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Greater than the Sum of its Parts:

Blended Finance Roadmap for Global Health

From CII's Investing for Impact Series

USAID's **Center for Innovation and Impact (CII)** takes a business-minded approach to fast-tracking the development, introduction and scale-up of health interventions that address the world's most important health challenges. CII invests seed capital in the most promising ideas and novel approaches, using forward-looking business practices to cut the time it takes to transform discoveries in the lab to impact on the ground.

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USAID would like to thank our team of advisors and experts for their invaluable input into *Greater than the Sum of its Parts: Blended Finance Roadmap for Global Health.* An incredible amount of work went into its creation and we are especially thankful to Kois for their partnership in developing this report. Questions and comments are welcome and can be directed to the USAID leads for this guide, Amy Lin and Priya Sharma.

For contact information, and to download the latest version of this report, please visit www.usaid.gov/cii

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Foreword

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When USAID was established in 1961, the space race was at its peak, the world's first supercomputer was introduced, and traditional development assistance from bilateral donors was the primary source of funding for global health. Twenty years ago, the first space tourist visited the International Space Station, the floppy disk was replaced by the USB flash drive, and the development landscape expanded to include new players, like the Bill & Melinda Gates Foundation, Gavi and the Global Fund to Fight AIDS, TB, and Malaria. These new players and their partnership with traditional donors has transformed development beyond what we thought possible, and has led to incredible health gains around the world.

Today, modern smart phones are more powerful than the computers used by NASA during the Apollo years, and the progress we have made towards improving the health and well-being of people around the world means that we can imagine a world without the need for foreign assistance. But the path we need to take is still unfolding in front of us. The private sector has recently emerged as a critical player in development with increasing investments in low- and middle-income countries. USAID and the development community have welcomed the private sector's growing participation, and partnership opportunities have led to new ways of working towards a healthier world free of poverty.

Greater than the Sum of its Parts: Blended Finance Roadmap for Global Health, picks up on this opportunity and offers a roadmap for how USAID can build on its history of partnering with the private sector to attract new financiers and partners to tackle health challenges and help close the funding gap. This roadmap is a practical resource for USAID, other donors and our partners, and it highlights findings from India, Tanzania and Liberia on how to catalyze blended finance transactions. The funds unlocked by blended finance instruments not only address the health needs of today, but also build sustainable platforms to help meet the health needs of tomorrow. By drawing in new partners, we expand the universe of competencies, networks, and funding for meeting global health goals–and eventually contribute to ending the need for foreign assistance.

The world has drastically changed over the last half century, and the world of health financing is no exception. We must adapt, and applying blended finance approaches more systematically and strategically can help us prevent child and maternal deaths, control the HIV/AIDS epidemic, and combat infectious diseases. We invite you to put this roadmap to the test, share your experiences, and partner with us in exploring new blended finance opportunities.

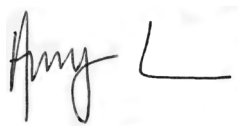

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Photo Credit: Maggie Moore/USAID

Executive Summary

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Blended finance can help close the health funding gap

Significant strides in global health outcomes have been made over the last two decades on the back of increased funding by governments and donors, including USAID. Recent trends in global health financing, however, indicate that these funding levels may not be adequate to meet the health and well-being Sustainable Development Goals (SDGs). In 2016, the funding gap to achieve the health SDGs in low- and middle-income countries (LMICs) was estimated to be approximately $134 billion, and this gap is expected to increase threefold by 2030. Blended finance—the strategic use of public and philanthropic resources to mobilize private capital to achieve development outcomes—can be an important tool to address this funding gap. Blended finance uses public sector funding, financing instruments and other assets to overcome barriers preventing commercial private capital from being invested.

In addition to channeling increased funding towards development outcomes, blended finance offers several other benefits. For example, it can improve the sustainability of an intervention by catalyzing investments that can be scaled and replicated even after the exit of donor capital. It can also stimulate innovation in high-impact sectors and foster the development of domestic markets, thereby contributing to countries' increased self-reliance. Like USAID, many development organizations have recognized the role of blended finance and are increasingly engaging in blended finance transactions.

USAID seeks to engage in blended finance in a strategic and systematic way

USAID can leverage its unique advantages (listed below) as the Agency looks to engage in blended finance to further its mission globally:

- Grant capital and credit guarantee authorities
- Technical and programmatic expertise in global health
- Convening power and credibility
- Country presence and relationships
- Ability to influence and accelerate policy

A roadmap for engaging in blended finance in global health

USAID can engage in blended finance transactions for health using this roadmap:

1. Identify the country archetype: The three country archetypes can guide the shortlisting of blended finance instruments that are most likely relevant for any given country context. These archetypes were determined by two composite indicators, one to measure a country's health system status and the other assessing attractiveness to investors.
2. Define the health issue: Identify the issue of focus that contributes to poor health outcomes in a specific area.
3. Prioritize financing challenges: Analyze the specific financing challenges underpinning the health issue.
4. Evaluate the potential for blended finance: Determine the potential for adopting a blended finance approach by evaluating: the sustainability of the underlying program or intervention; the potential for increased efficiency by engaging the private sector; and the presence and interest of private sector players.
5. Shortlist blended finance instruments: If there is potential for a blended finance approach, shortlist instruments that both address the financing challenges prioritized in step 3 and align with the country archetype identified in step 1.
6. Identify activities for further engagement: List the key follow-on activities to be undertaken in order to select the most appropriate instrument and identify the role(s) that USAID could play in the transaction.

The six-step roadmap was tested in three country deep-dives—India, a *transition* archetype; Tanzania, a *strengthen* archetype; and Liberia, a *build* archetype—illustrating the flexibility and utility of blended finance across health financing contexts. This report summarizes two illustrative transactions that emerged: a health loan facility that helps low income TB patients with out-of-pocket payments (OOP), and a revolving debt fund for health facilities run by faith-based organizations (FBOs). Through the deep-dives and broader analysis, five design principles emerged:

1. Define transaction's high-level design: Outline key parameters early, and identify assumptions, risks and enablers.
2. Identify project champions and key expert resources: Identify internal and external experts to support the design and implementation of the transaction.
3. Leverage the broader USAID toolkit: Other instruments, including non-financial tools, may be needed to achieve the desired impact from the blended finance transaction.
4. Engage stakeholders: Actively involve all key stakeholders at all stages of the transaction and ensure objectives are aligned.
5. Attract/encourage new actors: Crowd in new actors and funding into the health space.

This roadmap is a starting point for USAID staff in Missions and the Global Health Bureau to strategically assess when a blended finance approach could be appropriate and how to apply it—while leaving room for a more opportunistic approach that leverages existing partners and initiatives. It provides a common framework, language, and understanding of blended finance tools to help teams identify and address important health challenges.

Importance of blended finance

03

Significant funding gaps remain in order to meet SDG health targets by 2030

Over the past 60 years, enormous strides have been made in the global health space, but much more work is still needed to achieve the targets included under the health and well-being Sustainable Development Goals (SDGs) by 2030. In order to meet the SDGs, substantially more funding for global health must be mobilized. Recent trends in development finance have resulted in significant funding gaps. Since reaching an all-time high in 2013, development assistance for health has largely remained stagnant (see Figure 1 below). This, coupled with insufficient government spending on health, has resulted in a $134 billion annual investment gap for the health SDGs in low- and middle-income countries (LMICs). By 2030, the estimated annual funding gap is projected to be $371 billion[1]. Traditional grant funding alone cannot fill these gaps–this presents donors and country governments with an opportunity to fill this need in innovative ways.

