



TECHNICAL BRIEF

Photo: Pexels, Athit Perawongmetha

# Blended Finance for Healthcare Services

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## Introduction

**This technical brief is intended to serve as a practical guide for including healthcare services financing in program design and implementation; specifically, within the healthcare sub-sector of small and mid-size enterprises (SMEs) and social enterprises.** The primary audience for this brief is development practitioners who are leading healthcare sector program design and implementation efforts. This document aims to provide targeted design considerations and guidelines for how to frame the discussion – including practical advice around potential market opportunities and the respective stakeholders, financing needs and challenges to accessing finance, and relevant innovative financing mechanisms to unlock capital. Any given opportunity and its recommended design, however, will depend significantly on a range of project/enterprise-specific characteristics, including geography, value chain, stakeholders, size, sophistication, among others.

Designing programming to support the adoption of innovative business and financing models in the healthcare sector has been gaining traction in the wake of shifting disease patterns and funding mixes. Key healthcare indicators have improved significantly at the global level in the last two decades, however, there has been a recent slowdown in these trends. In addition, the changing disease mix toward non-communicable diseases continues to test the abilities of legacy health systems. In that light, more countries are adopting universal health coverage with a steady focus on engaging the private sector and social enterprises in various degrees and forms. Countries and health ecosystems are also looking at innovative business models and technologies to aid the effectiveness and efficiency of this healthcare shift.

The total additional funding needed by low- and middle-income countries (LMICs) to achieve the global health SDGs is estimated at \$134 billion annually and is expected to reach \$371 billion by 2030<sup>1</sup>.

## Context

**Healthcare across LMICs has received increased governmental spending, but funding gaps remain.** While the global average for public sector spending as percentage of GDP rests at 9.9%, the figure for LMICs languishes at 2.9% despite a 20% jump between 2010 and 2015. Consequently, out of pocket expenditure (OOPE) as percentage of total health expenditure sits at 40-45% for LMICs — double that of high-income countries<sup>2</sup>. In parallel, donor funding has stagnated with official development assistance (ODA) declining from a 9% annual YoY increase from 2000-10 to a 1.6% annual increase between 2010 to 2018<sup>3</sup>. As a sub-trend, donor funding has also been steadily shifting away from Asia and Latin America toward Africa<sup>4</sup>.

In this context, SMEs and social enterprises can play increasing roles in delivering healthcare in LMICs. **However, current funding for healthcare is disproportionately focused on established players, urban areas, models catering to high-income populations, and specialty services.** Subsequently, healthcare SMEs and enterprises suffer from a lack of adequate capital. This can be attributed to a mix of factors, including lack of pipeline, high risk profiles, long return horizons, and inability of traditional financial institutions to move beyond asset-backed lending.

**Blended finance is increasingly seen as an important part of the toolkit for driving the growth of SMEs and in engaging the private sector.** The number and value of blended finance transactions in health has been growing steadily over the years, however, health has remained a relatively low focus overall at only 6% of the total blended finance transactions so far. This may change, with 19% of upcoming transactions related to health.<sup>5</sup>

Specifically, blended finance can offer a significant impetus to high-risk models and innovations in service delivery. This requires financial structures that involve more patient capital, flexible repayment terms, and higher risk-taking ability. Donors and implementing partners have a critical role in addressing these market needs and enabling structures that “crowd in” private capital and allow for greater innovations in service delivery.

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1 Source: SDG Health Price tag (WHO)

