

INNOVATIVE HEALTH FINANCING MODELS FOR UNIVERSAL HEALTH COVERAGE IN KENYA

3 GOOD HEALTH AND WELL-BEING



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GLOSSARY OF TERMS

1. AIDS - Acquired Immune Deficiency Syndrome
2. AMC - Advance Market Commitments
3. AMREF – African Medical and Research Foundation
4. BFSI - Banking and financial institutions
5. BMGF - Bill and Melinda Gates Foundation
6. CBHI - Community Based Health Insurance
7. CHAI - Clinton Health Access Initiative
8. CHE - Catastrophic Health Expenditure
9. CHE – Current Health Expenditure
10. CMA – Capital Market Authority
11. CMFIU - Capital Markets Fraud Investigation Unit
12. CSR – Corporate Social Responsibility
13. DAH - Development Assistance for Health
14. DALY - Disability Adjusted Life Years
15. DFI- Development Financial Institution
16. DIB – Development Impact Bond
17. DIFID - Department for International Development
18. EU - European Union
19. GAVI - Global Alliance for Vaccines and Immunization
20. GDP – Gross Domestic Produce
21. GHIF - Global Health Investment Fund
22. GoKe – Government of Kenya
23. GPEI - Global Polio Eradication Initiative
24. GSK – Glaxo Smith Kline
50. UAE - United Arab Emirates
51. UHC – Universal Health Care
52. UK - United Kingdom
53. UNDP - United Nations Development Programme
54. UNFPA - United Nations Population Fund
55. UNICEF - United Nations International Children's Emergency Fund
56. USA - United States of America
57. USAID - United States Agency for International Development
58. USD – American Dollar
25. HIV - Human Immuno Deficiency Virus
26. HLPPT - Hindustan Latex Family Planning Promotion Trust
27. INR – Indian National Rupees
28. KHF - Kenya Healthcare Federation
29. KHSSIP 3 - Kenya Health Sector Strategic and Investment Plan III
30. KSh – Kenyan Shilling
31. LMIC – Low and Middle Income Countries
32. M&E - Monitoring and Evaluation
33. MIF – Multilateral Investment Funds
34. MNC – Multi-National Companies
35. MOH - Ministry of Health
36. MSD – Merck
37. NHIF - National Hospital Insurance Fund
38. NHIL - National Health Insurance Levy
39. ODA - Official Development Assistance
40. OOP - Out of Pocket Expenditure
41. PHC – Primary Health Care
42. PPP – Public Private Partnerships
43. PSHP – Private Sector Health Partnership
44. SDG - Sustainable Development Goal
45. SIB – Social Impact Bond
46. SPV – Special purpose Vehicle
47. TB - Tuberculosis
48. EAVCA: East Africa Venture Capital Association
49. DAH: Developmental Assistance for Health

BACKGROUND AND CONTEXT

Health is a fundamental human right and a key indicator of sustainable development as enshrined in Sustainable Development Goal 3 (SDG 3), that seeks to promote Universal Health Coverage (UHC) by 2030 across the globe. While Kenya has made notable progress, significant challenges continue to face the healthcare value chain that hamper the achievement of SDG 3 and stifle improvement in health outcomes. The country has made commendable improvement in communicable diseases control, maternal and child health outcomes. For instance, infant mortality fell from 77 deaths per 1000 live births in 2003 to 39 deaths per 1000 live births in 2014 while maternal mortality ratio fell from 488 per 100,000 live births to 362 during the same period¹. Despite this, the rates of overall deaths and health losses as estimated by Disability Adjusted Life Years (DALY) for all ages in Kenya are below that of the average rates across Eastern Sub-Saharan Africa and many neighboring countries². In addition to communicable diseases, Kenya also suffers the highest burden of non-communicable diseases in Sub-Saharan Africa at 20.3%³. *Some of the key challenges facing the healthcare lifecycle include poor public funding over the years, shortage of human resources for health, insufficient health delivery infrastructure, low levels of research and development, fragmented supply chains and low levels of health insurance coverage.*

The global economic crisis has adversely affected Development Assistance for Health (DAH). From a peak in 2013 at US\$38 billion, DAH fell to \$36.3 billion in 2015.¹ Financing channelled via bilateral and multilateral agencies—the traditional sources of financing—followed a similar trajectory; UN agencies accounted for 27.6% of DAH in 1990, which fell to 12.4% by 2015, and funding from development banks declined from 18.6% of DAH in 2000 to 8.6% in 2015.¹ These trends are concerning. The trajectory of flat financing will likely continue into the future and will increase the reliance on domestic and innovative financing sources to sustain and scale health programmes in low-income and middle-income countries (LMICs). Innovative financing for the social sectors is forecast to grow rapidly to reach \$500 billion over a 10-year period⁴.

*In line with the WHO's call for 'Leaving no one behind' and 'delivering the Triple Billion Together!'; the vision and commitment of 'His Excellency, President Uhuru Kenyatta's' to achieve Universal Health Coverage (UHC) by 2022, has been widely appreciated and supported in Kenya as well as globally⁵. **To achieve UHC, the Government of Kenya has developed the "Roadmap towards Universal Health Coverage 2018-2022" and identified key strategic interventions and priorities in a bid to solve these challenges.** The *Kenya Health Sector Strategic and Investment Plan III 2018–2023 (Draft)* in line with the Kenyan Constitution and the Kenya Health Policy 2014-2030, also outlines 'The attainment of Universal Health Coverage' as the main sectoral priority and includes expansion and coverage of services for the last mile. The development of a unified health benefit package has been envisioned and the existing scope of services is expanded to include sub-specializations in various service areas including a renewed focus on primary health care. The plan targets that by 2022, all persons in Kenya should have access to essential services for their health and wellbeing through an explicit essential benefit package, without the risk of financial catastrophe as a result.*

The Universal Health coverage will ensure that Kenyans receive quality, promotive, preventive and curative and rehabilitation health services without suffering financial hardship. Preventive and promotive health services

¹ Kenya Demographic Health Survey 2014

² Global Burden of Disease Study, 2015. Report for Kenya

³ World Health Organization, 2010

⁴ Kohli J. *Financing what works: social impact bonds hold promise*. Washington: Center for American Progress, 2010. <https://www.americanprogress.org/issues/general/news/2010/11/18/8668/financing-what-works-social-impact-bonds-hold-promise>

⁵ <https://www.afro.who.int/news/kenya-rolls-out-universal-health-coverage>

have been recognized as critical tools to achieve UHC under *KHSSIP 2018-23 (Draft)*. The main strategic objectives towards UHC in Kenya include;

1. *Progressively increase the percentage of Kenyans with coverage for essential health services*
2. *Increase the percentage of Kenyans covered under prepaid health financing mechanisms such as health insurance, subsidies and direct government funding to access health services*
3. *Progressively expand the scope of the health benefit package accessible to all Kenyans*
4. *Improve the quality of health services*
5. *Protect Kenyans from catastrophic health expenditures, in particular the poor and the vulnerable groups*
6. *Provide and retain health resources appropriate for the delivery of health services*
7. *Strengthen the leadership and governance within the health sector*

Overview of the health financing landscape in Kenya

The composition of healthcare financing in Kenya has witnessed changes in the last 5 years. The total health expenditure of the government has grown from Ksh 38,197.29 bn in 2013-14 to Ksh 69,227.25 bn in 2016-17. While the increase is approximately 80%, the percentage of healthcare spending as a proportion to the total government spending has hovered around 2.5% over the period. The County government expenditure on health as a proportion to the overall county government spending also rose from 5.26% (2013-14) to 19.28% (2016-17)⁶.

Government overall revenue and expenditure have seen significant year on year increase in the past 5 years – finally passing the threshold of 20% of GDP in 2016/17. County government expenditures are also seen to increase each year, at a rate faster than the increase in national government expenditures. ***Health expenditures at national and county governments are on an increasing trend in absolute terms, but are stagnant in real terms at an average of 5% of total government expenditures (20% for county expenditures).***

The total health expenditure has increased by 167.5% in Ksh (111.4% in US\$) since 2001/02, suggestive of more resources available for health. However, the total expenditure per person is much lower, at 88.8% in Ksh (49.1%) largely driven by the high population growth implying the health expenditures are used on more people than in 2000/01. In addition, the health expenditure has been increasing at the same rate as the GDP (170% increase since 2000/01), leading to stagnation of the health expenditure as % of GDP. In real terms, therefore, health /expenditure has not changed significantly. Current health expenditure is driving the total, expenditure, at the expense of capital formation. *The health sector is therefore primarily focused on recurrent spending, while the wider government is shifting towards development spending and capital formation.*

Donor spending has decreased significantly between 2010 and 2016. A significant share of the donor funding is for key programs such HIV/AIDS, TB, malaria, reproductive health and immunization and thus a need for innovative financing mechanisms towards the same.

⁶ Kenya Health Financing Strategy 2016-2030

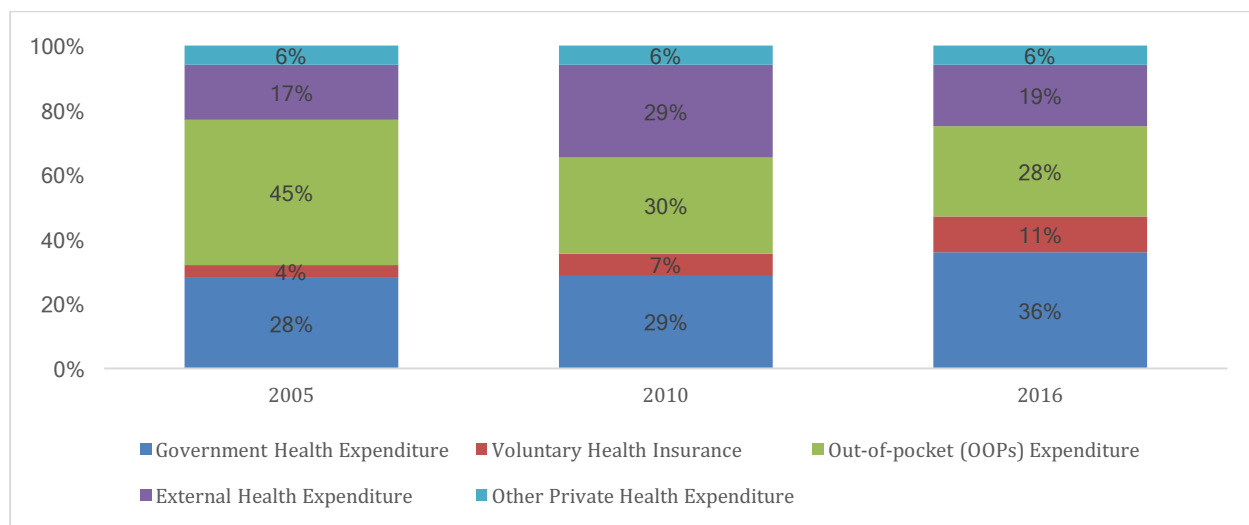


Figure: Trends in health expenditure by financing scheme⁷

Although the government currently accounts for the largest proportion of health spending, Kenya is far from fulfilling the Abuja target of 15% of total government budget allocation to the health sector. In 2001, African head of states met in Abuja and committed to allocate at least 15% of their national budget to the health sector⁸ in order to improve access to quality and affordable healthcare.

Existing Policy Environment for healthcare and financing in Kenya

Kenya has put in place key policies and strategies to enhance access to quality healthcare with the objective to achieve universal health coverage.

| Key Strategies | Brief Description | Relevance |
|--|--|--|
| Constitution of Kenya⁹ | Promulgated in 2010, the constitution of Kenya lays down a conducive legal framework that guarantees an all-inclusive rights-based approach to health service delivery to all Kenyans. The Constitution provides the overarching legal framework to ensure comprehensive right based approach to health delivery. It provides that every person has a right to the highest attainable standards of health which include the reproductive health rights. It also outlines that a person shall not be denied emergency medical treatment and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependents. According to the | Health services are devolved to the level of the counties; in order to ensure that affordable, quality care is accessed by all. As envisaged in the Constitution, Kenya has a devolved system of governance. Health functions are largely devolved under Schedule 4 of the Constitution with the national and county governments having been allocated specific roles and functions. |

⁷ [Global Health Expenditure Database](#)

⁸ https://www.who.int/alliance-hpsr/projects/alliancehpsr_kenyaabridgedprimasys.pdf

⁹ <http://www.kenyalaw.org/lex/actview.xql?actid=Const2010>

| Key Strategies | Brief Description | Relevance |
|--|---|--|
| | <p>constitution, the county governments shall among other things promote primary health care in their respective counties.</p> | |
| <p>Vision 2030¹⁰</p> | <p>Kenya's Vision 2030 aims to transform Kenya into a modern, globally competitive, middle income country providing a high quality of life to all of its citizens. It is anchored on 3 key pillars; economic, social and political. Health is one of the key components of delivering the Vision's Social Pillar given the critical role it plays in maintaining a healthy and skilled workforce necessary to drive the economy. Flagship projects set to achieve the health sector vision include; establishment of social health insurance; Human resource for health development and developing equitable financing mechanisms; and accelerating health facility infrastructure development to improve access.</p> | <p>Two main approaches have been identified to push the agenda of an efficient health system:</p> <ol style="list-style-type: none"> 1. <i>Devolution of funds and management to counties, and</i> 2. <i>Shifting the base of national health from curative to primary health care including preventive care</i> |
| <p>Kenya National Health Policy 2014-2030¹¹</p> | <p>The policy's main goal is to attain the highest possible health standards in a manner responsive to the population needs. Health financing is one of the identified policy orientations to achieve this goal with the aim to remove or minimize all financial barriers hindering access to services for all persons requiring health and related services; guided by the concepts of Universal Health Coverage and Social Health Protection.</p> | <p>The Kenya Health Policy identifies key areas of focus for the policy period. These include reducing the burden of communicable and non-communicable diseases through, strengthening of primary health care infrastructure and services.</p> |
| <p>Health Sector Strategic and Investment Plan III 2018-2023 (Draf 1)</p> | <p>The Kenya Health Sector Strategic and Investment Plan (KHSSP) 2018-2023 is the second five-year strategic plan for implementing the Kenya Health Policy (KHP) 2014 – 2030. The KHP provides a framework for translation of the requirements of the Constitution 2010, Vision 2030 and Global commitments in the Health arena into shorter term actionable strategies that cumulatively will achieve the health policy goal of “Attaining the highest possible standard of health in a responsive manner”</p> | <p>The review of KHSSIP 2013-2017 showed that progress was made in the area of reproductive, maternal and child health. The burden of communicable diseases though declining still remains high in the country, while there is a rising trend in non-communicable conditions and injuries. Progress has been made in strengthening the health systems through provision of critical inputs there is still need to strengthen intra-sectoral collaboration. The review findings further highlighted some of the emerging issues as shown below:</p> |

¹⁰ <https://vision2030.go.ke>

¹¹ <http://publications.universalhealth2030.org/ref/d6e32af10e5c515876d34f801774aa9a>

| Key Strategies | Brief Description | Relevance |
|---|---|--|
| | | <ul style="list-style-type: none"> • <i>Inadequate funding for rehabilitation and provision of health products and technologies.</i> • <i>Inadequate and uneven distribution of health personnel.</i> • <i>Rising incidence of non-communicable diseases; high prevalence of preventable communicable diseases.</i> • <i>Inadequate health protection for vulnerable groups.</i> • <i>Heavy reliance on donor funded projects and programs.</i> • <i>Persistent knowledge action gap.</i> |
| <p><i>UHC Domestic Resource Mobilization Blueprint, Kenya¹²</i></p> | <p>The blueprint provides a roadmap for Ministry of Health, Kenya to address key financial challenges to ensure sustainability of the healthcare system in the country. It is a key reference document for domestic resource mobilization for health in Kenya.</p> | <p>The document highlights five key strategies and intervention points:</p> <ul style="list-style-type: none"> • <i>Adopt an approach of urgent incrementalism towards 13% health allocation by 2022</i> • <i>Priority focus on increasing Efficiency in delivery of health care services</i> • <i>Explore innovative ways of raising domestic resources for health</i> • <i>Leverage ICT for better health outcomes & efficiencies</i> • <i>Create synergies with other key sectors that are critical health enablers to health service delivery</i> |
| <p><i>National Hospital Insurance Fund (NHIF) Act</i></p> | <p>The act established NHIF¹³ to provide health insurance to the population initially beginning with those in formal employment. This was later revised to allow for membership for those in the informal employment. The salaried employees' premium is calculated on a graduating scale between Ksh 150 - 1700 monthly while the unsalaried members pay Ksh 500 per month. To date, the fund has 7.3 million principal contributors and has grown membership to about 22 million members who include contributors' dependent¹⁴.</p> | <p>Several programs have been developed under the NHIF including:</p> <p>Health Insurance Subsidy Program: Started in 2015, focuses on health coverage for the poor, the elderly and persons with severe disabilities.</p> <p>Linda Mama program (free maternity services): Launched in 2016, the program provides cover for four visits of antenatal care, delivery, postnatal care, conditions and</p> |

¹² https://www.globalfinancingfacility.org/sites/gff_new/files/documents/The-role-of-the-Investment-Case-in-Domestic-Resource-Mobilization.pdf

