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**19<sup>TH</sup> GENERAL MEMBERSHIP MEETING OF THE  
REPRODUCTIVE HEALTH SUPPLIES COALITION**



# Mobilizing Private Investment for Global Health

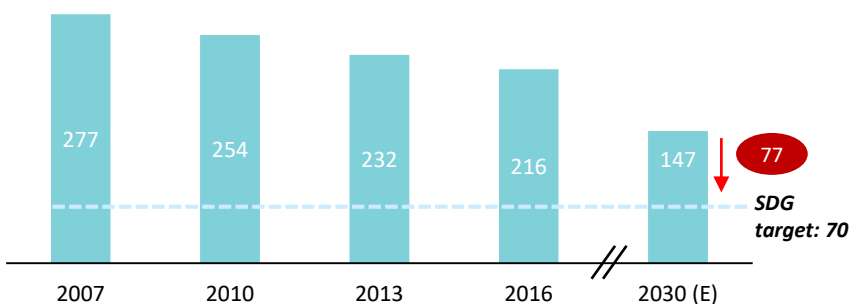
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Center for Innovation and Impact, USAID

# We are all aiming for ambitious global targets, but trajectory suggests more progress must be made

MMR has fallen by a quarter over the last decade, but it's still far from the SDG goal...

## Maternal mortality ratio (MMR) - global

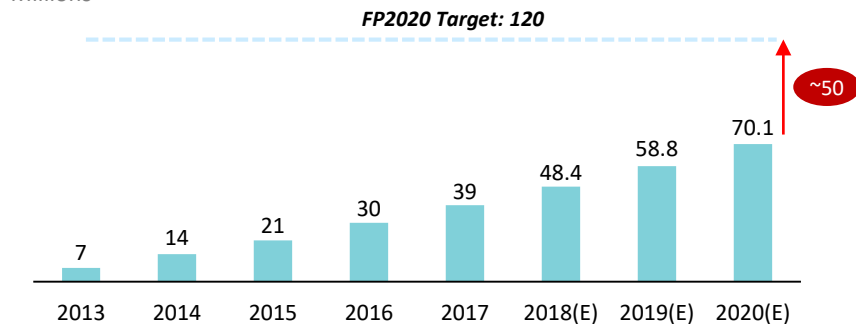
Per 100,000 live births



...and more focused efforts are needed to reach the FP2020 target of adding 120M users of modern contraception methods

## Users of modern contraception methods (cumulative)<sup>1</sup>

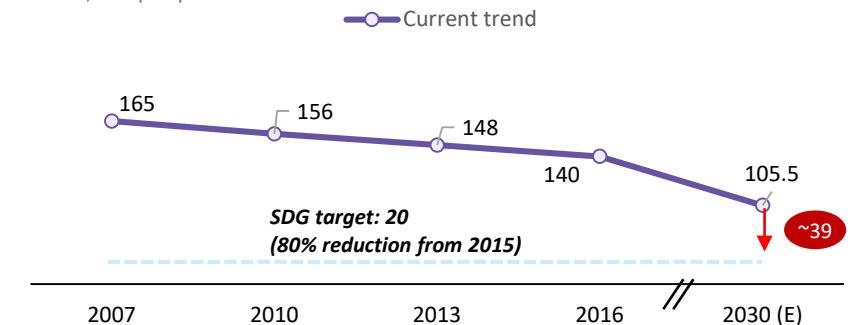
Millions



At the current rate of progress, TB incidence in 2030 will be above the SDG target...

## TB incidence rate

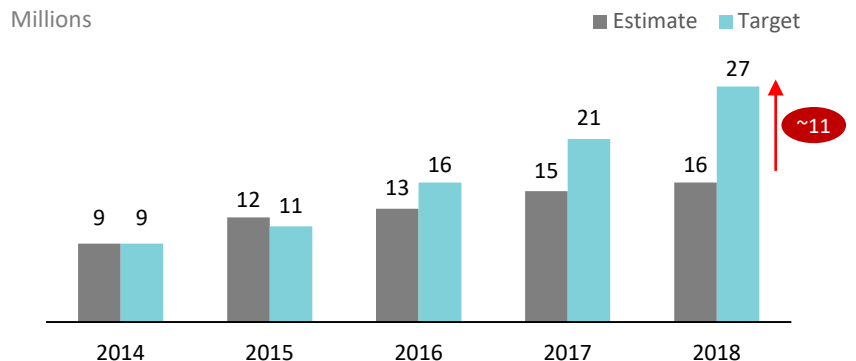
Per 100,000 people



...while HIV viral-load testing efforts needed to reach the 90-90-90 targets are estimated to fall short

## Viral load tests – demand vs tests conducted

Millions



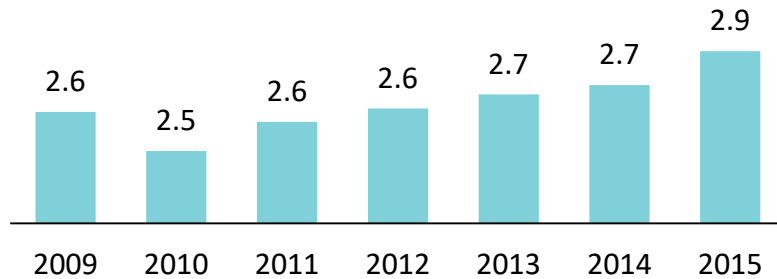
<sup>1</sup>69 focus countries

SOURCE: UNAID's Global AIDS Update 2017, WEF Blended Finance Vol. 1: A Primer for Development Finance and Philanthropic Funders, FP2020 – Track20 indicators, '17, World Bank, WHO the availability & use of HIV diagnostics: a 2012/13 WHO survey in low-and middle-income countries Dec 14

