‘DOUBLE BLENDED’ FINANCING

The key to sustainable business models for Primary Health Care in Africa

Introduction

There is a near universal drive to achieve Universal Health Coverage (UHC) in Africa in the next decade, and primary healthcare provides the programmatic engine for achieving this vision. In late 2019, leaders across Africa urged the necessity of attaining UHC. President Uhuru Kenyatta of Kenya stated, “We have made UHC a critical pillar of our strategy because we are fully aware that the economic gains Kenya has made over the past seven years can easily be clawed back by crippling health care costs;” Ethiopian Prime Minister Abiy Ahmed echoed that UHC is vital to making sure Africa is not left behind in the quest to meet the Sustainable Development Goals.[1] Ahmed and many others closed their speeches with a pivotal argument—that the private sector has a critical role to play in achieving these goals. The COVID-19 crisis has only dramatized the importance of achieving UHC in a reasonable timeframe, not only for public health purposes but also as a precondition for a healthy economy.

This article argues that attaining UHC in sub-Saharan Africa requires leveraging public, private, and philanthropic sector capacity to create new service delivery and financing models that can strengthen primary health care (PHC) at a system-wide scale. We further argue that to unlock new investments and spur private parties to invest and innovate in the primary care arena, it is critical to blend a mix of revenue sources and de-risking instruments at the project level. This new approach can drive the necessary change: wide-spread adoption of innovations and new delivery models to reach everyone, not just the most affluent. This article will further explain how to drive this change through innovative and sustainable financing and revenue mechanisms.

Primary care is the foundation for universal health coverage, in need of renovation in Africa

Primary healthcare is the foundation and programmatic engine for realizing Universal Health Coverage (WHO). [2] It has been touted as “the most inclusive, effective and efficient approach” to enhance people’s physical and mental health and improve socioeconomic outcomes.[3] Up to ninety percent of all healthcare services can be delivered at the primary level,[4] making it the most cost-effective way to address comprehensive health needs close to people’s homes and communities.[5] Return on investment in primary health care—due to increased productivity from a healthier population and economic impact of increased employment—amounts to as high as USD 44:1 for immunization.[6] Beyond the economic case, the human case for focusing on PHC is immense: the WHO estimates that 60 million lives per year could be saved through investments in quality primary care services.[7] The Covid-19 crisis further lays bare a critical need

[1] https://www.devex.com/news/africa-s-66b-health-financing-gap-requires-private-sector-power-experts-say-94269
[2] https://pmac2020.com/site/what_news/5/detail
[3] ASTANA Declaration 2018. WHO, “Building the economic case for primary health care: a scoping review,” 2018
[4] https://www.ncbi.nlm.nih.gov/books/NBK10248/
[5] https://www.who.int/docs/default-source/global-action-plan/accelerator2.pdf ; https://pmac2020.com/site/what_news/5/detail
[6] https://www.who.int/docs/default-source/primary-health-care-conference/phc---economic-case.pdf?sfvrsn=8d0105b8_2
[7] https://www.who.int/health-topics/primary-health-care#tab=tab_1

to step up long-term investments in primary care systems, beyond just emergency response, to catalyze healthcare improvements at the systems level. This was echoed by WHO Director General Tedros Adhanom Ghebreyesus in his opening speech to the World Health Assemblee, only a month ago: "…The world needs a fundamental rethink of what we mean by global health security. We cannot build a safer world from the top down; we must build from the ground up… It starts with strong primary health care and public health systems, skilled health workers, and communities empowered and enabled to take charge of their own health."[8]

However, it is widely acknowledged that primary care systems in many sub-Saharan African countries are not functioning properly. There is a critical shortage of healthcare workers (a deficit of at least 2.4 million doctors and nurses in SSA),[9] limited availability of necessary medicines, and weak or broken referral systems. This combination often leads patients to refrain from seeking care until their conditions deteriorate, forcing them to seek care, further away from home at more expensive secondary and tertiary hospitals. These hospitals are often overcrowded with patients who should have been treated at the primary level, close to their homes, far more easily and cost-efficiently.[10] The dynamic creates a vicious cycle where limited access to quality primary care discourages patients, employers, governments and insurers from paying for primary care, thereby further inhibiting the investments necessary to create the primary care services for which people and institutions would be willing to pay. As a result, the private sector has shied away from investing in primary healthcare in Africa.

