

Understanding Private Sector Domestic Resource Mobilization for Health



Summary

Traditionally, domestic resource mobilization focuses on the government as the primary stakeholder responsible for raising and managing funds for health, often through taxes. Given the uncertainty around future donor commitments, sustainability concerns, emphasis on countries' self-reliance, and increasing demand and costs for health care, there is growing interest to look beyond the public sector for additional revenues to fund health. Within this context, stakeholders agree that the private sector is an important source of additional resources that can fill global health funding gaps and help reach targets such as the Sustainable Development Goals. However, there is no consensus on what private sector domestic resource mobilization actually looks like, or its realistic potential. This primer considers a definition and examples, and examines ways to mobilize local private sector resources for health with a focus on family planning. The primer provides lessons learned and recommendations for donors who want to support future efforts in private sector domestic resource mobilization for health.

Keywords: corporate engagement, domestic resource mobilization, family planning, health financing, private sector engagement, public-private engagement, sustainability

Photo: Jessica Scranton

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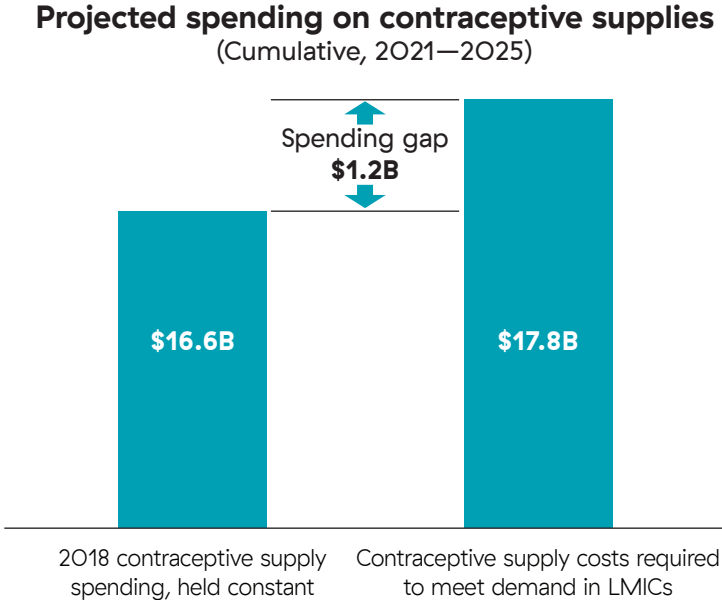
Table with multiple columns and rows of data, likely a financial or operational report, located in the bottom left corner of the image.



Introduction

Gaps in funding needed to meet global health targets highlight an opportunity for countries to raise local resources. As of 2016, the funding gap to achieve the health-focused Sustainable Development Goals in low- and middle-income countries (LMICs) was approximately \$134 billion; this gap is expected to increase three-fold by 2030 (CII 2019a). Similarly, there is a projected family planning funding gap: If spending on contraceptive supplies in 2018 remained constant from 2021 to 2025, there would be a \$1.2 billion gap in funding needed to meet the demand in LMICs (Figure 1) (RHSC 2019).

Figure 1. Projected gap in funding to meet demand for contraceptive supplies



Source: RHSC 2019

Role for domestic resource mobilization for health

Domestic resource mobilization (DRM) for health, the process by which countries raise new funds for health, offers a way to fill these projected funding gaps. They can do so in a number of ways, such as tapping into new funding sources or increasing the efficiency of spending (USAID 2019).

Traditionally, DRM for health focuses on the government as the primary stakeholder responsible for mobilizing and managing additional funds for health, often through new taxes. However, given uncertain donor commitments, sustainability concerns, emphasis on countries' self-reliance, and increasing demand and costs for health care, there is growing interest to look beyond the public sector for additional revenues to fund health.

At times, health stakeholders seem to regard the private sector as a primary solution to bridge revenue gaps, and calls for DRM for health from the private sector have proliferated. In several of its strategy documents, the Global Financing Facility cites the private sector as an innovative source of resource mobilization (GFF 2015); however, details are scarce about what the private sector's contribution could actually be. Similarly, family planning documents such as the High Impact Practices in Family Planning brief on domestic public financing and the Family Planning Financing Roadmap call on the private sector to contribute to DRM, with few details on the approach (HIPs 2018; Family Planning Financing Roadmap, n.d.). In addition, numerous documents from USAID's Center for Innovation and Impact call on the private sector to mobilize additional resources for health and family planning specifically, or advocate for private capital to unlock additional resources for health (CII 2015, 2017, 2019a, 2019b). However, these documents use many different terms for specific

strategies to mobilize private resources for health. They generally do not address the scale of funds raised and the ability to reduce the funding gap.

Purpose of this primer

Health stakeholders increasingly call upon the private sector to increase its contribution to DRM for health, but there is little consensus on what this would look like and the extent to which it can be delivered. This primer aims to examine the capacity and role of the private sector to raise additional funds for health in LMICs by suggesting a definition of private sector DRM for health, presenting examples, discussing challenges and scalability, considering applications for family planning, and identifying a potential role for donors.

Box 1

Private sector DRM for health raises private funds for health within a country. A private or public sector stakeholder may manage these funds.

Defining private sector DRM for health

This primer defines *resources* for health to be financial in nature. It does not consider other types of resources that stakeholders leverage from the private sector, such as innovations, infrastructure, or in-kind donations. Stakeholders form their definitions of private sector DRM for health based on their own perspectives. Their definition then shapes their expectation of the role DRM from private sources could play in financing health in LMICs. As a result, stakeholders define private sector DRM for health in different ways, associating it with different terms and buzzwords.

