SPECIAL STUDY

EBRD's Health-Focused Interventions

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EBRD EVALUATION DEPARTMENT

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Abbreviations

AGM	Annual General Meeting
ASB	Advice for Small Businesses
ATC	Assessment of Transition Challenges
ATQ	Assessment of Transition Qualities
BIS	Board Information Session
BSTDB	Black Sea Trade and Development Bank
CPA	Composite Performance Assessment
COO	Country of Operation
CS	Country Strategy
CSDR	Country Strategy Delivery Review
CSG	Client Services Group
CSRF	Country Strategy Results Framework
CSRM	Country Strategy and Results Management team
CSU	Country Strategy Update
DD	Due diligence
DCF	Donor Co-financing
DFF	Direct Financing Framework
EBRD	European Bank for Reconstruction and Development
EIB	European Investment Bank
ETC	Early Transition Countries
ETI	Expected Transition Impact
EvD	Evaluation Department
FIF	Financial Intermediaries Framework
FW	Framework
IA	Integrated Approach
IEG	Independent Evaluation Group
IFI	International Financial Institution
IPPF	Infrastructure Project Preparation Facility
IsDB	Islamic Development Bank
LiTS	Life in Transition Survey
MTD	Medium Term Directions
NCBI	Net Cumulative Bank Investment
RSF	Risk-Sharing Facility
SBI	Small Business Initiative
SCF	Strategic and Capital Framework
SEMED	Southern and Eastern Mediterranean Region
SIP	Strategic Implementation Plan
SSF	EBRD Shareholder Special Fund
TC	Technical Cooperation
TI	Transition Impact
TIMS	Transition Impact Monitoring System
TOMS	Transition Objectives Measurement System
TOR	Terms of Reference
TQ	Transition Quality
VCIP	Venture Capital Investment Programme

Defined terms

Advice for Small Business	Donor-funded activity under the EBRD's SME Finance and Development Team. Products are delivered through international advisory, local consultancy, market development activities and/or sector development activities. International advisory activity is designed for larger more mature SMEs. It focuses on deploying technical expertise into the enterprise, suitably experienced to tackle any strategic and operational issues. Most projects are designed with sector specific expertise, delivered by sector experts with at least 15 years' experience at the forefront of their industry. The focus on implementation is through mentoring rather than pure consulting. Local Consultancy projects are business advisory projects delivered to SMEs by local consultants who can help achieve a specific goal. Local Consultancy projects are delivered in the following areas; strategy, marketing, organisation, operations, ICT, engineering solutions, quality management, resource efficiency and environmental management. Each advisory project is run on a cost-sharing basis, with the client paying a portion of the total cost.
Assessment of Transition Quality	A measure of the progress of each Country of Operations along a transition pathway to provide an objective cross-country comparison. Introduced to the Bank in 2017 along with the adoption of the six transition qualities that are seen to characterise a sustainable market economy.
Delegated approval	Delegated approval refers to EBRD pipeline approvals where final approval is delegated from Board to Management (i.e. OpsCom, with further delegation when applicable to SBIC or Designated Approvers).
Donor funds	Donor funding provided to support EBRD investments or activities in the form of grants, risk participation and loans.
Expected Transition Impact	Expected Transition Impact (ETI) is a score assigned at the project level, derived using an internal scoring system based on the transition impact assessment of investment projects. ETI incorporates both transition impact potential (i.e. setting the appropriate objectives for projects in the context of transition challenges in a country) and risks to achieving those objectives, thus reflecting the most likely "transition value" of a project. The ETI in the Bank's scorecard measures the average ETI of all new projects rated over the course of a year. The Bank's projects are assessed individually during the project approval process and categorised according to the matrix in the scorecard.
Healthcare Sector	As defined by the Global Industry Classification Standards, Healthcare Sector comprises both healthcare equipment and services as well as Pharmaceuticals, Biotechnology and Life sciences industry groups..
Healthcare equipment and Services Industry Group	As defined by the Global Industry Classification Standards, Healthcare equipment and Services Industry Group includes healthcare equipment and supplies, healthcare providers and services and healthcare technology industries
Healthcare Equipment and Supplies Industry	As defined by the Global Industry Classification Standards, Healthcare equipment and Supplies includes two sub-industries: Health care Equipment (Manufacturers of health care equipment and devices. Includes medical instruments, drug delivery systems, cardiovascular & orthopaedic devices, and diagnostic equipment); Health care Supplies (Manufacturers of health care supplies and medical products not classified elsewhere. Includes eye care products, hospital supplies, and safety needle & syringe devices).
Health Care Providers and Services Industry	As defined by the Global Industry Classification Standards, the Health Care Providers and Services Industry includes four sub-industries: Health Care Distributors (distributors and wholesalers of health care products not classified elsewhere), Health Care Services (providers of patient health care services not classified elsewhere. Includes dialysis centres, lab testing services, and pharmacy management services. Also includes companies providing business support services to health care providers, such as clerical support services, collection agency services, staffing services and outsourced sales & marketing services), Health Care Facilities (owners and operators of health care facilities, including hospitals, nursing homes, rehabilitation centres and animal hospitals) and Managed Health Care (owners and operators of Health Maintenance Organisations (HMOs) and other managed plans).
Health Care Technology Industry	As defined by the Global Industry Classification Standards, the Health Care Technology Industry includes companies providing information technology services primarily to health care providers. Includes companies providing application, systems and/or data processing software, internet-based tools, and IT consulting services to doctors, hospitals or businesses operating primarily in the Health Care Sector

Pharmaceuticals, Biotechnology and Life sciences Industry Group	As defined by the Global Industry Classification Standards, Pharmaceuticals, Biotechnology and Life sciences Industry Group includes Biotechnology, Pharmaceuticals, and Life Sciences Tools & Services.
Technical cooperation (transactional and non-transactional TC)	Funding that donors provide for a particular project or programme/framework on a non-reimbursable basis. Funds can be related to an EBRD investment or standalone, in support of project preparation and implementation, training, legal and regulatory reform, research and analysis, client capacity building, policy dialogue and other forms of assistance. TCs are considered transactional when they include pre- and/or post-signing activities to directly support a related investment operation. The intention of transactional TCs is to strengthen the design (including feasibility assessment) of an investment and/or support its implementation, thereby bolstering the project's transition impact. Non-transactional TCs include activities that do not directly support an investment or do so only indirectly through their contribution towards enhancing the wider environment for transition. Typically, such TCs would target activities in the sphere of policy dialogue, legal and regulatory reforms, research and capacity building.
Transition qualities	In December 2016, the EBRD's Board of Directors approved an update to the transition concept whereby progress towards a sustainable market economy should be considered against six key qualities: competitive, well-governed, green, inclusive, resilient and integrated.

Executive Summary

All EBRD countries of operation (COO) face multiple challenges to provide healthcare, including outdated infrastructure, low service delivery standards, and policy and regulatory difficulties. Access and affordability are major concerns; public opinion consistently ranks healthcare as a top priority, and consistently confirms high dissatisfaction with public services. There are difficult and unavoidable trade-offs among access, quality, and cost.

The EBRD's operational engagement in healthcare equipment and services was minimal for most of its first two decades. The first treatment of a role in health was a 2008 Board paper proposing limited and gradual support for private sector participants -- Bank support for small projects to assist private insurance providers, improve contracting/purchasing to boost efficiency and quality, and improve private healthcare service providers. However, the combined effects of the global financial crisis, rapid rises in service costs, and demographic pressures put great additional pressure on existing (mainly government) capacity.

Against this backdrop, and after extensive internal debate, the Bank introduced an Updated Approach (UA) in 2014 for engagement in specific areas of healthcare services. A strong private sector role in a COO's own strategy was set as a precondition for engagement, and projects to expand the availability of good quality medical services at affordable (and transparent) prices were identified as the main focus.

This evaluation is a first focussed EvD effort to assess activities under the UA. Its scope and focus have been shaped by several key factors. First, healthcare is not treated as a distinct sector by the EBRD (such as Power or Transport), with an assigned team, budget, or institutional home. Operational work is done out of multiple departments, under multiple programmes and using multiple instruments. Second, while the UA is the most complete available treatment of the Bank's work in health, in fact it does not cover substantial Bank activities.

The UA applies only to private sector health-services investment activities undertaken by the Manufacturing & Services Department. It does not cover work undertaken by other departments, including most principally the Sustainable Infrastructure Group, Equity funds, or Advice to Small Business team.

Across all departments, the EBRD engaged in 64 health-focused investments between 2000 and 2018, amounting to €1 billion. But of these, only 28 (amounting to €228 million) fall under the operational scope of the UA**.**

This evaluation covers both investment and non-investment activities approved between 2008[1] and 2018[2], whose use of proceeds and/or transition ambition directly affected the Healthcare Sector; it is not limited to operations covered by the UA.

The evaluation focuses on three specific questions, for which the main findings are summarised below.

- How well does EBRD's institutional architecture support its health sector objectives?

[1] when the Bank first outlined its approach to the healthcare services sector specifically
[2] Given COVID, the report looks more widely at some of the Bank's recent support efforts beyond 2018, where appropriate.

- How does EBRD's approach and operations reflect its mandate, COO needs and wider agenda?
- What findings and insights may be identified regarding Bank performance?

With regards to Bank performance this evaluation set out to look at the full portfolio of health engagement, as constructed by EvD, via internal documentation, and selected representative interventions via field work. COVID-19 made it possible to carry out field work. Large gaps in portfolio monitoring (given classification problems and framework-level monitoring and mismatches between health objectives and TI benchmarks) prevented extracting much insight from existing documents for such a small population. Therefore, the evaluation looks closely at three illustrative cases and the emerging insights and learnings from each; specifically:

- the PPP hospitals framework in Turkey led by the Sustainable Infrastructure Group, representing a large portion of the Bank's portfolio volume
- the Assistance to Small Businesses programme, a major area for non -investment work with private healthcare services; and
- a recent, evaluation-ready stand-alone investment project, North Africa Hospitals Co-Investment, which reflects equity work as well as M&S engagement, and was notably the first Board-approved project after the UA.

How well does the EBRD's institutional architecture support its health sector operations?

- The Bank lacks a comprehensive strategy/policy level statement of its objectives in the health sector. The fullest presentation of its role in health is found in the "Updated Approach to Healthcare Services" which was discussed in a Board Workshop in 2014; no formal Board approval was sought.
- The Updated Approach applies only to a subset of health-related activities, specifically those undertaken by the Manufacturing & Services Department. Considerable other health-related project and advisory work is delivered by the Sustainable Infrastructure Group (formerly Municipal and Environmental Infrastructure Department), the Equity Department and the Advisory for Small Business, entirely outside the scope of the UA.
- As a result, health work is dispersed across multiple departments with multiple reporting lines to different senior managers. Activities that are conceptually similar are developed and delivered by different teams, creating real challenges to developing a coherent picture of the Bank's work, and to monitoring, reporting and results management.
- The existing patchwork policy/strategy approach appears designed around pre-existing organisational structures rather than as a means to achieve greater operational coordination and coherence, or demonstrable results on the ground.
- The UA has not been translated into a set of clear practices or criteria to guide operational work, so there is no agreed means to ensure consistency or compliance. Substantial ambiguity exists in important areas.
- The concept of healthcare "affordability" was central to Board concerns about the Bank's prospective engagement and for this reason featured prominently in the UA. However, it doesn't

appear to have been operationalised in any meaningful or systematic way to inform project selection and assessment.

- Dedicated resourcing for healthcare operations is difficult to identify with confidence, but appears minimal and subject to key person risk. Resourcing issues are likely also a factor in the observed problems with affordability analysis and other institutional delivery systems.

How well does the EBRD's approach and operations reflect its mandate, COO needs and wider agenda?

- There is no evidence of the UA being meaningfully integrated into country strategies; no country strategy gives priority to transition challenges in health; a review of all of them reveals only rare mention of healthcare and a lack of health-related objectives, activities and indicators.
- No effective framework is now in place to assess healthcare service projects' transition potential. As now articulated health objectives cannot be effectively mapped to the Bank's Transition Qualities. The Bank's internal systems (Transition Objective Measurement System, Compendium of Standardised Indicators, and Assessment of Transition Qualities) do not enable projects to be assessed ex ante for potential contribution to healthcare system accessibility and resilience.
- The Assessment of Transition Qualities (ATQs) does have several indicators directly related to health, such as those measuring gender and regional equality in healthcare service access. But these are specified as country-level measurements and lack project-level connections. So even if a project would indeed promote gender equality in access there is no clear mechanism to assess its potential to do so.
- The overall implication is that there is no conceptual or evidentiary basis on which to tell a story of likely positive effects. The Bank cannot show how its inputs and contributions support better access to quality healthcare, system resilience, or reduction of gender and regional inequality in access – all very much central to existing corporate and shareholder priorities.
- This is a missed opportunity to show an alignment of Bank work with the 2030 Agenda for Sustainable Development; the Bank itself reports that none of its interventions contribute to SDG3, regarding "Good Health and Well-being".

What findings and insights may be identified regarding Bank performance?

- EBRD operations in healthcare provide examples of sound work that is both additional and positive. Project investments have improved standards and governance systems in hospitals; Public Private Partnerships (PPP) for hospitals in Turkey have helped expand privately financed, procured and operated hospital infrastructure; the Advice for Small Business programme (ASB) has supported growth of small and medium providers.
- In one specific area, recognising antimicrobial resistance risk and promoting good prevention practices, the EBRD has been a leader.
- However, performance is difficult to assess given the lack of clarity in stated transition goals and insufficiencies in monitoring.

- Common insights from the engagements examined here – PPP, Abraaj, ASB – include absence of adequate institutional guidance, and difficulty identifying evidence of success, the contributions of technical assistance and specialists, and productive cross-IFI collaboration.
- North Africa Hospitals Co-Investment with Abraaj – successfully delivered expected outcomes in corporate governance and quality-assurance standards. Less clear is progress on broader objectives for clinical performance and bed supply.
- ASB's International advisory services in healthcare has been generally successful. The vast majority of EBRD clients realised their original ambitions (expanding clinics in main urban centres, renovating rehabilitation facilities or introducing new products). This is typically accompanied by an increase in employment as well as market share. Additionally, COVID-19 enhanced clients' willingness to undertake transformation programmes focused around introduction of information technologies and digitalization in private clinics – the core of ASB's delivery in the sector. In this context, ASB clients introduced services for remote control and treatment of most prevalent diseases and maintained or increased revenues under pandemic conditions.
- Turkey Hospitals Facilities Management PPP Framework - the EBRD met expectations for diversification of funding sources and commercial financing for privately financed, procured and operated hospital infrastructure, but only partly in supporting development of the PPP healthcare sector market. An important challenge has been institutional capacity for project preparation, contract management and assessment of delivery modes. Overall, EBRD's involvement supported the creation of 13,462 hospitals beds with negative pressure ventilation system and hospitals with on-site PCR testing capacity. This substantially contributed to the resilience of the healthcare system in Turkey during the pandemic.

Recommendations

1. **Prepare a health sector strategy or approach for Board review and endorsement**. It should provide clear strategic direction for work post COVID-19 and cover organisational and structural issues, resourcing, results frameworks, and reporting means and obligations.
2. **Establish a transparent, adequately resourced and clearly managed results system.** Projects should be assessed for potential contribution to the accessibility and resilience of healthcare systems; ATQs should measure country-level transition progress in health sector resilience; and, the Annual Transition Performance Report 2020 should discuss alignment of Bank work with SDG3.
3. **PPP engagements should conduct a prior review of the capacity of the procuring authority and consider capacity building TA as a condition of EBRD involvement.** This should be presented to the Board as part of the project submission where upstream work with the procuring authority has not been possible.
4. **Prepare a full analysis of how PPP design balances public and private interests, how it allocates risks and how it compares to PPP best practice as part of future PPP Board approval.** The objective would be to ensure: (i) the compensation on termination payments is well structured to achieve performance incentives as per PPP best practice, and; (ii) budget affordability considerations (including FX risk) are properly assessed (iii) Value for Money Methodology is developed to justify if the PPP model is appropriate. Availability-based PPP models have specific fiscal management and budgetary affordability considerations. These must be properly analysed

and managed by the public sector. Greater attention is needed to reduce and manage FX exposure in PPP projects.

1. Introduction and methodology

All COOs face varied challenges to ensuring the provision of quality affordable healthcare; these include outdated infrastructure, poor management and service delivery standards, and unsuitable regulations. Access and affordability are often directly affected by corruption, typically in the form of informal payments. The Life in Transition Survey II (2010) demonstrated that people in COOs consider healthcare services as a top priority for extra government spending, and the Life in Transition Survey III (2016) documented that almost 40% remain dissatisfied with the provision of public healthcare services. It is reasonable[3] to consider that the current COVID-19 global pandemic can only have served to heighten the urgency of addressing these challenges.

