Mainstreaming Innovative Health Financing Models In Africa

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AFRICA HEALTH BUSINESS

Time to reflect and take healthcare where it's needed the most

Health is a fundamental human right and a key indicator of sustainable development. In recent years, notable progress has been made, but significant challenges remain that hamper the achievement of SDG 3 and stifle improvement in health outcomes. The challenges are well known; Africa accounts for 22% of the global health burden with increase of non-communicable diseases; it lags behind other regions of the world on almost all healthcare indicators and has the lowest ratio of health workers per population. Traditional donor funding on its own cannot meet these challenges; there is a need to attract private capital and national resources to sustainably achieve these objectives.

Innovative health financing models where donor funding can be used to catalyze private sector and national resources provide an opportunity to transform healthcare in Africa. Much work has commenced in the space with health financing mechanisms such as Social Impact Bonds, Volume Guarantees, Results Based Financing Models, Risk Pooling, being tested in Africa and globally.

A key challenge is that many of these innovative health financing models are unable to move from innovation to scale both in coverage and geography. While they have been successful as pilots, it has resulted in more pilots and not enough replications and scale.

Why are we trapped in pilotitis? What will it take for us to move to scale? Is it only about lack of financial resources or is it much more?

It is becoming inevitable that for health financing interventions to be scalable, sustainable and resilient for future generations, infrastructure needs to be cost recovering, value driven and services delivered in partnership with the private sector and catalytic investment. The private sector should not only be considered a funder alone but also a co-implementer of health solutions. Mainstreaming Innovative Health Financing Models in Africa provides a holistic approach based on key internal, external and environmental drivers that will facilitate scale and address the existing barriers to successful replication of such initiatives.

We are optimistic that this paper and its collaborative approach for validation and feedback from a diverse range of stakeholders will yield new insights, ongoing dialogue and opportunity for collaboration across donor, private sector and various governments. We hope that the conceptual framework will provide a new direction and hope to those seeking to scale various health financing models. Finally, we hope that the paper brings in key players from the health-care ecosystem to form a working group to create an action plan to achieve the scaling of some of the innovative health financing models. This is our chance to ensure that the innovative models are no longer looked upon as innovations but as the new mainstream and new normal. Africa has the potential and opportunity to lead the health financing sustainability and demonstrate the potential of health financing.

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Intellecap

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Africa Health Business is an African health consultancy company with the aim of changing the business of health across Africa. AHB provide specialised knowledge, expertise and support allowing our partners to operate effectively and make sound decisions in today's rapidly evolving health sector. AHB's team includes experts with direct experience working with the African public and private health sector, civil society, academia, and development agencies. AHB is committed to co-creating tailored local solutions with the potential to change the trajectory of health across the African continent through specialised knowledge, expertise and support.

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SETTING THE CONTEXT

OVERVIEW OF HEALTHCARE VALUE CHAIN IN AFRICA

Health is increasingly recognized as a key aspect of human and economic development in Africa and countries are continually focusing on actions and reforms to improve health outcomes and accelerate progress towards achieving Sustainable Development Goal (SDG) 3 that seeks to promote universal health coverage (UHC) by 2030. UHC is achieved when everyone has access to quality healthcare without experiencing financial hardship. Additionally, most African countries recognize the right to health in their national constitutions.

The healthcare value chain in Africa however, continues to face a myriad of challenges that hamper achievement of SDG 3 and stifle improvement in health outcomes but that at the same time, present opportunities for growth. Africa, home to 17 percent of the world's population – accounts for 22 percent of the total global disease burden. The continent continues to face a double burden of the traditional persisting health challenges (communicable) and emerging health challenges (non-communicable). Additionally, health indicators like life expectancy, maternal and infant mortality rates remain worse than most low-income and middle-income countries in other parts of the world. Low levels of research and development, low per capita income, limited capacity for domestic revenue mobilization, lack of an enabling environment and systemic level supply chain bottlenecks complicate governments' abilities to respond effectively to the health challenges in African countries.

	Africa	South East Asia	Global
Life expectancy at birth	61.2 years	69.5 years	72.0 years
Maternal mortality (100,000 births)	542	164	216
Under five mortality (1,000 births)	76.5	37.9	40.5

There exist inadequacies, inefficiencies and unmet needs across the healthcare lifecycle from initial research to service delivery to overarching health systems in Africa. It is critical to understand these challenges and gaps to identify potential intervention opportunities for better healthcare. The key stages of healthcare lifecycle and their associated challenges are described below:

[1]*Global Health and Human Rights Database – lists constitutions from 18 African countries. Accessible here.*
[2]*World Bank Development Indicators. Accessible here.*
[3]*Institute for Health Metrics and Evaluation (IHME). Accessible here.*
[4]*World Health Organisation /Africa Health Observatory. Accessible here.*

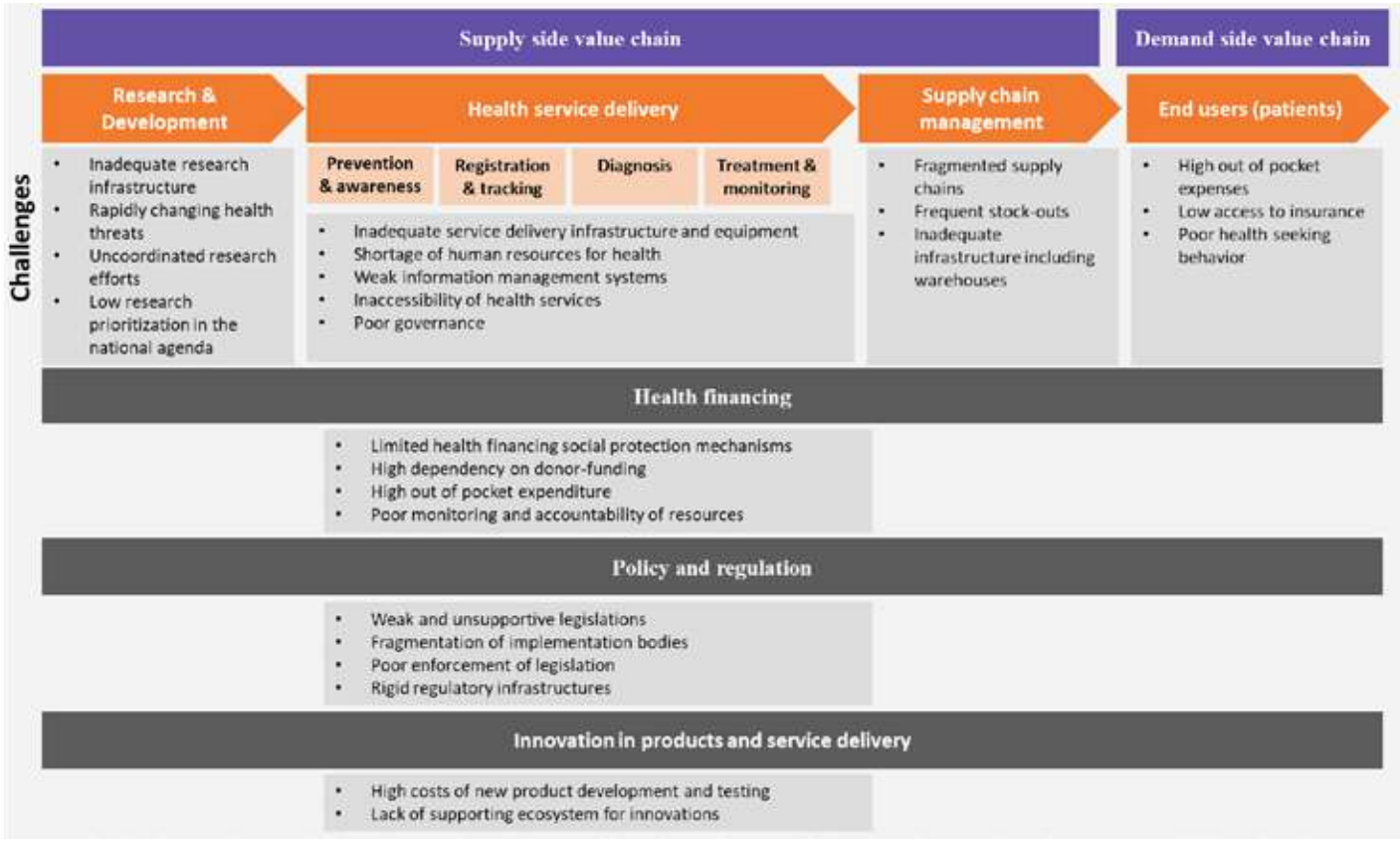


Figure 1: Healthcare Lifecycle & Challenges in Africa

- **Research and development:** R&D is a crucial component of the value chain, as it gives rise to innovative products to combat the increasing and changing health threats. The state of health research in Africa is very weak; while Africa carries 22% of the global disease burden it only produces 2% of the global research output. This is attributed to the lack of adequate health researchers in the region and limited financial support towards health research. There exists an unmet need to invest in research capacity, and this will be a key component in creating contextualized solutions and promoting evidence-based decision making by policy makers and other health stakeholders.
- **Health service delivery:** Relative to population needs, the health infrastructure and skilled health professionals in Africa are insufficient, resulting in poor quality and coverage of health services. Africa has the lowest number of health workers per 1,000 people with a shortage of 6 million health workers predicted by 2030. There are only 2.3 doctors per 1,000 people in Africa, less than one tenth of the figure in Europe and less than half the figure in South-East Asia. Approximately 65,000 African-born physicians and 70,000 African-born professional nurses were working overseas in a developed country in the year 2000. This represents about one fifth of African-born physicians in the world, and about one tenth of African-born professional nurses. Further, weak information systems hinder development of data and information-backed policies. The high opportunity cost to access health services, makes them inaccessible for low-income communities. Amidst all these challenges, however, are vast opportunities. For

[5] *Lancet Commission – The path to longer and healthier lives for Africans by 2030, 2017. Accessible here*
[6] *http://www.intellecap.com/imagine-the-future/africa/*

example, Africa has seen growth in the middle-income class that is capable of paying for access to quality and assured health services. Africa's youthful population is large and growing; with the right skills development and training, this group could bridge the human resources deficit in the sector. The increased recognition and uptake of technology is also key in enhancing health services delivery, e.g. through tele-medicine.

- **Supply chain management:** Various health supply chain systems in Africa include public, private and faith-based systems. High rates of fragmentation in the distribution chain prevent drugs from achieving the scale required to obtain optimal efficiency. Inefficiencies in supply chain often result in frequent stock-outs of essential medicines and the inadequate levels of regulations have led to increased flow of counterfeit and substandard drugs in the region. Digital technologies that enable efficient tracking and provision of drugs, however, are emerging as an effective way to manage the health supply chain in Africa.
- **End users (patients):** The biggest challenges facing the demand side of the value chain are high out-of-pocket expenditure and low income levels. A significant proportion of the population in Africa is pushed into poverty every year because of medical costs. While some countries have introduced mandatory insurance, the informal nature of many African economies limits the collection of premiums. Technology is playing a big role in solving this by enabling development of health micro-insurance products, easing the collection process and reducing the administrative costs associate with the reimbursement and service delivery process.
- **Health financing:** Sustainable health financing is required to solve most of the health challenges facing the region in a bid to achieve the targets set out under SDG 3. African countries however, continue to face limitations and challenges in the mobilization of funds for health. Low government budgetary allocation, reducing donor funding and low levels of health insurance penetration not only lead to high out of pocket expenditure but also limit accessibility and availability of critical health services. Innovative health financing that leverages public, private and donor partnerships is, thus, key in moving Africa forward on the path to UHC.

