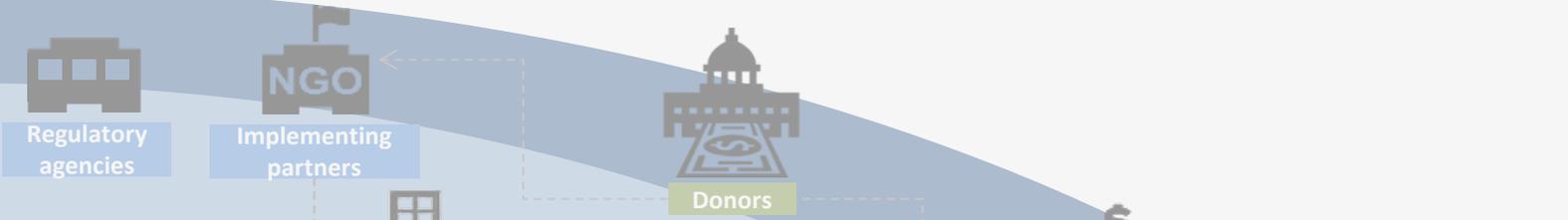


SYMPTOMS



ISSUES



SOLUTIONS



TOOLS



FRAMEWORK



Financing Framework to End Preventable Child and Maternal Deaths

Summer 2015

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The Financing Framework

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Identifying symptoms, underlying financing issues, and solutions

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Case study library

The EPCMD Financing Framework outlines ways USAID can support the transition to sustainably-financed health systems



Principles for the EPCMD Financing Framework

A sustainable financing approach for ending maternal and child deaths will:

- **Prioritize equity** in health service delivery, and support models that reduce the share of health expenditure shouldered by the poor and maximize use of funds;
- **Aim towards sustainable domestic financing**, both public and private, in line with economic growth;
- **Recognize that there is no one-size-fits-all model**, and that the path to self-financing will not be uniform across countries



Source: USAID (2015): Financing Framework Concept Note; Neil Brandvold for USAID (photo); Dalberg analysis.

This Financing Framework is a first step toward achieving these dual EPCMD and transition goals



The Financing Framework does...

- Promote the **broad understanding** of financing tools and their potential to accelerate progress toward EPCMD goals *and* help countries transition to self-financing
- Prioritize **results** and **equity** through the lens of ultimate self-financing
- Accelerate use of financing instruments in countries that are **graduating** or close to graduating to middle-income status
- Complement the ongoing efforts of the **Global Financing Facility**



The Financing Framework does not...

- Serve as an official **strategy** with specific targets and budget asks
- **Cover all aspects** of financing for global health
- Attempt to **replicate** other efforts in the space; instead, it draws from best practices already being used by the Agency and its partners
- Dictate **programming**

The Financing Framework explores financing opportunities to improve EPCMD funding flows, and considers their applicability to USAID's strategy for maternal and child survival

The United States has made bold commitments to ending preventable maternal and child deaths globally



The United States is committed to ending preventable newborn, child, and maternal deaths in a generation.

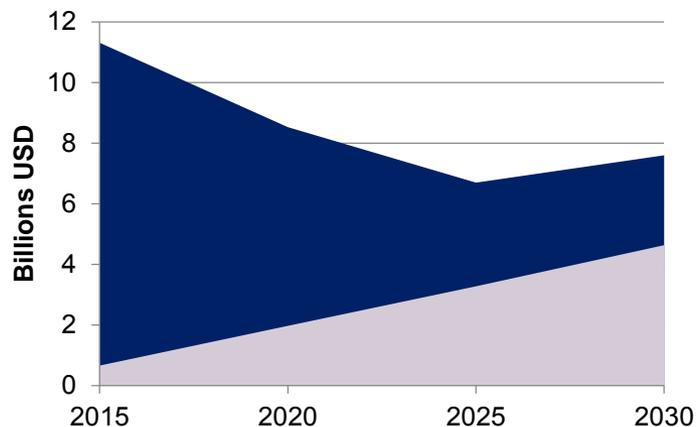


However, our maternal and child survival goals will not be achieved by 2035 without mobilizing additional resources for health



RMNCAH financing

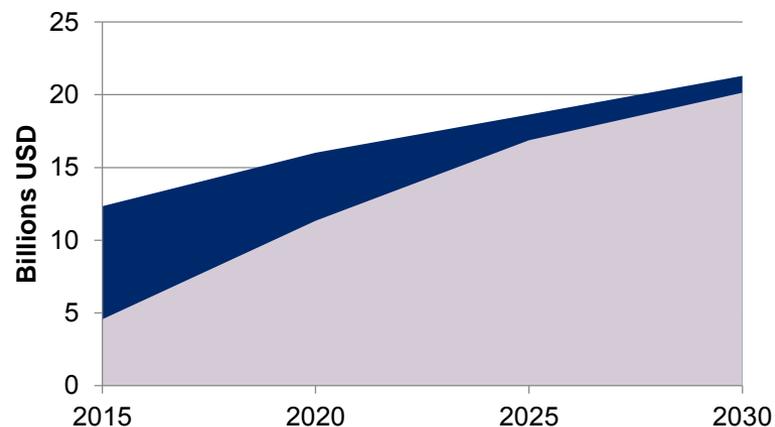
Low-income countries among 24 priority countries*



■ Unmet resource need
■ Domestic government expenditure on RMNCAH

RMNCAH financing

Lower-middle-income countries among 24 priority countries

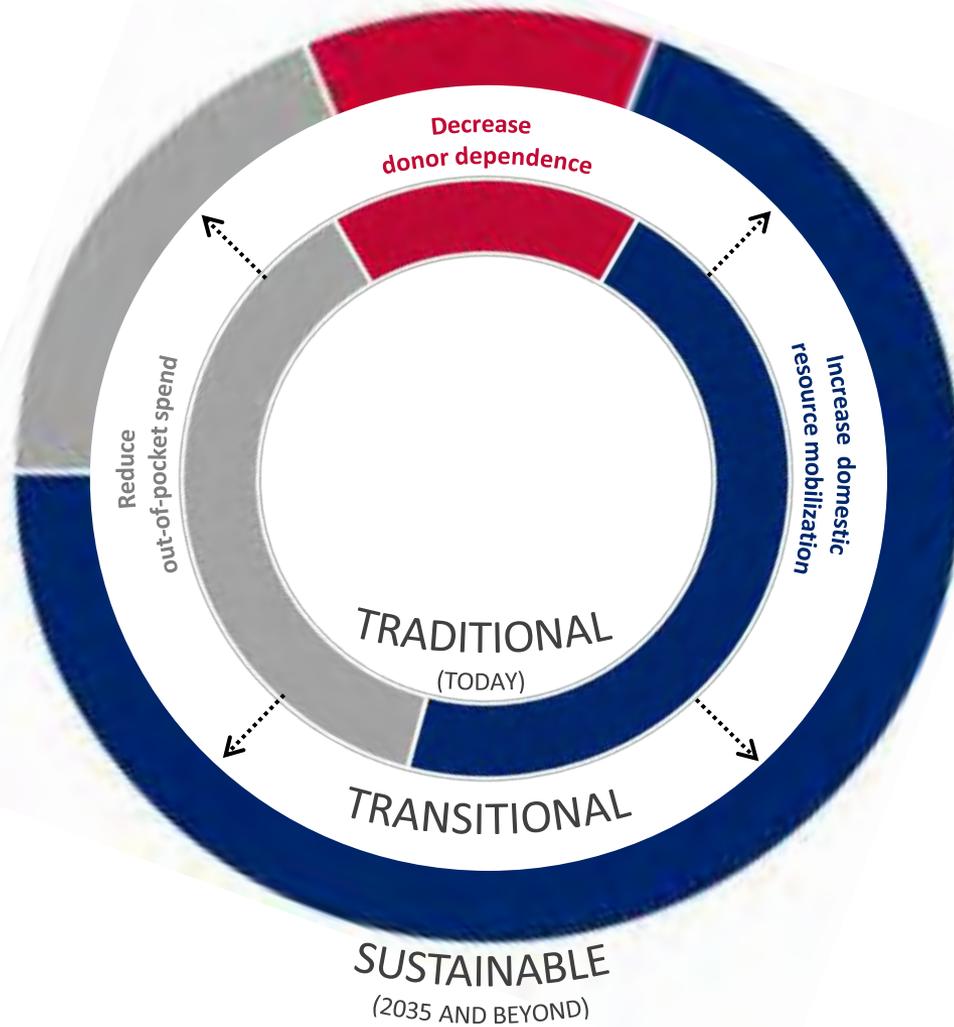


■ Unmet resource need
■ Domestic government expenditure on RMNCAH

- The EPCMD resource gap is currently \$27 billion in high burden low- and lower-middle-income countries
- This gap will decrease over time as economic growth fuels domestic resource mobilization
- This gap will range from \$4-8 billion in 2030, depending on domestic government RMNCAH spend

*Note: South Sudan not included in analysis due to lack of data. Source: World Bank (2014): "GFF Concept Note;" USAID (2014): "Acting on the Call Report;" Dalberg analysis.

Alongside achieving EPCMD goals, USAID envisions transitioning toward sustainably financed health systems



↓ DONOR DEPENDENCE

- **Traditional:** Development assistance for maternal, newborn, and child health surpassed \$6 billion in 2011; much of this assistance is in the form of grants, upon which many LMICs are dependent
- **Transitional:** Donors gradually sunset grants, increase the use of financing instruments to facilitate country-led transition to more sustainable health budgets, and reserve grant-based aid for global public goods and the last mile

↑ DOMESTIC EXPENDITURES

- **Traditional:** Many LMICs spend less than 15 to 30% of their government budget on health (Abuja Declaration target); many opportunities for private sector mobilization go unrealized
- **Transitional:** Through taxation and transparency programs, budget allocation efforts, and private sector mobilization, domestic public and private sectors increasingly replace donor funding

↓ OUT-OF-POCKET EXPENDITURES (OOP)

- **Traditional:** Out-of-pocket spending makes up over 40% of average total health expenditure in low-income countries, putting the poorest at risk of health-related financial catastrophes
- **Transitional:** Transitional support plans should ensure that out-of-pocket spending decreases to less than 20% of total health expenditure (e.g., through universal health coverage)

Source: IHME (2013): "Financing For Global Health 2013;" WHO (2011): "The Abuja Declaration;" WHO (2014): "Global Health Expenditure Database;" WHO (2006): "Exploring the thresholds of health expenditure for protection against financial risk;" Dalberg analysis.

Towards Sustainability: Understanding where we are and what we need to get there



TRADITIONAL

(2015)

- **Currently, the majority of donor budgets go toward grants** to implementing partners
- **To begin, consider which underlying financing issues** are currently most impacting your country's progress toward EPCMD goals
- **Connect with resources within the Agency** that can help you decide which tools might be right to try, and weigh the pros and cons of each before moving forward
- **Reach out to others at the Agency, within *and* outside health,** to understand how they think about and use financing tools at their mission, and identify opportunities for learning and collaboration

TRANSITIONAL

- **In program design and planning cycles,** actively consider the transition to sustainable finance
- **Increase direct use of tools** (e.g., DCA) and experiment with creative applications to the health sector
- **Work with other stakeholders,** such as domestic governments and implementing partners, to implement new tools indirectly
- **Plan for a self-financed future** through building graduation plans for EPCMD on a country-by-country basis
- **Consider the enabling environment required** to facilitate the use of tools, and collaborate with other parts of the Agency to find solutions

SUSTAINABLE

(2035 and beyond)

- **Many countries (with the exception of fragile or conflict states) are no longer donor-dependent;** some have achieved MDG maternal and child mortality targets
- **Health outcomes are equitable,** and even the poorest can access quality care without financial burden
- **If USAID maintains a presence in the country,** funds are focused on new health priorities, and directed at reaching last mile populations in a sustainable way

Sustainable financing tools are used in a small share of EPCMD programming today, but will be key to navigating the transition to self-financed health systems

It was developed through a collaborative process that sought to identify best practices within the Agency and beyond



**We THANK all the
Partners and
Agency staff who
participated in
developing this
Financing
Framework.**

Towards Sustainability: Introduction to the Financing Framework for EPCMD

▶ The Financing Framework

Resources to apply the Financing Framework

Deep dive on symptoms, underlying financing issues, and solutions

Tools to enable solutions: when and how they apply

Case study library

The Financing Framework promotes an understanding of how different financial tools support EPCMD and transition goals



IDENTIFY SYMPTOMS

Certain **symptoms** in EPCMD, felt across the health system, may be evidence of an underlying financing issue

***Example:** Frequent stock-outs at local dispensaries are causing disruptions in care*

DIAGNOSE ISSUES

These symptoms can be indicative of **underlying financing issues** that disrupt progress toward both EPCMD and transition goals

***Example:** Working capital gaps throughout the supply chain lead to delayed payments, and subsequently stock-outs*

ASSESS SOLUTIONS

Each of these issues can be addressed through a set of **solutions**; assessing the conditions under which solutions may work is critical before execution

***Example:** There is a solution space around increasing lending to the private sector to smooth working capital gaps*

EXECUTE TOOLS

There is a set of financing **tools** that USAID and its partners can use to enable solutions

***Example:** Guarantees to local banks can encourage increased lending to private health providers, dispensaries, or distributors*

The Financing Framework is a learning resource for USAID and partners to demonstrate the potential value of financing tools by linking them to EPCMD and transition goals

...and provides missions with a clear pathway to understanding when and how financing tools can be applied