Figure 2. Many terms relate to private sector DRM for health



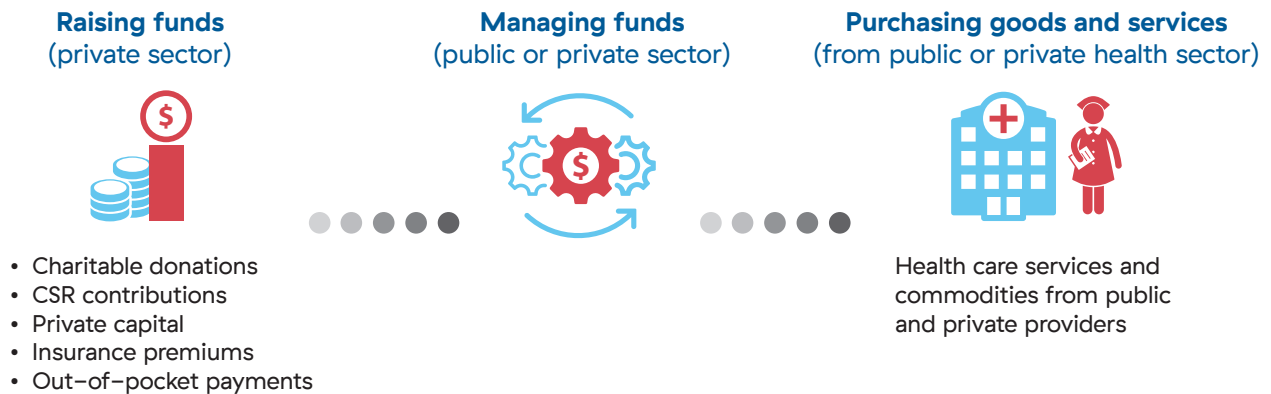
The authors reviewed terms associated with private sector DRM (Figure 2). To determine whether the examples constitute private sector DRM, the authors considered the role of the private sector in each of the three health financing functions:

1. **Raising funds:** This function mobilizes resources with the intention of funding health programs. Mechanisms that raise funds differ in terms of the source of funds, and the entity responsible for raising those funds and allocating them to a particular financing scheme, or manager.
2. **Managing funds:** A stakeholder pools and manages funds in a financing scheme. Examples include government-sponsored health insurance or other programs, or private health insurance. The stakeholder responsible for managing the funds may be the same one responsible for raising the funds.

3. **Purchasing goods and services:** Revenues raised and managed are put to use. The purchaser decides on the types and amounts of health goods and services to purchase and from whom.

DRM describes the first of these functions: raising resources for health (Figure 3). This primer defines private sector DRM for health to include any mechanism or process that raises new funds for health by mobilizing resources from the local private sector (Box 1). The primer considers mechanisms such as taxes on households to be private sector DRM because the source of funds is private individuals or households, even if the government is responsible for raising those funds and allocating them to a financing scheme. Private sector funding sources may include, but are not limited to, corporations, faith-based organizations, philanthropies, private capital investors, NGOs, households or individuals, and banks.

Figure 3. In private sector DRM, a private stakeholder provides funds for a health program



To illustrate the flow of funds across the three financing functions, consider a government tax on alcohol sales. In this example, the source of funds is out-of-pocket (OOP) payments from individuals purchasing alcohol. The government then collects and manages the tax revenues, taking the necessary steps to make funds available to government agencies that purchase health goods and services from public or private providers.

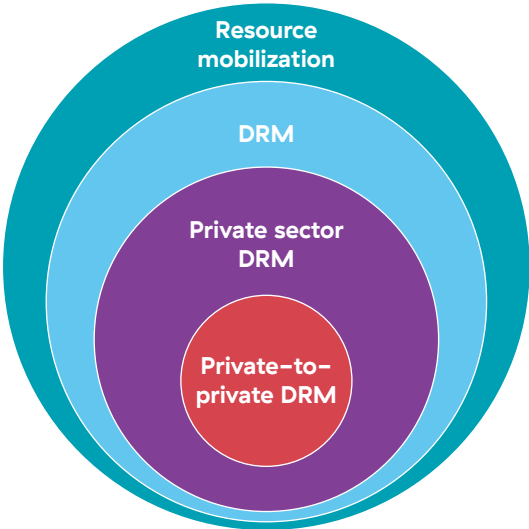
Traditionally, DRM for health focuses on the government as the primary stakeholder responsible for raising and managing additional funds for health.

Photo: Jessica Scranton



Promising strategies to tap private sector resources

Figure 4. Subsets of resource mobilization for health



Resource mobilization for health raises funds to finance health programs from domestic and international sources. This primer discusses subsets of resource mobilization, focusing on private sector DRM and private-to-private DRM (Figure 4). For example, private sector DRM is one type of DRM in which the funds raised originate from the *local private* sector. Private-to-private DRM is a subset of resource mobilization with the highest degree of private sector involvement: A private sector stakeholder raises and manages private funds and uses those funds to purchase goods and services in the private sector (Box 2).

Box 2

Private-to-private DRM for health refers to instances in which a local private sector stakeholder raises and manages funds for health and uses those funds to purchase goods and services in the private sector.

The following sections discuss the nuances of private sector DRM and private-to-private DRM and explain the logic behind this primer’s classification of examples.

Private sector DRM for health

After reviewing the gray literature on health financing, including innovative financing, DRM, and the private sector, the authors identified examples of resource mobilization mechanisms that fit this primer's definition of private sector DRM for health. These examples generally fall into nine broad categories. The categories have some overlap, with examples potentially falling into more than one category. However, their purpose is to provide a method to organize information while highlighting commonalities and differences between private sector DRM mechanisms.