Innovative health financing *is an emerging approach to funding health interventions, through pooling of funds from different sources. Some of the common innovative financing mechanisms in Africa include; volume guarantees, micro-health insurance, and public private partnerships.*

- **Policy and regulations:** Effective healthcare policy and regulation implementation in the region is often hampered by limited institutional capacity and a lack of harmonization of regulations. Only 7% of the African countries have moderately developed capacity for medicines regulation with more than 90% having minimal or no capacity. Further the regulatory processes are cumbersome and time consuming which frustrates the efforts of medical products and service providers. A typical lag of 4-7 years between first regulatory application for medical drugs and equipment and approval in Africa. This drives up costs and limits availability of medical products and services to the patients. Identifying this challenge, the World Health Organisation (WHO) has been working with African governments to harmonize regulatory standards across countries with the objective of sharing the costs of regulatory work and thus expedite the approval of life saving medical products. Some countries like Tanzania where high user fees is common, there are exemption mechanisms for reproductive and child health services, chronic illnesses and epidemic diseases and for the poor which is built into their health policy framework thus ensuring affordability of these services if the policy is properly implemented.

[7] *Medicines Regulation in Africa: Current State and Opportunities, 2017. Accessible here*

- **Innovations in products and service delivery:** Information and communications technology present immense opportunities to address some of the healthcare challenges facing the region through innovations in product development and service delivery. Health care innovators have taken advantage of the growing mobile and internet penetration to deliver solutions like telemedicine, point-of-care diagnostics, screening services and access to health insurance. In Kenya, for example, most innovators have leveraged the high penetration of m-pesa to develop and deliver innovative health products. These innovative solutions are playing an important role in increasing access, affordability and quality of healthcare services. However, these innovations have faced scalability and sustainability challenges as a result of lack of adequate financing and mentorship support, with some of them unable to move past the pilot stage.

GROWING IMPORTANCE OF HEALTH FINANCING

The Sustainable Development Goals present ambitious plans for universal health coverage, the attainment of which requires considerable financial investment and, thus, the high need for strong health financing systems. The current level of healthcare financing in Africa is not sufficient to meet the scale and ambition of the SDGs and the African governments continue to face fundamental health financing challenges in the area. The question on how to raise the necessary funds, how to maintain financial risk protection and how to ensure efficient use remains unclear for most of the African countries.

> ***Health financing*** *involves not only methods of raising and accumulating funds but also ensuring financial protection and efficient allocation of the funds to cover the health needs of the population.*

Many African countries have undertaken a host of reforms touching on the various health financing functions with the core objective to increase health coverage and financial protection. Common among them being elimination of user fees, introduction of mandatory insurance, and value added tax and special levies for purposes of health. For example, in Sierra Leone, a clause has been included in the Finance Act 2016 that states: 'A national health insurance levy shall be imposed at a rate of 0.5% on the value of all contracts relating to the supply of goods and services in support of the Free Health Care Programme'. This is a president's flagship program that was launched in 2010 with the aim of removing user fees for maternal and child health services. In 2009, Gabon also introduced new taxes in 2009 to raise additional funds to subsidize health care for low income groups. Of these, one was a money transfer tax of 1.5% and another was 10% tax on mobile phone operators in the country. The two taxes raised an equivalent of US$ 30 million for health in 2009 which were used to improve healthcare access for the poor. While increased health spending has been observed across African countries, most of the health indicators remain low, which raises questions about how effectively the funds are being utilized. Thus, health financing reforms need to not only focus on mobilizing funds but should also ensure efficient utilization of the same. Additionally, sustainable health financing requires a shift from over dependency on external donor funds to an increase in internal resource mobilization. Also, the external donor funding should be utilized as "catalytic capital" to drive in more private / domestic funding / investments in the sector and interventions.

[8] *Medicines Regulation in Africa: Current State and Opportunities, 2017. Accessible here*

The shift towards sustainability is giving rise to innovative, non-traditional forms of health financing. Such innovations include conditional and catalytic financing from external financiers, impact investments and public-private partnerships arrangements. Innovative health financing has the potential to tap into trillions of dollars available through private sources of capital as well as the way that it leverages private-sector expertise and business solutions to tackle development problems. It can employ mechanisms like challenges and prizes, volume guarantees, Small & Medium Enterprise and trade finance, impact bonds and investment funds.

UNDERSTANDING AFFORDABILITY AND UNIVERSAL HEALTH COVERAGE

One of the key dimensions of UHC is financial protection that requires self-sustaining health systems that will reduce the out of pocket expenditure of the end consumer. Thus, UHC seeks to ensure that even poor and vulnerable groups are able to access quality healthcare services when the need arises.

> ***Universal health coverage (UHC) means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.***
>
> ***World Health Organisation (WHO), 2013***

Affordability of health services remains a significant prerequisite and one of the primary hindrances to the attainment of UHC. Forty-three percent of Africa's population is poor, living on less than $1.9 a day, and depend largely on out-of-pocket expenditure for financing health. This is a vicious circle that ultimately pushes them further into poverty and hinders them from accessing health services. Mechanisms for financing health services to ensure affordability and to prevent people from suffering financial hardships are critical for the success of UHC. The success of the interventions will be based on their ability to promote and integrate equity in health interventions. Equity requires the distribution of the burden of health financing based on individual's ability to pay, such as where a government finances the health needs of all poor and vulnerable groups and there is mandatory insurance contribution for all employed people.

How can we make healthcare in Africa more equitable?

[9] *Global Health and Human Rights Database – lists constitutions from 18 African countries. Accessible here.*

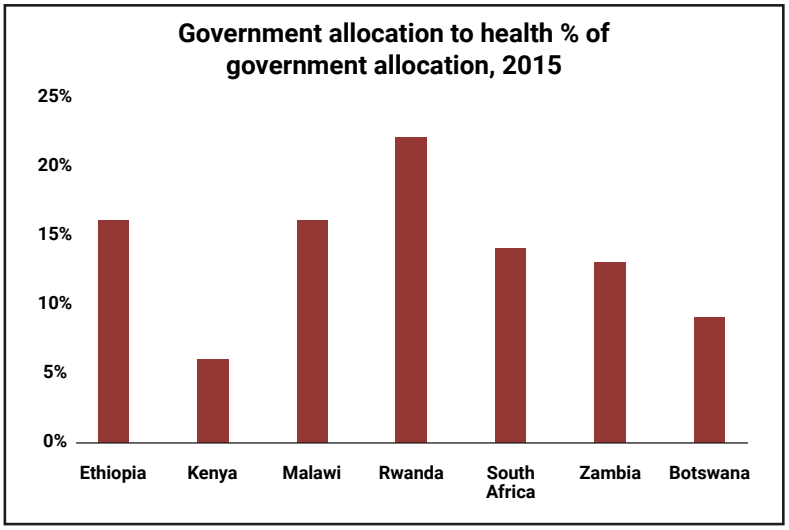
KEY CHALLENGES IN HEALTH FINANCING

LEVEL OF HEALTH EXPENDITURE IN AFRICAN COUNTRIES

Health funding across African countries originate and flow through several sources and mechanisms, including government, donors, households and NGOs. The average total health spending in Africa has been 6% of the Gross Domestic Product (GDP) over the past decade, with higher levels recorded in Liberia (15%), Zimbabwe (10.3%), Sierra Leon (18%), Namibia (8.9%), Malawi (9.3%) and Burundi (8.2%). Although the region's health per capita average ($115)8 is higher than the minimum ($44) recommended by the 2009 High Level Task Force on Innovative International Financing for Health Systems, large disparities exists across countries, ranging between $16 and $506, with 42% of African countries are still below the recommended minimum. Nonetheless, the region has made good progress in the mobilization of funds for the sector, as depicted by the growing health expenditure per capita. Health indicators across African countries have, however, not shown much improvement, raising the question on how efficiently the resources are being utilized.

General government expenditure on health

Public health financing has become a priority in the political and development agendas of most African governments. In 2001, African leaders met in Abuja and pledged to allocate 15% of their government budget to the health sector with the objective of improving access to quality and affordable healthcare. This was an important step for many governments to orient their health financing reforms and mobilize more monies for health. Years after the Abuja Declaration, Africa as a whole is still far from achieving this target, with a regional average of 7% over the last decade and over 60% of the countries still allocating less than 10% to health. The informal structure of many African economies and the limited capacity of the governments to raise, manage and account for public funds have stifled the achievement of the targets. However, government spending still accounts for the highest proportion (34%) of health funding.



[10] *WHO – Global Health Expenditure Database. Accessible here.*
[11] *World Bank Development Indicators Database. Accessible here*

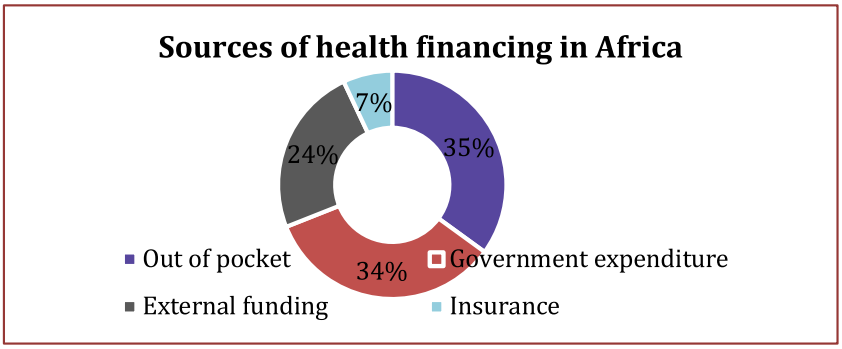
External (Donor) funding on health

The reliance on donor funding for health in Africa has been on the rise, with external funding contributions to health increasing from 13% to 24% over the last decade. In most African countries, donor funding is less than 20%. Some countries like Uganda and Malawi, however report more than 40% of their total health expenditure comes from donor funding in health. This reliance leads to instability in the health systems, especially given the unpredictability and volatility of external funding. External sources of funds should ideally play a catalytic role and the bulk of health funding should be mobilized from domestic sources. Most of these donor-driven finance interventions adopt traditional vertical strategies targeting one specific disease (example: focus on malaria, tuberculosis, maternal and child care and HIV/AIDs) and providing support for rapidly reducing the incidence and ultimately prevalence of that disease are necessary, but do not address the full scope of health issues faced by African countries. Some of the common programs include Global Fund, GAVI, and President's Emergency Plan for AIDS Relief (PEPFAR).

Out of pocket expenditure (OOPE)

Most Africans still depend on out-of-pocket payments for health services. This includes user fees at public sector facilities, as well as direct payments to private providers. OOPE currently accounts for 35% of total health expenditure in the region, with more than three-quarters of African countries spending more than 20%9 on OOPE. The high OOPE is a big concern for most African countries and many countries, including Ghana, Uganda, Burundi and Zambia, have key initiatives that are aimed at controlling or reducing it. The common initiatives include abolition of user fees and fee exemption policies for essential health services like maternal, child and reproductive health, as well as the introduction of health insurance.

Insurance financing



Health insurance is slowly gaining popularity as a health financing option across the African countries. Insurance spreads out health costs over time using a prepayment mechanism and mutualises risk thus helping avoid catastrophic health expenditure (CHE). Kenya, Ghana, Gabon, Tanzania and Togo are some of the African countries that have set up mandatory health insurance funds for the formal sector financed with contributions from employees and employers. Additionally, voluntary community based health insurance (CBHI) and private insurance schemes exists in some countries. Coverage of health insurance however, remains very low with both mandatory and social insurance schemes contributing only 7% of total health expenditure.