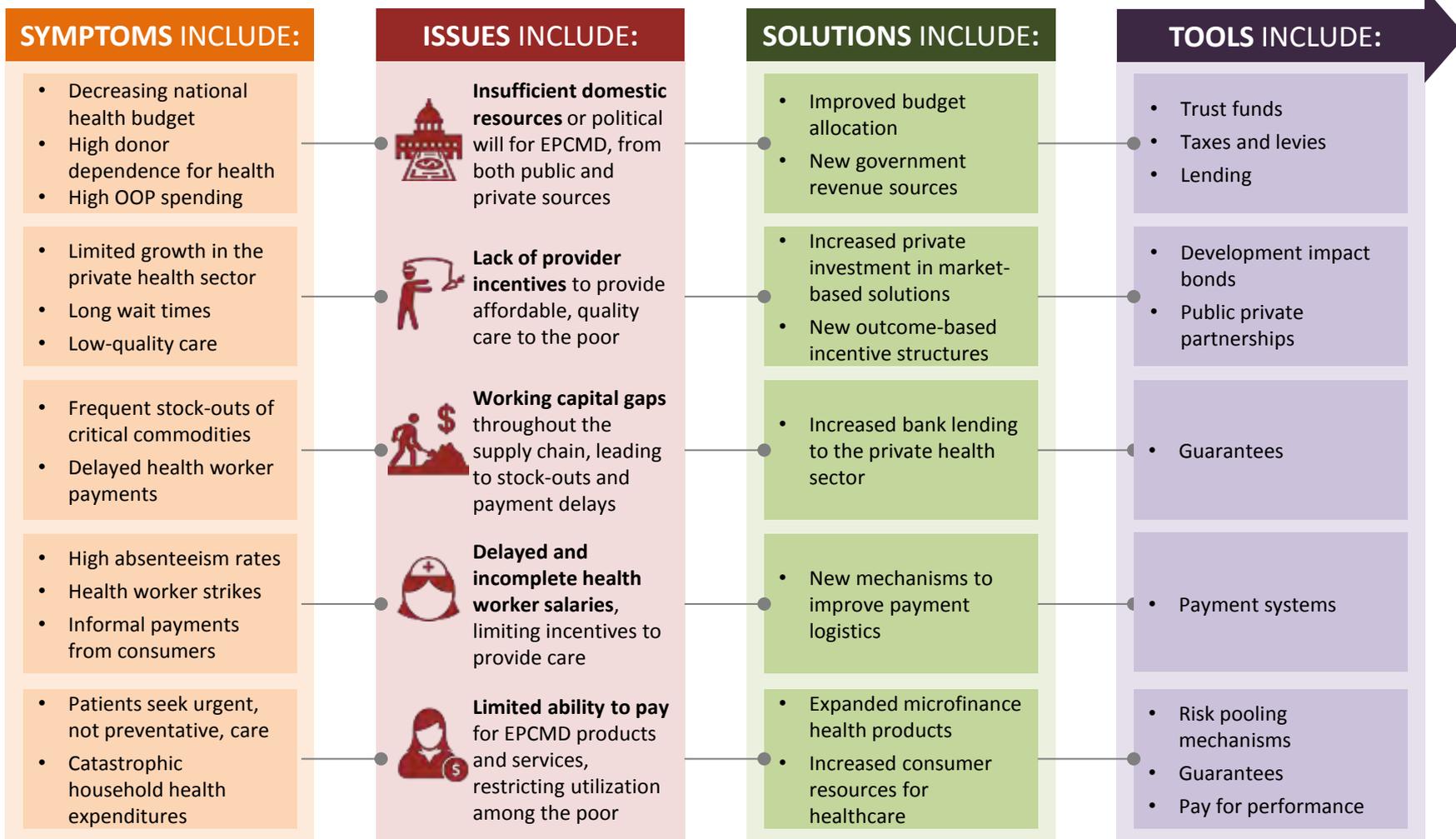
SYMPTOMS

ISSUES

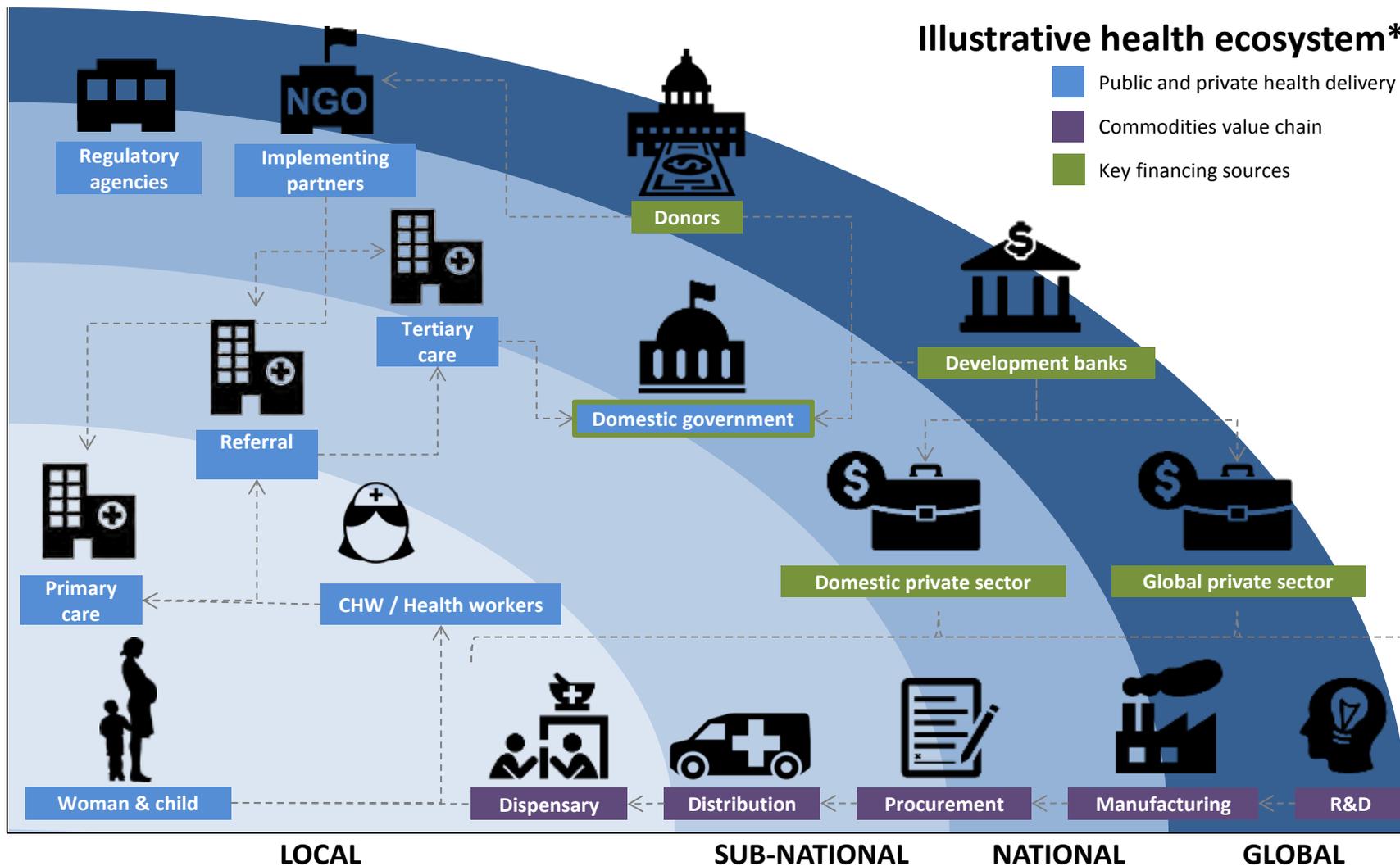
SOLUTIONS

TOOLS

FRAMEWORK

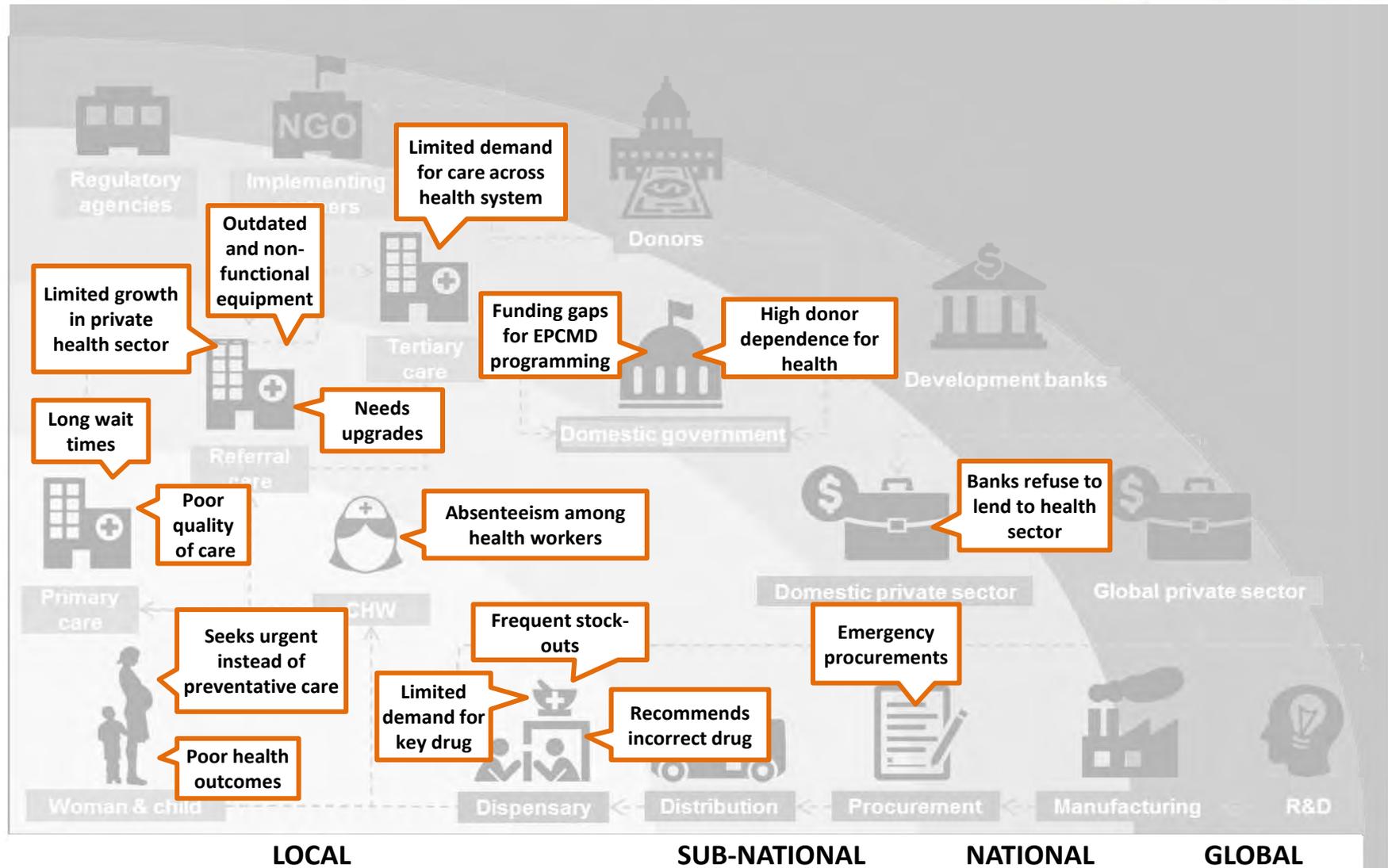


EPCMD products and services are produced and delivered through complex health ecosystems



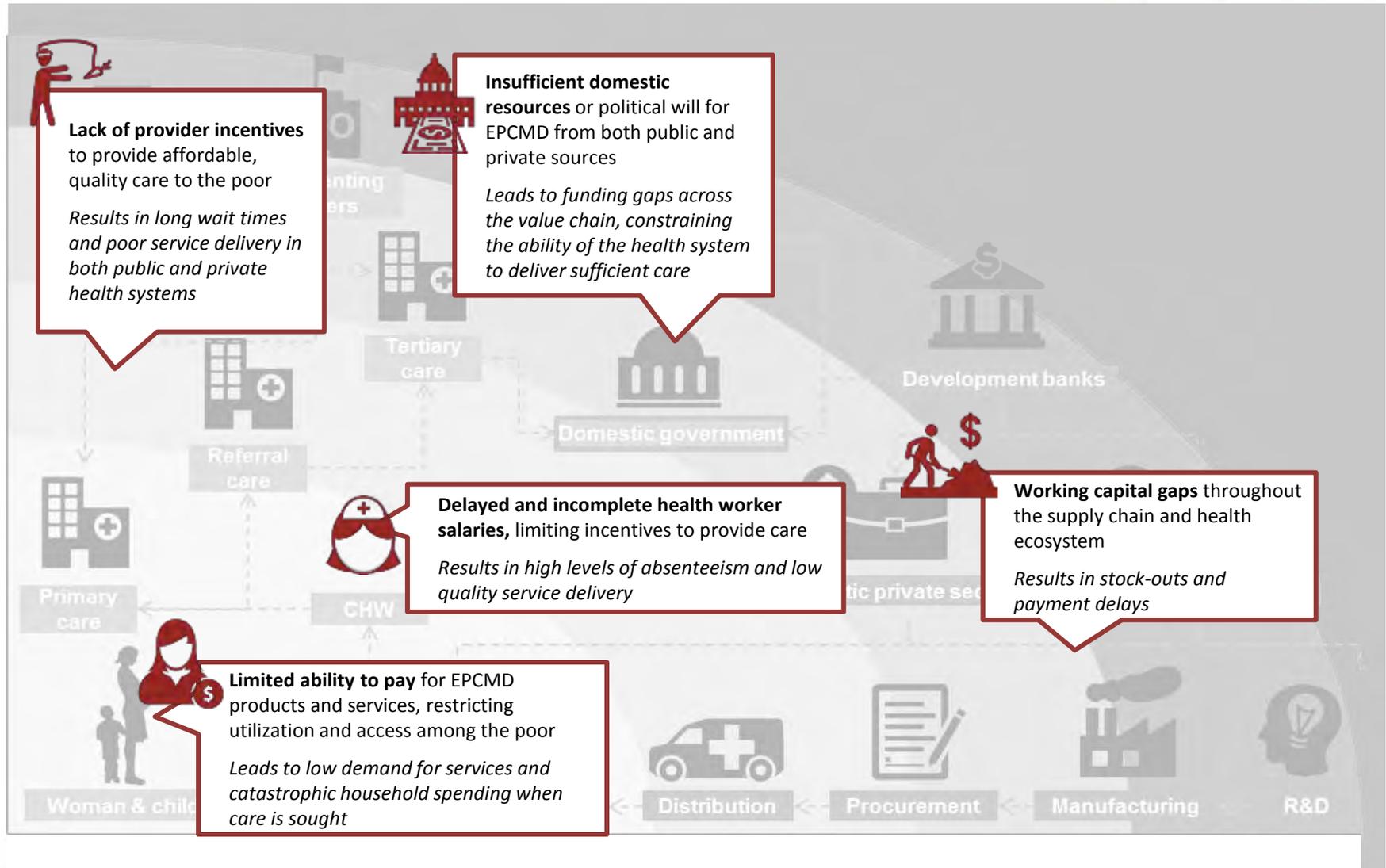
*Note: Not exhaustive; health systems vary considerably by country, and involve a complex set of players

A variety of symptoms exist within the health ecosystem that may indicate underlying financing issues that hinder our health goals



Source: Expert interviews; Dalberg analysis.

The Framework identifies five common financing issues that are often causes of these symptoms



Source: Expert interviews; Dalberg analysis.

The Financing Framework considers how and when these symptoms may be evidence of an underlying financing issue...



Symptoms include:	Financing issues	Alternative explanations include:
High donor dependence for health	 Insufficient domestic resources or political will for EPCMD, from both public and private sources	Extremely low-income or fragile economy
High percentage of out-of-pocket spending		Lack of coordination
Funding gaps for EPCMD programming		Limited capacity to absorb funding
Limited growth in private health sector	 Lack of provider incentives to provide affordable, quality care to the poor	Strong public delivery systems
Low quality care in public and private facilities		Insufficient training for health workers
Long wait times		Lack of health workers
Frequent stock-outs	 Working capital gaps throughout the supply chain, leading to stock-outs and payment delays	Broken supply chains; poor forecasting
Delayed health worker payments		Payment logistics challenges
Absenteeism among health workers	 Delayed and incomplete health worker salaries, limiting incentives to provide care	Insufficient non-financial incentives
Frequent health worker strikes		Insufficient funding for salaries
Informal payments from consumers		Lack of transparent payment systems
Low utilization of EPCMD interventions	 Limited ability to pay for EPCMD products and services, restricting utilization among the poor	Unavailability or unreliability of service providers; cultural norms
Patients seeking urgent instead of preventative care		Inaccessibility of service providers; lack of knowledge
Catastrophic household health expenditures		Lack of innovation in low-cost models

Source: Expert interviews; Dalberg analysis.

...relates each underlying financing issue to potential solutions...



Issues	Solutions include:	Examples
 <p>Insufficient domestic resources or political will for EPCMD, from both public and private sources</p>	<ul style="list-style-type: none"> • Improved government budget allocation to EPCMD • New government revenue sources • Increased government borrowing for health 	<ul style="list-style-type: none"> • Bonds • Concessional loans • Health budget increases
 <p>Lack of provider incentives to provide affordable, quality care to the poor</p>	<ul style="list-style-type: none"> • Increased private investment to scale market-based solutions • Greater incorporation of private provision into public health schemes • Increased consumer resources for healthcare • New outcome-based incentive structures 	<ul style="list-style-type: none"> • Investment funds • Public-private partnerships • Performance-based incentives
 <p>Working capital gaps throughout the supply chain, leading to stock-outs and payment delays</p>	<ul style="list-style-type: none"> • Increased bank lending to the private health sector 	<ul style="list-style-type: none"> • Debt facilities for providers and distributors
 <p>Delayed and incomplete health worker salaries, limiting incentives to provide care</p>	<ul style="list-style-type: none"> • New mechanisms to improve payment logistics 	<ul style="list-style-type: none"> • Mobile payments
 <p>Limited ability to pay for EPCMD products and services, restricting utilization among the poor</p>	<ul style="list-style-type: none"> • Increased consumer resources for healthcare • New national policies to improve access to care • New or expanded health savings, lending, and insurance products 	<ul style="list-style-type: none"> • Vouchers • Health insurance schemes

Source: Expert interviews; Dalberg analysis.

...and explores how financing tools can enable these solutions



SYMPTOMS					Relevant financing issues	Solution	Tools
Domestic resources	Provider incentives	Working capital	Delayed salaries	Ability to pay			
✓	✓		✓	✓	Improved government budget allocation to EPCMD	Trust funds	
✓	✓		✓	✓	New government revenue sources	Improved tax collection system	
✓	✓	✓	✓	✓	Increased government borrowing for health	Lending (including bonds and concessional loans)	
✓	✓	✓	✓	✓	Increased private investment to scale market-based solutions	Investment funds	
✓	✓	✓	✓	✓	Increased bank lending to the private health sector	Guarantees	
✓	✓	✓	✓	✓	Greater incorporation of private provision into public health schemes	Public-private partnerships	
✓	✓	✓	✓	✓	New outcome-based incentive structures	Pay for performance mechanisms e.g. development impact bonds and vouchers	
✓	✓	✓	✓	✓	New national policies to improve access to health care including new/expanded health savings, lending and insurance	Risk pooling mechanisms; investment funds; guarantees	
			✓		New mechanisms to improve payment logistics	Payment systems	

Source: Expert interviews; Dalberg analysis.

✓ First-order impact ✓ Second-order impact

There is a growing set of financing tools with potential for greater application to EPCMD programs



Tool	Definition
Guarantees	A DCA credit guarantee offers partial protection for lenders willing to enter and deploy capital (e.g. working capital) into developmentally important sectors like health. At USAID, guarantees can be arranged with sub-sovereign public sector and private sector entities (e.g. NGOs and non-profits), but not sovereign entities.
Lending	Lending includes bonds (e.g. diaspora bonds, health systems bonds), concessional loans, local currency loans, notes, and facilities. Bonds can be used to frontload access to ODA by leveraging long-term commitments to smooth financing flows.
Investment funds	Impact and other investment funds pool funds from socially responsible individuals and institutions and make investments that aim to solve social or environmental challenges, while generating financial returns.
Taxes and levies	Countries can strengthen and improve tax administration and collection processes for the purpose of increasing resources allocated to health.
Public-private partnerships (PPP)	Government service or private business ventures are funded and operated through a partnership of government, and one or more private sector companies, and other partners, such as NGOs.
Pay for performance (P4P)	Specific objectives are outlined when a financing agreement is made with a contractor. Funds are disbursed according to how closely these objectives have been met. Can be used to incentivize individual behavior change to increase demand for and use of services. They can also be used to incentivize innovation in a delivery system.
Risk pooling mechanisms	Health insurance schemes (e.g. national, micro, employee-sponsored) pool risk among consumers to improve efficiency and predictability of spending.
Payment systems	Payment systems include mechanisms that improve the efficiency and accuracy of payments within a health system (e.g. mobile payment platforms for community health workers).
Corporate social responsibility (CSR)	Companies integrate social/development issues into their business operations.
Trust funds	Country trust funds mobilize resources for a particular issue by pooling donor and domestic funding.
Development impact bond (DIB) and social impact bond (SIB)	All partners agree on a common goal and a way to measure success. Private investors finance a program aimed at achieving these agreed outcomes. If the program is successful – confirmed by independently verified evidence – then the ‘outcomes funder’ (usually a public sector agency, external donors) repays the investors.

Source: Dalberg (2014): “Innovative Financing for Development;” Expert interviews; Dalberg analysis.