2 Source: World Bank Open Data

3 Source: OECD

4 Source: Financing Global Health (IHME)

5 Source: The State of Blended Finance 2020 (Convergence)

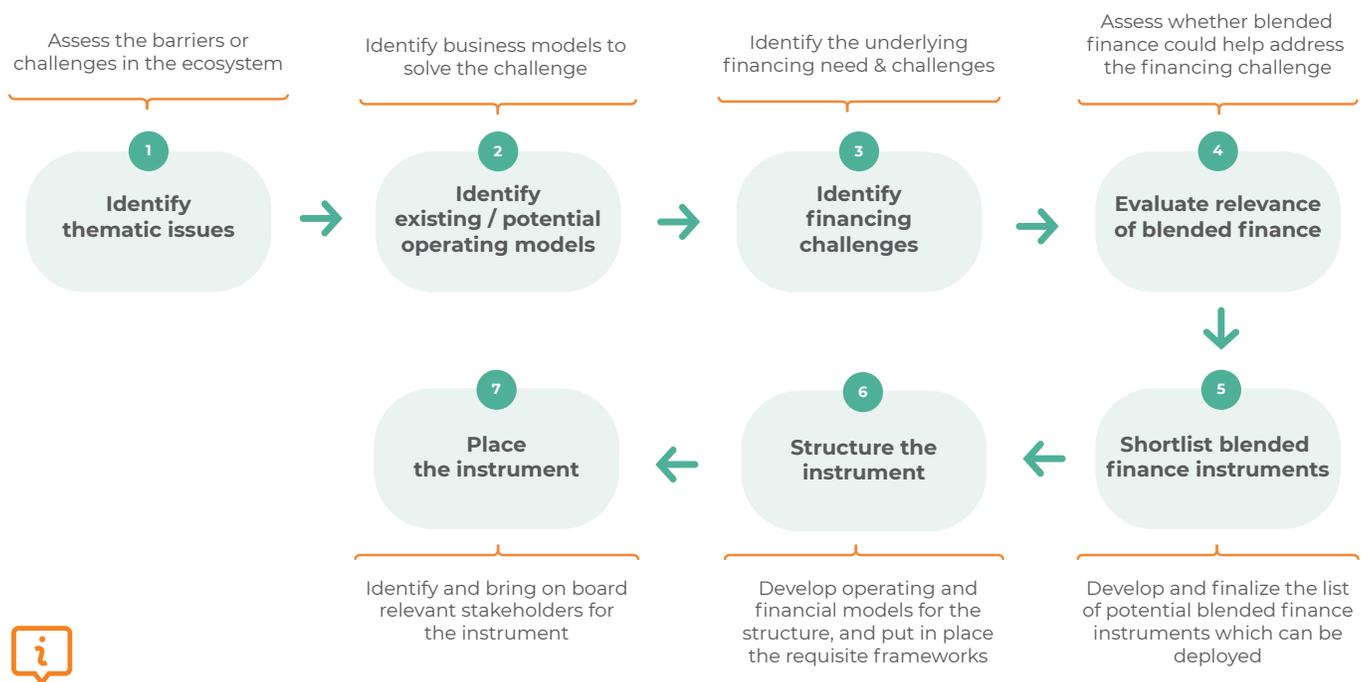
## Methodology

This brief highlights three core segments where blended finance can support SMEs and social enterprises and illustrates a problem-to-solution approach to identify the right instruments step-by-step in the subsequent tables:

1. **Strengthening existing healthcare service delivery models:** providing accessible capital to small-scale, brick-and-mortar healthcare practices for infrastructure.
2. **Fostering new and innovative business models:** innovative pilots of models that aim to bridge the access and quality gap in less accessible and affordable geographies (e.g., teleradiology and telemedicine, healthcare analytics, disintermediated supply chain and trading companies).
3. **Enabling transition of providers into pooled procurement mechanisms:** existing and new healthcare providers looking to cater to public-sector healthcare purchasing mechanisms. Financing can be aimed at both upfront costs to buy equipment and leasing infrastructure as well as working capital to bridge the gap between provision of services and payment by the public sector.

### Step-by-step approach to blended finance

Developed by KOIS



Do note that this brief covers only steps 2 to 5 of the framework within its focused scope. More detailed illustrations of such a step-by-step approach can be found in [this](#) blended finance roadmap report by USAID.

Table 1: Target market opportunities

	IMPACT	FINANCING NEED	CHALLENGES TO ACCESS FINANCING NEEDED
<b>Strengthening existing healthcare service delivery models</b>			
<p><b>Strengthening existing business models:</b> small-scale brick-and-mortar healthcare practices</p>	<ul style="list-style-type: none"> <li>Capacity building of staff can lead to significant increase in quality of care and ability of service providers to pass on cost benefits to consumers; upskilling in specialty areas and community outreach programs can lead to creation of additional revenue streams and sustainable businesses and increased access for consumers</li> </ul>	<ul style="list-style-type: none"> <li>Collateralized concessional lending for infrastructure and equipment; non-collateralized revenue-based lending for operating expenses (OPEX); skilling loans for capacity building; grants for community outreach programs</li> </ul>	<ul style="list-style-type: none"> <li>Low creditworthiness due to lack of past financial history and low resale value of assets due to geographical factors; long payback horizons and low scalability; inability of traditional lenders to offer profit and loss (P&amp;L) based loans</li> </ul>
<b>Fostering new and innovative business models</b>			
<p><b>Telemedicine and telediagnosis models</b></p> <p><b>Healthcare analytics providers</b></p> <p><b>Disintermediated trading and supply chain cost</b></p>	<ul style="list-style-type: none"> <li>Bridging the rural-urban demand- supply gap for healthcare services and increasing healthcare access</li> <li>Better epidemic and outbreak monitoring, centralized antibiotic resistance management</li> <li>Reduced rate of spurious/ sub-standard products due to abridged supply chains; developing inventory management technology to lower costs of inventory and higher range of products for SMEs; aggregated demand lowers cost of goods for intermediaries as well as end users</li> </ul>	<ul style="list-style-type: none"> <li>Technical assistance on managing product-service continuums as telemedicine providers transition to service models</li> <li>Grants for data aggregation and developing new products for public health; patient equity to finance opex costs; technical assistance to create public sector linkages</li> </ul>	<ul style="list-style-type: none"> <li>Low asset base to provide as collateral; long gestation period for demand generation and creating customer stickiness</li> <li>Lack of an established monetization model - As epidemic monitoring is a public health issue, monetizing analytics requires a longer time horizon to convert latent demand by generating adequate public sector interest and payment</li> </ul>
		<ul style="list-style-type: none"> <li>Short-term working capital for value chain financing</li> </ul>	<ul style="list-style-type: none"> <li>Market rates are too high given lack of collateral and risk of obsolescence of products, especially PPEs</li> <li>Tenors tend to be inflexible while payables period for intermediaries tends to be highly variable</li> </ul>