1. **Lotteries earmarked for health** that the government runs, such as one in Costa Rica, earmark lottery revenues from individuals' ticket purchases to a health program, such as one for immunization.
2. **Trust funds** are private sector DRM for health if the majority of funds that they mobilize come from the private sector, and they fund health programs. Examples include Bhutan's Health Trust Fund, which mobilizes funds from several private sources in the country, such as private donations, salary deductions, and investment income. The government in Bhutan uses these revenues to fund health programs, including those for immunization (Thinley et al. 2017; Results for Development 2017).
3. **Taxes and levies earmarked for health** that constitute private sector DRM include taxes such as an alcohol tax on households or a tax on private employers. An example is Guatemala's alcohol tax that mobilizes funds for family planning commodities.
4. **Corporate social responsibility (CSR)** for health includes contributions from companies to fund programs that aim to improve the health of employees, such as workplace wellness programs or company-run health clinics. Alternatively, CSR contributions may fund a local hospital or health program, benefiting the larger community.
5. **Lending** mobilizes private sector funds by injecting private capital into a private health enterprise.
6. **Private capital investments** constitute private sector DRM because they mobilize funds for health enterprises that aim to generate a financial return. An example includes investments in a health clinic. A less conventional example of private capital investment designed to generate funds for health comes from the Nam Theun 2 project in Laos in which a quasi-government entity (that mobilized public, private, and development partner funds) invested in a hydroelectric plant. The government of Laos reinvests revenue from the plant in health and development programs (Nakhimovsky et al. 2014).
7. **Health insurance contributions** from households or individuals and private employers in the form of pre-payments (premiums) are forms of private sector DRM for health. Households can fund contributions from current earnings, savings, loans, or remittances. Private health insurance and government-sponsored health insurance schemes (where the government typically subsidizes and manages the scheme) both mobilize private sector funds for health.
8. **Out-of-pocket payments** are "direct payments made by individuals to health care providers at the time of service use" (WHO, n.d.). Individuals can fund these payments from current earnings, savings, loans, or remittances. OOP spending differs from pre-payments, such as premiums paid for health insurance, in that OOP payments cover all or a portion of an amount owed, made when an individual uses a service. Examples of OOP spending

include direct payment of fees by an individual to a provider, or cost sharing in the form of copayments, deductibles, or coinsurance, paid by individuals when they use services.

9. **Philanthropy** for health includes contributions from individuals, philanthropic arms of a private business (such as a company foundation), and charities (such as religious institutions).

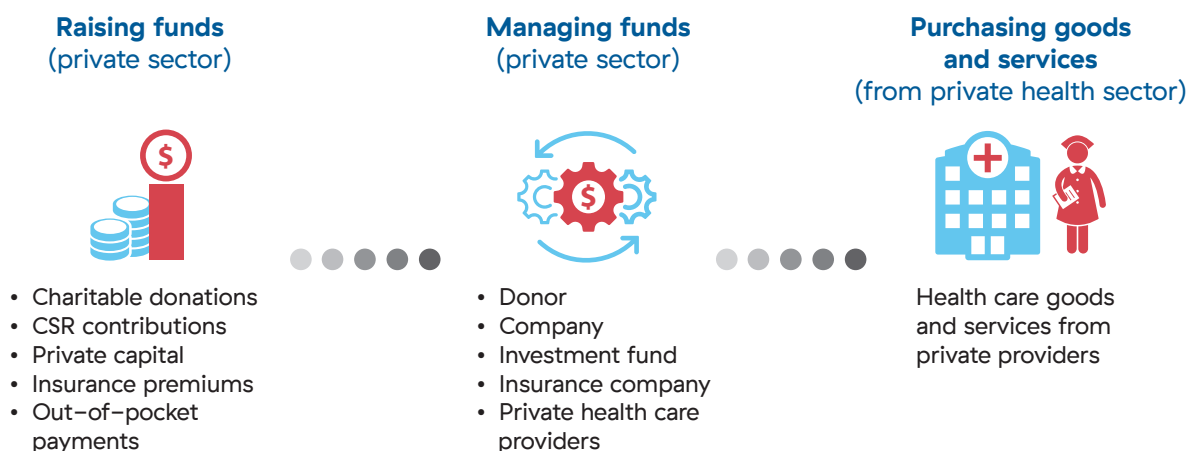
Criteria for private-to-private DRM

The aforementioned categories describe strategies to raise private sector funds for health. To understand how increased local private sector involvement would affect the scalability, impact, and sustainability of private sector DRM, the authors considered which examples illustrate this primer’s definition of private-to-private DRM (Box 2). Each example of private-to-private DRM demonstrates a mechanism that raised local private funds that a private stakeholder managed and used to purchase health goods and services in the private sector (Figure 5). This is in contrast to the

depiction of private sector DRM in Figure 3, in which only the source of funds must originate from the private sector.

The authors found only a few examples that fit this definition of private-to-private DRM for health. Instead, they observed that most examples include elements of public or private international engagement or both. In some cases, public bodies manage funds raised by private DRM (as is the case with earmarked taxes); international organizations mobilize some of the funds (as is the case with development impact bonds); and/or the mechanism uses resources for purposes other than health (as is the case with India’s diaspora bonds). While technically not DRM, another example worth mentioning is remittances from diaspora populations, often used to pay for health care of family and friends in an LMIC. While none of these examples constitute private-to-private DRM, they may illustrate that resource mobilization, DRM, or private sector DRM can raise considerable funds for health.