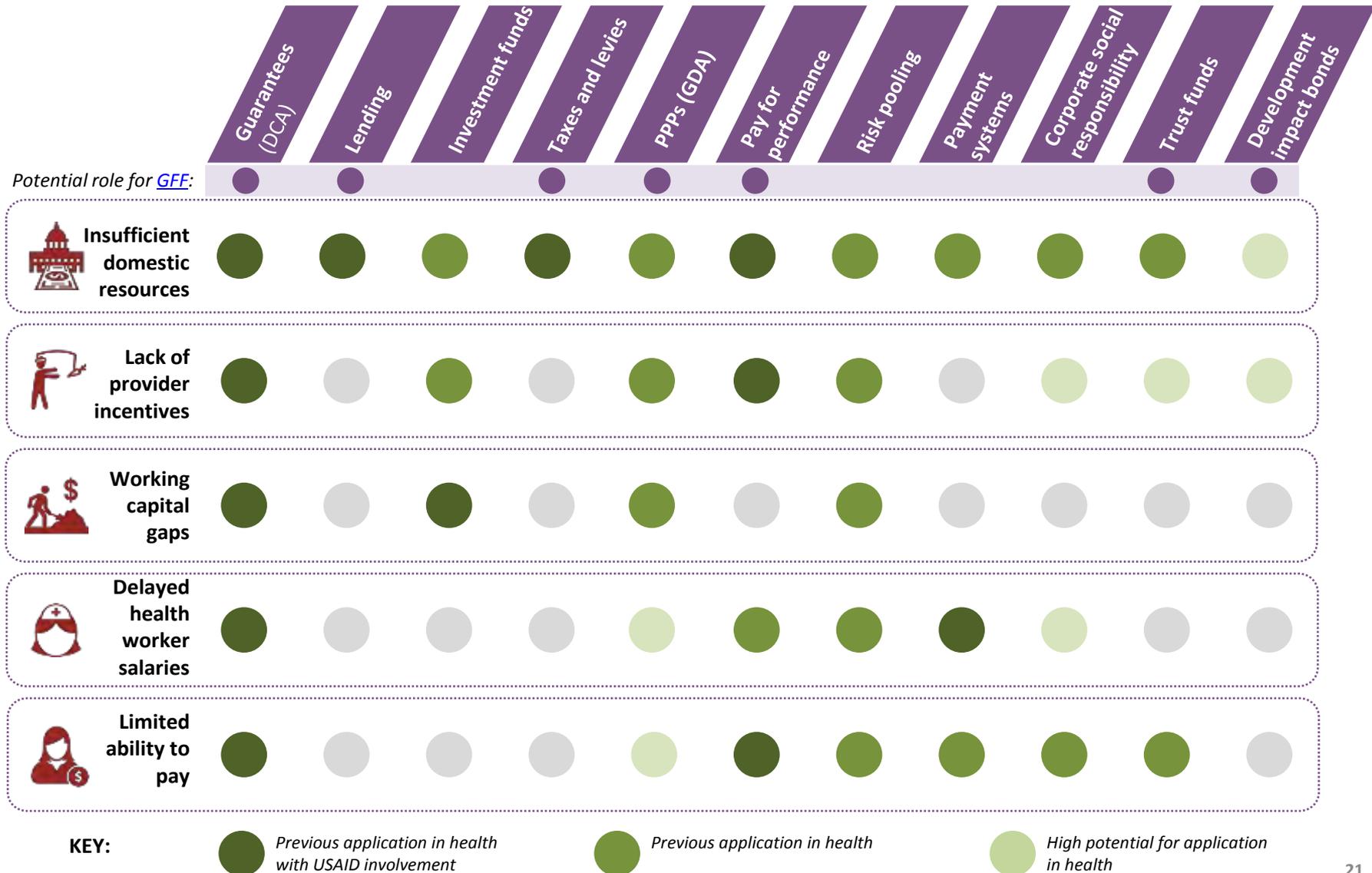
These tools have been underutilized in health and USAID has built support structures for many of them



Tool	Illustrative USAID support structure	Example
Guarantees	<ul style="list-style-type: none"> Development Credit Authority (DCA) 	Health lending DCA w/ Diamond Bank (Nigeria)
Lending	<ul style="list-style-type: none"> Strategic Transactions Group (within DCA) 	Bond issues or IDA borrowing for health
Investment funds	<ul style="list-style-type: none"> Global Development Lab (GDL) 	SHOPS program TA & grants for businesses
Taxes and levies	<ul style="list-style-type: none"> Bureau for Economic Growth, Education, and Environment (E3) 	UNITAID (various countries)
Public-private partnerships	<ul style="list-style-type: none"> Global Development Lab (GDL) 	Karuna Trust PPP (8 states in India)
Pay for performance	<ul style="list-style-type: none"> HQ-level knowledge management 	USAID Rwanda PBF (Rwanda)
Risk pooling mechanisms	<ul style="list-style-type: none"> Country-specific 	Linda Jamii microinsurance
Payment systems	<ul style="list-style-type: none"> mSTAR 	MAMA CHW mobile payments (Bangladesh)
Corporate social responsibility	<ul style="list-style-type: none"> Global Partnerships Team 	Product(RED) (Various countries)
Trust funds	<ul style="list-style-type: none"> Office of Private Capital and Microenterprise (PCM) 	Health insurance trust fund (Ghana)
Development impact bonds, social impact bonds	<ul style="list-style-type: none"> Headquarters-driven 	Educate Girls DIB (India)

Source: Dalberg (2014): "Innovative Financing for Development;" Expert interviews; Dalberg analysis.

Mapping the tools to financing issues reveals opportunities for USAID to further enable sustainable financing



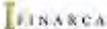
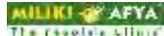
Interactive Tool: Click the links below to navigate and explore **financing issues**, financing tools, and **case studies**



Hover your mouse over different financing tools (right) or issues (below) or select logos and click to explore further

- Guarantees (DCA)
- Lending
- Investment funds
- Taxes and levies
- PPPs (GDA)
- Pay for performance
- Risk pooling
- Payment systems
- Corporate social responsibility
- Trust funds

Potential role for GFF:

	Insufficient domestic resources	 			 		
	Lack of provider incentives	 		 		 	
	Working capital gaps	 					
	Delayed health worker salaries						
	Limited ability to pay	 			 		

At any point, use the  icon to navigate back to this page

 Indicates a link to a case study

SYMPTOMS
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Towards Sustainability: Introduction to the Financing Framework for EPCMD

The Financing Framework

Resources to apply the Financing Framework

▶ Deep dive on symptoms, underlying financing issues, and solutions

Tools to enable solutions: when and how they apply

Case study library

The next chapters will take a closer look at the five prioritized financing issues and what it takes to identify and solve them



For each underlying financing issue...

	Insufficient domestic resources or political will for EPCMD, from both public and private sources
	Lack of provider incentives to provide affordable, quality care to the poor
	Working capital gaps throughout the supply chain and across the health ecosystem, leading to stock-outs and payment delays
	Delayed and incomplete health worker salaries , limiting incentives to provide care
	Limited ability to pay for EPCMD products and services, restricting utilization among the poor

...we provide three types of resources

Context and evidence	<ul style="list-style-type: none">• Provides an overview of the financing issue, its drivers, and evidence of its existence and effect in EPCMD priority countries
Diagnosis	<ul style="list-style-type: none">• Outlines a process for identifying whether a financing issue is the root cause of a symptom seen in the health system• <i>In many cases, financing issues will exist alongside other challenges, which must be addressed in tandem to effect change</i>
Solutions and tools	<ul style="list-style-type: none">• Outlines potential solutions to financing issues as well as when and how particular financing tools can be applied to enable those solutions• See the <i>“Tools to enable solutions”</i> section for more information on practical first steps to supporting a financing tool





Issue: Insufficient domestic public resources or political will for EPCMD result in funding gaps at all levels of the health system



Issue

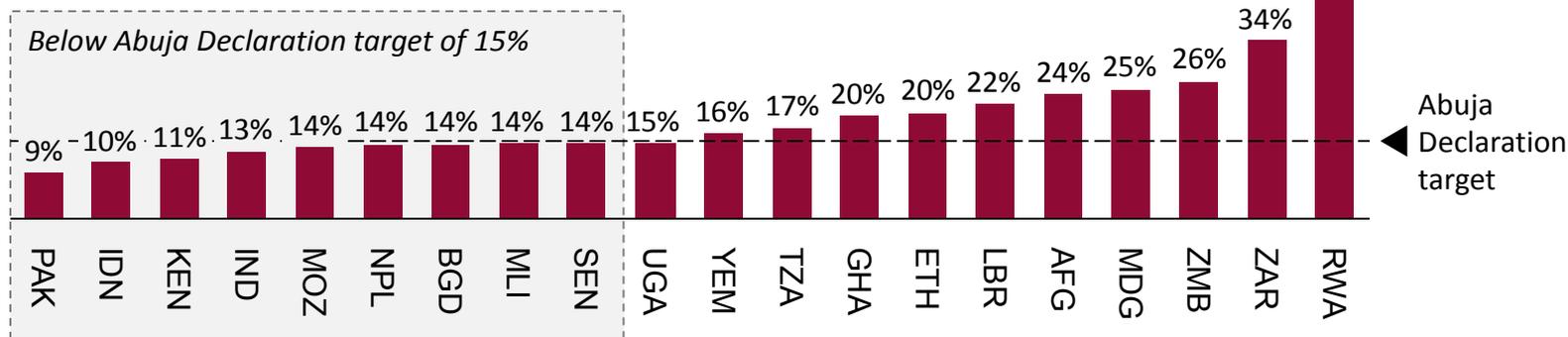
Domestic governments have limited resources for EPCMD due to, among other factors:

- *A limited tax base* as a result of widespread poverty and large informal economies
- *Limited capacity* for tax collection and high incidence of corruption and leakage
- *Competing budget priorities*, and a history of donor-funded health programs
- *Difficulty making the case for EPCMD spending* among other health priorities, especially as middle class constituencies grow



Over one-third of priority countries do not meet the Abuja target of 15% of general government expenditures going towards health

Health expenditure, public (% of GDP) / Tax revenue, total (% of GDP), 2012*

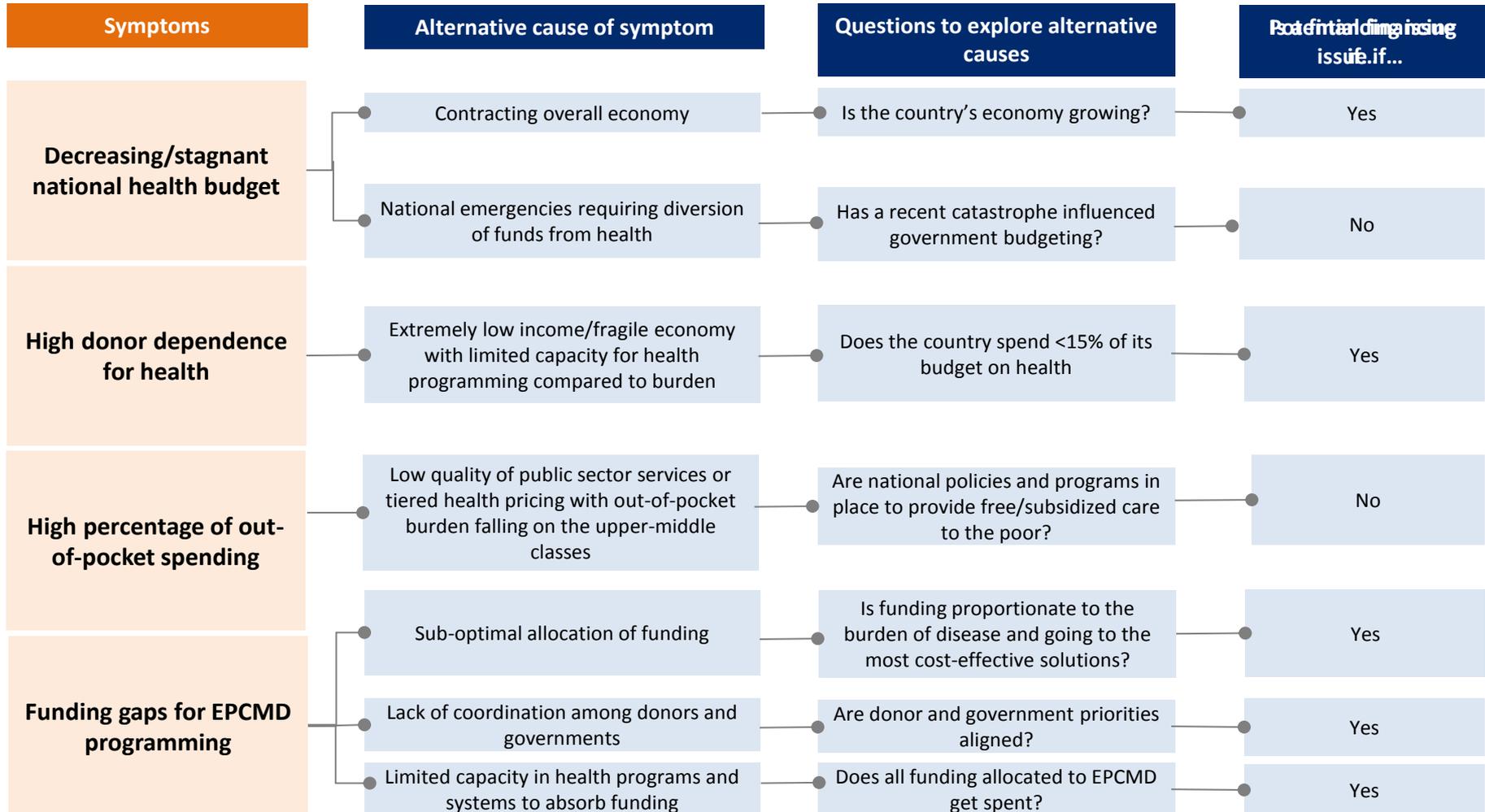


*Figures may seem high because they include on-budget donor funding

Source: World Databank (2013): "Size and Causes of the Informal Sector of the Nigerian Economy;" CSIS (2014): "Paying for Development: Domestic Resource Mobilization;" WHO (2011): "The Abuja Declaration 10 Years On;" Ebere Uneze (2014): "Domestic Resource Mobilization: A Financing Option for Sustainable Development in Africa;" International Business Times (2013) "How many people in India pay income tax? Hardly anyone;" Expert interviews; Dalberg analysis.



Diagnosis: Donor dependence and high OOP spend are common symptoms of insufficient domestic public expenditure



Source: Expert interviews; Dalberg analysis.





Solutions and tools: Taxes, trust funds, and lending can enable solutions to insufficient domestic resources



Solution	Tools	Conditions for application
New government revenue sources	Taxes and levies to increase government resources available for health and EPCMD	<ul style="list-style-type: none">• Political will exists to improve the tax collection capacity increase and increase health spending• Public delivery systems have capacity to absorb more funding
Improved government budget allocation to EPCMD	Trust funds to ring-fence domestic resources for EPCMD	<ul style="list-style-type: none">• Political will exists to allocate funds specifically to EPCMD• Donors are willing to coordinate their funding and contribute to trust funds
Increased government borrowing for health	Lending (e.g. bonds, concessional loans) to domestic governments on a long term basis for investment in health	<ul style="list-style-type: none">• Political will exists for long-term government investment in health• Large donor commitments exist and can be leveraged to enable stability and flexibility in EPCMD spending• Donors or governments are willing and able to guarantee bonds

Source: Expert interviews; Dalberg analysis.





Case study: USAID supported El Salvador on tax reform, mobilizing significant public spending



USAID
FROM THE AMERICAN PEOPLE



Before 2004, El Salvador had among the lowest tax revenues in Central America, with rampant tax evasion and limited capacity for collection. It lacked the resources it needed to invest in infrastructure, education, health, and other social services.

USAID partnered with the government of El Salvador in 2004 to reform its tax code, upgrade tax collection capacity, launch new audit systems, and adopt new technologies for tax collection authority.



WHAT IS THE MODEL?

Tax reform mobilized new domestic revenue sources and enabled increased spending on development, including on health.

WHAT IS THE IMPACT?

These reforms enabled the government of El Salvador to increase its revenues by \$350 million per year, enabling the country to double its per capita spending on health, education, and social spending while reducing extreme poverty by 25%.

Source: USAID: "Domestic resource mobilization: financing country-led development;" Dalberg analysis. USAID (photo)





Issue: Lack of provider incentives to provide affordable, quality care to the poor



Issue

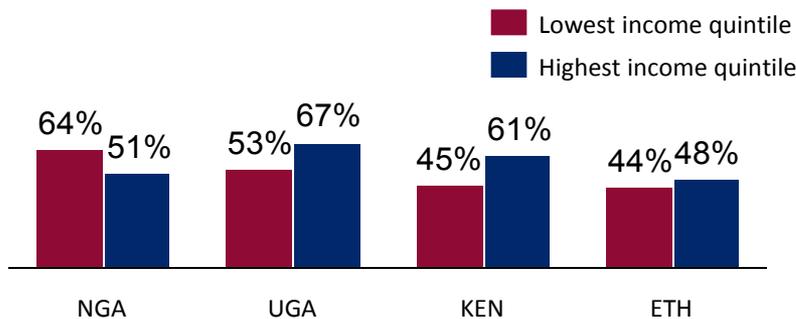
- Public providers offer **heavily subsidized care** to the poor, but resource constraints and poor incentive structures limit the quantity and quality of service provided. The difficulty of measuring quality as an output makes it hard—but not impossible—to incentivize quality care
- Artificially low prices in the public system **limit private providers’ incentives to compete** for low-income consumers on the basis of price.
- A lack of experimental, venture capital results in little to **no innovation in provider business models** to serve the poor
- Poor consumers’ limited ability to pay and difficulty assessing quality **constrains their ability to shape the market** by choosing among providers or demanding higher quality services
- As a result, **poor consumers lack viable options** for affordable, high quality healthcare. At public and private facilities, they encounter poor management, long wait times, absent or overburdened health workers, and rushed service



Evidence

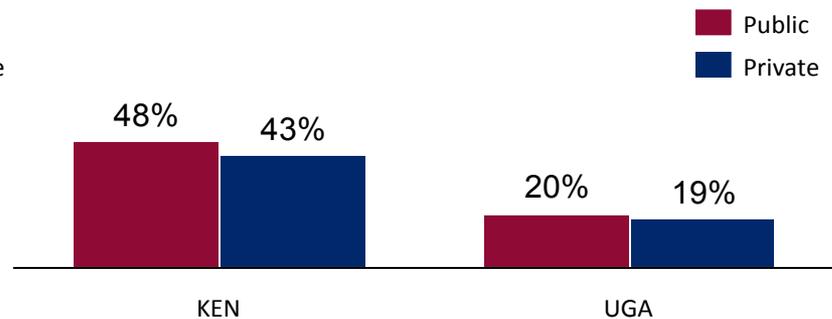
Despite subsidized public care, many customers, including the poor, choose private providers...