	IMPACT	FINANCING NEED	CHALLENGES TO ACCESS FINANCING NEEDED
<b>Enabling transition of providers into pooled procurement mechanisms</b>			
<b>Service providers catering to large-scale public sector purchasing</b> <ul style="list-style-type: none"> <li>Healthcare delivery</li> <li>Diagnostics services</li> <li>Sale plus maintenance services for equipment</li> </ul>	<ul style="list-style-type: none"> <li>Reduces total cost of providing services for public sector by outsourcing</li> </ul>	<ul style="list-style-type: none"> <li>Project financing and working capital</li> </ul>	<ul style="list-style-type: none"> <li>Public sector procurers tend to pay with sizeable lag after delivery of services. SMEs and social enterprises are unable to enter these contracts due to lack of upfront project financing and inability to raise capital from lenders</li> </ul>
		<ul style="list-style-type: none"> <li>Scale-up financing (e.g., product development, sales and marketing, customer acquisition, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>Lack of entrepreneurial capacity to fundraise from venture capital providers (particularly for social entrepreneurs)</li> <li>Resistance from venture capitalists to fund public sector-focused enterprises due to associated business risks e.g., non-payment for large orders</li> </ul>

Table 2: Relevant innovative financing instruments<sup>6</sup> (see Annex 1 & 2 for additional details)

TARGET MARKET OPPORTUNITIES	FINANCING NEED	MATURITY / SOPHISTICATION OF ENTERPRISE AND/OR MARKET	RELEVANT INSTRUMENT <sup>7</sup>	RISK PROFILE
<b>Strengthening existing business models:</b> small-scale brick-and-mortar healthcare practices	<ul style="list-style-type: none"> <li>Capital for infrastructure and equipment; lending for opex costs and capacity building; funding for community outreach programs</li> </ul>	<ul style="list-style-type: none"> <li>High maturity</li> </ul>	<ul style="list-style-type: none"> <li>Collateralized and non-collateralized debt with flexible/concessional/first-loss terms</li> <li>Guarantees</li> </ul>	<ul style="list-style-type: none"> <li>Low risk (steady businesses with highly stable cashflows and sustainable models although lacking scalability)</li> </ul>
			<ul style="list-style-type: none"> <li>Conditional grants (based on % of low-income population served) for community-level activities and demand generation</li> </ul>	

6 Traditional commercial debt and equity financing instruments can often fail to offer terms sufficiently adapted to cover healthcare sector financing needs. Specifically, we highlight a range of instruments (including quasi-grants, debt, mezzanine finance, and risk-sharing mechanisms) that can be tailored to meet the need for flexibility, concessionality, and first-loss capital provisions. It is important to note, however, that as customization and non-standardization/innovation of financial instrument are increased to address the unique needs of an enterprise, the greater the complexity (for both investor and investee) and the higher the transaction costs. Please refer to Annex 1 and Annex 2 for further details.

7 Deploying equity instruments may be attractive as it can provide investees with much-needed patient capital. Such equity instruments, however, can be particularly difficult for investors to appraise an enterprise's fair valuation at initial investment, given the uncertainty inherent in the business model and market. Mezzanine/convertible securities share similar characteristics with equity instruments but provide for regular liquidity events for investors.