Figure 5. Private-to-private DRM raises private funds that private sector stakeholders manage and use to purchase health goods and services in the private sector



One can visualize the range of private sector DRM examples along a continuum of private sector engagement to purchase health goods and services (Figure 6). Examples of resource mobilization that are not private-to-private DRM for health appear on the left side of the spectrum (e.g., development impact bonds and diaspora bonds). Moving toward the right end of the spectrum, the examples eventually meet the definition of private-to-private DRM (e.g., lending and philanthropy).

Figure 6. Local private sector engagement in resource mobilization for health

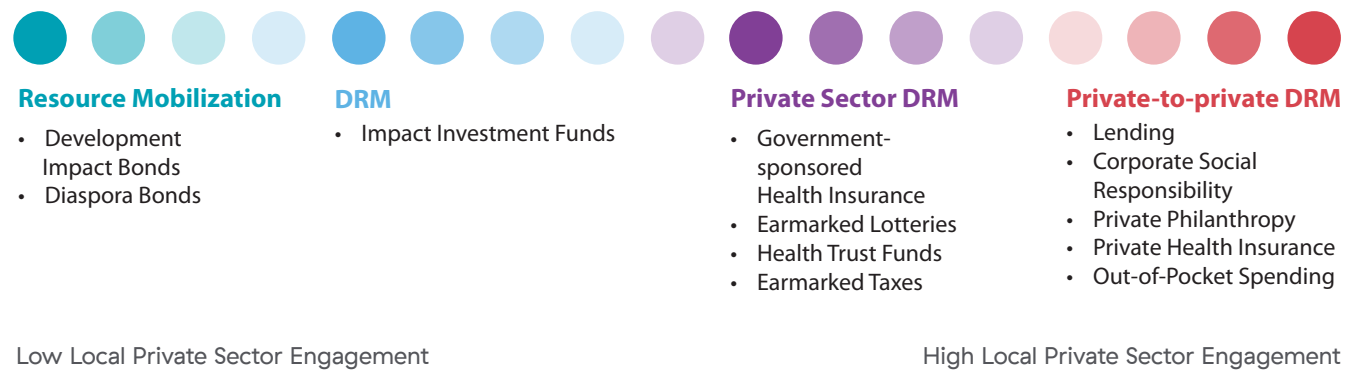


Figure 7 shows the criteria used to determine whether an example meets this primer’s definition of private-to-private DRM. For each example of resource mobilization, the authors looked at whether the source of funds, the manager of those funds, and the purchaser was private and local. The authors also determined whether the funds raised were used to purchase health goods and services in the private sector. If a resource mobilization example had a private and domestic source, manager, and purchaser, and it used funds to purchase health goods and services in the private sector, it was considered private-to-private DRM (the red rows in Figure 7). If an example of funds used for health had a source of funds that was both private and domestic, but the manager and purchaser were not private and domestic, it was labeled private sector DRM (the purple rows in Figure 7). This primer classifies impact investment funds as DRM (appearing as blue in Figure 7) because the authors did not find any examples that exclusively mobilized local private sector funds for health, although they found examples of funds that draw on private or domestic

sources, such as funds that receive capital from pension funds or private investors. Examples of resource mobilization (appearing as teal in Figure 7) mobilized new funds (for health or other development programs); however, these funds were not domestic. The examples in Figure 6 and Figure 7 are not an exhaustive list of resource mobilization, DRM, private sector DRM, and private-to-private DRM mechanisms; they are examples encountered in the gray literature that best illustrate each category.

Figure 7. The role of private actors, domestic funding, and applications to health in private sector DRM

	Source of Funds		Manager		Purchaser		Purchasing in the Private Sector	Purchasing for Health
	Private	Domestic	Private	Domestic	Private	Domestic		
Development Impact Bonds	■							■
India’s Diaspora Bonds	■			■		■		
Impact Investment Funds*	▵	▵		■	■			
Government-sponsored Health Insurance	■	■		■		■		■
Costa Rica’s Lottery for Immunization	■	■		■		■		■
Bhutan’s Health Trust Fund	■	■		■		■		■
Guatemala’s Alcohol Tax for Family Planning	■	■		■		■		■
CRDB Bank’s Lending	■	■	■	■	■	■	■	■
Caribbean Apparel’s CSR	■	■	■	■	■	■	■	■
The Dangote Foundation’s Philanthropy	■	■	■	■	■	■	■	■
Private Health Insurance in Kenya	■	■	■	■	■	■	■	■
OOP Payments for Family Planning	■	■	■	■	■	■	■	■

■ Resource mobilization ■ DRM ■ Private sector DRM ■ Private-to-private DRM

*The examples of impact investment funds that the authors found do not exclusively mobilize local private sector funds for health.



NATIONAL BANK

Examples of private-to-private DRM for health

Private sector DRM provides a way to mobilize additional resources for health as countries become more self-reliant and donor support declines. Five of the nine private sector DRM categories discussed previously best represent examples of *private-to-private* DRM for health:

1. Lending
2. Corporate social responsibility
3. Philanthropy
4. Private health insurance contributions
5. Out-of-pocket payments

The following pages provide an example for each of these five mechanisms and illustrate nuances across the three financing functions and the scale of resources raised.

Lending

Loans that raise capital for health enterprises are an example of private-to-private DRM. The primary motivation for a lender is the income earned from interest and any fees on loans. Lenders include commercial banks, microfinance institutions, community groups, and informal lenders.

CRDB Bank

CRDB Bank in Tanzania demonstrates the role that commercial banks can play in private-to-private DRM for health: By lending money to a health enterprise, the bank mobilizes capital that would not otherwise be available to the business. The case of CRDB Bank also illustrates the catalytic role that donors can play in private sector DRM. CRDB Bank received its first Development Credit Authority (DCA) guarantee in 2014, amounting to \$2.8 million. A DCA guarantee is an agreement between USAID and a financial institution that typically guarantees 50 percent of the loan principal, with the intention of reducing the risk of lending to underserved markets and demonstrating the commercial viability of those markets (USAID 2018).