Population receiving care from private, for-profit providers in select priority countries (%)



...but private providers often don’t provide higher-quality care

Health facility performance in MCH complications (Kenya/Uganda, %)

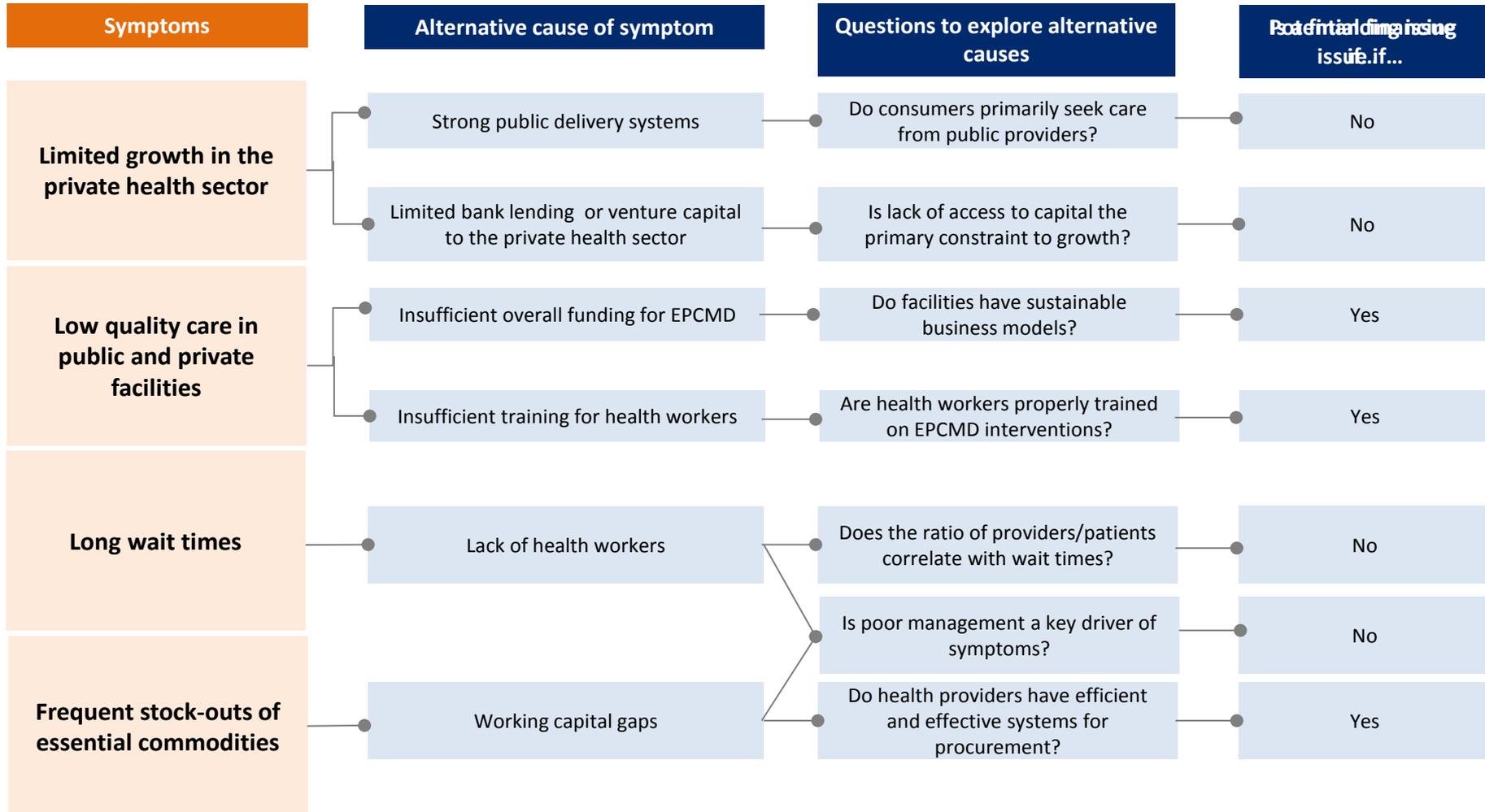


Source: IFC (2008): “The Business of Health in Africa;” World Bank: “Service Delivery Indicator Data;” WHO (2001): “Working with private sector providers for better healthcare;” USAID (photo); Expert interviews; Dalberg analysis.





Diagnosis: Low private sector growth and low quality care are common symptoms of limited incentives



Source: Expert interviews; Dalberg analysis.





Solutions and tools: PPPs, P4P, and DIBs can enable solutions that improve provider incentives



Solution	Tools	Conditions for application
Increased private investment to scale market-based solutions	Investment funds to invest in successful private business models to enable them to scale	<ul style="list-style-type: none"> • Innovative, financially viable private delivery models to serve the poor exist but lack the capital they need to scale • Investors are willing to accept the risk/return profile of these models
Increased resources for healthcare	Pay for performance mechanisms on the demand side (e.g. vouchers, CCTs) that empower consumers to help shape the market by choosing between providers	<ul style="list-style-type: none"> • Consumers have the knowledge necessary to make informed decisions about provision • The marketplace is competitive: consumers have access to multiple providers
Greater incorporation of private provision into public health schemes	Public private partnerships to bring private delivery models into the public health system, improving efficiency	<ul style="list-style-type: none"> • Poor management in public systems constrains efficiency and quality • Private providers exist that have the capabilities to run components of the public delivery system at low-enough cost • The government has sufficient resources to contract out and/or private sector players have vested financial interest
New outcome-based incentive structures	<p>Pay for performance mechanisms on the supply side that catalyze innovation in delivery models by linking incentives to outcomes rather than inputs</p> <p>Development impact bonds to catalyze innovation and improve efficiency in delivery</p>	<ul style="list-style-type: none"> • Political will exists to incorporate P4P incentive structures • Measurable outcomes and strong metrics and evaluation systems (M&E) exist • Funders structure incentives to strengthen the overall health system, not just for one vertical (e.g., family planning) • Measurable outcomes and strong M&E systems exist • Investors, donors, governments, providers, and intermediaries are all willing and able to coordinate • Investors are willing to commit to a longer time horizon

Source: Expert interviews; Dalberg analysis.





Case study: Rwanda's performance-based financing program with USAID is used as a model globally



In 2000, Rwanda's health system suffered from poor quality of care, maternal and infant mortality rates among the highest in the world, and low utilization of health services even when available. The health sector as a whole was both demoralized and severely understaffed.

Performance-based financing was one of three key prongs to a health sector reform strategy, alongside community-based health insurance to address ability to pay, and quality assurance to monitor the PBF program.



WHAT IS THE MODEL?

USAID, through PEPFAR funding, contracted Management Sciences for Health (MSH) to support the Ministry of Health with health sector reform. MSH worked with the MOH to develop and roll out PBF models nationally for HIV and primary care, including evaluation tools and a web-enabled information system for tracking.

WHAT IS THE IMPACT?

From 2005-2007, the program saw an increase in percentage of births attended by skilled health personnel from 31% to 52%, and a reduction in childhood mortality from 152 to 103 per 1,000 live births. All health centers in Rwanda are now under PBF.

Source: USAID (2009): "A Vision for Health: Performance-Based Financing in Rwanda;" USAID (photo); Dalberg analysis.





Issue: Working capital gaps across the value chain limit the quality and quantity of healthcare provided



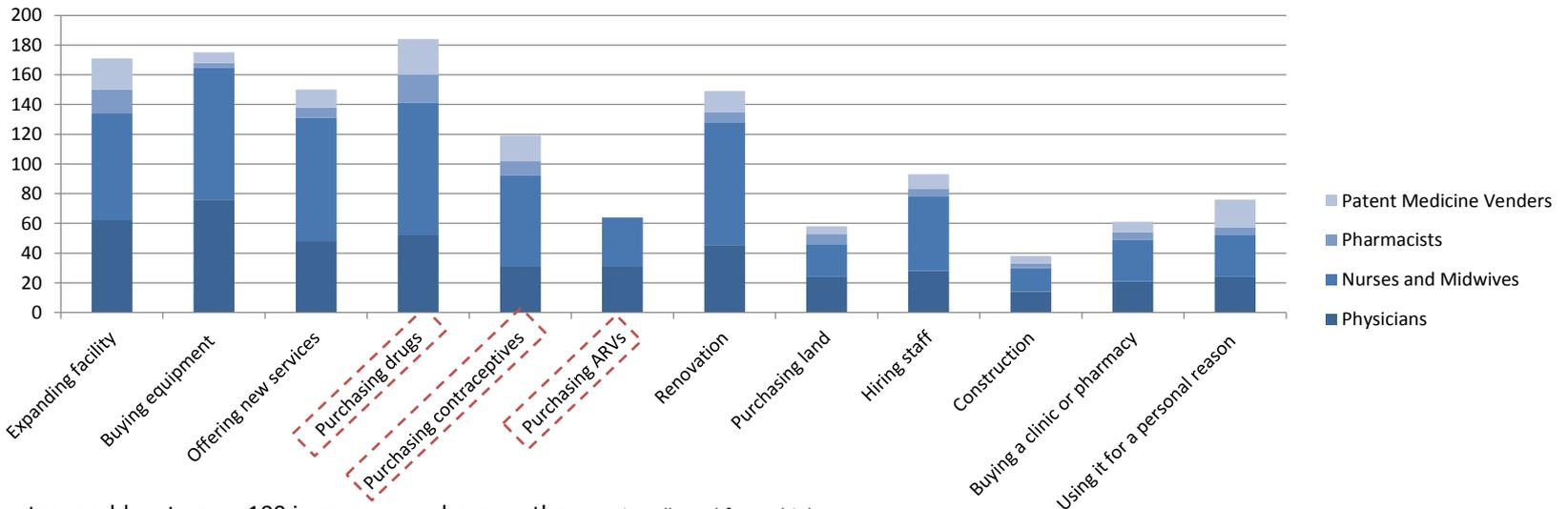
Issue

- Across the commodities value chain, **healthcare providers’ revenue streams often misalign with operating expenses**. Distributors, providers, and dispensaries must hold large inventories, but customers (individuals, insurance companies, government ministries, donors) often cannot pay up front.
- At the same time, providers **lack access to the credit to bridge their working capital needs**. Banks’ limited knowledge of the health sector and providers’ lack of formality and financial management skills prevent providers from accessing loans
- Without access to working capital, providers **cannot hold inventories, buy in efficient volumes**, and health worker payments may be contingent on accounts receivable. Working capital gaps thus lead to **stock-outs, delayed health worker payments, higher costs, and lower quality commodities and services**
- Working capital gaps are most common in private facilities, as many public providers receive in-kind support (commodities, labor), not cash

Evidence

Use of loans secured by private health providers in Nigeria

Lack of working capital among private health providers increases the need for credit to bridge the gap. In Nigeria, the majority of loans secured by private health providers were used to purchase commodities.*

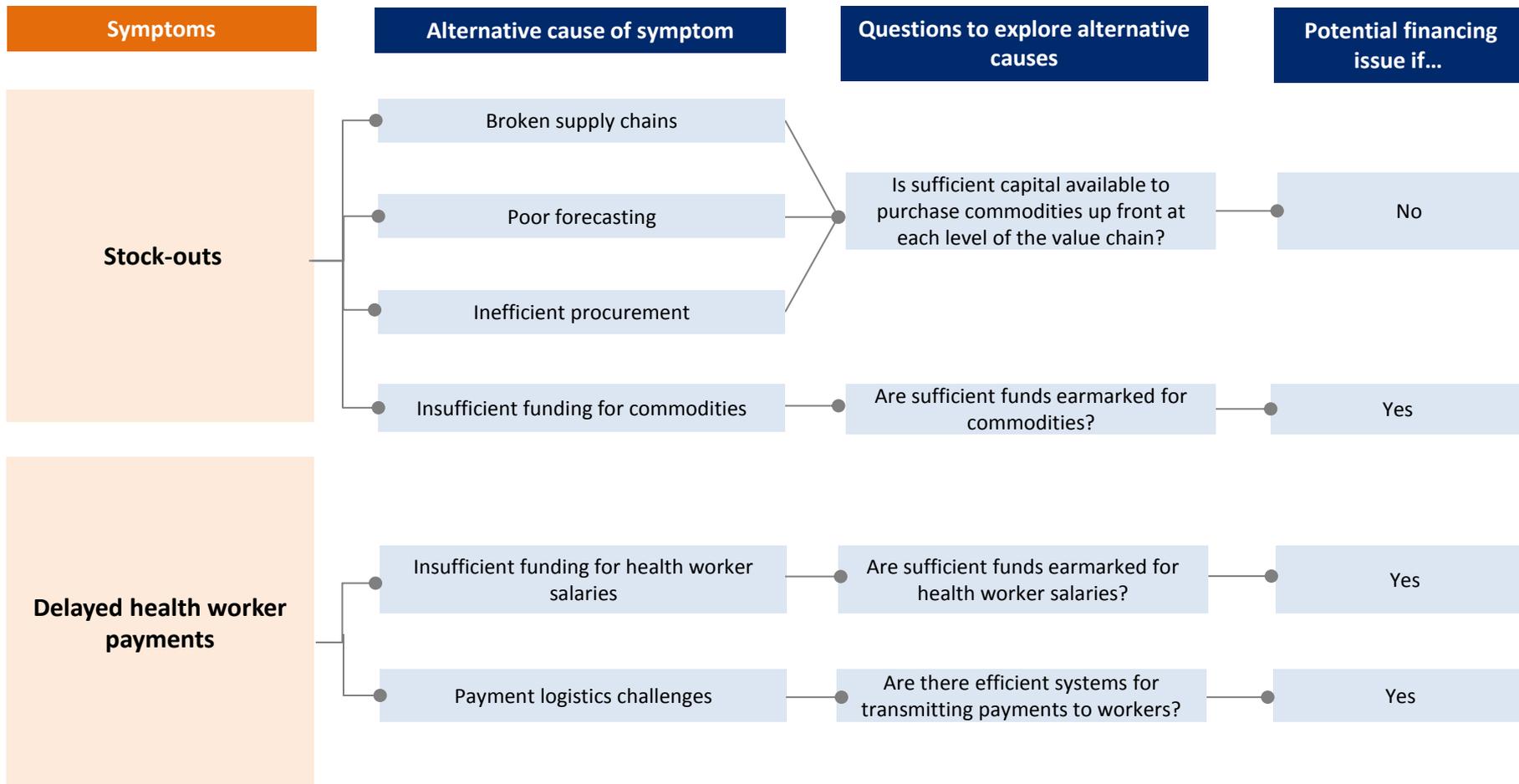


* Percentages add up to over 100 in some cases because the question allowed for multiple responses

Source: USAID (2009): “Financing and Business Development Needs of Private Health Care Providers in Nigeria”; Expert interviews; Dalberg analysis.



Diagnosis: Some stock-outs and delayed health worker payments in the private sector are symptoms of working capital gaps



Source: Expert interviews; Dalberg analysis.





Solutions and tools: Increased private lending to the health sector can be enabled through guarantees



Solution	Tools	Conditions for application
Increased private lending to the health sector	Guarantees to local banks can encourage increased lending to private or sub-national health providers, dispensaries, or distributors (often paired with technical assistance to borrowers and lenders)	<ul style="list-style-type: none">• A strong domestic private financial sector that is willing to consider health sector lending• A private (or sub-national) healthcare delivery system with financially viable business models that can or does provide products and services to the poor

Source: Expert interviews; Dalberg analysis.





Case study: A USAID DCA in Nigeria helped a major Nigerian bank start lending to healthcare providers



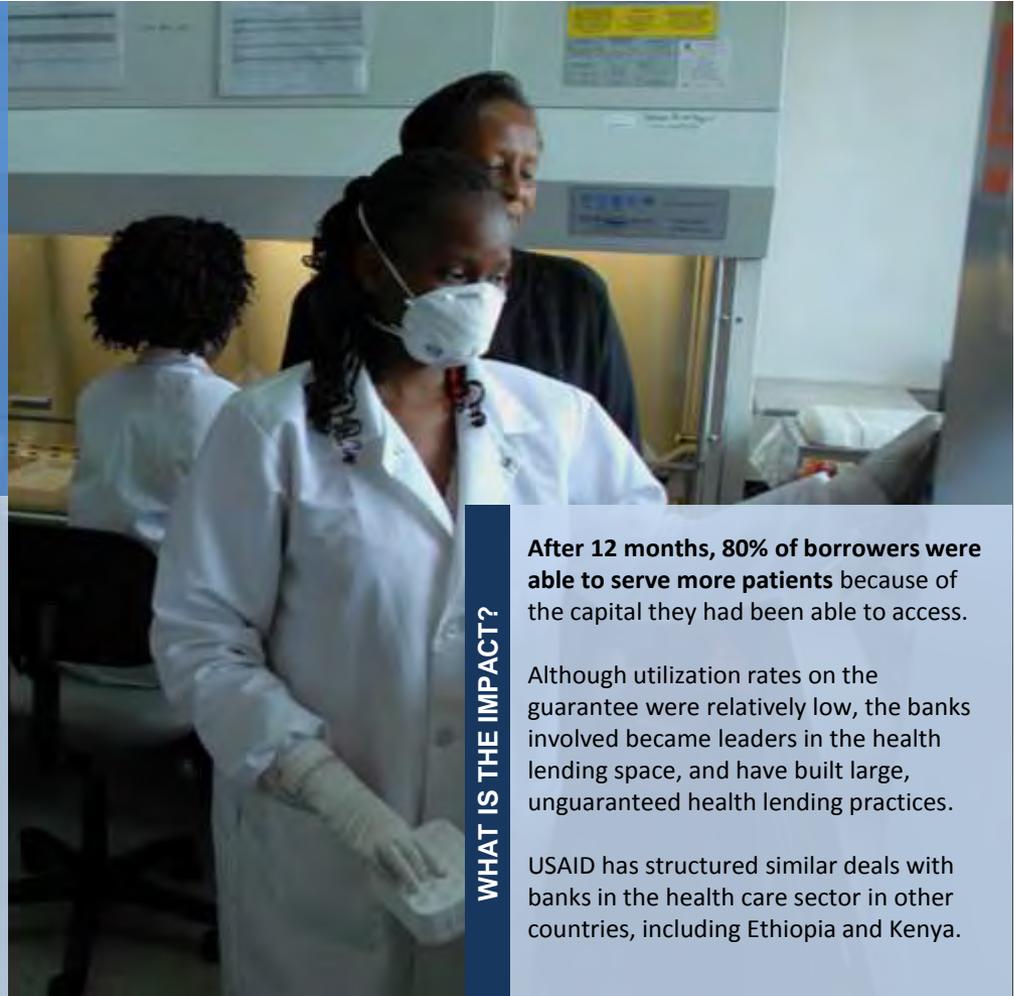
Development Credit Authority

Putting local wealth to work

Private healthcare companies in Nigeria are capital-constrained. This is a barrier to:

- Serving patients or customers, who often don't pay up front
- Holding inventory, which requires capital to be locked up for months, and
- Investing in their facilities, which may require borrowing against future revenues

This capital constraint reduces the quantity of patients they serve and the quality of that service.



WHAT IS THE MODEL?

- **USAID** guarantees loan portfolios to encourage **Diamond Bank and ACCION Microfinance** to begin lending in health sector
- **SHOPS**, funded by USAID, provides TA to banks to build their health sector portfolios, and to borrowers (e.g. clinics, pharmacies, midwives) to help make the business case to banks for loans and manage debt. SHOPS also facilitated linkages between banks and private healthcare providers.
- **Borrowers** can place larger orders to hold inventory, for example

WHAT IS THE IMPACT?

After 12 months, 80% of borrowers were able to serve more patients because of the capital they had been able to access.

Although utilization rates on the guarantee were relatively low, the banks involved became leaders in the health lending space, and have built large, unguaranteed health lending practices.

USAID has structured similar deals with banks in the health care sector in other countries, including Ethiopia and Kenya.