Government policies vary widely. In all cases cost control is a major challenge and a high priority. Many governments want to decentralise services to increase efficiency; others are recentralising to increase control over supply and demand. Many consider that greater private sector involvement improves access and controls costs. Yet, regulatory frameworks are often ill-suited to encourage private sector provision; private sector firms often face significant regulatory risks; policy changes can be sudden and dramatic. **There is no one-size-fits-all approach to coping with these challenges. The range of models in developed countries stems from inherent trade-offs between the three key objectives of any healthcare system: access to care, quality of care, and cost of care.**

The EBRD's first document to acknowledge a role in health was with reference to supporting healthcare services, via a paper presented to the Board in 2008. This paper presented the EBRD's experience and expertise until then, describing its limited involvement, and then proposed to support private sector participants in a gradual, modest and coherent way, involving healthcare financing (relevant support to private health insurance providers), contracting/purchasing (development of procurement methodologies that improve efficiency and quality outcomes) and delivery (private healthcare service providers). The Bank allowed for small projects focused on funding private healthcare service providers under frameworks, with any sizeable project assessed on a case-by-case basis by the Board.

Nevertheless, in the aftermath of the global financial crisis, the continued rise in healthcare costs as well as demographic shifts continued to squeeze public capacity. Yet, regulatory frameworks were in nascent form or misaligned to fill the widening gap between supply and demand within public health systems, in particular where the public sector is a key financier and provider of these services.

Against this backdrop the Bank substantially updated its approach to healthcare projects that are led by Manufacturing and Services Team in 2014. **The Updated Approach outlines the Bank's aim to promote market-oriented behaviour across the healthcare services sector[4] while at the same time ensuring high quality and affordable healthcare provision.** To this end, the presence of a strong role for the private sector in the COO's own strategy is set as a precondition for the Bank's engagement, and supporting projects expanding the availability of good quality medical services at affordable (and transparent) prices is established as the main focus.

While the Updated Approach was an attempt to define the Bank's role in the healthcare services sector, the Bank undertakes far more work in the broader health sector: the Bank's portfolio of

[3] Based on observations of the characteristics of the Bank's financing pipeline among others
[4] As defined by the Bank

health-focused interventions are spread across various departments and include a combination of instruments. The overall investment portfolio of debt and equity totals circa **€1 billion in 64[5] health-focused investments between 2000 and 2018[6].**

- The Manufacturing and Services portfolio includes circa €230 million across 28 projects, mainly in private hospitals. This comprises both direct and indirect financing, and includes many projects which are part of the Bank's SBI programme and financed under such frameworks. Most of the portfolio is debt, all is private.
- The Sustainable Infrastructure portfolio includes nine projects for €600 million; eight are PPP debt financed investments in Turkey. Again, the portfolio is almost all private[7]. Significantly, these projects are part of a package of investments financed via the EBRD's first health bond, 2018[8]. In addition EBRD has developed a new way of supporting such projects in the form of credit enhancement. Specifically, EBRD provided the liquidity facility during construction and operation period for the green bond issuance in the Elazig PPP Hospital Project.
- Between 2000 and 2018, 27 EBRD-supported funds made 30 investments in private hospitals and clinics and eight in diagnostic centres, using €177 million of EBRD capital. Some of these investments support companies also benefitting from direct Bank financing. Investments are highest in Turkey (44%), Poland (25%), and Romania (10%).

In addition to investments, the Bank also uses technical cooperation, IPPF advisory and small business advisory services in support of healthcare.

- Support to businesses in the healthcare sector[9] is a significant part of the Bank's SBI ASB programme, both through international advisory (40 approved projects across 18 COOs since 2012[10] – most active in Kazakhstan, Mongolia and North Macedonia) and local consultancy work (31 COOs since 2012). The goals of the international advisory in healthcare, much like in other areas of ASB work, are to support local/regional companies with business advice in specific areas, in order for those companies to thrive and be bankable[11].
- The Bank is involved in supporting PPP in health through its IPPF, specifically through the delivery of Legal-Technical-Financial Advisory Services for the PPP Tender Process. At the time of this evaluation, the IPPF PPP Preparation window covered three projects in health, which represents a quarter of the IPPF portfolio in number. The goal of the advisory is to increase the capacity of the respective authorities to prepare and tender in line with best practice. Using IPPF funds[12], the Bank teams work closely with Government on project preparation, organising and conducting the concession tenders in accordance with EBRD policies, to ensure bankability.

[5] This includes the sub-projects of the Turkey Hospital Facilities Management Framework and Extension, (rather than the Framework/Extension themselves)
[6] As reference to the other part of Healthcare Sector, EBRD's investment during this time in pharmaceutical and medicine manufacturing stands at €610mn across 49 projects.
[7] There is one exception: GrCF-Energy Efficient Refurbishment of Zenica Hospital (49431) is an investment under the Green Cities (48171). This was a €10 million sovereign loan for Energy Efficient Refurbishment of Zenica Cantonal Hospital in Bosnia and Herzegovina.
[8] The health bond was created in recognition of the importance of the health sector, including health care and pharmaceutical providers.
[9] As defined by individual OLs in the SBI ASB programme for MIS category Human health activities
[10] The MIS system does not allow access to records pre 2012.
[11] As indicated by a combination of the following: improved management skills, increased productivity, turnover, business planning and improved understanding and capability in marketing and design
[12] Fully recoverable

In addition to ASB and IPPF advisory, the Bank has selectively used TC to support the implementation of some of its investments. Separate to this, partnerships in investments (with the IFC, Proparco and DEG in particular[13]) and knowledge exchange (in the area of antimicrobial resistance, AMR, informal exchange on affordability analysis approaches with IFC, provision of TC to Turkish MoH for the development of VfM methodology and related training to the MoH team and a one-off EPG-led paper analysing the healthcare sector in the EBRD's COOs 2016) are part of the Bank's work in health. It is noteworthy that the Bank's revised 2019 Environmental & Social Policy recognises AMR risk, the first such policy among MDBs.

Box 1: Antimicrobial resistance and EBRD response

Antimicrobial resistance (AMR) occurs when bacteria, viruses, fungi and parasites change over time and no longer respond to medicines. The cost of AMR to national economies and health systems is significant. The World Bank estimates that without effective interventions, AMR could cost the international community US$100 trillion from now to 2050, and the expected deaths associated with AMR could be more than cancer deaths in 2050.[14]

The EBRD's revised 2019 Environmental & Social Policy (ESP) recognises AMR risk and promotes good international practices to prevent the proliferation of AMR. It is the first MDB policy to do so.

Since then the Bank has supported AMR related capacity building activities and policy engagement (advocacy workshops) in multiple healthcare investments. These include technical cooperation projects as part of Adana Hospital PPP (BDS14-229), Project Elixir (BDS19-223) and Ronesans Healthcare Investment (BDS20-68). In Georgia, an AMR audit of two M&S clients (GHG and Aversi) focused on quality assurance on mitigating infection risk. This was followed by an in-country capacity building workshop with public and private participants. Additionally, the Bank encouraged another M&S client (Hellenic Healthcare, BDS18-118) to sign up for an international initiative aimed at addressing AMR and antibiotics prescription issues worldwide.

This evaluation is a first effort to assess EBRD's increased engagement in health against the background of the 2014 Updated Approach and its objectives.

The approach and methodology used for this review are specified in the approach paper which was approved in January 2019. The ambition of the evaluation approach is to answer three evaluation questions:

(i) How well does the Bank's institutional architecture support its health sector objectives? – Given the gravity of the internal architecture issues which frame all else, it is pertinent to tackle this first.

(ii) How relevant are the Bank's engagements to its mandate, COOs and wider global agenda? –Understanding what the Bank has chosen to do in this space and why - how this relates to the Bank's transition mandate as per the six qualities, the needs of its COO as per the country strategies, - is an essential part of any evaluation.

(iii) What are the emerging insights in performance from the Bank's interventions? This evaluation set out to be a results-based evaluation, with corresponding look at the full portfolio via internal documentation, and selected representative interventions via field work. Within the COVID-19 context, no field work was carried out. Given the lack of monitoring data coverage on the health portfolio, it was not possible to extract insights from such a small population. Therefore this evaluation takes a look at

[13] Other partners also included EIB, BSTDB, IsDB, among others.

[14] https://www.worldbank.org/en/topic/health/publication/drug-resistant-infections-a-threat-to-our-economic-future

three illustrative experiences and the emerging insights and learnings of each. The team looked specifically at the Bank's involvement in health via:

- the PPP hospitals framework in Turkey, hiring both a local and international expert;
- the Assistance to Small Businesses programme; and
- the validation of a recent, evaluation-ready stand-alone investment project.

A combination of desk research, virtual/pre-COVID face to face structured meetings with the EBRD, clients, partners and beneficiaries, provide a basis for the findings of this study.

The findings arising from each evaluation question have been used to derive conclusions and recommendations. The report is structured as follows:

– Section 3 consolidates the findings on the adequacy of institutional support

– Section 4 consolidates the findings on the relevance of engagement.

– Section 5 consolidates the findings related to the performance of Bank engagement in health related PPP, and summarises observations from other interventions, with details available in the annexes.

– Section 6 summarises the recommendations for the future.

The annexes attached to this document contain the more detailed findings in each intervention (ASB, PPP and investments), as well as Management Comments. In a departure from normal practice, and in keeping with global good practice regarding data privacy across Evaluation departments, this report will not contain an annex detailing the list of those interviewed, although one is included in the internally-discussed version, to aid discussion and transparency.

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2. Does EBRD's institutional architecture support its health work?

Main points

The Bank lacks a comprehensive strategy/policy level statement of its objectives in the health sector.

The fullest presentation of its role in health is found in the "Updated Approach to Healthcare Services" which was discussed in a Board Workshop in 2014; no formal Board approval was sought. The approach established an estimated portfolio volume for eligible projects that should not exceed EUR 100 million per year; it also excluded policy engagement as a potential area of activity.

The Updated Approach applies only to a subset of the Bank's health-related activities, specifically those undertaken by the Manufacturing & Services Department. Considerable other health-related project and advisory work is delivered by the Municipal and Environmental Infrastructure Department, the Equity Department and the Advisory for Small Business entirely outside the scope of the "Updated Approach."

As a result, health-related activities are dispersed across multiple departments with multiple reporting lines to different Senior Management. Activities that are conceptually similar are developed and delivered by different teams, creating real challenges to developing a coherent picture of the Bank's work and to monitoring, reporting and results management.

It appears that the Bank's existing policy/strategy approach was designed around pre-existing organisational structures rather than as a means to achieve greater operational coordination and coherence or demonstrable results on the ground.

The updated approach has not been translated into a set of clear practices or criteria to guide operational work in the healthcare sector; as a result there is no basis for mechanisms to ensure consistency or compliance. There are important areas where substantial ambiguity exists.

The concept of healthcare "affordability" was central to Board concerns about the Bank's prospective engagement in the sector and for this reason featured prominently in the Updated Approach. However, it doesn't appear to have been operationalised in any meaningful or systematic way, such as to inform project selection and assessment.

Dedicated resourcing for healthcare operations is difficult to identify with confidence, but appears to be minimal and subject to key person risk. Resourcing issues are likely also a factor in the observed problems with affordability analysis and other institutional delivery systems.

2.1 Is the Health sector well-defined as part of the Bank's operations?

The Bank's definition of health exists in only partial form within one formal document – the 2014 Updated Approach to Healthcare Services.

Healthcare services for the purposes of this paper are defined as activities primarily engaged in the provision of medical, surgical and other health services to persons such as hospitals, clinics, diagnostics centres and specialty care facilities (all broadly "private hospitals").

A wider definition of healthcare also includes related sectors such as the production and distribution of pharmaceuticals and medical equipment, health insurance or PPPs for infrastructure facilities management. However, these sectors have different characteristics than healthcare services and thus not detailed in this note.

Thus while this definition covers work run out of the Manufacturing & Services Department (M&S) it explicitly does not apply to other areas of Bank health activity. This includes projects and advisory across SIG, Equity and ASB. Among these are projects which conceptually have similar objectives to other classed as health, but for administrative reasons, sit with different teams and are thus categorised differently. For example, an MEI hospital management PPP which includes diagnostics/lab service provision is fundamentally similar to M&S support for an imaging lab; but one is considered health and falls under the Updated Approach, while the other is not.

More widely, the Updated Approach does not cover interventions whose inputs (finance/advisory) arguably (seek to) affect improvements to the COO's health space, either via improved accessibility or affordability of quality of care. Finally, the Bank sometimes applies its definition in a contradictory manner - for example, classifying PPP as health for the purposes of its health bond but not as a health project at the time of Board review.

Without a clear and comprehensive definition or operational framework it is difficult to develop an accurate picture of EBRD's overall role, footprint and transition objectives in health. From this follow issues with governance, organisational ownership and accountability and results management.

IFC, one of EBRD's main partners in investments, does have a strategy for health interventions. CDC uses a healthcare strategy underpinned by a healthcare impact framework for its interventions; EIB has comprehensive lending guideline including a results framework for its health sector transactions.

Other IFIs involved in health define their work differently. IFC's banking operations and advisory support falls under the unit entitled "Global Health and Education" that is situated under "Manufacturing and Services". Hence, for instance, this unit – but not infrastructure – leads the design and execution of transactions under the Turkey Hospital PPP programme with the support of PPP specialists.

2.2 Strategic Framework and Operational Arrangements

The stated main objective of the Updated Approach was to give more structure to the Bank's then ad-hoc and marginal engagement and increase its significance while maintaining a well-controlled approach.

The Updated Approach established a portfolio volume for M&S projects not to exceed EUR 100 million per year; it also excluded policy engagement as a potential area of activity. The main criteria were the following; additional detail in Table 1:

- Engage if government policies are clearly geared toward a well-regulated, transparent and contestable private sector involvement.
- Include an experienced healthcare delivery operator
- Focus on providing high quality affordable healthcare
- Mitigate reputational risk via a quality assurance action plan, international accreditation and comprehensive legal and commercial due diligence
- Assess and support development of skills consistent with Bank's strategy for supporting knowledge economies

Table 1: Summary of Do's and Don'ts taken from 2014 Updated Approach

	Can do	Cannot do	Expertise/experience
INSURANCE			
Public health insurance		X	
Private insurance	V		FI team has done a few some small projects
PUBLIC DELIVERY[6]			
Public hospitals		X	
Other public healthcare (e.g. retirement homes)		X	
Energy efficiency (boilers, new windows) in public hospitals		X	
PPPs for public hospitals			
Construction and building maintenance (no health services)	V		As agreed under MEI team strategy
Energy efficiency (new boilers, new windows) in public hospitals via private ESCOs	V		Indirect from the healthcare point of view. We have a few private ESCO projects that serve both public buildings and private industry.
PHARMACEUTICALS AND MEDICAL EQUIPEMENT			
Private production, distribution and retail of pharmaceuticals	V		The largest "healthcare" portfolio in the Bank. Extensive expertise in M&S team with €500 million in the pharmaceutical sector with nearly 40 projects.
Private production, distribution and leasing of medical equipment	V		Very few small projects (e.g. operating tables). M&S has pursued larger (high tech) projects but it has low potential.
Public production/purchase of pharmaceuticals or equipment		X	
PRIVATE DELIVERY			
Private hospitals (and ancillary services such diagnostic labs and imaging x-rays)	V		M&S has significant experience of smaller projects (and EBRD equity has extensive experience of this segment). This area is the subject of the detailed risk analysis and criteria in this paper.
Private other non-medical services (e.g. retirement homes)		X	No direct experience. EBRD equity funds have some experience. However it is not proposed to enter this segment directly.
POLICY DIALOGUE		X	The Bank is not involved in policy dialogue in healthcare, except for TC support to private clients to improve standards and quality of services.

Source: Updated approach to projects in healthcare services in 2014 (WS14-02).

But while the Updated Approach provides some useful operational detail it also leaves open substantial ambiguities; for example:

- **The "do's and don'ts" have at times been applied and other times not.** Policy dialogue is listed as a 'don't', except for TC support to private clients to improve standards and quality of services. But the EBRD has also provided policy dialogue TA to ministries on skills development for health services skills like nurses, and TA on contract monitoring. Similarly, the list enjoins against involvement in public hospitals, but recent work in Turkey and under Green cities seem to be just this.
- **Similarly, the affordability related criterion ("*focus on providing high quality affordable healthcare*") is applied inconsistently.** An approach to assessing affordability was developed by Banking and OCE, taking into account approaches at the World Bank, IFC, Proparco and DEG. The assessment is reported to have been developed in response to Board concerns about reputational risk related to the affordability of healthcare service provision. However, there is inconsistency and weak functionality with the screening tool. EvD screened all project approval

documents and found that only those that went to the Board for approval from M&S included affordability analyses. Other projects that fall under health but which are not led by M&S, and those M&S projects which did not go to the Board for approval, do not present with such an analysis. The box below summarises EvD concerns with the affordability analysis beyond its weak coverage.