In Tanzania, the DCA remained unutilized and CRDB Bank had not disbursed any health sector loans as of 2017. Subsequently, USAID, through the SHOPS Plus project, provided technical assistance to stimulate use of the DCA (Estevez 2019). This support helped bank managers see that the health market presents a significant business opportunity. As a result, CRDB Bank established a unit that specializes in lending to the health industry to scale up activities. As of 2019, the bank had almost fully utilized the guarantees available under the DCA as it expanded loans targeting the health sector. The value of the non-DCA health loan portfolio eventually surpassed the value of the DCA-backed portfolio, and the portfolio continues to grow. By 2019, CRDB Bank had made an additional \$8.8 million in DCA-guaranteed loans and loans without guarantees to the health sector in Tanzania. Loans financed inputs such as equipment and provided working capital or funds for investment.



CRDB Bank's lending
to the health sector,
2017–2019:
\$8.8 million

In the case of one medical hospital in Dar es Salaam, a DCA-backed construction loan provided capital for the hospital to expand its physical capacity to serve increased numbers of patients expected after the hospital contracted with Tanzania's National Health Insurance Fund. Following the expansion, the hospital served twice as many patients each month. The example of CRDB Bank demonstrates the catalytic effect that DCA guarantees can have on lending and the viability of commercial lending in the absence of any guarantee.

Discussion

The average amount loaned to providers tends to be small relative to the other private-to-private DRM examples that this primer discusses. This is partly because the size of a loan corresponds to the amount that the health facility requires and is able to repay. However, when the entire health portfolio of a commercial bank and other types of lenders are taken into account, the total funding mobilized is greater.

Financial institutions may view health businesses as social rather than for-profit enterprises and perceive higher risk associated with lending to them. They may also be reluctant to lend to health enterprises, believing that the enterprises compete with publicly provided or donor-funded health services. To address such concerns, lenders may benefit from adapting policies and processes used

to extend credit to other sectors. This could enable them to better analyze the creditworthiness of health enterprises. An important capability for lenders is to identify and value assets specific to a health enterprise that serve as collateral for a loan, such as diagnostic equipment. Another concern for lenders is how to mitigate reputational risk should they have to seize assets of a facility in the case of default. Conversely, health providers may lack business skills needed to manage a growing health business or records required by commercial banks to provide loans.

Corporate social responsibility

This primer defines CSR in the context of DRM for health to include activities that a company invests in with the goal of improving the health and well-being of its employees, participants along its value chain, or the community at large. A company often has dual motivations for investing in these activities: There can be a business as well as a social case for investing in a venture such as a workplace wellness program, a company-run health clinic, or donating to a hospital. A slightly different example of CSR is that of employer-sponsored benefits, in which employers pay for employees' medical expenses, usually in the absence of any employer-sponsored health insurance. We differentiate CSR from corporate philanthropy in that the company makes the financial contribution; meanwhile, philanthropy comes from a separate entity, such as a foundation set up by but operating independently from the company or wealthy individual(s).

While CSR is typically voluntary, some countries such as India require companies earning above a certain financial threshold to allocate a proportion of their profits to social causes. Additionally, India's regulations do not consider programs that exclusively benefit a company's employees to be CSR. Between 2013 and 2017, these regulations raised \$422 million of domestic philanthropic and CSR funding for health (OECD 2019).¹



India's philanthropic and CSR funding for health, 2013–2017:
\$422 million

¹ Philanthropic and CSR contributions are presented together because a disaggregated estimate of CSR contributions was not available.

Caribbean Apparel

Caribbean Apparel, a clothing manufacturing company in Port-au-Prince, Haiti, is one of numerous examples of a local company implementing a workplace wellness program. Caribbean Apparel provides family planning, gynecological, and other health services to workers through an on-site clinic that serves more than 2,600 workers. After receiving technical assistance from NGOs to expand and improve the clinic's services, the company has sustained this program without external funding (UN Foundation, Evidence Project, and HERproject 2017).

Discussion

In countries like India, where regulations mandate CSR, it may be possible to mobilize large sums of philanthropic and CSR funding for health. However, CSR remains voluntary in most countries, limiting programs' potential for larger-scale impact. CSR programs reduce a corporation's bottom line. While a company may experience returns on CSR investments in the form of increased brand visibility and loyalty—or increased employee productivity—in periods of lower financial performance, managers may struggle to justify expenses for a voluntary CSR initiative.

Philanthropy

Philanthropy that constitutes private-to-private DRM for health may come from a number of different local sources, including individuals and foundations. The motivation for philanthropy is social impact or a charitable mission as in the case of faith-based NGOs; there is no expectation of a financial return or benefit. This primer differentiates philanthropy from CSR in that philanthropic contributions come from a separate entity, such as a company's foundation or a charity. Additionally, many companies choose to support causes that relate to their core business or mission, or their owners' interests. In addition to donations, other revenue for philanthropy may come from investment income on funds placed in an endowment or other investment vehicle.



The Dangote Foundation's endowment: **\$1.25 billion**

The Dangote Foundation

The Dangote Foundation is a private philanthropy that contributes considerable resources to improving health in Nigeria. It is the largest foundation in Africa, with an endowment of \$1.25 billion (ONE [n.d.]). The foundation is “locally focused, but globally minded.” It has contributed to a number of health initiatives, including Nigeria's Saving One Million Lives program, which expanded access to primary health care; Saving One Million Lives grants may go to health NGOs or other organizations (ONE [n.d.]).