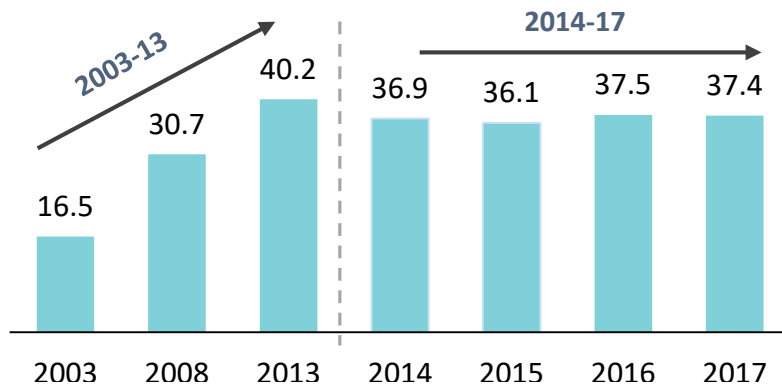
# Critically, significant funding gaps exist to meet these targets

Public healthcare expenditure has increased, while global development assistance for health has stagnated since 2013

**PHE as % of GDP – low- and middle-income countries (2009-15)**  
% of GDP



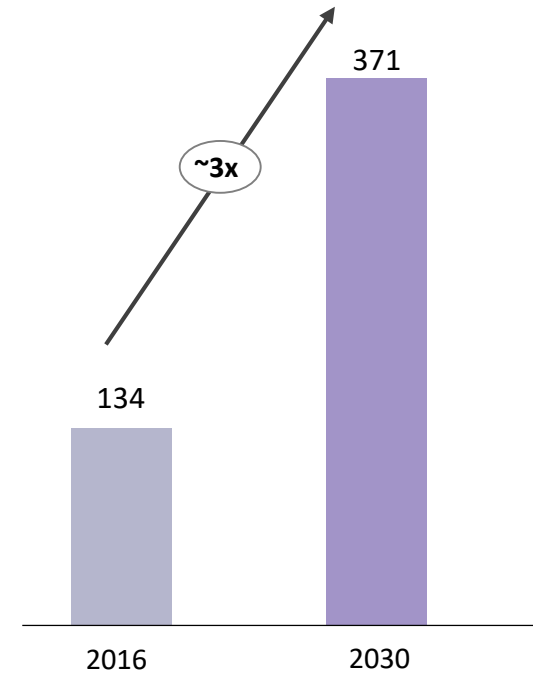
**Development assistance for health - global (2003-17)**  
USD Billion



If current trends continue, significant additional investments needed over the next decade

**Additional annual investment required<sup>1</sup> to meet health SDGs for low- and middle-income countries**

USD Billion



1. Refers to the collective additional investment needed from all entities (Governments, donors, private players) towards healthcare in 2016 and in 2030 in order to meet SDG targets 2. The final funding gap may be smaller if governments scale up health expenditure: In the 'progress' scenario, the final gap to address SDG needs is \$54 billion, whereas in the 'optimistic' scenario the final gap is \$41 billion

SOURCE: WHO report (SDG Health price tag) covering 67 LMI countries, Congressional Budget Justifications 2016-2019, Investing for Impact Report (CII, USAID – Aug 2017), Stakeholder interviews

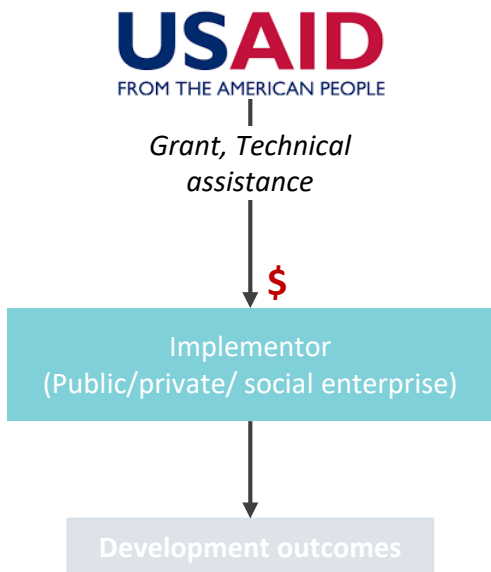
# Blended finance can contribute to bridging these funding gaps by engaging the private sector

