42 percent) and private (58 percent) healthcare units,¹⁶ and, despite large external funding, only 37 percent of HIV patients receive Antiretroviral (ARV) treatment.¹⁷ The issue of access is further complicated by the high but uneven economic growth, and rapid urbanisation. Africa is witnessing its longest period of economic growth, averaging at five percent per annum for the last decade,¹⁸ but 47 percent of the Sub-Saharan African population still live on less than 1.25 dollars-a-day.¹⁹ This has created a fragmented health market based on the different capacities to pay for treatment, or what is generally termed as the two-tiered health system. Often poor individuals with serious ailments have no recourse other than to borrow beyond their means and seek treatment in the 'upper-tier' facilities, which in turn leads to medical poverty trap. The second main challenge for Africa is the shortage of trained medical personnel. Combined with a lack of education and training, large-scale migration of health personnel to better paying countries has led to severe shortages, and today there are only

two doctors and 11 nurses for every 10,000 Africans.²⁰

The challenges are not too different for the Indian health system. For one, India also suffers from the double disease burden: NCDs such as hypertensive heart disease and stroke co-exist with infectious diseases like tuberculosis (TB) as the top causes of death in the country.²¹ The main challenges in terms of healthcare provision in India also correspond with those in Africa, and these include poor access to health care (particularly in rural areas), lack of trained medical professionals (again, primarily in rural areas), and high out-of-pocket costs. Similar to a number of African states, the Indian government spends woefully little on healthcare provision and in 2012-13, India allocated only 1.08 percent of its GDP on health, ranking it the lowest among BRICS countries.²² The current public health structure is thus unable to meet the demands of the population. The gap created by the lack of public spending is being filled by the private sector, though it remains largely unaffordable to most, and high out-of-pocket costs drive millions back into poverty.

Given the distinct lack of health infrastructure, along with the projected escalation of healthcare demands, health is high on the agendas of India and Africa. Both regions have developed new strategies that are better suited to address the changing realities of their respective health landscapes. India, for example, has recently introduced an updated national health governance framework — the National Health Policy 2015. This policy aligns domestic health aspirations with global targets like the Millennium Development Goals, and also takes into account emerging challenges such as the dual disease burden and the issue of 'provider pluralism'.²³ The African region too has formulated a regional roadmap, the Agenda 2063, which highlights the catalytic role of health in its social and economic development strategy.²⁴ As per the agenda, "every citizen will have full access to affordable and quality health care services" by 2063.²⁵ The private sector undoubtedly has a

significant role to play in realising these endeavours.

FOUR OPPORTUNITY SECTORS

Medical Tourism

Indian cities have emerged as popular destinations for international patients seeking treatment. According to the KPMG-FICCI joint study on medical value travel, India is ranked as the second largest recipient of medical tourists in Asia.²⁶ Most of these patients come from the Global South. The Apollo group, for example, with one of the largest international clientele, receives 30 percent of its patients from South Asia, 30-32 percent from Africa, 10 percent from the Commonwealth of Independent States (CIS), Oceania and Europe, and the remaining from West Asia.²⁷

Structural adjustment programmes in the 1980s led to significant cuts in the public health budgets of several African countries.²⁸ The resulting poor conditions of healthcare facilities thus compelled many African nationals to look for treatment options abroad; India emerged as a chief candidate, owing to the relatively economical treatment options and high-quality services offered in its private hospitals. For example, a heart bypass surgery in India costs US\$ 7,000, which is a measly 0.054 percent of the cost of the same procedure in the United States (US\$ 130,000).²⁹ In fact, curative healthcare services in India are much cheaper than even those which are offered by its competitors like Thailand, Malaysia and Singapore.