FIGURE 1: Development assistance for health

USD Bn, global (2003-17)[2]

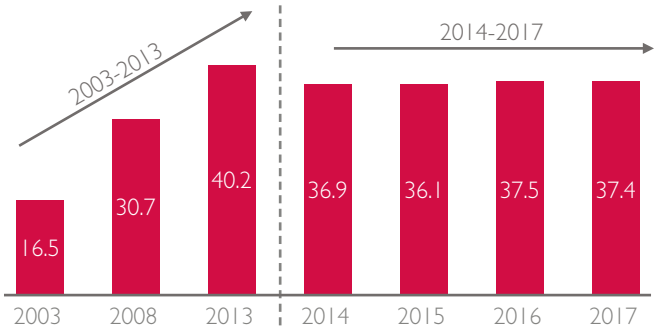
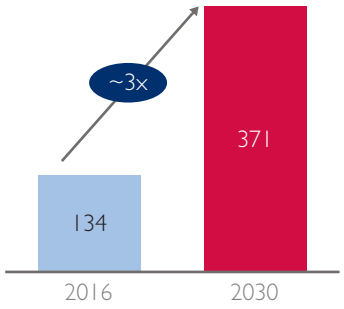


FIGURE 2: Additional annual investment required in health

USD Bn



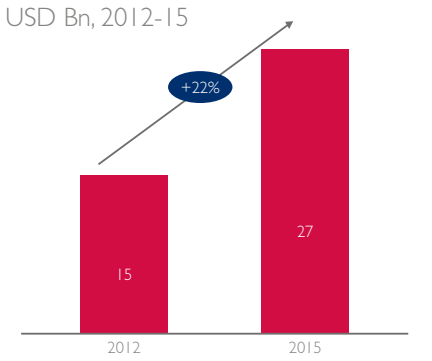
At the same time, there has been an increase in the amount of foreign direct investment, i.e., private capital, flowing into LMICs. In the 1960s, when USAID was established, foreign direct investment (FDI) made up only 29% of funding flowing to LMICs[3], but by 2013, that percentage increased to 84% of all financial flows. In fact, FDI made up 91% of US financial flows to LMICs[4]. This trend demonstrates an increasing interest in LMIC markets by the private sector, and provides donors and country governments with new sources of capital to help close the funding gap and achieve the SDG health targets.

1. Refers to the collective additional investment needed from all entities (governments, donors, private players) towards health in 2016 and in 2030 in order to meet SDG targets. The final funding gap may be smaller if governments scale up health expenditure. From 'Financing transformative health systems towards achievement of the health Sustainable Development Goals' - WHO report (SDG Health price tag) covering 67 LMI countries (which represents 95% of the total population in LMI countries)
2. Financing Global Health (IHME), 2017, p. 25
3. Our Shared Opportunity: A Vision for Global Prosperity (Center for Strategic and International Studies), 2013, p.2
4. The Index of Global Philanthropy and Remittances 2016, Hudson Institute. 2016, Page 9 Table 1. Financial flows include U.S. ODA, U.S. Private Philanthropy, U.S. Remittances, U.S. Private Investment.

Blended finance can bridge the SDG funding gap by mobilizing private capital

In recent years, blended finance has emerged as a way of catalyzing investment into markets and sectors traditionally ignored by the commercial private sector. In 2015, blended finance mobilized $27 billion of private capital, representing a steady 22% annual increase between 2012 and 2015. Moreover, health has been one of the key areas where blended finance has been applied worldwide–according to the OECD, almost 30% of the capital mobilized through blended finance between 2000 and 2016 was for health investments and activities. See Figure 3.[1]

FIGURE 3: Private capital mobilized through blended finance



There are several benefits to using blended finance to complement traditional donor financing, namely:

- Increased funding for development outcomes: By leveraging additional private capital, some public and philanthropic funding can be redeployed towards programs that still require grants or highly concessional, i.e., below market rate, capital.
- Improved sustainability: Blended finance can catalyze private investment that can help an intervention or project scale and replicate, even after the exit of donor capital.
- Incentivized innovation: Donors can support and de-risk[2] investments in high-impact sectors where normal market fundamentals do not function adequately. This support is particularly important in markets that require innovation in products and services to reach underserved segments of the population.
- Enhanced local markets: De-risking entry into new markets or sectors deepens local financial markets and improves access to capital for small and medium enterprises (SMEs). Drawing in foreign capital into developing countries can advance the growth, capacity, and sophistication of local economies, businesses, and investors.

What is blended finance?

Blended finance is the strategic use of public or philanthropic resources to mobilize new private capital for development outcomes. Blended finance uses public sector funding, financing instruments and other assets to overcome barriers that otherwise prevent this commercial, private capital from being invested in LMIC markets.

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

A number of development organizations are strategically deploying blended finance tools at scale. These include multilateral organizations such as the International Finance Corporation (IFC), bilateral organizations such as the Department for International Development (DFID), and philanthropic organizations such as the Bill & Melinda Gates Foundation. For USAID, blended finance can be an important tool to help set countries on their path to self-reliance and improve the efficiency and effectiveness of its existing resources.

1. Global, excluding high income countries, where the classification of global excluding high income countries is based on the World Bank classification of countries with a GNI per capita of less than $12,476 (2015), OECD
2. De-risking refers to mechanisms that reduce, transfer or compensate for risk to achieve a risk-return profile that can catalyze private sector investment at scale
3. OPIC, Center for Global Development

Blended Finance Roadmap

04

USAID can leverage key advantages when engaging in blended finance transactions in health

USAID has an important role to play in the blended finance space. Discussions with internal and external stakeholders identified five advantages that USAID can leverage to support blended finance transactions at both the global and country level (see Figure 5). These advantages can catalyze blended finance opportunities in global health, help maximize success and learning opportunities from blended finance, and help demonstrate the power and impact of blended finance as a broader approach for development partners.