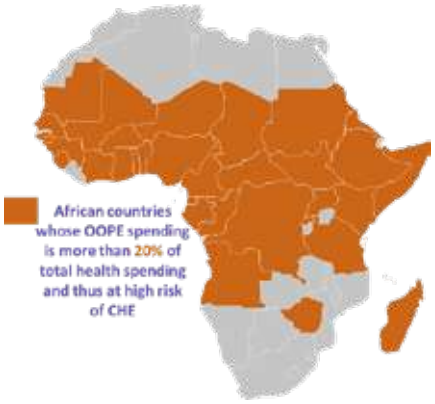
DEMOGRAPHIC PROFILE OF THOSE MOST AFFECTED BY HIGH OUT OF POCKET EXPENDITURE (OOPE) IN AFRICA

Across Africa, studies have established that OOPE is higher for older individuals, women and the more educated segment of the population. Specifically, individuals aged 65 years and above are more likely to have higher OOPE compared to younger age groups. This could be linked to the higher health needs associated with this group as a result of multiple chronic illnesses. The educated population is more likely to seek treatment from a health facility than the uneducated counterparts, increasing their OOPE. Higher OOPE among women can be attributed to their reproductive, maternal and child care needs and, while key donor and government programs across African countries focus on reproductive, maternal and child health (RMCH+A), a significant gap still exist.

High absolute OOPE has also been observed among the wealthier population in Africa. This is due to the high demand of quality health services among this population, who thus often seek health services from private and specialized health facilities, which are more-costly. Health seeking behavior is also high among this group. On the other hand, a significantly higher proportion of OOPE to total or non-food household spending is observed across the poor population. This is attributed not only to the low-income levels, but also to the low health seeking behavior among the poor.

HIGH OOPE AND ITS RELATION WITH POVERTY

OOPE is a policy concern because of its regressive nature and negative impacts on equity, access, use of health services and household CHE. All these factors contribute to increased poverty on the continent. High out-of-pocket payments mean that unpredictable illnesses can be financially devastating, diminishing overall health and negatively impacting the economic wellbeing of households. CHE remains low in countries where out-of-pocket expenditure is less than 20% of the total health expenditure and few households are shown to be impoverished in such countries. In Africa, more than 70% of the countries face incidences of high CHE and impoverishment, so it is no surprise that high levels of poverty are witnessed in these countries. Also, Africa has the fastest increase in population facing catastrophic payments (an annual average of 5.9%).



Most of the African population lives below the poverty line and bears the greatest burden of CHE, competing with other basic needs such as food, shelter and clothing. Even relatively small expenditures in health can be financially disastrous for poor households who often end up not using healthcare services when the need arises.

Catastrophic health expenditure (CHE) *occurs when OOPE for health services consume a large proportion of a household's income with the consequence that households suffer the burden of disease. A household is said to be* ***impoverished*** *when health-care expenditure has caused it to drop below the poverty line. The incidence of CHE is reported on the basis of the OOPE exceeding 10% of household total expenditure or 40% of household's non-food expenditure.*

[12] *USAID – Levels and determinants of OOPE in selected African countries, 2016*
[13] *WHO Africa Region Atlas, 2014. Accessible here.*
[14] *WHO – Tracking universal health coverage, 2017. Accessible here*

KEY HEALTH FINANCING CHALLENGES ACROSS THE VALUE CHAIN

- **Limited public resources and the need to protect and increase government spending in health.** Many African countries lack the capacity to raise public revenue, mainly due to the informal nature of the economies, which makes tax collection difficult. As a result, countries often fall into a budget deficit, with limited public resources competing for many different needs. Additionally, the inadequacy in accountability and administration of tax systems further suppress public revenue. In recent years, this has led to reallocation of public budgets and reduction in public health financing in countries like Tanzania, Zambia and Botswana. This challenge can be addressed by the introduction of alternative revenue collection mechanisms specifically for health like a "sin tax" on things like alcohol and tobacco, levies on large profitable businesses, taxes on unhealthy foods and special levies on value added taxes. Ghana, Gabon, Guinea and Zimbabwe are some of the African countries that have adopted such mechanisms for public health financing. For example, In Ghana, a "health insurance levy" is collected through which 2.5 percentage points of the total 17.5% VAT is earmarked for the NHIS (National Health Insurance Fund). In South Africa, 14% of the consolidated budget is earmarked for various social security funds including those linked to health emergencies like road accidents etc.
- **Ineffective governance, inadequate regulatory mechanisms and lack of institutional capacity, resulting in poor health coverage, financing and service delivery.** Lack of transparency and accountability of funds, both at the national and health service delivery levels, continue to frustrate efforts to improve access to health. Funds are frequently not used for their intended purpose, with corruption emerging as a key challenge. In other cases, patients are asked to pay for services even when fees have been abolished. This also leads to a decrease in quality of services with inadequate staff and shortages of essential drugs at the facility level. Introduction of performance based financing in healthcare, as was done in Burundi, is a way of enhancing accountability, as it links financing to mutually agreed performance outcomes and results.
- **High OOPE negatively impacts on equity, access, and use of health services.** High OOPE and, in particular, catastrophic expenditure can be linked to high poverty levels. Across Africa, OOPE is mainly incurred by the poor and sick, which further worsens living conditions. Abolition of user fees and introduction of fee exemption mechanisms, as has been witnessed in countries like Uganda, Kenya, Burundi, Burkina Faso, Niger and Sierra Leone, have the potential to reduce OOPE.
- **Health insurance design and the challenge of expanding coverage to the informal sector, which include the poor and vulnerable.** While health insurance has significant potential, it faces limitations and challenges in coverage, adoption, utilization and reaching the last mile. While CBHI has been used as a financial protection tool for the informal sector, there are still limitations in the scope of services provided as well as sustainability, due to the voluntary nature of the schemes. Health insurance coverage can be expanded by using non-contributory revenues like taxes, state subsidies and public budget transfers. In Kenya, for example, one of the county governments (Makueni) has provided a subsidized insurance program for its residents with an annual premium of only USD 5 compared to the national insurance premium of USD 60. Inclusive and structured schemes like the Rwanda system can also be considered.

Rwanda community health insurance scheme:

To extend coverage to all Rwandans, the government launched the CBHI in 1999. CBHI schemes are regulated and require that every person not insured by any other health insurance scheme must join a CBHI, thereby making affiliation to CBHI mandatory. The annual contributions are based on a three-tiered premium scaling system, which further divides members into six categories based on income and assets. The government fully subsidizes the contribution of the two poorest and most vulnerable categories; the two middle categories pay $3.4 while the two highest groups pay $7.9. More than 60% of the funding is covered by contributions and the government accounts for 14% of the funds financed through the national budget. This has seen an increase in coverage, with more than 90% of the population now covered by insurance.

Source: *Ministry of Health Rwanda, International Labour Organisation (ILO)* - Rwanda: Progress towards Universal Health Coverage, 2016

- High dependency on unpredictable external funding makes health systems financing unstable and, therefore, ineffective in supporting long-term, sustainable health plans. A number of health projects in Africa are funded by development institutions, including USAID, World Bank, AFDB, GIZ and the Bill and Melinda Gates Foundation (BMGF). External funding accounts for a significant proportion of the total health budget in some African countries, including Uganda, Malawi and Liberia. External funding priorities, however, are frequently not aligned or harmonized with government plans. This then can lead to inefficiencies where external funding creates parallel funding channels and duplicates management and procurement units. Establishment of a common coordination mechanism for donor input would enhance economies of scale and reduce inefficiencies. For example, Benin and the Democratic Republic of Congo (DRC) have created systems of pooled procurement of medicines.

UNDERSTANDING HEALTH FINANCING STRUCTURES

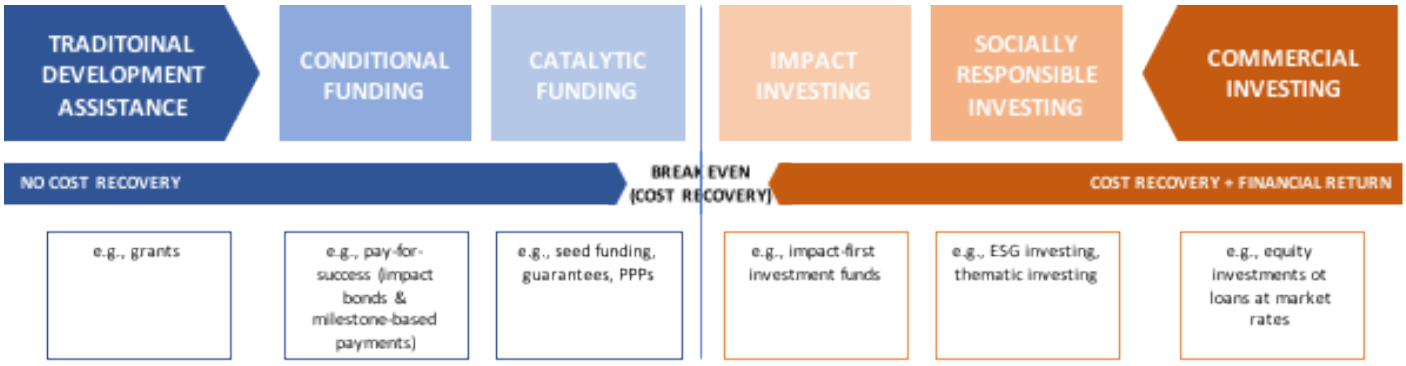


Figure 2: The Financing Spectrum

Traditional development assistance is taking new forms and instances of supplementing traditional grant-based financing with new forms of conditional & catalytic support has emerged as a preferred option for investors and funders. There is a growing consensus that with pure grant opportunity, sustainability of business cannot be ensured. Also, at the other end of the spectrum is commercial capital, which results in Real return vs Expected return mismatch for social enterprises and businesses. Donors, governments, private and philanthropic funders are transacting across an increasingly diverse financial landscape. There is a growing consensus about need for returnable social capital to be integrated in the development landscape for better accountability and long-term sustainability.

Returnable Social Capital refer to loans, equities, guarantees and other similar financial instruments beyond grant . However, it should be noted that these interventions and mechanisms are complementary and supplementary to public healthcare investments and interventions. Some of the potential innovative health financing mechanisms / structures are as below:

1. **Social Impact Bond:** To achieve a specific impact, social impact bond collaborates with the government agency to pay for improved social outcomes that eventually result in public sector savings. The Utkrisht Impact Bond in Rajasthan, India developed by Merck for Mothers, USAID, the UBS Optimus Foundation and the Hindustan Latex Family Planning Promotion Trust (HLFPPT), was launched in 2017. The Utkrisht Impact Bond will enable financial assistance for 440 small healthcare organisations to improve the quality of maternal and child care in Rajasthan's hospitals and adhere to the government's quality standards.
2. **Result based Financing:** Grant funding that is disbursed to recipients if and when pre-determined outputs or outcomes are achieved. In Zambia, studies showed an increase in coverage of institutional deliveries in districts with performance-based financing and districts with input-based financing. Such models result in greater accountability, increased efficiency and enable a drive towards equitable healthcare over a period of time.

[15] *As mentioned in the 'The Future of UK Development Co-operation: Phase 1: Development Finance - International Development Committee' report*
[16] *https://www.usaid.gov/cii/indiadib*
[17] *http://siteresources.worldbank.org/INTAFRICA/Resources/AHF-results-based-financing.pdf*

3. **Blended Fund with Flexible Repayment Terms:** Grant and non-grant (debt) funding is blended and provided as debt with flexible repayment options to the social enterprises. By adding returnable capital models to their modus operandi, foundations can a) help social entrepreneurs and other innovators bridge the "missing middle" financing gap; and b) create revolving funds where the same money can be invested repeatedly over the years, thereby increasing capital efficiency and social impact. The Bill & Melinda Gates Foundation invested US$10 million to acquire a stake in Liquidia Technologies, a biotechnology company working on new ways to deliver vaccines.

4. **Guarantee:** Partial protection to lenders willing to extend loans to development sectors. BMGF provided a guarantee to Clinton Health Access Initiative (CHAI) to structure volume guarantees to reduce the price and increase access to life-saving commodities in the developing world. To increase supply and lower the price of contraceptive implants, the Gates Foundation offered Merck & Co., Inc. and Bayer a sales volume guarantee of double the current demand over a six-year period. This volume guarantee was secured by US$340 million in legally binding agreements by the Gates Foundation, which committed US$120 million. Other guarantors included the governments of Norway and Sweden, and the U.K. - based Children's Investment Fund Foundation. USAID, and the U.K. Department for International Development supported implementation. The donors first signed an agreement with Bayer, which agreed to provide its Jadelle implants at $8.50 per unit, a 53% reduction, in return for a guarantee of orders of at least 27 million units over six years—approximately 3-5 million units per year. A similar agreement was later made with Merck & Co., Inc which committed to supply 13 million units.