## What is blended finance ?

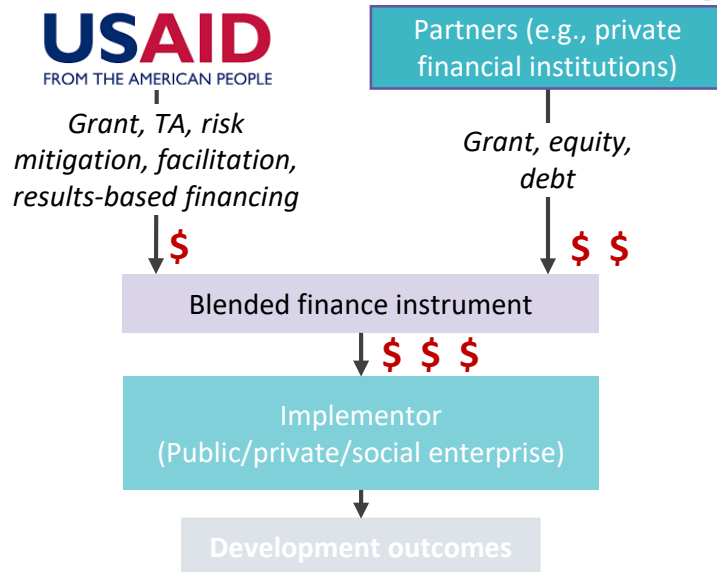
Blended finance is the strategic use of public or philanthropic resources to mobilize new *private capital* for development outcomes. Blended finance helps overcome barriers impeding private capital from flowing into developing country markets.

*In global health, private capital could come from new funding or in-kind investments from banks, impact investors, high net-worth individuals, pharmaceutical or medical technology companies, healthcare providers, equipment leasing firms, distribution companies, or other private actors.*

### Traditional grant funding (Status quo)







### Blended finance



Note: 'Innovative finance', is a broader term, and refers to "approaches to mobilize resources and to increase the effectiveness and efficiency of financial flows that address global social and environmental challenges.", while blended finance is a subset of innovative finance. For more details, please refer to the [2017 USAID Investing for Impact Report](#).

# Blended finance offers multiple benefits

Benefit	Description
Increase funding towards development outcomes 	By leveraging additional private capital, more philanthropic and public funding can be redeployed towards programs that still require grants or highly concessional capital.
Improve sustainability 	When deployed strategically, blended finance plays a transitional role by catalyzing investments that the private sector <sup>1</sup> can scale and replicate even after the exit of donor capital.
Stimulate innovation 	Donors can support and de-risk investments in high-impact sectors where normal market fundamentals do not function adequately. This is particularly important in markets that require innovation in products and services to reach underserved segments of the population.
Develop local capital markets 	De-risking entry into new markets or sectors deepens local financial markets, and improves access to capital for small and medium enterprises (SMEs). Catalyzing foreign capital into developing countries can advance the growth, capacity, and sophistication of local economies, businesses, and investors.

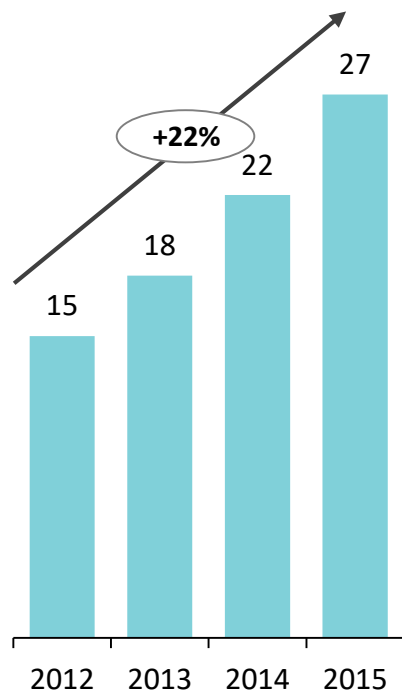
<sup>1</sup> Private sector here refers to for profit entities and their affiliated foundations; financial intermediaries; business associations; large, medium, and small businesses; multinationals, regional and local businesses; and for profit approaches.

# Blended finance has been increasingly successful in mobilizing private capital

Private capital mobilized through blended finance has been growing..

Private capital mobilized through blended finance – 2012-15<sup>1</sup> (Global – excluding high income countries)

USD Billion



..with healthcare emerging as a major area of capital deployment

## Global Health Innovation Fund

**Size and timeline of instrument:** ~\$108 million<sup>2</sup> from 2012 onward

**Instrument:** A pooled social impact investment fund with a partial loss guarantee

**Stakeholders:** Investors include International Finance Corporation, GlaxoSmithKline, Merck, Pfizer Foundation, Grand Challenges Canada, the German Ministry for Economic Cooperation and Development (through KfW), Children's Investment Fund Foundation, AXA, Storebrand, and JPMorgan Chase. The Gates Foundation and the Swedish International Development Cooperation Agency provide investors with a partial loss guarantee, assuming the first 20 percent of loss. Above that amount, the guarantors share risk equally with investors. A total of about \$65 million of investors' capital is protected through this mechanism.