TARGET MARKET OPPORTUNITIES	FINANCING NEED	MATURITY/ SOPHISTICATION OF ENTERPRISE AND/ OR MARKET	RELEVANT INSTRUMENT	RISK PROFILE
<b>Fostering new and innovative business models</b> <ul style="list-style-type: none"> <li>· Telemedicine and telediagnosis models, healthcare analytics</li> <li>· Disintermediated trading and supply chain cost</li> </ul>	<ul style="list-style-type: none"> <li>· TA/capacity-building for market creation</li> <li>· Scale-up financing (e.g., product validation, marketing, customer acquisition)</li> </ul>	<ul style="list-style-type: none"> <li>· Early stage – seed stage</li> <li>· Series A financing</li> </ul>	<ul style="list-style-type: none"> <li>· Recoverable grants</li> <li>· Convertible debt; subordinate equity</li> </ul>	<ul style="list-style-type: none"> <li>· Non-risk capital</li> <li>· High risk with high impact and financial returns</li> </ul>
	<ul style="list-style-type: none"> <li>· Working capital (typically short-term financing)</li> </ul>	<ul style="list-style-type: none"> <li>· High maturity</li> </ul>	<ul style="list-style-type: none"> <li>· Non-collateralized debt with flexible tenor</li> <li>· Convertible debt</li> <li>· Guarantees</li> </ul>	<ul style="list-style-type: none"> <li>· Moderate risk (inter-country supply chains subject to transport and currency risks)</li> <li>· Product obsolescence risks with equipment</li> </ul>
<b>Enabling transition of providers into pooled procurement mechanisms</b> <ul style="list-style-type: none"> <li>· Healthcare delivery</li> <li>· Diagnostics services</li> <li>· Sale plus maintenance services for equipment</li> </ul>	<ul style="list-style-type: none"> <li>· Project financing and working capital</li> </ul>	<ul style="list-style-type: none"> <li>· Series A financing</li> </ul>	<ul style="list-style-type: none"> <li>· Non-collateralized concessional debt (with interest buydowns linked to health outcomes) with flexible tenor and invoice discounting</li> <li>· Convertible debt</li> </ul>	<ul style="list-style-type: none"> <li>· Moderate risk</li> </ul>
	<ul style="list-style-type: none"> <li>· Scale-up financing (e.g., product development, sales and marketing, customer acquisition, etc.)</li> </ul>	<ul style="list-style-type: none"> <li>· Series A and B financing</li> </ul>	<ul style="list-style-type: none"> <li>· Equity; Convertible securities</li> </ul>	<ul style="list-style-type: none"> <li>· High risk with high return profile</li> </ul>

## Case Studies



### CASE STUDY 1: MEDICAL CREDIT FUND

**Context:**

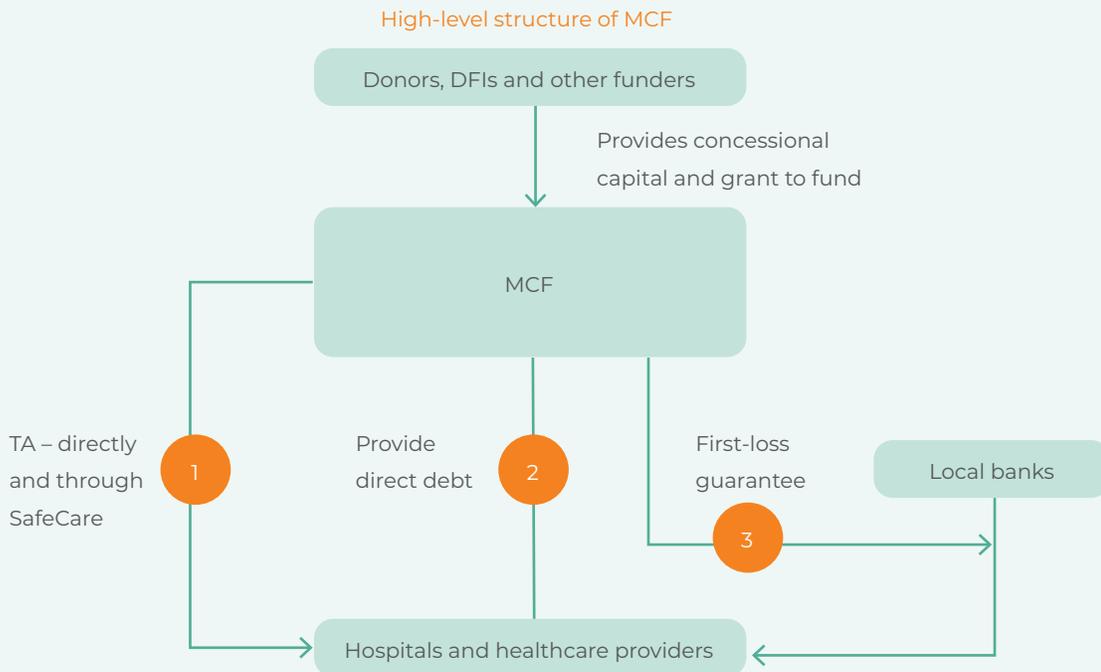
The Medical Credit Fund (MCF), launched in 2009 by PharrmAccess, aims to increase access to better healthcare services for low-income patients across Africa. MCF does so by working with local financial partners to provide loans to health SMEs facilitated by a blend of catalytic first-loss capital and technical assistance. The fund focuses on healthcare providers including small- and medium-sized health providers, diagnostic centers and specialized clinics, secondary hospitals; networks