Box 2: Analysis of the affordability assessment function under the updated approach

The Bank's affordability analysis function is ineffectual and inconsistent. The affordability analysis is a joint banking-EPG product during the preparation of a health project as part of the principles of the updated approach. There are three issues here: (i) lack of common understanding of the function of the analysis; (ii) varying quality of analysis presented to the Board; (iii) artificial eligibility criterion.

The original rationale behind affordability analysis reflects Board concerns about reputational risk related to the affordability of healthcare service provision. The objective was to ensure that confirm that beneficiary hospitals provide service substantially beyond high-income/high-wealth patients. But as it currently stands the affordability analysis is not a useful measure of this.

Board sources now, including DAQs, indicate a mixed view on the role of affordability analysis: an overarching aims for work in the sector; an aspect of potential inclusion impact; or a risk mitigant against doing harm.

Management clearly sees affordability as a reputational risk issue rather than as a project development factor. For example, often wording refers to *'The affordability analysis confirms that the project is not supporting a healthcare provider exclusively for high-income households'.*

In contrast, the IFC and the CDC consider aspects of affordability as a core part of their development impact assessment. Both institutions use affordability related project information to incentivise projects that serve a wider spectrum of wealth distribution.

Current affordability analysis is not useful as a tool for eligibility because affordability it is linked by teams to sound banking; there is no possibility a project that would otherwise come to the Board failing this. As described to EvD, this is included in any hospital financial sustainability model, meaning that a project considered by the EBRD from a sound banking perspective would inevitably also consider this.

Even where affordability is discussed at Board as a significant issue, there is little route to follow up. In the case of the North Africa Hospitals Co-Investment with Abraaj, one Director explicitly requested a post-implementation look at affordability and was supported by others. Management committed to ensuring that it would be possible during monitoring to ensure that the client base was middle income, but this was missed at draft self-evaluation stage, and during valuation there was no accessible document that tells the story – no ex-post affordability analysis was conducted, per se.

Finally, the affordability analysis is not presented with sufficient or consistent detail to be useful. EvD review of project documents found full affordability analyses presented only in cases of M&S projects going for Board approval. Older cases generally show greater detail than more recent ones; some recent projects in fact came to the Board without a full analysis attached. Affordability analyses are simply absent in the case of DFF SME. Again, there are no formalised guidelines and the use and operationalisation of the approach are unclear.

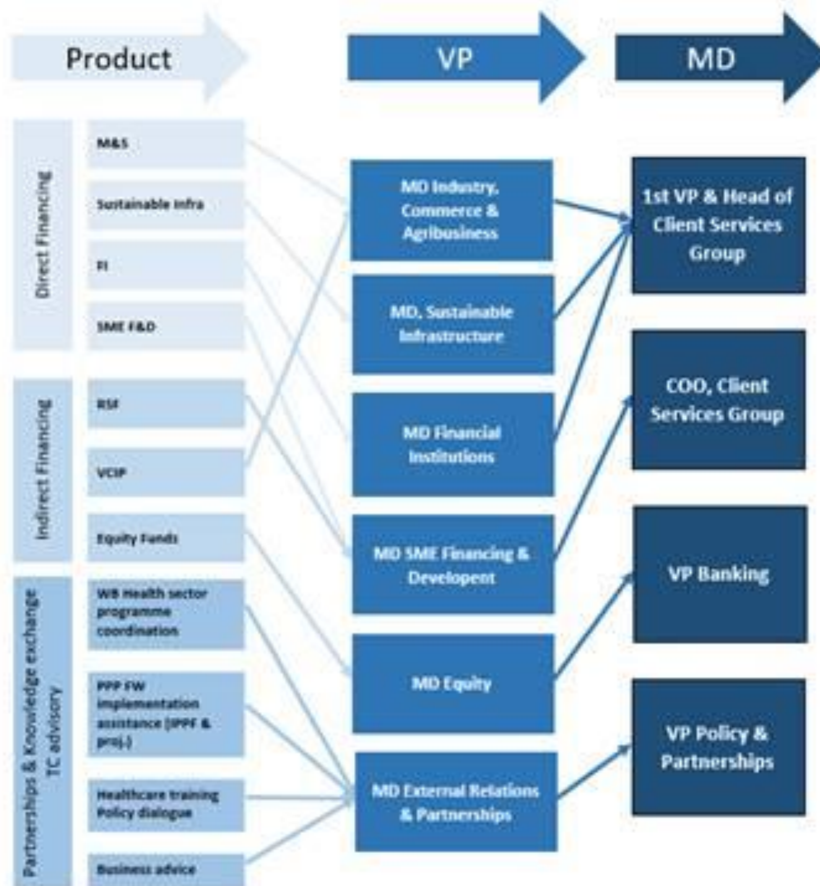
Inconsistencies in operationalisation of the UA also partly reflect the fact that no processes for execution/compliance were introduced by Management.

- At no point during project development does the team need to confirm its compliance with the criteria set out in the Updated Approach. While EPG has commented on affordability as part of the internal review there is no formal process of consistent screening takes place.
- There is no formally responsible team for this and no operational process or template has been formalised. Documentation on project approval discussions suggests EPG is responsible for escalating to approval committee level if it has affordability concerns; but there is no formal framework.

2.3 Organisational Structure

The chart below illustrates the current organisational location, management and reporting lines of various health-related operational activities in the Bank

Figure 1: Organisational matrix for EBRD health engagements



Source: EBRD intranet

2.4 Resources for health work

In terms of dedicated health sector expertise, EBRD has one in-house consultant who has worked long-term as a sector specialist, on a regularly extended term contract within the M&S team. This consultant has historically worked across MEI and M&S teams and almost all the banking portfolio in health. There is one expert assigned to health in ASB; there are no dedicated economist or ESD positions.

As a useful comparison, in 2014 the IFC already had approximately 25 people dedicated to healthcare transactions and advisory in a dedicated team, alongside a World Bank Group wide strategy[15]. IFC has an active portfolio of $2 billion in health care companies – approximately 3.4% of entire portfolio.[16] CDC has a health and education sector strategist. CDC's impact in health sector is managed by an executive covering consumer, healthcare and internet connectivity. CDC has an active portfolio of $348 billion in health care companies – approximately 7% of entire portfolio.

While it is true that, at least for M&S, expertise via consultants is the operating model for all specialisations, the health portfolio has evolved from a small project base. It is correct that the (Turkish) PPPs are managed by a large team in SIG. However, with a significant overall health portfolio, key person risk is not addressed across the portfolio. It is likely that part of the reason for the variability of the quality and presentation of affordability analysis is rooted in insufficient capacity and the absence of institutional systems.

3. How relevant is Bank work to its mandate, COOs and wider global agenda?

Main points

There is no evidence that the Updated Approach has been meaningfully integrated into country strategies. No country strategy gives priority to transition challenges in health. A review of all current and prior country strategies reveals very little mention of healthcare and an absence of health-sector related objectives, activities and indicators.

There is presently no effective framework in place to assess projects' transition potential in healthcare services. Health objectives, as articulated, cannot be effectively mapped to the Bank's Transition Qualities. The Bank's internal systems (Transition Objective Measurement System, Compendium of Standardised Indicators, Assessment of Transition Qualities) do not enable projects in the healthcare sector to be assessed in terms of their potential contribution to promoting the accessibility and resilience of healthcare systems.

Assessment of Transition Qualities (ATQs) do have several indicators directly related to health. For instance five indicators measure gender and regional equality in accessing quality healthcare services. However these are specified as country-level measurements and have no project-level connections. Thus, even if a project promotes gender equality in healthcare access there is no clear mechanism in place to assess the project's transition potential.

The overall implication is that there is no conceptual or evidentiary basis on which to tell a story that is likely in many cases to be relatively good. Close comparators such as IFC and CDC do better. This also prevents seeing alignment of Bank work with the 2030 Agenda for Sustainable Development; the Bank itself reports that no its interventions contribute to SDG3.

[15] As a 2016 IEG report states, 'PPPs and other forms of private sector involvement in health are now also an important element of the World Bank Group's response to country health challenges, as reflected in the 2013 *World Bank Group Strategy*, the 2008 *World Bank Group Health Development Strategy*, the 2015 joint World Bank Group Approach to Harnessing the Private Sector in Health, various CASs and CPFs and IFC's FY17-19 and prior Strategy and Business Outlook reports.'

[16] As a comparison, EBRD's active portfolio in health (as calculated by the EvD) can be approximated at EUR 1 billion. This corresponds to 2% of the Bank's entire portfolio.

3.1 Relevance of bank work to COO health challenges

The Bank sets strategic priorities at the country level, but no strategy prioritised transition challenges in health. A review of all current and prior country strategies reveals very little mention of healthcare, either in terms of explicit reference as a transition challenge (except sometimes in the area of economic inclusion), or as part of the Bank's operational response; 5 Country Strategies between 2006 and 2019 mention healthcare engagement as part of the Bank's operational response but with no explicit prioritisation, only indirect references to private sector development, services and exploration of activities in PPP. This is the case, even where the Bank has longer standing and/or multiple types and substantial volumes of engagement (such as Turkey, Egypt, Georgia). The 2016 Georgia Country Strategy illustrates this.

Box 3: Extract from Georgia Country Strategy 2016

Theme 1: Support private sector competitiveness through innovation, enhanced value-added and convergence to DCFTA standards and obligations

	CHALLENGES	OBJECTIVES	ACTIVITIES	TRACKING INDICATORS
1.1	The economy remains dominated by low-value industries, while standards need to be raised in the areas of product quality, safety management and food security	**Foster productivity and efficiency through improved operating standards and implementation of requirements under the DCFTA**	• Investments in selected private corporates and SMEs with focus on agribusiness, tourism, healthcare, light manufacturing, mining, and value chain approaches • Direct lending and on-lending including risk sharing, supporting convergence towards DCFTA, complemented by Advice for Small Businesses on DCFTA requirements and implementation • Support to the Investors Council and Competition Authority	• Number of projects successfully introducing standards and operating models meeting DCFTA requirements *(Baseline – 0)* • ASB indicator on increased productivity *(Baseline – established at project approval)* • Qualitative account of improvement in investment climate as a result of the Bank's engagement with IC and Competition Authority(e.g., tax administration, pension, commercial justice reform, Competition Authority), *(Baseline - N/A)*

Source: Georgia Country Strategy BDSGE1601FX

This absence of health-sector related objectives, activities and indicators in country strategies demonstrates that the Bank did not operationalize the Updated Approach at the country-level. Without any strategic direction at the country level the Bank primarily designed and assessed its engagement in the health sector based on generic project characteristics such as efficiency gains, cost savings and greater profitability. Consequently, the Bank did not identify and monitor project-level transition potential in terms of expansion of quality and affordable healthcare services although this was the main motivation of the Bank's involvement in the sector as per the Updated Approach. This is discussed further in Section 4.1.1.

3.2 Suitability of current definitions of TQs for measuring impact in the health sector

The Bank's transition qualities and assessment systems do not fully account for health goals as reflected by the portfolio.

The healthcare portfolio approved as standalone projects (mainly the M&S) intends to support Competitiveness as its primary transition quality. Similarly, the Bank considered Competitiveness as the primary transition driver of its transactions under the hospital management PPP framework in Turkey (MEI) as well.

Table 2: Transition impact objectives for health-focused interventions[17]

Transition source/quality targeted	# of Projects	Sectors
Demonstration effects: Transfer of new behaviours and activities	26*	M&S and MEI
Standards: Setting standards for corporate governance and business conduct	16	M&S
Frameworks for markets: Institutions, laws and policies that promote market	8*	MEI
Private ownership: More widespread private ownership and entrepreneurship	4	M&S
Skills: Transfer and dispersion of skills	4	M&S
Competition: Greater competition in the project sector/quality of care access	4	M&S
TQ: Competitive	5, in two cases as primary	M&S
Other (Resilient, Inclusive, Well-governed, Market expansion etc)	*5*	M&S

Source: EvD elaboration of Board/approval documents; *Includes 2FW as 8 projects

Note: Transition source/quality targeted for projects under frameworks generally depends on the transition source/quality targeted at the framework level. For instance, Hospital Facilities Management PPP Framework and the extension (BDS14-229 and BDS16-097) target Framework for markets and there are in total eight sub-operations under these frameworks. Thus, in addition to standalone and DFF non-SME projects, the table reports the total number of sub-operations with respect to the transition source/quality targeted by their respective framework. These are MCFF, DLF, LEF, DFF, RSF, GrCF and abovementioned PPP frameworks.

Consequently, the transition ambition of these transactions primarily focused on efficiency gains, cost savings, greater profitability, private ownership and improvement of corporate governance. Further, as a result of framework usage for many projects, many of the portfolio have no link made between inputs and health related outcomes. The consequence is that it is not possible to tell the story of how EBRD has impacted quality and accessibility of healthcare systems.

Box 4: Excerpt from Abraaj validation in relation to project design

> What is less clear is what the project achieved towards the spirit of its broader health quality related objectives in terms of improved clinical performance and addressing the undersupply of beds. Whether projects are truly making a difference to affordable high quality healthcare services is unanswered. This is partly because this type of performance – quality of care/improved clinical performance is not formally targeted or directly tracked through its indicators. Further, one of the main indicators currently used to measure changes in quality improvement standards, the JCI accreditation, is not necessarily able to best reflect improvements in quality standards of healthcare.

Source: Draft EvD validation

Particularly following the COVID-19 response, approved projects appear to reflect some new thinking -- that the supply and quality of healthcare services as well as medical equipment can be about

[17] The majority of transition ambition in the portfolio was designed before the introduction of the six current transition qualities; hence many use typologies set under Transition Checklist (CS/FO/97-3). Mapping of the Transition Checklist into the Qualities Framework (BDS16-181, Annex 3) helps in resolving this discrepancy to a substantial degree: In the evaluation portfolio, demonstration effects are broadly captured by Competitive quality. Standards (higher quality standards), Private ownership, Skills and Competition fall exclusively under Competitive quality. Framework for markets and standards (corporate governance improvements) roughly correspond to Well-governed quality.

supporting health system resilience. In recent months, the Board has approved projects that financed the purchase of hospital equipment to fight the COVID-19 pandemic. In these cases, the primary transition quality was identified as "Resilient" with a transition objective of preparing the sector for rapid response to future emergencies. The EBRD monitors the progress of this transition dimension by indicators such as *modernisation the quality of physical infrastructure in the hospitals* and *installation of certain number of hospital beds*. **This development effectively adds another transition dimension to the Bank's approach to the healthcare sector.**

Box 5: Health impact frameworks of the IFC and the CDC

Both the IFC and the CDC consider expanding quality healthcare services as a core component of development impact of their healthcare sector portfolio:

The ultimate objective of the IFC's health interventions is to increase the availability of healthcare services. This has two elements: (i) quality and (ii) affordability. Both of these are assessed against alternative/counterfactual provisions. The IFC makes a distinction between accessibility and availability; from its perspective, availability is much more about the increase of supply whereas accessibility has a distributional (pro-poor) emphasis. Projects are not required to hit both elements (i.e. quality and availability). Yet, there are rare cases where this is possible. Typically, these are small and innovative projects.

The IFC collects data on *number of patients served* and reports this figure in alignment with Sustainable Development Goal 3, Good Health and Well-being. The Health Sector Framework under the IFC's Anticipated Impact Measurement and Monitoring (AIMM) tool is yet to be developed. However, during an interview with EvD, the IFC's sector economists stated that the supply of medical services as well as equipment are likely to be considered under Resilient within the AIMM. Along these lines, the IFC recently launched a $4 billion facility dedicated to healthcare supplies to build the foundations for more *resilient* healthcare systems[18].

The CDC's impact framework for the healthcare sector is more sophisticated than that of the IFC and has four impact dimensions: In addition to access and quality, the CDC looks at *workforce* and *stewardship*. *Workforce* is mainly about a project's impact on the next generation of health workforce (i.e. training), as well as on the loss of staff from the public sector. *Stewardship* includes: complementing existing systems by addressing unmet needs; self-regulation, such as accreditation schemes; showing leadership in the spread of innovation; and participating in health promotion activities. Within this framework, in addition to *patients served*, the CDC tracks metrics such as *hospital mortality rates*, *readmission rates*, *infection rates*, *post-surgical complications* and *mortality from general anaesthesia*, amongst others.