5. **Pooled Investment Fund:** Funds from multiple parties are aggregated and used to support market-based solutions.

6. **Asset Lease Financing:** The owner of the asset (equipment manufacturer or the SPV created for lease financing) provides the right to use of the assets to another party against periodical payments.

7. **Social Insurance:** Insurance for social impact projects that unlocks private capital by protecting against some level of loss in the event the project is unsuccessful or the borrower is unable to repay the capital. Community led micro-insurance models and health mutual are examples of social insurance and protection that enables consumer / last mile financing as well.

[18] *https://www.bsr.org/reports/BSR_Healthcare_Innovative_Finance_Final_September_2017.pdf*

KEY HEALTH FINANCING MODELS TRIED SO FAR

The various health financing models and mechanisms have relevance at various stages of health financing both at the demand and the supply side of value chain. While a volume guarantee is more suited for core operations and access to health products, a result based financing is suited for overall programmatic intervention and service delivery. Similarly, models like micro-insurance are more inclined towards consumer financing and last mile service delivery. Our study of multiple health financing models and interventions in Africa as well as across other developing countries have shown few interesting trends:

1. Interventions are more focused towards demand side challenges with limited focus on supply side interventions and models.
2. All stakeholders are more inclined to implement and test consumer financing models which engage directly with the community. Health System improvement models are less common.
3. Public institutions are inclined towards insurance and micro-insurance linked models for healthcare service delivery. Community Based Health Insurance models are currently being tested almost exclusively by private sector players.
4. Not-for-profit organizations are inclined towards micro-entrepreneurship based models to provide access to health products and services at the last mile.
5. Public Private partnerships are an emerging form of health financing opportunity. It can leverage various mechanisms and execution approaches ranging from volume guarantee to asset leasing to last mile service delivery. A critical element for the success of these models is is ample competition among private sector players to ensure competitive bidding process.
6. Political buy-in was a key ingredient of successful health financing models especially when it is donor funded.
7. Very few examples of research and development models indicating that there is not enough resource allocation in this area aside from what is being done by large corporations.
8. Supply Chain models (especially for drugs) are mostly being implemented by public sector players and provide scope for improvements and potential private sector participation.
9. Policy and Regulatory ecosystem is important in designing institutional structure of the model and its scale up plan. Rwanda has 7-year corporate income tax holiday for selected sectors like manufacturing, ICT, energy and health services for a company investing at least 50 million USD.

We have also highlighted few case studies in detail, which have demonstrated successful health financing interventions and benefited from some of the above-mentioned trends across the healthcare lifecycle.

CASE STUDY-1: LIVING GOODS, UGANDA

Core Focus Area

Community Based Health Insurance

Program Overview

Country of Operation	Nigeria
Year of Launch	2007
Implementation Body	Hygeia Group in collaboration with Pharm Access International
Funding Body	Collaboration between Dutch & Nigerian state government (Kwara) and the World Bank

Enablers

- Provider Accreditation
- Demand Driven Enrolment
- Standardized Facility Norms

Service Type

- Preventive Care
- Curative Care
- Insurance Coverage

Key Takeaways

- ✓ ***Need for Incentivizing Providers to Increase Quality of Services:*** There is a natural reluctance among providers to adapt quickly to emerging health technology and service delivery solutions. Incentives structures need to designed in such a way that they are able to circumvent this.
- ✓ ***Importance of Sharing outcomes and audit results between Providers*** can result in driving healthy competition among them.

The Need: About 30% of rural Ugandan households live more than 5 kilometres away from a health facility. Furthermore, lack of transportation options and services, serve as a significant barrier to healthcare access. Living Goods aims to address this gap in the community.

Key Program Objective: Sustainably expanding access to life changing healthcare products and services by using a door-to-door approach.

The Program Model: Living Goods works using an "Avon-like" network of franchised community health promoters who earn a living by providing health education and access to essential health products at the doorstep of the community with the aim of providing a sustainable, affordable and reliable delivery channel for essential health products to rural areas. To achieve this, it has organized a group of community health promoters who are trained to provide basic public health counselling on the use of these products and to facilitate referrals as required. The model adopts best practices from public health, social marketing and micro franchising initiatives and recoups 100% of the products costs. The wholesale margin covers a proportion of the costs of running the network, thus allowing the model to deliver robust impacts for less than $2 per capita per year.

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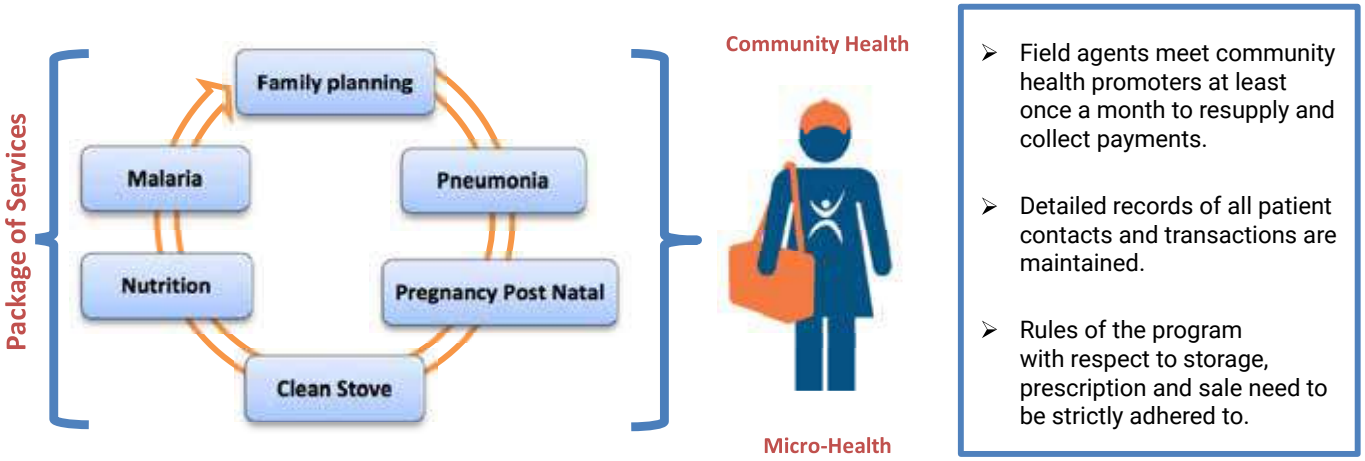
[19] *Planning Health Infrastructure in Uganda. Report available here.*

[20] *Health Policy and Planning Papers: Assessing access barriers to maternal healthcare: Rural Uganda, Sept 2009 & Health Facility Management and access, Sept 2017. Available here and here respectively.*

[21] *https://brandongaille.com/avon-business-model-and-growth-strategy/*

[22] *Healthcare Products offered by Living Goods. Available here.*



Impact:

- *Reduced child mortality:* A three-year independent randomized control trial showed that Living Goods has contributed to reduction in under-five mortality by over 27%[1]. This was achieved by 17% increase in diarrhoea treatment; 54% increase in follow-up visits for children sick with malaria, pneumonia or diarrhoea; and 72% increase in home visits to new-borns in the first seven days.
- *Increased access to drugs:* With respect to medications, which are often the largest contributor to out-of-pocket health spending, prices fell 17% at nearby clinics and drug stores, and prevalence of fake drugs fell by 50%, suggesting positive competition pressure.
- *Better knowledge and behaviours linked to malaria and diarrhoea:* The study also found that the residents of the catchment communities had better knowledge about the treatment and prevention of these diseases and were more likely to treat water before drinking.
- *Community health promoters act as micro-health entrepreneurs:* They are digitally empowered and incentivized to expand their reach, which increases their sense of ownership to deliver high impact in hard-to-reach areas at a fraction of the cost of training of doctors and nurses.

Similar Health Financing (Service Delivery) Models from Other Countries			
Model Name	**Implementing Agency**	**Funding Agency**	**Country of Operation**
Project Shakti	Hindustan Unilever	Hindustan Unilever	India
Shasthya Sena	International Centre for Diarrheal Disease Research	DFID & SIDA	Bangladesh

[23] *Study conducted by researchers from MIT, Yale and Stockholm University. Research summary: Available here.*

CASE STUDY-2: HYGEIA COMMUNITY HEALTH PLAN (HCHP), NIGERIA

Core Focus Area

End-to-end last mile support for healthcare delivery

Program Overview

Country of Operation	Mozambique
Year of Launch	2002
Implementation Body	An international NGO, VillageReach in partnership with Mozambican Foundation for Community Development
Funding Body	Bridgeway Foundation, BMGF, the BridgeWay Foundation, the Flora Foundation etc.

Enablers

- Technology Integration
- Government On-boarding
- Entrepreneurial Approach

Service Type

- Primary Care
- Vaccinations
- Access to Medications

Key Takeaways

- ✓ ***Transitioning to local ownership*** should be a part of the design of the program mode if it is donor funded and active planning is required for this transition for sustainable impact for the long term.
- ✓ ***Supporting local entrepreneurship in healthcare*** can help to plug critical gaps in health service delivery at the last mile while simultaneously achieving the dual objective of employment creation and improved healthcare access.

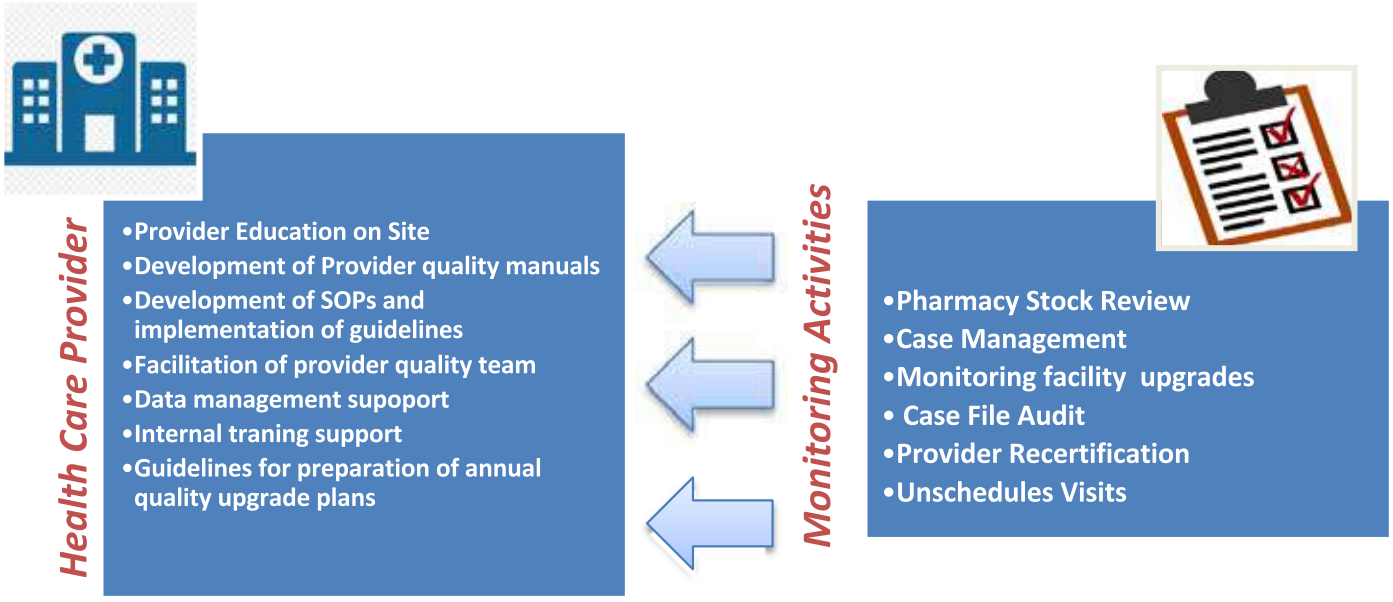
The Need: A study by the Lancet found that incidence of catastrophic health expenditure was as high as 27% in some Nigerian states[2]. Simultaneously, more than 90% Nigerian households remain uninsured in-spite of the establishment of the National Health Insurance Fund.

