

**PROPOSAL TO THE HIGH LEVEL TASKFORCE ON
INNOVATIVE INTERNATIONAL FINANCING FOR
HEALTH SYSTEMS**

**ENCOURAGING NON-STATE ACTORS TO CONTRIBUTE
TO EQUITABLE ACCESS TO HEALTHCARE**

Purpose of this Document

The purpose of this document is to provide recommendations to Working Group 2 of the High Level Taskforce on Innovative International Financing for Health Systems (HLTF) on mechanisms which might be utilized to encourage non-state actors (NSAs) to improve equitable access to healthcare.

Background

Almost every health system is a hybrid of both state and non-state actors. The state is the overall steward of a country's health system. To varying degrees, it also finances and provides health services. It is clearly the most important and significant actor in any health system. However, non-state actors also play a role. The extent of this role varies from one country to another. This is certainly the case in most of the countries targeted by the HLTF.

Hybrid health systems are more effective and integrated when: i) there is an effective and efficient interface between state and non-state actors; ii) the role and place of each actor is clear (even if they overlap); iii) there is sufficient and effective regulation and competition; iv) inputs, such as capital, human resources are readily available and appropriately priced; and v) publicly-funded patients can access both state and non-state providers.

Proposals

It is recommended that the HLTF consider the following proposals (outlined in more detail in the table in Annex A):

A) Support a facility to advise governments on policies, regulations, institutions, supervision and quality control as they relate to NSAs. The non-state health sector plays a large and growing role in developing countries. However, technical support to countries has focused primarily on the public sector and, with a few exceptions, the efforts to improve the effectiveness of policy toward the non-state health sector have not gotten far. Research has revealed skepticism and anxiety among policymakers about the private health sector. But the binding constraint in many places is knowledge and capacity to engage, not unwillingness to do so. Such a facility would:

- Provide technical assistance and capacity building to governments on a broad range of policy issues surrounding non-state health sector engagement and

- enablement (e.g. public-private partnership (PPP) frameworks; enhancing the business environment; effective health services contracting; franchising; and incentivizing and regulating insurance/risk pooling);
- Provide support on an “on-demand” basis;
 - Build local capacity to undertake technical and implementation support activities; and
 - Provide research and analysis on the role of the non-state sector and the public and non-state interface, including developing and disseminating practical knowledge on priority topics related to non-state health sector engagement and enablement strategies.

B) Support an advisory facility to assist governments in identifying, developing and implementing specific PPP transactions and projects. This advisory support would involve assistance in preparing and structuring PPP projects, promoting the opportunities to potential investors, drafting PPP contracts and tender documents, assisting with the tender process, and supporting government in post-award negotiations with winning bidders and their lenders up until financial close. There has been growing demand from World Bank Group (WBG) client countries for advisory assistance in developing and implementing PPPs for health as a mechanism to expand access for publicly-funded patients to quality health care. Yet, a major obstacle continues to be the thin pipeline of well defined PPP projects.

PPPs are an attractive solution for governments for several reasons:

- Governments face increasing demand for healthcare, but also rising costs due to new medical technologies and treatments, and shifting disease patterns. PPPs provide a mechanism for expanding access and delivery within constrained public finances.
- PPPs, if properly structured, implemented, and regulated can expand access and provide high quality facilities and care. Monitoring of service quality to ensure patient care/safety and contract compliance constitute an integral part of the contracting arrangement, with clear and unambiguous sanctions for underperformance.
- PPPs do not require the introduction of user fees, or increasing existing user fees. Rather, the PPP operator is typically funded on a performance basis by the government or national health insurer.

Based on recent successful experience with health PPPs in WBG countries, it is expected that US\$20 million of donor funds for PPP assistance could catalyze US\$500 million in private sector investments, and make available improved healthcare services to about 10 million previously underserved people.

C) Create a number of innovative capital-pooling instruments aimed at increasing at-risk and debt capital to NSAs, particularly those that are focused on servicing the poor (see Annex A). With certain exceptions (e.g., large tertiary care hospitals, drug

manufacturing facilities), the majority of private sector health care businesses in the HLTF-focus countries are small and medium enterprises. A key characteristic of this industry is its fragmentation, driven in part by a lack of access to capital. Using equity, there is significant opportunity to drive greater efficiencies in the health care industry through consolidation in health care sub-sectors, as well the opportunity to replicate business models proven in one country in other countries and regions. Simultaneously, there is substantial demand for debt financing for expansion capital. Innovative mechanisms can play a significant role in the provision of both debt and equity to private sector health care enterprises in HLTF-focus countries.

- D) Support a mechanism to seed larger health infrastructure projects. Large and complex infrastructure, particularly in the form of tertiary/teaching hospitals and complicated supply chains, are an important part of any complete health system. The non-state sector is usually reluctant to undertake this development. It is simply too risky. As a result, the development of this type of infrastructure has typically fallen to the state. However, in the countries that are the focus of the HLTF, the state is often ill-equipped and without sufficient resources to invest in large infrastructure development. There is a case to be made, therefore, for supporting a mechanism to seed these larger health infrastructure projects. Such a mechanism could be established along a commercial basis with the aim of developing these projects to the point where another investor is prepared to take them over as the risk of the project is reduced. Such a mechanism would be expected to have a reasonably high hit:miss ratio in the order of 1:3-4.
- E) Use output based aid financing mechanisms to: i) provide targeted, subsidized health services and, possibly, health insurance coverage to the poor; and ii) increase the output of health workers, particularly nurses and community workers. One of the key constraints to expanding quality public health services to poor patients who cannot afford high out-of-pocket expenses remains the need for governments to subsidize services and foster the adoption of risk pooling mechanisms. Output based aid is a promising approach to financing services because it provides:
- A clear framework for accountability – disbursement of funds is tied to results in terms of improved access and quality of services and access;
 - Opportunities for carefully managed competition – governments can procure services from providers offering the best value, for money thereby encouraging greater efficiency in the way services are provided, subject to careful vetting and oversight of provider quality;
 - Opportunities for targeting select groups who are either particularly poor or particularly at risk of any disease; and
 - Support for both individual Millennium Development Goals (e.g. maternal health) and broader strengthening of the health system.