Source: USAID (2014): "Global Health DCA Primer;" SHOPS: "Nigeria;" US Army Africa (photo); Expert interviews; Dalberg analysis.





Issue: Delayed and incomplete health worker salaries limit incentives to provide quality care



Issue

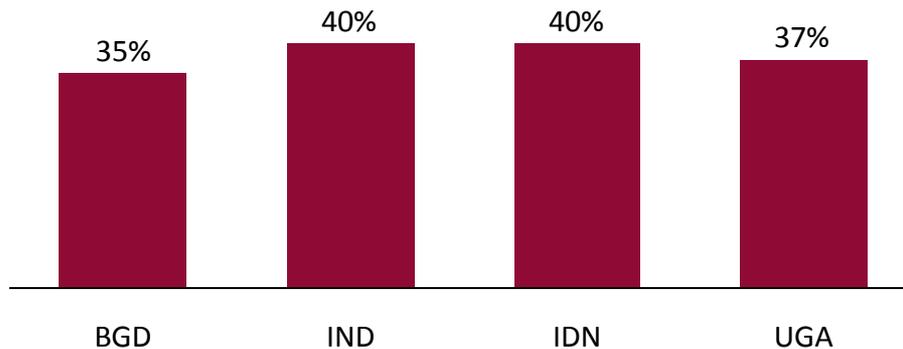


- Even when sufficient funding has been budgeted for health worker salaries, **salaries may not reach them on time or in full** due to inefficiencies in payment delivery systems, logistics management or lack of available funds
- Payments may pass through **several intermediaries** before reaching workers, resulting in **long processing times** and increasing the chance of **leakage and corruption**, particularly when salaries are **paid in cash**
- **Logistical difficulties** also impede efficient delivery: especially in rural areas, payments have to be sent over long distances to reach health workers
- Delayed and incomplete salaries limit health worker incentives to provide quality care, resulting in absenteeism, strikes, and informal payments from consumers to subsist in the face of incomplete or late salaries

Evidence

Absenteeism among health workers is common

Health worker absence rates in public clinics in select priority countries (% absent at time of spot check)

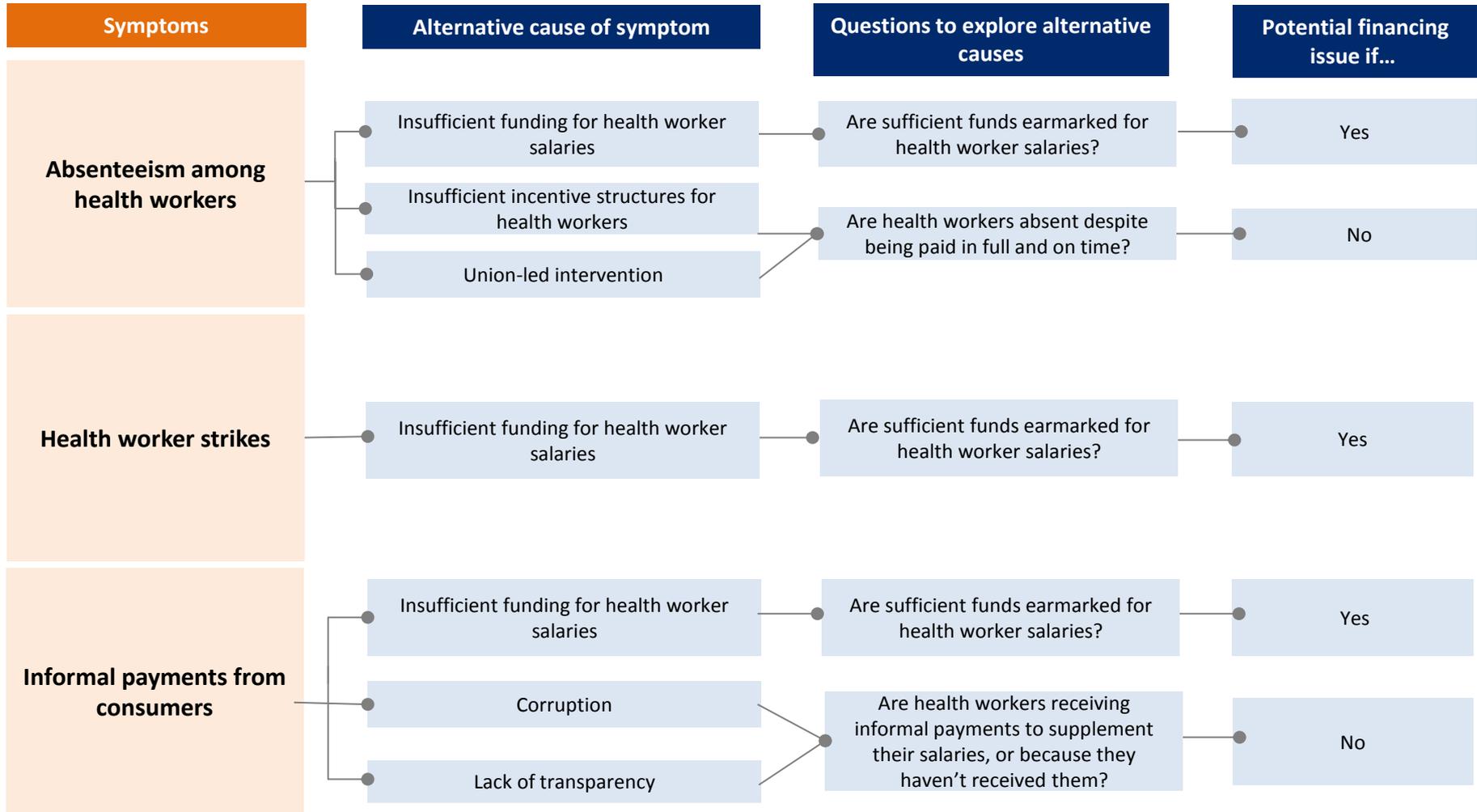


Source Chaudhury et al. (2006): "Missing in action: teacher and health worker absence in developing countries;" World Bank: "Service Delivery Indicators Data;" Kalra (2015): "Payment delays dent India's flagship health, AIDS programmes;" Brac (2015): "Mobile money improves incentive schemes for health workers;" USAID (photos); Expert interviews; Dalberg analysis.





Diagnosis: The key challenge is to distinguish delayed payments from insufficient funding for salaries



Source: Expert interviews; Dalberg analysis.





Symptoms and tools: Payment systems enable more efficient delivery



Solution	Tools	Conditions for application
New mechanisms to improve payment logistics	Payment systems to improve the efficiency of health worker payments, e.g. through digital currency and mobile money platforms	<ul style="list-style-type: none">• Sufficient funding exists for health worker payments• Strong and trustworthy digital infrastructure and banking systems exist in country• Mobile penetration is high
Increased private investment to scale market-based solutions	Investment funds to provide capital to design or scale models for efficient payment delivery	<ul style="list-style-type: none">• Successful payment delivery system models exist, but lack the investment capital they need to scale

Source: Expert interviews; Dalberg analysis.





Case study: MAMA and USAID had success using mobile payments for CHWs in Bangladesh



With the support of USAID's mStar project and FHI 360, MAMA created a strategy to use mobile payments for its CHWs.

1,200 CHWs with BRAC in Bangladesh had a partnership with MAMA, which offers healthcare SMS messages for expecting mothers – for every new subscriber, they received a monetary incentive. However, MAMA incentives **took 41 days and 32 person hours to process**, and had to be picked up in person, which posed opportunity costs and other deterrents for CHWs .



WHAT IS THE MODEL?

- **USAID's mSTAR project and FHI 360** supported MAMA in building the strategy and providing technical assistance (to both BRAC and the CHWs themselves)
- **MAMA's implementing partner Dnet** coordinated the process
- **Mobile payment services** like bKash and DBBL were selected as the partner payment platform

WHAT IS THE IMPACT?

- **Processing time for CHW incentives was reduced** from 41 days to 11 days
- Using mobile financial services instead of processing the payments in cash **saves nearly \$6,000 per year and 25.5 workdays per 1,000 CHWs**
- CHWs report satisfaction with the new system, including **feeling safer** that they do not have to carry cash back from the district offices

Source: BRAC (2015): "Mobile money improves incentive schemes for health workers"; UN (2014): "UN says health workers in Sierra Leone to receive hazard pay using mobile money;" Center for Health Market Innovations (2015): "Lessons Learned from Pathfinder on mobile money payments for CHWs;" DFID/BRAC (photo); Dalberg analysis.





Issue: Limited ability to pay prevents the poor from accessing care, hindering progress in EPCMD



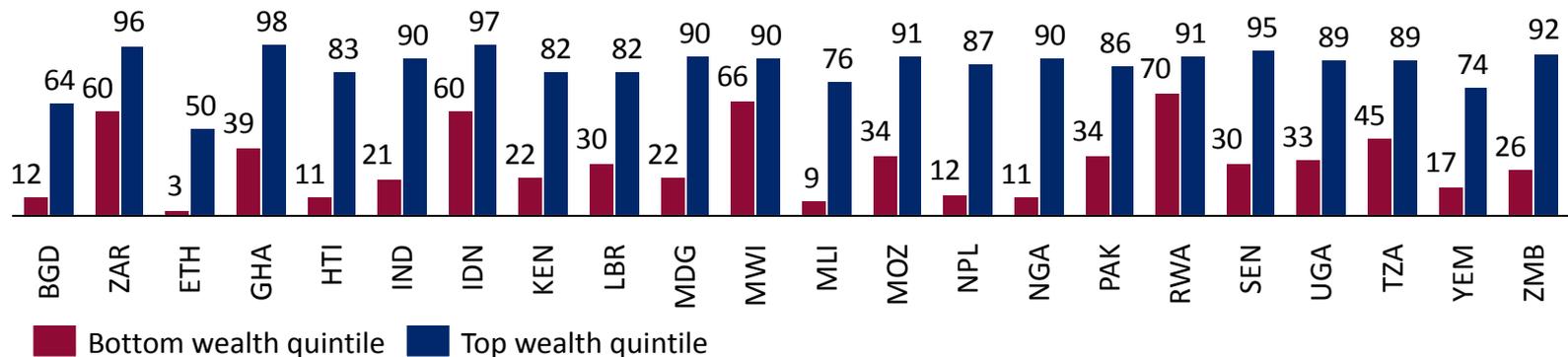
Issue

- High direct costs, indirect costs, and limited **incomes prevent women from being able to pay** for the EPCMD services they need without enduring financial hardship
- Financial considerations can outweigh perceived benefits of seeking care, **limiting mothers' use of services**
- As a result, many mothers do not access healthcare until their conditions have **escalated to emergency levels**, when interventions are both more expensive and less effective
- **High out-of-pocket costs** can subject those who do seek care to **financial catastrophe**, pushing them (further) below the poverty line
- Because consumers, especially the poor, lack resources, providers have few incentives to invest in serving them

Evidence

Ability to pay determines access to critical EPCMD services, as evident in the gap between rich and poor

Skilled attendant births by wealth quintile in USAID priority countries (% of births)¹



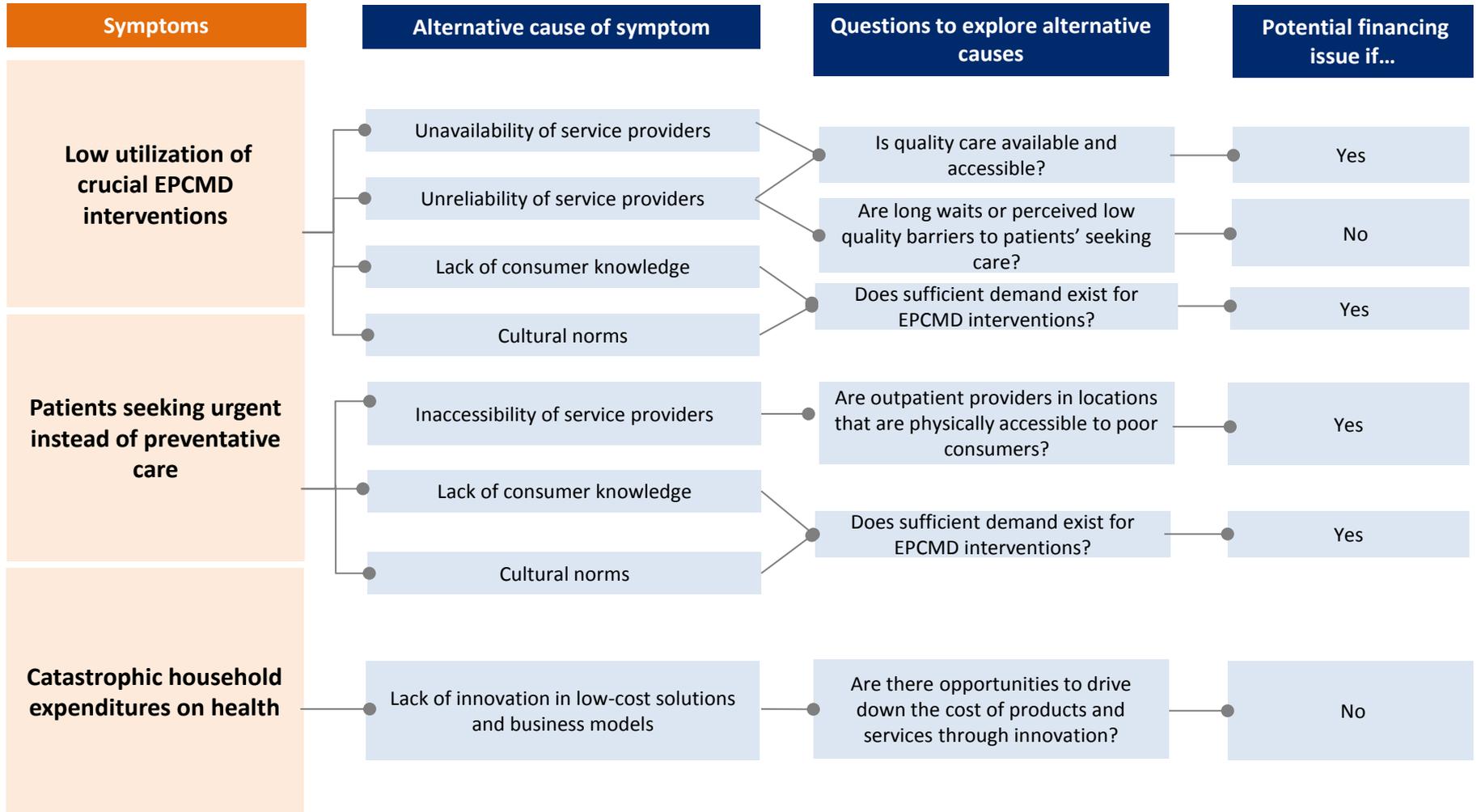
*Most recent DHS or MICS data available for each country. No data available for South Sudan or Afghanistan.

Source: WHO: "Global Health Observatory Data Repository;" Expert interviews; Dalberg analysis.





Diagnosis: Low utilization, delays in seeking care, and catastrophic expenditures are common symptoms



Source: Expert interviews; Dalberg analysis.





Solutions and tools: Financing instruments can enable national health schemes, vouchers, and microinsurance



Solution	Tools	Conditions for application
<p>New national policies to lower healthcare costs to consumers</p>	<p>Risk pooling mechanisms (i.e. national health insurance schemes) to make health spending more efficient and predictable</p> <p>Risk pooling mechanisms to make health spending more efficient and predictable through microinsurance schemes</p>	<ul style="list-style-type: none"> • Political will and domestic resources exist to create or scale national health insurance schemes • Healthcare providers are available, accessible, and reliable
<p>New or expanded health savings, lending, and microinsurance products</p>	<p>Guarantees to microfinance institutions to facilitate health financial products (e.g. credit, savings, insurance), or to banks to facilitate on-lending to microfinance institutions</p> <p>Investment funds to help scale successful microfinance and microinsurance models for health</p>	<ul style="list-style-type: none"> • A strong microfinance sector exists and is willing to consider health insurance models • An ecosystem of low-cost healthcare providers exists • A strong domestic financial sector (including banks and MFIs) exists, and is interested in health lending and knowledgeable about the health sector and its borrower classes • Lack of access to finance is the primary constraint for MFIs looking to expand into health • Microfinance and microinsurance models for health exist, are financially viable, and can achieve modest returns • Lack of access to investment capital for experimentation or scale is a primary constraint for successful microfinance health models
<p>Increased consumer resources for healthcare</p>	<p>Pay for performance mechanisms on the demand side (e.g. vouchers, CCTs) to increase ability to pay and utilization of key services</p>	<ul style="list-style-type: none"> • Healthcare providers are available, accessible, and reliable

Source: Expert interviews; Dalberg analysis.





Case study: Demand-side financing vouchers in Bangladesh support access to maternal health services



Limited ability to pay for products, services, and transport prevents Bangladeshi women from accessing the maternal health services they need. Only 12% of women in the poorest quintile give birth with skilled attendants. In 2004, Bangladesh launched demand-side financing vouchers for reproductive health to help overcome financial barriers, incentivize health seeking behaviors, and increase utilization of key EPCMD services such as antenatal care and institutional delivery.



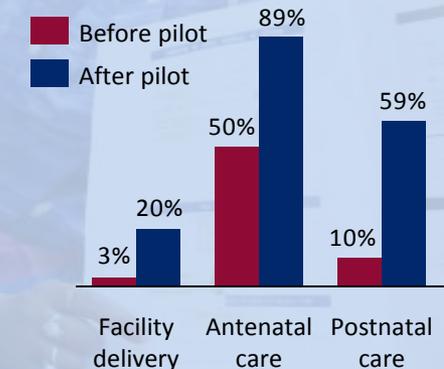
WHAT IS THE MODEL?

- **The Ministry of Health and Family Welfare, in partnership with the WHO,** offers vouchers to pregnant women for pre/post natal care, delivery (including emergency obstetric care), and transportation
- **Health providers** receive payments for registering and serving voucher recipients
- **Patients** receive free or subsidized maternal health services

WHAT IS THE IMPACT?

Pilot results

% women, before and after pilot



Source: Hera (2013): "Program Evaluation for Demand Side Financing Maternal Health Voucher Scheme in Bangladesh;" USAID (2010): "Performance Based Incentives Primer;" Population Council (2014): "Evaluating Voucher-and-Accreditation Programs to Improve Maternal and Reproductive Health Service Delivery;" USAID (photo); Dalberg analysis.



Towards Sustainability: An Introduction to the Financing Framework for EPCMD

The Financing Framework

Resources to apply the Financing Framework

Deep dive on symptoms, underlying financing issues and solutions

▶ Tools to enable solutions: when and how they apply

Case study library



In this chapter, we will consider what options are available, within and outside of USAID, to implement each of the tools



For each profiled tool....