¹³ <http://www.nhif.or.ke/healthinsurance/>

¹⁴ National Hospital Insurance Fund (NHIF) profile. Accessible [here](#)

| Key Strategies | Brief Description | Relevance |
|---|--|--|
| | | <p>complications during pregnancy and care for the infant for a period of one year.</p> <p>Students medical cover: Includes inpatient and outpatient services, dental, optical, local road ambulance and emergency air rescue services for students in public secondary schools</p> |
| Health Act 2017¹⁵ | Establishes a unified health system that encompasses the public and private sectors and the national and county governments. It harmonizes fragmented legislation governing the health sector. It provides for low and affordable quality PHC services to all the citizens at their area of habitation. | The Act defines roles of the various county and national governments, and allocates PHC functions to be fulfilled at the county government level. |
| Human Resources for Health norms, standards guidelines for the Health sector 2014-2018 | Defines the staffing norms and standards for facilities at each level of the health system. Meant to be the minimum standards to assure high-quality services | PHC facility staffing requirements outlined. These include clinical staff, pharmaceutical staff, nursing staff and support staff requirements. |
| Roadmap towards Universal Health Coverage in Kenya 2018-2022 | The roadmap sets the UHC goals and aspirations for Kenya and recommends strategic interventions and priority areas of implementation to achieve UHC. The document states the role of the different players/enablers in achieving UHC. In addition, it details the monitoring and evaluation plan as well as the communication plan for UHC. | Kenya Essential Package for Health (KEPH) which focuses on meeting the needs of an individual through the entire life cycle (cohort). The roadmap will ensure that the sector is working towards common UHC goals in a synchronized manner. It is expected to result in reduced duplication of efforts and enhanced resource efficiencies. |
| PPP Act 2013¹⁶ & PPP Regulations 2014 | The act provides for participation of private sector in financing, construction, development, operation, or maintenance of infrastructure or development projects of the Government through concession or other contractual arrangements. It also provisions for establishment of institutions to regulate, monitor and supervise the implementation of project agreements. The law provides a clear legal | The act provides written commitment to private investors for accountable delivery of PPPs. The Act provides a structured and legal for PPP Agreements, and in turn, has catalysed several developmental projects currently under development The PPP Regulations provide details on how projects will be prepared, tendered, approved |

¹⁵ <http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/HealthActNo.21of2017.pdf>

¹⁶ <https://www.pppunit.go.ke/wp-content/uploads/2017/11/ppp-act-2013-2.pdf>

| Key Strategies | Brief Description | Relevance |
|---|---|--|
| | process to undertake PPP projects as well as provides the institutional framework to support delivery of PPP projects. | and implemented and provide details on the roles and responsibilities of parties involved in the PPP Transactions. |
| CMA regulations Chapter 485A 2000, Amendment 2003^{17, 18} | <p>The Capital Markets Authority is an independent public agency established in 1989 and is responsible for regulating and promoting the development of orderly, fair and efficient capital markets in Kenya.</p> <p>CMA is driven to regulate and supervise the capital markets industry as per Capital Markets Act and the Regulations. The Authority operates an Investor Compensation Fund to grant compensation to investors who suffer pecuniary loss resulting from failure of a licensed stockbroker or dealer to meet his contractual obligations. The Authority has established a Capital Markets Fraud Investigation Unit (CMFIU) for financial crimes and forensic investigation in order to proactively manage the risk of fraud through prevention, detection and response.</p> | <p>CMA established a Capital Markets Master Plan committee involving local and international stakeholders to chart strategic mechanisms for the capital markets to attainment of the Vision 2030.</p> <p>It enables Kenya to leverage structured international debts (ABS, Covered Bonds, Convertible Bonds), Credit Rating, Credit Enhancement Services, Trading Platforms, Private Equity, Futures Exchange and the establishment of the Carbon Credit Market. <i>The Act also has enabled withdrawal of taxes applicable to dividend, reduction of withholding tax rate on interest income arising out of fixed income securities such as bonds as well as Tax exemption for investment income of pooled funds.</i></p> |
| County Government Act 2012¹⁹, Amendment 2018²⁰ | It is an Act of the Parliament to amend the County Governments Act, that originally was drafted to give effect to Chapter Eleven of the Constitution; to provide for county governments' powers, functions and responsibilities to deliver services and for connected purposes. The Act provides frameworks, processes and mechanisms for, reviewing and reassigning powers and competencies between the national government and county governments in accordance with the provisions of the Constitution. | The act provided for decentralization of initiatives, <i>including healthcare</i> a first step towards development in Kenya. The act provided the counties with the much-needed powers, privileges and immunities for themselves and their members, that is required to make adept decisions. |
| Government support measures policy, October 2018²¹ | It helps the Government intensify the implementation of private sector led growth strategy across sectors. It is aimed at establishing practice principles that minimize and manage the risks created by every Government Support Measure and is applicable at the National as well as county level. | The Government, through the National Treasury as well as other state agencies, has in the past granted various support tools to promote private sector participation in public investment programmes. This policy rolled out in late 2018, provides just that conducive environment to convince private investors to |

¹⁷ <https://www.sbgsecurities.co.ke/standing/Kenya/sgbsecurities/downloads/CapitalMarketsAct.pdf>

¹⁸ https://www.africanbondmarkets.org/fileadmin/uploads/afdb/Countries/Kenya/Capital_Markets_Authority/Capital_Markets_brochure-Kenya.pdf

¹⁹ <https://nakuru.go.ke/wp-content/uploads/2018/03/CountyGovernmentsAct17of2012.pdf>

²⁰ http://www.parliament.go.ke/sites/default/files/2017-05/The_County_Governments_Amendment_Bill_2018.pdf

²¹ <https://pppunit.go.ke/wp-content/uploads/2018/11/GOVERNMENT-OF-THE-REPUBLIC-OF-KENYA-FINAL-VERSION-DONE-BY-AG-AND-NT.pdf>

| Key Strategies | Brief Description | Relevance |
|----------------|-------------------|--|
| | | participate in developmental activities in Kenya |

Further, the Government is committed to implementing UHC as one of the Big Four agenda. This will ensure that all individuals and communities in Kenya have access to the quality essential health services they need without suffering financial hardship. This access to and use of health services will enable Kenyans to be more productive and active contributors to their families, communities and society at large. UHC is expected to bring health and development efforts together and contribute to poverty reduction as well as building solidarity and trust, aspirations also enshrined in the Kenya Vision 2030, the government development blueprint.

OBJECTIVES OF THE STUDY

Building on the outputs of the SDG-Partnership Platform for the Primary Healthcare Window, the whitepaper focuses on the innovative health financing work streams for PHC in Kenya. The overall goal of the whitepaper is to identify potential innovative health financing models which can be replicated in Kenya and a provide a roadmap to implement the same. The specific objectives are as below:

- *Map out the various stakeholders within the innovative health financing landscape in Kenya.*
- *Identify differential innovative & blended finance instruments that exist nationally, regionally, and globally, and can be leveraged for PHC interventions in Kenya.*
- *Identify best practices and enabling features of successful and scalable healthcare financing models in different countries.*
- *Shortlist drivers both internal and external throughout the value chain / financing spectrum for public and private sector to collaborate for healthcare financing*
- *Recommend 3-5 innovative health financing models appropriate for Kenya with brief details for implementation, including operating models, partner selection frameworks.*
- *Propose a roadmap towards future of innovative health financing in Kenya*

STUDY SCOPE AND CONTEXT

To guide the implementation of UHC agenda in the health sector and the country at large, the Kenya UHC roadmap was developed. The process of developing the roadmap was consultative and participatory under the stewardship of the UHC coordination department in the Ministry of Health. The roadmap spells out the UHC goals and aspirations for the country, and further provides the strategic interventions and priority areas of implementation required to achieve them. Primary Healthcare has been identified within the roadmap “as the best bet” to swiftly and sustainably attain UHC in Kenya.

There is a growing need for Innovative Health Financing Models where traditional healthcare funding and more importantly the government funding has to be optimally utilized to catalyze funding from the private sector with an emphasis on sustainable and scalable models. Innovative health financing is an emerging approach to funding health interventions, through pooling of funds from different sources. It involves the ‘mixing or blending’ of two or more sources to fund the program and or activity in consideration and has been used in several countries across the world- including that in developed, developing and LMIC countries. Governments, donors, private and philanthropic funders are transacting across an increasingly diverse financial landscape.

The outlook towards health sector’s potential for private sector engagement has significantly improved over the years²². Today entrepreneurs and businesses are looking at healthcare as a market yielding high profits and margins that help them recover their ROI in a short-span of time. One of the key factors leading to this change of belief is the hand-holding and encouragement of the government of Kenya and the ability of the private investor’s to cater to scale that helps lower costs and accelerate ROIs.

Financing has two diverse ends of a spectrum: those that provide free funds or grants – thus not requiring any return of investment made by an organization and the other where investors look forward to a profit, over and above the return of the principal investment made. In between the two lie numerous types of financiers with differing, intermediate prerogatives of receiving their ROI or ROI+ achieving social development milestones.

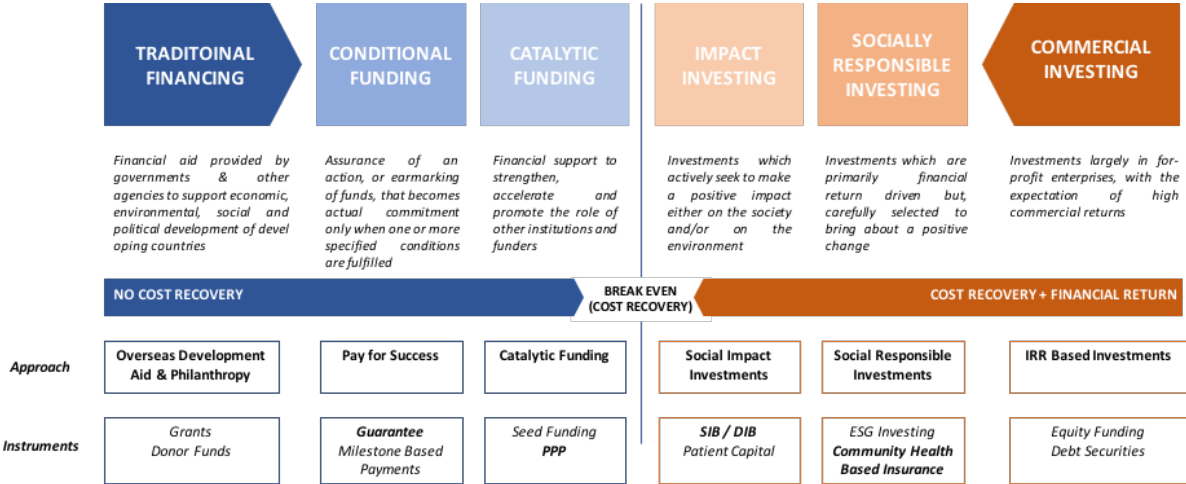
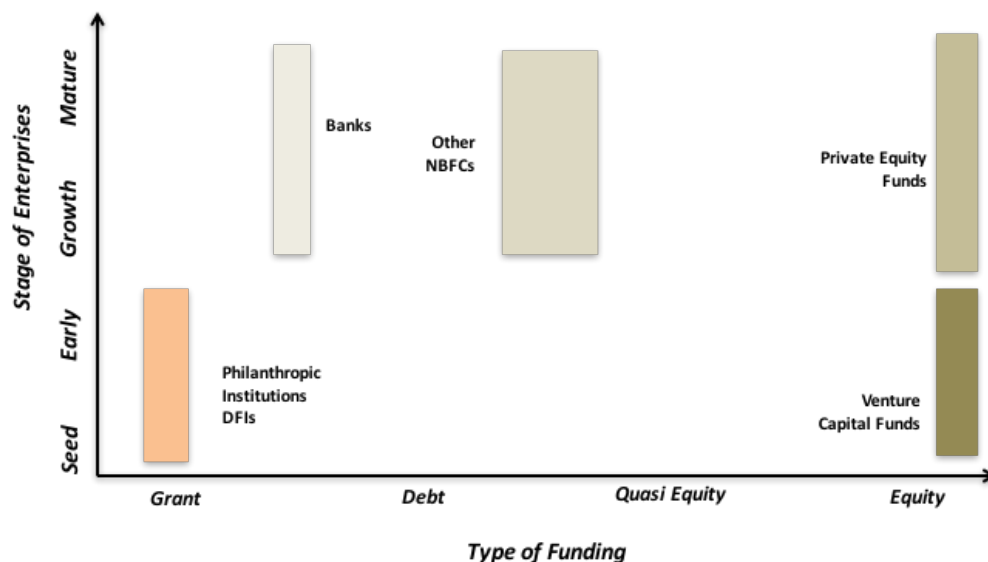


Fig 1: The Financing Spectrum²³

Different health financing models and mechanisms have relevance at various stages of health financing both at the demand and the supply side of the value chain.

²² The business of health in Africa, IFC, Accessed [here](#)
²³ Adapted from USAID’s [Investing for Impact Framework](#)



- Early stage companies, past their seed stage, that have already established their revenue trajectory are targeted
- Profits may not have come - though the profitability has been established with revenue and expense drivers stabilised
- These may still not be PAT +ive. These may be EBIDTA +ive or about to turn EBIDTA +ive.
- Within such companies, high growth enterprises are targeted since they will be able to generate free cashflows to be able to service debt

Fig 2: The stages of financing

Examples of innovative health financing mechanism/ structures include social impact bonds, results -based financing, blended fund with flexible prepayments, guarantees, pooled investment funds, social insurance, and asset lease financing. While a volume guarantee is more suited for core operations & manufacturing and access to health products, a result- based financing is suited for overall programmatic intervention and service delivery. Similarly, models like micro-insurance are more inclined towards consumer financing and last mile service delivery.

A careful analysis of the landscape, national regulations and policies, natural and national resources, needs-gaps, national fiscal space and or deficit, GDP contributors, % GDP allocations to sectors, key market players, , risk appetite, investor readiness, readiness of international lenders and banks or financing institutions to participate in these geographies and or areas/ sectors of work, learning from other sectors and geographies are some of the key aspects that are taken into consideration while analyzing the need and relevance of a funding mechanism.

The whitepaper focuses on identification of relevant innovative health financing instruments that are most suited for enhancements to Primary Health Care in the Kenyan context, with a clear potential to catalyze private sector investment.

BRIEF REVIEW OF LITERATURE

Evolution of Innovative Health Financing²⁴

²⁴ <https://www.convergence.finance/blended-finance#deal-sizes-and-types>

Currently, Kenya, India, Uganda, and Tanzania are the most frequently targeted countries in blended finance globally. 12% of the total blended finance transactions have been implemented in Kenya. The various assessments and data collected in literature have shown that of the top 10 sectors of investment, while energy is the most favorable, health (6%) as a preferred sector for investment is ranked 6th. *However, these deals are often significant in terms of total size, therefore healthcare reflects 16% of total capital flows from blended finance in developing countries.* Within healthcare, blended finance investments have been made in health services (2%), pharmaceuticals & vaccines (2%), and insurance (2%). It was seen in the various pieces of literature reviewed, that only select innovative models were being leveraged in healthcare and that these have gained substantial attention in recent years.

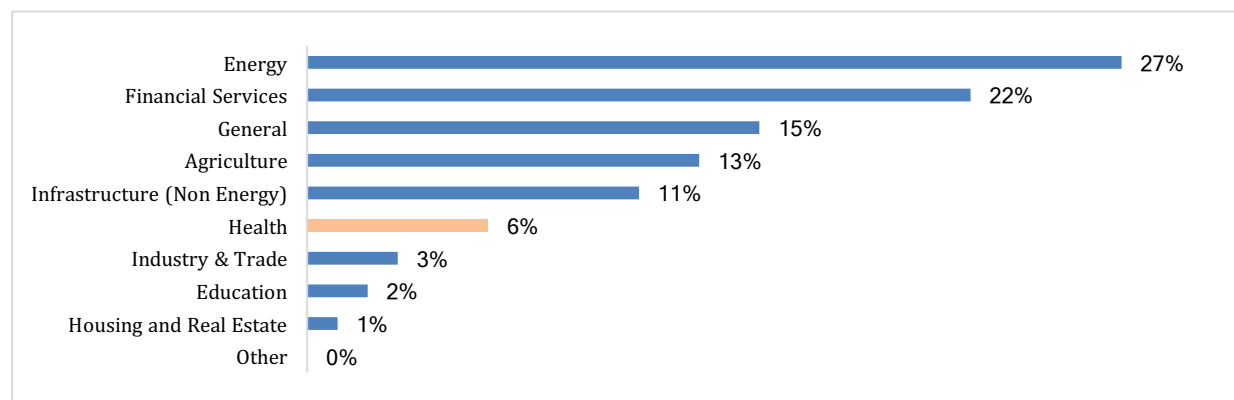


Fig 3: Sector Preference for Innovative Financing Investments

Over 50% of all investors in the market (across all sectors) are private investors, with public and philanthropic investors evenly split at around 25% each²⁵. Around half of private investors have an explicit impact mandate. The most active public investors with a development mandate in blended finance include USAID, DFID, and Multilateral Investment Funds (MIFs). The most active public investors with a commercial-development mandate in blended finance include development finance institutions and development such as IFC, FMO, OPIC, and KFW. The average investment size for public investors is in the range of USD 10 – 20 million. The most active philanthropic investors in blended finance include BMGF, Omidyar, and Shell Foundation.