Private sector is key to spur innovation for affordable, high quality service models

Solving these significant capacity gaps at the scale needed for UHC in 2030 requires new, efficient, and high-quality service delivery models. The private sector can play a critical role in creating and rolling out these innovations, including digital health and data analytics, innovative financing, and Public-Private Partnerships (PPPs), amongst other.

Digital technologies, data analytics, and patient-centered design provide new opportunities to deliver care in more efficient, cost-effective ways. Digital tech can connect disparate elements of the current fragmented health system into comprehensive delivery models, which transparently measure health and other social outcomes. For example, Kenya's Penda Health uses tech-enabled systems to build scalable, cloud-based EMR systems, track clinical outcomes and referrals, and provide affordable, convenient care through telehealth.[11] Ghanaian startup mPharma uses a digital tool to dispense and track prescriptions in order to prevent drug stockouts, negotiate lower prices with manufacturers, and eliminate the risk of counterfeits.[12]

Other private sector solutions include innovative health payment mechanisms. One example is CarePay, which developed a digital health payment system that operates on a wallet on the mobile phone,

8 https://reliefweb.int/report/world/director-generals-opening-remarks-world-health-assembly-24-may-2021
9 https://pubmed.ncbi.nlm.nih.gov/20979978/
10 Studies show that preventative services and early diagnosis and treatment can save billions in costly complications. Source: WHO, "Building the economic case for primary health care: a scoping review," 2018.
11 https://www.pendahealth.com/ and Penda Health Pitch Deck
12 "mPharma Organization Profile." Skoll Awardee Profiles. Available at: http://skoll.org/organization/mpharma/.

providing a quick, cost-efficient digital platform for processing claims, transparent pricing schemes, and data insights for improving quality of care.[13] Sister organization PharmAccess has used this platform to leverage government subsidies, individual co-payments and donor funds with a view to increasing access to health insurance for low income families.

Finally, innovative collaborations between public and private sector parties allow governments to leverage private sector capacity to address system-wide problems that neither public nor private could tackle on its own. And they can make it politically desirable to dedicate more resources to health over time. For example, Philips is working in Congo Brazzaville with national government parties and the UNFPA to transform maternal and child care and referral systems. The project leverages public health infrastructure, HR capacity, UNFPA last mile delivery of medicines and commodities, and innovative basic and emergency obstetric technology, including data driven driven referral techbnology enabled by Philips' Mobile Obstetric Monitoring (MOM) technology. Philips is also working in Kenya through a comprehensive partnership with a county government and Amref Health Africa to improve the county's primary healthcare system. While proven successful at relatively small scale, scaling the business model is now the bottleneck.

Case Study: Partnership for Primary Care (P4PC), Public-private partnership with Amref and the Makueni country government

Philips and Amref Health Africa have been pioneering a public-private collaboration project in primary care in Kenya, combining the strengths of the public and the private sector. A project company is being set up to manage the PPP contract with the Makueni county government.

The model:

- Makueni county government responsible for HR, supplies and infrastructure maintenance
- ProjectCo responsible for:
  - Upgrading of facility infrastructure
  - Supply and maintenance of equipment and furniture
  - cluster management of primary care facilities and referrals, performance management, functioning of community health units
  - roll-out of social health insurance
- Business model combines a base payment with an availability fee per facility and community health unit and a performance-based fee
- The government pays the public-private collaboration fee from its health budget, complemented with increased revenues from social health insurance claims
- The investment is financed from a combination of equity (in the project company), a stand-by credit facility, a guarantee on government payments and viability-gap grant funding.

The massive health funding gap in Africa

Substantial investments are required to accelerate Africa's progress towards UHC. The WHO estimates that additional spending of $58 per person per year is needed in developing countries by 2030, of which

[13] www.carepay.com

the majority should be spent on primary care.[14] According to a recent UNECA report "Healthcare and Economic Growth in Africa," Africa faces a health financing gap of at least $66 billion per year.[15]

Business as usual through existing health financing models cannot bridge this massive financing gap. Sub-Saharan African governments do not have the financial capacity, as their funding is mainly available for operational costs such as staffing, supplies, and facility operational budgets, and annual government budgets only increase gradually over time. Funding for capital costs and deployment of innovations and new delivery models at scale is limited. Isolated donor grants are often irregular and provide an unsustainable source of funding, and therefore cannot bridge the funding gap either.

