Innovative Health Financing Mechanisms Primer

Americas RISE for Health has identified that sufficient, efficient, and equitable health investments are essential for providing individuals with the health services they deserve and to ensure the cost of these services does not create financial hardship. While public financing for health remains essential, innovative health financing mechanisms can harness public and private funding sources in new ways to supplement traditional funding. Recognizing this opportunity, during the 2nd annual RISE meeting, stakeholders committed to convening governments, private sector, international development banks, and civil society to build awareness for innovative health financing mechanisms, including those that can help reach our most vulnerable populations.

This primer serves to identify multiple innovative health financing mechanisms that are applicable to countries in the Western Hemisphere, to educate those interested in generating sufficient health financing, and to catalyze agreements amongst interested parties.

We thank the contributions of the RISE health financing experts group, including ADD US Business Council; Argentina's Ministry of Health, Beckton Dickinson; Brazilian Ministry of Health, Dominican Republic Ministry of Health, Grupo HUMANO; ILAR; Interfarma; Johnson & Johnson; Kenvue; Merck; Moonlight International; Novo Nordisk; Organon & Co; Pfizer; REDLAD/Centro de la Mujer Panameña (CEMP); Roche; Sense and Science; US Chamber of Commerce; USAID; Viatris.

What is Innovative Health Financing?

Innovative health financing can be defined as an "alternative approach to raising funds for healthcare beyond traditional methods such as government budgets, donor funding, or out-of-pocket payments."[1] Innovative mechanisms aim to support, catalyze and supplement traditional models of health financing by mobilizing additional resources and improving efficiency, thus expanding access to healthcare services to reduce inequalities, particularly for underserved populations. Innovative mechanisms often involve channeling private resources, combined with public funds, to generate additional revenue for health system transformation projects and to reduce out-of-pocket costs. These mechanisms also strengthen health systems by diversifying funding sources, making them more resilient, and encouraging experimentation and innovation in healthcare delivery and financing models.

Why Does it Matter?

The Latin America and the Caribbean (LAC) region continues to face challenges in delivering equitable access to healthcare. 29% of the population lives below the poverty line, 30% of the population does not have access to healthcare for financial reasons, and 21% of the population does not seek healthcare due to geographical barriers. Inflation and various limitations on public spending, together with additional economic challenges, are compelling governments to seek out

[1] Nabyonga-Orem J, Christmals CD, Addai KF, Mwinga K, Karenzi-Muhongerwa D, Namuli S, Asamani JA. The nature and contribution of innovative health financing mechanisms in the World Health Organization African region: A scoping review. J Glob Health 2023;13:04153.

creative strategies to expand fiscal capacity for health. The Pan-American Health Organization (PAHO) recommends that for countries in the Americas, their public expenditure on health should reach at least 6% of their gross domestic product (GDP)[2], however the health budget in many countries has not reached that threshold. Innovative health financing mechanisms can help close the gap and ease the financial burden of cost for individuals and communities.

[2] Pan American Health Organization. "Health Financing." Pan American Health Organization, https://www.paho.org/en/topics/health-financing. Pan American Health Organization (PAHO). "Health Financing"

Types of Innovative Health Financing Mechanisms

This primer covers three types of innovative health financing mechanisms, including:

1. **Mobilizing Funds**: Channeling private resources combined with public funds to generate additional revenue for health system transformation projects, including trying to reach hard to reach / vulnerable populations, and reducing out-of-pocket costs for patients.

2. **Pooling Funds**: Collecting financial resources from various sources to ensure that risks are shared and that funds are available to cover healthcare investments and costs. This can include using digital tools like artificial intelligence and big data analytics to support access to and uptake of insurance policies that may otherwise be overlooked.

3. **Purchasing Healthcare Services**: Arrangements between pharmaceutical manufacturers and payers to cover new medicines while addressing concerns related to cost-effectiveness, efficacy, and safety.