There have been many notable pharmaceutical and vaccination-focused blended finance structures, including the Global Alliance for Vaccines and Immunization (GAVI) and the Global Health Investment Fund (GHIF), which can be considered early market influencers. While blended finance deals focused on health have become less frequent in recent years, health remains a critical development challenge with a significant financing gaps.

Changing Role of the Kenyan Government

Over the past few years, Kenya is committed to change how its healthcare system is financed. The current constitution has, shifted the main responsibility to deliver healthcare from national to 47 subnational county governments. The national government is responsible for health policy standards and regulations, major referral hospitals, capacity building and Technical assistance to counties while the county governments are responsible for operationalization and delivery of health services²⁶. The Government has been cognizant of the changing financial landscape and has established key priorities to leverage innovative health financing

²⁵ <https://www.convergence.finance/blended-finance>

²⁶ For County specific data: <http://www.opendata.go.ke/>

instruments & opportunities in the Roadmap towards UHC in Kenya. *The Government is exploring strategic outcome linked procurement of medical assets and services, innovative tax and non-tax means to generate additional revenue to deliver healthcare services, leverage instruments like impact bonds for outcome linked service delivery.* Kenya's funding need for HIV, TB and Malaria would total KES 84 billion annually between 2019 – 2022 excluding health provider and infrastructure costs already funded by Government²⁷. The Government is exploring opportunities to engage the private sector to cover the funding gap in primary healthcare.

Currently, 37% of all primary healthcare facilities in Kenya are private, while 52% are government-run and the remaining 11% are run by Faith-based organizations²⁸. There is immense potential for the private sector to emerge as a champion in the delivery of affordable quality healthcare services in Kenyan market with strong support from the public sector. *The primary healthcare market in Kenya is worth ~\$4.5bn today and is expected to grow to ~\$11bn over the next 10 years; growing in line with GDP-per-capita growth*²⁹.

The Government has also acknowledged the need to promote private sector participation and Kenya Commercial Bank, USAID along with private sector players have committed to providing \$10M in financing for the development of small to medium private health facilities. These include doctor partnerships, clinics, diagnostic centres and hospitals. Kenya has also adopted an innovative Managed Equipment Services (MES) model in 2015 that allowed the Kenyan Ministry of Health (MOH) to enter into a multi-year contract with equipment providers, so that the MOH benefits immediately from the latest medical technology, and can sustainably budget costs over several years instead of huge capital outlays upfront. As part of the MES, various corporate institutions trained the technicians and biomedical engineers to handle the equipment, supporting capacity building as a priority for overall health sector development across 98 public hospitals in 47 Kenyan counties.

In 2015, another PPP³⁰ was established involving Philips, Merck Sharp & Dohme-MSD, GlaxoSmithKline-GSK, Safaricom, Kenya Health Care Federation and Huawei (6 private players) to improve maternal health in historically marginalized counties. This initiative was launched in Mandera, Marsabit, Migori, Isiolo, Lamu and Wajir and led by Government of Kenya and the UN. The 3 million USD initiative was launched during the UN General Assembly, in support of Every Woman Every Child campaign. Another PPP venture to strengthen PHC delivery in Nairobi is the Kenyatta National Hospital initiative with a requirement of Ksh 5.7 billion through PPP arrangements, under KHSSP III 2013-18^{31, 32}.

The recent PPP approach to strengthen the PHC delivery in Makueni county led by the Makueni County administration, AMREF and Phillips Healthcare is another example of PPP implementation.

Moving Beyond Traditional Funding Mechanisms for Healthcare

Traditionally, public healthcare has been financed by Government and donor agencies through grants and donor funds. It is primarily extended to the community through subsidies and insurance schemes. Kenya has also adopted the traditional approaches like National Health Insurance Fund (NHIF) to improve access to health services at the last mile. However, research has shown that four out of every five Kenyans have no access to

²⁷ Opening Remarks, Principal Secretary, High Level Policy Dialogue on Sustainable Domestic Resource Mobilization for Health in Kenya

²⁸ The healthcare system in Kenya, Accessible [here](#)

²⁹ IMF, UN Department of Economic and Social Affairs, National Health Accounts, McKinsey analysis

³⁰ <https://kenya.unfpa.org/en/publications/assessment-unfpa%E2%80%99s-advocacy-campaign-end-preventable-maternal-and-new-born-mortality>

³¹ http://knh.or.ke/wp-content/uploads/2017/03/KNH_Strategic_Plan_2013-2018.pdf.pdf

³² <http://unidoseoul.org/en/?p=2142&ckattempt=1>

medical insurance. There is an urgent need to look beyond the traditional approaches to health financing and identify ways to engage private sector, attract private capital and reduce dependency on already drying donor funding.

Globally, numerous initiatives have been implemented to address these financial challenges. UNITAID, an International Drug Purchase Facility for AIDS, tuberculosis, and malaria is supported mainly through the airline ticket tax. In the year 2015, the Airline levy alone contributed \$106.7 million (~88.7% of revenues)^{33, 34}. *The Airline Solidarity contribution is an innovative attempt to gain the benefits of a global tax.*

The opportunities to leverage innovative financing mechanisms in Kenya are immense. However, to ensure effective utilization of it's potential, a collaborative approach between the public and the private sector along with enabling regulatory ecosystem is required. *Enhancements to taxation codes, regulatory frameworks for digitization, an efficient CSR policy and support for private sector will be key to achieving the true impact of innovative financing in healthcare in Kenya.*

INNOVATIVE HEALTH FINANCING MODELS

Long term sustainability of health financing is the most essential aspect of a financing strategy for the health sector in Kenya. In the recent past, Kenya has experienced positive economic growth and become a lower Middle-Income Country; thus, the country is set to move progressively from external donor financing for health towards domestic funding. For this to happen, Kenya must now start planning for the challenge of replacing the current external partner investments with internal resources from national and county governments and the private sector. Importantly, during this process, the significant achievements of Kenya's health response must be safeguarded.

Where the Government should significantly increase its budgets for health to deliver on the Country's ambition to realize UHC, it should also tap into other sources of financing to optimize the existing resources and bridge critical gaps.

In various parts of the world, special taxes have been introduced specifically to finance health care reforms in general and health care financing in particular. Taxes can be earmarked to finance specific schemes or healthcare targets based on national priorities. This mechanism has the capacity to generate earmarked domestic financial resources and it has a relatively low cost of collection since it uses established indirect tax collection channels. Few select models that can be adopted are as below:

- *Airtime Levy*: A tax on airline tickets – air travel being a luxury good, primarily tourists will tend to pay.
- *Telecom Cess*: Partnering with mobile phone service providers and charging a small fee on mobile data and voice usage can potentially generate the necessary resources to support UHC in the country. *An estimated US\$122.5 million (ksh12.5 billion) is transacted daily in the form of mobile money transactions. By contributing roughly one percent on a graduated scale, Kenya can easily raise US\$ 1.2 million (ksh125 million) daily to finance UHC³⁵.*
- *Sin tax (tax on Alcohol and Tobacco Products)*: A tax on goods that have an adverse effect on health notably tobacco and alcohol. Such taxes are considered justified as they represent the imposition of a consumption charges on those who use them in lieu of the costs that these products generate and the impact their use has on society beyond those who simply consume them.

³³https://www.who.int/immunization/programmes_systems/financing/analyses/Brief_18_Airline_Ticket_Tax.pdf

³⁴<https://www.thelancet.com/action/showPdf?pii=S2214-109X%2817%2930198-5>

³⁵https://www.the-star.co.ke/news/2017/06/19/achieving-universal-health-coverage-in-kenya-through-innovative_c1582454

- *Tourism Levy*: A Cess tax levied on tourists availing Kenya’s wildlife and related tourism and recreational services. The total contribution of Travel & Tourism alone to Kenyan GDP was KSH769.1bn (USD7,432.9mn), 9.7% of GDP in 2017, thus showing tremendous potential to support specific healthcare services in Kenya.
- *CSR Act 2013*: The CSR act is not a tax but a legal act launched by the Government of India in 2013. As part of this act, companies whose net worth is of USD 70 million or whose revenue sums up to USD 140 million or whose net profit is of USD 0.7 million will have to spend 2% of their average profit of previous three years on CSR.

In Kenya, Robin Hood’ tax was announced by the Cabinet Secretary for Treasury in June 2018; a 2% increase on excise duty on mobile money transfers and 0.05 per cent excise duty on bank transfers of Ksh 500,000 or more. The sin tax was also proposed on sugary and alcoholic beverages but both these taxes didn’t see light of the day due to resistance from key stakeholders. The flip side of such taxes is that the tax impacts are usually passed on directly to end consumers, increasing the costs of these products or services. This may reduce the demand positively (e.g. for alcohol) or may increase the cost of living for those who can least afford the additional taxes (e.g. the cost of remittances by mobile money). *A structured & graded approach to taxation is necessary to address the unintended negative impact on the underserved communities.*

Moreover, as Kenya climbs up the middle-income ladder, ODA support from traditional development partners is shrinking. More resources need to be mobilized through new partnerships with the private sector, philanthropy and other key stakeholders. In the meantime, and just as mobile payments have transformed Kenyan markets, tech-innovations in the health sector— from artificial intelligence algorithms that predict disease outbreaks and accelerate disease diagnosis; telemedicine to ease care; to technology optimizing interoperability between health information systems to create dashboards for informed health policy decision making— all have potential to help strengthen the efficiency, effectiveness and accountability of the health sector. Access to data will ensure informed results, targeted investments, increase innovations and facilitate private sector participation. This, in turn, would encourage new financing for the sector to further contribute to improved health status and quality of life in the country.

Innovative financing models therefore have the potential to better leverage the private sector’s growing capacity. Yet the successful implementation of innovative financing mechanisms particularly in healthcare requires that key partners, such as donors, governments, and private investors, understand the potential and perils of each approach. Generating an evidence base on what works where and what further information is needed is thus critical to moving the sector forward.

The economic dimension generally dominates investment and financing decisions, particularly among private capital providers. Hence, to catalyze private capital, *there is a need for the policy environment to incentivize investors to maximize synergies and minimize trade-offs between the objectives of economic growth, inclusive social progress and environmental protection*, the 3 key pillars of SDGs.

Innovative financing models help develop these synergies and minimize risks, which attract fresh capital to flow into the system. Some of the potential innovative health financing mechanisms / structures are as below:

1. **Social / Development Impact Bond³⁶**: To achieve a specific impact, social impact bond collaborates with the government agency to pay for improved social outcomes that eventually result in public sector savings. The *Utkrisht Impact Bond* in Rajasthan, India developed by Merck for Mothers, USAID, the UBS

³⁶ <https://www.usaid.gov/cii/indiadib>

Optimus Foundation and the Hindustan Latex Family Planning Promotion Trust (HLFPPT), was launched in 2017. The Utkrisht Impact Bond will enable financial assistance for 440 small healthcare organizations to improve the quality of maternal and child care in Rajasthan's hospitals and adhere to the government's quality standards.

2. **Result based Financing** ³⁷ : Grant funding that is disbursed to recipients if and when pre-determined outputs or outcomes are achieved. In Zambia, studies showed an increase in coverage of institutional deliveries in districts with performance-based financing compared to districts with input-based financing. Such models result in greater accountability, increased efficiency and enable a drive towards equitable healthcare over a period of time.
3. **Blended Fund with Flexible Repayment Terms:** Grant and non-grant (debt) funding is blended and provided as debt with flexible repayment options to the social enterprises. By adding returnable capital models to their modus operandi, foundations can a) help social entrepreneurs and other innovators bridge the "missing middle" financing gap; and b) create revolving funds where the same money can be invested repeatedly over the years, thereby increasing capital efficiency and social impact. *The Bill & Melinda Gates Foundation invested US\$10 million to acquire a stake in Liquidia Technologies, a biotechnology company working on new ways to deliver vaccines.*
4. **Advance Market Commitments / Guarantee**³⁸: Partial protection to lenders willing to extend loans to development sectors. *BMGF provided a guarantee to Clinton Health Access Initiative (CHAI) to structure volume guarantees to reduce the price and increase access to life-saving commodities in the developing world.*
5. **Pooled Investment Fund:** Funds from multiple parties are aggregated and used to support market-based solutions.
6. **Asset Lease Financing:** The owner of the asset (equipment manufacturer or the SPV created for lease financing) provides the right to use of the assets to another party against periodical payments.
7. **Social Insurance:** Insurance for social impact projects that unlocks private capital by protecting against some level of loss in the event the project is unsuccessful or the borrower is unable to repay the capital. Community led micro-insurance models and health mutual are examples of social insurance and protection that enables consumer / last mile financing as well.
8. **Debt Swaps:** A debt swap (also called debt conversions) is a method of transforming debt into resources for development work. Global Fund is a pioneer in debt swaps in health. Pakistan and Côte d'Ivoire have received a further €59 million of debt relief from Germany, generating €29.5 million for Global Fund projects.
9. **Taxes & Levies for PHC:** Taxes can be earmarked to finance specific schemes or healthcare targets based on national priorities. This mechanism has the capacity to generate earmarked domestic financial resources and it has a relatively low cost of collection since it uses established indirect tax collection channels. Airline Tax, Sin Tax are examples of how taxes can be leveraged to support developmental interventions.

In the next section, we have detailed five key innovative health financing models that are relevant to the Kenyan primary health care context. An overview of the innovative financing instruments and their applicability to various aspects of primary health care delivery is summarized below:

³⁷ <http://siteresources.worldbank.org/INTAFRICA/Resources/AHF-results-based-financing.pdf>

³⁸ https://www.bsr.org/reports/BSR_Healthcare_Innovative_Finance_Final_September_2017.pdf

| Models | Infrastructure | IEC & SBCC | Manufacturing – Drugs, Medical Products, Consumables, Vaccines | Medical devices | Medical Education | Insurance |
|-----------------------|----------------|------------|--|-----------------|-------------------|-----------|
| SIB/ DIB | √ | √ | √ | √ | √ | |
| CBHI | | √ | | | | √ |
| AMCs | | | √ | √ | | |
| Debt Swaps | | | √ | √ | | |
| Asset Lease Financing | √ | | | √ | | |

SOCIAL AND DEVELOPMENTAL IMPACT BONDS FOR HEALTH

Social Impact Bonds (SIBs) and Developmental Impact Bonds (DIBs), have the potential to improve the efficiency of government healthcare spending at the county as well as national levels and facilitate result oriented programmatic funding and support. These innovative financing models help to fund healthcare through contracts where private investors provide upfront flexible funding to healthcare providers and outcome funders (usually government in case of social impact bonds and development finance institutions in case of development impact bonds³⁹) repay these investors based on the healthcare outcomes achieved by those who receive the services.

Demystifying SIB/ DIBs

In financial terms, a SIB/ DIB is not technically a bond. Bonds generally have an unconditional and guaranteed rate of return, while in a SIB/ DIB, the financial return is tied to the performance of the contract provider, and will vary. In this model, the investors carry some or all of the risk of non-performance while sheltering service providers from this.

³⁹Development impact bond and a social impact bond. Details available [here](#).

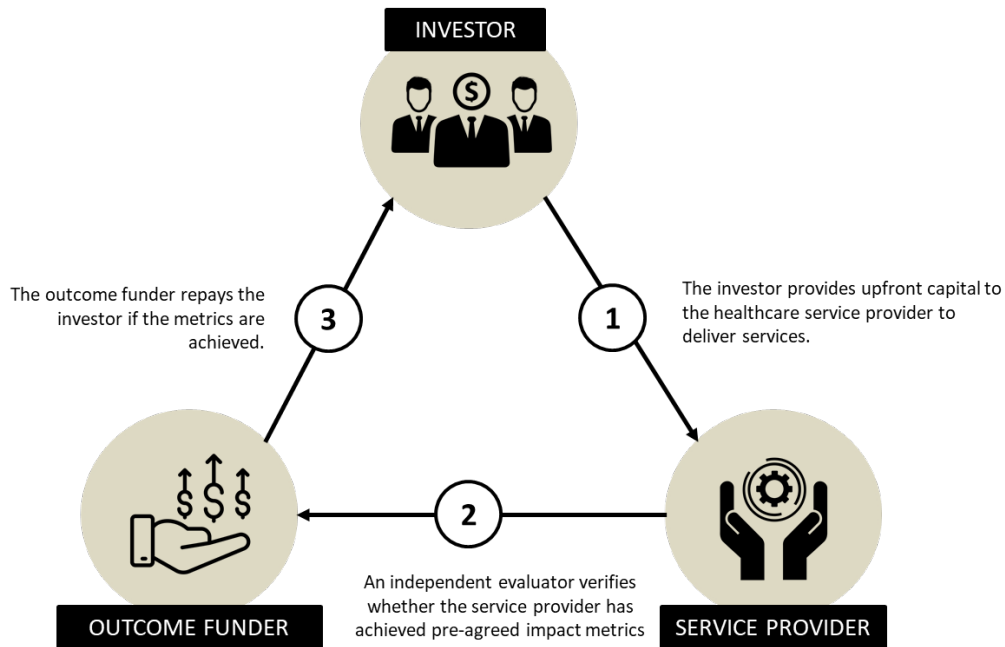


Fig 4: Depiction of SIB working and flows (financial and processes)

The central feature of such a funding model is that it brings together three key partners: an outcome payer, a service provider, and an independent investor (although in practice SIBs or DIBs may involve more than one of each type of partner). The outcome payer is typically a central or local government organization (SIB) or a DFI (DIB); service providers are often the local hospitals, primary health centers etc.; and the independent investors can be mainstream, socially motivated, and/or charitable institutions.