Discussion

Philanthropic endeavors may be one of the most scalable ways to mobilize additional private-to-private resources for health. A concern surrounds the ethics of allowing an individual or group of individuals (or an individual's or group's foundation) to influence a country's health priorities. Ideally, private philanthropies would act in collaboration with government counterparts; however, this is not a requirement of philanthropic giving. In the end, a private donor retains power to influence national priorities based on funds it provides, irrespective of national priorities.

Private health insurance

Purely private health insurance schemes that operate without government subsidy exemplify private-to-private DRM. In high-income countries, private health financing schemes (mostly insurance) have evolved over time alongside government schemes that anchor efforts to achieve universal health coverage (Kimball et al. 2013). Revenues of private health insurance companies continue to rise and are projected to reach approximately \$2.9 trillion globally by 2025 (Finn et al. 2017).

Philanthropic endeavors may be one of the most scalable ways to mobilize private-to-private resources for health.

Private health insurance products are distinguishable on at least two main dimensions: *who offers them* and *which population segment they target*. On the first dimension, private health insurance products can be formal, meaning they are offered by licensed insurers or their affiliates and are subject to regulation. Alternatively, private health insurance products can be informal, meaning they are unregulated and typically managed by community members not trained in insurance. On the second dimension, most private health insurance products target one of two distinct demographic groups: (1) affluent and formal sector clients or (2) less affluent households and informal sector clients. Informal insurance programs often referred to as community-based health insurance typically rely on donor funding and operate on a small scale. They tend to be a population's first foray into health insurance, leveraging social capital of communities and building initial experience with insurance. Meanwhile, licensed insurers tend to target formal sector and affluent households; their insurance products usually cover very small numbers of people, often far less than 10 percent of the population. However, increasingly in LMICs in Africa and Asia, simple, mobile-enabled, and more affordable private health insurance products that complement public programs and target lower-income households are scaling up.

According to the GSMA's Mobile Insurance Survey, mobile-enabled insurance policies in force across 27 countries nearly doubled from 31 million in June 2015 to 61 million by June 2017. Of these, about 26 percent—nearly 17 million policies—were health insurance. An additional 8 percent (4.9 million policies) included health benefits bundled with other benefits, such as coverage for financial risks of death, disability, or accidents (Raithatha and Naghavi 2018).

Private health insurance companies in Kenya

Health insurance premiums in Kenya, where economic growth and regulation are robust, grew by a compound annual growth rate of 22 percent between 2014 and 2017 (Max et al. 2019). Currently, about 8 percent of Kenyans are covered by private health insurance, and the top six insurers that cover 80 percent of the market expanded by a rate of 48 percent from 2014 to 2016 (Max et al. 2019). This rapid growth rate is possible when the market is nascent and absolute numbers of insured people are small; it will taper as the market matures. Jubilee Insurance Company is the current market leader in health insurance in Kenya. It also operates in four other East African countries. Across all private insurers in Kenya, the net earned health insurance premiums in 2018 amounted to \$267 million² (Insurance Regulatory Authority 2019).



Net earned private health insurance premiums in Kenya, 2018: **\$267 million**

Discussion

Global experience shows that purely voluntary, private health insurance schemes with comprehensive benefits struggle to reach scale and viability and do not contribute materially to universal health coverage (Kimball et al. 2013). This is due to multiple factors, including unaffordable premiums, poor quality health services, high administrative costs, cumbersome processes, medical inflation, adverse selection and moral hazard, and limited understanding of and demand for insurance. However, private health insurance can play a role in a country's health financing efforts; among other reasons, no government can provide all services to everyone, at all times, free of charge.

A challenge for private (and public) health insurance schemes is the common mismatch between what services are covered (the benefit package) versus what services clients need and want. Traditionally, health insurers collect and pool funds from a sufficiently large number of enrollees to cover high-cost, infrequent, randomly occurring health risks. However, increasingly it is the “constantly dripping faucet,” the ongoing need for primary and preventive care such as family planning or chronic disease management, that fuels burdensome household spending and from which clients seek protection.

² In 2018, the net earned health insurance premiums in Kenya were Ksh 27.13 billion; this amounts to approximately \$267 million at the mid-year 2018 exchange rate.

Out-of-pocket payments

OOP payments for health include spending by individuals at the time of service use. These do not include pre-payments for health care, such as premiums or taxes (WHO [n.d.]). OOP payments made from all sources—including earnings, savings, remittances, loans, and transfers or subsidies—represent an opportunity to mobilize private resources from households who can afford them.

However, targeting only those households with the ability to pay, and knowing how much they can afford to pay, is difficult. In a well-functioning market, households could choose to obtain free health services in the public sector or in the private sector, including retail pharmacies, drug shops, and other outlets at a cost. If wealthier households are able to seek care from private facilities that require an OOP payment, this may free up public resources for poorer households.

Digital financial platforms such as M-Tiba are enabling payments for health from more people, especially the unbanked and those working in the informal economy. In Kenya, M-Tiba allows nearly 5 million clients and their sponsors to “save, send and spend” for health (M-Tiba [n.d.]). This includes making OOP payments to health providers as well as enrolling in and paying premiums for health insurance, all via a mobile phone application.

Out-of-pocket payments for family planning

Data on where poor and wealthy women obtain modern contraception illustrate the opportunity to better target the use of OOP payments for family planning services so that wealthy women who can pay out of pocket for contraception do so. As Figure 8 demonstrates, in 37 countries with Demographic Health Survey data more recent than 2012, more than 2 in 10 women in the poorest income quintile rely on private sources, while almost half of the wealthiest women get their modern contraception from public sources (Bradley and Shiras 2019). It is unclear what causes these trends. Reasons may include poor women obtaining contraception in private facilities if they lack a nearby public facility offering the method they seek. Conversely, wealthy women who obtained contraception from public facilities may have been willing and able to pay for them at a private facility, but there was no trained private provider accessible to them. The issue is how to ensure that those who can afford to pay have the opportunity and choice to make these payments, thereby freeing up public sector resources for poorer women.