...there are three possible pathways for implementation

Guarantees

Lending

Investment funds

Taxes and levies

Public-private partnerships

Pay for performance

Risk pooling mechanisms

Payment systems

Corporate social responsibility

Trust funds

Development impact bonds

USAID structures transactions for some tools themselves, with HQ offering support to missions throughout the process (e.g. guarantees)

Implementing partners or other donors can lead or co-lead the execution of some tools, with missions providing financial support and/or TA (e.g. impact investments, payment systems)

Governments lead execution of some tools, with missions providing thought partnership and TA (e.g. taxes and levies)

Source: Expert interviews; Dalberg analysis.

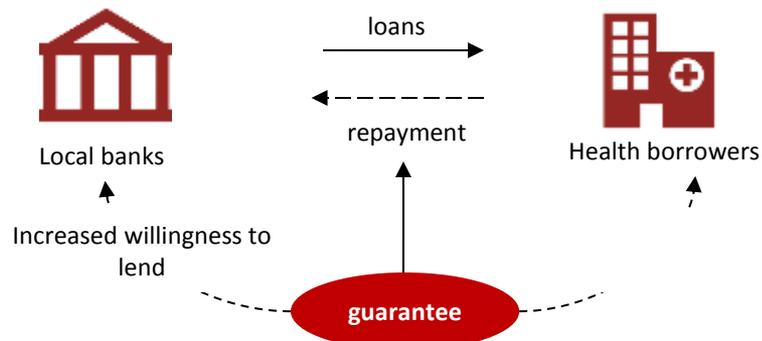


Guarantees: Missions can support guarantees directly through DCA to mobilize private lending for EPCMD



Overview of tool

How does it work? Guarantees mobilize private sector lending to increase healthcare providers' access to capital, enabling them to provide more and higher quality health products and services.



What impact can it have on EPCMD? Guarantees can mobilize private lending to help providers at all levels of the health system access the capital they need to:

- Purchase commodities and equipment
- Train health workers
- Invest in infrastructure
- Expand operations and improve quality

Pathways to implementation

USAID's Development Credit Authority (DCA) can work with missions to structure guarantees.

When can it be used? DCAs work in contexts where loans are withheld because a lender (such as a bank) lacks the information, or risk-willingness. This requires a market with:

- A **strong domestic private financial sector** that is willing to consider health sector lending
- A **private or sub-national healthcare delivery system** with financially viable business models that can or does provide products and services to the poor

What are first steps? The DCA team in Washington can help missions determine whether guarantees are appropriate, and if so, can structure, execute, and monitor transactions



If you're interested in considering the use of a guarantee, read the DCA primer and reach out to the [DCA office](#) to learn more

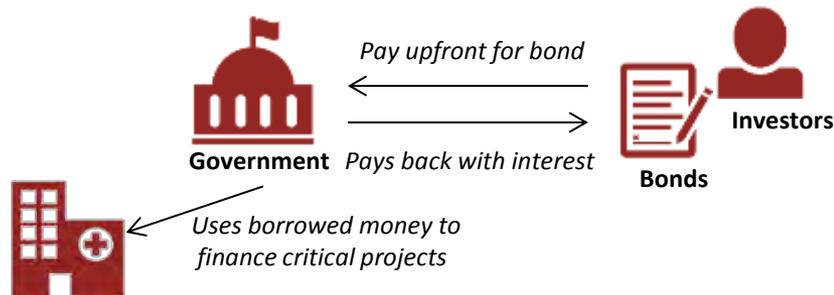
Source: USAID (2014): "Global Health DCA Primer;" Expert interviews; Dalberg analysis.

Lending: In certain countries, the development of a municipal bond market can have a big impact on health



Overview of tool

How does it work? A bond issuer (in this case, a municipality) sells a bond to investors. These can be individuals, often citizens, but can also include other types of private investors depending on how risky it is lending to the government. The government pays the administrative and legal costs of issuing the bonds, but can use the rest to finance public projects such as building a network of hospitals. Investors are paid interest according to a set of pre-agreed terms and conditions.



What impact can it have on EPCMD? Most bonds are “general” rather than sector-specific, but they can help governments increase domestic spending on health (or anything else) without creating a new revenue stream or cutting other spending.

Pathways to implementation

Missions can primarily play a technical assistance role in promoting the use of municipal bonds for health. There are a number of advantages to using municipal bonds to finance critical projects, and many policymakers have become interested in developing and/or strengthening their municipal bond market. Providing TA to develop stronger transparent, and accountable financial management and reporting systems is key to success in bond issuance.

When can it be used? Bonds for health work best when:

- **Tax revenue as a % of GDP is high.** If tax revenue is not sufficient to pay back significant levels of debt, borrowing using bonds may not be the right course of action.
- **The political environment is relatively stable.** Although some are more risk-tolerant than others, investors typically shy away from high-conflict states and volatile economies.
- **Governments are committed to health goals.** Because most municipal bonds are not sector-specific, building municipal bond markets will have the most impact if the government is already meeting its Abuja targets, and you believe that if the budget was higher, this would result in more funding overall for health.

What are first steps? Reach out to DCA to learn more.

If you are interested in municipal bonds, contact the [DCA office](#) to learn more

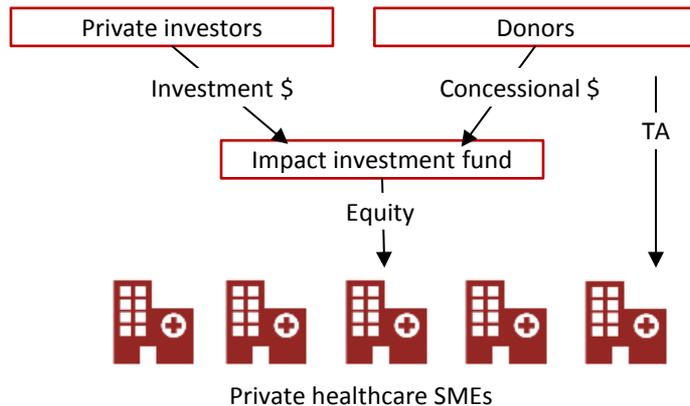
Source: USAID (2014): “City of Dakar announces first West African municipal bond;” USAID (1997): “Municipal Bond Market Development;” Leighland, James (1997): “Accelerating municipal bond market development in emerging economies: an assessment of strategies and progress;” Dalberg analysis.

Investment funds: Missions can provide grants, guarantees, or TA to support investment in health



Overview of tool

How does it work? Socially responsible investors provide investment capital (usually equity, but can also be debt) to businesses that generate financial returns as well as social impact. In some cases, this private capital is blended with donor funding or guarantees to mitigate risk, enhance returns, or provide TA to investees.



What impact can it have on EPCMD? Impact and other investment funds can help grow the private healthcare sector, enabling innovative business models (e.g. clinics, dispensaries, insurance schemes) that serve low-income consumers to reach scale.

Pathways to implementation

Missions can provide grants or guarantees to investment funds to catalyze private investment in the health sector.

When can it be used? Investment funds for health are an appropriate model when:

- Financially viable private sector business models exist but need investment capital to scale
- Socially responsible impact investors are interested in investing in the health sector but may need risk-sharing mechanisms to incentivize investment

What are first steps? Reach out to the Private Capital Group in E3 to think through how to structure USAID involvement.

Missions can provide TA through implementing partners to investees, helping them achieve greater financial and social returns.

When can it be used? Where investment funds for health have already been set up, missions can help provide TA to (potential) investees to help them strengthen management and capacity.

What are first steps? Reach out to SHOPS to learn more about TA for investees.

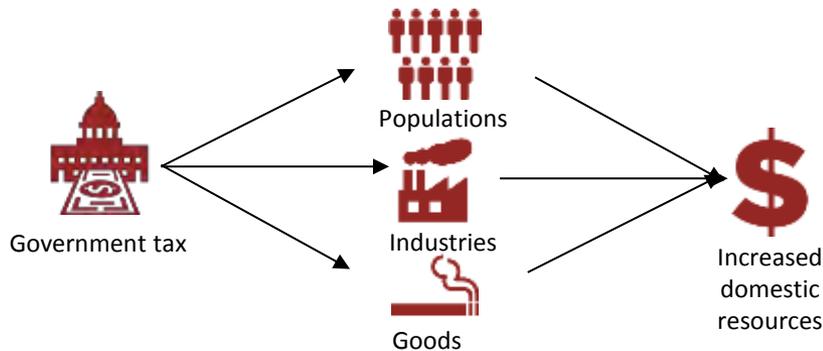
If you're considering supporting investment funds for health, reach out to [PCG](#) or [SHOPS](#) to learn more

Taxes and levies: Missions can help governments improve tax administration and collection, increasing public resources available for EPCMD



Overview of tool

How does it work? Taxes are a source of government revenue, however, weak administration and collection systems, and corruption can limit the amount of revenue raised. Improving this process ensures that additional resources are available for health.



What impact can it have on EPCMD? Improved taxes administration and collection can increase the amount of government resources available for health, which can enable:

- Reduced dependence on donors for health funding
- Improvements to the overall public health delivery system
- Funding for commodity procurement
- Financing for national health insurance schemes

Pathways to implementation

Missions can provide TA and advisory support to governments on improving tax administration and collection.

When can it be used? Where USAID missions have close working relationships with governments, and where political will exists to address corruption, tax evasion and collection issues, USAID can provide TA to governments to improve collection capacity, infrastructure, effectiveness, and transparency.

What are first steps? USAID's Office of Health Systems is collaborating with the Office of Economic Policy in the Bureau of Economic Growth, Education, and Environment (E3/EP) and can provide expertise and analysis to support missions' work with governments on taxes.

If you're considering improving tax administration, reach out to the [Office of Health Systems](#) to learn more

Source: USAID: "Domestic resource mobilization: financing country-led development;" USAID Office of Economic Policy (2015); Expert interviews; Dalberg analysis.

PPPs: Missions can support the government and the private sector to structure partnerships



Overview of tool

How does it work? PPPs allow the private sector to play a role in delivering a government service, using a combination of public and private capital. They work by turning service provision into an opportunity to earn a profit—but may still deliver a lower cost or higher quality service than a non-profit or state agency. Success of PPPs depends on how incentives and outcomes are structured.

At the national level, **most PPP opportunities for EPCMD are in:**

- Service delivery and facility management: providing public services on behalf of the government
- Logistics and distribution: PPPs have been and are used to support the distribution of commodities, both by private and non-profit actors

What PPPs are not: PPPs are not privatizations--ministries are still accountable for service quality—and they are not service delivery contracts—the partnership is longer term and often incorporates private capital.

What impact can it have on EPCMD: PPPs can impact EPCMD in two ways: first, if the private sector can deliver a service more effectively. Second, they often bring additional private capital into play.

Pathways to implementation

Missions are uniquely positioned to begin a dialogue between the government and private sector and help structure an agreement. Successful PPPs are attractive to both the state and the private sector, but identifying a workable opportunity can be difficult. Missions can identify high potential opportunities for impactful PPPs and bring in expert support in structuring, which is a key driver of success.

When can it be used? PPPs work best when:

- **There is a qualified private sector actor with a low cost basis** who can deliver a similar quantity of service at a similar cost with higher quality
- **Improved management of a critical segment of the health infrastructure commodity logistics** improves efforts across the network
- **Outcomes can be measured without creating perverse incentives**
- **There is a genuine service gap or systematic need, not a short term challenge** (e.g. H1N1 outbreak)

What are first steps? Reach out to the Global Health Bureau's Center for Accelerating Innovation and Impact (CII) to learn more.



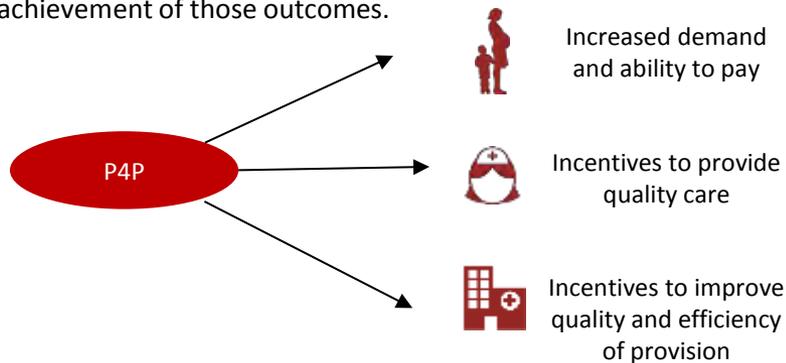
If you are interested in PPPs, contact [CII](#) to learn more about how USAID has supported this work in the past. The SHOPS program also produced a [useful primer](#) on PPPs in health

Pay for performance: Missions can implement P4P programs directly or by supporting partners or governments



Overview of tool

How does it work? Pay for performance mechanisms link financial or other incentives to pre-agreed and measurable outcomes or performance targets to catalyze improvements in the achievement of those outcomes.



What impact can it have on EPCMD? Funders (donors, governments, private investors) can implement P4P mechanisms to increase accountability and improve outcomes at any level of the health system, including:

- Increased utilization of EPCMD products and services
- Improved health workforce effectiveness
- Better quality of care and health outcomes
- More innovative, efficient supply chains/delivery systems

Pathways to implementation

Missions can implement P4P by funding pilots or incorporating incentives into existing programming.

When can it be used? Missions that have prior experience with P4P, or that have significant time and resources to dedicate to structuring mechanisms, may want to consider direct implementation.

What are first steps? Missions can consult internally or regionally on past experiences with P4P, or reach out to the Office of Health Systems for help determining the best path forward

Missions can provide grants, TA, and advisory support to implementing partners, other donors or governments to start or scale P4P programs.

When can it be used? In countries where P4P pilots are underway, missions can support program improvements and scale up. Where P4P efforts are more nascent, mission can convene governments, implementing partners and other donors to advise on and support incorporating incentive structures into private and public provision.

What are first steps? Identify existing P4P efforts underway in country and reach out to learn more



If you're interested in considering the use of a P4P mechanisms, read the [performance based incentives primer](#) and reach out to [the Office of Health Systems](#) to learn more

Source: USAID (2010): "Performance Based Incentives Primer;" Expert interviews; Dalberg analysis..

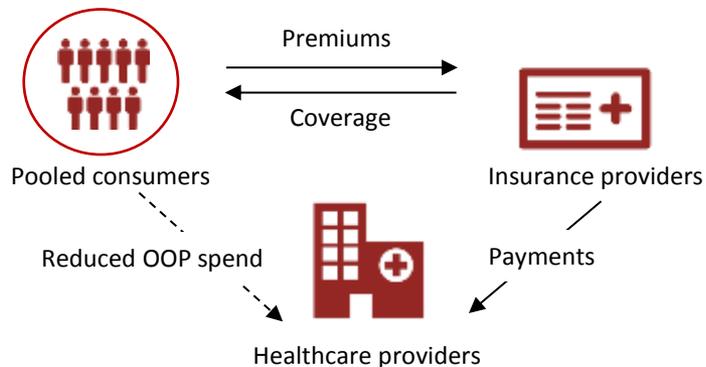


Risk pooling mechanisms: Missions can support governments and MFIs to promote health insurance models



Overview of tool

How does it work? National, sub-national, private, micro, and employee sponsored insurance schemes pool risk to make health costs more predictable, reduce out-of-pocket spending, spread financial risk, and improve access to care



What impact can it have on EPCMD? By improving efficiencies in spending on healthcare, risk pooling mechanisms can:

- Make health costs more predictable, increasing ability to pay
- Enable health spending at times when family savings are low
- Increase demand for health products and services
- Increase utilization of EPCMD interventions thereby improving health outcomes

Pathways to implementation

Missions can provide TA and advisory support to governments to create health insurance models

When can it be used? In countries where governments are considering implementing health insurance schemes, USAID missions can provide TA and advisory support to structure models.

What are first steps? Reach out to the Office of Health Systems to learn more about supporting the development of health insurance schemes

Missions can provide grants to and/or convene implementing partners to create and scale microinsurance models.

When can it be used? Missions can best support microinsurance in countries where:

- High-potential microinsurance models funding to scale, or
- Microfinance institutions are willing to consider health lending but need TA, access to capital, and appropriate partners

What are first steps? Research microfinance institutions to see whether any are involved in the micro-health insurance space

 If you're considering supporting risk pooling mechanisms, reach out to the [Office of Health Systems](#) to learn more

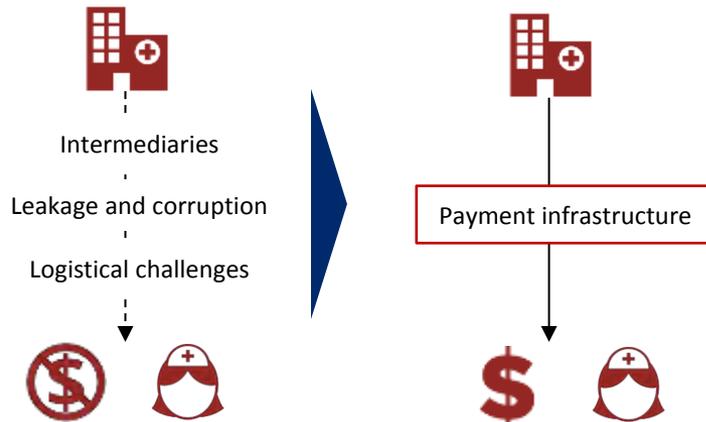
Source: Expert interviews; Dalberg analysis.

Payment systems: Missions can support digital payment systems with grants and TA



Overview of tool

How does it work? Payment infrastructure (e.g. mobile money) helps smooth logistical difficulties, cut out intermediaries, and enhance transparency to ensure that health workers receive salaries on time and in full.



What impact can it have on EPCMD? By helping salaries reach workers quickly and completely, payment infrastructure can:

- Reduce health worker absenteeism and strikes
- Improve the quality of care by improving incentives
- Reduce the incidence of informal out-of-pocket payments

Pathways to implementation

Missions can provide grants and TA to implementing partners to support the creation and scaling of payment infrastructure.

When can it be used? Payment infrastructure works best when:

- Sufficient funding for salaries exists, but logistical difficulties, transaction costs and/or corruption prevent health workers from receiving them on time and in full
- Digital infrastructure and banking systems exist in country and can support digital payment platforms, and mobile penetration is high
- Partner organizations (e.g. telecoms and relevant government ministries) are willing to support payment infrastructure for health

What are first steps? Reach out to the Digital Development team within the U.S. Global Development Lab to learn more about mobile solutions for payment infrastructure and what it would take to adopt/scale mobile payment platforms.