The roles of each player is indicated

- **Outcome payer** – they identify the unmet needs and expresses a ‘willingness to pay’ for specific social outcomes.
- **Service providers** - they offer a service or intervention intended to meet the needs of those beneficiaries and to achieve the outcome desired. As in other forms of outcome based contracting, the payment to the provider (wholly or partly) depends on whether are achieved.
- **Investors** – they provide flexible arrangements to finance the project over its duration, rather than expecting the provider to finance from their own services or from loans with set payment schedules. The explicit involvement of one or more investors differentiates SIBs from other forms of outcome based contracting.

The SIB may be an instrument of choice when a Government cannot invest in a social project despite the expectation of accruing both substantial cost savings and positive social/environmental outcomes. The Government might not be able or willing to invest in the first instance due to limited access to finance or the difficulty of accepting the project’s risks. SIBs are most appropriate:

- *When focusing on areas of priority for both the public sector and investors;*
- *The cost of the intervention can be offset by the potential cost savings;*
- *There is solid evidence backing the project’s outcome metric*

Potential benefits and pitfalls of SIBs

These financing models offer benefits to all stakeholders involved; mission aligned investment opportunities for investors, eliminate operational risks for outcome payers and upfront access to working capital for healthcare

service providers. On the flipside, creating a social or development impact bond is usually costly and time consuming. Planners usually need to spend a lot of time pinning down the outcomes that the bond hopes to achieve, how these would be measured and how much is to be repaid. Furthermore, healthcare outcomes may not always be verifiable and quantifiable. Furthermore, if the healthcare outcomes are not achieved, the investor loses their investment and this may motivate investors to demand lower success thresholds.

Using SIBs in Primary Health care in Kenya

The Division of Reproductive Health (DRH) is one of four divisions in the Department of Family Health, within the Ministry of Health (MOH)⁴⁰; works with numerous partners throughout Kenya to reduce the high rates of maternal, neonatal and child morbidity and mortality and to help achieve the child and maternal health. A SIB/DIB structure may be explored in this, which will improve effectiveness of the nationally envisaged reproductive health program. In line with the Utkrisht bond in India⁴¹, the bond can aim to reduce the number of mother and baby deaths by improving the quality of maternal care in Kenya's private health facilities. However, in order to implement such an initiative a new certification and quality improvement system needs to be developed in Kenya primarily focusing on Maternal and Child health. Earlier, Ministry of Health and Public Sanitation (MOHPS) along with few medical professionals had developed standards for obstetric emergencies, such as hemorrhage, sepsis, pre-eclampsia and eclampsia, obstructed labours and abortions. These standards can be the basis on which stringent quality conditions are prescribed. Agencies (implementing partners) can be identified to improve the capacity of private healthcare facilities to match the quality standards identified by the certification and quality improvement system. Outcome payment can be based on the number of facilities achieving the standards. Philanthropic foundations and DFIs working in MNCH could be the outcome funder. The programmatic oversight including the recommendation of quality standards, impact assessment and fund management can be provided by DRH.

Similarly, SIB can also be developed for procurement of GeneXpert machines by smaller laboratories and standalone hospitals, empowering of community health workers to deliver last mile screening services and insurance uptake and prevention of diarrhoea among under 5 population.

Successful Use Cases

- **Israel:** SIB for type 2 diabetes was one of the first of its kind for preventive health which has raised capital of about \$ 19.4 Million USD put in between 15 impact investors to treat 2,250 high risk pre-diabetics⁴². The SIB saw participation from 15 impact investors (50% Israelis) and outcome payers like Leumit (An Israeli HMO) among others.
- **India:** DIB for maternal and child health outcomes in Rajasthan valued at \$8 Million USD with the aim of saving the lives of 10,000 women and children in Rajasthan over a 3-year period⁴³. USAID and Merck for Mothers were the outcome payers while UBS Optimus Foundation was the investor (*Co-investment from service providers: Palladium, HLFPPT, PSI*) and Population Services International (PSI) & Hindustan Latex Family Planning Promotion Trust (HLFPPT) were the service providers.
- **Mozambique:** Malaria Performance Bond (MMPB): An initial \$25 million USD bond piloted in Maputo to help fund malaria prevention efforts meant to reach 1.1 million people⁴⁴. *Malaria Mozambique (BAMM) Operating Company is the service provider, Nando's is the investor, Bhp Billiton Limited, Samsung Group, The Coca-Cola Foundation, Standard Bank Group Limited, Anglo American are the outcome payers in this bond*⁴⁵.

⁴⁰ <https://www.k4health.org/toolkits/kenya-health/drh-structure>

⁴¹ Read Annexure: Utkrisht Impact Bond [here](#)

⁴² Social Finance Israel website. Details available [here](#).

⁴³ Utkrisht Impact Bond/. Details available [here](#).

⁴⁴ Malaria Performance Bond. Details available [here](#).

⁴⁵ Stakeholder detail for MMPB Available [here](#)

- **Cameroon:** Cataract Development Impact Bond is valued at \$2 million USD and is designed to finance 18,000 cataract surgeries over a 5-year period⁴⁶. *Magrabi ICO Cameroon Eye Institute (MICEI) is the implementation agency, Conrad N. Hilton Foundation, Fred Hollows Foundation and Sightsavers are the outcome payers and Overseas Private Investment Corporation (OPIC) & the Netri Foundation are the primary investors in the initiative.*

COMMUNITY BASED HEALTH INSURANCE (CBHI) SCHEMES FOR PRIMARY CARE

CBHI refers to the protection of low-income people against specific perils in exchange for regular premium payments proportionate to the likelihood and cost of the risk involved⁴⁷. In other words, these are community managed insurance schemes which are designed to help members manage financial risks associated and vulnerability associated with unexpected healthcare costs. Health financing needs of the community are met through pooled resource allocation decisions by the community.

Demystifying CBHIs

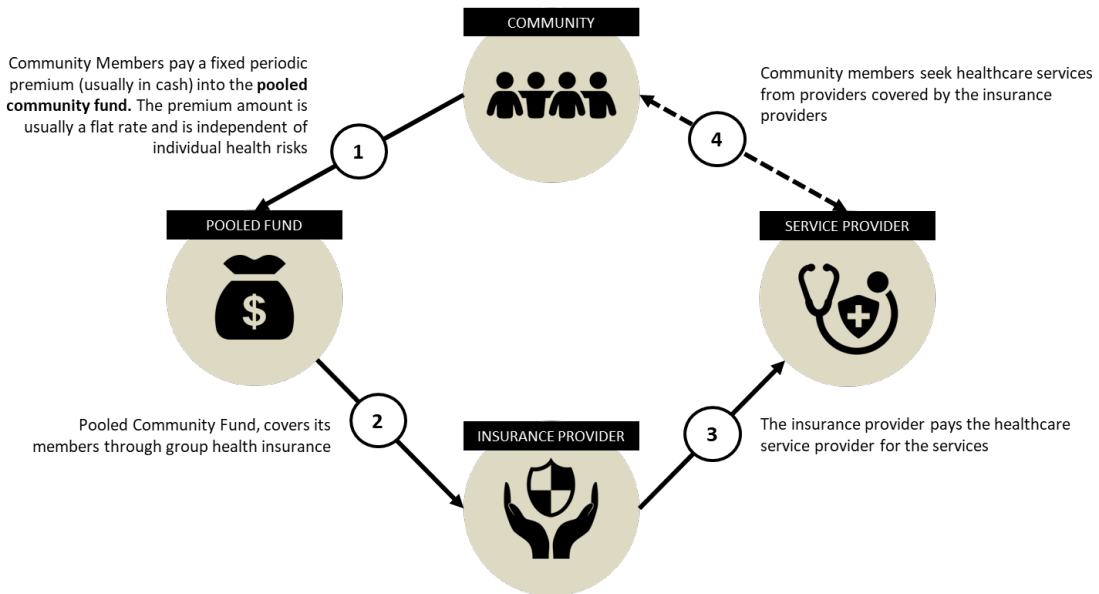
CBHI emanates from the limitations of the loan-based microcredit programs (microfinance) in protecting low-income households from health shocks. CBHI differs from other forms of microfinance in that it uses an insurance mechanism, i.e. a financial instrument which, in return for payment of a premium, provides members with a guarantee of financial compensation or service on the occurrence of specified events. Unlike microfinance where transfer in the first instance takes place from the credit provider to the poor, in case of CBHI a reverse transfer takes place, i.e., from the poor to the insurance provider. The success of CBHI depends on the existence of social capital in the community. Most of the CBHIs are voluntary and provide a pre-defined benefit package against the payment of premiums. According to WHO's Health Policy Brief, CBHIs are generally characterized by the following institutional design features:

- *The community is involved in driving its setup and in its management;*
- *It is a prepayment mechanism with pooling of health risks and of funds taking place at the level of the community or a group of people, who share common characteristics (e.g., geographical or occupational);*
- *Membership premiums are most often a flat rate (community-rating) and are independent of individual health risks;*
- *Entitlement to benefits is linked to making a contribution in most cases;*

⁴⁶ *Cameroon's Cataract Development Loan. Details available [here](#).*

⁴⁷ *Churchill C. Geneva: A microinsurance compendium. International Labor Organization; 2006.*

- The CBHIs operate on a non-profit basis.



- Fig 5: Understanding Community Based Health Insurance

Potential benefits and pitfalls of CBHIs

CHBIs are a useful means of reaching out to those working in the informal economy. This model is based on strong social controls at the community level and hence the incidence of abuse and fraud are largely minimized. However, there is also a risk of the most financially vulnerable being excluded due to adverse selection. Such schemes also tend to be financially vulnerable if they are not supported by other larger schemes or national level subsidies. Problems are chiefly operational in nature and include lack of clear legislative and regulatory frameworks for these in most countries coupled with inadequate financial support, and unrealistic enrolment requirements⁴⁸.

Using CBHIs in Primary Health care in Kenya

While there have been some experiments around Community Based Health Insurance schemes in Kenya (Chogoria Hospital Insurance Scheme), it has not been adopted at a large scale in the region. CBHI operations have achieved limited successes in designing and implementing affordable, participatory, and sustainable health care financing mechanisms for populations with limited resources but great need for health services. Community participation is important to the success of a community-based health insurance scheme and also underwriting of the initial losses by the government can help the scheme set low rates at the beginning but may also give a false sense of affordability to the potential clients. Hence the schemes can be sustainable in the long term only if serious attention is paid to their design and management. The premiums set should also be reviewed at periodic intervals to ensure relevance and chargeability as per paying capacity. *Technology can also be leveraged to make CBHIs more robust, transparent, efficient and scalable. Also, it will be critical to align CBHI to the existing NHIF for long term sustainability. CBHIs is a way of ensuring those who are currently unemployed and cannot afford NHIF premiums are also provided adequate health coverage. It can act as a bridge between NHIF and the unemployed communities. Over a period of time these CBHIs can be aligned and merged into NHIF.*

Successful Use Cases

⁴⁸ Community-based health insurance programs and the national health insurance scheme of Nigeria: challenges to uptake and integration. *Journal for Equity in Health* 2014. Available [here](#).

- **Hygeia Community Health Plan (HCHP), Nigeria:** This scheme aims to provide health coverage to the uninsured through innovative risk pooling between different stakeholders. Members are charged around \$2 USD per person per year which has now been subsidized by a non-profit.
- **Rwanda's CBHI scheme,** under leadership from the Government of Rwanda, has been recognized internationally as a model for its success advancing UHC. Health insurance coverage went from less than 7% of the CBHI target population in 2003, to 74% in 2013. In the 2013 CBHI survey, respondents indicated that the benefits of CBHI membership included lower health care costs (97%) and better access to drugs (73%)⁴⁹.
- **Ghana:** The National Health Insurance Scheme in Ghana grew out of preceding CHBI schemes in the country which grew to a significant size. For instance, the Nkoranza scheme at St. Therea's hospital had enrolled nearly 30% of the district's population⁵⁰ by 2000.

ADVANCE MARKET COMMITMENT (AMC)

Pharmaceutical & Diagnostic companies have long been reluctant to invest in producing new vaccines, drugs and diagnostics for the developing world because they have little prospect of earning an attractive return. One way to stimulate such investment is the use of an advance market commitment, an innovative financing program that guarantees manufacturers a long-term market. Under this arrangement, international donors pay a premium for initial doses sold to developing countries. In exchange, companies agree to continue supplying the vaccine, drug or the diagnostic device (along with the consumable) over the longer term at more sustainable prices.

These are de-risking mechanisms in financing healthcare whereby investors commit to procuring large orders from medical suppliers, enabling them to forecast production and adequately leverage economies of scale. It is legally binding for the guarantors (investors) and primarily used to guarantee supply volumes or selling price of certain essential drugs and medical equipment thereby incentivizing them to invest in the production process and expand manufacturing capacities for these.

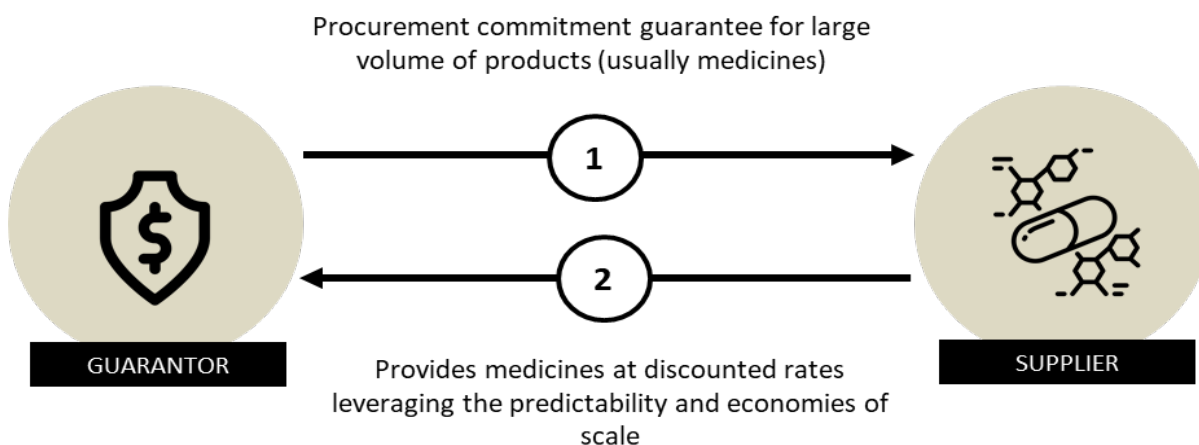


Fig 6: Understanding Advanced Market Commitments

⁴⁹ Report: *The Impact of Community Based Health Insurance on Access to Care and Equity in Rwanda*. Available here.

⁵⁰ The "Universal" in UHC and Ghana's National Health Insurance Scheme: policy and implementation challenges and dilemmas of a lower middle income country

Demystifying AMCs

Through the AMC mechanism, donors would subsidize the purchase of vaccines or diagnostics by developing countries, up to a fixed number of sales or a fixed total amount. Once this fixed number of sales or total amount has been reached, manufacturers having benefited from the subsidy would be contractually obliged to either sell to developing countries at a price affordable over the long term or to license their technology to other manufacturers.

It is envisaged that the AMC framework will encourage not only the discovery and development of first-generation vaccines, but also the development of subsequent improved vaccines, which are more efficacious and/or are easier to distribute and use.

This model involves an agreement between the following two parties:

- *The Guarantor:* This can be an individual or a consortium of a range of public and private sector funders, foundations or development finance institutions. The more players acting as the guarantors, the higher is the degree of risk sharing between them.
- *The Suppliers:* This is typically a private sector manufacturer of essential drugs or medical equipment. This mechanism also encourages the entry of new suppliers into the market by removing the high risk of production which otherwise acts as a barrier to their entry.

Potential benefits and pitfalls of AMCs

AMCs create the right market incentives that create the possibility of more than one supplier will qualify, thereby facilitating healthy competition among firms leading to improved product outcomes. It can also successfully complement existing public sector funding for R&D.

Although these financing mechanisms can successfully incentivize R&D investments from private sector players, they do not work as well in case of long term R&D projects. For long term R&D projects, there is a risk of changing demand patterns or the introduction of new technology that may make the prior commitment less meaningful than when they were signed. Further, if the fixed cost of production is very high, it undermines the supplier's incentive to produce under the advance market commitment.

Such commitments cannot be successfully designed without the involvement of philanthropic or international aid agencies to act as the guarantor. Another challenge is the development of independent, transparent and accountable public financial management and procurement systems is an important pre-requisite for the financing of this scheme.

Using AMCs in Primary Health care in Kenya

GAVI has been assisting the Government of Kenya in the area of immunization and health development since 2001 with USD 479 million disbursed (as on 26 Dec 2018).⁵¹ However, similar approaches could be applied to other therapeutic areas and product adaptations for low resource settings such as heat stable therapies or product and packaging redesign to align with how low income consumers purchase medicines (e.g., often in smaller packages/dosages) in Kenya. AMCs could also be used to incentivize companies to invest in identifying pandemic virus strains that would make it easier to respond to an outbreak.