Figure 8. Looking at 37 countries, opportunities exist to free up public sector resources for poorer women to access contraception



Discussion

The goal with OOP payments is to apply them progressively to those who can afford to pay, and minimize or eliminate them for poorer populations. OOP payments for family planning (long-acting methods in particular) or other health services are problematic when they cause financial hardship among those who do not have the ability to pay. However, OOP payments remain a part of the health financing landscape given countries’ inability to finance all health services for everyone at all times. If OOP payments (whether to public or private providers) are unaffordable, affected households may face catastrophic health expenditures or may simply forgo care due to an inability to pay. Ideally, wealthier households would make the majority of OOP payments, thereby freeing up additional public resources to fund health care for poor and vulnerable populations. However, challenges to target poor and vulnerable populations persist. Market segmentation can help programs to identify target groups, but accurate and cost-effective means testing remains difficult.

Private sector DRM strategies for health that are not private-to-private

Several examples of resource mobilization listed in Figure 7 do not constitute private sector DRM nor private-to-private DRM for an array of reasons. However, these examples highlight important lessons about designing private sector DRM mechanisms.

Guatemala’s alcohol tax for family planning: A 15 percent alcohol sales tax raised more than \$7.3 million for family planning and sexual and reproductive health in 2016 (HIPs 2018). Consumption taxes such as Guatemala’s receive attention for their revenue-raising potential; however, it is important to understand that passing legislation for such taxes is no easy task. Guatemala’s alcohol tax was a hard-fought victory and required several years of lobbying and advocacy from civil society organizations. This is one of the few examples of private sector DRM the authors found that raise funds specifically for family planning (Box 3).

Bhutan’s Health Trust Fund: Bhutan’s Health Trust Fund is a government agency that raises private funds from several sources, including private donations, a 1 percent salary deduction, and investment income (Results for Development 2017). In 2014, the fund contributed more than 5 percent of the country’s total health expenditures (Thinley et al. 2017). While an interesting and impressive example of mobilizing revenue from the private sector, this mechanism would be difficult to replicate in other countries, as Bhutan’s small size and ability to generate popular support for health creates a unique operating context.



Guatemala’s alcohol tax revenues, 2016:
\$7.3 million



Costa Rica's annual
lottery revenues:
\$100,000–200,000

Costa Rica's lottery for immunization: Each year, Costa Rica's lottery raises about \$100,000–\$200,000 for vaccines. This amounts to about 1 percent of total vaccine financing (Results for Development 2017). A unique aspect of this example is Costa Rica's enabling environment, which includes a long history of using lottery revenues to fund social welfare programs. This reduced the need to generate political will and popular support that other countries may face when attempting to establish a new earmarked lottery.

Impact investment funds: The authors found impact investment funds that mobilize new resources for development in LMICs. However, none of them completely fit this primer's criteria for private-to-private DRM for health because they neither focus on health nor mobilize a majority of their funds from the local private sector. Nevertheless, these funds could serve as models for future efforts in private sector DRM for health.



India's revenues from
three diaspora bond
offerings:
\$11 billion

India's diaspora bonds: India's central bank, the State Bank of India, issued diaspora bonds in 1991, 1998, and 2000. Collectively, these bonds raised over \$11 billion (Nakhimovsky et al. 2014). These bonds do not fit this primer's definition of DRM for health because the funds did not originate from within India, the public sector manages the funds, and the bonds did not earmark funds for health. However, this example demonstrates the large amount of funds that diaspora populations can mobilize and suggests one way that countries can reduce their funding gap for health, especially as donor support decreases.

Development impact bonds: Development impact bonds mobilize funds from a mix of sources, including international donors and the international private sector, to finance social programs including those for health. Investors (typically from the private sector) provide funds for social services that are repaid (often by the public sector or international donors) if the program achieves its targets. While development impact bonds generate additional revenues for health, they have yet to mobilize local private sector resources. However, they could be a way to engage the local private sector as investors in health programs.

Box 3. Applicability of private sector DRM to raise funds for family planning

Certain strategies for private sector DRM for health may be more suitable to mobilize funds for family planning. The public sector and donors have historically shouldered a large portion of spending on family planning, leading to more examples of private sector DRM than of private-to-private DRM that mobilize funds for family planning. One of these examples is Guatemala's alcohol tax, which earmarked revenues for family planning commodities. CSR and philanthropy are two additional strategies that may be good candidates for raising funds for family planning. An example of CSR is Twinings' program in Kenya for its supply chain workers, which expanded access to voluntary family planning services (Every Woman Every Child 2019).

Private sector DRM strategies discussed in this primer that may be less applicable to family planning include lending and impact investing. This is because health providers would likely use new capital to purchase equipment or make investments that may not focus directly or exclusively on provision of family planning services and commodities. Additionally, private health insurance often covers curative care but excludes family planning from benefit packages. Health insurers have little incentive to cover family planning when the government and donors have historically paid much of the cost of these services and commodities.

Looking ahead, private sector DRM strategies may become more relevant for family planning as this health area integrates more fully with primary and preventive health care service delivery, and family planning has more opportunities to benefit from increased resources for health.