FIGURE 5: USAID advantages to support blended finance transactions

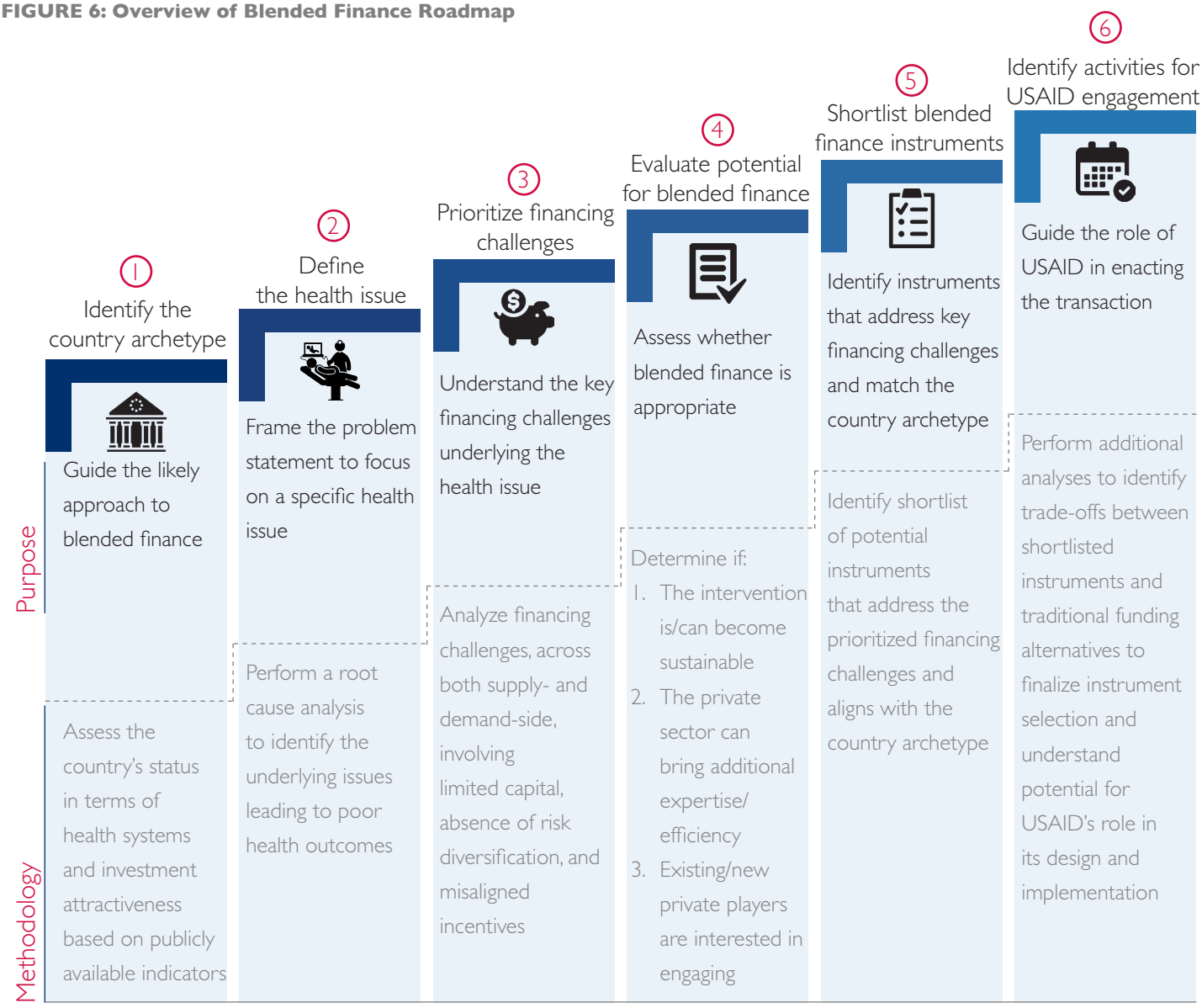
Grant capital and credit guarantee authorities	Extensive experience deploying grant capital as the largest donor in global health and in implementing Development Credit Authority (DCA) guarantees across sectors and countries
Technical and programmatic expertise in global health	Wide-ranging experience identifying health challenges and implementing interventions across health areas
Convening power and credibility	Expertise crafting multi-stakeholder arrangements, with a track record of partnering across the private, public, non-governmental, and faith-based sectors
Country presence and relationships	Mission presence in 60+ countries with specific local knowledge, networks, and stakeholder relationships
Ability to influence and accelerate policy	Ability to support policy/regulatory advances to attract and oversee private investments

Roadmap can guide how USAID engages in blended finance transactions

USAID has a long history of partnering with the private sector to advance health outcomes and has successfully leveraged tools, such as its DCA and Global Development Alliance (GDA), to help mobilize funding and in-kind resources from the private sector. More recently, USAID has also begun using other non-traditional financing tools, such as DIBs. To date, however, many of these transactions have been ad hoc and opportunistic, and particularly in the global health space, there is much to be gained from being more purposeful and strategic in the application of blended finance. To support this effort, USAID has developed a six-step roadmap and accompanying tools to help guide health staff through the process of identifying appropriate blended finance approaches. It is hoped that this Roadmap will be useful for other donors and development organizations considering blended finance approaches as well.

This roadmap builds on *USAID's Financing Framework to End Preventable Child and Maternal Deaths* and *Investing for Impact* reports. It is designed to guide USAID health technical staff through the process of determining if a blended finance tool is better suited to address a health challenge than traditional grant funding. Figure 6 provides an overview of this approach, and each step is briefly discussed below.

FIGURE 6: Overview of Blended Finance Roadmap



Step 1: Identify the country archetype to guide the selection of blended finance instruments and USAID's role

The country archetype exercise can guide the shortlisting of blended finance instruments that are most relevant for a particular country. These archetypes are determined by two composite indicators, one to measure a country's health system status, and the other to track attractiveness to investors (see Appendix A for additional information on the metrics and data sources used). The three archetypes are: *build, strengthen,* and *transition* (see Figures 7 and 8).

Countries in the *build* archetype, with less-developed health systems and lower private investor attractiveness, should deploy simpler blended finance instruments, while *transition* countries with more developed health systems and greater levels of private sector investments, can explore more complex instruments. However, this guidance based on archetypes is directional and complex instruments are certainly feasible in *build* countries with the right set of enablers in place. Moreover, subnational situations may differ significantly from the country's overall status, and as a result, specific regions within a country may not align with the country's overall archetype. More importantly, the specifics of the health and financing challenge at hand should be the determining factors for identifying the most appropriate blended finance instruments to analyze and consider.

FIGURE 7: Country archetypes

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

USAID's PCMD countries were mapped to three country archetypes

As a starting point, these composite metrics were applied to USAID's 25 Preventing Child and Maternal Deaths (PCMD) countries, using publicly available data. Figure 8 shows this archetype mapping.

FIGURE 8: USAID's 25 PCMD countries mapped to the three archetypes

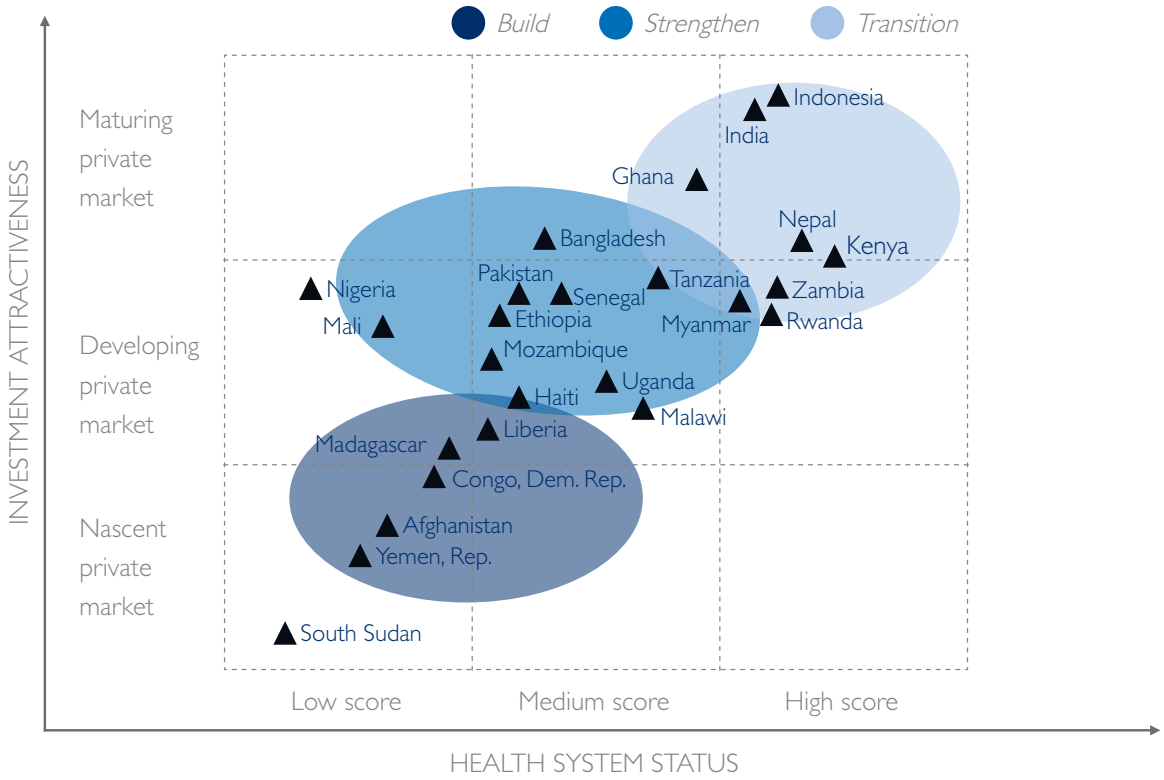


Figure 9 illustrates how a country's archetype can help identify appropriate blended finance instruments and the role(s) that USAID can play, and how both elements can change across archetypes.