Mobilizing Funds	Pooling Funds	Purchasing Healthcare Services/Medical Devices
Debt-for-Health Swaps	Digital Health Insurance (insurtech)	Managed entry agreements
Blended Financing • Social Impact Bonds • Development Impact Bonds	Complementary Insurance	Value Based Care
Fund Transfers		Patient Affordability Solutions
Health Funds (ex., Excise Taxes)		Performance-Based Financing

Case Study: The Value of Innovative Health Financing

Innovative financing mechanisms for vaccines have been crucial for improving accessibility and affordability, especially in lower-income countries. Key mechanisms that have improved availability of and accessibility to vaccines in low- and middle-income countries include:

- International Finance Facility for Immunisation (IFFIm)[3]: This facility uses long-term donor pledges to issue vaccine bonds in capital markets, raising funds for immunization programs.

[3] International Finance Facility for Immunisation. IFFIm: International Finance Facility for Immunisation. https://iffim.org/

- Vaccines Advance Market Commitment (AMC)/Advanced Purchase Agreements: This mechanism incentivizes vaccine production by guaranteeing a market for vaccines, ensuring sufficient supplies at reduced costs for developing countries.
- Gavi Matching Fund: This public-private funding mechanism doubles the impact of private sector investments in immunization.[4]

- Loan Buydown Facility: This mechanism provides affordable loans to improve immunization coverage, particularly in regions like Africa's Sahel.

- INFUSE (Innovation for Uptake, Scale, and Equity in Immunisation)[5]: This initiative engages entrepreneurs and nurtures solutions to build a pipeline for strategic investments in vaccine delivery.

These mechanisms collectively help bridge the vaccine equity gap by providing sustainable and predictable funding, enabling the adoption of new vaccines, and modernizing immunization delivery systems.[6]

[4] Gavi, the Vaccine Alliance. "Innovative Financing." Gavi, the Vaccine Alliance, https://www.gavi.org/investing-gavi/innovative-financing.
[5] Gavi, the Vaccine Alliance, "INFUSE" https://www.gavi.org/investing-gavi/infuse
[6] Gavi, the Vaccine Alliance, "How Innovative Finance Helps Close the Vaccine Equity Gap," https://www.gavi.org/vaccineswork/how-innovative-finance-helps-close-vaccine-equity-gap

MOBILIZING FUNDS

Debt-for-Health Swaps

How it works: A bilateral agreement between two countries in which the "donor country" (or creditor country) cancels debt owed by the "implementing country" or (debtor country) if the implementing country agrees to invest in health programs and/or services.[7]

Stakeholders:

1. **Donor (Creditor) Country**: The country that cancels the debt of the "implementing country."
2. **Implementing (Debtor) Country**: The country that converts its canceled debt into investments for health programs and/or services as determined by the bilateral agreement.
3. **Private Funding Sources (companies/organizations):** Can provide additional funding, expertise, and resources to support health initiatives in debtor countries.

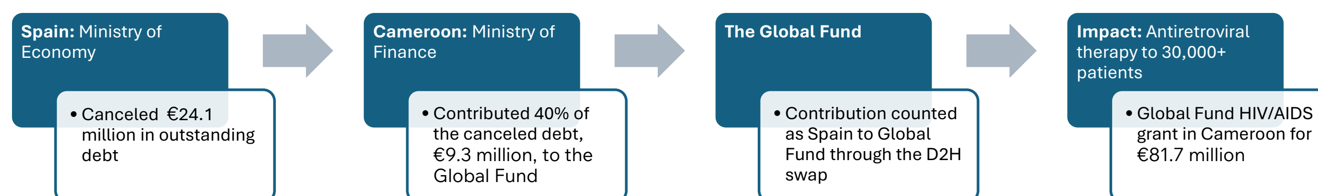
What it Offers

1. **Increases Long-Term Investments**: Debt-for-health swaps are designed to increase domestic financing for health by converting debt repayments into investments in health programs and/or services. Benefits for the donor country include investment in health, and political visibility as a donor/co-financier. Benefits for the implementing country include receiving official development assistance (ODA) and accessibility of funding for domestic health programs.[8]

Case Study: Debt2Health (D2H)[9]

In 2007, The Global Fund to Fight AIDS, Tuberculosis, and Malaria introduced a debt swap mechanism to help countries generate domestic funds for health initiatives. Since then, this program has facilitated 12 transactions across 13 countries, resulting in an investment of $226 million in health programs and the cancellation of $366 million in debt through D2H swaps.