**Outcome:** Advancing the development of drugs, vaccines, diagnostics and other interventions against diseases that disproportionately burden low- and middle-income countries

## Cameroon Cataract Bond

**Size and timeline of instrument:** ~\$2.5 million investment over 5 years (2018-22)






**Instrument:** Development Impact Bond (DIB) - to provide working capital to eye-care service provider, to help them scale up number of cataract surgeries being performed

**Stakeholders:** OPIC and Netri foundation (Investors), Magrabi ICO Cameroon Eye Institute (Service provider), Conrad N. Hilton Foundation, The Fred Hollows Foundation, and Sightsavers (Outcome funders)

**Outcome:** Improving availability and quality of cataract surgery services in Cameroon by enabling completion of 18,000 quality (as per WHO standards) surgeries over the next 5 years, and thereby resulting in a ~40% increase in Cameroon's cataract surgery capacity

# USAID brings a unique combination of 5 advantages to support blended finance transactions in health

## USAID advantages in spurring blended finance transactions (compiled based on 40+ internal & external stakeholder interviews)

Advantage	Description
<b>1 Grant capital and credit guarantee authorities</b> 	Extensive experience in deploying grant capital as the largest donor in global health and implementing DCA guarantees across sectors and countries
<b>2 Technical and programmatic expertise in global health</b> 	Wide-ranging experience in identifying health challenges and implementing interventions across health areas
<b>3 Convening power and credibility</b> 	Expertise in crafting multi-stakeholder arrangements, with a track record of partnering across the private, public, NGO and FBO sectors
<b>4 Country presence and relationships</b> 	Mission presence in 60+ countries with specific local knowledge, networks, and stakeholder relationships
<b>5 Ability to influence and accelerate policy</b> 	As an official US government agency, able to support policy or regulatory advances to attract private investments as well as ensure appropriate governance and monitoring of transactions

## Voices from within and from partners emphasized a greater role for USAID in blended finance

“USAID’s **focus should be on how to increase private capital** in healthcare delivery – not just investment, but financing from all sources to allow private sector to play a larger role”

– USAID/OPCM

“With large resources at their disposal, **USAID adds credibility** to any project. They should have a very **hands-on project outlook** for best outcomes”

– OPIC

“**Innovative financing is gathering a lot of momentum**, and I think USAID should also actively engage in this exercise”

– IFC

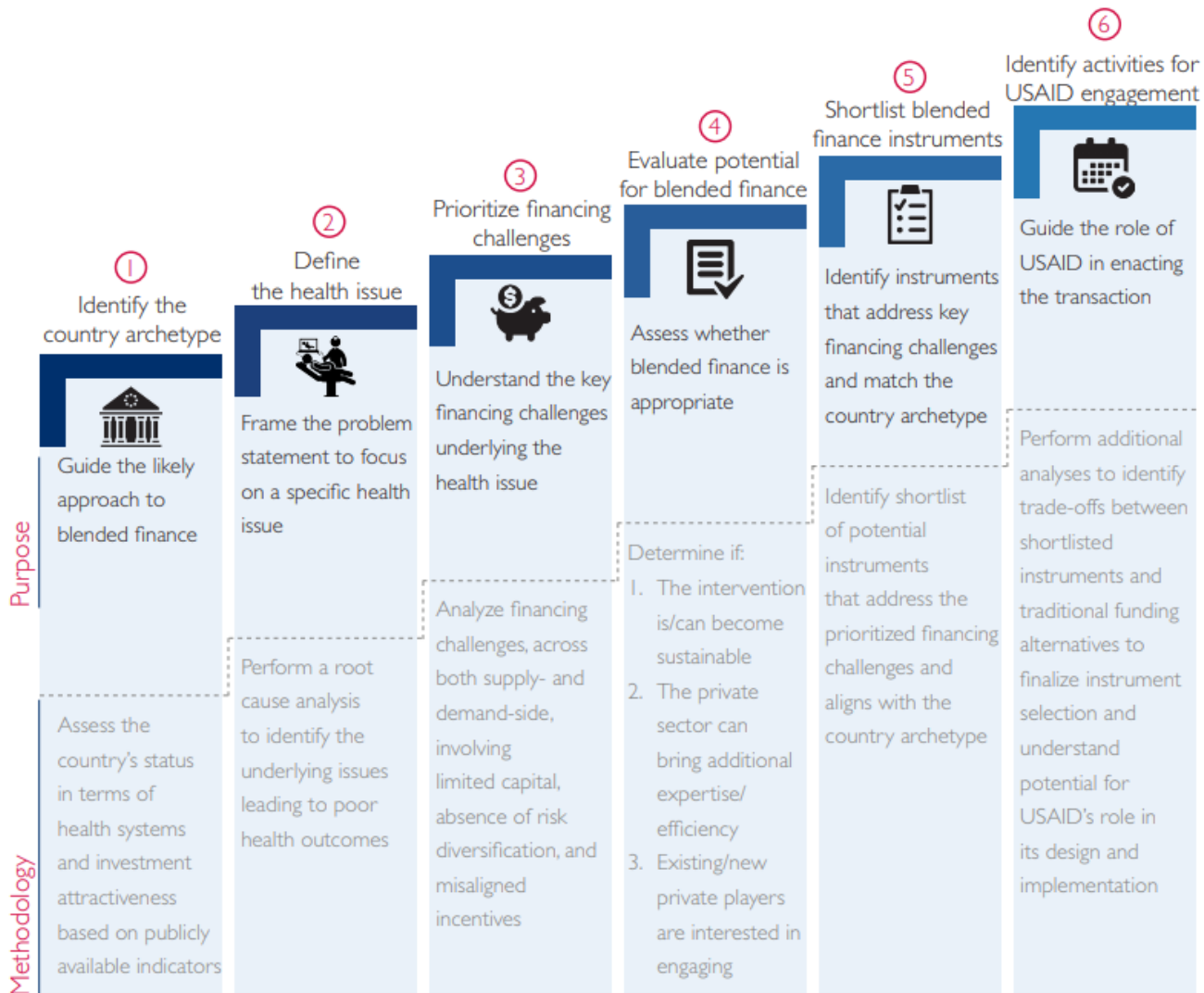
**USAID’s ability to convene parties and power is tremendous.** It can help in health sector by increasingly tying outcomes to investment which is something commercial investors overlook