Source: EvD interviews with the IFC and the CDC

The operationalisation of this in TOMS (Transition Objective Measurement System) has important implications that further constrict the Bank's ability to assess its health work.[19]

- TOMS does not allow project proposals in healthcare to be assessed for potential contribution to promoting the resilience and/or accessibility of healthcare systems. Ae a result banking teams

[18] https://ifcextapps.ifc.org/IFCExt/Pressroom/IFCPressRoom.nsf/0/70763342FB27B761852585B40058C13A

[19] EvD notes that Intranet Space of Project Christopher (PC/TOMS) guidelines and updates has been updated on 13 April 2021 and a new version of a document entitled "All Qs and pre-assessment tool 2021" has been uploaded. This document includes a TOMS questionnaire section dedicated to health sector. This is a welcome development given because this questionnaire will help the Bank to assess the transition potential of projects in health sector in a transparent and rule-based manner.

have little incentive provided to look for projects that expand affordable high quality healthcare services. For example, even if a private hospital project improves system resilience (by increasing the ICU capacity, or introducing state-of-the-art antimicrobial resistance (AMR) practices) or gender equality (expanded child and maternal services), transition potential is typically assessed in terms of its contribution to Competitiveness (market expansion, private ownership, corporate governance etc).

- There is also a gap between TOMS and inclusion goals. Assessment of Transition Qualities (ATQ) has a number of indicators to capture the degree of regional and gender inequalities in accessing healthcare services. But these remain country-level measurements without any operational implications for the Bank. This is because these dimensions are not operational under the TOMS. Thus, even if a project promotes gender equality in accessing healthcare service the Bank does not have a transparent rule-based mechanism in place to assess the project's transition potential.

Box 6: Selected EBRD clients that promote the resilience of healthcare systems[20]

Georgia Health Group – Georgia

- Mobilising equipment and isolation beds in six selected hospitals for Covid-19 patients
- Rearranging the reception and entrance areas in accordance with WHO guideline
- Expanding PCR diagnostic testing capacities

Codra Hospital - Montenegro

- Expanding maternity & gynaecological services for COVID-19 patients
- Addition of 40 beds for Covid-19 patients and one floor for the ICU

Cleopatra Group – Egypt

- Transforming two hospitals into Covid-19 isolation hospitals
- Treatment for 300 Covid-19 positive or suspected cases

Medlabs – Jordan

- Government authorised testing centre in Jordan
- Performed 13,453 PCR diagnostic tests by end of August 2020

PPP Hospitals – Turkey

- 13,462 hospitals beds with negative pressure ventilation system
- Provided training and updated diagnosis and treatment algorithms
- On-site PCR testing capacity

Infermedica – Poland

- Developed an AI-based symptom checker and free of charge on-line Covid-19 Risk Assessment Tool in 32 languages for the general public, based on the WHO technical information

Source: Evaluation analysis of BOLDnet and project link documents

- ATQ for Resilient has no sub-components or indicators related to access to healthcare services; resilience consists only of financial sector and energy sector resilience by design.

An important implication of the current structure of TOMS as well as ATQ is that it is not possible to assess the degree to which the Bank's approach and interventions match with global objectives under

[20] Infermedica is not listed in the portfolio under evaluation as it was approved later than the approach paper.

Sustainable Development Goal 3 (SDG3) "ensure healthy lives and promote well-being for all at all ages."

Consequently, the Annual Report on Transition Performance 2019 does not refer to any Bank intervention contributing to SDG3. This is a missed opportunity because a substantial number of projects where the EBRD financed capex for expanding healthcare services indeed supported SDG3.8 - *expansion of access to quality essential healthcare services.* Similarly, in several projects, the Bank targeted upskilling of health support staff and paramedics, i.e. SDG3.c - *enhancement of health financing and the recruitment, development, training and retention of the health workforce*. Finally, the Bank did take a leading role in promoting best practices and policies in combating the spread of antimicrobial resistance, i.e. SDG3.d - *strengthening the capacity of developing countries, for early warning, risk reduction and management of national and global health risks*.

4. What are the Main Findings on operational performance?

Performance is difficult to assess given the lack of clarity in stated transition goals and insufficiencies in monitoring.

This evaluation looked at illustrative experiences across healthcare engagements: SEI (Turkey Hospitals Framework, representing almost all the SEI portfolio), M&S (Abraaj, the first project to have been approved after the updated approach was introduced) and non-investment work (ASB international advisory, a significant reflection of the bank's non-investment work in health). **In general each intervention shows EBRD engagement in health was additional and one which contributed to expected transition results.**

Common insights from the full range of engagements – PPP, Abraaj, ASB – include the absence of adequate institutional guidance to shape interventions, which in turn allows success to be only partially visible, the vital contributions of technical assistance to the success of EBRD efforts, the vital role of specialists to carry out engagements in health, and the productive IFI collaboration.

Abraaj:

This was a successful project in terms of delivering expected project outcomes in corporate governance and quality-assurance standards. **What is less clear is what the project achieved towards its broader health quality related objectives in terms of improved clinical performance and addressing the undersupply of beds.**

ASB:

ASB's international advisory has generally been successful at achieving its intended objectives. At the same time, in the current COVID context, there are increased pressures on the smaller enterprises. The Small Business Initiative Annual Review 2019 and Strategic Priorities (CS/FO/20-12, 15 June 2020) do not foresee tailoring its healthcare international advisory programme in response to COVID-19. Therefore, **it is not clear whether international advisory in the healthcare sector will remain relevant during the outbreak and subsequent recovery period.**

Turkey PPP:

In Turkey, EvD found that the EBRD met its expectations, and indeed played a crucial role, with respect to enabling the diversification of the funding sources and commercial financing for privately financed, procured and operated hospital infrastructure, but despite significant effort, only partly met

its expectations in supporting the development of the PPP healthcare sector market. **An important challenge to this has been institutional capacity for project preparation, contract management and assessment of best delivery modalities.**

4.1 Insights from PPP work: Turkey Hospitals Facilities Management

The Board approved the Hospital Facilities Management PPP Framework in September 2014 to support Turkey's Ministry of Health (MOH) in preparing and delivering a large-scale hospital facilities management PPP programme covering up to 60 facilities across Turkey for total investment costs of €12 billion. The PPP programme was part of a much larger national policy initiative called Health Transformation Programme launched in 2003. The ultimate aim of the HTP was to expand access to universal healthcare in Turkey.

The evaluation found that the proposition of the Framework and the objectives of the Health Transformation Programme's PPP programme were in close alignment and that the Bank was highly additional. The Government of Turkey was seeking MDB support to scale up long-term private finance, strengthen project preparation to build bankable pipelines and design new financial instruments to help bridge project risks and financier risk appetite. Nevertheless, local banks lacked the resources for long-term financing due to the constraints of regulatory restrictions (Basel III regulations) with limited debt capabilities, high financing costs and insufficient capacity to support project parties. In addition there were a number of bankability issues which was blocking the financing of these projects. On the other hand, the EBRD was already experienced in deploying the PPP model in the Turkish transportation sector, as co-lender in the Eurasia Tunnel Project - working closely with Turkish authorities to improve the bankability issues and come up with structures in accordance with the needs of these large infrastructure projects over 4 years re. Eurasia Tunnel project, and also gathering the knowhow and expertise to work on the bankability issues of these kind of projects.

In terms of results, the evaluation found that the EBRD met its expectations with respect to commercial financing for privately financed, procured and operated hospital infrastructure as well as enabling the diversification of the funding sources by improving the bankability of these projects and working out a bankable template of the funders direct agreement.. Under the PPP programme, the EBRD co-financed eight projects and in total 18projects have reached financial closure since 2014. Concurrently, the EBRD introduced new instruments such as the first greenfield bond (Project Hestia) and Islamic financing tools. Combined with the Bank's efforts focused on ensuring the bankability of PPP documentation these instruments enabled the entrance of new lenders into the PPP programme. The role and support provided by the EBRD include the following:

- The EBRD working with the IFC played an essential role in engaging with the MOH to develop bankable contract conditions to achieve financial close. While there were few potential lenders in the process initially, over time and through the EBRD's involvement the number of interested lenders grew.
- The EBRD and the IFC with their lender's legal advisor reviewed the project contracts. The review indicated that while most provisions relevant for financing were in place (e.g. lenders' direct agreement, termination provision, etc.) the contracts were generally not suitably/clearly drafted and there were vague parts which were causing bankability issues that would need to be improved. Similarly, the contract schedules when reviewed by the lender's technical advisor were found to be inadequate. In addition, there was no drafted template of Funders direct agreement in bankable form.

- The EBRD and the IFC developed a 'must have' list of requirements necessary for international financing of the projects and engaged on this with the MOH. This resulted in engagement initially on the project contracts and subsequently on the funders' direct agreement. Simultaneously, the EBRD provided a technical advisor available to the MOH to revise contract schedules, penalty formulas, etc. The EBRD and the IFC reportedly did not make any fundamental changes to the project structure, but introduced various provisions required for bankability.

Prior to the EBRD's involvement, originally tendered projects that reached commercial close in 2010 were not bankable and did not reach financial close until 2014. After the initial award and commercial close of some transactions prior to 2014, the MOH organised all party meetings to get feedback from sponsors and lenders, This was a largely unsuccessful process until the start of the involvement of the EBRD and the IFC. It does not appear that the MOH had the expertise and skills required to play a meaningful role at this stage

During this process, the EBRD became the major market maker for substantial lending into the hospital PPP sector by a range of international and domestic lenders. Specifically, the Bank facilitated innovations with the involvement of the Islamic Development Bank and Islamic financing, as well as in supporting greenfield bond financing. The EBRD explored equity involvement principally via a fund together with Meridiam, however ultimately made an equity investment in 3 of the hospitals.

Still, five out of eight projects co-financed by the Bank faced substantial financial distress. One of the main reasons of this outcome was out-of-proportion variation orders issued by the MOH. These orders requested significant variations to the size of most of the hospitals prior to and especially during the construction phases. While some variations (including to equipment, some facility adjustments, etc.) can be expected, major increases in bed size suggest weakness in the original specifications and project preparation.

The variations became problematic as the MOH itself did not formalise variations following the contract provisions, and many sponsors began implementing the variations without having contractually formalised them. As variations meant project sponsors required additional financing, this created a problem for the EBRD and other lenders. In one instance, the sponsor undertook additional construction of $165 million with its own equity without the variations having been formalised. The lack of formal approval of the variations led to default events, lenders stopped disbursements, this led to project cash flow issues that affected construction, and this caused further construction delays, which resulted in defaults, eventually leading to substantial financial distress. This cycle potentially would lead to termination.

The sponsors of the three projects that did not face financial trouble insisted on the formalisation of variations before implementation. Overall, the projects that have experienced major problems are the ones in which large variations orders are coupled with sponsor-specific problems such as general financial difficulty, group-level problems unrelated to the specific project, problems with EPC contractors due to insufficient market capacity and differences between domestic sponsors and international sponsors.

The EBRD has played a major and lead role representing other lenders in resolving distressed projects. Lenders, sponsors and the MOH wanted to avoid slipping into termination procedures and ending up at arbitration. Resolution of issues and continuation of construction and operation were the priorities of all involved parties.

The resolution required the direct involvement of the MoFT (Ministry of Finance and Treasury). At first, the Bank approached the MOH to initiate the resolution process. However, the MOH lacked capacity in

effectively engaging with these matters and delivering on solutions ('agreeing to things but unable to deliver'). Then upon the request of the lenders, the MoFT became involved and has since been the EBRD's key counterparty in reaching and implementing solutions. A key part of resolving this has been the formalisation of contract variations. This has required, inter alia, the passing of legislation that regulates the procedures to implement out-of-proportion variation orders. The legislation and in turn formalising of the variations has allowed lenders to restart disbursements.

At the onset, EBRD was aware of the limited capacity of MOH and, for this reason, the framework also set out to transition objectives aiming to enhance the institutional capacity of the MOH. These consisted of (i) implementation of Value for Money (VfM) assessments for hospital facilities management PPP projects and (ii) strengthening the monitoring function for hospital facilities management PPPs:

With respect to these objectives the Bank only partially met the expectations set at the approval:

Following the successful completion of the technical assistance for the VfM methodology, in 2017, the MOH started to use the VfM methodology without any support. The EBRD's VfM technical assistance remains as the first and foremost technical cooperation in Turkey in this area.

On the other hand, the technical assistance for the dedicated monitoring unit did not progress. This was mainly due to mid- and high-level staff changes and subsequent re-prioritisations of the MOH's policies. Following the opening of the first PPP hospitals, the MOH established its own internal procedures to assess the performance of service delivery, calculate penalties, availability and services payments. Therefore, it is not clear whether the MOH sees any need for further technical cooperation in this area.

Although EBRD's involvement supported the creation of 13,462 hospitals beds with negative pressure ventilation system and hospitals with on-site PCR testing capacity, it is not clear whether or not the influence of the Bank's efforts on the development of the PPP healthcare sector will be sustained. This is because, after financially closing 19 projects, the MOH decided to suspend the PPP programme in 2019. The remaining hospital projects have been included in Turkey's 2020 Annual Investment Program. It had already been decided to implement several of these projects via the PPP model and some of them were already in the tendering phase.

The factors that led to the suspension of the MOH's PPP programme are manifold and mainly related to the fragmented nature of PPP governance in Turkey, the MOH's original level of preparedness and the required size and pace of the PPP programme (see Annex 1 for these details).

In terms of a way forward, and in spite of the substantial progress made by Turkey in the business environment and the regulatory framework for PPP, several core problems persist:

- Extensive legislation represents a complex system, which makes it hard to navigate and lacks a sense of uniformity.
- Grounds for termination vary between the laws: some laws do not regulate this matter at all, some list the termination grounds exhaustively, while others set out an open list. The list of grounds for termination may in some cases adversely affect the contractual balance between the parties in favour of the contracting authority. Compensation for termination is neither prohibited nor explicitly regulated by laws, so it is commonly left to be regulated by a project agreement; otherwise the general rules of the Civil Code apply.
- There is no central PPP unit (or a central entity in charge of PPP) acting as a "task force" in charge of assisting the contracting authorities in their PPP projects. Instead, each contracting authority (sector-specific ministries and their directorates) acts independently with no sector- or project-specific coordination.

In its essence, these policy-level shortcomings shed light on the causes of problems faced by the MOH during the preparation and implementation of the PPP programme. Because of the experience with hospital PPPs, the Government of Turkey and the MoFT in particular are in the process of amending its procedures and responsibilities for PPP projects, to create more centralised control and oversight. While a central PPP framework law has been under discussion since 2007, it has not yet been established in Turkey. Since 2016 there has been ongoing process in central government to enact a general PPP Framework Law. Most developed PPP programmes, e.g. Australia, Canada, UK, France, and several countries in Latin America, have incorporated fiscal reviews and approvals by the planning authority or Treasury at specific project milestones during the gateway process. In contrast, fiscal oversight responsibilities in Turkey are fragmented and limited to the earliest project preparation phases. The prospect of progress on these issues is likely to affect the financial and operational performance of the PPP programme in general and the PPP hospitals that the EBRD co-financed: Namely (i) The MOH's capacity to manage contracts will remain critical because the services that the PPP hospitals provide are subject to market testing; (ii) The MOH's capacity to undertake a health sector demand study and plan public investment in the health sector will shape the utilisation of services and, ultimately, the performance of PPP hospitals.

Lessons from the PPP Turkey experience

1. **The EBRD should ideally start its involvement in a country's health sector at the earlier stage of PPP project identification, preparation and transaction with technical advisory support.** This might require further upstream support in health sector planning if that is not appropriately in place (see Box 7 **Where the EBRD enters at a later stage, a thorough PPP-oriented due diligence should be conducted** to assess whether the projects were properly prepared and transacted, whether required PPP analyses and assessments were conducted, and whether the procuring authority made properly informed project decisions.

Box 7: Possible upstream support

The EBRD can consider conducting a 'health sector PPP diagnostic' at an initial stage in a country to identify the places in the health system, and the types of PPP models that can be used. The PPP model used in Turkey is appropriate for hospital facilities and ancillary services. However exactly what components are included in the PPP should always be adjusted to a country and health sector situation. PPP models that include also medical services (and in some cases are directly paid by patients) can also be used, such as for haemodialysis services, diagnostics, medical laboratories and testing, and so on. These models can involve partial or full patient payment direct to the provider (i.e. revenue-based PPP model). There are also PPP models where commercial private medical facilities/services (e.g. private rooms with higher standards) are included to cross-subsidise public facilities/services (e.g. general wards).