of clinics and primary health facilities. The fund operates in Ghana, Kenya, Nigeria, Uganda and Tanzania and plans to ramp up operations to Zambia, Cote d'Ivoire, and Senegal.

The fund was catalyzed by USAID's \$1 million grant in 2010. Since then, MCF has raised capital from the formerly Overseas Private Investment Corporation (OPIC) now the U.S. International Development Finance Corporation (DFC), Calvert Impact Capital, FMO, Goldman Sachs, the Bill and Melinda Gates Foundation, the Soros Economic Development Fund, CDC, IFC, the Deutsche Bank Americas Foundation, and Dutch private investors.

**Fund structure:**

MCF is structured as a \$50 million blended finance facility with \$41.5 million debt capital and \$7.75 million first-loss capital to catalyze loans from local banks. It also has \$12 million grant capital to provide technical assistance to its borrowers. MCF operates on two key principles: a) fostering the local healthcare banking ecosystem by co-investing and providing guarantees to loans by local banks b) providing strong technical assistance from designing a hospital's layout to inventory management to quality assurance (through their SafeCare program) to borrowers.



**Results and impact:**

Through its 18 local banking partners, MCF has disbursed 1,760 loans as of March 2019 with a 97.2% repayment rate. The loans range in ticket size from \$1,000 to \$2.5 million. Through its technical assistance program, it has trained 2,400 staff.

**Practical lessons learned:**

1. Donors can deploy technical assistance to bolster both financial returns and development impact.
2. Donors can partner with local financial partners, which allows for both operational and financial leverage, but must do so responsibly: Making local partner banks take the lead can increase their capacity to subsequently recruit health SMEs for loans. An increased risk participation by these partners also shows an increased appetite to take a greater stake in the game. While working with local partners, however, donors should be cautious to not distort the market (e.g., supporting subsidies that inhibit long-term sustainability), and must ensure partners have a significant and growing exposure to the loans and setting the terms at a market rate (never imposing terms).
3. Donors may face a long pathway to financial sustainability for impact-first vehicles: Time may be required to a) establish a track-record in a high-impact sector and b) fine-tune the investment model to attract more commercial capital. Moreover, there can appear to be a trade-off between expediting the journey towards financial sustainability and maintaining the original development mandate (e.g., focusing on larger health SMEs that are a more profitable segment to finance, vs. financing small-sized health facilities, where donors can potentially generate more impact).



**CASE STUDY 2: USAID-SIDA HEALTH GUARANTEE TO CRDB UGANDA<sup>8</sup>**

**Context:**

The health guarantee program to Centenary Rural Development Bank (CRDB) in Uganda was co-funded by the Swedish International Development Cooperation Agency (Sida) and USAID and executed between 2012 to 2018. It sought to expand access to credit for private-sector health-services providers, and thereby increase the access and quality of medical care available to rural Ugandans. The effort had three key objectives – (a) increasing the interest and ability of the local banking sector in lending to private healthcare providers in Uganda, (b) increase the number and quality of services offered by private healthcare providers, and (c) increase the use of high-quality healthcare by the target population.

**Structure:**

The instrument had two key components:

1. A 7-year first-loss guarantee to facilitate up to \$10 million in lending.
2. Technical assistance to CRDB bank employees in understanding of the health sector, credit assessment and the loan recipients to deploy the funds effectively.

The loans were predominantly used for infrastructure and purchase of equipment. Smaller clinics outside the capital area were selected, and loans were made available across CRDB's 58 branches in Uganda.

8. Source: Evaluation of Health Guarantee to Centenary Rural Development Bank in Uganda report, SIDA

- Average loan value - \$17,917
- Interest rate – 23% (range of 15-43%)
- Guarantee – 60% with, USAID and SIDA overing 30% each

**Results and impact:**

122 loans were disbursed over the six-year period, with the facility using 63% of the guarantee by 2016.