⁵¹ <https://www.gavi.org/country/kenya/>

AMCs can be leveraged to address the large-scale procurement of upcoming research drugs for Multi Drug Resistant (MDR) - TB and Extremely Drug Resistant (XDR) TB such as *Belaquidine and Delamind*, or advance TB vaccines, HIV, HPV vaccines or even the Malaria vaccine that is being discussed and researched worldwide.

AMCs can also be leveraged for low cost devices like spectacles, lenses, implants, point of care testing solutions and diagnostic devices and their consumables which ensure a sustained demand and repeat use over a period of time.

It is important that to achieve a viable scale for the private sector to participate and the Government of Kenya can collaborate with other East African Countries and pool the demand for relevant health products, vaccines & medicines. The resultant consortium can provide guarantee and procure the products at a special subsidized rate.

Successful Use Cases

- ✓ **Pneumococcal AMC:** This program is financed by Italy, the United Kingdom, Canada, the Russian Federation, Norway and the Bill and Melinda Gates Foundation. GSK and Pfizer signed 10-year contracts through the Pneumococcal AMC, managed by GAVI, to provide up to 300 million doses each of their pneumococcal vaccines, at an approximate reduction of 90 percent of the cost in developed markets. In 2011, GSK expanded its agreement to provide an additional 180 million doses of its pneumococcal vaccine, Synflorix, over the next 12 years to 72 developing countries by 2023. To meet the demand, GSK invested more than US\$400 million in a dedicated manufacturing plant in Singapore that will produce several hundred million doses of the vaccine annually in the coming years.⁵² In 2016, both GSK and Pfizer lowered the price of the vaccine specifically for humanitarian organizations that serve refugee and crisis-affected children.⁵³

VARIANTS OF AMCS: ADVANCE PURCHASE COMMITMENTS AND VOLUME GUARANTEES

The advance market purchase and or volume guarantees- are a variant of the advance market commitments in which there is an innate component of research and development of a particular product for a particular issue in the latter.

Successful Use Cases

- ✓ **Implant Access Program:** This is a group of public and private organizations (including the Bill & Melinda Gates Foundation, the Children’s Investment Fund Foundation, CHAI, and the governments of the United States, the United Kingdom, Norway, and Sweden) that came together to provide volume guarantees (secured by US\$340 million in legally binding agreements by the Gates Foundation, which committed US\$120 million) to make Bayer AG and Merck & Co. implants available at price reductions of about 50%. The donors first signed an agreement with Bayer, which agreed to provide its Jadelle implants at \$8.50 per unit, a 53% reduction, in return for a guarantee of orders of at least 27 million units over six years—approximately 3-5 million units per year. A similar agreement was later made with Merck & Co., Inc which committed to supply 13 million units. More than 25.6 million contraceptive implants have been distributed since the launch of the program in 2013. The cost saving from this program for donors and developing countries is estimated to be around \$240 million⁵⁴.

⁵² GSK, 2011. “GSK extends pneumococcal vaccine agreement with GAVI Alliance.”

⁵³ Medecins Sans Frontieres, 2016

⁵⁴ Implant Access Program. A BMGF Report, September 2017. Available [here](#).

ASSET LEASE FINANCING

Asset Lease financing is a type of a direct financing innovative tool to procure medical devices and other tangible assets used in healthcare service delivery. Traditionally, medical devices have been procured through either allocated budgets, grants and or donations. Asset lease financing provides an alternative mechanism to provide access to latest technology and medical devices at the last mile; without burdening the existing financial resources.

Demystifying Asset Lease Financing

Financing Lease Model: It is a contract between the Bank (Lessor) and the Customer (Lessee) for the hire of a specific asset, selected from a manufacturer / Supplier of lessee's choice (government) and to suit the lessee's requirements.

Operating Lease Model: An offset of this systems is seen in certain specific cases, where in the manufacturers of high-end equipment provide assets on lease for a fixed term to the government to serve the large-scale requirement of specific healthcare devices^{55,56}.

For the proposed duration of the agreement, the lessee has possession of the asset and uses the same as a franchise. The lessee pays agreed rentals and other usual charges / fees, while the lessor (bank or even government) retains ownership of the asset. Most of this model is governed by two chief factors:

- The market value of the device/ equipment
- The Procurement Size / Volume

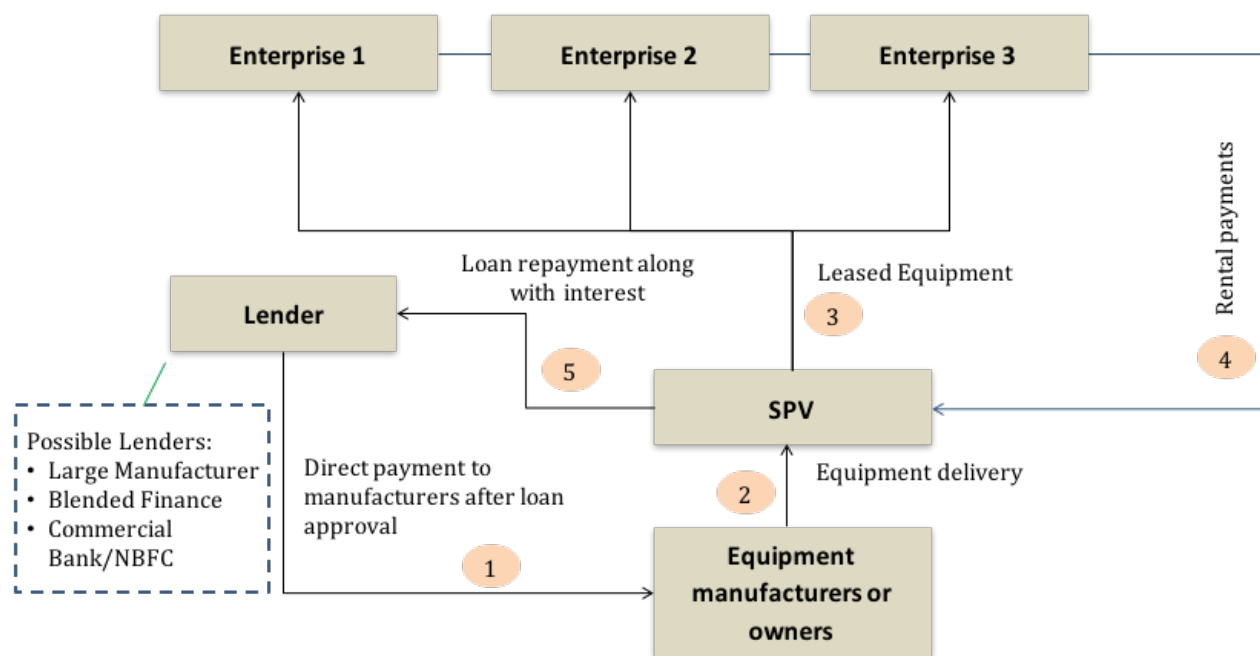


Fig 7: Understanding Advanced Market Commitments

The key ingredients of the instrument are as below:

- *Similar Enterprises come together to lease the assets & equipment instead of purchasing them*

⁵⁵ <https://www.sbi.co.in/portal/web/customer-care/faq-lease-finance>

⁵⁶ <https://maxxia.co.uk/blog/finance-lease-vs-operating-lease/>

- *A Special Purpose Vehicle (SPV) may be formed/promoted by financiers who specifically are interested in the health financing space*
- *This SPV acts as a centralized leasing and rent collection hub (lessor) for all lessee enterprises*
- *SPV pools funds from multiple investors and buys equipment/assets or leases directly from coordinates the equipment financing with the equipment manufacturers and provides them on rental basis to enterprises*
- *The SPV also raises an asset backed loan from the lender and the lending financial institution directly disburses to equipment manufacturers and collects repayments from the SPV*

Potential benefits and pitfalls of this model:

Lease financing reduces the need for upfront capital by leveraging availability of an investor to buy assets and lease it to the enterprise for use. Repayments are made in the form of periodic rentals. All the risks (major or minor) and rewards of ownership are normally transferred to the lessee and the lessee bears the costs of insurance, maintenance and other related operational expenses. If structured appropriately, Asset Lease Financing can incentivize the equipment provider and the lessor to ensure the equipment is used and maintained *and has the potential to link the usage to periodic payments as well.*

Owing to the large-volume procurements, the pricing as compared to the open market is less and extremely cost-efficient. Also, no regulatory changes are required for implementation of asset lease financing mechanism. To the lessor, the known benefits are⁵⁷ Assured Regular Income, Preservation of Ownership, Benefit of Tax, High Profitability, High Potentiality of Growth: and Recovery of Investment.

An example of this type of financing is the Managed Equipment Services or MES in Kenya⁵⁸. Seen as a viable and sustainable business model emerging in Kenya's healthcare system involving partnerships between the private sector and public healthcare providers that offers solutions to some of the challenges posed by the dynamic healthcare industry. Here the government of Kenya entered a fixed term – asset-lease agreement in which the manufacturers was paid periodic, pre-arranged payments based on agreed performance parameters. MES arrangements offer public entities an opportunity to spread costs over the contract period, thereby allowing for long-term, sustainable budgeting.

Another offset of this model is the procurement of multiple medical devices in one go through transparent bidding, thus providing the hospitals an opportunity to procure all devices and equipment necessary for care in one single stretch of financing. Payments of the devices, i.e. rental to the lessee or manufacturer is based on the usage and performance of the devices in the hospitals, thus giving impetus to the lessee or manufacturers to actively participate and ensure training of the healthcare personnel while using the devices.

The disadvantage of the mechanism is that the impact of inflation can make it unviable for the private provider and perceived compulsion to use the technology even if it becomes obsolete. Also, the potential interest payments over the lifetime would make the equipment more expensive than buying it up front.

Using Asset lease financing in Primary Health care in Kenya

While there already has been some initiatives that have been taken by the government to ensure the medical facilities are equipped with requisite devices and equipment's in Kenya (across 98 hospitals in Kenya). The model has so far not been explored from the perspective of sole support and providing equipment and devices for PHC in Kenya. The model can be adopted for procurement of high cost laboratory equipment like GeneXpert, CD4 Analyzers, X-Ray machines at the county as well as the national level. The mechanism can also be leveraged

⁵⁷ <http://www.yourarticlelibrary.com/financial-management/lease-financing-types-advantages-and-disadvantages/43833>

⁵⁸ <https://blogs.worldbank.org/ppps/how-managed-equipment-services-kenya-help-private-sector-contribute-healthcare>

to procure ambulances for emergency primary care and maternal and child health service delivery. Dental equipment can also be leased under this arrangement reduce the financial burden on the government. It can also be used for technology such as EMR or telemedicine equipment linked to outcome / adoption based payments, which ensures that the provider trains, upgrades, maintains the equipment and staff etc, which are often problems with technology that is purchased once and rarely maintained or well-used.

Successful Use Cases

- ✓ ***Kenya Managed Equipment Services Initiative⁵⁹***: In Feb 2015, the Government of Kenya committed US\$450 million to towards procurement of state of the art medical devices and equipment. They partnered with GE Healthcare (radiology), Philips (ICU), Mindray (theatre equipment), Esteem (surgical theatre central services), and Bellco (dialysis) for procurement of devices. A total of 98 health facilities, 2 in each county and the four national level referral hospitals were covered under the arrangement. Initially, counties were paying Ksh 95 million annually under the scheme. This figure has since been revised upwards to KSh 200M, representing a cumulative figure of Ksh 9.4 billion per year up from Ksh. 4.5 billion. These amounts are deducted directly from county allocations and paid to private suppliers by the National Treasury.
- ✓ ***Siemens Healthineers & Royal London Hospital***: Started in 2010, Siemens Healthineers has a 35-year MES partnership to support the redevelopment of St Bartholomew's (Barts) and the Royal London hospitals and provide them with the latest medical technology. Through this arrangement, Siemens is slated to not only supply and manage medical technology for the hospitals' radiology and cardiology departments but also share their expertise during the construction phase of the hospitals.
- ✓ ***Siemens and The Ministry of Health of Murcia***: In 2010, the Ministry of Health of Murcia signed a 15-year MES partnership contract with Siemens Healthineers to improve the technological innovation as well as financial and planning security. In 5 years, the partnership led to 83% improvement in resolution times and 90% reduction in equipment damage costs for Cartagena Hospital, as well as 25% lower administrative costs and 0% re-scheduling rates for patients at Mar Menor Hospital.

DEBT SWAPS FOR HEALTH

A debt swap (also called debt conversions) is a method of transforming debt into resources for development work. Debt swaps are a type of debt relief, often as part of the official development assistance (ODA) funding: instead of paying back the debt to creditor countries, debtor countries use the debt money for their social development, such as education and health care. The mechanism of debt swaps is that they make a fiscal space that enables the debtor government to channel fiscal resources, otherwise devoted to debt servicing, into social development programs without sacrificing fiscal and macroeconomic sustainability.

Demystifying Debt Swaps for Health

Several hundred million dollars in debts have been cancelled thus far. It is estimated that Debt2Health could raise about \$100 million per year. Australia and Germany are the core supporters of Debt Swaps. A debt-for-development conversion or swap regularly involves three actors (creditor, development agency and debtor government) who all benefit from the difference between the nominal value and the real value (defined by the secondary market or some other mechanism) of a country's foreign debt. In principle, any debt can be converted (private commercial debt, official bilateral debt) — provided there is an agreement between seller, buyer and debtor on the conditions of the arrangement.

⁵⁹Parliament of Kenya, MES Brief, Available [Here](#)

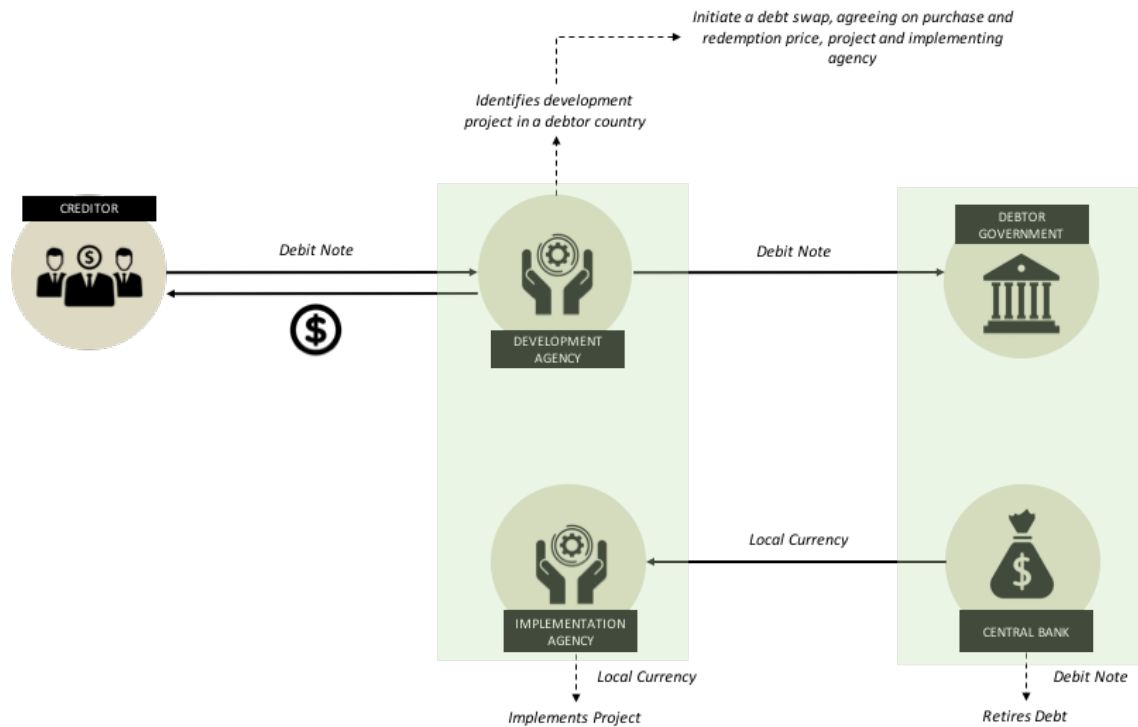


Fig 8: Depiction of SIB work flow

Potential benefits and pitfalls of Debt Swaps for Health

Debt Swaps effectively use the limited available resources in developing countries toward specific health investments rather than debt repayment. It makes use of existing multilateral channels to target financing for health, yielding lower transaction costs compared to using disparate bilateral channels. Also, trilateral arrangement among creditors, grant-recipient countries, and a multilateral institution could potentially strengthen recipient country ownership and accountability. For a commercial creditor, the possibility of a swap transaction makes it possible to recover at least part of its non-performing loan, and the intervention by aid donors to finance debt-conversion schemes actually increases all creditors' chances of recovering their loans. However, debt swaps revenue potential is often unpredictable and depends on donors' willingness to cancel debt and the stock of debt available to be cancelled. Also, development is not their core mandate, so the challenge is to make creditors understand that the agreement will be a win-win-win situation. Another negative impact of debt swaps in some countries "has been the injection of excessive amounts of local currency into the national economy resulting in inflation. This is one reason why debt swap programs in Latin America were suspended. Finally, Swaps can be cumbersome, time-consuming and expensive to implement.