If you're considering supporting payment infrastructure, reach out to the [Digital Development Team](#) to learn more

Source: FHI360 (2015): "Mobile Solutions Technical Assistance and Research," Expert interviews; Dalberg analysis.

Corporate social responsibility: Missions can play a key convening role in promoting CSR programs



Overview of tool

How does it work? Corporate social responsibility (CSR) is a wide-ranging set of activities in which companies integrate both social and environmental concerns into their operations. Traditional CSR is most appropriate at addressing specific market failures or helping to catalyze and de-risk private sector investment. Examples of CSR activities in health include:

- **Grants or other funding** to the communities in which the company manufactures or sells its product
- **Drug donation programs** for neglected and tropical diseases (e.g. Pfizer-supported Trachoma Initiative)

Unlike a PPP, CSR generally does not result in immediate financial benefits, but rather bolsters a company's reputation.

What impact can it have on EPCMD? If a CSR initiative is structured appropriately, it can:

- Crowd domestic philanthropic funding towards last mile health delivery, especially where it would be difficult to engage the private sector with market or profit-based incentives
- Ensure patients have access to the treatments they need, especially those that might be otherwise unavailable or inaccessible to poor and marginalized groups

Pathways to implementation

Missions can be especially effective in the CSR space by leveraging USAID's convening power. USAID can bring together corporations interested in CSR and key stakeholders within health.

When can it be used? From a sustainable finance perspective, CSR has highest potential if:

- **There is a pre-existing CSR law:** Countries like South Africa and, more recently, India, have laws that require companies of a certain size to donate some percent of their profits to charitable causes.
- **There is a thriving domestic private sector:** To mobilize domestic resources, there should be a base of large companies that are sufficiently affluent to consider investing in CSR.
- **Consumer bases are growing:** Corporations are often incentivized to conduct CSR in regions in which they would like to expand.

What are first steps? The Global Partnerships Team within the U.S. Global Development Lab coordinates USAID's activities with multinational corporations, and can also help missions think through CSR partnerships with local companies – this is the first place to reach out if you are considering supporting CSR.



If you're considering supporting CSR, contact the [Global Partnerships Team](#) to coordinate and learn more

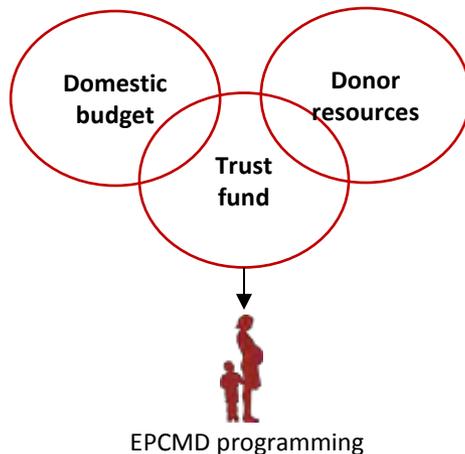
Source: Expert interviews; Dalberg analysis.

Trust funds: Missions can provide TA or grants to help structure and grow country trust funds



Overview of tool

How does it work? Country trust funds ring-fence domestic government and donor funding to facilitate long-term investment in a particular health issue.



What impact can it have on EPCMD? Trust funds can increase overall funding for EPCMD programming by:

- Mobilizing domestic and international resources
- Increasing coordination and aligning priorities
- Optimizing long-term budget allocation

Pathways to implementation

Missions can provide TA and advisory support to governments to help them structure country trust funds.

When can it be used? In countries where there is political momentum around EPCMD (or a related health issue, e.g. national health insurance), and where missions have close relationships with ministries, missions can help governments set up trust funds.

What are first steps? Reach out to the Office of Health Systems to learn about how and where trust funds have been applied to support sustainable and predictable financing for health.

Missions can contribute to existing trust funds with grants through implementing partners.

When can it be used? Where country trust funds exist, missions can align their funding through grants.

What are first steps? Reach out government counterparts or partners and other donors to learn more about existing or potential trust funds that USAID can contribute to.



If you're considering supporting country trust funds, reach out to [the Office of Health Systems](#) to learn more

Source: World Bank (2014): "GFF Concept Note;" SHARE (2013): "Tanzania: government urged to set up health trust fund;" Expert interviews; Dalberg analysis.

Development impact bonds: Missions can support HQ to identify opportunities for and structure DIBs



Overview of tool

How does it work? Development Impact Bonds help incorporate and incentivize the most effective public or private solutions to a challenge that donors or development agencies would otherwise address. In the simplest case, a measurable metric that corresponds to the outcome sought is identified and a partner proposes to hit targets on an agreed to timeframe against those goals. Using a Development Impact Bond, the implementing partner sources private capital to finance their program implementation, and if they achieve their targets they are paid by donors who would have otherwise funded a traditional grant funded intervention, and the implementers can in turn repay their bondholders who financed their work. There are many variants on this structure.

What impact can it have on EPCMD: Many EPCMD objectives could be documented by specific targets that respond to successful interventions. In those cases, development impact bonds can allow donors to use more diverse partners as implementers while minimizing the financial (if not outcome) risk of failure, leverage private capital, and use the investor marketplace to assess effectiveness.

Pathways to implementation

At present, there is limited experience using DIBs in health, however, it is a tool with the potential to incentivize improved health outcomes, create efficiency gains in service delivery, and provide a new vehicle for private sector investment in countries.

When can it be used? DIBs work best when:

- **There is a clear metric that corresponds to impact (or outcomes) and is directly affected by effective programming.** Measurement is a difficult challenge in many environments today, but a proliferation of information technology is changing this.
- **A DIB can be structured around programming that would otherwise be funded by a donor.**
- **Outcomes can be measured without creating perverse incentives:** in many EPCMD applications, outcomes (i.e. # of IUDs implanted), risks creating a perverse incentive for providers

What are first steps? Reach out to the CII team to learn more.



If you are interested in DIBs, contact [CII](#) to learn more about them

Source: Expert interviews; Dalberg analysis.

Contacts: Reach out to these resources to learn more about supporting financing tools



Tool	USAID Resource Contact Information
Guarantees	developmentcredit@usaid.gov
Lending	developmentcredit@usaid.gov
Investment funds	sustainablefinancing.gh@usaid.gov
Taxes and levies	sustainablefinancing.gh@usaid.gov
Public-private partnerships	cii@usaid.gov
Pay for performance	sustainablefinancing.gh@usaid.gov
Risk pooling mechanisms	sustainablefinancing.gh@usaid.gov
Payment systems	sustainablefinancing.gh@usaid.gov
Corporate social responsibility	sustainablefinancing.gh@usaid.gov
Trust funds	sustainablefinancing.gh@usaid.gov
Development impact bonds	cii@usaid.gov



Towards Sustainability: An Introduction to the Financing Framework for EPCMD

The Financing Framework

Resources to apply the Financing Framework

Deep dive on symptoms, underlying financing issues and solutions

Tools to enable solutions: when and how they apply

▶ Case study library

Case study: The Global Financing Facility will be a pathfinder mechanism for development finance in the post-2105 agenda



The Global Financing Facility for Every Woman Every Child aims to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths. The GFF brings partners together to provide:

- **Smart financing** to ensure that evidence based, high impact interventions are prioritized
- **Scaled financing**, mobilizing the additional resources necessary to finance the full RMNCAH agenda from both domestic and international resources
- **Sustainable financing** to main increased RMNCAH results



WHAT IS THE MODEL?

The GFF will operate as a facility that maximizes the comparative advantage of a broad set of partners to accelerate efforts to end preventable deaths. A number of approaches and mechanisms are used to do this, including:

- **Investment Cases for RMNCAH**
- **Mobilization of financing for Investment Cases**
- **Medium-term health financing strategies focused on sustainability**
- **Investments in global public goods that support RMNCAH results at the country level**

WHERE DOES IT FIT IN?

- The GFF is not a financing tool, but rather a **financing facility** for a variety of sustainable financing tools, approaches, and activities
- **The Financing Framework complements the GFF** by encouraging missions to think through near-term and medium-term sustainable financing activities that fit into the GFF's broader architecture

Source: World Bank (2014): "GFF Concept Note;" USAID (2015): "GFF Brown Bag Lunch;" USAID (photo); Dalberg analysis.





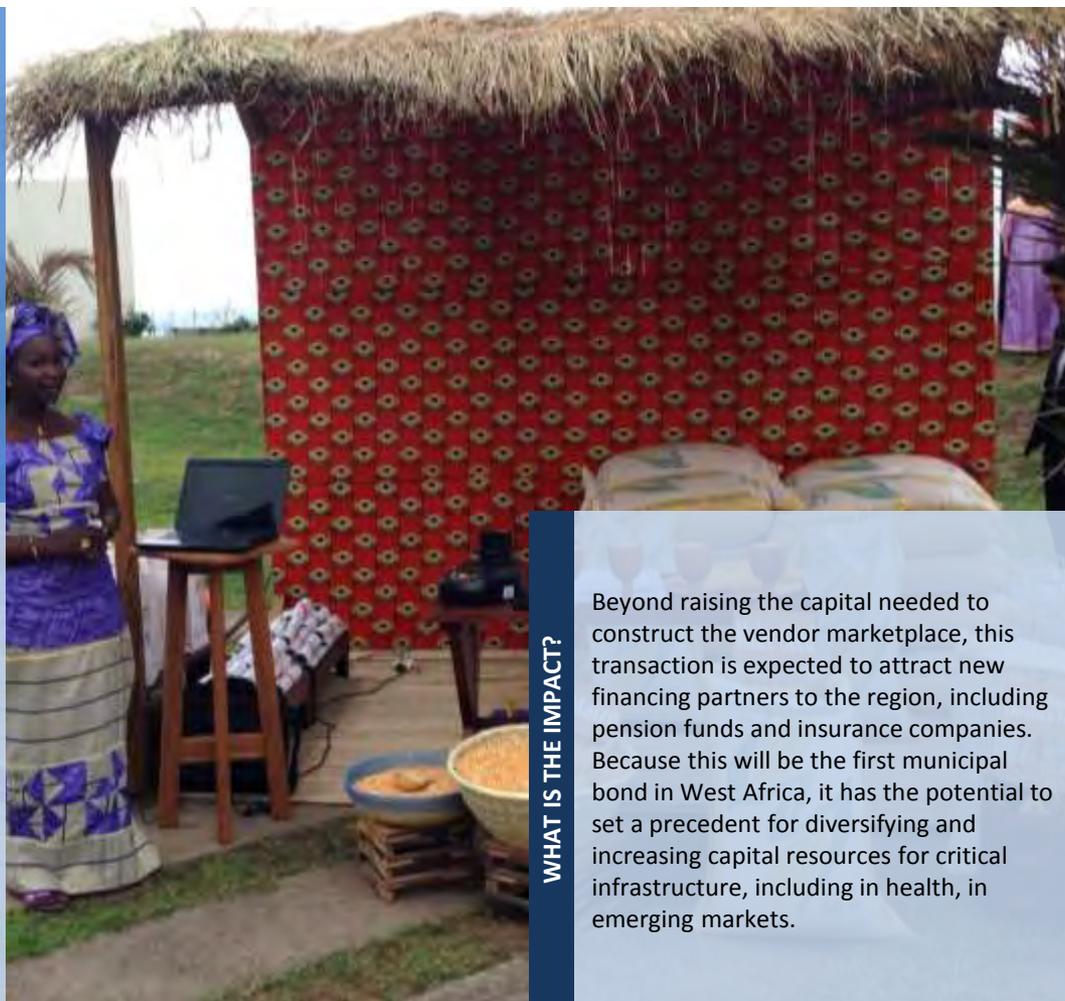
Case study: The City of Dakar, with the support of DCA, announced the first municipal bond in West Africa



USAID
FROM THE AMERICAN PEOPLE



In 2014, the City of Dakar announced a \$41.8 million bond to raise funds for the construction of a marketplace for more than 3,500 street vendors.



WHAT IS THE MODEL?

The bond will be backed by a DCA bond guarantee, and supported with technical assistance from the Gates Foundation.

WHAT IS THE IMPACT?

Beyond raising the capital needed to construct the vendor marketplace, this transaction is expected to attract new financing partners to the region, including pension funds and insurance companies. Because this will be the first municipal bond in West Africa, it has the potential to set a precedent for diversifying and increasing capital resources for critical infrastructure, including in health, in emerging markets.

Source: USAID (2014): "Supported by USAID guarantee, city of Dakar announces first West African municipal bond at USAID Frontiers in Development;" Dalberg analysis.



Case study: The Solidarity Levy on Airline tickets mobilizes funds for health through a small tax



The **airline solidarity levy** was designed as a way to provide dedicated, predictable funding flows to **UNITAID**; by placing a modest **tax on airline tickets**, countries are able to ensure that they are only collecting the tax from people likely to be able to afford it. UNITAID is a drug purchasing facility that negotiates global price reductions on pharmaceutical drugs, which all public health organizations are able to benefit from; emphasis is placed on diseases for which the poor shoulder the highest burden (e.g. tuberculosis, malaria and HIV).

WHAT IS THE MODEL?

- **Participating countries**, which include Cameroon, Congo, Madagascar, Mali, and Niger, determine the rate at which they will tax airline tickets
- **Consumers purchasing tickets in that country** (whether foreigners or domestic nationals) automatically pay the tax
- **UNITAID** uses the funds; the predictable funding flows help it to incentivize manufacturers to produce quality medical products at affordable prices



WHAT IS THE IMPACT?

- **9 countries have signed on** as participating partners
- **The levy has raised 65% of UNITAID's funds** (more than USD 1.9B)
- **It has had no negative effect** on revenue and profitability, air traffic, travel industry jobs and tourism. Also, the levy is implemented by existing national authorities so the setup costs have been low

Source: Dalberg (2014): "Innovative Financing Database;" UNITAID (2012): "UN World Economic and Social Survey discusses UNITAID's unique model;" EconoMonitor (2014): "Financing Development: Are International Solidarity Levies the Answer?;" Flickr user m01229 (photo); Dalberg analysis.



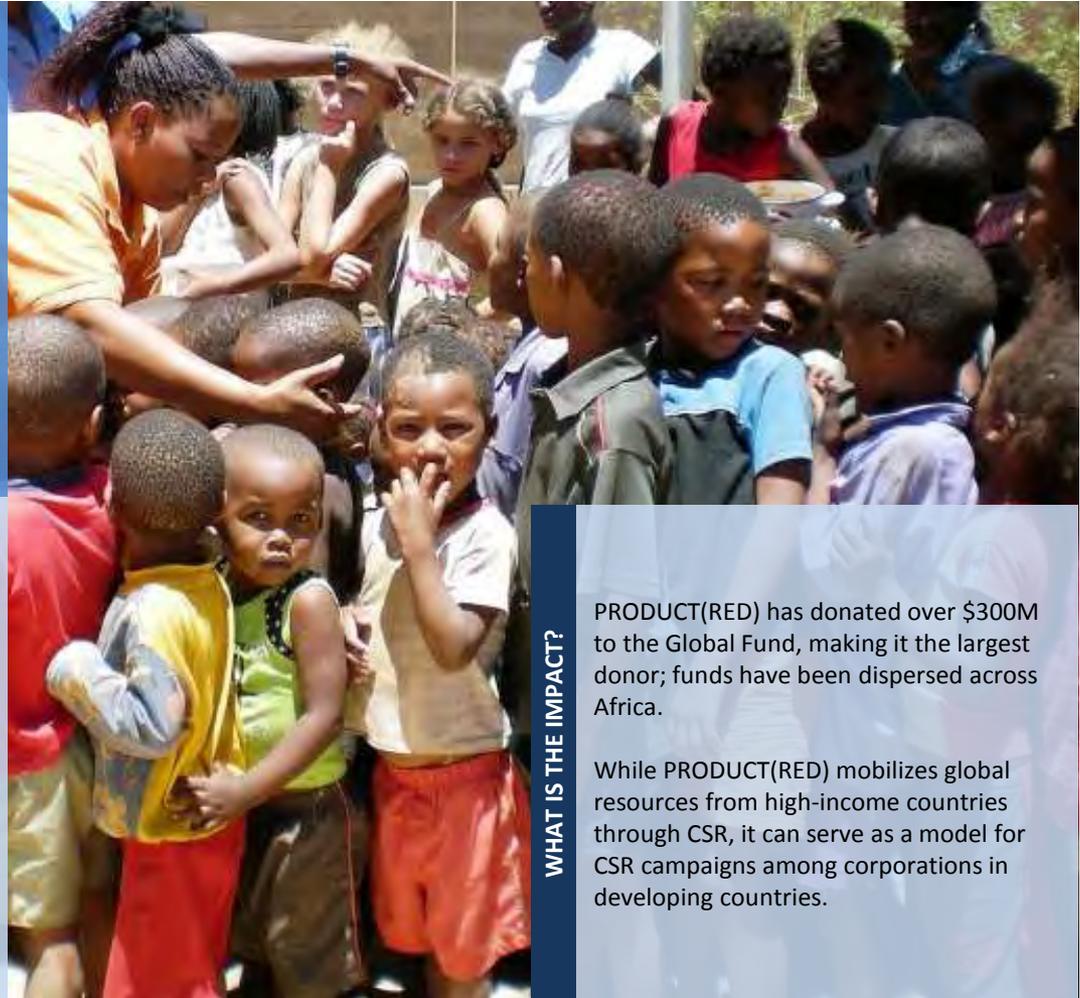


Case study: PRODUCT(RED) mobilizes private resources through donations in customer purchase



Despite proven interventions to prevent and treat HIV/AIDS, 22 million HIV-positive individuals **lack access to lifesaving treatment**. The bulk of HIV/AIDS occurs in the **poorest countries**.

PRODUCT(RED), founded in 2006 by Bono and Bobby Shriver, provides a platform for corporations to engage in CSR for HIV/AIDS. Its success depends on high-profile corporate partners, which currently include Gap, Apple, and Beats by Dre.



WHAT IS THE MODEL?

Licensed partners create (RED)-branded products, and donate up to 50% of profits on these products to the Global Fund (percentage set by the company). The business model was designed to increase consumer purchases for the company, while simultaneously resulting in increased donations and awareness.

WHAT IS THE IMPACT?

PRODUCT(RED) has donated over \$300M to the Global Fund, making it the largest donor; funds have been dispersed across Africa.

While PRODUCT(RED) mobilizes global resources from high-income countries through CSR, it can serve as a model for CSR campaigns among corporations in developing countries.

Source: Dalberg (2014): "Innovative Financing for Development;" Nora Hanagan: "Product(RED);" Dalberg analysis.