A detailed assessment revealed that:

1. The interest rates were not in line with the profitability of the healthcare businesses – after paying the interest back, the enterprises were left with little profits
2. The default rate was 1-2%, much lower than the expected rate at 13.5% and the bank’s portfolio in other sectors
3. The guarantee may not have led to an increase in new banking customers and led banks to lend to existing customers
4. The guarantee did not serve to reduce the collateral - >75% of borrowers were made to provide collateral of 100% of more of loan value
5. The technical assistance provided did not appear to reach its objectives because a) the duration of TA was shorter than needed b) it did not identify key needs of the recipients beforehand e.g, it did not assist the borrowers on developing a business plan for appropriate use of funds
6. The program increased the access to healthcare for the target population by increasing the basket of services available at the centers

**Practical lessons learned:**

1. Donors should be strategic while delivering the technical assistance package. It is important to ensure that technical support: a) should specifically target loan beneficiaries, b) should be developed as a response to borrower and lender knowledge base, c) should also serve to ensure that data, both financial and patient care, is more rigorously recorded and used and d) may also support loan officers to better assess the reliability of business plans, and not solely focus on repayment potential based on alternative sources of income.
2. Donors should ensure there is a clear path to sustainability. To do so, it is vital to ensure that the partnering bank is aligned with the donor in its mission and shows clear interest in developing a financial product in the future. This might require a number of criteria be met for example, the sector should be large enough to warrant the bank’s investment, and that the bank is able to use an interest rate and collateral demand that is aligned with the sector’s specific growth expectations.
3. Donors should work directly / through the engagement of a delegated cooperation partner with the bank to help develop an adequate loan product. The loans must allow the bank to make a profit but must also serve to ensure that they are not solely serving the interest of the bank, but rather that they also allow the borrower to develop a thriving business. Not doing this will stunt rather than develop the private sector.



### CASE STUDY 3: INDIA COVID SUPPLIES REVOLVING FUND

#### Context:

The supply chain for medical supplies across the developing world is highly fragmented and multi-layered with entrenched players – importers, distributors, and wholesalers. The Indian landscape is similar with only 15% of the market catered by organized players. Healthcare SMEs that operate in tier 3 and 4 cities of India are dependent on these intermediaries, who extract significant margins at ~30-35%. Medikabazaar<sup>9</sup> aims to connect equipment and supplies manufacturers directly to these small healthcare providers through the use of technology and an inventory-and-marketplace. By disintermediating the supply chain, the company aims to provide a broader range of higher quality products at lower costs through demand aggregation and bulk procurement, just-in-time delivery, and scientific inventory management.

With COVID-19, the company rapidly expanded its portfolio to act on demand for Personal Protective Equipment (PPE) kits, infrared thermometers, masks, air purifiers, and testing kits. Healthcare providers also have increasingly shifted to such newer supply chain actors through the year. However, these actors are hampered by three key issues:

- I. Low revenues due to COVID-19 lockdown have hampered the health care providers' ability to pay
- II. Public sector actors have prolonged procurement and payment timelines of up to 120 days, which locks up significant working capital
- III. Overseas manufacturers demand upfront payment for shipping of products

#### Structure:

Mainstream lenders do not provide financing to these products due to import risks, lack of collateralization, and product obsolescence risks. Kois structured a working capital fund in Q2 2020 to finance the COVID-19 related working capital needs of Medikabazaar. The \$1 million facility is structured as a revolving credit fund and raised through funds from impact investors. The funds are placed as collateral with the overseas entity of a global bank which allowed their Indian entity to lend at highly concessional rates to Medikabazaar. In return, the investors are offered a share of the resultant profits from the sale of goods. The funds will continue to be recycled over the course of the current pandemic.

Tenor: 3-6 months

Expected IRR for investors: 10-14% per year.

#### Results and impact:

The facility was fully used by the intermediary for financing the purchase and sale of COVID-related equipment by September 2020. The facility plans to extend the financing towards newer business lines including cold chain equipment. In phase 2 of the effort in 2021, the credit facility will be expanded to other supply chain providers in India for COVID-19 related products and structured as a \$10 to 20 million facility.

9. a Kois investee company

## Conclusion

Blended finance in health is poised for an upward trajectory with recent interest and fundraising efforts in the space. It also needs to be viewed in the context of the huge funding gap in reaching the health SDGs. While there is significant room to grow, it also points to the need for a more extensive portfolio of tools apart from blended finance.

Despite the benefits, blended finance is yet to provide a proof of concept for truly unlocking healthcare for the lowest-income segments of the population. In that light, grants continue to hold an important role. Grants remain essential for fostering product innovation through prizes and awards, funding disruptive technologies and service models, providing technical assistance, or funding other models where the risk/financial return profiles may not be at market levels.