Key Program Objective: Provision of access to medical care for previously uninsured low-income communities through donor subsidized health insurance schemes.

The Program Model: This community-based health insurance scheme aims to provide health coverage to the uninsured through innovative risk pooling between different stakeholders. The Dutch Health Insurance Fund is the Fund Manager covering 95% of the costs, along with PharmAccess Foundation as the monitoring and evaluation (M&E) partner. The benefits package includes primary care, limited secondary care and medication, including HIV/AIDS drugs. This model of insurance helps to address the challenges on both the supply and the demand side of the healthcare system, with demand driven enrolments using sensitization strategies for providers and beneficiaries:

[24] *Out of Pocket payments in Nigeria. Study summary available here.*

- Demand Side: For previously uninsured people, premiums are subsidized by external donors to make them more affordable and collected as single payment per-person, per-year (between 200 and 500 Nigerian Naira which is approximately $0.55 to $1.38 USD). Risk pooling has been further enhanced by operation of four different schemes under the same fund. Beneficiaries of these four schemes are typically from different occupational backgrounds and regions (some associated with SMEs), thus helping to hedge risks. As per July 2010, there were 60,000 members enrolled in the scheme.
- Supply Side: All health facilities enrolled in the scheme are put through a systemic approach to service quality improvement. All quality standards and elements are included in the service provider's contract at the time of enrolment and renewed annually.



Demand Side Impact	Supply Side Impact
High User Satisfaction Rates: An impact evaluation study revealed that 93% of beneficiaries were satisfied with the service offerings.	Increased stock of Essential Drugs: 95% reduction in stock outs of anti-malarial and other essential drugs among provider network.
Access to Better Quality of Care in the Enrolled Health Facilities: This includes regular upgrades to IT, data systems and technology infrastructure.	Improvement in Management of Malaria: This scheme has recorded a declining use of chloroquine and increasing use of ACTs (artemisinin-based combination therapy) following training and implementation of treatment guidelines among providers.
Increased Utilization in the Health Facilities: With the removal of the financial barrier to access, the providers have seen an increase in utilization since the launch of the program.	Increased standardization of treatment pathways: This is achieved using protocols and periodically updated guidelines for facilities.

Similar Health Financing (Risk Pooling) Models from Other Countries			
Model Name	Implementing Agency	Funding Agency	Country of Operation
Microcare	Microcare	Microcare	Uganda
Uplift Mutuals	Uplift Mutuals	Uplift Mutuals	India

CASE STUDY-3: VILLAGE REACH, MOZAMBIQUE

Core Focus Area

Health Insurance Coverage using Mobile Technology

Program Overview

Country of Operation	Kenya
Year of Launch	2015
Implementation Body	Hello Doctor, Kenya
Funding Body	Hello Doctor along with Cannon Assurance

Enablers

- Cross Sectoral Approach
- Private Sector Engagement
- Collaboration with NHIF

Service Type

- Preventive Care
- Curative Care
- Health Insurance

Key Takeaways

- ✓ The ***role of enabling technologies*** can be vital in the success of a health financing solution like leveraging the strengths of mobile money etc.
- ✓ ***Waiting periods & exclusions play an important risk management and costs containment role in insurance products which are voluntary*** & pre-determined value of the benefit also reduces the risk.

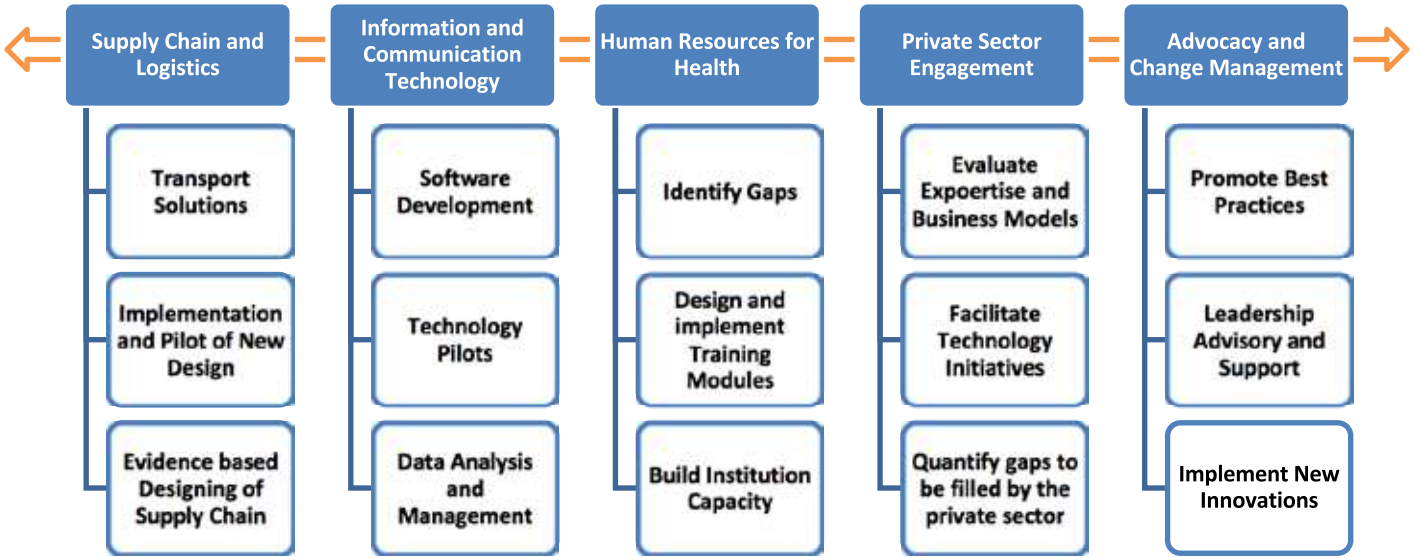
The Need: The long-lasting war in Mozambique has severely damaged health infrastructure, especially at the primary level of healthcare service delivery[3], with access to improved latrines and piped water at 15% and 8% respectively[4]. Access to affordable healthcare services is low, with less than half of the population able to access a health facility in less than 45 minutes[3]. The National Health Service (NHS) also indicated that there has been an increase in dependence on hospitals over time and a reduction in the demand for primary healthcare facilities.

[25] *World Health Organization, Workforce alliance knowledge resources. Available here.*
[26] *World Bank, Policy Research Working Paper, Mozambique's infrastructure. Available here.*
[27] *Republic of Mozambique, Health Sector Strategic Plan 2014-19. Available here.*

Key Program Objective: Improving access to vaccines, medicines and other essential health services at the last mile by empowering health workers and harnessing the power of data for better decision making.

The Program Model: The VillageReach program uses an integrated end-to-end platform in order to bring together the many components of the health system that work in parallel. It is focused on improving the reliability and quality of the public health system by using data for better management and quality control. This data is then used to ensure regular service and infrastructure improvements, train community health workers and other tasks as needed. The model also brings in the private sector in three ways: first, by identifying gaps for private sector interventions; secondly, by evaluating private sector expertise, costs and business models for outsourcing or investment; and lastly, by leveraging private sector investments in new initiatives. The Central Ministry of Health has requested that the program be expanded nationally.

The model primarily works in the following **Five Intervention Areas** as follows:



The Impact:

- The VillageReach program is expected to be fully transitioned to local authorities by 2020.
- Real time data collection and analytics allow timely and efficient logistics and infrastructure management.
- Support to local businesses & entrepreneurs to plug existing infrastructure gaps.
- Infrastructure improvements have increased the number of fully immunized children each year in participating districts of northern Mozambique by 40% and reduced stock-out rates to 2% from 80%.

Similar Health Financing (Supply Chain) Models from Other Countries			
Model Name	Implementing Agency	Funding Agency	Country of Operation
E-Choupal Health	ITC Ltd.	ITC Ltd.	India

CASE STUDY-4: SEMA DOC, KENYA

Core Focus Area

Improved Access to high quality, regulated, accredited and affordable pharmaceutical drugs

Program Overview

Country of Operation	Tanzania
Year of Launch	2003
Implementation Body	Government of Tanzania in collaboration with Management Sciences for Health
Funding Body	The Bill and Melinda Gates Foundation, DANIDA, Global Fund, USAID, Rockefeller Foundation etc.

Enablers

- Cross Sectoral Approach
- Standardized Accreditation Systems
- Private Sector Engagement

Service Type

- Access to Medications

Key Takeaways

- ✓ ***Strengths from multiple stakeholders;*** both private and public must be leveraged in order to achieve scale while simultaneously giving government ownership of the intervention
- ✓ ***Decentralized models can potentially scale faster:*** Shifting implementation to districts from the central level can allow for multiple regions to be scaled up simultaneously.

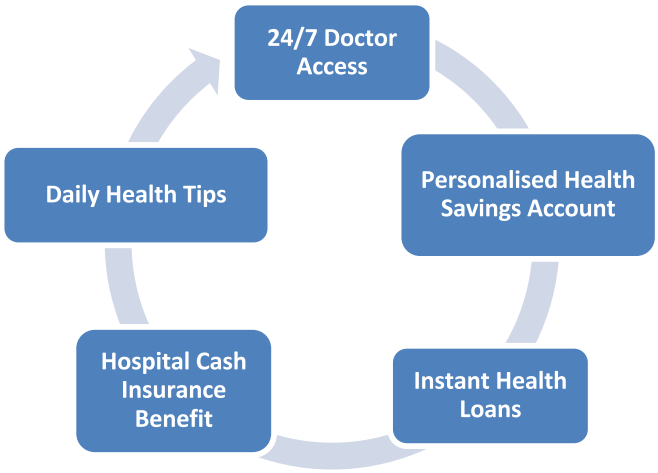
The Need: Kenya currently has about 1.8 physicians per 1000 people and 11.2 nurses per 10,000 people. Further, these doctors are inequitably distributed within the country making access in some parts almost negligible. In addition, about 75% of Kenyans are currently uninsured[3].

Key Program Objective: Widen access to healthcare in rural areas by providing reliable, high quality, online and telephonic health consultations, diagnosis and treatment.

The Program Model: This model leverages the ubiquitous mobile phone, using the Safaricom network with the approval of the Ministry of Health. The program offers m-health solutions to address the physical access constraints in rural areas as well as voluntary individual cover on a month-on-month basis. Premium collections are tied into existing mobile money solutions, and thus provide a high level of flexibility. Sema Doc is available for a monthly subscription service of 300 Kenyan shillings payable via m-Pesa or m-Shwari.

Doctors are able to provide advice and have been given medical regulatory approval to diagnose and treat 22 conditions over the phone. The subscription consists of five key offerings:

1. 24/7 mobile access to medical doctors via text or voice.
2. An account dedicated to health save for medical emergencies thereby reducing the incidence of catastrophic health expenses.
3. Access to instant health loans.
4. A Ksh 5,000 hospital cash benefit (by Cannon Assurance) to be used in case of emergencies: If a member is admitted to hospital and spends one night or more at an NHIF facility, Sema Doc pays out this amount into the member's dedicated health account, thus reducing in-patient care costs in NHIF facilities.



5. Access to daily health tips and recommended preventive intervention.

The Impact:

- Behaviour change initiation for patients from curative to health seeking behaviour.
- Benefits delivered at a very affordable rate of 2% of the minimum wage in Kenya.
- 2,350 members within the first month of launch, with approximately 12,000 enrolled users today.