Tailoring the PPP models and approach is needed for any country. Having generally 'standardised' models (e.g. the UK PFI) and certainly project contracting standards that are internationally recognisable is useful and important. However these need always to be tailored to local situations. This is in regard to local specifics of the health sector, population, legal system, economics, etc., but also to issues such as the contracting culture.

The availability-based PPP model is common in the social sectors, since payments health and social systems are funded from government budgets or public and/or private insurances. The AP model has specific fiscal management and budgetary affordability

considerations for an authority and the EBRD should ensure that these are properly analysed and considered by the public sector, and that it is properly managed within the public financial management system.

2. **The EBRD should conduct a thorough review of the capacity of the procuring authority to prepare, transact and to manage PPP projects**. Depending on how PPP responsibilities and procedures are set up in a country, this should cover the responsible health ministry, procuring authority (if different) and the financial and treasury ministry/ies. A robust package of technical advisory support should be tailored and provided, and should be conditional on other EBRD involvement, including in financing of projects.

3. **The EBRD should where possible use a framework approach** (as opposed to ad hoc projects) as it allows for a more programmatic approach that can be synergised with the countries health sector development programme, and can build the public (and private) capacity to deliver health facilities via PPPs. A programmatic approach potentially creates a deal pipeline that attracts the interest of larger firms, investors and financiers. However to have sustainable impact, a health sector PPP programme needs to be incremental and ramped up at a pace that the procuring authority and the market can handle. Using pilot transactions is better than diving directly into a high volume of untested deals.

4. **The EBRD should ensure that the fundamental risk allocation, and especially underlain by the termination compensation provisions, are correctly in place in future health sector PPP projects**. This is essential to ensure that sponsors and lenders are at appropriate risk to the performance of the private company, which creates their basic incentive to ensure performance.

5. **The EBRD should seek to play a lead role in financial structuring and financing of health sector PPPs, and continue to use its A/B loan structure, as well as to further innovate in local markets.** FX exposure as a result of hard currency lending is an additional complexity in EBRD countries for PPP projects which are already complex by their nature. The EBRD has reportedly had lending operations in 27 local currencies, and the EBRD should give attention to how FX exposure in PPP projects can be reduced, eliminated or better managed. Innovation may also include potentially combining sovereign financing (providing loans or grants to the public sector which are used to make milestone payments – indicatively amounting to ~40% of capital costs – during construction), with project financing in the SPC of the remaining (~60%) capital costs. This model combines the benefits of cheaper sovereign financing with PPP benefits of private capital at risk.

4.2 Insights from non-investment work: Advice for Small Business Programme

Support to businesses in the healthcare sector is a significant part of the Bank's SBI ASB programme, both through international advisory (36 approved projects across 18 COOs) and local consultancy work (31 COOs) since 2012. The goals of the ASB work are to support local/regional companies with business advice in specific areas, in order for those companies to thrive and be bankable and contribute to the creation of a vibrant SME sector. International advisory provides management advice to mid-sized companies utilising international consultants; whereas local consultancy works to develop the local SME consulting sector and targets its support primarily to micro and small companies utilising local consultants.

The Updated Approach for Healthcare Services Projects did not specify what the role of the SBI could be in the Bank's approach to healthcare services because it concerned itself with M&S led projects. As discussed above, healthcare services are very rarely referred to in the country strategies and further, SBI strategic priorities do not target specific sector. Therefore, there is very little institutional/strategic guidance or diagnostics, if any, that the SBI's Business Advise could be anchored upon.

International advisory services in the healthcare sector has been generally successful in terms of achieving expected objectives. In the majority of the evaluated projects, EBRD clients managed to realise their original ambitions. These were typically in the form of expanding clinics operations in main urban centres, renovating rehabilitation facilities or introducing new products. Further, three out of five enterprises increased their staff count substantially and the remaining remainder preserved it. Similarly, with one exception, all enterprises managed to increase their market shares with varying degrees.

In the current COVID context, clients' interest to undertake ASB's international advisory services in healthcare sector is sustained, if not increased. This is because private clinics, typically, require to transform their business via introduction of information technologies and digitalization during the pandemic. Concurrently, these elements constitute the core of ASB's on-going delivery in the sector. Accordingly, ASB observes an overall increase in client-in buy-in of its advisory services in healthcare sector. EvD notes that there has been ASB clients that introduced services for remote control and treatment of most prevalent diseases and maintained or increased revenues under pandemic conditions. This is very important because data from 12 low- and middle-income countries demonstrate that the stress is particularly acute for small and medium-sized enterprises in the healthcare sector, such as solo practitioners, small hospitals, labs, and pharmacies, some of which may not survive the crisis without support.[21]

The case of OKI Private Clinic – Azerbaijan

OKI Private Clinic is located in the rural North part of Azerbaijan, Qusar region (population 96,000), approximately 200km away from the capital, Baku and 400km away from Grozny in Russia.

The ASB team started to work with the clinic before the pandemic on marketing and restructuring their medical services portfolio. The client faced with the demanding conditions triggered by the pandemic during the implementation of the advisory services demonstrated increased enthusiasm for innovation as well as transformation. This accelerated the implementation of the advisory services and potentially impacted its reach positively. The client has achieved the following during the pandemic with the support of the advisory services:

- Integrating Primary Health Care with hospital services with an aim to prevent avoidable hospitalisation
- Integrating e-health and remote monitoring/management with in-person patient contacts.
- Addressing the health needs of population in Qusar region through restructuring health care services portfolio
- Community engagement:
    - OKI has established patient committees that inform the management of clinic's services portfolio
    - Education (remote and in person) of patients in management and prevention of chronic diseases and COVID-19

[21] Barbara O'Hanlon and Mark Hellowell. Enabling the private health sector in the national response to COVID-19: Six Current Policy Challenges. Geneva. (2020)

   - Setting up patient schools on lifestyle interventions
   - Sharing existing best practices guidelines and programs for patients
- Continuous medical education (CME) for doctors
- OKI team visited integrated health care organisations in Russia and Netherlands.
- OKI started to operate a commercial training and knowledge centre serving other clinics.
- Focusing on secondary prevention issues that are cost effective and preferable for State Insurance Agency:
   - anticoagulation
   - cardiovascular diseases management (CVRM) and prevention
   - diabetes

E-health care and remote management was proved to be successful way of working during pandemic and contributed to lowering the cost of services with increased effectiveness. Combined with the structuring of the services portfolio and focus on CVRM, the client estimates that the prevalence rate of anticoagulation has been reduced by 50 per cent mainly through prevention of secondary strokes, personalized disease management for diabetes patients and improving lifestyle of patients through better CVRM.

The clinic recently organized an e-conference to share its experience in re-structuring its profile of services as well as introduction of e-health care. The main topics of the conference were as follows:

- OKI's response to the pandemic
- Innovations and transformation within their organisation
- Protocols for e-health and ambulatory services in the light of COVID-19

Private and state clinics, Ministry of Health, State Insurance Agency, EBRD, WHO, WB attended this e-conference.

Lessons from ASB experience

In the early years, ASB's international advisory services were more ad hoc than systematic. This has changed with the recruitment of a sector team leader who designed a structured intervention of international advisory in healthcare services. The core of this programme consists of introduction of information technologies and digitalization in private clinics and small hospitals.

While this structured intervention modality was relatively successfully in supporting the clients before the pandemic, the awareness of small private clinics and hospitals about their need for an urgent transformation has substantially increased when faced by pandemic conditions. Therefore, the international advisory services in healthcare has proven to be relevant during the pandemic as well.

With respect to post-pandemic period, it is unlikely that the health sector will go back to bricks and mortars. However, instead, the current sector trends will continue. Some of these are a move towards preventive activities, expansion of remote monitoring and management, targeted and personalized interventions at the scale with the help of digitalization. ASB clients demonstrated considerable agility in embracing such transformations during the pandemic. Therefore, ASB's current approach to international advisory in health services should be preserved and strengthened in its reach during the post-pandemic period, if possible.

4.3 Insights from an investment project: North Africa Hospitals Co-Investment

In August 2014, the EBRD's Board of Directors approved a co-investment of USD $25 million Creed Healthcare HoldCo. Ltd for 12.5%, the first healthcare investment following the workshop on the Bank's updated approach to healthcare services. **The project was intended to support acquisitions and modernisation to international standards of four private hospitals in Egypt and Tunisia and through this to target affordable high quality healthcare services to the middle income segment in a region historically characterised by a significant undersupply of quality hospital beds.**

The project went ahead and indeed major stakes were acquired in four hospitals in Egypt and Tunisia. The capex investment programme financed new technologies and centralised systems, and specialisation of hospitals in Egypt. The corporate governance changes occurred and with all this, the Tunisian hospitals acquired international accreditation, while the Egyptian ones are reported as underway.

While the investment is currently active, the team are expecting a successful exit, as envisaged before end 2021.

The validation found the following:

1. Reflective of a larger issue, **strategic relevance for this project was limited** to its connections with private sector development and particularly as an equity co-investment, rather than how it might impact the health sector and EBRD ambitions there.
2. The project presented with **good additionality** to the client, both ex ante and during implementation. In particular, during the controversy in the press surrounding the allegation of Abraaj's misuse of investor's funds, Abraaj faced difficulties in securing regulatory approval to acquire the Egyptian hospitals. A letter was signed by the EBRD's MD for SEMED to the Minister of Investment and International Cooperation of Egypt, asking for support in considering the regulatory approvals. Following the receipt of these letters from the EBRD and other co-financiers, DEG and Proparco, the approvals for the pending acquisitions were eventually granted.
3. **Good project structure as a co-investment that served the Bank's institutional capacity development** to invest in a new COO in a non-typical sector. The banking team reports that Abraaj were the driving force behind the value creation plans and that the build-up of knowledge made it possible for the EBRD to confidently proceed with other projects in healthcare in Egypt, such as Andalusia (2018 –OPID 49372) and Humania (Project Elixir, 2019 – OPID 50583) and buy and build platforms like CVC, Greece (2018 – OPID 50042), Cairo Scan/Raylab (2019 – OPID 50896) and Project Cure (2020- OPID 51370).
4. **A successful project in terms of delivering expected project outcomes in corporate governance and quality-assurance standards.** The project has contributed to a successful model of restructuring and created potential for demonstration effect from setting higher standards in medical treatment, though there is little evidence of spillover to the rest of the region. The hospitals are reported to be strongly managed and indeed Cleopatra, one of the Egyptian hospitals, went to a successful IPO.
5. **What is less clear is what the project achieved towards the spirit of its broader health quality related objectives in terms of improved clinical performance and addressing the undersupply of beds. Whether projects are truly making a difference to affordable high**

quality healthcare services is unanswered. This is partly because this type of performance – quality of care/improved clinical performance is not formally targeted or directly tracked through its indicators. This is an issue of relevance of project design and was somewhat discussed at the time of approval - of note, affordability concerns at the time of project approval led to a request captured in the verbatim minutes for an ex-post analysis to understand if the target clients were indeed middle income, but this did not take place.

In an attempt to put this investment experience into context, the EvD team also looked at the available monitoring documentation for other health projects. The monitoring reports tend to detail a project's achieving achievement of certification or improved standards, or expansion of expanding new products/services. Some indicate that the negative regulatory environment hindering hinders the achievement of other expansion goals. Monitoring tends to focus on outputs such as expansion or certification. No project monitoring report looks at more direct health related performance outcomes.

Lessons from Abraaj experience

With this in mind, and taking also from the validation in Annex 3, EvD considers there are some general **lessons for future investment operations**:

1. **Transition monitoring indicators must be appropriate to the EBRD's expected outcomes and corresponding transition ambition**, which itself needs clarifying in relation to health.
2. **Co-investments in new COOs in non-traditional sectors are insight rich** for the Bank's capacity development.

5. Implications of Findings

The evaluation findings indicate four pertinent actions, two of which that would more broadly strengthen the Bank's work in this area and two of which pertain to PPP, overwhelmingly an important product for the Bank in this sphere going forward. These form the evaluation's recommendations.

5.1 Recommendations

1. **Prepare a health sector strategy for discussion with and endorsement by the Board.** This needs to be comprehensive, covering not only healthcare services, but all the health related support products (except for pharma). This should set out the policy that permits the Bank's work, and be accompanied by guidelines for its operationalisation. This should include a section on the transition goals/expected results for the Bank with links to its six transition qualities, and link the sectoral goals to country work. This will also provide a currently lacking record, through minutes, of the Bank's institutional mandate in health

   There is no point in producing a policy alone, as it does not specify the results management approach inherent in any strategy. A strategy provides clarity of intention and will go far to eliminate much of what this evaluation has found to be challenging to date.

2. **Ensure that a transparent, adequately resourced and clearly managed results management system is in place.** It would be valuable specifically to consider:

   i. Augment TOMS so that it facilitates transparent and rule-based transition assessment of projects in the healthcare sector.

   ii. Introduce a sub-dimension under the Resilient ATQ to measure and monitor country-level transition progress in health sector resilience to transition reversals such as public health crises. Consider this sub-dimension in each country diagnostic.

   iii. Ensure that the Annual Transition Performance Report demonstrates the alignment between the EBRD's interventions and SDG3.

3. **As standard practice in PPP engagements, SEI3 should review the capacity of the procuring authority and consider integrating capacity building TA as a condition to further EBRD involvement.** Make EBRD involvement in PPPs conditional on robust due diligence that ensures fiscal management and budgetary affordability considerations of PPP programmes are properly analysed, and the public interest is as well as protected as the interest of the Sponsors and Lenders.

4. **Submit a comprehensive analysis of how PPP design balances public and private interests, how it allocates risks and how it compares to PPP best practice as part of future PPP Board approval.** Additionally, the EBRD has substantial strength and expertise in financial structuring, and the high credibility of the EBRD adds substantial value and security to projects and for other lenders. The EBRD should seek to play a lead role in financial structuring and financing of health sector PPPs, and continue to use its A/B loan structure, as well as to further innovate in local markets. FX exposure because of hard currency lending is a complexity in EBRD countries for PPP projects. Greater attention is required to reduce and better manage FX exposure in PPP projects.

Annex 1 Selected findings on PPP in Turkey

Context of EBRD involvement

- The EBRD played a crucial, lead role in achieving bankable project contracts and bringing eight hospital projects to successful financial close. The EBRD has facilitated substantial financing involvement of international and domestic lenders to these projects, and generally built the enabling conditions for health sector PPP financing. The EBRD hospital financings have included several innovations in the Turkish PPP market. The EBRD has also played the lead role in engagement with the Turkish government to resolve problems encountered during the implementation stage of some hospital projects, acting on behalf of lenders.
- The EBRD became involved as a lender after the structuring and tendering of the hospital PPPs had already been done. The majority of problems encountered (and ultimately requiring years to solve), derive from inadequate general PPP capacity of the Ministry of Health (MOH) and insufficient Transaction Advisory capacity during the original project preparation and tendering stages.
- The use of a framework was beneficial in that it allowed a model financing for hospital PPPs to be developed and then replicated to other projects more efficiently (reduced transaction costs). It also allowed the EBRD's financing activities in the sector to be aligned to the country's health sector (beneficial to both the EBRD and the MOH), and to define complimentary areas or technical assistance support (albeit that the TA identified was not fully implemented in reality). The disadvantage of the framework approach was perversely the effect of one of its advantages, namely that it allowed too many hospital projects to be financed by the EBRD too rapidly. This is relevant as the size and pace of the PPP programme appears to have been too much for the MOH to effectively manage.

PPP model and programme

- The PPP model used is appropriate for hospital facilities and ancillary services. However project contracts drew too directly from UK and Spanish templates, and could have been more tailored to Turkish conditions.
- The size of the hospital PPP programme was too big for MOH to effectively manage, especially at the speed and transaction volume that was attempted (17 hospital PPPs tendered in a short timeframe) and without proper and adequate project preparation, without piloting and adequate transaction advisory capacity.

MOH capacity to prepare and transact PPPs

- The hospital PPPs were the first in the health sector, and were also the first large-scale availability-based PPP projects implemented in Turkey. MOH did not assess the affordability or fiscal impacts of the APs. As no debt assumption was provided, the Ministry of Finance and Treasury (MoFT) was not involved. An alternative to the debt assumption was found by MOH providing a guarantee on termination payments. In this sense the hospital PPPs 'fell through the cracks' of the public financial management system and scrutiny of MoFT, and the MOH was allowed alone to enter into long term availability-based PPP contracts.
- Most of the analyses and assessments that would normally be done by a procuring authority in the stage of PPP project preparation, structuring and development of bid documents for deals of

this nature do not appear to have been done, or were done after tendering and contract award, or were done by other parties than the MOH. This includes:

  - Full business case, including financial model
  - Value for money assessment – qualitative and quantitative
  - Fiscal affordability and budget impact
  - Risk matrix and assessment
  - Market testing of project contracts including with lenders

- One result, and reflecting that the MOH did not appear to have experienced transaction advisors, is that the tendered (and awarded) project contracts and terms were not bankable. Hence awarded projects failed to reach financial close, and this was the basis for the EBRD's initial involvement.
- The EBRD, the World Bank and other donors offered various capacity building and technical assistance support to the MOH. The majority was not utilised, due, inter alia, to frequent senior staff turnover. Of the two areas of EBRD support included in the framework – support with value for money methodologies, and support to build contract management capacity in MOH – only the Value for Money (VfM) support was actually provided.