To achieve UHC and meet Africa's healthcare goals, we need a new approach—one that also leverages private return-seeking capital to serve the countries with the greatest need to bridge the massive health financing gap.

What has prevented investors from investing in primary healthcare strengthening ?

To date, however, only 1.6 percent of the $500 billion impact-oriented investment market is invested in the health sector in Africa, and a fraction of that is invested in primary healthcare.[16] The business case for primary health care is challenging, and investments are perceived as too high risk, even by seasoned impact investors. Major barriers include (1) thin profit margins due to weak revenue base, (2) high upfront development costs, and (3) structural reliance on government support.

With regard to the first issue of a weak revenue base, Government supply-side financing streams are theoretically supposed to cover costs of staff, infrastructure, and medicines, but in practice these are often insufficient to cover the costs to provide quality services to the vast majority of the population. Demand-side financing is often considered the most efficient way of financing healthcare, but health insurance coverage in sub Saharan Africa is extremely low, ranging between 5 to 15 percent across much of sub-Saharan Africa.[17] Insurance reimbursements by far fail to generate the required payment flows to health facilities to repay investors. Business models are therefore often dependent on a third and often controversial demand-side financing stream: out-of-pocket payments. Such payments are unaffordable for many African countries' populations and can lead to catastrophic health expenses for low-income families.[18] Out-of-pocket payments are also irregular and often made in cash, making them difficult to and manage, and unreliable as underpinning for revenue projections and related investment cases.

Secondly, high upfront development costs contribute additional investor risk , as repayment capacity of government and/or other payers can be challenging over time. While donor grants could potentially be

[14] https://www.who.int/news/item/17-07-2017-who-estimates-cost-of-reaching-global-health-targets-by-2030
[15] https://www.devex.com/news/africa-s-66b-health-financing-gap-requires-private-sector-power-experts-say-94269; "United Nations. Economic Commission for Africa (2019-02). Healthcare and economic growth in Africa. Addis Ababa. https://repository.uneca.org/handle/10855/43118
[16] GIIN. https://thegiin.org/assets/GIIN%20Annual%20Impact%20Investor%20Survey%202020.pdf
[17] https://ideas4development.org/en/expanding-health-insurance/
[18] In Nigeria, for example, out-of-pocket payments represent 77% of health expenditure. https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=NG-GH-KE-ZG; Across sub-Saharan Africa, out of pocket expenses represent 36% of health expenditure, making the African region the highest impoverished region due to catastrophic health expenses. https://link.springer.com/article/10.1007/s40258-020-00618-0; https://www.who.int/healthinfo/universal_health_coverage/report/fp_gmr_2019.pdf?ua=1

used for upfront capital and development expenditures, they are not sufficient, secure, or comprehensive, as they are often based on predetermined parameters, often 'siloed'-i.e. vertically focused on certain diseases vis a vis health systems- and hence not easily accessible. The donor funds that are directed to primary healthcare mostly focus on paying for operational costs in specific disease areas or regions and not on horizontally strengthening the primary care system which requires more capital investment.

Finally, government payments can be erratic and thus the risk for project parties and investors is often perceived as too high to absorb, especially because business cases need to be developed with long-term horizons in order to recoup investments at the low margins that are characteristic for primary healthcare service delivery models.

Double blended financing as a solution to scaling primary care innovations

The investment case for primary health care is challenging due to limitations in the revenue model, high development costs and political risk factors. To break the impasse and unlock much needed investments into better primary healthcare, we propose applying a 'double blended' finance approach. Double blended financing refers to **(1) Investment blending** to cushion the investment and early-stage development risk using first loss and development grants and (2) **Revenue blending** at the project/venture level by strengthening the revenue sources and de-risking instruments to ensure that innovations thrive in the long term and reach everyone, including the poor.