Similar Health Financing (Mobile Technology) Models from Other Countries			
Model Name	Implementing Agency	Funding Agency	Country of Operation
MicroEnsure	MicroEnsure	MicroEnsure	Kenya, Tanzania, Ghana
Mobile Kunji	BBC Media Action	BMGF	India

CASE STUDY-5: ACCREDITATION DRUG DISPENSING OUTLET (ADDO), TANZANIA

Core Focus Area

Improved Access to high quality, regulated, accredited and affordable pharmaceutical drugs

Program Overview

Country of Operation	Tanzania
Year of Launch	2003
Implementation Body	Government of Tanzania in collaboration with Management Sciences for Health
Funding Body	The Bill and Melinda Gates Foundation, DANIDA, Global Fund, USAID, Rockefeller Foundation etc.

Enablers

- Cross Sectoral Approach
- Standardized Accreditation Systems
- Private Sector Engagement

Service Type

- Access to Medications

Key Takeaways

- ✓ ***Strengths from multiple stakeholders;*** both private and public must be leveraged in order to achieve scale while simultaneously giving government ownership of the intervention
- ✓ ***Decentralized models can potentially scale faster:*** Shifting implementation to districts from the central level can allow for multiple regions to be scaled up simultaneously.

The Need: Pharmacies in Tanzania are located almost exclusively in major urban areas (60%-70% in the capital alone) while about 75% Tanzanians live in rural areas. Further, those selling pharmaceuticals are typically untrained and unqualified, with many offering unauthorized products kept in poor storage conditions. Price regulation is not enforced and supply is unreliable and sporadic.

Key Program Objective: Provide pervasive access to good quality, safe and affordable drugs to all Tanzanians.

The Program Model: The Tanzanian authority took on the onus of creating accredited drug-dispensing outlets with the support of public and private sector stakeholders by introducing an accreditation program for community-based drug shops based on guidelines in the Ministry of Health's standards and regulations. This model is unique because it focuses on both the demand and supply sides of the market.

- On the supply side, product availability is continuously monitored and quality checks are conducted periodically. Inspectors conduct mapping and preliminary pre-accreditation inspections of community based drug shops to assess individual needs as well as conduct regular supervisions of these stores. ADDO accreditation is given on the basis of premise infrastructure, staff qualification, training, drug quality and availability, accurate record keeping and regular inspections. Curriculum for the staff includes laws and regulations, best practices, common medical conditions, communication skills and more.

- On the demand side, private sector capacity building initiatives are provided to improve the business skills of sellers. This includes things like record keeping training, affordable loans using microfinance initiatives, information exchange about availability and promoting the use of mobile technology for the purpose of fee collection, data collection and reporting. Further, patient and consumer awareness is developed through public education and marketing efforts. The scope of the ADDO initiative can be expanded by linking it to specific treatment protocols on family planning, HIV/AIDS, management of childhood illnesses and so on.

Decentralization, in this case, helped the model scale quickly. It took Tanzania six years to roll out ADDO in four regions under the centralized system and 10 more regions within three years under the new decentralized system.

The Impact:

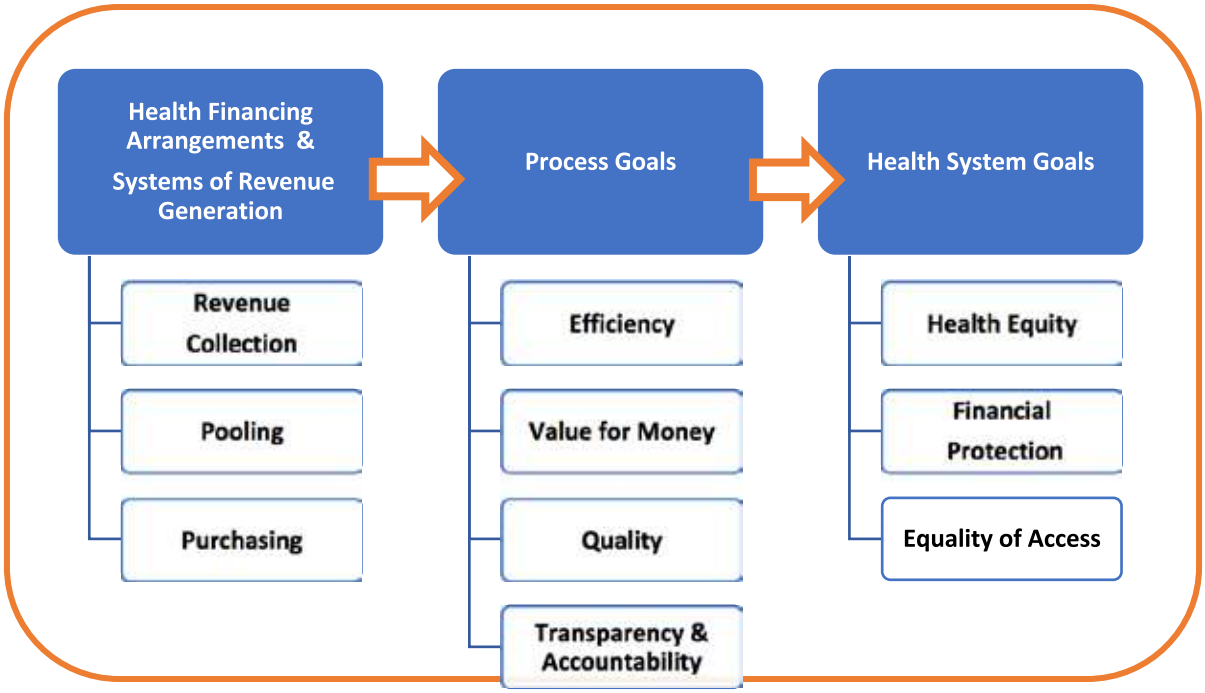
- Over 9,000 shops now accredited in Tanzania covering about 21 regions.
- Accuracy and adherence to treatment protocols increased. For example, the percentage of those receiving appropriate malaria treatments increased from 24% to 63% between 2004 and 2010.
- Linking ADDO with insurance schemes has reduced out of pocket payments since drugs tend to be a significant portion of household healthcare costs.
- The program was successfully able to leverage economies of scale. As the program evolved and scaled, the estimated implementation cost decreased by 55% (from US$126,000 to US$ 57,000 per district), which resulted in a shift in program costs to owners and dispensers who were able to pay for branding and renovations.
- The key program components from this model are being replicated in Liberia and Uganda in the form of Accredited Medical Stores.

Similar Health Financing (Policy Regulation and Contracting) Models from Other Countries			
Model Name	Implementing Agency	Funding Agency	Country of Operation
Performance based contracting	Afghan Ministry of Public Health	Donors; European Commission, USAID and the World Bank.	Afghanistan

CHAPTER 4: LEARNINGS SO FAR: WHAT HAS WORKED WHAT HASN'T

KEY LESSONS FROM BEST PRACTICES & MODELS

Many countries have adopted innovative approaches to financing their healthcare needs. However, several African countries are still heavily reliant on traditional aid for this purpose. The variations in emerging health financing model designs across Africa are based on existing local needs and capabilities as well as political, economic and technological factors which influence scale and success. The overarching objective for the health financing models should be to gain ***'more health for the money spent'***.



Adapted From: Kutzin, J (2013), "Health financing for universal coverage and health system performance: concepts and implications for policy." Bulletin of the World Health Organization 91(8):602-611. Available here.

Some common factors that have a more direct bearing on the goals illustrated above as well as on the success of the model are as follows:

- Revenue Collection is the means by which a health system is able to raise money from different sources with the aim of utilizing these funds towards the achievement of healthcare goals.
  - Self-financing of health initiatives allows governments to have greater autonomy in determining its priorities and areas of focus.

- Transparency in managing government funds serves as a basis for attracting donor funds for other interventions. Transparency on the utilization of funds is also essential for policy makers, implementers and the population and tends to result in more robust models overall.
- Health financing efforts that focus on improving government resources through over-burdensome taxes should be avoided. They can impede the growth of business and the formal sector, ultimately hindering the achievement of UHC.
- Equitable contribution mechanisms, like pre-payment for risk pooling models where people contribute regularly to health costs in the form of tax payments and/or health insurance contributions, should not be made mandatory. This is especially applicable to lower income groups, since it can lead to further mistrust of healthcare systems and public service providers if they do not see the benefit of the compulsory insurance scheme.
- While determining exclusion criteria for insurance pre-payments, it is a necessary precondition to have robust and up to date national census data on income strata of different individuals (assuming income group is in the criteria for exclusion) in order to successfully exclude those at the very bottom of the pyramid. There are countries that have rolled out mandatory national insurance schemes in the absence of census data and this has proven to be less successful.

➢ ***Pooling of Funds includes the management and accumulation of funds in a way that risk can be collectively shared.***

- Pooling of funds through national single-payer risk pools allows cross-subsidization of those insured. Fragmentation of risk pools limits the potential for cross-subsidy and unnecessarily increases administrative costs in countries with very limited funding. For example, countries like Rwanda have a single donor fund pool, which acts as a common pot. 'However, most African countries have fragmented risk pools with donors' liaising with multiple government departments and ministries. Therefore, high levels of cross-subsidization are harder to achieve due to multiple fund pools.
- Health reforms like health insurance should be introduced gradually and incrementally. This approach gives the authorities important opportunities for learning by doing. Additionally, insurance uptake is contingent on the extent to which a community can see the value in pre-payments for coverage. Efforts to improve health-seeking behavior can have a positive bearing on health insurance uptake and willingness to pay.
- A public financing option or insurance should be included, in addition to private insurance, as it is effective in bringing down the share of OOPE and can also put pressure on the private payers to keep costs down and remain competitive.

➢ ***Purchasing refers to the mechanisms by which limited health funds in 'pool' are used to purchase different healthcare services (core and allied) from private and public sector players in a way that is efficient and equitable.***

- Health financing reforms should move from breadth to depth, focusing first on providing coverage for basic primary care to the entire population before expanding the depth of the coverage to include more complex secondary and tertiary care.
- The system should encourage health care benefit packages that cover major causes of ill health in the country. Such an arrangement ensures that those in need derive optimal benefit from health services and receive value for the money spent on these services.

- Strategic purchasing mechanisms should not be overlapping or conflicting in nature. For example, if a county is implementing a performance based financing (PBF) scheme to incentivize health workers, its national insurance scheme should be designed to successfully supplement this and not be in conflict.
- Purchasing mechanisms should be strategically planned in a way that maximum health benefits can be bought with the limited funds in the pool. For example, shifting from branded to generic drugs would be more cost effective. Also, financing mechanisms like pay for performance and health impact bonds can lead to streamlined payments for pre-determined health outcomes, thus allocating cost to each healthcare outcome achieved at the onset.

In addition to the above-mentioned mechanisms relating to revenue collection, pooling and purchasing requires the question of how much additional fiscal space can be generated for health within the system to be asked consistently. For example, how many additional financial resources can be made available for health in the existing state? This can be done by making the existing purchases of healthcare services more cost effective, reducing systemic leakages and increasing process efficiencies so that 'more health can be purchased for less'.

WHAT'S LIMITING HEALTH FINANCING INITIATIVES?

i. Service Delivery

- Reluctance among providers to adapt quickly to emerging health trends, including technology and service delivery solutions.
- Lack of performance incentives for providers to enhance provision of quality care and adopt new innovations.
- Misalignment of stakeholder vision and focus, which stifles implementation of health financing programs.
- Inadequate workforce and infrastructure to support delivery of key health initiatives.
- High cost of delivering healthcare services at the last mile due to low resource availability.
- Ineffective data collection and reporting mechanisms which limits accountability and data-backed decision making.
- Lack of coordination between external aid donors who can have varied or even conflicting priorities that lead to uncoordinated approaches to healthcare delivery.

ii. Risk Pooling

- Limited uptake/enrolment hinders sustainability of social health insurance models. The success of social insurance schemes lies in the ability to enroll more people into the scheme. This has, however, emerged as a key challenge, especially in voluntary schemes that target low-income populations.
- Low contribution and frequent drop-out rates limit the health service benefits that can be provided by such schemes.
- Limitations to cover and collect contributions from the non-salaried or informal sector, which are the largest proportion of the economy in most African countries.
- Lack of availability of comprehensive data to effectively determine the exclusion criteria for premium payments.
- Weak institutions that are not able to effectively collect and manage funds.