However, ***Debt Swaps have re-emerged in the past one year as a probable health financing instrument.*** Driven by Global Fund, it is expected that many debt-ridden countries can benefit from the same. Considering the debt among African countries from oil rich nations, this can be a viable option going forward.

Successful Use Cases

- **Triple Swap:** Spain will waive debts owed by Ethiopia, the Democratic Republic of Congo, and Cameroon in exchange for investments in domestic health programs supported by the Global Fund. Under the new deal, Spain will cancel outstanding debts amounting to a total of 36 million euros (\$42.6 million), which will allow

Cameroon to invest 9.3 million euros (\$11 million) in programs to fight HIV; the DRC to invest \$3.4 million in projects to fight malaria; and Ethiopia to invest 3.2 million euros (\$3.8 million) in initiatives to strengthen its health system.

- **Indonesia:** Germany was the first donor country to participate in the Debt2Health programme, cancelling €50 million of its debt with Indonesia to provide €25 million of funding for Global Fund activities in that country over a five-year period from 2008. Australia has cancelled €54.6 million of bilateral debt with Indonesia, generating €27.3 million (Leading Group on Innovative Financing for Development, 2012).
- **Pakistan:** Pakistan and Côte d'Ivoire have received €59 million of debt relief from Germany, generating €29.5 million for Global Fund projects.
- **Egypt:** In June 2011, in a new type of “triangular” agreement, Germany also agreed to write off €6.6 million of Egypt’s debt, in return for Egypt’s contribution of half of that amount to Global Fund anti-malaria programmes in Ethiopia.

KEY FINDINGS AND INFERENCES FROM THE STUDY

STAKEHOLDER MAP

The in-depth review of various innovative health financing models and key interactions with industry experts, highlight that there are seven key stakeholders in the health financing ecosystem. While, each of the stakeholder has a defined role in the process, it is extremely critical for them to engage with each other in a coordinated manner with focus towards developmental impact. Also, the most critical stakeholder is the beneficiary who is central to the health financing ecosystem and should be involved in the decision-making process. The key stakeholders are as below:

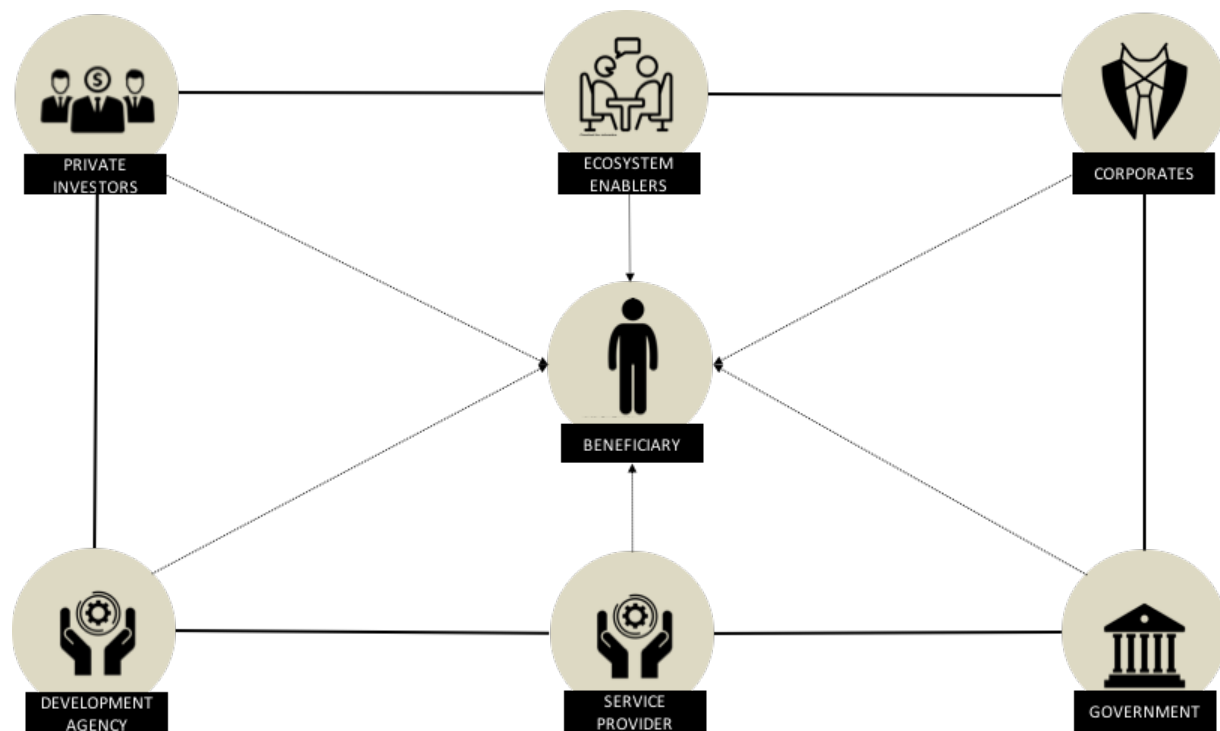


Fig 9: Depiction of key stakeholders in the ecosystem

1. **Government:** The National and the County Governments are the main driver for health financing initiatives. With the devolution of healthcare, the county level administration has a major role in risk mitigation, last mile service delivery, increasing local participation and also drive the political will & commitment, to create an enabling environment to implement innovative financing initiatives.
2. **Development Agencies:** Philanthropic donors & development agencies like BMGF, Global Fund, Rockefeller Foundation, USAID, DFID, EU act like catalysts for innovative financing models and have the potential to drive them at large scale. They also act as a bridge between government and the implementation agencies to drive the impact at the last mile. They are often the early adopters of these models and have the potential to hedge the risk during the initial years and enable maturity of health financing options resulting in gradual transition to government and other stakeholders.
3. **Private Investors:** Among private investors, there is a spectrum of investors with different objectives and risk appetites. At one end of the spectrum are investors who consist of socially motivated individuals and organizations with an appetite for risk in exchange for some social return. On the other end are investors who expect double-digit financial returns, without necessarily any social return (e.g. private equity investors). In this spectrum, there are impact funds (Socially motivated commercial funds) and venture philanthropists (traditional venture capital financiers who aim to achieve philanthropic endeavors) as well. They can also play a major role in ensuring higher return on investment and unlocking greater investment in this space.
4. **Service Providers:** The service providers are the implementation agencies and healthcare service institutions who deliver the impact at the last mile. It is critical to engage them early in the process to ensure that relevant health areas are in focus and potential impact at the last mile.
5. **Corporates:** They are often the innovators, technology providers and potential source of services / consumables for healthcare delivery. Corporates can ensure channelization of profits towards impact creation as part of their social responsibility and also collaborate with development agencies to execute initiatives like volume guarantees.
6. **Ecosystem Players:** Considering the current understanding of the innovative health financing, there is an ever-growing role for subject matter experts, intermediaries and knowledge players to disseminate the role of innovative health financing in the global health community.
7. **Beneficiary:** Central to the overall health financing landscape, their role has been limited in the current context. It is important to engage with the beneficiaries at wider scale and involve them in the decision-making process for health financing.

Key stakeholders involved in various health financing instruments are summarized below:

| Models | Government | Beneficiary | Ecosystem Enablers | Private Investor | Lending Banks: Local | Service Providers | Corporates | Development Agencies |
|-----------------------|------------|-------------|--------------------|------------------|----------------------|-------------------|------------|----------------------|
| SIB/ DIB | √ | √ | √ | √ | | √ | | √ |
| CBHI | √ | √ | √ | √ | | √ | | |
| AMC | √ | √ | √ | | | | √ | √ |
| Debt Swaps | √ | √ | √ | | √ | √ | | √ |
| Asset Lease Financing | √ | √ | √ | | √ | √ | √ | |

INSIGHTS FROM VARIOUS HEALTH FINANCING MODELS CONSIDERED

The primary and the secondary research around innovative health financing provided some key insights at the strategic, operational and behavioural level. It brought out the need to create a more cohesive environment for such innovations to thrive and strengthened the belief in the role that various stakeholders should play moving forward. An active and participative role of the government was seen to be most crucial for increased private sector participation. The increasing database of knowledge around such models and cross-sectoral successful implementations were also instrumental in increasing acceptance or evaluation of innovative financing models. Also, it's widely accepted that innovative financing mechanisms facilitate reduction in donor dependence and provide viable options to generate / leverage internal funds for health delivery.

Role of Government is Central to Innovative Health Financing Rise in Kenya: The National Government and the County Governments have the potential to drive these innovations forward. There is a need for political stability and strong backing of the Government to infuse confidence among private sector stakeholders. This will also facilitate increased multi-year funding opportunities and long-term investments in the country. *The Government can also introduce special taxes like Sin Tax, Airtime Tax and improve the efficiency of existing taxes to increase the revenues. The Government can be the outcome payer for impact bonds and ensure accountability for the results.* Also, the willingness of the Government will ensure that mechanisms like Debt Swaps or Guarantees are implemented at scale.

Multi-stakeholder partnerships & their right implementation are critical to long-term success: Partnerships between Government, Private Sector, Not for Profit Sector, Investors and other stakeholders holds the key to mitigate risks, understand context, drive impact, stronger social returns and profits for all involved. For Example: *the capping of lending interest rate to Micro, Small & Medium Enterprises (MSMEs) was rolled out to encourage the MSMEs across sectors to come forth and take loans. However, the lending banks refused the loans due to perceived risks. Thus, a noble initiative was rendered ineffective as key stakeholders were not on-boarded at the right time.*

Effective monitoring & reporting mechanisms across the health value chain will drive investor confidence and attract more investment: *Efficient and robust monitoring, reporting & transparency has shown increase in investor confidence and risk appetite.* It is difficult to measure the true impact and implementation potential for health projects. Lack of well-defined and structured metrics, limited ways to measure the impact effectively and limited dissemination reduce the confidence among investors to invest in healthcare models.

Enabling Infrastructure for Service Delivery is important to achieve desired impact at the last mile: While, the innovative mechanisms can facilitate access to capital, the efficient use of capital is dependent on the quality of services and infrastructure available for the same. There is a need to improve the primary healthcare infrastructure and PPPs can be one of the ways to achieve the same.

Transparency and Accountability: The most successful partnerships have a clear alignment and adherence to inbuilt processes by all stakeholders including the government. Accountability to one's own as well as being cognizant of how one partnership would influence that of another's in an ecosystem, is very essential as it brings about a self-inflicted sense of responsibility and contribution to the purpose.

Technology Integration & Adoption will accelerate the impact of innovative financial models: Technology innovations both in service delivery as well as data analytics are critical to make informed choices. This will ensure that efficiencies of the instruments are improved and desired impact is also achieved.

There exists preference for selective health financing instruments and model among key stakeholders:

SIBs are most commonly and widely accepted as they have the innate ease of bringing various and multiple investors into a single program, including the government together. Inherent performance-linked-payment mechanisms are also seen as crucial to the success and acceptance of the model. Supply-commitment driven financing models such as the Advance Market Guarantees also have a high acceptance among specific programs with definite single factor outcomes (detrimental disease oriented).

Institutionalization & Integration of Existing Interventions will be key to success: Many insurance schemes have been designed & executed at the national and county level. It is critical to find ways to make them synergistic and institutionalize them to ensure scale up and replication. *Do we want to continue at a small scale and pilots or do we want to explore the full potential?*

Legal Framework needs to step up going forward: Policies around Corporate Social Responsibility, Public Private partnerships need to be strengthened, streamlined and executed to support the fast expanding space of innovative financing.

Immense potential to tap 'other' capital market sources: Kenya's capital market presents a huge source of private capital (including pension funds), that can be tapped as a potential source of financing. Currently, the Capital Market Authority (CMA) has been enabling issuance the issuance of bonds e.g. development of green bond guidelines.

High level of mobile penetration can drive Primary health care: Kenya has a high mobile penetration rate and the increase in digital financial transactions should be leveraged to provide PHC. The mobile revolution can be leveraged for digital health payments, development of integrated medical records, provision of mobile-enabled diagnostic devices or software, creating an online integrated healthcare delivery system. It can also pave way for special taxes which can support investments in UHC activities.

KEY RECOMMENDATIONS

Adopting innovative financing mechanisms in a country requires collective participation of all the key stakeholders; investors, government, service providers and ecosystem players. A systematic approach shall enable effective flow of private sector capital. A five-step roadmap is being identified in the following section:

1. **Step 1 - Need Identification and Prioritization of Actions:** It is critical to do a detailed landscaping to identify the specific areas of interventions where innovative financing mechanisms can improve primary healthcare, what are the real challenges to adoption of these mechanisms and finally what can be the potential interventions to adopt some of these tools for primary health care in Kenya.
2. **Step 2 - Identifying barriers to catalytic capital:** Primarily barriers to uptake of catalytic capital exist at environmental level and project specific level. The environmental barriers comprise of regulatory, governance, infrastructure and market risks that often require policy solutions or reforms but sometimes can be addressed or circumvented by innovative finance solutions. Project level barriers include operational and contract risks, factors that have a direct impact on project cash flows and returns, as well as the operating costs incurred by investors to source, structure and execute a transaction.
3. **Step 3 - Identifying Project pipeline:** Once, the key barriers for private sector involvement are identified and solutions which can mitigate the risks are developed, it is necessary to identify pilot projects in Primary Health Care for investments. These projects can be identified from the existing pipeline of government interventions as well as identified through a structured process of inviting projects interests from private parties.

4. **Step 4 – Implementing an effective monitoring and data management structure:** Private sector capital providers appreciate transparency and effective data management practices in the investments. In many cases globally, M&E is a key for attracting investments. While dealing with Government infrastructure (in this case Primary Health Centres), policy makers should adopt effective steps to map and report data on the key outcomes expected from the investments.
5. **Step 5 – Develop an investor body:** Thousands of key stakeholders from the impact field are working in their respective countries to build conducive ecosystems for impact investment, to benefit people and the planet. Many of them are doing so by building national structures, known as “*National Advisory Boards – NABs*”, engaging diverse players in dialogue, developing policy recommendations and implementing a range of innovative financial instruments. Kenya and many other African countries have an opportunity to become true Impact Nations, and attractive platforms for investors committed to Africa and the SDGs. A national body, such as a National Advisory Board, is a powerful tool to lift barriers and create a more fluid, more efficient ecosystem, unlocking further private capital for public good. East Africa Venture Capital Association (EAVCA) is one such body that exists to promote private investor activity across the region. However, there is a need to create an exclusive socially focused investor body consisting of socially inclined high net worth individuals, impact funds, development sector focused investments arms of DFIs (like CDC, KfW).

These overarching strategic interventions should be supported by few operational interventions over a period of time to accelerate the private sector participation in leveraging innovative health financing instruments for primary health care in Kenya. Some of the key operational interventions include:

Legal and Regulatory Reforms

It is critical to focus on enhancing the legal and regulatory environment to increase the sectoral attractiveness for the private sector. The Government needs to address the lacunae of regulations and frameworks that will facilitate the private investors in Kenya to come forth and invest in healthcare. Such reforms can include:

- *Strengthen regulatory institutions that promote private investments in the country by allocating sufficient funds and resources.*
- *Roll out legislations that lay out the plan for distribution of profits and blueprint for scaling the projects being pursued.*
- *Review existing taxation structures to improve efficiency of corporate tax, value added tax, feasibility to introduce special taxes (sin tax), and also graded taxation based on nature of enterprises and not limited to type of legal entity.*
- *Lay-down and implement a strict corruption-free and anti-bribery policy that puts in place punitive actions against people who engage in such activities.*
- *Adopt regulations for the adoption of digitization and capturing of data, its usage which are essential to attract and facilitate investment and protect the interests of the investors.*
- *A dedicated and structured CSR Act which can provide a guided approach to private sector to engage in public health activities can be instrumental in making UHC a reality. The Government of Kenya can identify key areas within healthcare where private sector can contribute and also access taxation benefits. Countries like India and UK have implemented the CSR Act mandating private sector contribution with positive outcomes.*

Collecting and Providing Health Data Information

An integrated health data platform that can provide access to real time, trustworthy health care data from community level to county level to national level is the need of the hour. Establishing national data standards and creating a data platform (which protects the privacy of the data sources) and enable the investors to make informed choices.

Creating Structures for Innovative Financial Interventions

To ensure participation of key stakeholders it is critical to develop structured approaches and guidelines for key financial instruments and how each stakeholder can participate in the same. This will require in-depth analysis of the sector, key engagement with decision makers and policy influencers to establish the approach to how these instruments can be leveraged, potential benefits, expected investment and perceived returns for each stakeholder. There is an urgent need to create a model road-map that helps all identified stakeholders understand their role and participate in the implementation of these measures.

De-risking and protection against losses

The government and/or the development partners can put in place mechanisms to protect private participants against losses incurred in investing in specific ventures identified by the government as areas/projects of priority. This could be through guarantees, assurance mechanisms like interest rate swaps (to manage movements in exchange rates), commodity derivatives (to fix the price of commodities over time), future contracts etc. Other mechanisms like Viability Gap Funding which is more a protection mechanism (currently being implemented under Project Facilitation Fund) should be extended to include more sectors and to encourage private sector participation.