FIGURE 9: Blended finance instruments and USAID's potential role across country archetypes (illustrative)

Build	*Strengthen*	*Transition*
Grant Capital	Seed capital	Impact funds
Provide grant for developing proof of concept for health product/service idea	Provide grant for developing a prototype with potential for substantial impact	Provide grant for structuring the fund and/or initial capital to attract investors
DCA support	SME loan enabler	Debt buy-down
Use DCA guarantee to encourage local lending to private health enterprises	Provide TA to local banks to set up a credit rating facility for health SMEs to access loans more efficiently	Use grant to partially re-pay a loan contingent on achieving health milestones
Milestone-based payments	Pay-for-success mechanisms	Impact bonds
Provide grant to a service provider if input milestones are achieved	Provide grant to a service provider if output milestones are achieved	Act as outcomes funder by using grant to pay for achievement of health milestones

Archetypes are matched with relevant instruments, but an individual country can consider any blended finance instrument based on its health and financing needs

Step 2: Define the health issue

Once a country's archetype has been identified, the next step is to clearly define the health issue that needs to be addressed. This step should be guided by programmatic priorities and the health needs of the country. Once a health challenge has been identified, a more detailed analysis should be conducted to help identify the primary pain points and the underlying root cause(s).

As an example, suppose a USAID Mission identified high maternal mortality as a programmatic priority. Further analysis might determine that poor quality of care in private health facilities was a key problem area and was tied to two root causes: 1) the lack of an accreditation body to certify and enforce quality of care; and 2) the need to upgrade equipment in health facilities. These would be considered the two underlying challenges that a team would focus on to explore if and how blended finance might help improve the country's maternal mortality rate.

Photo Credit: Allan Gichigi/ The Maternal and Child Survival Program (MCSP)

Step 3: Prioritize the underlying financing challenges

The next step of the process is to analyze any financial challenges underpinning the health issue identified in step 2. Supply-side challenges may prevent the supplier from providing the health products or services effectively. Suppliers can include healthcare and diagnostic providers, pharmaceutical and biomedical firms, health insurers, or lenders. For example, working capital constraints may cause a medicine stockout in hospitals and lead to interruption of care. Demand-side challenges may prevent the end-users or patients from accessing health products or services effectively. For example, patients may opt not to obtain health insurance because they may value having cash on hand instead of protecting against the future risk of catastrophic expenses. This patient-level challenge reflects misaligned demand-side incentives and can impede access to healthcare.

The supply- and demand-side financing challenges in both the public and private health sectors can be characterized into the three groups listed below:

Limited capital

Inadequate funding, either on the side of the end-user or of the provider.

Absence of risk diversification

Different stakeholders in the health ecosystem can bear, share or transfer financial, political, or operational risks. High perceived or real risk may result in an investor/operator choosing not to invest in solving a health issue.

Misaligned incentives

Misaligned incentives arise when stakeholders focus on areas that generate higher profitability or short-term results at the expense of high-impact or long-term benefits.

After identifying the underlying financing challenges, it is important to ensure that addressing these will contribute to addressing the priority health issue. Many systemic barriers can contribute to the health challenge and in some cases, programmatic, policy or other interventions should be prioritized over addressing the financing issues.

Continuing the hypothetical example from step 2 above, poor quality care was identified as one of the main factors for the high maternal mortality rate. If the lack of an accreditation body to certify and enforce quality standards is a root cause, then there is no underlying financing challenge, and a more effective intervention would be to help set up an accreditation system. The other possible root cause noted, health care facilities requiring equipment upgrades, could have an underlying financing challenge such as insufficient funds to make these upgrades. In this case, a financing intervention, like providing facilities with access to working capital for equipment upgrades, could be effective.

Step 4: Evaluate the potential for blended finance

If financing challenges underlying the priority health issue are identified in step 3, the next step in the Roadmap is to determine if there is potential for blended finance. This assessment can be done by answering the following set of questions:

1 Is the underlying intervention or program financially viable (i.e., can it become sustainable)?

Blended finance can catalyze investments into business models or approaches that can be scaled and replicated even after the exit of donor capital. If an intervention or program can be sustainable in the long run (financially or otherwise), it is likely a good candidate for blended finance. In addition, it is valuable to understand why private providers or investors have not participated to date, and whether USAID can address these roadblocks. In some cases, new types of financing through blended finance instruments can unlock new cost savings or generate new revenue streams to enable long-term sustainability.

2 Can the private sector bring additional expertise, resources, or efficiency?

Blended finance provides USAID with the opportunity to work with new partners in the private sector, leveraging not only additional funding and resources for global health, but complementary or new skill sets that can help improve the efficiency and effectiveness of a health project or intervention.

3 Are there existing or potential players in the private sector that are already active and/or interested in engaging to address these financing challenges?

The last check is determining if there is an existing network of private suppliers or providers, or sufficient interest from potential investors to engage with. Additionally, it will be important to ensure that incentives and objectives are clear and aligned from the start in order to help ensure that the intervention will be scaled even after the exit of the public or philanthropic partner(s).

Step 5: Shortlist blended finance instruments

If there is potential for adopting a blended finance approach, the next step is to identify a shortlist of potential instruments that both address the financing challenges prioritized in step 3 and align with the country archetype identified in step 1. This shortlist is a subset of instruments that show promise for addressing the defined health challenge, but it is important to note that other blended finance instruments can be considered as well. The country deep-dives illustrate how a shortlist of blended finance instruments can be determined based on the specifics of the country archetype, and the health and financing challenges.