- Lack of community engagement and slow behavior change, reducing the uptake and ownership of such models.
- High fragmentation of risk pools, which reduces income cross-subsidization.
- The risk of anti-selection, where members only take up the cover when they are ill.

iii. Supply Chain

- Fragmented supply chains, limiting the ability to leverage economies of scale to negotiate better prices and/or discounts.
- Inadequate infrastructure to ensure last mile delivery of pharma and non-pharma goods.
- Lack of automation, allowing for human error, which can lead to stock-outs and interruptions to supply of essential drugs and supplies.
- Lack of energy infrastructure to ensure the timely availability of cold chain.
- An inability to pre-empt demand, leading to stock-outs

iv. Research & Development

- Stringent and inflexible financing that stifles innovation, especially in the case of grant funding.
- Lack of health research prioritisation at the national level.
- Lack of research and development capacities in terms of laboratories, equipment and technical expertise.

v. Policy Regulation & Contracting

- Political challenges from the party in power that can limit implementation of such models.
- Lack of government ownership and political will and, thus, limited allocation of funds to the models.
- Poor enforcement of regulations due to limited capacity and weak systems.
- The presence of very few contractors leads to a lack of competition, which can further lead to implementation inefficiencies. Barriers to entry for new contractors must be removed in order to encourage healthy competition among them.

THE SCALING UP ISSUE: OUR POINT OF VIEW

Many innovative health financing models continue to face the challenge of moving from innovation to scale, both in coverage and geography, with most of these models unable to move past the pilot stage. The lack of adequate funding is one of the major barriers. Most of the models in Africa are donor financed with limited ownership and contribution from the government and/or private sector. As such, once the donor funds dry out, so does the model. Donors need to pull and ensure government and private sector commitment in health financing programs, with either of the parties taking up the implementation of the programs once the donor exits. Health financing programs should also seek flexible private equity or venture capital funding that allows for innovations as the program is implemented.

Leveraging the right partnerships and stakeholder engagements are also key in scaling up. Most health financing programs fail to identify and map these crucial stakeholders and provide specific incentives and value proposition to motivate them to be part of the project. Further, the lack of constant engagement often leads to resistance. Establishing mutually beneficial partnerships among stakeholders in the value chain and ensuring constant stakeholder engagement

can help accelerate the proliferation and scale up of health financing solutions in the sector. Additionally, there is need to ensure vision alignment among the stakeholders with value propositions established for each of the stakeholders that are aligned to the vision.

Community behaviour and engagement is at the heart of any health financing reform. Health financing programs are often designed without taking into consideration the health seeking behaviours of the community. Consequently, there is limited uptake of such programs by the community, leaving them unsustainable. The health seeking behavior of the community needs to be incorporated into health programs and interventions for behavioural change management should be designed. Additionally, the community should be included in the design of such programs.

KEY DRIVERS OF CHANGE: CRITICAL SUCCESS FACTORS

The outcome of health financing interventions is driven by certain key critical success factors:

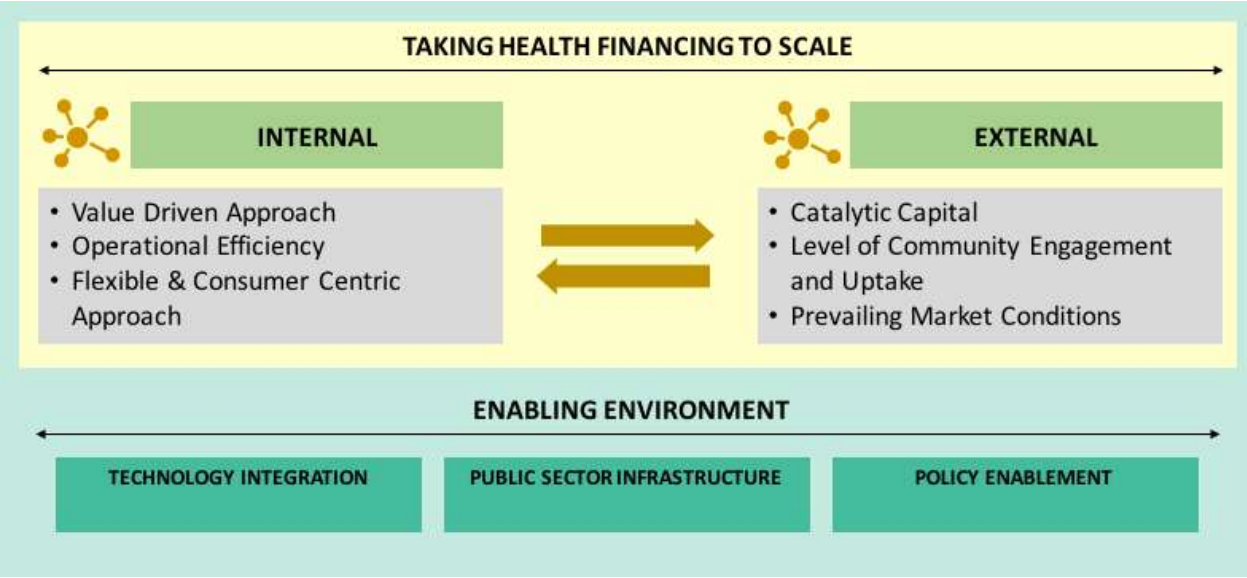
- **Private sector participation and capacity building:** The information and behaviour change enablers for private participants should be identified, and change management and capacity building efforts should be planned. Sufficient administrative, technical and operational capacity through engagement of adequate resources and dedicated interface agencies will be critical.
- **Resource commitment:** Resources should be committed at the beginning of the project. These can include fund allocation, handheld devices (if required), mobile phones etc. Timely availability of central and state funds and participation of human resources at the facility level is critical.
- **Support at the highest level:** Policymakers should introduce policy changes for enablement of innovative health financing. Senior officials in health ministries, information technology ministries and other key departments should support health financing and promote it as an essential service at the national level.
- **Change management:** Focus should be on trainings and effective communication covering health financing skills, soft skills, dashboard analytics and domain-specific skills at various levels for effective service delivery.
- **Prioritization of health initiatives:** Given the limited government resources in most African countries, prioritization of health problems and diseases is a necessary means for putting scarce resources to the best use.

HEALTH FINANCING FRAMEWORK FOR SCALE

So, what will help the innovative financing models achieve the desired scale?

How can we move away from the trap of pilotitis and instill more confidence in these models so that they are no longer branded as innovative but are the new normal?

Based on the learning from various health financing interventions globally, learning from what has not worked, interaction with key sectoral experts and stakeholders, scale interventions in other sectors and our prior experience of working in various sectors, we have identified a mix of internal, external and enabling factors that will help drive scale for health financing interventions.



INTERNAL FACTORS DRIVING SCALE

Value-Driven Approach

1. Strong Leadership and Vision: A medium- to long-term vision is needed to recognize that scaling up of an innovative healthcare financing idea is not only necessary and desirable, but also feasible if the model is well designed. Visionary leaders and champions are the most critical element in the process of driving a model to scale. As the model scales up, it is essential that strong leadership can be decentralized effectively.

    a. Aravind Eye Care System, the world's largest community eye care provider, has been fueled by the passion, vision and leadership of Dr. G Venkataswamy. Under his guidance and leadership, the organization has expanded to create an end-to-end service delivery system from an in-house manufacturing of artificial lenses, a model of community-based paramedical personnel (vision care technicians), cross subsidization of health services (80% free services, 20% subsidized services) and a robust research and development arm.

2. Transparency and Accountability: Sharing of data insights and ensuring a culture of transparency can go a long way in enabling models to scale. This is an essential prerequisite, especially for donor-funded models as funding is contingent on this.

    a. Hygeia Community Health Plan in Nigeria nudges service providers' performance along by sharing outcomes and audit results between different healthcare providers of a similar levels as a way of driving healthy competition between them.

Operational Efficiency

3. Forging Meaningful Partnerships: In order to achieve scale, it is important to leverage the strengths and assess the weaknesses of different stakeholders towards achieving common healthcare financing objectives. Most successful healthcare financing models were able to effectively channel unique stakeholder capabilities to scale their innovations and solve complex healthcare challenges in their areas of operation. Successful health care financing models would have a clear value proposition for each stakeholder involved and a continuum of partnerships between private and public players[3]. This process includes designing a program that strategically articulates the right incentives for the partners involved. These incentives can be in the form of monetary rewards, healthy competition, political favors, reputation or brand value enhancement. Some successful examples include:

    a. VillageReach in Mozambique has not only been able to bring the national government on board, but has also strategically identified local healthcare entrepreneurs to help fill existing supply chain gaps.

    b. Accreditation Drug Dispensation Outlet (ADDO), Tanzania is a collaborative partnership between the Government of Tanzania, as the program implementer, and multiple donor agencies like BMGF, DANIDA, the Global Fund and USAID, as funding agencies.

    c. The 108 Emergency Management and Research Institute (EMRI) in India is a unique public-private-partnership model between state governments in India and private players that employ an 'operate and maintain' service contract between the two[3].

4. Choosing the Right Health Financing Mix: There is no single model that fits all approaches to health financing interventions. Based on the problem at hand, the sectoral needs and the challenges of the key stakeholders, a targeted approach should be adopted. This may require the selection of a mix of health financing approaches. For example, an impact bond for maternal and child health interventions may not be a suitable option for addressing sickle cell anemia. Similarly, a mix of consumer financing options linked to micro-insurance and other delivery channels might be required for diseases with high prevalence, incidence and associated out-of-pocket expenditure.

5. Sustainable Funding Model: Most successful health financing initiatives have access to venture capital style funding modalities, which tend to be more flexible. This gives implementers the scope to help tweak their models so they can evolve and expand. Donor funded models that are tied to a specific grant tend to be less flexible, as they are usually for a fixed funding amount and have rigid project timelines for implementation. In the cases where the model is being piloted by the donor, it is imperative that a financial sustainability plan is put in place to ensure that implementation and scale up continues even after donor funds run dry. Some examples of this include:

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[29] *Taking Innovations to Scale. Available here.*

[30] *108 Emergency Medical Response Initiative. More information available here*

a. Drishti Eye Care in India uses a 70:30 (for profit: free services) finance model, wherein the revenue generated by paying sections cross-subsidizes the expenses that would be incurred by the non-paying section, thereby ensuring long-term financial sustainability and decreases dependence on external funding sources[3].

b. LifeSpring Hospital Private Limited has a for-profit hospital operated on a 50/50 equity partnership between the Acumen Fund and Hindustan Latex Limited, which provides flexible financing to help fuel scale.

6. Contextualization to Fit Local Settings: Healthcare program designs need to be adapted to the context in which it operates in order to scale effectively. Some of the main factors to be considered for successful contextualization include cultural norms and behavioral practices prevalent in the country of operation, level of literacy among program beneficiaries and health workers, familiarity with technology and language of communication. Some notable examples include:

   a. BBC Media Action Mobile Kunji, India: This model operates in rural Bihar, India where traditional customs govern childbirth. While reaching the target audience through traditional means would have been difficult, health workers were provided with an innovative, audio/visual aid that communicated positive behavioral messages that were designed with the target audience's level of literacy, language of communication and cultural practices in mind. Their messages will be redesigned to fit different contexts as this model expands to other South Asian countries[3].

   b. Novartis Arogya Parivaar, Kenya: This model trains locals in remote villages to become health educators. Educational material, product packaging and training is adapted to local settings and medicines are made available in small packages to make them more affordable to low-income groups. Starting from India, Novartis is now replicating this model in Indonesia and Vietnam after a program redesign to fit the specific country context.