Recognising this emerging market, Indian hospitals have also developed strategies specifically targeting foreign patients. Teams of health workers are sent to international exhibitions and promotional events in source countries for better doctor-patient interface. For instance, the Aga Khan group of hospitals organises regular visits of their medical team to hospitals in Kenya and Tanzania to establish initial contact.³⁰ Apart from targeted marketing,

large private hospitals now arrange for additional hospitality services such as accommodation and travel. Aiming to improve a patient's experience, Apollo has also collaborated with the Emirates airline for discounted airfares.³¹ Further, the Indian government has also relaxed the medical visa rules to allow consecutive visits without a two-month gap.³² State governments are also engaged in boosting medical tourism. Maharashtra, for example, along with FICCI, set up its own 'Medical Tourism Council' as early as 2003.³³

Despite the increase in supply of health providers, and expanded access, travel for health continues to have certain limitations. Most importantly, there are issues of equity of access as only those who can afford the high costs of off-shore treatment have the potential to gain. The medical tourism model thus privileges the African elite, in an already fragmented health marketplace. Governments of source countries also have minimal control over health standards and other regulations of destination countries. Even as a temporary option, post-recovery follow-ups generally take place through emails, phones or local doctors in the respective countries of residence, thereby increasing chances of treatment failure. Renu Modi cites the example of a Kenyan patient who died in her home country in spite of a successful treatment in India, due to poor follow-up.³⁴

Medical tourism is thus only a second-best option and cannot substitute for local health providers. The India-Africa partnership on healthcare must therefore rely on other more sustainable solutions. From an Indian perspective as well, medical tourism diverts scarce medical resources such as doctors, nurses and beds towards medical tourists, and away from Indian patients, primarily the poor. In a country where there is an acute shortage of trained medical personnel and quality healthcare facilities, and where the state invests little in healthcare, the promotion of medical tourism for private profit is discouraging from a social justice perspective.

Concerted efforts must be made to bridge the two tiers that currently exist in the Indian health system and this requires creating a mechanism to transfer both manpower and health infrastructure from the so-called upper tier to the lower one.

Tele-health: Pan African e-Network Project (PAENP)

The use of technology and telecommunication to enhance well-being has multiple unique attributes – the ability to overcome geographical barriers, the cost-effective nature of treatment, and the comparative ease of access to remote areas. While these advantages are well-recognised globally, high costs of setting up the associated infrastructure have impeded most developing countries from employing telemedicine.³⁵ In the case of Africa, however, a fairly extensive network has already been laid down through the Pan African e-Network project which can be further leveraged for improved healthcare.

The Pan African e-Network Project was established under the technical cooperation wing of India's development partnership with Africa. Launched in 2009, the project aims to link Indian hospitals and universities to 53 African nations through a fibre-optic network. Work has already commenced in 48 of these 53 countries.³⁶ The planned utility of the network can be clubbed into two components, namely, telemedicine and tele-education. Under telemedicine, consultation centres have been created in 12 Indian super-specialty hospitals across multiple cities and they are currently connected to 49 Patient-End (PE) African hospitals. This is generally used to link health professionals in the two regions for online consultations. Under the education component, medical courses are offered by Indian and African Union (AU) Regional hospitals. As of 31 May 2014, some 3,724 such sessions in English, and 444 in French, have been conducted through Indian hospitals.³⁷

While the creation of such large-scale infrastructure is commendable, its limited range

of applications illustrates the sub-optimal utilisation of this US\$1-billion investment. The scope for tele-health to address the demands of a broad health system is immense. Apart from its current use for online consultation on curative techniques, the PAENP could be employed as a platform for knowledge-sharing and collaboration on various other facets of healthcare like the pharmaceutical sector, or innovation for the bottom of the pyramid. For instance, there are several small- and medium-scale healthcare enterprises catering to the poor in both regions; connecting them through the e-network could facilitate collaboration on new solutions or scaling up of existing innovations. In the case of pharmaceuticals, PAENP could provide an e-depository for R&D on neglected diseases that are not commercially attractive for Big Pharma companies but have huge public health gains for India and countries in Africa.

Another aspect that must be considered in delivering health services through information and communication technologies (ICTs) is the health landscapes of developing countries. Health markets in these countries do not conform to those in advanced economies. The private sector is generally composed of multiple actors who may or may not fall within the formal structure, and applications of service delivery must take these institutional realities into account.³⁸ For example, traditional healers are the first source of treatment especially in rural areas; the WHO estimates that 80 percent of the African population regularly use these services. Because they fall outside the formal parameters, they have largely been ignored in mainstream development discourses. Integrating them to the healthcare system could address the lack of health personnel to a great extent. A case in point is that of the Hlabisa district of KwaZulu/Natal, where an innovative collaboration between doctors and traditional healers was used to treat TB patients in the area.³⁹ By training them on basic TB symptoms, the healers were able to recognise the onset of the disease and refer the patients for necessary diagnostic tests. Further, treatment

courses supervised by healers had higher chances of being completed in comparison to those led by volunteers. Given the remote access provided by ICTs, traditional healers across countries could be given basic courses with minimal costs.