While blended finance is expected to play only a transitory role, past transactions show that the period of transition may be longer than anticipated. Therefore, blended finance transactions should be initiated with a clear sustainability plan — a robust pool of partners to eventually take the program forward, a strong technical assistance program to support the partners in this journey, and a clear ongoing assessment and redress of gaps.

Additionally, the programs supported by blended finance need not become sustainable purely on a commercial basis even in the medium to long terms and may need concessional / grant funding to bridge the sustainability gap. In such cases, the transaction should aim for a clear target in terms of the eventual blend — a sustainable donor-capital to commercial-capital mix.

Annex 1: Relevance of innovative financing instruments

FINANCIAL INSTRUMENT	DESCRIPTION	KEY FINANCING CHALLENGES ADDRESSED	BENEFITS AND CHALLENGES
<b>Quasi-grant</b>			
<b>Recoverable grants</b>	<ul style="list-style-type: none"> <li>• A financial tool that mimics features of a zero-interest loan and a grant. There is no automatic repayment obligation and no interest accrued on the disbursed amount</li> <li>• The principal amount is paid back only if the project reaches certain pre-defined milestones, such as a level of minimum commercial viability. If the milestones are not reached, the recoverable grant is converted into a simple grant</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term patient/risk capital</li> <li>• Access to financing for businesses without collateral</li> </ul>	<p><b>Benefits:</b></p> <ul style="list-style-type: none"> <li>• Incentivizes experimentation and innovation</li> <li>• Simplicity of transaction and low transaction cost</li> <li>• Enables recycling of grants</li> </ul> <p><b>Challenges:</b></p> <ul style="list-style-type: none"> <li>• Capital preservation as a maximum, with losses on proportion of principal highly likely</li> <li>• Grants can fail to encourage financial rigor in companies compared to debt and equity investments</li> </ul>
<b>Debt</b>			
<b>Straight debt with flexible/concessional terms</b>	<ul style="list-style-type: none"> <li>• Traditional debt instrument with periodic amortization of principal (unless bullet) and interest repayment, adapted with more favorable terms</li> </ul>	<ul style="list-style-type: none"> <li>• Longer tenors (except for working capital), concessional interest rates can provide patient capital needed by many enterprises</li> <li>• Unsecured debt/first-loss provisions can increase access to financing for enterprises without collateral</li> </ul>	<p><b>Benefits:</b></p> <ul style="list-style-type: none"> <li>• Standardized instruments can reduce transaction costs; highest investee appetite</li> </ul> <p><b>Challenges:</b></p> <ul style="list-style-type: none"> <li>• Additional concessional, appetite for loss/first-loss provisions may be required to manage default risk</li> </ul>
<b>First-loss capital (as subordinated debt)</b>	<ul style="list-style-type: none"> <li>• A form of credit-enhancement in which a third party agrees to cover a certain amount of loss for an investor. If the project fails, the first-loss loan provider is the last to be repaid, which makes it more likely that other investors recoup</li> </ul>	<ul style="list-style-type: none"> <li>• Risk-reduction mechanism to attract more risk-averse debt capital</li> </ul>	<p><b>Benefits:</b></p> <ul style="list-style-type: none"> <li>• Attract greater amounts of capital towards a targeted impact</li> </ul> <p><b>Challenges:</b></p> <ul style="list-style-type: none"> <li>• Disproportionate levels of first-loss capital (far higher than anticipated default rates) could misalign incentives for more senior capital to save due diligence costs, increasing the risk of higher default rates</li> </ul>

Quasi-debt/equity			
<p><b>Mezzanine finance / convertible securities</b></p>	<ul style="list-style-type: none"> <li>Subordinated debt instrument, with equity conversion in a Series A (typically in event of default, though this can also be structured as a call option)</li> </ul>	<ul style="list-style-type: none"> <li>Long-term patient capital for entrepreneurs</li> <li>No amortization of loan principal; ability to defer interest payments</li> <li>Founders can repay principal and interest payments in full (to maintain owner equity share) or convert to equity in Series A</li> </ul>	<p><b>Benefits:</b></p> <ul style="list-style-type: none"> <li>Typically, higher yields/returns (though interest rates offered can be made to be concessional)</li> <li>Periodic interest payments (if not deferred) provide regular liquidity events</li> <li>Equity valuation on principal (and any deferred interest payments) can be delayed until Series A financing round</li> </ul> <p><b>Challenges:</b></p> <ul style="list-style-type: none"> <li>Subordinated to senior debt</li> <li>Eventual equity exits at significant multiples remain rare; high failure rates</li> <li>Potential for poor time value of money, depending on timeline for equity exit</li> </ul>
Risk-sharing mechanisms			
<p><b>Guarantees</b></p>	<ul style="list-style-type: none"> <li>Partial or full credit guarantees on value of financing instrument in the event of non-payment or loss of value. Resources are only disbursed in the case of losses and can remain funded or unfunded on guarantor balance sheets until default event</li> </ul>	<ul style="list-style-type: none"> <li>Risk-reduction mechanism to attract more risk-averse investment capital</li> </ul>	<p><b>Benefits:</b></p> <ul style="list-style-type: none"> <li>Guarantees can be an effective tool to mobilize additional private capital especially for asset-light healthcare businesses that cannot put up adequate collateral</li> <li>Unfunded guarantees can optimize the use of resources, as disbursements only occur in the event of default</li> </ul> <p><b>Challenges:</b></p> <ul style="list-style-type: none"> <li>Despite guarantees, traditional lenders continue to demand significant collateral and charge market to higher-than-market interest rates for perceived high-risk customers</li> <li>Managing unfunded liabilities on balance sheet can require costly due diligence to reduce high risk of disbursements; conversely, funded guarantee liabilities will require earmarked reserves that cannot be deployed for other uses</li> </ul>