Achieving bankable PPPs

- After becoming involved in 2013, the EBRD, working with the International Finance Corporation (IFC), was the lead party in amending lenders' direct agreements and PPP contracts ('Implementation Agreement') to achieve bankability. This established an improved model that enabled other awarded hospital PPPs to ultimately achieve financial close.
- The capacity of MOH during the process of improving project bankability is unclear. The adjusted package of contracts and agreements has been described as lender friendly. For example, the AP-indexation formula covering FX risk which was adjusted during this process was overly lender and sponsor beneficial, and has since been amended.

Problems encountered in some projects

- Of the eight EBRD-financed PPP hospitals, four have been constructed and are operating with favourable reports, whereas the other four have experienced significant problems and have been in distress. The problems have principally been caused by:
  - Substantial variations made by MOH before and during construction to the scope and size of hospitals, which in some cases have been implemented by sponsors without formalising the variations
  - The sponsors' financial problems, not usually directly related to the projects, but in some instances involving a sponsor of several EBRD-financed hospitals
  - Problems with EPC contractor capacity and performance
  - Deterioration in macro conditions
- The EBRD has led efforts representing lenders to resolve the problems of distressed projects. MOH has not had sufficient capacity to resolve the issues, however after the MFT became

involved solutions have been developed and are being effected. The major aspect for resolution has been the process of formalising the variations, including passing the relevant legislation.

- The parties' behaviour regarding contracts was a factor in the variation problems encountered. The MOH made substantial variations, which most sponsors began to implement without them being formalised in the contract (which would require adjustments to the relevant AP payments and contract durations). An exception was the Renaissance project where the foreign sponsor insisted on formalising variations. This underlines the need for contracting culture to be considered with PPP contracts.

Structuring and financing

- The PPP projects (after improvements were made to the main contracts, schedules and support contracts during the process to achieve bankability) appear to be well structured, following the UK PFI model, and they have established an initial model applicable to other hospitals. Main risk allocations, such as design, construction and O&M are transferred to the SPC, and where the start of AP payment after contraction and the use of AP penalties for lack of availability enforces SPC performance.
- The sponsors have been able to establish normal SPC structures and to pass risk through to subcontracted EPC and O&M parties, as part of project financings. The EBRD has played a key role, inter alia through its A/B loan structures to both finance the projects and to syndicate substantial additional financing from other international and some domestic parties.
- As the debt is EUR denominated and the AP payments are in Lira from the MOH, the treatment of FX risk has been an issue. During the EBRD/IFC bankability process, the tendered formula was adjusted where the AP was fully indexed quarterly for FX change (the standard in Turkey PPPs was annual indexation), and a provision was added to prevent the AP from ever being adjusted downward. In 2018 the Lira depreciated sharply, and then appreciated somewhat. The quarterly indexing meant the AP immediately rose substantially, and then could not be adjusted downward as the Lira appreciated. This caused a public and Parliamentary push back, leading to the MOH deciding to move the next ten planned hospital PPPs to the public delivery route. The MFT has since adjusted the formula to a more balanced approach, including ceiling and caps, which is being applied to the PPP hospital portfolio.
- A major concern is that the same repayment of equity, debt and profit to sponsors and lenders is made by the MOH in the event of termination for reasons due to either the administration or default, termination or non-performance by the private partner. This is very unusual as it means that sponsors and lenders don't bear any risk related to their own performance and that the fundamental risk allocation sought in a PPP project is not in place.

Lessons for transferability

- The EBRD should ideally start its involvement at an early stage, potentially with a 'health sector PPP diagnostic' or health sector planning support, PPP project identification, preparation and transaction with TA support.
- Where the EBRD enters at a later stage (e.g. at the financing stage), it should undertake a thorough PPP-oriented due diligence of the prior transaction stages.

- The EBRD should always conduct a thorough review of the capacity of the procuring authority to prepare, transact and to manage PPP projects. A robust package of TA support should be provided as condition to further EBRD involvement.
- Where possible, the EBRD should use a framework approach (as opposed to ad hoc projects) in synergy with the country's health sector development programme, building the public (and private) capacity to deliver health facilities via PPPs.
- There are many PPP models suitable for the health sector, which can be explored through a 'health sector PPP diagnostic' at an initial stage in a country.
- Developing health sector PPP models and (contract) standards is useful, but tailoring to local circumstances should always be undertaken.
- The EBRD should ensure that the project risk allocation, and especially the compensation on termination payments, are well structured to achieve performance incentives.
- Availability-based PPP models have specific fiscal management and budgetary affordability considerations, and the EBRD should ensure that these are properly analysed and managed by the public sector.
- Supporting a programmatic PPP approach to PPP is better than ad hoc project support, however the programme needs to be ramped up in a manageable fashion, and the use of pilot transactions is preferable.
- The EBRD has excellent expertise in financial structuring, and should use this to leverage additional finance and innovation around health sector PPP financing. It should especially give attention to how FX exposure in PPP projects can be reduced, eliminated or better managed.
- The EBRD should develop and promote the model of blended public and private finance for health sector PPP projects, by combining sovereign and project finance operations. This model combines the benefits of cheaper sovereign financing with PPP benefits of private capital at risk. The EBRD can have a significant impact on health sectors by further developing and innovating this model.

Annex 2 Assistance to Small Businesses (ASB) – International Advisory

Support to businesses in the healthcare sector[22] is a significant part of the Bank's SBI ASB programme, both through international advisory (36 approved projects across 18 COOs[23]) and local consultancy work (31 COOs) since 2012. The goals of the ASB work are to support local/regional companies with business advice in specific areas, in order for those companies to thrive and be bankable[24]. However, international advisory and local consultancy programmes have different goals and delivery mechanisms. International advisory provides management advice to mid-sized companies utilising international consultants; whereas local consultancy works to develop the local SME consulting sector and targets its support primarily to micro and small companies utilising local consultants.

The Updated Approach for Healthcare Services Projects did not specify what the role of the SBI could be in the Bank's approach to healthcare services and healthcare services are very rarely referred in the country strategies. Therefore, there is very little institutional/strategic guidance, if any, that the SBI's Business Advice could be anchored upon. Consequently, despite the guidance of the Operations Manual of International Advisory, the documentary review of evaluated advisory projects in the healthcare sector failed to identify any reference to the projects' contribution to country strategy objectives.

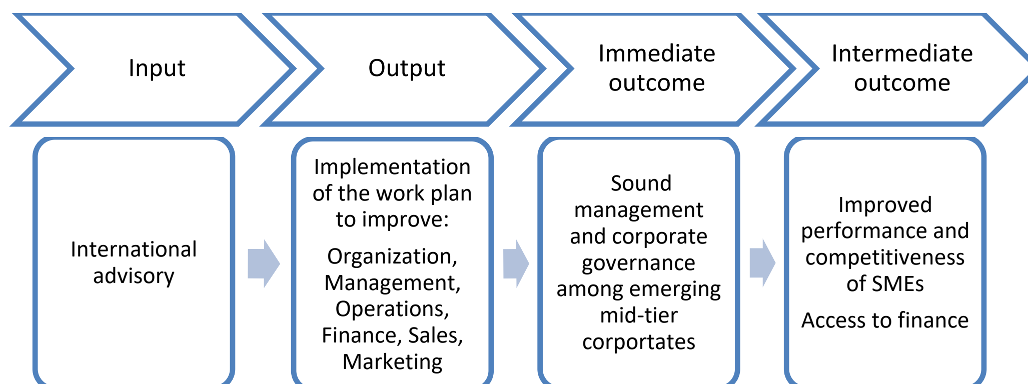
International advisory services in the healthcare sector have been mainly successful in terms of achieving expected objectives. In the majority of the evaluated projects, EBRD clients managed to realise their originally set plans. These were typically based on expanding clinic operations in main urban centres, renovating rehabilitation facilities or introducing new products. Nevertheless, two Bank clients failed to achieve their hospital expansion plans. There is no record of the clients obtaining external financing in the reports from visits a year after the completion of the international advisory projects. **Further, their operations have performed well.** Three out of five enterprises increased their staff count substantially and the remainder preserved it. Similarly, with one exception, all enterprises managed to increase their market shares with varying degrees.

In the current COVID context, clients' interest to undertake ASB's international advisory services in healthcare sector is sustained, if not increased. This is because private clinics, typically, require to transform their business via introduction of information technologies and digitalization during the pandemic. Concurrently, these elements constitute the core of ASB's on-going delivery in the sector. Accordingly, ASB observes an overall increase in client-in buy-in of its advisory services in healthcare sector. EvD notes that there has been ASB clients that introduced services for remote control and treatment of most prevalent diseases and maintained or increased revenues under pandemic conditions. This is very important because data from 12 low- and middle-income countries demonstrate that the stress is particularly acute for small and medium-sized enterprises in the healthcare sector, such as solo practitioners, small hospitals, labs, and pharmacies, some of which may not survive the crisis without support.[25]

[22] As defined by individual OLs in the SBI ASB programme for MIS category Human health activities
[23] The MIS system does not allow access to records pre 2012
[24] As indicated by a combination of the following: improved management skills, increased productivity, turnover, business planning and improved understanding and capability in marketing and design
[25] Barbara O'Hanlon and Mark Hellowell. Enabling the private health sector in the national response to COVID-19: Six Current Policy Challenges. Geneva. (2020)

International advisory in the healthcare sector constitutes the focus of this special study. It is an intensive, 18-month business advisory offer designed for larger, more mature SMEs. It focuses on deploying technical expertise into the enterprise, suitably experienced to tackle any strategic and operational issues. Most projects are designed with healthcare sector expertise, delivered by sector experts with at least 15 years of experience at the forefront of their industry.

Figure 2: A stylised theory of change – International Advisory



Source: EvD elaboration based on the Operations Annual Report of International Advisory. Please see Thematic Evaluation - EBRD Small Business Support Programme (2011-2015) (SS15-087) for a complete theory of change of ASB.

Local consultancy projects are not within the scope of this special study. This is mainly because (i) sector information as reported by the OLs in the ASB database is noisy and challenging to align with the classification used in this study and (ii) the intensity of the duration of each local consultancy project is limited: In essence these are business advisory projects where beneficiary enterprises are connected to local consultants with specific know-how, who can help achieve a narrowly defined short-term objective. For further detail on the scope of evaluation comprising international v local, please contact EvD.

International advisory projects supported these enterprises in designing and executing business plans that could potentially help them reach their ambitious goals. To this end, for each project, the Bank brought together a project team consisting of a team coordinator, a senior industry advisor and one or a few specialists. Under the supervision of the team coordinator the project team interacted with the enterprise for a period ranging between 15 and 34 months. The purpose of this interaction was to implement the work plan that was put in place in the first meeting with the enterprise. This work plan defines the areas of assistance and objectives to be targeted by the project.

Table 3: Ingredients of international advisory projects

Company	Duration (months)	Number of visits	Man days	Committed amount (EUR)	Formal Client Cost-Share (EUR)
Spitali Special Per Rehabilitim	28	11	42	39864	4000
Bayangol Hospital	15	9	52	59999	6000
Tunisian Health Care Centre	22	8	54	34688	15000
Healthy & Happy	34	10	48	46614	5750
Dobra Syla LLC	19	7	56	55993	5600

Source: ASB database, project summary reports

Each work plan is tailored to specifically match the enterprise's needs through the experience and expertise of the project team as well as the relevant EBRD banker. For instance, (i) Tunisian Health Care Centre is in need of *improvements in supply chain management* to strengthen its control over consumption of pharmaceuticals within its operations whereas (ii) Bayangol Hospital needs to *re-structure its top management* and clarify division of labour between medical professionals and managers or (iii) Spitali Special Per Rehabilitim needs to expand the spectrum of products via the introduction of new rehabilitation services.

Still, although the advisory services were bespoke, all projects had four common priority areas:

- **Standardise the product and introduce a quality assurance mechanism:** The advisory project helped the enterprises to improve their working practices; ensure that services meet patients' requirements and are in line with international quality standards. In clinics, enterprises introduced custom developed process maps based on scientific evidence related to diagnostic and therapeutic guidelines. This has formed the basis for the standardisation of services and is a vehicle for improving service quality. The ultimate goal of this effort was to improve (i) output efficiency using existing or new staff or equipment; (ii) adherence to service specifications and quality standards and (iii) quality and design of services. Following these activities the enterprises obtained various quality management certifications:
    - Healthy & Happy > ISO 9001:2015
    - Tunisian Health Care Centre > HAS V2010
    - Bayangol Hospital > ISO 9001:2008
    - Spitali Special Per Rehabilitim > EUROPESPAmed quality certificate

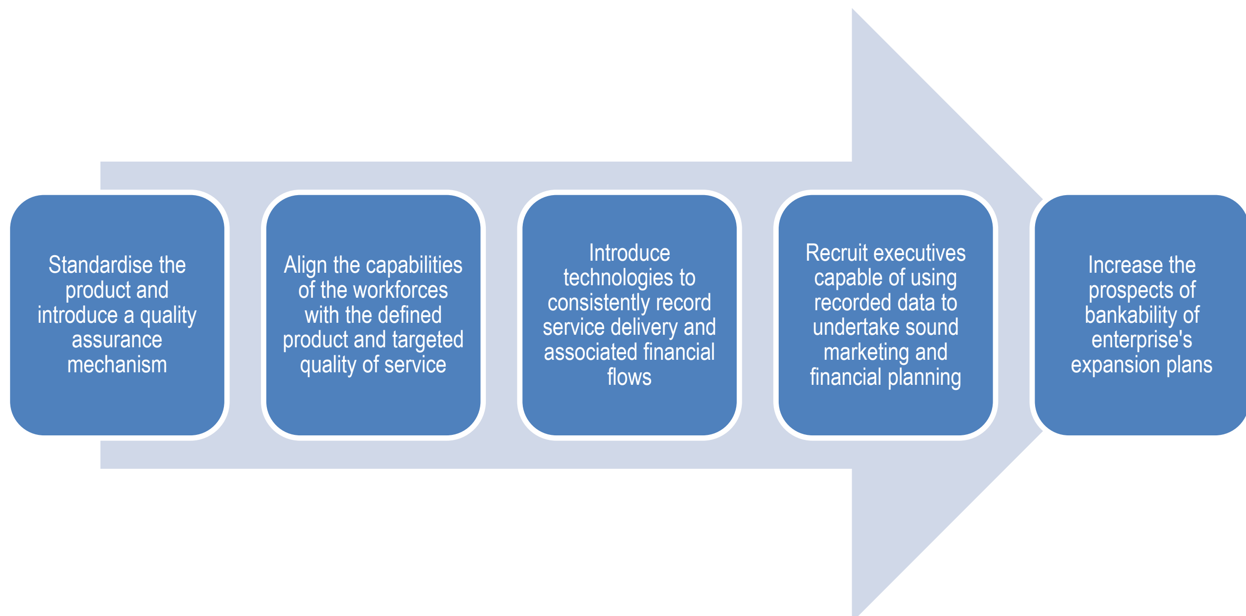
  The Tunisian Health Care Centre and Bayangol Hospital have become the first private hospitals and Spitali Special Per Rehabilitim the first rehabilitation centre in their respective countries to hold an internationally recognised quality management certification.

- **Align the capabilities of the workforces with the defined product and targeted quality of service:** In all of the cases the advisory project helped the enterprises to reform their human resource processes and practices. To this end, the enterprises:
    - brought their human resource management systems into compliance with the requirements of the certifications obtained;
    - introduced competency frameworks and job descriptions;
    - developed performance assessment systems with clear compensation guidelines;
    - developed a human resource management strategy.