Frugal Innovations

The 'bottom of the pyramid' approach to healthcare delivery is another area through which the private sector can specifically target developing countries. Inadequacy of public healthcare has meant that majority of the poor residing in the Global South must seek private healthcare treatment. This demand has driven frugal innovations in a range of business processes, including marketing, finance, and operations. Aravind Eye Care System is one such model, which relies on an innovative financing strategy to provide low-cost treatment. This Indian innovation is now the largest eye care facility in the world, reporting infection rates even lower than those of hospitals in developed countries. Through cross-subsidisation, fully paying patients subsidise for 70 percent of costs for low-income patients.⁴⁰ The easy scalability of the model across varying contexts provides a large scope for adaptation. In fact, they are already consulting for the national prevention of blindness in India. Through revolving loans, the Kisumu Medical and Educational Trust (KMET) – an NGO based in Kenya that provides training in reproductive health – also provides funds to franchisees through an innovative financing system.⁴¹ There are various other cases of such social entrepreneurship such as Vision Spring, which deals with vision correction through distribution of glasses⁴² and Jaipur Foot, which manufactures prosthetics specifically designed for the poor.⁴³

The multiplicity of such innovations highlights the existing gaps in the health systems of both India and Africa. On the one hand, public medical facilities in both regions are unable to keep up with growing demand. On the other, large private hospitals only cater to patients with high

disposable incomes, leaving a large low-income section underserved. This lacuna is perhaps a consequence of the skewed understanding of these health systems, and much like the case of tele-health, 'off-line' delivery of health services must leverage practices that may be better suited to the local context. Scaling or adapting these creative solutions borne out of complicated healthcare realities could prove to be a more effective route to achieving expanded access.

The Pharmaceutical Industry

An essential component of any health system is the availability of affordable pharmaceutical drugs. Due to the exemption of medical patents prior to India's economic liberalisation, the country was able to develop a large generic drug industry and carve a niche in the global pharmaceutical market. For instance, as early as 2001, Cipla – one of India's largest generic drug manufacturers – supplied the ARV treatment for less-than-a-dollar-a-day to Doctors without Borders for distribution in Africa: a price that was .025 to .03 percent of what was being charged by Big Pharma companies at the time.⁴⁴

The export of low-cost drugs presents a mutually beneficial opportunity for both Indian pharmaceutical companies and African patients. India, however, is under growing pressure particularly from the US through the US International Trade Commission (USITC) and US Trade Representative (USTR) to strengthen its IPR protection framework.⁴⁵ In fact, India is currently developing a national IPR policy despite the existence of a fully effective and TRIPS-compliant patent law – which may perhaps be a consequence of the mounting external pressure.⁴⁶ Following this trend, African leaders at the Third India-Africa Summit expressed concerns regarding the large health implications in the region of an alteration in India's IPR regime.⁴⁷ While India tries to address the mounting pressure from developed countries, it is important that it retains policy space to determine its own IPR laws, from both profit and social justice perspectives.

In the long run, however, it is not in African interests to rely heavily on pharmaceutical imports: Africa currently imports about 70 percent of its total drugs demand.⁴⁸ A few countries have started developing indigenous manufacturing capacity, such as South Africa, Nigeria and Ghana,⁴⁹ and the African Union has developed a Pharmaceutical Manufacturing Plan for Africa (PMPA) aimed at promoting local production.⁵⁰ Individual governments like Algeria, Nigeria and South Africa are also offering a range of incentives to domestic pharmaceutical manufacturers such as tax exemptions and reduced land prices.⁵¹