FIGURE 10: Illustrative list of potential blended finance instruments

Instrument	Definition	Example
Debt buy-downs	Donor commits to paying off part/all of the principal or interest of a loan, contingent on achieving health milestones	The World Bank established a trust fund with grants from donors to buy down credits, or loans, by the International Development Association for polio-eradication programs in Pakistan and Nigeria based on their polio immunization results
Development impact bonds	A pay-for-success model that ties payment to the attainment of a pre-determined social outcome. Stakeholders include outcome funders, investors, service providers, and independent evaluators	USAID is an outcome funder for the Utkrisht impact bond aimed at improving maternal and newborn health outcomes by working with private health facilities to achieve rigorous quality accreditation standards
Guarantees	Partial protection to lenders willing to extend loans to developmentally important but underserved sectors such as health	DCA partnered with the USAID Uganda Mission and the Government of Sweden to provide a 7-year, $3 million loan portfolio guarantee (LPG) to the Centenary Bank to increase access to credit for the Ugandan private health sector
Impact investment funds	Funds that make investments into companies and organizations with the intention to generate a measurable, beneficial social or environmental impact alongside a financial return	USAID provided $1 million in grant funding that helped the Medical Credit Fund raise $17 million from a mix of public and private institutions to provide credit to health SMEs in Africa
Leasing	A contract between two parties where one party (the lessor) provides an asset for use to another party (the lessee) for a specified period of time, in return for specified payments	The Asian Development Bank (ADB) provided a $75 million loan on favourable terms, i.e. with a longer tenure, to enable Yingda International Leasing in China to lease out modern medical equipment to public hospitals in underdeveloped regions that were otherwise unable to access long-term finance
Milestone-based funding	Grant funding that is disbursed to recipients if and when pre-determined outputs or outcomes are achieved	Ujjwal, a program designed by DFID to set up a network of 280 franchisee clinics for quality family planning and reproductive health (FP/RH) clinical services in underserved rural areas, had 70 payment milestones based on defined outcomes verified by a third-party assessor

SOURCE: USAID Investing for Impact, World Bank, IFC, WEF Blended Finance Vol. 1, UNDP

Step 6: Identify follow-up activities to select the appropriate instrument and map USAID's role(s)

The shortlisted blended finance instruments from step 5 will require more analysis and vetting to understand the trade-offs between them and the traditional funding alternative (referred to as the status quo instrument below and in the case studies), and to better understand USAID's potential role in design and implementation. Thus, the last step of this Roadmap is to consider additional analyses needed to help select the most appropriate blended finance instrument and map out next steps for USAID or another development actor. Figure 11 highlights key dimensions for analysis, along with the key questions to consider.

FIGURE 11: Parameters to conduct trade-off analysis to finalize blended finance transaction

Potential health impact

Depth of Impact: Extent of impact on health outcomes for each beneficiary during the lifetime of the transaction

What is the potential impact of the transaction versus the status quo?

Breadth of Impact: Number of beneficiaries reached through the lifetime of the transaction

How many more beneficiaries could be reached through the transaction versus the status quo?

Sustainability of Impact: Likelihood that the impact will continue even after the exit of blended finance

- Could a blended finance approach be more sustainable (financially or otherwise) than a status quo approach?
- Will the impact of the intervention continue even after the exit of the public or philanthropic partners?

Implementation feasibility

Time to implement: Overall duration from assessing feasibility to implementing the transaction

How long will it take to align and design the concept, align partners, and launch the transaction?

Cost of structuring & implementation: Total cost borne by all partners from feasibility analysis to implementation

What is the total amount of human and financial resources required to support the design, structuring, and implementation of the transaction (versus a traditional status quo project)?

Additional factors for consideration

- Would new financiers enter the health sector because of this transaction?
- How much external financing could be leveraged from this transaction?
- Are there project champions and experts at the USAID Mission or headquarters that can support this work?

USAID can play a number of roles throughout the life cycle of a blended finance transaction, and these roles are linked to the Agency's advantages outlined in Figure 5. The list below illustrates the different ways USAID can support the design, development, and implementation of a blended finance transaction, but it is by no means exhaustive. Additionally, USAID can play more than one role during the course of the design-to-implementation process, and most importantly, not all of these roles require funding. Indeed, many of USAID's greatest strengths are not related to the availability of funding the Agency has, but rather its influence and convening power, as well as its vast and deep technical knowledge and expertise.

Grant capital and credit guarantee authorities

USAID can use its grant funding for the design of a blended finance instrument, as a de-risking component of the instrument itself (such as a DCA guarantee), as a pay-for-success incentive like an outcomes payment or interest buy-down, or for monitoring and evaluation of a transaction to help measure the health impact.

Technical and programmatic expertise in global health

USAID can leverage the extensive technical expertise and knowledge of its staff, at all stages of the development of a blended finance transaction, to ensure that it is designed and implemented appropriately, and most importantly, that it will have a positive impact on health outcomes.

Convening power and credibility

As the world's largest bilateral donor, USAID is able to bring together potential partners for a transaction from the public and private sectors, at both the global and country level. In addition, USAID can actively attract new private sector players. For instance, by working with banks new to lending to the health sector or crowding in high net-worth individuals (HNWIs) as social investors for impact bonds. These partnerships can bring additional technical expertise or funding to global health and enable greater cross-sector learning.

Country presence and relationships

USAID's knowledge of local contexts and its relationships with key stakeholders in country can be particularly useful during the design and development stages, as it can help to ensure the appropriateness of the program and intervention, as well as identify partners to provide additional input and/or participate in the blended finance transaction.

Ability to influence and accelerate policy

In some cases, especially in *build* countries, USAID's role will be to work with governments and other key stakeholders to implement policy reforms and strengthen the enabling environment needed to attract private capital and support blended finance transactions.

Photo Credit: Mubeen Siddiqui/ The Maternal and Child Survival Program (MCSP)

Country deep-dives

05

USAID's approach to blended finance was tested in three country deep-dives: India, a *transition* country, Tanzania, a *strengthen* country, and Liberia, a *build* country. The deep-dives illustrate the six-step Roadmap in action, as well as its flexibility and utility across different health financing contexts. Two illustrative transactions that emerged from the deep-dives are presented in the following pages.

I Identify country archetype and health context

MFI Loan Facility in India

- India falls within the *transition* country archetype–it continues to strengthen its health systems, as demonstrated by its improving health indicators. For instance, India's maternal mortality rate has fallen from 280 per 100,000 live births in 2005 to 174 in 2015, and its infant mortality rate has declined from 55.7 per 1000 live births in 2005 to 35.3 in 2015[1]. India also has an established financial sector, with increasing investor interest in healthcare.
- India's health system is predominantly private-sector driven, and out-of-pocket expenditures account for 64%[2] of India's total health expenditure. The Government has launched the National Health Protection Scheme (NHPS) to provide health insurance coverage to 100 million low-income families[3]; however, coverage for many low-and middle-income families is likely to remain low in the near term, leading to the problem of the 'missing middle'.
- 27% of global TB patients and 24% of global multi-drug resistant-TB (MDR-TB) patients are in India[4]. The Government, under the National Strategic Plan, has set an ambitious target of a TB-free India by 2025, with interventions along the spectrum of care ranging from diagnosis to treatment. The plan also aims to focus on the private sector, which is expected to handle approximately 50% of the nation's TB diagnosis and reporting.[5]

Working Capital Revolving Fund in Tanzania

- Tanzania falls in the *strengthen* archetype – its health systems continue to improve, which is reflected in its health indicators. Tanzania's maternal mortality rate has fallen from 514 per 100,000 live births in 2010 to 398 in 2015[1]. Additionally, Tanzania's financial sector is still developing, with some private players starting to show an interest in the health sector. For example, leasing companies such as Equity for Tanzania Limited are actively lending in the health sector.
- The Government of Tanzania is increasingly moving towards supporting the public sector as the primary healthcare provider. However, the expansion of public health systems is a long process, and other providers including FBOs still form a crucial link to service delivery for the country's low-income population. Importantly, FBOs operate approximately 40% of all hospitals in Tanzania.[6]
- The government is actively rolling out the National Health Insurance Fund (NHIF) as part of its move towards Universal Health Coverage (UHC) and is targeting coverage for 50% of the population by 2030 under the scheme.[7] This roll-out will ensure access to services for patients at qualifying health facilities, including FBOs and private providers.