– Global Innovation Fund

USAID has a **huge amount of transferable knowledge**, and can take results-based financing to the next level

– World Bank

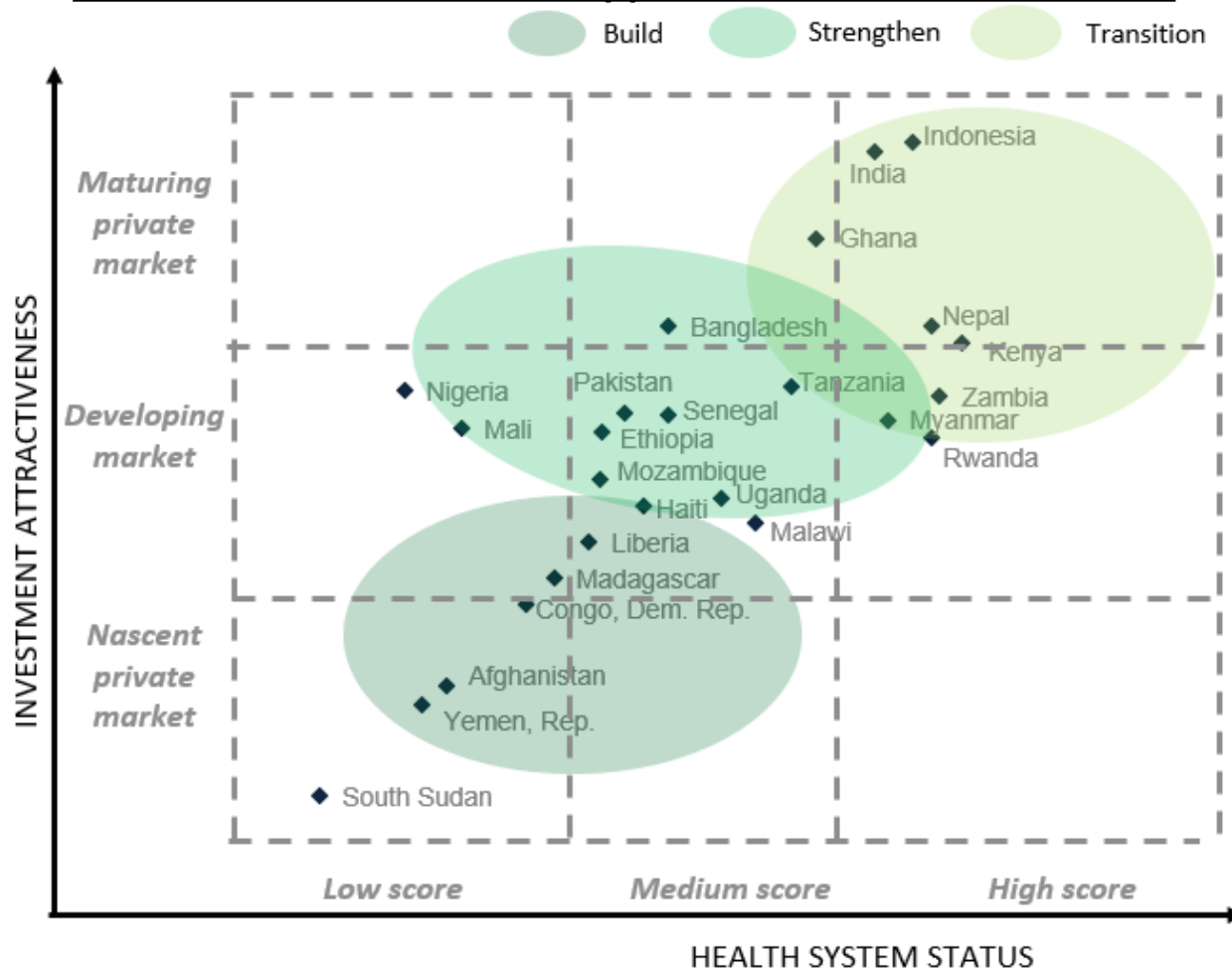
# We developed a roadmap—a six-step process—to help USAID identify blended finance opportunities to achieve its health goals





# Archetypes suggest different blended finance approaches for USAID's 25 PCMD countries

## USAID's PCMD countries mapped across 3 blended finance



**Build:** Countries with basic financing systems. Difficult to deploy blended finance instruments but can support market development by strengthening the enabling environment.




**Strengthen:** Countries with growing private markets. Can implement basic blended finance transactions to demonstrate the opportunity for investment to improve health outcomes.