Catalytic role for donors

Private sector DRM does not happen in isolation from broader efforts to mobilize resources, strengthen the health system, and advance toward universal health coverage. These efforts can range from advocacy to improve the enabling environment for health financing, stimulating private sector engagement and competitive markets, improving governance, or investing in health information systems and digital technology. In some cases, private sector DRM may benefit from public sector or international donor support of systemic improvements to catalyze financial investments, as discussed in this section. Donors can help in several ways.

Play the role of “matchmaker” by introducing health enterprises to potential investors and lenders. USAID’s Saving Lives at Birth Grand Challenge is an example of a donor-organized event with the purpose of connecting investors with marketable health innovations that save the lives of mothers and their babies. The Grand Challenge provides an opportunity for nascent innovators to obtain seed capital to develop their business case, as well as publicity that helps them attract long-term investors who will help bring their products to market (CII 2017).

Mitigate the risk associated with investing in or lending money to health enterprises. Donors can reduce the risk of working with health enterprises for financial institutions by mitigating the risk of default on a loan or an investment with a negative financial return. Risk-mitigation instruments such as USAID’s DCA guarantees and third-party loan insurance ensure repayment of a portion of a lender’s principal by the guarantor or insurer if the borrower defaults on the loan. Similarly, donors

can mitigate the risk of health investments through a range of strategies, such as by taking first-loss positions in impact investment funds (GIIN 2013).

Support technical assistance that increases health enterprises’ ability to access credit and financial institutions’ capacity to lend.

Financial institutions experience a learning curve when making health investments. Similarly, health providers often require training to increase their capacity to operate a sustainable business. Donors such as USAID have funded technical assistance to private health providers and financial institutions with the goal of increasing their readiness to make and receive loans (SHOPS Plus Project [n.d.]).

Catalyze private sector DRM through technical assistance. Donor-supported technical assistance can facilitate private sector DRM in a number of different ways. For example, while there may be interest from a corporation in CSR, the company may lack the knowledge or capacity to establish this type of program; donor-supported technical assistance can play an important role to help a company establish a sustainable and impactful CSR program. Similarly, a country may be interested in establishing an earmarked consumption tax for health but may lack the research and advocacy necessary to pass the legislation; donor-supported technical assistance can provide evidence and capacity building to enable countries to advocate for earmarked taxation.

Looking
ahead



Looking ahead

Donors are preparing to reduce and eventually stop funding for health programs in LMICs as demand for health care continues to grow and countries become more self-reliant. In this context, the private sector has received increased attention as a potential solution to fill the funding gap to finance priority health services.

Box 4. Scalability of private sector DRM

This primer considers the scale, or amount, of funds raised by strategies for resource mobilization with a focus on those that include private sector engagement. A few of these strategies have raised substantial amounts of funding for health, such as private philanthropy, consumption taxes, and diaspora bonds. Others that are less tested or have limited potential to cover the population equitably are development impact bonds, earmarked lotteries, and private health insurance. Stakeholders should consider the effort and resources required for specific strategies on a case-by-case basis.

This primer discusses a range of solutions that can fill the funding gap with varying degrees of local private sector involvement (Figure 6). Examples that feature the greatest level of private local engagement (private-to-private DRM) include philanthropy, CSR, private health insurance, commercial lending, and OOP spending. Other examples of resource mobilization that feature less local private sector engagement range from earmarked taxes to diaspora bonds and development impact bonds. While examples of private sector DRM, DRM, and resource mobilization typically include a smaller role for the local private sector and a more prominent role for the public sector or international donors, they still represent potentially important ways to mobilize additional, scalable, and sustainable funding for health. Donors can also catalyze private sector DRM in a number of supporting roles, such as mitigating the risk associated with health lending and providing technical assistance to enhance private sector DRM efforts.

Below are recommendations for donors considering investments in private sector DRM.

1. **Assess the fit of a DRM strategy within a country's context.** Many of the examples of private sector DRM that the authors found are relatively untested. This should not discourage donors from exploring ways to support private sector DRM, but it highlights the need to assess a country's context and which DRM options offer the best fit. At the same time, donors must gauge the feasibility of a private sector DRM strategy, including whether its potential scale, impact, and applicability to a particular health need make sense in a country.
2. **Encourage resource mobilization strategies that support collaboration between the public and private sectors.** When considering the potential scale and impact of private-to-private DRM strategies, the authors found that focusing on private-to-private DRM may exclude broader examples of resource mobilization that have the potential to raise funds for health (Box 4). There is potential in strategies such as consumption taxes, trust funds, and diaspora bonds that highlight how the public sector can facilitate the flow of private sector resources for health.
3. **Strengthen the enabling environment for private investment in private health.** A favorable enabling environment can amplify efforts to mobilize private DRM for health. Donors can lend support at the systems level: helping to improve regulation, supervision, and quality assurance of private health service delivery; developing guidelines for private insurance products that complement public programs for low-income households; or investing in health information systems and digital technology.
4. **Consider catalytic investments in private sector DRM that will contribute to countries' self-reliance.** Donors should embrace their potential to support private sector DRM, especially through catalytic support such as technical assistance, risk mitigation, and matchmaking for investors and lenders. While private sector DRM that minimizes donor involvement may seem attractive for its apparent sustainability, solutions that mobilize catalytic support from donors may be more sustainable in the long term.

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Sustaining Health Outcomes through the Private Sector (SHOPS) Plus is a five-year cooperative agreement (AID0AAA-15-00067) funded by the United States Agency for International Development. The project strategically engages the private sector to improve health outcomes in family planning, HIV, maternal and child health, and other health areas. Abt Associates implements SHOPS Plus in collaboration with the American College of Nurse-Midwives, Avenir Health, Broad Branch Associates, Banyan Global, Insight Health Advisors, Iris Group, Population Services International, and the William Davidson Institute at the University of Michigan.



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