Take the case of the Spain-Cameroon debt swap:



In this case, the debt swap created a win-win-win situation, where the creditor country gained global visibility for its contributions to global health, the debtor country converted debts into

[7] Filipp, Robert, "Innovative Financing of the Global Fund Debt2Health", OECD Global Forum on Development
[8] The Global Fund. "Debt2Health Overview." https://www.theglobalfund.org/media/12284/publication_debt2health_overview_en.pdf
[9] The Global Fund. "Debt2Health Overview." https://www.theglobalfund.org/media/12284/publication_debt2health_overview_en.pdf

additional health funding, and extra resources were provided to finance global health programs.

Blended Finance

How it works: A system that combines public and philanthropic resources to mobilize private sector financing to implement health programs and/or services. These combined resources include using public sector funding, financing instruments, and other assets to overcome the barriers that prevent commercial private capital from being invested within a region or country.[10] The idea behind blended finance is to use concessional or "softer" finance (such as grants or low-interest loans from governments or philanthropic organizations) to mitigate the risks for private investors, thereby attracting additional private capital that might not otherwise be invested in health projects due to perceived risks or low returns.

Stakeholders[11]:

1. **Public Sector Actors:**
- **Multilateral Development Banks and/or Institutions:** Can serve as catalysts for blended finance, can offer risk-sharing mechanisms, and/or facilitate partnerships between public and private actors.
- **Government Agencies:** Can provide policy support, funding, and regulatory frameworks to encourage private sector investment.

2. **Private Sector Actors:**
- **Commercial Banks:** Can provide loans and guarantees. Can offer market-rate financing alongside philanthropic funding to bridge the funding gaps and reduce risks for private investors.
- **Institutional Investors:** Can include pension funds, insurance companies, and asset managers that have long-term investment goals.
- **Impact Investors:** Can provide innovative financing structures that align with mission-driven objectives of the health initiative.

3. **Philanthropic Organizations:**
- **Foundations:** Can provide grants, concessional financing (financing that is more favorable than market-rates) or guarantees that support development projects.
- **Non-governmental Organizations:** Can provide knowledge of local contexts, needs to beneficiaries, technical assistance, capacity building support, or act as intermediaries between public and private sector actors.

What is Offers:

[10] Health Finance Institute "Blended Finance, Social Impact Bonds, and investments in global health", August 2020

[11] Finance Strategists. "Blended Finance", https://www.financestrategists.com/wealth-management/investment-management/blended-finance/

1. **Flexible Capital**: Blended finance provides investors, both public and private, with flexible capital and favorable terms when implementing a health program or initiative. For the public or development sector, this means implementing financial tools like grants, equity, and debt to facilitate blended finance initiatives. For the private sector, this means gaining access to local market knowledge and experience and building local capacity, ultimately improving sustainability and health innovation within the country.

Case Study: The Pneumococcal Advance Market Commitment (AMC)[12]

The Pneumococcal Advance Market Commitment (AMC), launched in 2009 with $1.5 billion from the governments of Italy, the United Kingdom, Canda, Russia, and Norway and the Bill & Melinda Gates Foundation, aimed to address the high demand for vaccines in Asia and Africa, where pneumococcal disease causes significant mortality.

This innovative approach guaranteed vaccine manufacturers a market price of $7.00 per dose for the first 20% of doses, in exchange for long-term commitments to supply vaccines to developing countries at $3.50 per dose. By providing this price assurance, AMC incentivized manufacturers to expand their production capacity and develop new vaccines. This model facilitated a healthier competitive market, promoting a sustained supply of vaccines and affordable pricing.

As a result, over an estimated 25 million children were vaccinated in Asia and Africa by the end of 2013, with projections indicating over 80 million by 2015, potentially preventing 1 million deaths by 2020. AMC has thus successfully improved health outcomes in target countries by increasing vaccine availability.

Key Types of Blended Finance

Social Impact Bonds (SIBs)/Development Impact Bonds (DIBs)

How it works: Governments enter into agreements with social service providers, such as a non-profit organization, and investors (such as the private sector), to pay for the delivery of pre-determined health outcomes.[13]

Stakeholders:

1. **Investors**: Provide an upfront financial investment for health programs within a country.
2. **Intermediaries**: A financial intermediary or social finance intermediary raises capital from investors and uses funds to support service providers that address the targeted health challenge.
3. **Service Provider**: Implements the identified health program or initiative.
4. **Target Population**: The population that is identified for the health program or initiative.