Basis of these Proposals

The proposals recommended above:

- Build on existing mechanisms and instruments so as to avoid the creation of new institutions and “initiatives” which take considerable time to establish;
- Strengthen the interface between the state, as the steward of health systems, and NSAs, in ways which improve the overall effectiveness of the system;
- Minimize the need for additional government and/or donor funding; and
- Mobilize investment funds from sources other than official development assistance (ODA) including from domestic actors in HLTF target countries. It is estimated that every dollar of ODA funding will lead to 5-8 dollars of NSA funding.

Annex A

The table below summarizes the proposals. Further details can be provided upon request.

Target Area	Proposal	Cost	Timeline	Expected Impact
Advisory support towards improving the effectiveness and efficiency of health systems	Expanding and broadening the activities of the Bank-IFC units that are: i) researching ways to enhance the state and non-state interface; ii) advising governments on policies, regulations, institutions, supervision and quality control in relation to healthcare finance and provision of goods and services.	US\$50-75m for 3-5 years	A Bank-IFC unit responsible this sort of advisory support in Africa is already operational. It is working on policy issues in Kenya, Ghana, Mali, and Nigeria. It has started preliminary analysis in South Asia. An expansion of its operations could begin immediately.	<ol style="list-style-type: none"> 1. If provided, funds proposed would permit work to be undertaken in 20-25 countries 2. More effective and efficient interface between state and non-state sectors 3. Mobilization of private investment once policy environment clearer and through the establishment of PPPs
	Expanding advisory services to government agencies in implementing public-private partnerships for health care provision.	US\$20m for 3-5 years	No start-up time required; scaling up of existing and successful interventions; IFC has implemented health PPPs in several countries and has a robust pipeline of potential mandates in IDA/IHP+ countries.	US\$500 million in private sector investment, improved healthcare services to about 10 million previously underserved people

Target Area	Proposal	Cost	Timeline	Expected Impact
Improving access to capital for private health companies	Creating targeted private equity vehicles to provide capital and, just as importantly, expertise to private health companies. Fund managers to be incentivized to invest in companies providing services to the poor.	US\$5m as seed money US\$500m-1b over 3-5 years of investment funds to be provided by private sector DFIs and private investors US\$30-50m of technical assistance funds	IFC, AfDB, Gates Foundation, and DEG have together already established a \$100m fund for health companies in Africa. FMO and Goldman Sachs have established a similar fund based out of Amsterdam. Other funds could be established in other geographies within 12-18 months.	<ol style="list-style-type: none"> 1. At-risk capital at a reasonable price for qualifying private health companies 2. Better managed, more efficient, and larger companies better able to provide high quality, low cost goods and services 3. Increased access to goods and services for the poor
	Provision of lines of credit and credit enhancements to local banks to encourage them to lend at reasonable rates to NSAs. Such facilities should be supplemented by technical assistance to build the capacity within local banks and the health care companies they fund.	US\$50m of technical assistance funds US\$1b of credit facilities over 3-5 years funded through a combination of the balance sheets of local bank and DFIs	Institutions such as IFC, USAID, and AfDB already have products that provide such support to local banks. If technical assistance funds are provided also, these facilities could be rolled out immediately	<ol style="list-style-type: none"> 1. Reasonably priced loans for qualifying private health companies 2. Mobilization of domestic savings into the provision of health-related goods and services 3. Increased access to goods and services for the poor
	Creating a targeted venture capital fund to provide capital and expertise to start up health care companies so as to encourage entrepreneurship and risk taking in health, particularly as it relates to providing services to the poor	US\$1m of seed money US\$50m of investment funds as an initial pilot US\$10m of technical assistance funds for initial pilot	Would take 18-24 months to establish such a fund	Entrepreneurship and risk taking in health – new products and services
Creation of a mechanism to seed larger health infrastructure projects	This entity would develop larger more complex projects that local companies, funded by mechanisms described above, do not have the capacity to develop. The idea is that this entity would seed the projects and develop them to the point of viability so other financiers could take them to completion	US\$1m of seed money to test the idea and develop a pipeline of projects US\$50m of investment funds as an initial pilot	This could be established quickly through InfraCo, an existing entity focused on developing projects in infrastructure (InfraCo are already contemplating replicating this in health)	The creation of larger and more efficient infrastructure better able to deliver health care goods and services

Target Area	Proposal	Cost	Timeline	Expected Impact
Output based aid for healthcare services	Supporting innovative approaches to funding the delivery of healthcare services and health insurance	US\$200m	No start up time required – IFC's Performance based Grant Initiative has been operating since 2006, in close coordination with the Global Partnership for Output Based Aid (GPOBA). Other institutions have also successfully piloted voucher schemes.	Increased access to healthcare for 2-3 million low-income people, with average household incomes below US\$1/capita/day
Increasing the supply of educated healthcare workers	Provision of subsidized student loans for education of healthcare workers. Non-state service providers to supply education services	US\$20m pilot, followed by an increase if successful	GPOBA could be used to deliver this pilot initiative. These existing mechanisms could be employed after a short start up period.	Increased production of healthcare workers, particularly of nurses and community workers (this mechanism would be very targeted and focused)