1. World Bank
2. WHO
3. India National Health Protection Scheme, 2017
4. End TB Report, WHO
5. India National Strategic Plan (2017-2025)
6. Christian Social Services Commission, Tanzania
7. Government of Tanzania data

MFI Loan Facility in India

2 Define the health issue

For low-income TB patients, out-of-pocket payments (OOP) incurred during treatment can be catastrophic[1] – primarily due to the loss of two to four months of income during the diagnosis and intensive treatment phases. Patients may not complete the full course of treatment as a result.

3 Prioritize financing challenges

This step identified existing and potential options for TB patients to access financing to help cover their OOPs. Demand- and supply-side financing challenges were then mapped to each financing option to help identify bottlenecks to be addressed.

Existing/potential options for patients to manage OOP	Key financing challenges	
	Demand-side	Supply-side
Cash transfer through banks: Direct cash transfers to patients' bank accounts. Govt of India currently provides Rupees 500/ month (~7 USD) which covers only the nutritional needs of TB patients		**Limited capital:** Grant funding is limited and not sustainable
Loan by non-governmental organizations (NGOs): Concessional loans to patients who may not be eligible for market rate loans	**Poor financial means of patients:** Patients have limited savings and/or cash flows to manage out-of-pocket expenditures and/or patients do not have collateral to put up against any loans	**Revenues insufficient to cover costs:** Under a concessional lending model, revenue generated is not sufficient to match the cost of lending to patients
Loan by banks/ NBFCs: Provision of loans by banks/ non-banking financial companies (NBFCs) to credit-worthy patients		**High default rates:** High potential for loan defaults among low-income TB patients; **High perceived risk:** Lenders see patient loans as very high-risk and currently avoid lending to them
Loan by MFIs: Provision of loans by microfinance institutions (MFIs) to patients who typically are not able to access credit		**Access to capital:** MFIs have limited access to bank lending to fund health loans

4 Evaluate potential for blended finance

The potential for blended finance to address the above financing challenges was assessed by examining:

1. Sustainability of the underlying intervention

Cash transfers are fully dependent on grants, and hence not sustainable. Loans by NGOs may also not generate sufficient revenues to cover the costs sustainably. Banks/NBFC loans and MFI loans are more sustainable—the former because they only lend to patients with high credit-worthiness, and the latter because their interest rates[2] are higher compared to banks in order to compensate for the defaults in the portfolio.

2. Additional efficiency brought by private players

All the mechanisms offer added efficiencies by engaging private players. NGOs have lower enrolment costs due to their pre-existing TB patient networks, while banks/NBFCs have low default rates due to their highly effective credit assessment systems. MFIs have low operating costs since their credit and collection systems are tailored to lend to low-income patients.

3. Availability of interested existing/ potential partners

Several NGOs and MFIs are interested in lending to TB patients, and a few already do so. Banks/NBFCs, however, are not interested in entering the unsecured health lending space since they anticipate high default rates.

Based on this analysis, loans by NGOs and loans by MFIs emerged as potential financing options to explore.

1. Catastrophic health expenditure occurs when OOPs for health services consume a large portion of a household's available income, and as a result the household may be pushed into poverty.
2. MFI interest rates are 18-24%, compared to the 12-15% charged by banks and NBFCs

5 Shortlist blended finance instruments

Three blended finance instruments were shortlisted for the selected financing options and compared to a status quo instrument.

(Status Quo) Conditional cash transfer (CCT): Grants from donors to provide direct cash transfer to patient bank accounts, linked to adherence to treatment

Concessional debt by NGOs with grant support: Concessional loans provided by NGOs, with grant funding to buy down interest rates

Debt to MFIs: Banks provide debt to MFIs to set up health loan facility; includes a guarantee to the banks

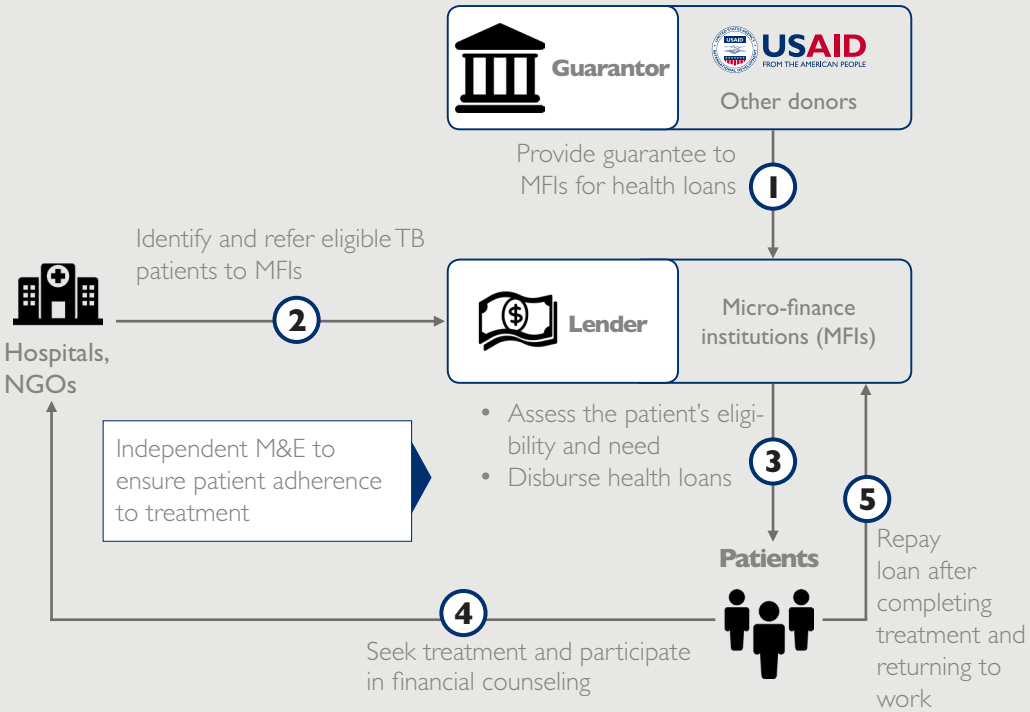
MFI health loan facility with a guarantee and TA: A guarantee provided to MFIs to de-risk their health loan portfolio, and TA to MFIs for health sector lending and to financial counselling

6 Identify activities for USAID engagement

Additional analyses determined that a health loan facility established by MFIs with a guarantee and TA was the optimal instrument to address the health and financing challenges. This is primarily due to the breadth and sustainability of impact, as well as the lower cost to structure and implement this transaction compared to other options. Key findings from the trade-off analysis are:

1. **Depth of impact:** The MFI health loan facility targeting low-income TB patients will be as effective as a CCT project in covering the temporary cash flow issues that can hamper TB treatment.
2. **Breadth of impact:** The guarantee enables a smaller proportion of funds to reach the same population (than would have been possible under a CCT) as it is used to pay the subsidy of a DCA guarantee only. Further, it also enables the MFIs to reach a segment (TB patients) that was not served by them before.
3. **Sustainability of impact:** The health loans facility brings in a new set of private actors by engaging, MFIs that currently do not provide health loans. This could make the impact sustainable if MFIs continue to lend even after the guarantee expires.
4. **Time to implement:** All the instruments considered have variable implementation timelines that are dependent on a number of factors. For example, on-boarding an MFI lender with aligned financial and social impact goals can be time-consuming. Similarly, setting up a CCT project could involve significant time devising a monitoring and evaluation framework and implementation plan.
5. **Cost of structuring and implementation:** Setting up a guarantee can be complex compared to a CCT project with potentially higher structuring costs. This additional cost will, however, be offset by the lower operating costs of the transaction, given the MFIs' pre-existing credit and collection mechanisms.