Case study: Karuna Trust uses PPPs to leverage private sector resources within the health system in India



In India, over 30% of people living in rural areas and 20% in urban areas **do not seek care**. Every year, nearly 39 million people are pushed into poverty due to **financial catastrophe** caused by poor health and health emergencies, and **out-of-pocket spending** remains high at 72% of expenditure on drugs.

Launched in 1986, Karuna Trust is a public charitable trust in India that leverages **public-private partnerships** to support the Government of India's goal to deliver quality health care to the last mile.



WHAT IS THE MODEL?

Karuna Trust takes over management of poor-performing Primary Health Care Centers (PHCs) and, using a combination of PPPs and CSR, engages the private sector to rehabilitate these centers and transform them into models of care.

WHAT IS THE IMPACT?

The Trust currently manages 68 PHCs in 8 states – Karnataka, Andhra Pradesh, Orissa, Arunachal Pradesh, Manipur, Maharashtra, Meghalaya, and Rajasthan; total staff at these centers tops 1,000, reaching over 1 million people.

Source: Karuna Trust (2015); Center for Health Market Innovations (2015):“Karuna Trust;” Dalberg analysis.

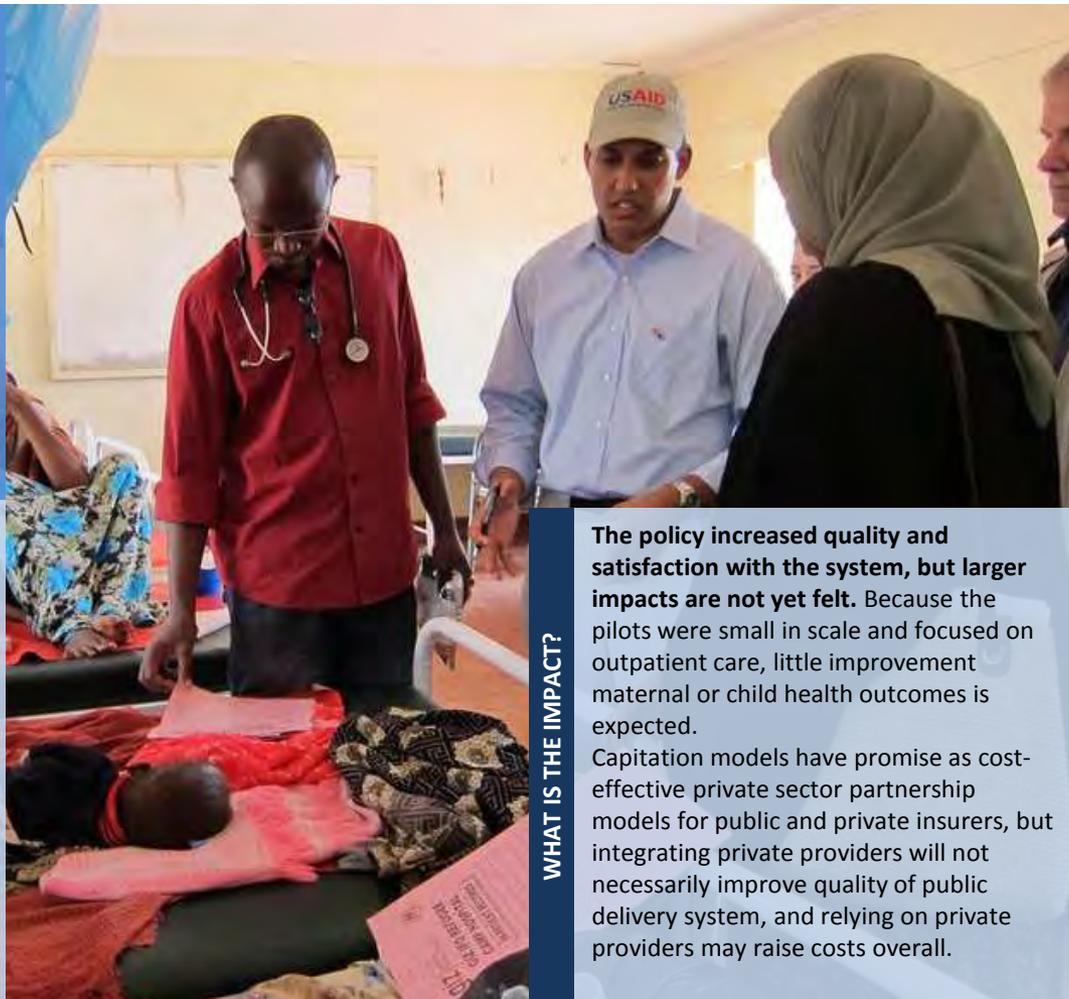




Case study: Kenya incorporated private providers into the public health insurance scheme



Kenya administers a compulsory **national health insurance scheme (NHIF)** for all formal-sector employees, and until 2012 relied on public healthcare providers. Despite paying for coverage, those who could afford it **turned to private insurance schemes or paid out-of-pocket** at private facilities. Those who couldn't afford private care encountered **low quality and long wait times in public facilities**. Kenya is one of several countries experimenting with ways to **incorporate private provision into publicly financed schemes** to improve quality and equity, especially for the poor.



WHAT IS THE MODEL?

Kenya **partnered with established private providers** to improve NHIF's service quality through a tender process **to pilot private outpatient care**.

Multiple, pre-approved outpatient clinic networks agreed to capitation model based fees for NHIF members, pre-paying on per head visits.

WHAT IS THE IMPACT?

The policy increased quality and satisfaction with the system, but larger impacts are not yet felt. Because the pilots were small in scale and focused on outpatient care, little improvement maternal or child health outcomes is expected.

Capitation models have promise as cost-effective private sector partnership models for public and private insurers, but integrating private providers will not necessarily improve quality of public delivery system, and relying on private providers may raise costs overall.

Source: Witter et. al (2009): "Providing free maternal health care: ten lessons from an evaluation of the national delivery exemption policy in Ghana;" USAID (photo); Dalberg analysis.





Case study: Children’s Investment Fund Foundation, Instiglio, UBS, and Educate Girls launched the first development impact bond in India



A **pilot development impact bond** was launched in Rajasthan, India, to help address high drop out rates and poor education quality. In Rajasthan, 40% of girls leave school before 5th grade and only 15% of primary school children can read a simple story in Hindi.



WHAT IS THE MODEL?

The UBS Optimus Foundation raised initial funding from investors. With this funding, Educate Girls, an NGO, will implement programs to improve educational outcomes. Instiglio, a non-profit intermediary, manages the project and CIFF, the outcome payer, will pay returns to investors if pre-determined outcomes are achieved.

WHAT IS THE IMPACT?

The DIB was launched in June 2014, and service delivery will begin in June 2015, so results of the pilot have not yet been demonstrated. The project aims to retain 10,000 girls and improve basic Hindi, English, and math skills for 20,000 students in 150 poor performing schools. If Educate Girls achieves these outcomes, CIFF will pay back investors with 7-13% returns.

Pilot development impact bonds in health, which use a similar model to improve healthcare through outcomes-based incentive structures, are currently under development by other donors.

Source: CGDev (2014): “First Development Impact Bond is Launched;” Pasand (photo); Dalberg analysis.





Case study: SHOPS provides TA to help innovative private health businesses access capital



While the private sector provides more than half of all healthcare in Africa, **quality is low**. In many countries, private health companies are unable to **access the finance**, including **working capital**, they need to improve and expand. **Banks are unwilling to lend to the health sector** and there is no venture capital available to foster **innovation in business models**.

SHOPS, a USAID project, provided **technical assistance and grants** to high potential private healthcare companies, helping them improve management, capacity, and quality so that they can attract the finance they need to scale.

WHAT IS THE MODEL?

SHOPS provided TA to healthcare companies so that they can better access bank lending and ultimately attract impact investment to expand. It worked with DCA to structure guarantees to increase health lending. It also facilitated linkages between private healthcare SMES, banks, and other potential investors.

WHAT IS THE IMPACT?

SHOPS has worked with healthcare companies in 10 countries, including supporting DCAs in 5. SHOPS has helped mobilize almost \$14 million in commercial financing to the health sector.



Source: SHOPS(2014); USAID (2014): "Access to Finance and the Private Health Sector in USAID;" USAID (photo); Dalberg analysis.





Case study: The Medical Credit Fund provides working capital and TA to healthcare SMEs across Africa



MEDICAL CREDIT FUND AFRICA

Medical Credit Fund (MCF) is a non-profit **health investment fund** seeking to strengthen the private healthcare sector in developing countries. Private healthcare companies, who provide the majority of health services in Africa, particularly to the poor, **lack access to the finance they need**, particularly **working capital**, to expand and improve delivery of care. MCF **blends public and private capital** to finance loans, guarantees, currency risk facilities, and TA to help private facilities strengthen operations and increase quality of care.

WHAT IS THE MODEL?

- **Donors, DFIs, foundations, and private investors**, including USAID, IFC, BMGF, and Deutsche Bank, invest in a health investment fund that provides loans and guarantees to local banks to increase health lending, alongside TA grants to borrowers
- **Local banks** provide loans to private healthcare SMEs, increasing their access to working capital
- **Health organizations** scout and select eligible health SMEs and provide TA to strengthen management capacity
- **Healthcare SMEs**, including hospitals, clinics, and dispensaries, provide more and better services to poor populations



WHAT IS THE IMPACT?

Through MCF, **over \$7.5 million in loans have been disbursed to 968 healthcare SMEs** in Tanzania, Kenya, Ghana, and Nigeria, with 97.7% loan repayment performance.

Collectively, **these clinics serve more than 500,000 patients per month.**

Source: Neil Brandvold for USAID (photo)





Case study: Ghana introduced a national health insurance scheme, financed by a trust fund and levy



In Ghana, high user fees cause **low utilization of key services**, particularly among the poor, and **high out-of-pocket spending** for those who do seek care.

In 2003, Ghana created the National Health Insurance Scheme to increase utilization of key services, decrease out-of-pocket spending, and improve health equity. The program's benefits package covers 95% of the burden of disease, including maternity care.

WHAT IS THE MODEL?

The NHIS **pools risk** among the population to increase the efficiency and predictability of spending on healthcare. It is funded through a trust fund, the **National Health Insurance Fund**, which pools government and donor funds for allocation to the NHIS. The biggest revenue source (70%) to the fund is the **health insurance levy**, a 2.5% earmarked addition to the VAT. Individual premiums also finance the scheme, but certain populations, e.g. pregnant women, are exempt.



WHAT IS THE IMPACT?

NHIS enrolled women were 40% more likely than non-enrolled women to have visited a clinic in the past year, and 83% more likely to have stayed overnight in a hospital. However, only 35% of the population has enrolled in the NHIS to date, and significant reforms are needed to improve coverage and equity.

Source: UHCC (2013): "Ten years of the NHIS in Ghana;" Blanchet et al. (2012): "The effect of Ghana's NHIS on healthcare utilization;" USAID (photo); Dalberg analysis.





Case study: Cambodia's Health Equity Funds increase health access for the poorest



Health equity funds are autonomous, district-based schemes that reimburse health facilities for the cost of **user-fee exemptions**, which also include costs of transportation and meals. In 1996, Cambodia decided to exert a user fee in public facilities (formerly, health care was free). While this was intended to improve quality of health services by infusing capital into the health system, user fees deterred the poor from seeking care. To address this issue, health equity funds were structured **to enable the poor to access free or subsidized healthcare** while **wealthier populations still paid user fees**.

WHAT IS THE MODEL?

- **Donors**, including USAID, DFID, and UNFPA **pool resources** into regional trust funds alongside **domestic national health budget** allocated to the funds
- **Health providers** get reimbursed for providing services to the poor
- **Poor patients are exempt** from user fees and reimbursed for transport and other expenses, facilitating greater access to and utilization of health services



WHAT IS THE IMPACT?

By 2010, HEFs covered the poor population in over half of health districts in Cambodia. Literature concludes that HEFs appear to reduce impoverishment due to health costs and improve staff incentives and attitudes towards the poor. HEFs, by nature, rely heavily on external funds, and have high administrative overhead costs, and thus may not ultimately be sustainable

Source: Kingdom of Cambodia (2009): "Implementation of the Health Equity Fund Guideline;" Health Policy and Health Finance Knowledge Hub (2010): "A comprehensive review of the literature on health equity funds in Cambodia and annotated bibliography;" International Journal of Planning Management (2007): "A sustainability assessment of a health equity fund initiative in Cambodia;" AllAfrica (2014): "Ellen Considers Health Equity Fund;" CDC (photo); Dalberg analysis.

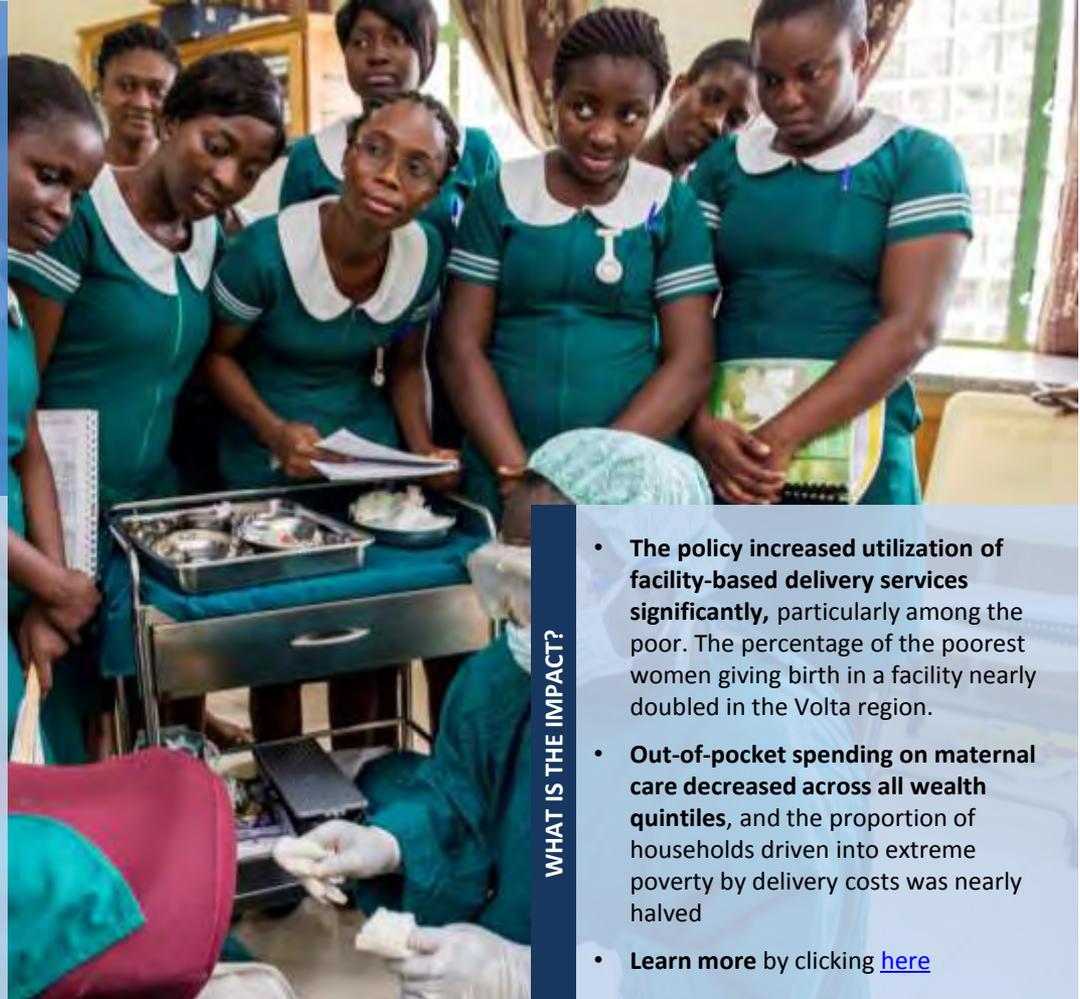




Case study: Ghanaian national fee exemption policy increased facility deliveries among the poor



The government of Ghana instituted an **exemptions policy for delivery fees** in 2004. The poor lack the ability to pay for the direct and indirect costs of healthcare, lowering utilization of key services such as facility-based delivery. At the same time, healthcare providers lack incentives to treat the poor, who cannot afford to pay in full for services. Ghana's fee exemption policy is part of a growing movement to reduce financial barriers to healthcare. Similar policies have been implemented in Burundi, Zambia, Burkina Faso, Kenya, Liberia, and South Sudan.



WHAT IS THE MODEL?

- Women, especially poor women, are able **to give birth in a facility** without paying for the direct costs of delivery
- Public and private providers were reimbursed for **all intrapartum care costs**, first through a debt relief fund, and then later through a national health insurance scheme

WHAT IS THE IMPACT?

- **The policy increased utilization of facility-based delivery services significantly**, particularly among the poor. The percentage of the poorest women giving birth in a facility nearly doubled in the Volta region.
- **Out-of-pocket spending on maternal care decreased across all wealth quintiles**, and the proportion of households driven into extreme poverty by delivery costs was nearly halved
- **Learn more** by clicking [here](#)

Source: USAID (photo).





Case study: Linda Jamii offers a mass-market, mobile-based microinsurance product



Limited ability to pay prevents Kenyan families from accessing the healthcare they need, especially primary and preventive care. Out-of-pocket spending accounts for 45% of healthcare expenditure in Kenya, and 97% of Kenyans are uninsured; many can't afford the high premiums of existing schemes. To solve this problem, Britam, Changamka, and Safaricom, with the support of Population Services International, launched a microinsurance and savings product for health.



WHAT IS THE MODEL?

- Consumers save and pay premiums for a micro health insurance model through an **M-PESA collection platform**, which lowers the administration costs as well as barriers to uptake
- Linda Jamii insurance covers inpatient and outpatient services (including maternity), as well as wages lost during hospitalization, increasing utilization of key EPCMD services and decreasing catastrophic out-of-pocket spending

WHAT IS THE IMPACT?

Linda Jamii's 36,000 subscribers can access healthcare, including maternity care, at over 600 Kenyan hospitals. In addition to increasing the efficiency of out-of-pocket payments, insurers are incentivized to teach and encourage for health-seeking behaviors such as better diets, safer sex, and exclusive breastfeeding. However, microinsurance may not be suitable for the poorest of the poor, who cannot afford to pay even small premiums for healthcare.

Source: WHO Global Health Expenditure Country Database; <http://changamka.co.ke/about/about-changamka>; CGAP Global Landscape Digital Finance Plus; Dalberg analysis; Walter Lamberson/Miliki Afya (Photo)