- **Introduce technologies to consistently record service delivery and associated financial flows:** In four out of five enterprises the advisory services supported the purchase or development of integrated management information systems (MIS). The digitalisation of recordkeeping has not been uniformly smooth in all enterprises; however all of them managed to put the systems in order, the latest being achieved one year after the completion of the project. This system enabled the managers to record service time and monitor staff availability and link payments to services:
    - Healthy & Happy > Developed an MIS (jointly with a local Ukrainian company) that integrates care pathways, admin, call centre and finance
    - Tunisian Health Care Centre > CliniSys
    - Dobra Syla LLC > Dr Eleks
    - Spitali Special Per Rehabilitim > Introduction of new (unnamed) software linking service time, billing and reception services

- **Recruit senior managers capable of using recorded data to undertake sound marketing and financial planning and increase the bankability prospects of the enterprise's expansion plans:** In four out of five enterprises the advisory services supported the enterprises in seeking and recruiting senior executives.
  - Bayangol Hospital > Establishment of positions of Chief Financial Officer (CFO)
  - Tunisian Health Care Centre > Establishment of positions of CFO and Chief Operating Officer (COO)
  - Dobra Syla LLC > Establishment of positions of COO and Chief Medical Officer
  - Healthy & Happy > Establishment of HR department and head of HR position

Figure 3: Common elements in international advisory interventions in the healthcare sector



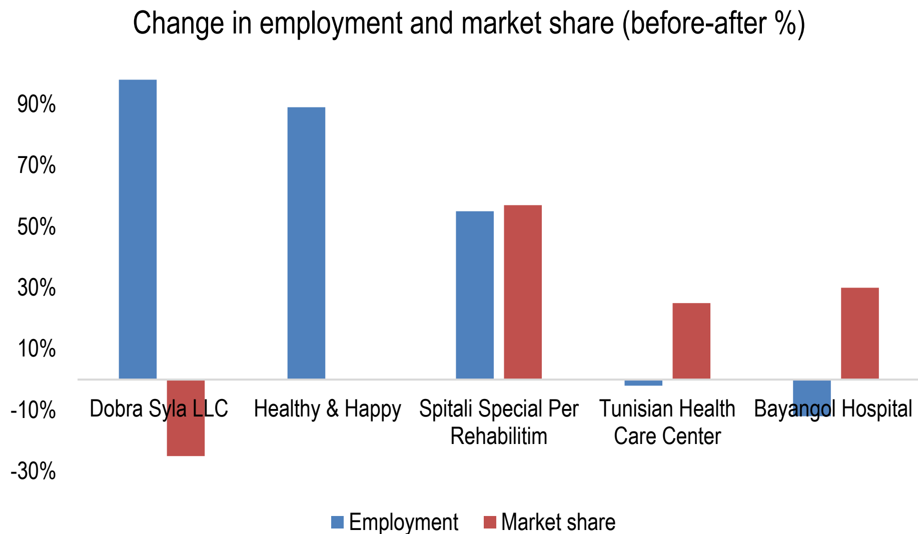
Source: EvD's elaboration from project summary reports; (iii) final handbooks and (iv) one year after visit (self-evaluation) reports.

Has this intervention modality been successful?

This intervention modality has been **partially successful**: Dobra Syla LLC and Spitali Special Per Rehabilitim managed to realise their originally set plans. Dobra Syla LLC spread out its operations in the main urban centres of Ukraine and Spitali Special Per Rehabilitim renovated its facilities and introduced new products. Healthy & Happy could not expand its operations within one year of the report being completed. However, a review of the company's online presence indicates that, later on, Healthy & Happy managed to branch out within Kiev.

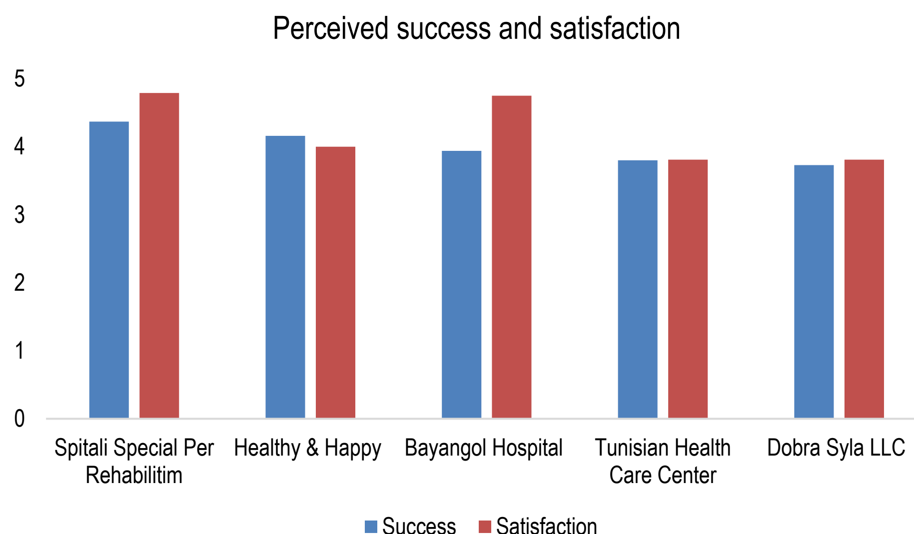
In the case of Tunisian Health Care Centre and Bayangol Hospital, the enterprises are yet to go ahead with their initial plans, i.e. expanding the capacity of their existing services: These enterprises' ultimate goals were to construct new hospitals, adding 200 beds to Tunisian Health Care Centre and 90-100 beds to Bayangol Hospital. To this end, Bayangol Hospital featured briefly in the Bank's pipeline but the project did not materialise. None of the other enterprises have managed to obtain external financing since the completion of the international advisory projects as recorded in reports on follow-up visits, a year after.

Nevertheless, the operations of the enterprises have been successful following the completion of the advisory projects. According to the reports on the follow-up visits, three out of five enterprises increased their staff count and the remainder maintained theirs. Similarly, with the exception of Dobra Syla LLC, all the enterprises managed to increase their market share to varying degrees.



In addition to these measures, the ASB team uses two survey-based metrics to assess the performance of its international advisory projects. These are Success Score and Satisfaction Score. Success Score summarises progress on objectives, improvement in management skills, CEO's perception of success and its prospects. Satisfaction Score, broadly, reflects the perceived satisfaction of the project team and the CEO with the performance of the project. Scores are on a scale from 1-5, ranging from 1/5 Highly Unsatisfactory to 5/5 Highly Successful.

According to these self-assessments, the *success* of the advisory services for Spitali Special Per Rehabilitim and Healthy & Happy are evaluated as above successful and the remainder as above satisfactory. With regards to satisfaction from advisory services, Spitali Special Per Rehabilitim, Healthy & Happy and Bayangol Hospital are evaluated as above successful and the remainder as above satisfactory – while noting that satisfaction scores are meaningfully higher than success scores across the board. Overall, these assessment could be considered as somewhat in alignment with the indicators discussed above, i.e. realisation of originally set plans, employment and market share.



In this context it is important to note that ASB does not select its clients randomly but intentionally targets high growth prospect clients as per the Operations Manual, and considers criteria of commitment to change and ownership of the project on the side of management. Therefore it is not possible to

exactly assess the contribution of international advisory projects to the observed changes. Nevertheless, this documentary review supports the conclusion that the international advisory projects in the healthcare sector add value in terms of performance improvements and the growth of its beneficiaries.

Annex 3 Insights from an investment project: North Africa Hospitals Co-Investment

In August 2014, the EBRD's Board of Directors approved a **co-investment of $25 million with Creed Healthcare HoldCo. Ltd for 12.5%, the first healthcare investment following the introduction of the Bank's updated approach to healthcare services.** The project was **intended to support acquisitions and the modernisation of four private hospitals in Egypt and Tunisia raising them to international standards and through this to target affordable high quality healthcare services for the middle income segment in a region historically characterised by a significant undersupply of quality hospital beds**. The project went ahead and indeed major stakes were acquired in four hospitals in Egypt and Tunisia. The capex investment programme went ahead into new technologies and centralised systems, and the specialisation of hospitals in Egypt also happened. The corporate governance changes occurred and with all this, the Tunisian hospitals acquired international accreditation, while the Egyptian ones are underway. The investment is currently disbursing, with the team expecting a successful exit, as envisaged before end 2021. The validation found the following:

1. Reflective of all health focused investments, below standard *strategic* relevance and issues around the design of 'quality' indicators as well as the project's ability, as designed, to contribute to stated wider health objectives. Affordability concerns at the time of project approval led to a request for an ex-post affordability analysis but this did not take place.
2. Good additionality both ex ante and during implementation. In particular, concurrent to the controversy in the press surrounding Abraaj related to the allegation of its misuse of investors' funds, Abraaj faced difficulties in securing regulatory approval to acquire the Egyptian hospitals. A letter was signed by the EBRD's MD for SEMED (similar to the relevant letters sent by DEG and Proparco) to the Minister of Investment and International Cooperation of Egypt, asking for support in considering the regulatory approvals. Following the receipt of these letters from the EBRD, DEG and Proparco, the approvals for the pending acquisitions were eventually granted.
3. Good project structure as a co-investment that served the Bank's capacity to invest in a new COO in a non-typical sector. The banking team reports that Abraaj was the driving force behind the value creation plans and that the build-up of knowledge made it possible for the EBRD to confidently proceed with new hospitals projects in healthcare in Egypt, such as Andalusia (2018 –OPID 49372) and Humania (Project Elixir, 2019 – OPID 50583) and buy and build platforms like CVC, Greece (2018 – OPID 50042), Cairo Scan/Raylab (2019 – OPID 50896) and Project Cure (2020- OPID 51370).
4. A successful project in terms of delivering expected project outcomes in corporate governance and quality-assurance standards. The project has contributed to a successful model of restructuring and created potential for demonstration effect from setting higher standards in medical treatment, though there is little evidence of spillover to the rest of the region. The hospitals are reported to be strongly managed and indeed Cleopatra, one of the Egyptian hospitals, went to a successful IPO.
5. What is less clear is what the project achieved towards the spirit of its broader health quality related objectives in terms of improved clinical performance and addressing the undersupply of beds. Whether projects are truly making a difference to affordable high quality healthcare services is unanswered. This is partly because this type of performance – quality of

care/improved clinical performance - is not formally targeted or directly tracked through its indicators.

In an attempt to put this investment experience into context, the EvD team also looked at the available monitoring documentation for other health projects. The monitoring reports tend to detail a project's achievement of certification or improved standards, or expanding new products/services. Some indicate that the negative regulatory environment hinders the achievement of other expansion goals. Monitoring tends to focus on outputs such as expansion or certification. No project monitoring report looks at more direct performance outcomes.

Lessons from the Abraaj experience

With this in mind, and taking also from the validation in Annex 3, EvD considers there are some **lessons for future investment operations**:

1. The Shareholders Agreement should cover to the maximum extent all foreseen risks related to possible future shareholders' disagreements. If the shareholders/co-investors into the Healthcare Platform (Creed) all originally invested at the same level, being standalone parties to the Shareholders Agreement, the current situation of disagreement between ANAF II and APEF IV, affecting all co-investors, would have been avoided.
2. Transition monitoring indicators must be appropriate to the EBRD's expected outcomes and corresponding transition ambition, which itself needs clarifying in relation to health.
3. Co-investments in new COOs in non-traditional sectors are rich in insights regarding the Bank's capacity development.

What follows is the DRAFT[26] validation report on Regional: Abraaj North Africa Hospitals Co-Investment BDS14-204.

Executive Summary

Operational Description and overall performance

In August 2014, the EBRD's Board of Directors approved a co-investment of $25 million Creed Healthcare HoldCo. Ltd for 12.5%, alongside Abraaj ($145m), DEG and Proparco (7.5% each).[27] The investment was the first healthcare investment following the introduction of the Bank's updated approach to healthcare services.

The project was intended to support acquisitions and modernisation to international standards of four private hospitals in Egypt and Tunisia and through this to target affordable high quality healthcare services to the middle income segment in a region historically characterised by a significant undersupply of quality hospital beds. At approval, exit was expected within 6 years through (i) sale of NAHHG to a strategic, (ii) IPO of NAHHG or (iii) sale of separate hospitals if attractive opportunity presents itself. The investment is currently active, with the team expecting a successful exit, as envisaged before end 2021.

[26] Comments by management will be collected at the same time as on the general health evaluation.

[27] After the bankruptcy of Abraaj following investigation of misuse of investors' funds in 2018, management rights of its various funds were put up for sale (the project, as a separate entity, was otherwise not affected). APEF IV is currently managed by Actis. ANAF II (where EBRD is also an LP) is currently being managed by Riyada Managers BV – a Dutch fund manager, with the original Abraaj team (namely Ahmed Badreldin, formerly a Partner at Abraaj) behind it.

The OPA rates the project as **excellent** based on standard relevance, outstanding effectiveness and outstanding efficiency, and their view of:

- The successful acquisitions and building of a leading healthcare platform in two countries
- The significant upgrades to medical equipment, medical service offering, and patient service across all hospitals, improving healthcare offering to the Egyptian and Tunisian markets
- The strong brand equity resulting from the above, which has generated strong interest from the market and should allow for a successful exit for the Bank.

EvD validates overall performance as **good**; EvD rates relevance, and effectiveness as standard and efficiency as good. Strategic relevance to the EBRD is limited at best, in the absence of any sector/country strategic direction. Project relevance suffers somewhat from weak benchmarks and a missed opportunity to better contribute to stated healthcare goals; on the other hand, additionality was high and the project was designed well as a co-investment to contribute to higher healthcare quality standards. In the end, the project made a contribution to supporting FDI and equity in the region, co-investing with PE funds and IFIs. Co-investment is reported by the banking team to have benefited the Bank's internal capacity for such projects[28]. For the healthcare sector, the project has contributed to a successful model of restructuring and created potential for demonstration effect from setting higher standards in medical treatment, though there is little evidence of spillover to the rest of the region. The hospitals are reported to be strongly managed and indeed Cleopatra went to IPO. What is less clear is what the project achieved towards the spirit of its broader health quality related objectives in terms of improved clinical performance and addressing the undersupply of beds.

Issues, lessons and recommendations

1. (OPA): If all shareholders / co-investors into the Healthcare Platform (Creed) originally invested all at the same level, being standalone parties to the Shareholders Agreement, the current situation of disagreement between ANAF II and APEF IV, affecting all co-investors, would have been avoided. Shareholders Agreement should cover to the maximum extent all foreseen risks related to possible future shareholders' disagreements.
2. (OPAV): Transition monitoring indicators must be appropriate to the EBRD's expected outcomes and corresponding transition ambition, which itself needs clarifying in relation to health.
3. (OPAV) Co-investments in new COOs in non-traditional sectors are insight rich for the Bank's capacity development.

A. Relevance: Operational description and rationale

A. 1 Was the project relevant to the EBRD's strategy?

As the OPA describes, the project was designed to upgrade the private hospitals to international standards. In addition, the project aimed to support affordable high quality healthcare services to the comprehensive middle income segment in a region characterised by a significant undersupply of quality hospital beds despite a high burden of disease and high availability of trained physicians. The OPA rates the project's strategic relevance as **standard**. EvD concurs.

EBRD strategic documents do not prioritise healthcare. In the absence of any country strategy for Egypt or Tunisia, the Country Assessment would traditionally provide the strategic direction of prioritisation. There are only tenuous links here, mainly via supporting corporate governance improvements in the

28 as indicated by the ability of the Bank to engage and approve several projects in the sector in a new COO following this project

service sector. This was also picked up during project approval discussions. Separately, at the time of approval, this project was presented on the basis that it satisfied requirements of the operational approach to healthcare services projects. The approval documents attempted to present the lines by which the project fulfilled the updated approach guidelines, and the OPA commendably goes through each element of this. At the same time, there remained some concern about the beneficiaries at Board discussion; the Board minutes observe remarks that the project may not necessarily benefit the target group for the aims of the Country Strategy. It was therefore requested to present an affordability analysis ex-post. This never happened.

How did the project design and structure contribute to achieving the expected results?

The OPA rates the design and structure as **standard.** EvD concurs on the **standard** rating and makes observations on the project structure and the adequacy of TIMS benchmarks and other indicators to monitor and measure results.

Without diagnostics within the EBRD, EvD sought to understand the healthcare sector elsewhere (via WBG and external research firms), and concludes that the project was well designed to support private hospitals' standards and systems. As the OPA describes, in Egypt, at the time of the EBRD investment most private hospitals were practitioner-owned and funded, and only few had professional and modern management. It is therefore reasonable to see how the project would contribute to improving this situation.

However, there is little evidence of the goal of supporting beds in the elements of the project - in Egypt the three hospitals operated in Cairo and Giza, where the majority of beds that do exist are. Similarly in Tunisia, both targets were in Tunis. A recent study[29] looking at the challenges in healthcare in Tunisia refer to regional inequalities both in access and quality of healthcare, citing that those in Tunis are of the similar quality to Europe. Further, to the extent those clinics served tourists is a factor in relevance to this transition challenge.

Adequacy of TIMS benchmarks and other indicators to monitor and measure results

The Board document includes only general financial/operational performance and on time implementation as the overall objectives, with corresponding measures of success.