**Transition:** Countries with stronger financing systems that can support more complex blended finance transactions to improve health outcomes.

*Note: This exercise has been performed using publicly available data sources. Please see [slide 71](#) in the annex for details.*

## Different country archetypes call for tailored blended finance approaches...

- The archetypes can be useful in shortlisting blended finance instruments that can likely be used in addressing the country's healthcare issue
- The country archetype is not prescriptive and is only meant to serve as broad guidance to identify potential blended finance instruments
- These archetypes should only be used as a starting point for considering blended finance options

Country Archetype			
	Build	Strengthen	Transition
Health status	Minimal PHE, insufficient access to health facilities, and poor health outcomes	Moderate PHE, better health infrastructure but low access, improving health outcomes	Better PHE with variable healthcare access and better health outcomes
Investment attractiveness	Underdeveloped financial sector, lack of investor interest	Financial markets still developing, but private healthcare players have better access to capital	Better established financial sector as well as moderately developed private healthcare sector
Likely approach for blended finance	Development agencies can focus more on building capacity and pipeline for blended finance	Amenable to deploying simpler instruments but not ready yet for complex blended finance tools	Development agencies can deploy complex blended finance tools, helping countries more quickly transition to self-reliance
			

## India is a *Transition* archetype; it aims to eradicate TB by 2025

### Health system status

India is doing better relative to other low-middle income countries, and continues to improve

- For instance, and number of doctors per 1,000 members of population has increased from 587 (2006) to 758 (2016)
- Health outcomes have also improved – MMR has fallen from 280 (2005) to 174 (2015) and IMR from 55.7 (2005) to 35.3 (2015)<sup>1</sup>

### Investment attractiveness

India has an established financial sector, with increasing investor interest in the health sector

- Foreign players have entered the country's private health sector either directly or through partnerships- e.g., Pacific Healthcare, IHH Healthcare
- The total value of private equity investments in healthcare has increased from 94 million USD in 2011 to 1,275 million USD in 2016

### Archetype

India falls in the *Transition* archetype, which indicates that relatively more complex blended finance instruments can be explored in the country

### Country healthcare context

India's health system is predominantly private-sector driven - 78% of the urban and 72% of the rural population seeks care in the private sector, and out-of-pocket expenditure accounts for 64% of India's total health expenditure. In this context, India launched the world's largest public health scheme – the National Health Protection Scheme (NHPS) – in 2018 to provide health insurance coverage to 100 million poor families. While this will cover the very-low income population, coverage for a huge number of low-income and middle-income families is likely to remain low leading to the problem of the 'missing middle'.

India has made considerable progress reducing the epidemic disease burden over the last few decades. However, it still has a long way to go in achieving the SDG 2030 goals to end the AIDS, TB, and malaria epidemics .

27% of the global TB burden and 24% of global MDR-TB cases are in India. The Government, under the National Strategic Plan (NSP) has set an ambitious target of TB-free India by 2025, with a strong focus on the spectrum of care and the private sector, which is expected to handle ~50% of the nation's TB diagnosis and reporting.

1. MMR refers to maternal mortality rate per 100,000 live births, IMR refers to infant mortality rate per 1,000 live births  
 2. Source: Funding Indian Healthcare (PwC, 2017), World Bank, WHO, USAID India CDCS, National Vector Borne Disease Control Programme; World Malaria Report 2017 NHPS, India National Strategic Plan (2017-2025), Stakeholder interviews

# TB patients in India face high out-of-pocket payments (OOPs)

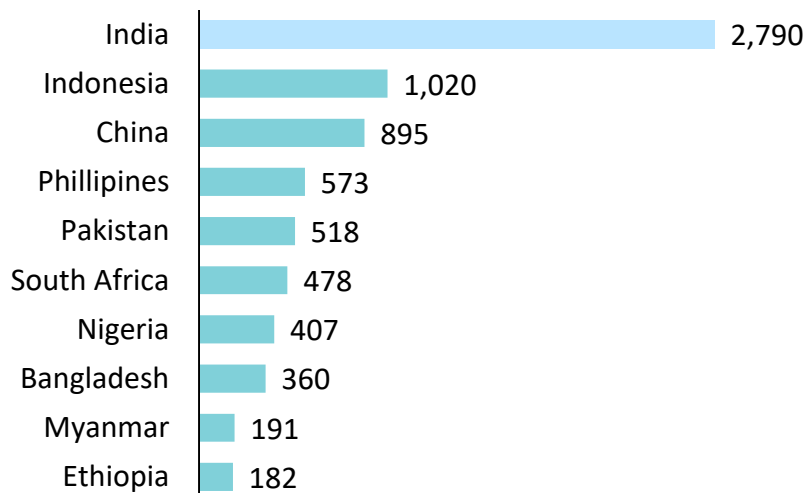
## Focus area: Tuberculosis



India has the highest TB burden in the world, contributing to over 27% of all TB incidences globally. This deep dive focused on the eradication of TB, a priority of the national government and the USAID Mission.

### Total TB Incidences

# of Incidences in Thousands



Prioritized based on Mission interest



## Underlying health issues

For low income groups<sup>1</sup> suffering from TB, OOPs can be catastrophic<sup>2</sup>, but the government has yet to address this issue comprehensively.