It will also be critical to provide technical and transaction based support to potential investments & enterprises including business planning, market assessment at a micro level, capacity building of key stakeholders in the enterprise particularly at the early stage. This will hedge the investment risk and also facilitate increase in investor appetite to invest in the region.

Leverage formal platforms for stakeholder engagement

Unlocking private sector capital requires an in-depth understanding of the landscape of investors and ensuring alignment of objectives. Regular interactions with the investors as well as other stakeholders will therefore be very crucial. Platforms like the *SDG Partnership Platform*, *Kenya Healthcare Federation as part of the Kenya Private Sector Alliance*, the Global Steering Group for Impact Investing National Advisory Board in Kenya, or the Africa Venture Philanthropy Alliance can be leveraged to bring together the private sector stakeholders along with representatives from Government and Healthcare Industry. These platforms can provide opportunities to:

- *Facilitation of regular meetings of all stakeholders to discuss progress, areas of issues, mitigation strategies, blind spots, sharing of best practices, future plan discussions for scale or sustainability.*
- *Facilitating a participative platform for closed networking, exchange of thoughts and interaction of all private investors.*
- *Create Action Groups focusing on specific innovative health financing instruments and models.*
- *Creating and listing specific roles and responsibilities of all stakeholders to be abided with mapping and alignment to capacity of the private player as an investment partner.*
- *Support government in formulating the policies required to make UHC a reality*

Moving beyond infrastructure

For UHC to become a reality, it is important to move beyond infrastructure interventions, PPPs and adopt an inclusive approach. Social Behaviour Change and Communication will be the key to long term adoption of innovative financing instruments and stakeholder engagement. This will require extensive capacity building of the all stakeholders across the healthcare spectrum from policy makers to implementers. There is need to recognize, engage, measure and reward behaviour change activities for adoption of innovative financing models in healthcare. Outcome based financing models should provide emphasis on behaviour change and softer adoption aspects which are often difficult to measure.

ANNEXURE

EXISTING BEST PRACTICES IN INNOVATIVE HEALTH FINANCING

UTKRISHT: A DEVELOPMENT IMPACT BOND

Utkrisht launched in Rajasthan in India, is world’s first maternal and newborn health impact bond. It was developed by USAID, Merck for Mothers, the UBS Optimus Foundation, PSI, Palladium, and HLFPPPT.

The Utkrisht bond aims at the reduction in the number of mother and child mortalities by improving the quality of maternal-care value-chain in Rajasthan, India. It will support approximately 440 health facilities to improve services, meet new government quality standards and adhere to them over the long term. It is also the first bond that uses genuine private capital raised from private investors. Through this public-private partnership, private capital from UBS Optimus Foundation is designed to front the costs to improve the quality of primary maternal health services. The implementing partners HLFPPPT and PSI are designed to use this capital to improve the quality of care in these select/ identified facilities and help them become accredited. In a first of its kind, the two implementation partners are also co-investors; together the three of them contributing to 20% of the capital requirements. The payment for the outcome achieved is only done when the requirements are met with. The outcome payers: USAID and Merck for Mothers (also known as MSD for Mothers) will pay the investment to the three co-investors only if certain targets to improve quality are met. The overall management of the work is done by Palladium. This coordinated effort initiative has the potential to reach up to 600,000 pregnant women and newborns in the target geography. The pay for success approach ensures appropriate stewardship of the funds and investments made, while unlocking both private capital and government resources for health.

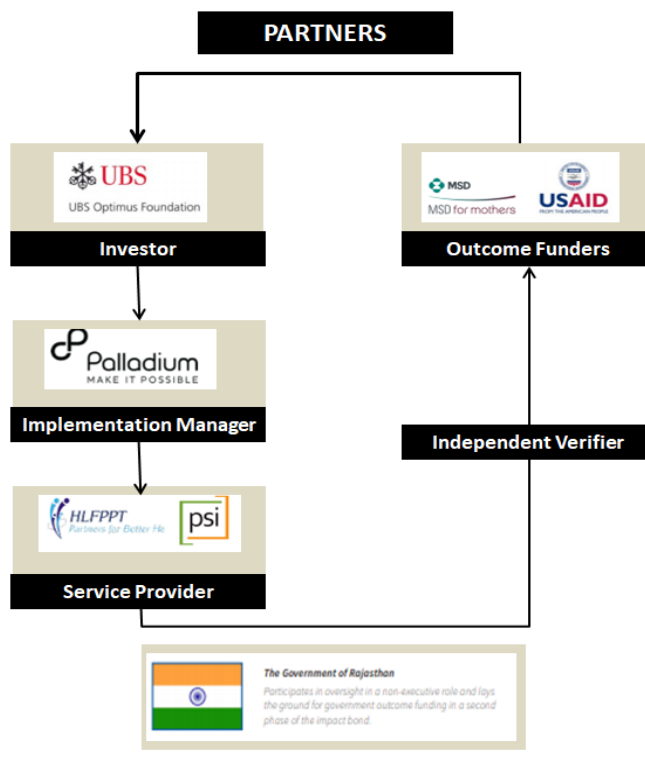


Fig 10: Utkrisht DIB model

GAVI'S ADVANCED MARKET COMMITMENT

In 2003, the Center for Global Development convened a working group to explore the merits of advance market commitments and initiate a pilot program. In 2007, the Bill & Melinda Gates Foundation and the governments of Canada, Italy, Norway, Russia, and the United Kingdom collectively pledged \$1.5 billion for *Advance Pneumococcal Commitment pilot*. GAVI predicted that the demand of obtaining pneumococcal vaccines would

be ~ 200 million doses of the vaccines annually by 2015⁶⁰. They roped in manufacturers such as GlaxoSmithKline and Pfizer to supply thirty million doses of second-generation pneumococcal vaccines annually for ten years through the advance market commitment initiative, starting in 2013. The fixing of the pricing (\$7.00 per dose) was based upon the commitment of the supplier for the vaccine in the said tenure. Since GSK and Pfizer's commitment to supply was 15% of GAVI's total requirement of 200 million-doses, each of the manufacturers were allotted 15% (\$225 million) of the \$1.5 billion fund towards price and volume guarantee. *In addition, the companies agreed to provide collectively seven million doses in 2010, twenty-four million in 2011, and twenty million in 2012 to countries eligible for GAVI's assistance.* The price guarantee helped manufacturers and research organizations that developed the vaccines to cover their costs and the volume of commitments helped profitability. The manufacturers also guaranteed further reduction in price to \$3.50 per dose for 8 years up to 2021. To offset the forecasting risk associated with AMC, UNICEF, agreed to purchase a minimum of 20% of GlaxoSmithKline's committed supply in the first year, 15% in the second, and 10% in the third, regardless of whether demand materializes in those years.

Other similar AMC examples include

- **PEPFAR:** An ongoing AMC for HIV, TB and Malaria Vaccines by President's Emergency Plan for AIDS Relief (PEPFAR)^{61, 62}.
- **GeneXpert:** UNITAID, the United States Government and the Bill & Melinda Gates Foundation, created an AMC of USD \$11.1 million for GeneXpert in 2012.
- **Novartis ACCESS:** This program leveraged the principles of AMC to provide 15 affordable quality drugs (addressing cardiovascular diseases, type 2 diabetes, respiratory illnesses and breast cancer) at below \$1 or free of cost, depending on the level of subsidy. *It works on the principle of forgoing the 100% to 300% mark up on manufacturing costs that are otherwise accounted towards costs for marketing and advertising and selling the drug, which in case of a volume guarantee is covered up for*⁶³.

SIN TAX

It is the Tax levied on certain consumer goods such as Alcohol and or Tobacco, Gambling (lottery), Sugary products, processed products with salt at the time of purchase. It is a widely accepted and adopted system as they are considered more politically viable than raising income tax or sales taxes⁶⁴. It is implemented by Governments of over 45 countries across the world^{26, 65, 66}. The taxation % or amount varies from country to country, depending upon the product and the extent of potential harm to health. *The tax levied ranges from \$1 USD to \$2 USD, while UAE placed a 50 per cent tax on carbonated, sugary drinks, and a 100 per cent tax on energy drinks and tobacco products*⁶⁷. *In some cases, it is attribute to % of total product cost, in others it is a fixed amount. In countries such as China, India, Thailand, Mexico, UK and USA*⁶⁸ *the % is determined by statistical analysis of the % reduction targeted in consumption of these specific goods.* The costs are credited back to the government to fund public healthcare programs. Sin taxes seek to deter people from engaging in socially harmful activities and behaviors, but they also provide a source of revenue for governments.

⁶⁰ *Economic perspectives on the advance market commitment for pneumococcal vaccines.* Christopher M. Snyder et. al.

⁶¹ <https://www.path.org/media-center/vaccine-financing-gains-support-in-pepfar-bill/>

⁶² <https://fas.org/sgp/crs/misc/R43232.pdf>

⁶³ Novartis Access 2017 Two-Year Report- Highlights [Available here](#)

⁶⁴ <https://www.thebalance.com/sin-tax-definition-examples-4157476>

⁶⁵ <https://www.dawn.com/news/1449578>

⁶⁶ <https://www.dawn.com/news/1449618>

⁶⁷ <https://www.businessinsider.in/Dubai-has-imposed-a-50-sin-tax-on-soda-and-it-could-have-global-consequences/articleshow/60930734.cms>

⁶⁸ https://www.ttb.gov/main_pages/schip-summary.shtml

In 2001, the Thai government established an autonomous Thai Health Promotion Foundation (also referred to as Thai Health) under the direct control of the Prime Minister. Thai Health is a strong body, with 21 members appointed by the cabinet. *Funding for Thai Health comes from 2% dedicated tax on tobacco products and 100% tax from alcoholic beverages, over and above the existing tax structure.* The funds thus raised are used to support 16 projects such as community mobilization on tobacco and alcohol control, prevention of road traffic injuries, health promotion for the elderly and so forth. **Evidence shows that earmarked taxes have succeeded in reducing the use of health damaging products and raising additional funds for health promotion programs**⁶⁹.

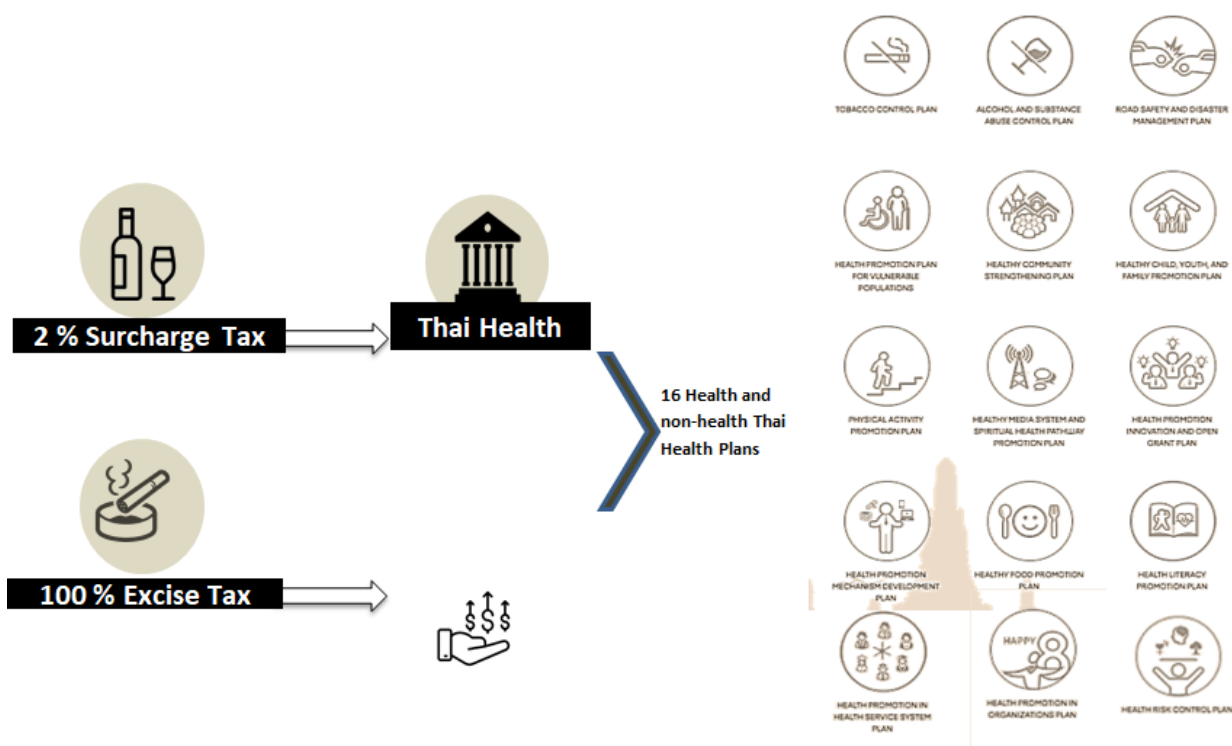


Fig 11: Thai Health- using Sin Tax and Excise Tax to fund non/ Healthcare Plans

PIGOUVIAN TAX

Similar to a sin tax, Pigouvian tax also imposes costs on socially harmful services and goods that do not cause addiction and / or to individuals directly. It is a levy on activities that create socially harmful externalities or activities that creates a negative effect on others such as tax on fuel that causes pollution, industries, gasoline, airports and or products that use natural resources such as ground water. A classic example is that of the **Aviation tax**, that is levied by the government of Germany on short-haul flights that halt at the Frankfurt airport. *The German ticket tax adds around €7 to a short-haul flight ticket and collects one billion in a year just through this Cess*⁷⁰.

⁶⁹ http://en.thaihealth.or.th/WHO_WE_ARE/THAIHEALTH_INTRO/

⁷⁰ <https://www.transportenvironment.org/newsroom/blog/ending-aviation%E2%80%99s-tax-holiday>

France has introduced **Noise tax** to curb noise pollution by airplanes at its nine busiest airports. It ranges from 2 euros to 35 euros depending on the airport and the weight of the aircraft.

Another example is the **Carbon taxes**^{71, 72} that are levied on carbon emitters such as thermal electricity plants causing environmental damage and pollution.

LUXURY AND VALUE ADDED TAXES

A form of excise tax, it is an *ad-valorem* tax placed on products or services that are deemed to be non-essential or unneeded⁷³. It is also called as a progressive tax, as only certain sects of the community access and use such products or services. The money collected is then routed back into the Government or for special programs such as subsidizing Social insurance.

Ghana's National Health Insurance Scheme (NHIS)⁷⁴ is subsidized through this channel. The NHIS is financed from four main sources: a value-added tax on goods and services, an earmarked portion of social security taxes from formal sector workers, individual premiums, and miscellaneous other funds from investment returns, Parliament, or donors. The 2.5% tax on goods and services, called the *National Health Insurance Levy* (NHIL), is by far the largest source, comprising about 70% of revenues. Social security taxes account for an additional 23%, premiums for about 5%, and other funds for the remaining 2%. It is a very unique social insurance design and is said to have a single benefit package and covers "95% of disease conditions" that afflict Ghanaians. It covers outpatient services, diagnostic testing and most in-patient services, including specialty care, surgeries, and hospital accommodation (general ward); oral health treatments; maternity care services including caesarean deliveries, emergency care and finally all drugs listed on the centrally-established Medicines List. *The financial contributions & premiums to NHIS are incremental and graded in nature, based on income and earning potential of the individual and their ability to pay taxes.*

MUTUELLES DE SANTE: RWANDA'S NATIONAL CHBI

Rwanda launched **Mutuelles de Santé**, the community-based insurance scheme in 1999 and it has grown to cover over 19 million people. The system utilizes a poverty map to categorize members into three groups based on economic status. The poorest members pay no premiums while the rest pay different levels of premiums and co-payments.

- *Category 1 members: the poorest group comprising 27% of total members, the premium per person is paid by the government.*
- *Category 2 members: the middle group, comprise of ~70% of enrolled members.*
- *Category 3 members: the better off group comprise of ~3% of members enrolled.*

Out of pocket health expenses dropped from 28% to 12% of total health costs. Some of the key reasons behind the success of the initiative include:

- *Influence and support of civil society, with key roles played by religious leaders*
- *Leadership of national and local government, facilitated the process and introduced relevant policies*
- *Key role of the Ministry of Health (MOH) as policy initiator and champion*
- *Ministry of Finance funding to cover premiums for the poorest section of the society*
- *Local government working with the Banque Populaire Rwanda to provide soft loans to help pay premiums*

⁷¹ <https://www.thebalance.com/pigouvian-tax-definition-and-examples-4157479>

⁷² <https://www.thebalance.com/carbon-tax-definition-how-it-works-4158043>

⁷³ <https://www.britannica.com/topic/luxury-tax>

⁷⁴ *The Effect of Ghana's National Health Insurance Scheme on Health Care Utilisation. N J Blanchet et al*

- Donors who facilitated pilot schemes and provided support and technical assistance through technical working groups organized and led by the MOH
- A heavy emphasis on creating awareness about the need and importance of the initiative

The contribution is made at the individual level, but the whole family is enrolled through the floating cover. The premium payment is for the entire year. There is no waiting period in this type of insurance, unlike similar community based insurances. A flat copayment fee (RWF 200) per visit to the health center is collected by the CBHI unit and is intended to cover CBHI administrative costs. A co-payment of 10% of the total hospital bill is collected from the patient and retained by the hospital.