Overall objectives of project	Monitoring benchmarks	Implementation timing
Good financial and operational performance	- Revenue of higher than USD 100m - EBITDA margin higher than 28% - Net Debt / EBITDA within covenant (3.0x)	By end-year 2016 By end-year 2018 Throughout life of investment
On-time project implementation	- Egypt: branding of CMC as "Cleopatra Specialised" - Egypt: Capex investments of min USD 16m - Tunisia: hiring of country-level CFO - Exit: min IRR of 13%	By end-year 2015 By end-year 2016 By end-year 2015 By end-year 2020

EvD considers that, together with TIMS benchmarks, these measures are too general to adequately track whether the project has contributed to its intended objectives.

- Most of the indicators are capable of tracking the EBRD's support acquisitions and modernisation/ upgrade to international standards of four private hospitals in Egypt and Tunisia. However, some are shallow, such as the JCI accreditation. There is no real discussion of the

29 Oxford Business Group 2016

value in the JCI accreditation versus another, perhaps even local, accreditation programme[30], and thus it is unclear to what extent international accreditation goes beyond local standard. Similar in Tunisia, wherein a bid to improve quality care in Tunisia, the government created the National Health Accreditation Authority (Instance Nationale d'Accréditation en Santé, INAS) in 2012. The INAS is tasked with promoting the quality and safety of healthcare services in compliance with the standards of the International Society for Quality in Healthcare. The authority is also in charge of implementing regulations, criteria and procedures for professional practice, granting accreditation to healthcare institutions, assessing the economic impacts of healthcare and diagnostic services, and coordinating between national and international accreditation agencies. There is no mention. Further, if this project is really about upgrading quality standards to international good practice, the ambitiousness of accreditation only targeted to one hospital, is weak.

- Importantly, there are no TI benchmarks relating to targeting affordable high quality healthcare services to the comprehensive middle income segment in a region historically characterised by a significant undersupply of quality hospital beds despite a high burden of disease and high availability of trained physicians. Only indirect systems directed (corporate governance again) indicators exist (KPI system, major equipment upgrade). Even the KPI system is not visible to the team ex-post.
- Further, though co-investment provided an important rationale for the relevance of the project and indeed was a stated expected outcome, there was no target, logic chain or tracking of this stated goal. There is no way of understanding how the project's co-investment structure contributed to achieving the expected results.

Further, safeguarding against negative externalities is weak. For example, the need to make sure private hospitals gain does not result in public hospitals loss, is not looked at all. Cleopatra is helping to enhance the skills of medical staff working for the state hospitals, under the Skill Enhancement Programme with the Egyptian Ministry of Health. Cleopatra is training the state hospitals employees in such areas as (i) standards of care (e.g. JCI), (ii) fundamentals of medical and non-medical function. (iii) health and safety, (iv) standardisation of procedures and introduction of KPIs etc.

A.2 Was the EBRD additional to the project?

The OPA concludes that the project was additional and rates this as **standard**. EvD concurs.

The OPA argues that additionality was strong, stemming from (i) the EBRD's equity financing, given this financing was crucial for the investment programme to be completed smoothly. (ii) the EBRD's ESAP conditionality to attain international accreditation went beyond what other IFIs had required. EvD agrees with these two reasons. The OPA also argues that the EBRD's attributes provided additionality. This was also discussed at Board - The Bank's capacity for regional co-investment in the healthcare sector alongside the private equity fund (in which the Bank is expected to be currently a limited partner), together with two DFIs, will allow this project to take place. However, there was no sign of this taking place.

The OPA discussed political comfort as an additional source of additionality and EvD concurs that in retrospect, the part the EBRD played was important during the crisis with Abraaj.

The EBRD was also highly additional in providing political support to the Healthcare Platform in August 2018, following the controversy in the press surrounding Abraaj related to the allegation of Abraaj's

[30] EvD understands that the government has developed quality accreditation standards for Primary Health Care (PHC) and hospitals based on international guidelines, but adoption has been patchy. Perhaps if these hospitals achieved this as well as other international, it would send a positive signal to others.

misuse of investor's funds. While such allegations were not related to Abraaj North Africa Hospitals Platform, and were not related to the two Abraaj Funds being the majority shareholders in Creed (the investee company for this Platform), Abraaj faced serious difficulties in Egypt with obtaining regulatory approvals for the acquisition of additional hospitals. One acquisition (El Khatib hospital) had funds kept in escrow for 6 months, pending the regulatory approval; the completion of acquisition became uncertain. Abraaj therefore asked for the DFIs help (the EBRD, DEG and Proparco) to voice the support vis-a-vis the Egyptian authorities. A letter was signed by the EBRD's MD for SEMED (similar to the relevant letters sent by DEG and Proparco) to the Minister of Investment and International Cooperation of Egypt, asking for support in considering the regulatory approvals. Following the receipt of these letters from the EBRD, DEG and Proparco, the approvals for the pending acquisitions were eventually granted.

Overall rating of Relevance

EvD concurs with the **standard** rating proposed by the OPA. The following reasons provide justification for such a rating:

- The project had marginal strategic relevance to the EBRD. EvD considers that it is curious that OCE supported the project because it demonstrates a key transition challenge in SEMED, when it is wholly absent from any of the Bank's strategic documents regarding transition and SEMED transition. At the same time, the case for this project's relevance to its COOs was made and the Bank was additional.

B. Effectiveness: What were the project objectives and how effectively were results met?

The achievement of results is assessed using the OECD-DAC criteria of outputs, outcomes and impacts. The OPA rates effectiveness as **outstanding**, based on the project achieving the majority of its intended outputs, outcomes and impacts. EvD rates performance as **good.**

B. 1 Did the project/client achieve its intended outputs (operational objectives)?

EvD rates this as **good**, in line with the OPA. The project was able to achieve on time project implementation in line with expectations. Majority stakes acquired in four hospitals (two in Egypt and two in Tunisia) providing healthcare services to middle income segment, as confirmed per discussions with management on pricing and patient profiles, but no ex post affordability assessment. Most of the ESAP was also implemented, which notably involved capex investments, centralised systems for training medical staff and procurement etc. It is the case that the client remains to report and also to implement HR policies on a country by country basis, but this is a matter of consideration rather than absence of action.

B. 2 Did the project achieve its intended outcomes (expected business results)?

As the OPA described, the project hit all its intended outcomes. Standards were most obviously raised in the hospitals through the value creation plan (purchase of new diagnostic equipment etc.) and corporate governance improvements (independent directors in boards etc.), as well as management upgrades. The OPA was able to show evidence of operational performance as a result of integration efficiencies, via increased revenue/EBITDA and net debt/EBITDA margin in line with the target. The OPA was not able to show evidence of enhanced clinical performance as a result of these changes, except in terms of the introduction of a KPI system and international accreditation that was acquired for the Tunisian hospitals (French HAS). The Egyptian hospitals currently implementing a roadmap to accreditation, though have not yet achieved this.

EvD notes **good** performance but flags that the project was not set up to be able to directly measure whether the outputs contributed to improved clinical performance. With a view of the de facto Bank-funded KPI system, this could have been achieved.

B. 3 To what extent did the project contribute to realised impacts?

EvD rates this as **standard**, while the OPA rates this as **good**.

The project seems to be on track to being a model of successful restructuring and platform for FDI; though the Bank has not yet fully exited, indications are positive. Egyptian hospitals were listed via an IPO on the Cairo stock exchange, where a partial sale of secondary shares provided a significant return of the Bank's capital ($18.75m received as a dividend vs $25m initial investment).

In terms of the intended take up of demonstrated new technologies, the platform is now the largest private sector hospital operator in both Egypt and Tunisia, and is listed in Egypt (with the resulting detailed coverage by and transparency to the market). The results are also sustainable as a professional management team is in place independent of the shareholders. That will provide continuation of these policies. The team reported that other platforms were developed thereafter:

- In Egypt: Alameda has 3 hospitals with 678 total beds, Elaj has 3 hospitals with 470 beds, and Andalusia has 3 hospitals with 98 beds. Cleopatra group currently has 6 hospitals with 782 beds.

- In Tunisia: El Manar has 2 hospitals with 200 beds, and Berges du Lac has 2 hospitals with 180 beds. Taoufik group currently has 4 hospitals with 614 beds.

In terms of the project's contribution to accessible and affordable healthcare and living standards for Egyptian and Tunisian people, affordability analysis is implemented as standard practice in the Bank's M&S Board approved Healthcare projects since the Abraaj hospitals project, although EvD notes that the quality of this analysis is discussed in the wider study on evaluation. The OPA puts forward indications that these hospitals mainly target middle income populations, but there is no separate analysis offered about furthering accessibility or affordability.

At project approval, the following table was submitted as part of the Bank's affordability analysis:

		Patient Profile	Pricing	Catchment Area	Patient Revenue Mix (% rev.)			Co-Pay
					Out-of-Pocket[2]	Public Insurance	Private Insurance	
Egypt	Hospital Cleopatra	A/B Class	Average[1]	Heliopolis (middle/upper income)	45%	0%	55%	Nominal
Egypt	Cairo Medical Center	B/C Class	Below Average	Heliopolis (middle/upper income)	30%	0%	70%	Nominal
Tunisia	Clinique Taoufik	A/B/C Classs	Below Average	Broad	74%	13%	13%	Varies
Tunisia	Clinique Soukra	A/B/C Classs	Below Average	Broad	80%	5%	15%	Varies

[1] Range is wider given some higher profile doctors

[2] This includes insured which pay cash but are reimbursed by the insurers

The only ex post information we have comes from the project approval documents for Project Elixir, rather than any similarly formatted table as that which was presented at Board. We can see from those project approval documents that the pricing for some core out-patient services is more expensive with Cleopatra than the average, though for in-patient it seems relatively lower. The project's banking team does report to EvD that further comfort is provided that the Cleopatra Hospitals strategy in terms of

patient profile has not changed. However, this leaves questions open, not least about the extent to which the affordability analysis presented at Board has changed.

Separate to this, the project approval document of Project Elixir suggests that the public deemed the Cleopatra hospital quality not as good because of the model of non-exclusive medical staff. This therefore also opens questions about whether this project had any impact on public sector – do doctors shift to private now pricing has increased? What does this mean for the quality of staff at those hospitals in which they worked? Likewise in Tunisia, where this is a recognised ongoing problem particularly in remote areas, there is no discussion of how this sectoral challenge might be impacted by the project.

B. 4 Did associated activities such as policy dialogue or donor-funded activities contribute to the achievement of operational objectives or larger outcomes or impact?

N/A

Overall rating of Effectiveness

EvD agrees with the OPA that it is reasonable to assume that the implementation of the value creation plan is linked to some associated improvement in the quality of the service provided but the monitoring of this project does not allow EvD to see what type and extent of associated benefits that is, either in terms of the quality of the service provided or in the access to that service.

Whereas the OPA rates effectiveness as **outstanding**, EvD validates a **standard** rating of effectiveness, largely because it is unable to assess the effectiveness of the project in health quality and access impacts.

C. Efficiency: How well were resources deployed?

C. 1 Did the project and/or client company achieve its projected financial performance?

The acquisitions were completed in-line with use of proceeds (no delays or cost overruns).

Financial performance was very good, although the investment is underperforming according to the latest CRS, due to significant local currency devaluation. Revenue growth in local currencies exceeded FRM expectations significantly: for the Egyptian Cleopatra Group the actual revenue in FY2019 was EGP 1,798m vs EGP 867m, while for the Tunisian Taoufik Group the actual revenue in FY2019 was TND 115m vs TND 112m projected at FRM. The OPA argues that comparison in USD is less relevant due to very significant devaluations to both the EGP and the TND over the Project course (EGP/USD= 7.15 at FRM vs current of 16.27; TND/USD= 1.68 at FRM vs current of 2.86). FX also affected margins across the sector due to the impact of imported equipment and consumables on costs, which were not fully absorbed by the market. Nevertheless, the Company has been able to improve margins through careful cost management and price increases in-line with country inflation and market tendencies. The actual Q1'2020 EBITDA margin on a fully consolidated basis stood at 27%, closely reaching the EBITDA margin in the Project Result Framework (28%). Since the Bank's investment, both Egyptian and Tunisian arms of the Group have grown impressively: Cleopatra Group has grown from 2 hospitals with 316 beds to 6 hospitals with 782 beds. Taoufik Group has grown from 2 hospitals with 266 beds to 4 hospitals with 614 beds.

The latest CRS does not flag concerns, and therefore EvD validates standard.

C. 2 Did the EBRD achieve its intended return?

At approval, exit timeline was in 6 years, i.e. by 2021, with a target IRR of 13%. The Bank has partially exited, recovering 75% of its investment in Q3'2019, via partial sale of shares in the listed Cleopatra Group on the Cairo Stock Exchange (Cleopatra carried out a successful IPO in 2016). The Team

expects successful and complete exit in 2021 above the target IRR. The most likely exit for the entire platform is via rolling Taoufik into Cleopatra (i.e. Cleopatra to acquire Taoufik Group), creating a listed regional hospital platform and then exiting via the sale of Cleopatra shares on the stock exchange.

C. 3 How well did the EBRD execute this project/operation?

The OPA rates Bank handling as **good**. EvD rates it as **good**.

The OPA rates Bank handling strongly, indeed as a positive driving factor in the project performance, with particular reference to pre-signing coordination efforts both across the Bank (with dedicated resources from equity and M&S, as well as OGC) and two other DFIs and a PE fund. This is reported as notable both given a difficult sector and new COO. The OPA reflects that project approval, signing, and disbursement took place quickly enough to allow this equity transaction to take place in a timeframe suitable for the sellers. EvD considers that with any such landmark project, it should be standard to apply such dedicated resources to its preparation. However, the Bank demonstrated wisdom in given the leading role of Abraaj as the experienced sponsor.

The OPA also suggests that the client found the EBRD most active in handling any concerns it had during preparation, though doesn't offer any evidence on this front. Further to this, the OPA notes how the EBRD has been active in monitoring and taking a leading role among the other DFIs (DEG and Proparco). EvD considers that it is reasonable to claim from the available documentation around the interventions taken as a lead DFI during the regulatory concerns in Egypt, that the EBRD had a positive impact on the performance of the project.

Aside from the points raised in the OPA, based on available documentation EvD considers that the project did not benefit greatly from a strong set of TI benchmarks. None were covenanted, and ambition was limited to output based results.

Overall rating of Efficiency

The OPA argues that the Bank's efficiency rating was strong on delivery by the EBRD, strong on financial performance, and strong on achieving the intended return; the Team therefore recommends assigning an **outstanding** rating for the Project. EvD rates efficiency as **good**.

D. Overall performance

D. 1 What was the overall project performance?

The OPA discusses how the success of expansion demonstrates the proof of concept, in which higher quality standards are rolled out through a large number of acquired targets, made possible by the participation of PE funds and institutional investors such as the Bank and other DFIs. The OPA notes that this is very important for EBRD equity investments.

The project's structure as a co-investment brought reported positive internal benefit to the EBRD. Through regular interaction with the Abraaj team covering different aspects of the business, the EBRD team reports that it has accumulated knowledge of conducting business in healthcare sectors in SEMED. Such built-up knowledge is reported to have allowed the Bank to confidently proceed with new hospitals projects in healthcare in Egypt, such as Andalusia (2018 –OPID 49372) and Humania (Project Elixir, 2019 – OPID 50583) and buy and build platforms like CVC, Greece (2018 – OPID 50042), Cairo Scan/Raylab (2019 – OPID 50896) and Project Cure (2020- OPID 51370).

D. 2 How sustainable are the results?

The OPA notes the corporate governance changes that would encourage stability and continuity of policies. At a project level therefore the results appear sustainable. Notwithstanding this, EvD notes that

the latest CRS states that the current regulatory changes are a concern- that Egypt is considering capping max prices for public and private hospital.

E. Lessons

The OPA proposes the following lesson:

1. (OPA): If all shareholders / co-investors into the Healthcare Platform (Creed) originally invested all at the same level, being standalone parties to the Shareholders Agreement, the current situation of disagreement between ANAF II and APEF IV, affecting all co-investors, would have been avoided. Shareholders Agreement should cover to the maximum extent all foreseen risks related to possible future shareholders' disagreements.

EvD agrees and offers two more:

2. (OPAV): Transition monitoring indicators must be appropriate to the EBRD's expected outcomes and corresponding transition ambition, which itself needs clarifying in relation to health.
3. (OPAV) Co-investments in new COOs in non-traditional sectors are insight rich for the Bank's capacity development.

F. EvD comments on the Operation Performance Assessment

The OPA was fairly well written. More insights might have been extracted in the lessons