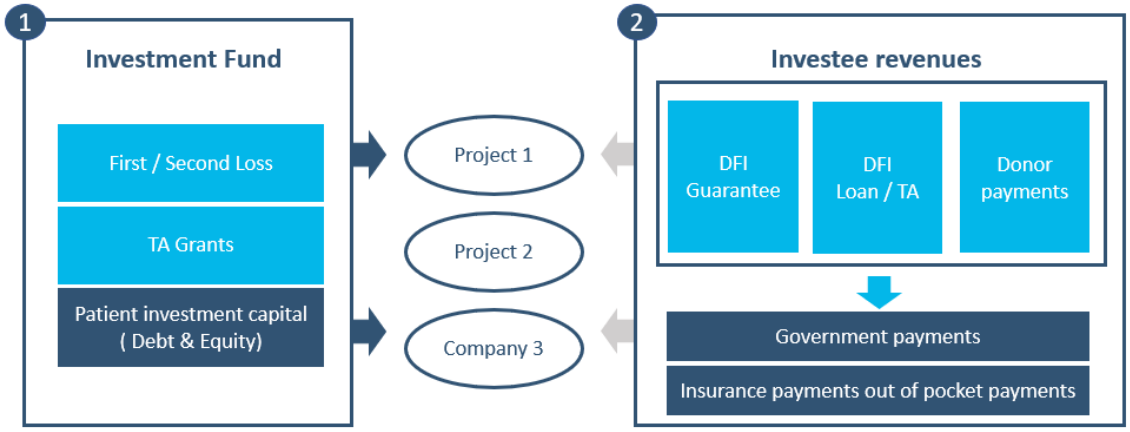

Figure 1: Double blending instrument to unlock investments in PHC

Investment Blending - Blending to de-risk investments at the fund level

Blending at the investment level is key to cushion the investment risk perceived by impact investors. While healthcare has increasingly become a sector of interest for the impact investing community, investors still shy away from primary care projects serving lower income groups, as revenue models and margins are yet not sufficiently stable in public and privately owned primary care services. Furthermore, many new innovative care models are not yet tested at scale and perceived as too high risk. It is therefore crucial to make first loss and development capital available to reduce the risk for investors. The high impact potential of investing in healthcare needs to be communicated to impact investors, in line with adjusted

risk-return expectations. The cost of financing will need to go down to make primaty healthcare projects viable.

One example of a successful investment blending vehicle for privately owned primary care facilities is the Medical Credit Fund,[19] where first loss capital from both public and private donors have generated substantial investment capital from multiple sources, including Development Finance Institutions (DFIs), impact investors and foundations, and local commercial banks. Its cushion grant capital has been instrumental in showcasing to impact investors and local banks and financial institutions that lending to healthcare SMEs can be a strong investment.

Revenue Blending - Blending to strengthening and smoothen revenues at the project/venture level:
While blending on the investment side is crucial to "crowd-in" investment capital, it is also critical to strengthen and blend the relatively weak revenue streams of primary care facilities in order to create a modest return. Because much of primary care delivery, especially for those living at the bottom of the pyramid, is financed by government payments, a secure revenue stream that can support private investment requires (A) some type of security that governments will continue to pay throughout the project lifecycle. and (B) additional revenue that can increase, diversify, and stabilize the government provided revenues, which can be erratic.

WEAK REVENUE BASE AND HIGH RISK, DUE TO (AMONGST OTHER FACTORS)	
Insufficient government budgets (i.e., Poor tax base & high indebtedness)	Poor affordability of the population (i.e., low insurance coverage, catastrophic out of pocket expenditures)
A Technical Assistance to government on health financing, guarantees on/budget support to government investment in projects	**B** Donor co-payments, or 'top ups' to complement revenues: e.g., for health insurance covers, for outcomes achieved, or for the bottom of the pyramid

Figure 2: Revenue risks and instruments to address them

To achieve (a), de-risking government contributions is pivotal to make projects investable. There are multiple de-risking instruments, varying from 1) technical assistance to the government treasury, national insurance funds and government health officials, to 2) loans to governments supporting the health

[19] www.medicalcreditfund.org

budget, (shown in Figure 1, box 1 above) to 3) guaranteeing government payments or guaranteeing the financial implication of a breach of contract. One example of an opportunity to deploy these instruments is a new trust fund that EIB and WHO aim to create. This offers the potential for de-risking the public and the private side, pieces of the same puzzle that are equally needed.

Achieving (b) requires different healthcare payers, such as the local government, insurance schemes, and innovative donors to work hand in hand on comprehensive, horizontal projects that strengthen primary healthcare and referral systems vis-a-vis focusing on specific disease area or one sub-segment of the population. Donor contributions can provide the necessary extra push to make it worthwhile for private companies to start these long-term projects and to firmly engage impact investors and governments.

For a donor, contributing this way can be a breakthrough: in contrast to funding an entire project's implementation (largely input based) or funding only specific vertical disease programs, donors now have the ability to contribute to Universal Healthcare Coverage (see Figure 4). Moreover, donors would only pay a fraction of the costs they are accustomed to making for financing fully vertical programs, as the base costs are covered in the business model.