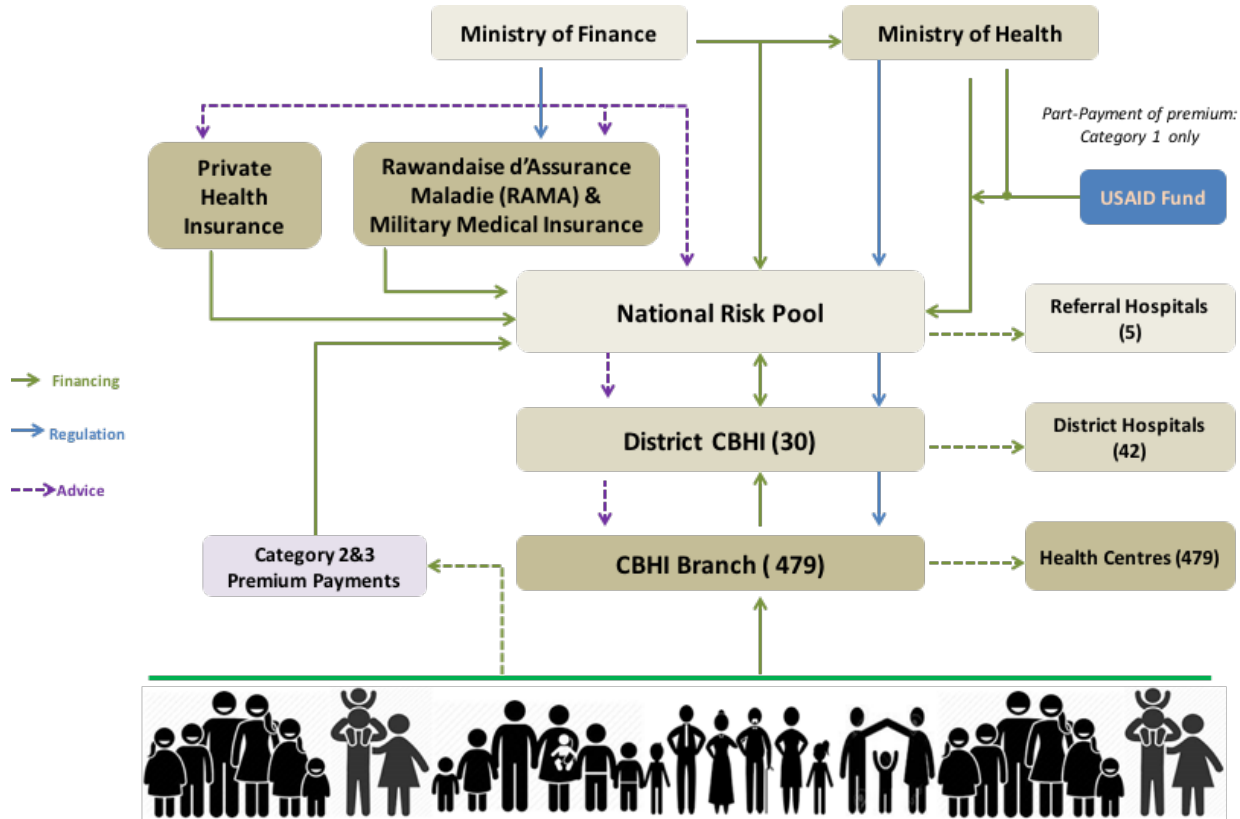


Fig 12: CBHI model: Rwanda

DEBT-SWAPS

The Global Polio Eradication Initiative (GPEI) launched in 1988 by the World Health Organization (WHO) had been highly successful, with the incidence of polio cases dropping by 99 percent globally since 1988 to only 1315 new cases in 2007.

In 2014, the Government of Japan agreed to provide an Official Development Assistance (ODA) Loan of up to 8.285 billion yen (approximately 77 million USD) to the Federal Government of Nigeria to support polio eradication efforts and the procurement of 476 million oral polio vaccine doses to inoculate children under the age of five throughout Nigeria. The loan applied an innovative financing approach referred to as a "Loan Conversion" mechanism. Under the agreement, the Gates Foundation would repay the loan to JICA on behalf of the Federal Government of Nigeria if the project is successfully implemented by the Nigerian government. The aim of this innovative mechanism is to support the recipient government's commitment to its polio eradication

efforts without imposing a financial burden. This was the second time JICA applied this loan conversion mechanism with the Gates Foundation, having used it in 2011 with a loan to Pakistan.

As the loan conversion has been effectuated, BMGF is scheduled to repay it, in lieu of the Federal Government of Nigeria, the loan obligations of the Polio Eradication Project over 20 years spread⁷⁵.

HDFC CHARITY FUND FOR CANCER CURE

The Scheme⁷⁶ enables the unit holders to donate full or part of dividend declared by the Fund to the corpus of Indian Cancer Society or any other eligible institution(s) for treatment of cancer. Such donations made by the Mutual Fund on behalf of the unit holders are facilitated to be eligible for claiming of tax deduction under special provisioned sections of the (Indian) Income Tax Act, 1969 and in alignment to the Securities and Exchange Board regulations. The investors were offered two investment options: 1) Arbitrage Plan and 2) Debt Plan. The Plans under the two schemes had a tenure of 1136 days from the date of allotment of the schemes.

- Arbitrage Plan⁷⁷: the income generated is through arbitrage opportunities of cash and derivative markets and through investments in debt and money market instruments.
- Debt Plan: the income generated is through investments in Debt / Money Market Instruments and Government Securities maturing on or before the maturity date of the Plan.

The percentage of donation to be made out of the dividend declared, if any is decided by the Investors by selecting either a 0% or 50% or 100% Dividend Donation Option. This amount donated to the beneficiary healthcare organization is additionally supported by a matching grant from HDFC Trustee Company Ltd. In this fund, the donor, retains his main fund while only *donating* his earnings (entire or retain a part of his earnings) unlike regular philanthropy wherein the donor *donates* his entire fund with little or no return.

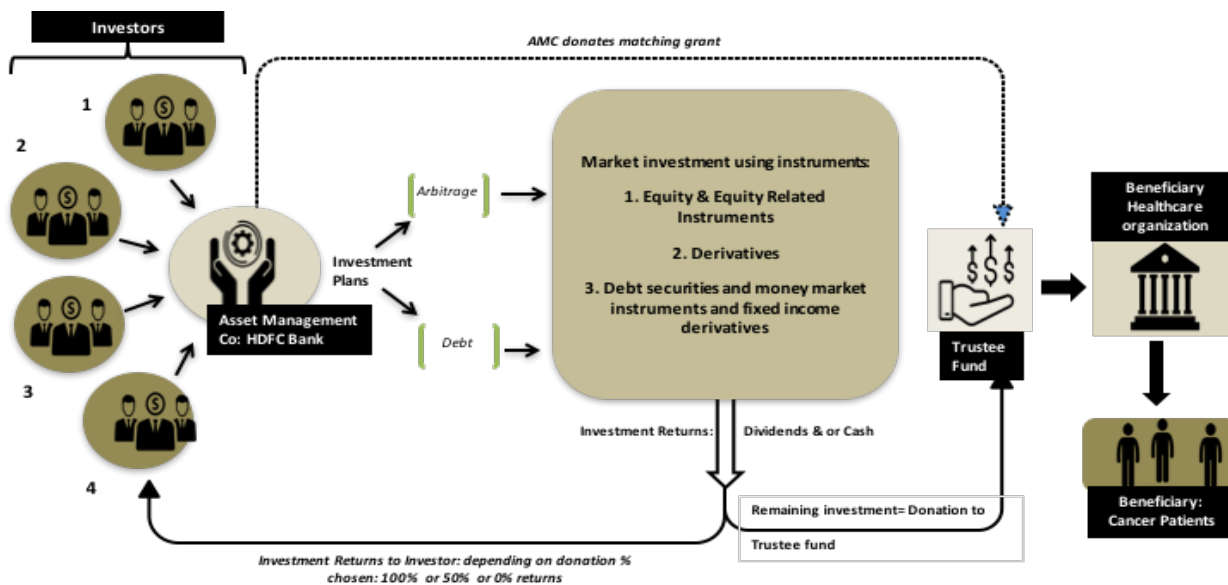


Fig 13: HDFC charity fund for cancer cure

⁷⁵ https://www.jica.go.jp/english/news/press/2014/140527_01.html

⁷⁶ <https://www.financialexpress.com/money/heres-why-you-should-invest-in-hdfc-charity-fund-for-cancer-cure/588818>

⁷⁷ <https://www.nseindia.com/archives/nfo/HCFCCDPR100.pdf>

CORPORATE SOCIAL RESPONSIBILITY (CSR) ACT, INDIA, 2013

Very few countries in the world have a dedicated CSR act that dedicatedly caters to routing part of the taxations on net profit towards social development. It was launched and introduced in India under the Companies Act in 2013. Effective from 1 April 2014, 2013 Regulation Act states that companies whose net worth is of INR 500 Crore or whose revenue sums up to INR 1,000 crore or whose net profit is of INR 5 crore will have to spend 2% of their average profit of previous three years on CSR.

The key activities covered under the CSR act include:

- *Eradicating extreme hunger and poverty;*
- *Promotion of education;*
- *Promoting gender equality and empowering women;*
- *Reducing child mortality and improving maternal health;*
- *Combating human immunodeficiency virus, acquired immune deficiency*
- *Syndrome, malaria and other diseases;*
- *Ensuring environmental sustainability;*
- *Employment enhancing vocational skills;*
- *Social business projects;*
- *Contribution to the prime minister's national relief fund or any other fund set up by the central government or the state governments for socio-economic development and relief and funds for the welfare of the scheduled castes, the scheduled tribes, other backward classes, minorities and women; and such other matters as may be prescribed.*

India is also the first to have brought about a legislation to implement CSR activities, followed by United Kingdom⁷⁸, ⁷⁹. The CSR Act helps streamline the need of larger private organizations to assess and take responsibility towards the society and participate in the social development. Also, socially responsible companies do not limit themselves to using resources to engage in activities that increase only their profits. They use CSR to integrate economic, environmental and social objectives with the company's operations and growth⁸⁰.

In Financial Year 2016, USD 1.15 billion was spent by 1,270 companies collectively, 27% more than spend of USD 897.8 million in Financial Year 2015. However, for a deeper and meaningful impact, organizations need to focus on long term initiatives and not look for instant results. Impact measurement is the need of the hour, it requires to be a continuum and not to be limited to a survey at the completion of activities.

⁷⁸ <https://blog.ipleaders.in/csr-laws-india/>

⁷⁹ <https://www.telegraphindia.com/opinion/spending-for-society/cid/1446603>

⁸⁰ <http://finance.bih.nic.in/documents/csr-policy.pdf>

LIST OF STAKEHOLDERS INTERVIEWED FOR THIS STUDY

We engaged with the following key stakeholders for the primary insights and discussions:

| Organization name | Organization Type | Name | Designation |
|--|--|---|--|
| M&E Unit, Government of Kenya | Government | <i>Dr. Isabella Maina</i> | Head, Health Sector M & E Unit. Ministry of Health. Government of Kenya |
| PPP Unit | Government | <i>Adah Olando Wycliffe Ondieki</i> | Adah: EA to Director Wycliffe: Monitoring & Evaluation Specialist |
| NACC | Government | <i>Mr. Stephen Mutuku</i> | Program Officer - HIV Investments |
| CMA | Government | <i>Anne A. Nalo, Luke Ombara & Wilberforce Ongondo</i> | Anne: Product Development Officer Luke: Director, Regulatory Policy and Strategy Wilberforce: Assistant Manager, ICT |
| Financing Alliance for Health | A partnership-Alliance. | <i>Ms. Lizah Masis</i> | Country Investment & Knowledge Director |
| Medical Credit Fund | Fund for financing MSMEs in healthcare in Africa | <i>Mr. Arjan Poels</i> | Managing Director |
| Data Driven Finance | Norwegian Fin-Tech private company. | <i>Mr. Jan Martin Hunderi & Ms. Henni Ann Aasen</i> | Jan Martin: Chief Executive Officer (CEO) & Founder Henni Aasen: Social Scientist |
| Aga Khan Foundation | International Not for Profit Organization | <i>Mr. Ravi Ram</i> | |
| East Gate International | Lending gateway | <i>Mr. Tim Smyth</i> | Founder & Executive Director |
| Huawei Technologies | An International Technology manufacturing organization | <i>Mr. Adam lane</i> | Senior Director, Public Affairs, Huawei Southern Africa |
| Renovatio Capital | Corporate finance and asset management firm | <i>Mr. Naaman Geda</i> | Africa Executive - Renovatio Capital |
| African Development bank | Development Bank - low interest lending | <i>Ms. Mona Sharan</i> | Senior Gender Advisor |
| AMREF | International Governmental Organization | <i>Mr. Peter Waiganjo</i> | Business Development Lead with AMREF Enterprises |

TRENDS IN SELECTED PUBLIC FINANCIAL INDICES 2012/13 – 2016/17⁸¹

| Financial parameters | Annual value | | | | |
|---|--------------|--------------|--------------|--------------|--------------|
| | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
| Total government revenue (bn KSH) | 875,506.86 | 974,417.72 | 1,112,289.98 | 1,235,702.30 | 1,514,988.76 |
| <i>Tax revenue</i> | 763,828.34 | 911,803.70 | 1,021,597.03 | 1,136,563.52 | 1,338,284.06 |
| <i>Non tax revenue</i> | 111,678.52 | 62,614.02 | 90,692.95 | 99,138.78 | 176,704.70 |
| Revenue as % of GDP at market prices | 18.07% | 19.70% | 19.63% | 18.82% | 23.35% |
| National government expenditure (bn KSH) | - | 1,532,993.05 | 1,950,709.06 | 2,047,351.75 | 2,496,107.94 |
| <i>Recurrent</i> | | 1,021,922.89 | 1,147,969.00 | 1,300,246.89 | 1,449,618.34 |
| <i>Development</i> | | 511,070.16 | 802,740.06 | 747,104.86 | 1,046,489.60 |
| Expenditure as % of GDP at market prices | 27.60% | 30.30% | 33.58% | 30.51% | 37.20% |
| Net borrowing as % of GDP at market prices | -5.63% | -6.30% | -9.22% | -7.50% | -9.94% |
| Government health expenditure (bn KSH) | - | 38,197.29 | 49,781.68 | 34,654.64 | 69,227.25 |
| <i>Recurrent</i> | | 21,574.67 | 28,307.73 | 19,504.30 | 34,144.02 |
| <i>Development</i> | | 16,622.62 | 21,473.95 | 15,150.34 | 35,083.23 |
| County governments revenue (bn KSH) | | | | 311,394.60 | 361,539.31 |
| <i>Equitable share</i> | | | | 259,774.50 | 280,300.00 |
| <i>Conditional grants</i> | | | | 16,598.53 | 21,898.52 |
| <i>Annual local revenue</i> | | | | 35,021.57 | 59,340.79 |
| Count governments expenditures (bn KSH) | | 161,397.47 | 271,309.98 | 317,005.69 | 359,997.11 |
| <i>County health expenditure (bn KSH)</i> | | 8,492.22 | 54,671.70 | 70,732.25 | 69,406.81 |
| <i>% county health expenditure on health</i> | | 5.26% | 20.15% | 22.31% | 19.28% |

⁸¹ Source: Economic Survey 2017

TRENDS IN HEALTH EXPENDITURE IN KENYA⁸²

| Indicators | 2001/02 | 2005/06 | 2009/10 | 2012/13 | 2015/16 |
|---|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| Total GDP at current prices (Ksh) | 2,483,087,8 95,837 | 3,372,242,4 85,458 | 3,502,864,2 14,981 | 3,986,072,4 38,769 | 6,709,670,6 50,000 |
| Total government expenditure (Ksh) | 469,454,10 7,719 | 891,152,52 9,242 | 1,173,991,1 83,006 | 1,485,559,8 82,940 | 2,271,729,8 50,000 |
| Total government expenditure (\$) | 5,972,698,5 71 | 12,141,042, 633 | 15,483,924, 862 | 17,415,707, 889 | 22,836,045, 939 |
| Total Health Expenditure (THE) (Ksh) | 125,436,83 3,424 | 155,556,80 5,311 | 187,400,99 2,010 | 268,332,87 1,444 | 335,600,79 3,580 |
| Current Health Expenditure (CHE) (Ksh) | n/a | n/a | 180,636,34 4,383 | 249,017,78 0,301 | 315,544,18 7,949 |
| Capital Formation (HK) (Ksh) | n/a | n/a | 6,764,647,6 27 | 19,315,091, 143 | 20,056,605, 631 |
| Total Health Expenditure (THE) (\$) | 1,595,888,4 66 | 2,119,302,5 25 | 2,471,656,4 50 | 3,145,754,6 48 | 3,373,550,3 98 |
| THE per capita (Ksh) | 4,021.60 | 4,364.80 | 4,853.70 | 6,514.00 | 7,592.80 |
| THE per capita (\$) | 51.17 | 59.47 | 64.02 | 76.4 | 76.3 |
| THE as a % of nominal GDP | 5.10% | 4.60% | 5.30% | 6.70% | 5.00% |
| Government health expenditure as a % of total government expenditure | 7.90% | 5.10% | 4.60% | 6.10% | 6.50% |

⁸² Source: National health accounts (Ministry of Health, 2017)