Illustrative design of the MFI loan facility



Long-term impact

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

Working Capital Revolving Fund in Tanzania

2 Define the health issue

Due to a shift of government funds towards public health facilities, FBO facilities are facing financial issues that have hampered their ability to provide uninterrupted health services to patients.

3 Prioritize financing challenges

This step identified the existing and potential options for FBOs to access the necessary capital to run their facilities. Challenges were then mapped against these options to identify barriers that need to be addressed. Importantly, a critical non-financial challenge was identified as well.

Existing/potential options for FBOs to access capital	Key financing challenges		Non-financing challenges
	Supply-side		
Grants from government: Grants to the health facilities through service agreements between the government and FBO.	**Shortage of working capital:** Mismatch between the timing of NHIF insurance payments (paid between ~30-90 days after invoicing) and funding needs for supplies and salaries	**Limited capital:** Govt. grants for FBO facilities have declined and are expected to decline further	**Limited financial skills of FBO facility management teams:** Doctors and nuns who run facilities are not formally trained in financial skills, supply chain management, etc.
Grants from donors/development partners: Grants for improving quality and service delivery in a specific disease area.		**Limited capital:** Donor grants to FBOs are limited and not regular in timing or amount	
Loans from commercial banks: Working capital loans to FBO facilities by banks at lower interest rates.		**Access to capital:** Commercial banks are unwilling to lend to health facilities due to lack of adequate collateral. Additionally, there is a high perceived risk of (and little experience with) lending to health facilities or providers	
Emergency loans using mobile wallets (m-wallet): Use m-wallets to extend short-term credit to FBO facilities to meet emergency cash requirements.			

4 Evaluate potential for blended finance

The potential for deploying blended finance across the delivery mechanisms was assessed as follows:

1. Self-sustainability of the underlying intervention

Grants from governments and donors are not sustainable options. With commercial loans from banks and m-wallet loans from Mobile Network Operators (MNOs), sustainability can be achieved. This is because facilities will not have to turn away patients and can thus repay their loans from revenues generated out of this increased footfall and borrow more when needed.

2. Additional efficiency brought by private players

Commercial banks can provide a larger amount of capital at lower interest rates, ensuring smooth financing and the continued operation of health facilities. In the case of loans through m-wallets, MNOs can disburse loans quickly and provide immediate access to funds, thus ensuring uninterrupted services at the health facilities.

3. Availability of interested existing/potential partners

Commercial banks are exploring lending to the health sector based on NHIF receivables. MNOs lend to the health sector, but charge high interest rates (approximately 48%, compared to 20-24% charged by traditional banks).

Based on this analysis, two financing options were chosen for further exploration: loans from commercial banks and emergency m-wallet loans.

5 Shortlist blended finance instruments

Three blended finance instruments were shortlisted for the selected financing options and compared to a status quo instrument.:

(Status Quo) Individual working capital loans with guarantee and TA: Working capital loans to facilities against their NHIF receivables, and TA to improve financial management

Revolving debt fund[1] with a guarantee and TA: Capitalization loan to the revolving fund against NHIF receivables with guarantee, along with a performance-based interest buydown to align incentives, and TA to facilities to improve financial management

Working capital loan to a pooled procurement facility, with a performance-based grant and TA: Working capital loan to a procurement facility allows them to then extend drugs on credit to FBO facilities. Grant funding can support a performance-based interest rate buy-down and TA can improve the internal procurement processes of the procurement facility

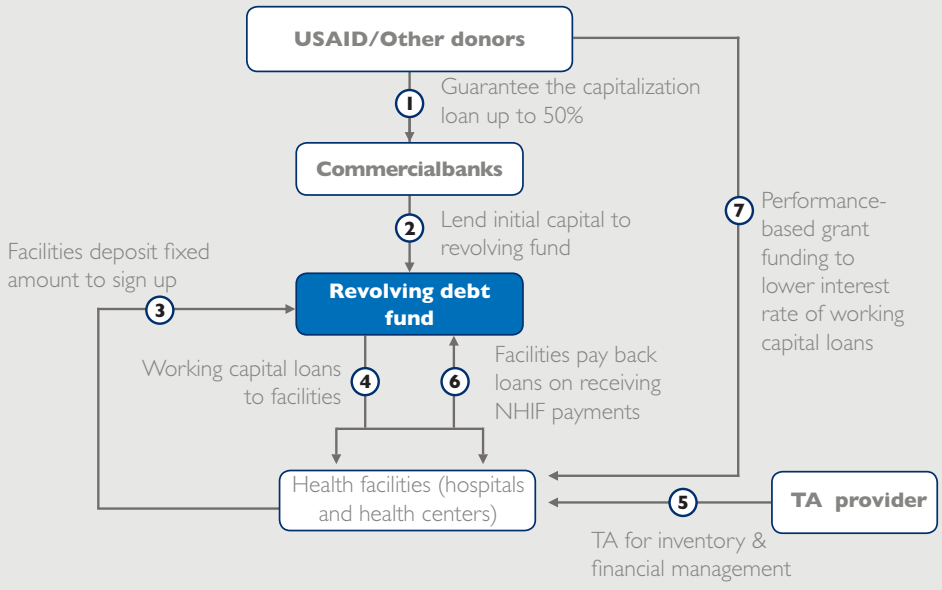
Quick concessional loans through m-wallets and TA:
Short-term (1-2 week) loans to facilities from MNOs through m-wallets, for emergencies. Grant funding helps subsidize the MNOs' cost of lending and pays for TA to facilities to improve financial management

6 Identify activities for USAID engagement

A revolving debt fund for FBOs with a guarantee and TA was the preferred instrument to address the financing and health challenges. The revolving fund scored more favorably than the other instruments because it can reach more beneficiaries in a sustainable manner and can scale more easily, even after the end of USAID support, despite having a slightly longer implementation timeline and a higher structuring cost. The key findings from the trade-off analysis are:

1. **Depth of impact:** The revolving fund scores similarly to the status quo mechanism, because both options enable FBOs to provide uninterrupted services to patients.
2. **Breadth of impact:** The status quo option (individual working capital loan) allows for only one loan per facility, whereas loans from the revolving fund can be repaid and redrawn multiple times by each facility as needed. A revolving fund can cover more facilities, and therefore more patients, by bringing in additional funding from banks and the facilities themselves, as needed.
3. **Sustainability of impact:** The revolving fund is more sustainable than working capital loans as the health facilities would eventually pay back the commercial loan and become self-reliant with only internal funds.
4. **Time to implement:** The revolving fund can take longer to set up as it involves convening multiple dioceses and hospital administrators, and the creation of a Special Purpose Vehicle (SPV) to house the fund.
5. **Cost of structuring and implementation:** The cost to set up the revolving fund is higher than the status quo as it involves significant structuring costs and monitoring and evaluation costs. However, the status quo option would incur structuring costs for each health facility loan, thus making it more difficult to scale.

Illustrative design of revolving fund facility



Efficiency gains

Increased revenues for facilities due to:

- Increase in number of patients being treated (who would have otherwise been turned away because of drug stockouts, for example)
- Increased sales of pharmacy products

TA would help reduce costs due to:

- Lower inventory carrying costs, as a result of accurate forecasting and inventory management
- Fewer emergency orders

1. A revolving debt fund is a self-replenishing pool of money, utilizing interest and principal payments on old loans to issue new ones

Conclusion

06

The deep-dives that pressure tested the roadmap in three countries, one from each archetype and the two transactions described in the previous section, illustrate how the roadmap can identify blended finance transactions to address specific health challenges. Five design principles that emerged from the deep dives and other analysis are summarized below.