7. Robust Stakeholder Contracts: The design and management of service and partnership contracts in healthcare can determine the extent to which programs can succeed. The absence of well-designed contracts can lead to lack of compliance by contractors, which sometimes cannot even be contested. This is especially important in situations where competition is limited due to low numbers of potential contractors. For example:

   c. The Medical College in Shillong, India was set up as a result of a robust partnership contract between the state government of Meghalaya and Calcutta-based KPC group leveraging their health sector expertise and reach.

[31] *Drishti Eye Hospitals. Available here.*

[32] *BBC Media Action, Mobile Kunji. Available here*

8. Implementation Monitoring Framework: Outcome- and implementation-related indicators around quality of service, response time and utilisation rates need to be closely monitored to access the performance of the model, both in terms of its impact and also to identify bottlenecks. Monitoring and evaluation against goals, benchmarks and performance metrics are essential ingredients to establish incentives and accountability.

    a. Shasthya Sena in Bangladesh: This program is designed to monitor and improve the quality of services provided by informal service providers in Bangladesh. It has established community health watch committees in villages to monitor informal providers' performance.

Flexible & Consumer-Centric Approach

9. Consumer/Patient-Centric Approach: Adopting a patient-centric approach to healthcare service delivery will help drive demand and increase a consumer's willingness to pay for the service being availed, thereby contributing to the long term financial sustainability of the healthcare financing model. For risk pooling models, the service offering should be designed in a way that is comprehensive and thereby increase demand for the product. For instance:

    a. Hygeia Community Health Plan (HCHP) in Nigeria provides access to medical care for previously uninsured low-income communities, with a relentless focus on the supply of good quality healthcare services and continuous technology improvements to enhance patient satisfaction levels, thereby boosting demand.

    b. Impact Bond for Maternal & Child Health is currently being piloted in Rajasthan, India where funders pay directly based on the maternal and child health outcomes that have been achieved.

10. Robust Data & Information Management Systems: A robust, interoperable data management system to successfully manage logistics, inventory and financial information is the backbone of a successful scalable health financing model. Healthcare data typically tends to reside in multiple places and can be sourced from different systems, like electronic medical records (EMRs) or health management information systems (HMIS) to different departments. Aggregating this data into a single accessible and centralized system helps to make this data useful and actionable. This is especially important for supply chain health financing models, as it helps preempt future inventory and other needs, thus increasing the level of preparedness and reducing instances of stock-outs.

    a. VillageReach in Mozambique uses an integrated end-to-end platform in order to bring together many components of the health system that work in parallel with each other. This helps to predict future needs and gaps in the areas of manpower and inventory.

    b. Health Management and Resources Institute (HMRI), India uses an easily accessible digital health platform that integrates a medical advice hotline, a mobile medical outreach component, and telemedicine solutions.

11. Ability to Leverage Cross-Sectoral Synergies to Achieve Healthcare Goals: Successful models are typically able to leverage strengths and achievements of different sectors and adapt them in ways that solve healthcare challenges. For example:

    a. Sema Doc by Hello Doctor in Kenya is a model that uses the extensive mobile phone penetration and success of mobile money tools like m-Pesa to provide tele-medicine and insurance services in many hard-to-access areas of Kenya.

b. Living Goods in Uganda uses livelihood incentives where community health promoters act as micro-entrepreneurs, which helps increase their sense of ownership to deliver high impact as well as scale their individual businesses.

EXTERNAL FACTORS DRIVING SCALE

1. Sources of Funding / "Catalytic Capital": Flexible and sustainable funding may be hard to come by and this can be outside the control of the health entrepreneur or innovator. In such cases, the program or business may find it difficult to scale quickly. Additionally, commercial bank loans may be associated with high interest rates and collateral requirements that are difficult to fulfil. The source of funds and specific funding modalities can determine the overall scalability of the healthcare financing model. Unrestricted or flexible capital can be catalytic in this regard.
2. Level of Community Engagement and Uptake: At the initial phases of program or model design, the level of community uptake for the product is typically unpredictable. Further, it can change continuously even after a program launch. There are two factors that tie into this and, if these are kept in mind during the design phase, it can help the program achieve and retain engagement and uptake during the rollout phase of the program:
    a. Designing a program that fulfills an existing and unmet healthcare need: The program offering must be unique. There should be no close substitute programs that have similar products or service offerings. The program should aim to fulfil a currently unfulfilled healthcare need within a community. This will help ensure sustained demand.
    b. Design a program that appropriately fits the context of operation: Adapting the program design to fit the applicable context will also go a long way in ensuring community uptake and engagement, since it makes the program more understandable and relatable to local communities.
3. Prevailing Market Conditions:
    a. Patient willingness to pay: The income level of catchment communities as well as their socio-cultural beliefs and practices affect their willingness to pay for a particular healthcare product or service. If consumers have a lower willingness to pay, this is likely to affect program sustainability since it is associated with a certain degree of price rigidity which may be limiting. This is typically seen in cases of preventive health services and insurance payment premiums, both of which tend to suffer from a lower willingness to pay by consumers since immediate benefits seem less obvious. For instance, this low willingness to pay among communities is seen as a major challenge for the Partnership for Primary Healthcare model currently being piloted in Makueni County, Kenya.
    b. Market Size: The overall size of the market affects scalability. Scaling beyond a particular geographical frontier like a country or state may require additional permits, additional contextual information, clearances, partnerships etc. For example, countries like Lesotho, Guinea-Bissau and Gabon have a total market size of roughly 1.9 million people and some healthcare models may find it difficult to leverage the benefits of economies of scale to a full extent.
    c. Price Changes of Substitute products if any: Ideally, a healthcare product or service on offer should not have close substitutes at the given price level as stated above. Price changes of substitutes will affect demand. For example, if competitors lower price, it is likely to negatively affect demand for the product on service on offer.

ENABLING ENVIRONMENT: TO HELP FUEL THE SCALE UP PROCESS

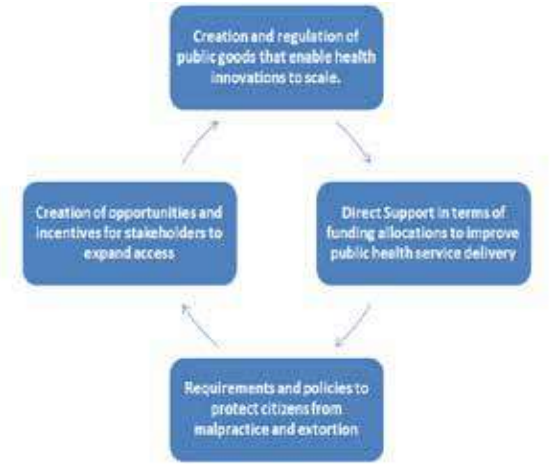
1. **Technology Use and Familiarity:** Many healthcare financing models are capitalizing on the opportunities that technology provides, using mobile phones for everything from making insurance payments, to issuing birth and death certificates, to gaining increased access to healthcare services. Technology is a very important enabler for scale, but the level of comfort and familiarity that the catchment population feels with using this technology is an important predictor of the level of uptake and engagement with the service. Successful models will strategically piggyback on existing technology to ensure faster uptake and scale[3].

2. **Public Sector Infrastructure Availability:**

   a. Transport: Ease and affordability of public transportation facilities can help with scale up of healthcare innovations. For example, in Rwanda, due to the landlocked nature of the country, transportation costs are often high. Rwanda has the highest imported freight service costs in the region, which is nearly three times that of the African average. This will further affect the country's ability to scale healthcare financing innovations and overall profitability, since healthcare infrastructure and supplies will probably be relatively more expensive to import.

   b. Communication: Health communication and information technology are central to health care and public health, and have an immense ability to facilitate behavior change within our communities. The level of public spending dedicated to improve these systems and the level of existing communication infrastructure present will impact the way in which healthcare innovations can be implemented and scaled.

3. **Policy Environment:** Policy and regulatory environments will either hasten or hinder the scale-up process[3]. Supportive government policies can include tax reductions, special economic incentives for innovators, healthcare workers' retention techniques, and investment in research and development of emerging healthcare technology. These can go a long way in fueling a healthcare model's ability to achieve scale. Additionally, in most African countries where external and donor aid plays a significant role in the healthcare landscape, national health policies, strategies and plans are increasingly seen as the key to improve aid effectiveness and the resulting healthcare outcomes. The public policy environment can affect the success of healthcare innovations in the following key and direct ways:



4. **Stakeholder Mission Alignment:** It is helpful for various stakeholders to have a common mission at the onset. Some instances of mission alignment which helped the successful scale up of health financing models include:

   a. Byrraju Foundation Health Program, India is a model that works in partnership with local communities and takes a holistic approach to village development using local stakeholders. Local ownership and buy-in is created at the onset, with the village members donating money for a common village health centre and a

[33] *Technology as an Enabler in Asia. Available here*

local doctor who is already settled in the village or a nearby area is recruited. Every health module in the program has a partner that provides services on a voluntary basis or at a discount. Thus, there is a common mission for all stakeholders involved which is to improve the health outcomes of the village. Mission alignment between various interacting stakeholders helps to keep each motivated towards the achievement of common healthcare objectives, even if this is not accounted for in the program design.

HOW DO WE IMPLEMENT FOR SCALE?

The framework proposed will only remain relevant if it is actually put to practice. The internal, external and the enabling drivers have all been part of some intervention or the other but the key is to unlock the secret of bringing them together at the right place at the right time.

Also, how do we address some of the polarities that exist between various drivers? Should we focus on the depth or breadth of scale? How do we ensure a balance between technology integration and human intervention? How cost effective should an intervention actually be to actually be effective and sustainable?

As we move forward, we would look to answer the following key polarities that will be critical in making this framework realistic and implementable:

- How may we ensure transparency along with respect for personalized information with technology advancements in healthcare?
- How do we ensure the balance between disruptive and sustained innovations in healthcare?
- How do we bring stakeholders together and on-board them for common action towards scale?
- How may we come up with a service delivery approach for healthcare in which patience health and money have an ethical and balanced relationship?

We would work to engage a diverse set of stakeholders and form a common action group to achieve the desired results.

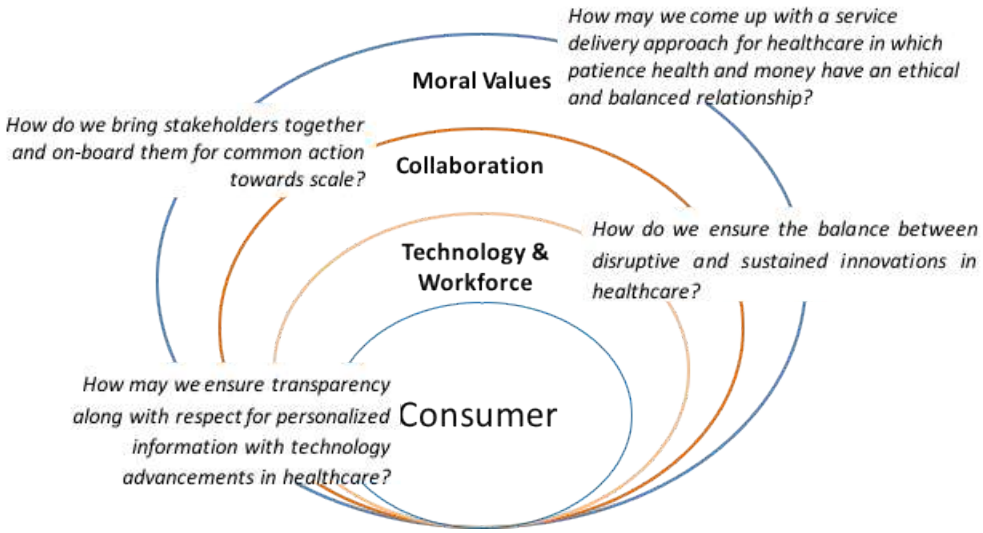


Figure 4: Addressing Critical Polarities