From the point of view of development effectiveness, therefore, it makes sense for Indian pharmaceutical companies to invest in Africa – to Make in Africa. Such investments will not only contribute to expanding access to low-cost drugs, but also create employment and build local productive capacity. A number of the big Indian generic manufacturers such as Cipla, Ranbaxy and Cadilla have now set up manufacturing units in Africa (South Africa, Nigeria, and Egypt, respectively).⁵² However, varying regulatory patterns in different countries means that Indian companies must review viability options on a country-by-country basis. For instance, in West Africa, Anglophone countries tend to have much more developed regulatory frameworks as opposed to Francophone ones.⁵³ Further, certain countries like Ghana have extremely strict IPR protection frameworks (comparable to the TRIPS-plus conditions), which could act as an obstacle to setting up domestic generic-drug manufacturing bases.⁵⁴

Another area for potential India-Africa collaboration relates to pharmaceutical R&D. Given that India and Africa face similar disease burdens, and that Western pharmaceutical companies invest little in R&D for diseases that primarily affect the poor,⁵⁵ there is a strong case to be made for joint investments in research and development and the creation of pooled mechanisms for technology sharing and transfer.

The rich common culture in traditional medicine can be leveraged for this endeavour. After all, modern drugs have long been derived from traditional medicines. For example, the most effective malaria-treatment base, Artemisinin, is derived from Chinese sweet wormwood.⁵⁶ The extensive traditional knowledge and practice in medicine would thus be an excellent starting point in the search for modern-day solutions. India already has an operational platform for technology sharing in this area – the Open Source Drug Discovery (OSDD) is an India-led global aggregator platform, where researchers can share information and conduct collaborative research.⁵⁷ Given the OSDD's focus on neglected diseases, it would be an appropriate avenue for an India-Africa partnership on pharmaceutical research.

PROMOTING DEVELOPMENT EFFECTIVENESS

As argued in the opening section, the private sector can make a significant contribution towards healthcare in Africa but issues of equity of access and care, the need for broader health systems that prioritise prevention, and the criteria of mutual benefit must be factored in while charting a way forward. In order to do this, the following set of recommendations might be considered:

1. Promote tele-education and tele-medicine not only as a one-way service delivery model, but as a platform for mutual learning and knowledge building between Indian and African medical practitioners. In doing so, consider ways of including and training informal medical practitioners and traditional healers that cater for the bulk of medical needs in India and Africa.
2. Re-consider the scope of what is traditionally defined as the 'private sector' in the context of healthcare – i.e., large generic pharmaceutical manufacturers and private hospital chains – to also include social entrepreneurs engaged in frugal innovation for healthcare. Promote bottom-up healthcare solutions that specifically serve the poor. Joint networking platforms or B2B platforms, for example, could be built and supported by a corresponding e-platform.
3. The two regions need to move beyond mere intellectual property (IP) consumption to IP production. By investing in joint R&D initiatives and creating technology-sharing mechanisms, India and Africa can build indigenous capacity and move away from the current reliance on the West for pharmaceutical innovations. The vast knowledge on traditional medicine must be leveraged for this.
4. Build policy convergence around existing IPR regimes. Global trade discourses are moving towards higher IPR protection, particularly in light of TRIPS-plus conditions. Access to low-cost health care is fundamental from a social justice point of view.
5. Consider new innovative models of financing low-cost healthcare; here is an opportunity for thought leadership. Alternatives are already being proposed for a health impact fund,⁵⁸ and for the separation of R&D costs from the pricing of medicines. Financing the health sector in innovative ways such as social insurance and cross-subsidisation should be explored.

Finally, however, the private sector can only play a complementary role: investments from the state are required to build health systems. An over-reliance on the private sector will create a patient-treatment model, rather than promote the building of comprehensive health systems. The private sector is structurally conditioned to favour curative solutions, even while these are costlier to the patient than preventive measures. PPP is an attractive model. However, even here, governments need to provide guarantees. Following the 2015 India-Africa summit, for example, Indian businesses expressed reluctance to invest in Africa without guarantees or risk-

underwriting from African governments.⁵⁹ The onus of managing PPPs will lie on African states as well. Indeed, the critical issue is whether African governments can negotiate agreements that enable medical access for both the rich and the poor, and which create the necessary policy space for the Indian private sector to Make in Africa.

Herein also lies an opportunity to build policy coherence into India's own development partnerships by promoting development-friendly infrastructure projects and linking mutually reinforcing instruments such as the Indian Technical & Economic Cooperation Programme to the PAENP. 

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