1. Define transaction's high-level design: Outline the key parameters early, and identify assumptions, risks and enablers for success.
2. Identify project champions and key expert resources: Identify internal and external experts to support the design and implementation of the transaction.
3. Leverage the broader USAID toolkit: Other instruments, including non-financial tools, may be needed to achieve the desired impact from the blended finance transaction.
4. Engage stakeholders: Actively involve all key stakeholders at all stages of the transaction and ensure objectives are aligned among the partners.
5. Attract/encourage new actors: Crowd in new actors and funding into the health space.

Blended finance promises to be an important tool in solving global health issues, however, it needs to be deployed systematically along with other interventions to maximize impact

The world of development finance is changing. While governments, donors, and philanthropic organizations have collectively spearheaded significant achievements in global health, accelerated progress and additional financing is needed to meet the health and well-being SDGs. Blended finance has the potential to be an important tool to address financing gaps, while simultaneously stimulating innovation in high-impact sectors and fostering the development of domestic markets.
It should, however, be noted that blended finance is not the appropriate tool for all financing of health challenges, and even when relevant and feasible, it may require complementary interventions to succeed. Traditional development assistance will continue to play an important role in global health and should continue to be leveraged as needed.

The roadmap in this report is a starting point to help USAID staff from Missions and the Global Health Bureau identify opportunities to apply blended finance more proactively, consistently, and strategically. By developing a common language and understanding of blended finance tools and approaches, USAID can better identify potential transactions, as well as outline key questions and steps to design and implement them. As USAID orients its efforts to support partner countries on their journey to self-reliance, domestic and international private sector actors will play an increasingly important role along this journey. By helping to mobilize additional resources for health and complementing the skills and resources of other organizations active in this space, USAID can amplify the potential of blended finance to improve the health of millions of people around the world.

Appendix

07

Appendix A: Inputs into archetype indicators

The table below lists the metrics used for calculating the scores for the country archetypes. Scoring is done on a relative basis for the 25 PCMD countries across two broad segments:

1. Health System Status: The health system status score is calculated by taking a weighted average of individual sub-segment scores (health financing and access to quality health systems). These sub-segment scores are computed based on a weighted average of individual metrics calculated using a relative ranking for the 25 countries. The overall weight of a metric denotes its weight in the health system status (segment) scoring.
2. Investment Attractiveness: The overall investment attractiveness score is calculated by taking a weighted average of individual sub-segment scores (conduciveness to financial transactions, status of economy and penetration of private sector). These sub-segment scores are computed based on a weighted average of individual metrics, calculated using a relative ranking for the 25 countries. The overall weight of a particular metric denotes its weight in the investment attractiveness (segment) scoring.

Sub-segment	Description	Sub-segment weight		Metric	Metric weight	Overall weight	Source
Health system status							
Health financing	Availability and allocation of funds towards the health systems in the country – public, private, and philanthropic	33%	+	Total health expenditure (per capita)	20%	6.6%	World bank open data
			+	Government health expenditure (% GDP)	20%	6.6%	
			–	Out of pocket expenditure (% of total health expenditure)	20%	6.6%	
			+	Insurance as % of total health expenditure	10%	3.3%	
			–	Poverty head count (% population below national poverty line)	10%	3.3%	
			–	Grants and other revenue (as a % of revenue)	10%	3.3%	
			+	Universal Health Care coverage (% of population)	10%	3.3%	
Access to quality health systems	Effectiveness of extending coverage and provision of quality health services and products across geographies and demographic segments	67%	+	Physicians (per 1000 people)	5%	3.4%	World bank open data UNICEF UNAIDS
			+	Nurses and Midwives (per 1000 people)	5%	3.4%	
			+	Hospital beds (per 1000 people)	5%	3.4%	
			+	Anti-retroviral treatment coverage (% of affected population)	5%	3.4%	
			+	% of births attended by skilled attendants	5%	3.4%	
			+	% of pregnant women undertaking at least 1 antenatal visit	5%	3.4%	
			+	Immunization with DPT vaccine (% of children ages 12-23 months)	5%	3.4%	
			–	Maternal mortality rate (per 100,000 live births)	5%	3.4%	
			–	Infant mortality ratio (per 1,000 live births)	5%	3.4%	
			–	% of deaths due to communicable diseases	5%	3.4%	
			+	% of successful TB treatments	5%	3.4%	
			–	HIV deaths as % of current infected population	5%	3.4%	
			+	% of successful TB treatments	5%	3.4%	
			+	BCG Vaccination coverage	5%	3.4%	

Appendix

Sub-segment	Description	Sub-segment weight		Metric	Metric weight	Overall weight	Source
Access to quality health systems (Continued)			+	% of new-borns receiving health check-up within two days of birth	5%	3.4%	
			+	% of pregnant women living with HIV who received ART for preventing mother-to-child transmission	5%	3.4%	
			–	% of previously treated cases of TB that are diagnosed with MDR-TB	5%	3.4%	
			+	Contraceptive prevalence among women of ages 15-49 years	5%	3.4%	
			–	Prevalence of underweight weight for age (% of children under 5)	5%	3.4%	
			–	% of under-5 child deaths due to Malaria	5%	3.4%	
Investment attractiveness							
Conducive-ness to financial transactions	Describes the current level of activity of external investors and perception of a country's business environment	40%	–	Rank on Ease of Doing Business index	25%	10%	World Bank open data OECD
			+	Corruption index	25%	10%	
			+	Foreign direct investment as % of GDP	25%	10%	
			+	Penetration of innovative finance	25%	10%	
Status of economy	Measure the economy's overall growth, status of the finance sector and private sector in country	40%	+	Domestic credit as % of GDP	17%	6.8%	World bank open data
			+	% firms using banks to finance investment	17%	6.8%	
			+	Market capitalization of listed domestic companies (% of GDP)	16%	6.4%	
			+	Gross savings (% of GDP)	17%	6.8%	
			+	GDP growth rate (%)	16%	6.4%	
			+	GDP per capita	17%	6.8%	
Penetration of private sector	Measures presence of private players in health sector and private sector penetration	20%	+	% children going to private health clinics	50%	10%	Private Sector Counts (SHOPS PLUS)
			+	% people using private facilities to source modern contraceptives	50%	10%	

Appendix B: List of Acronyms

ADB	Asian Development Bank
CCT	Conditional Cash Transfer
DCA	Development Credit Authority
DIB	Development Impact Bond
FBO	Faith-Based Organization
FDI	Foreign Direct Investment
FP/RH	Family Planning and Reproductive Health
GDA	Global Development Alliance
HNWI	High Net-Worth Individuals
LMIC	Low- and Middle-Income Countries
LPG	Loan Portfolio Guarantee
MDR-TB	Multi-drug Resistant Tuberculosis
MFI	Microfinance Institution
MNO	Mobile Network Operator
NBFC	Non-Banking Finance Company
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
NHPS	National Health Protection Scheme
OOP	Out-of-pocket payments
OPIC	Overseas Private Investment Corporation
PCMD	Preventing Child and Maternal Deaths
SDGs	Sustainable Development Goals
SPV	Special Purpose Vehicle
SME	Small & Medium Enterprises
UHC	Universal Health Coverage

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