[12] OECD "Blended Finance Vol. 1: A Primer for Development Finance and Philanthropic Funders", September 2015, pg. 18
[13] Health Finance Institute "Blended Finance, Social Impact Bonds, and investments in global health", August 2020

5. **Third Party Evaluator**: Provides an unbiased evaluation of the outcomes according to the pre-determined metrics identified by participating stakeholders. Whether or not investors are paid back is determined by the evaluation.
6. **Government**: Pays back investors if the health program successfully meets the pre-determined metrics. If the health program is *not* deemed successful, the government does not pay back investors.

What it Offers

1. **Specific Health Outcomes**: Social Impact Bonds (SIBs) can be used to fund preventive or health promotion programs, service delivery improvements, or interventions targeting specific health outcomes.

2. **Mitigate Financial Risk**: Within an SIB model, the investors carry the financial risk for a health initiative or project – not the government. This model allows governments to *only* pay for initiatives that are successful, based on the pre-determined metrics that have been identified.[14]

Case Study: Vaccine Bonds[15]

Vaccine Bonds issued by the International Finance Facility for Immunization (IFFIm) have raised nearly $7.9 billion from investors, providing Gavi, the Vaccine Alliance, greater funds to distribute vaccines. Vaccine bonds have enabled Gavi to immunize 80 million children ahead of receiving grants and contributing to saving more than 13 million lives from 2006-2019.

In the traditional model, Gavi receives money through pledges from donor governments. For example, a government pledges $100 million to Gavi, paid in $10 million annual installments over a decade, limiting Gavi to spending $10 million a year and delaying the full impact. Instead, IFFIm issues the vaccine bonds backed by the $100 million pledge. Investors buy these bonds, providing immediate funds to Gavi, which then buys vaccines and immunizes more people. The donor's annual payments are used to repay the bondholders.[16]

[14] Carè, Roselle ,"Developing Social Impact Bonds to Tackle Emerging Social Needs and Promote Social Welfare", 2021.
[15] International Finance Facility for Immunisation (IFFIm). "Vaccine Bonds." https://iffim.org/investor-centre/vaccine-bonds
[16] International Finance Facility for Immunisation (IFFIm), "Funding Immunisation", https://iffim.org/funding-immunisation

Fund Transfers

How it Works: Transferring financial resources to support healthcare services and initiatives.

Common types of fund transfers include:

Fund transfers that between entities that provide services:

- **Government Health Fund Transfers**: Governments often transfer funds to various health programs and facilities to ensure the delivery of healthcare services. These transfers can be part of budget allocations, grants, or specific health initiatives aimed at improving public health.

- **International Health Fund Transfers**: Organizations like the World Health Organization (WHO) and the World Bank often transfer funds to support health projects in different countries. These transfers are crucial for funding health interventions, especially in low- and middle-income countries.

Fund transfers that go directly to patients/consumers:

- **Electronic Funds Transfer** (EFT): This is a method used by health plans to electronically transfer funds to healthcare providers' accounts to pay for services rendered. EFTs streamline the payment process, reduce administrative costs, and ensure timely payments.[17]

- **Health Savings Account (HSA) Transfers**: Individuals can transfer funds between different HSA providers. This allows for better management and potentially lower fees by consolidating HSA funds through direct transfers or rollovers.

Stakeholders:

1. **Government Agencies:** These entities often design, fund, and oversee the implementation of fund transfer programs.
2. **Donors and International Organizations:** Entities like the World Bank, WHO, and other international donors provide financial and technical support for fund transfer programs.
3. **Healthcare Providers:** Hospitals, clinics, and individual healthcare professionals who deliver services funded by these transfers.
4. **Patients and Beneficiaries:** The individuals and families who receive the financial support to access healthcare services.
5. **Non-Governmental Organizations (NGOs):** These organizations may help implement and monitor fund transfer programs, ensuring they reach the intended recipients.

[17] Centers for Medicare & Medicaid Services (CMS). "Health Care Payment and Remittance Advice and Electronic Funds Transfer", https://www.cms.gov/priorities/key-initiatives/burden-reduction/administrative-simplification/transactions/health-care-payment-remittance-advice-electronic-funds-transfer

6. **Community Leaders and Local Authorities:** Play a role in mobilizing communities and ensuring the programs are culturally appropriate and effectively implemented.
7. **Private Sector Partners:** Companies may be involved in the logistics, technology, and infrastructure needed to facilitate fund transfers.