High OOPs are driven by **3 major factors**:

- 1 Loss of 2-4 months of income during the diagnosis phase and the intensive phase of treatment (50-70% of total out-of-pocket expenditure)
- 2 High cost of nutrition<sup>3</sup> and travel costs related to regular visits to health center (20-30% of total out-of-pocket expenditure)
- 3 High hospitalization costs for quality inpatient care in the private sector (10-20% of total out-of-pocket expenditure)

<sup>1</sup> Annual income of \$2,300-\$7,000 (Boston Consulting Group – NBFCs 2.0)

<sup>2</sup> Catastrophic health expenditure is defined as out-of-pocket spending for health care that exceeds a certain proportion of a household's income with the consequence that households suffer the burden of disease (WHO)




<sup>3</sup> Nutritional support for TB patients is the focus of a parallel effort by Mission

SOURCE: 1. World Bank database CSSC 2. Health Facility Registry, Ministry of Health, Community Development, Gender, Elderly and Children

## Providing support for out-of-pocket payments presents multiple demand-side and supply-side financing challenges

Existing/potential options for patients to manage out-of-pocket payments due to TB		Key financing challenges		
		Demand-side	Supply-side	
<b>A</b> Cash transfer through banks	Provision of direct cash transfers to patients' bank accounts. Govt of India currently provides Rs 500/ month (~7 USD) which covers only the nutritional needs of TB patients		<b>Limited capital:</b> Funding for pure grants is limited	
<b>B</b> Loan by NGOs	Provision of loans at a concessional interest rate to patients who may not be suited for traditional loans	<b>Poor financial means of patients:</b> Patients have limited savings and/or cash flows to manage out-of-pocket expenditure and do not have collateral to put up against loans	<b>Revenues insufficient to cover costs:</b> Under a concessional lending model, revenues generated are not sufficient to match cost of lending to patients	
<b>C</b> Loan by banks/ NBFCs	Provision of loans by banks/non-banking financial companies (NBFCs) to credit-worthy patients		<b>High default:</b> High potential for loan default among low income TB-patients	<b>High perceived risk:</b> Lenders see loans to patients as very high-risk and avoid lending to them
<b>D</b> Loan by MFIs	Provision of loans by micro-finance institutions (MFIs) to patients who typically aren't able to access credit		<b>Access to capital:</b> MFIs have limited access to bank lending to fund health loans	

# Assessing the potential for blended finance narrowed the options to NGOs and MFIs

 Preferred option  Favorable  Unfavorable

Existing/potential options	Self-sustainability of underlying intervention	Additional efficiency brought by private players	Availability of interested existing/ potential partners
<b>A</b> Cash transfer through banks	<i>Fully dependent on grant support</i>	<b>Bank transfers prevent leakages, since cash is transferred directly into patients' accounts</b>	<i>NGOs available to onboard patients; patients in target geographies already have low-balance deposit accounts with banks<sup>1</sup></i>
<b>B</b> Loan by NGOs	<i>Low interest rate structure does not generate sufficient revenues to cover costs sustainably</i>	<b>NGOs incur lower costs to enroll patients into scheme due to pre-existing network within TB population</b>	<i>One NGO currently lending to TB patients – offers loans at 9% per annum (pa); others willing to explore</i>
<b>C</b> Loan by banks/ NBFCs	<i>NBFCs face low defaults as they lend only to patients with high credit-worthiness</i>	<b>Banks/NBFCs have low default risks due to their highly effective credit assessment systems</b>	<i>Not keen on entering unsecured health lending space –expect default to be very high and hence foresee interest rate of ~45% pa</i>
<b>D</b> Loan by MFIs	<i>Relatively higher interest rates<sup>2</sup> compensate for the higher default on the portfolio</i>	<b>MFIs have low operating costs since their credit and collection systems are tailored to lend to low-income segment patients</b>	<i>One MFI actively lending to TB patients; Several others interested</i>

1. Over 318 million bank accounts were opened as a part of the Pradhan Mantri Jan Dhan Yojana (PMJDY), a financial inclusion program of the Government of India, from Aug 2014 – Jun 18 2. MFI interest rates are 18-24%, compared to the 12-15% charged by banks & NBFCs SOURCE: Team analysis, Government of India