Results- and outcome-based payment structures can become a valuable element in this regard. By participating in horizontal, large scale projects, donor funds will be more catalytic in multiple ways: first, additional revenues de-risk investments and encourage more investors to join the primary care space. Second, governments see their contribution being leveraged as well, increasing the value for money of their own investments. Finally, investee management (venture or SPV partners) are incentivized to provide quality and efficient care to improve their business models and increase their revenues.

UHC indicators	Baseline	Target	Maternal & child health donor	philantropist
Skilled deliveries		Increase of 20%		
4 ANC visits		Increase of 30%	☑	
Still births		Decrease of 30%	☑	
Children fully immunized		90%	☑	
Healthcare utilization (patient visits)		Increase of 30%		☑
Health insurance coverage indigents		50%		☑

Figure 4: illustrative example of donor contributions for UHC impact

It is also critical to achieve long-term (financial) sustainability beyond the project term. Therefore revenue streams need to be strengthened in the long term by working with local governments and gradually increase the uptake of national health insurance schemes and including everyone in the system. While public de-risking and guarantees are important for financial sustainability, they only work in the long term if governments gradually increase their buy-in and pay a larger portion of the bill by subsidizing access to health insurance for the poorest. For example, PharmAccess Foundation is designing private and public-private health insurance schemes for lower-income groups with easy access through mobile phones that the government can buy into over time.[20]

[20] https://www.pharmaccess.org/activity/health-insurance/

Conclusion

Universal Healthcare Coverage in sub-Saharan Africa can only be achieved if primary healthcare is transformed, providing quality care to the entire population, leaving no-one behind. Private sector innovations are pivotal for realizing these improvements, but they can only contribute to UHC if their innovations reach scale, underpinned by a sustainable business model. This requires a substantial investment, which governments can and should not take on alone. Private return-seeking capital as well as Development Finance capital can be blended to catalyze health system improvements at scale.

A double blended finance framework is key to mitigate risks both for individual investors and for public and private partners. At the investment level, engaging concessional capital de-risks investments and can provide for a cushion for first losses. At the investee level (venture or project), pooling different payment streams from the government, insurance, patient payments, and donor funds in comprehensive, horizontal projects enables far more effective use of the available financing. Providing guarantees on government payments further de-risks these projects. As a result, investors can achieve a modest financial return and a huge social return, and donors can maximize the impact of their support.

It is time for donors, philanthropists, impact investors, and government authorities to come together and create Primary Care investment mechanisms for Africa that embrace double blended financing. Each actor has a role to play to mobilize the required financial resources. Donors and philanthropists can 1) contribute grants for technical and transaction assistance, and first loss to support testing of innovative projects in real life settings and/or scaling interventions with proven impact, and 2) provide guarantees to de-risk equity and debt instruments. Impact investors can invest according to their risk appetite either in the testing of projects or in the de-risked (sub-national) roll out of proven projects. Governments must work to gradually increase the uptake of national health insurance schemes and increase domestic resource mobilization to sustain the business models.

Double blended financing is urgently needed to unlock investments into primary care and catalyze exponential improvements in health outcomes at the systems level. The authors of this article are delighted to see a nascent momentum towards this thinking. A striking example is the Health Finance Coaition (HFC), a group of leading investors, healthcare companies, and philanthropies focused on mobilizing significant private investment to achieve transformative healthcare impact in Africa. HFC intends to create a USD 100 mln impact investing vehicle, in collaboration with Fund manager AfricInvest, to invest in high impact projects and ventures focused HFC recognizes a need for 'deal construction': supporting deals that target lower income groups to become investable, a.o. by strengthening their revenue base with grant funds and/or guarantees. Also underpinning the vision is a shift at the European Commission (EC) level. Following months of consultations by the authors of this paper with Dutch Development Bank FMO, with numerous EU bodies in Brussels and in Africa, recently the EC announced a Human Development Window for healthcare and education aligns well with this thinking.

The task ahead now is to intelligently blend the financing instruments available to realise Universal Health Coverage. Only then can we realise the return on investment that investing in healthcare will bring to economies across Africa.

Authors: Jan-Willem Scheijgrond, Annette Jung, Royal Philips; John Simon, Femke Smeets, Allicen Dichiara, Bart Schaap, Total Impact Capital.