Annex 2: Structural features to address financing challenges, by type of innovative finance instrument

	RECOVERABLE GRANTS	STRAIGHT DEBT WITH FLEXIBLE/ CONCESSIONAL TERMS	MEZZANINE FINANCE	GUARANTEES
<b>Long-term maturity/tenors</b>	Yes. No explicit repayment obligations	Yes. Longer tenors can be adapted to provide patient capital; in principle, need for at minimum 7-10 year tenors, if not up to 12-15 years	Yes. Longer tenors can be adapted to provide patient capital until equity conversion	Yes. Risk-sharing mechanism to cover full life of financing instrument
<b>Concessional rates</b>	Yes. No interest on principal amount is required	Yes. Concessional rates can be adapted	Yes/No. Mezzanine financing typically requires higher yields to compensate for higher risk, though some concessionality can be adapted	Yes. Cost of guarantees can be subsidized
<b>Grace/ honeymoon periods</b>	Yes. No explicit repayment obligations	Yes. Long grace periods can be adapted to provide patient capital; longer-term capital needs may benefit from up to 3-5 year grace periods for first cashflows; though typical concessional grace periods between 1-2 years	Yes. Long grace periods can be adapted, in addition to standard deferred interest terms for mezzanine finance	n/a
<b>Flexible repayment terms</b>	Yes. Repayment only required if the enterprise reaches pre-set milestones. If those milestones are not reached, the instrument converts into a simple grant	No. Typically fixed period repayments once grace period ends	Yes. No periodic principal repayments. Deferred interest repayments can be capitalized and paid out through future preferred equity conversion	n/a
<b>Favorable default remedies and collateral/ security requirements</b>	Yes. Unsecured	Yes. Unsecured debt can be provided/higher loss provisions	Yes. Typically, unsecured. Defaulted payments are subordinated to senior debt and convert to preferred equity in a Series A financing round	n/a
<b>First-loss provisions for co-financiers</b>	Yes. First-loss grant capital	Yes. Can be subordinated to act as first-loss capital tranche	Yes. Subordinated position, only senior to common equity	Yes. Guarantees provide partial or full credit on value of financing instrument in the event of default

<p><b>Currency</b></p>	<p>Typically, in hard currency (US\$)                  For debt instruments with borrowers outside of export-oriented commodity value chains, local currency financing would significantly reduce debt burden (but is not readily available) and hedging instruments can be costly for international investors</p>			
<p><b>Streamlined administrative requirements (i.e., due diligence, M&amp;E/impact reporting requirements)</b></p>	<p>Yes. Standardized product with flexible terms</p>	<p>Yes. Standardized product with flexible terms, unless high impact reporting requirements; loan diligence costs can be high</p>	<p>Yes/No. Standardized product, though equity participation will have similar requirements to a straight equity instrument (unless following another lead investor in Series A)</p>	<p>Yes/No. Depends on specific requirements for release of guarantee capital to avoid moral hazard</p>
<p><b>Instrument complexity for investee</b></p>	<p>Low. Similar to traditional grant instruments</p>	<p>Low. Standardized debt instrument</p>	<p>Medium. Standardized instrument, though less sophisticated actors may have less familiarity with quasi-debt/equity</p>	<p>Medium. Depends on criteria for unlocking guarantee capital in event of non-payment</p>
<p><b>Board representation</b></p>	<p>No</p>	<p>No</p>	<p>Yes/No. Investor can demand Board seat or other direct involvement in governance</p>	<p>n/a</p>

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