# Blended finance instruments linked to NGOs and MFIs can address OOP expenditures

Status quo instrument

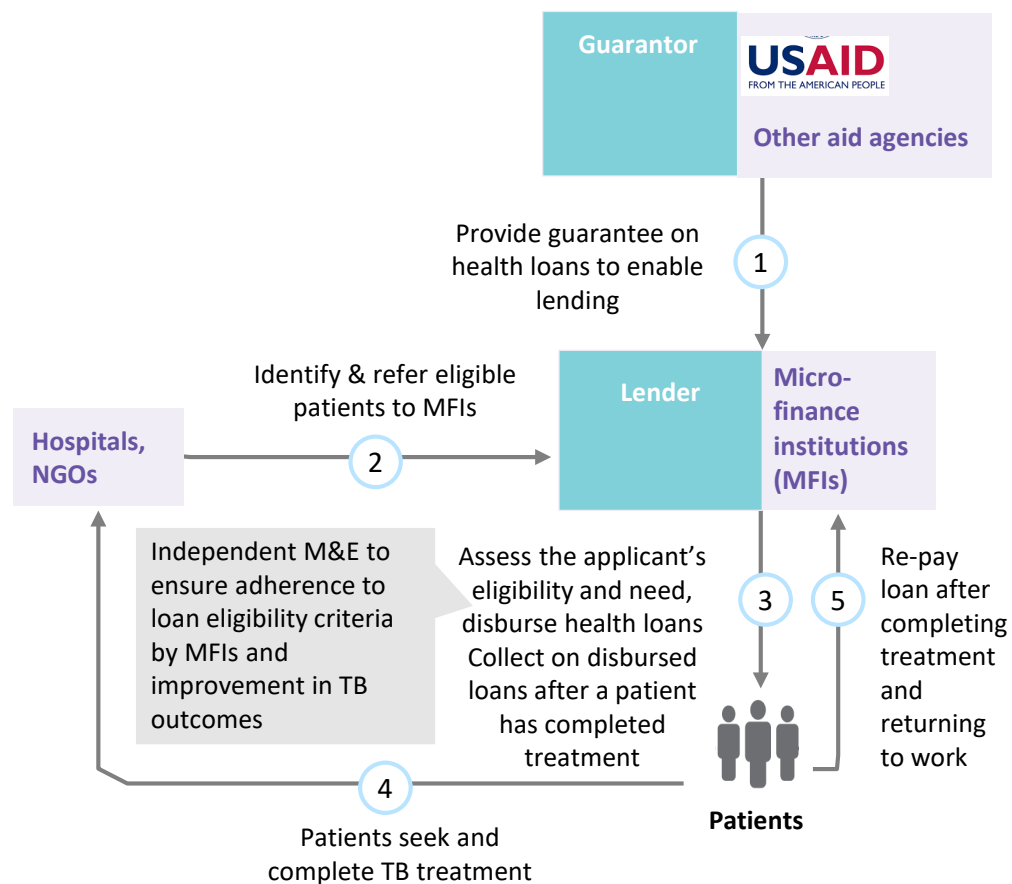
Financing challenges	Instruments	Blending mechanism	USAID role	Private sector role
Patients have limited savings and/or cash flows to incur any out-of-pocket expenditure	<b>Conditional cash transfer</b>	Grants by donor based on adherence to treatment + Cash transfer through bank accounts	<ul style="list-style-type: none"> <li>• Outcome funding</li> </ul>	<ul style="list-style-type: none"> <li>• NGOs/social enterprises to identify low-income patients</li> </ul>
Revenues generated are not sufficient to cover costs	1 <b>Concessional loan by NGOs with grant support</b>	Loans at highly concessional rates provided by not-for-profit lenders + Grant by CSR/ donors to buy down interest	<ul style="list-style-type: none"> <li>• Grants provided to subsidize debt</li> </ul>	<ul style="list-style-type: none"> <li>• NGOs/ social enterprises that would identify and target low income patients</li> </ul>
High potential of loan default among low income TB-patients High perceived risk of lending to patients	2 <b>Health loan by MFIs with guarantee to MFI + TA</b>	Guarantee to de-risk health loan portfolio of MFIs (who will then lend to low-income TB patients) + TA to MFIs to support health sector lending + TA to NGO partners in educating/providing financial counselling to patients	<ul style="list-style-type: none"> <li>• Develop a guarantee to de-risk lending to TB patients</li> <li>• Provide TA to MFIs</li> </ul>	<ul style="list-style-type: none"> <li>• MFI lenders providing health loans</li> </ul>
MFIs have limited access to capital in order to fund health loans	3 <b>Debt to MFIs with guarantee to debt provider</b>	Banks to provide debt to MFIs to set up health loan scheme + Guarantee to debt providers	<ul style="list-style-type: none"> <li>• Provide guarantee to banks</li> </ul>	<ul style="list-style-type: none"> <li>• Banks to provide initial debt to deploy in health loan portfolio</li> <li>• MFIs to provide health loan</li> </ul>

# A health loan facility by MFIs with USAID guarantee and TA could generate multiple impact benefits

## High-level design of the health loan facility

### Potential role of USAID

- Identify MFIs and partner NGOs that align with the project objectives
- Provide guarantee (DCA) to MFIs against loans towards TB patients
- Set up TA facility to:
  - support MFIs in lending to the health sector
  - support implementing NGOs in educating patients and providing them financial counselling



### Impact

- Sustainable return to productive workforce in the long run:** Though patients will forego income over the duration of their recovery, they will make a more sustainable return to the workforce after completing treatment. This leads to a net increase in their earning capacity in the long run.
- Reduced likelihood of relapse:** Treatment completion reduces likelihood of relapse and ensures continued workforce participation along with more stable earnings.



# Small Group Breakout Session

## Questions for discussion

1. Have you had any experience with blended finance? If so, briefly describe.
2. What opportunities and challenges could you envision with the use of blended finance for reproductive health programming?
3. How could the community prepare for these opportunities and challenges?
4. How could blended finance benefit your own work?
5. Other reflections you want to share?

Thank You!



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