What it Offers:

1. **Access to Health Services**: Fund transfers can offer significant benefits to the public by improving access to health services, enhancing financial security, and increasing health service utilization within a given country.

2. **Flexibility and Choice:** These transfers can provide flexibility and choice, allowing recipients to decide how best to use the funds.

3. **Supports Public Health Emergencies**: Fund transfers can also offer crucial support during public health emergencies, providing immediate relief to affected populations.

Overall, these financial supports play a vital role in promoting better health and economic stability for individuals and families.

Case Study: Mexico's PROGRESA Program[18]

In 1997 Mexico implemented a program called PROGRESA – aimed to provide cash transfers to families to support health care services and needs. Cash transfers were conditional on the family household engaging in a set of behaviors designed to improve health and nutrition. The family only received the cash transfer if: (i) every family member accepted preventive medical care; (ii) children age 0-5 and lactating mothers attended nutrition monitoring clinics where growth is measured, nutrition supplements are distributed, and they are provided education on nutrition and hygiene; and (iii) pregnant women visited clinics to obtain prenatal care, nutritional supplements, and health education

<u>Results</u>

In the first full year in which PROGRESA was operational in all treatment localities, there were 2.09 more visits per day (60% increase) to clinics in PROGRESA areas than in non-PROGRESA areas. In addition, children in treatment households had roughly a 23% reduction in the incidence of illness, an 18% reduction in anemia, and between a 1 and 4% increase in height. Adults in treatment households experienced a significant reduction in the number of days on which they had difficulty with daily activities due to illness, and in the number of days spent in bed due to illness. Adults in the treatment group also reported a significant increase in the number of kilometers able to walk without getting tired.

[18] https://www.povertyactionlab.org/evaluation/impact-progresa-health-mexico

PROGRESA ended in 2019 after 21 years of implementation.

Health Funds

Health funds are financial resources allocated specifically for health-related expenditures. These funds can come from various sources, including government budgets, insurance premiums, and specific taxes like excise taxes. Health funds can also be mobilized by public and private resources, like the Global Fund to Fight AIDS, Tuberculosis, and Malaria or the Bloemfontein Hospitals Public-Private Partnership in South Africa.

Key Examples of Health Funds

Excise Tax

How it works: Specific taxes imposed on certain goods, services, or activities (e.g., tobacco, alcohol) that can be applied to health-related goods and services and contribute to federal revenue, promoting public health.

Stakeholders:

1. **Government Agencies**: Design, implement, and enforce excise tax policies.
2. **Taxpayers**: Businesses and individuals who are subject to the excise tax, such as manufacturers and consumers of taxed goods.
3. **Public Health Organizations**: Groups that advocate for excise taxes on harmful products to improve public health outcomes.
4. **Consumers**: Individuals who purchase goods that are subject to excise taxes.

What if Offers:

1. **Source of Revenue**: Excise taxes provide a significant source of revenue[19] and can be earmarked for specific purposes, like health. These taxes can also help mitigate the costs associated with negative health outcomes from the taxed product. For example, the health costs associated with smoking can be offset by taxes on tobacco products. Overall, these types of taxes can help governments manage public health, fund essential services, and generate revenue efficiently.

While excise taxes provide one example of health funds, there are many other examples, like health mutual funds and health reimbursement arrangements that support specific health expenditures and initiatives.

Case Study: Mexico’s Sugar-Sweetened Beverage Tax[20]

In 2014, Mexico introduced an excise tax on sugar-sweetened beverages as part of a broader strategy to combat obesity and related health issues. The tax was set at 1 peso per liter, which

[19] https://www.taxpolicycenter.org/briefing-book/what-are-major-federal-excise-taxes-and-how-much-money-do-they-raise
[20] https://iris.paho.org/bitstream/handle/10665.2/53331/v45e212021.pdf?sequence=1

represented about a 10% increase in the price of these beverages. The objective of the tax was to decrease the consumption of sugary drinks, which is linked to obesity, diabetes, and other health problems. The tax also aimed to raise funds that could be used to support health programs and initiatives.

After the tax was implemented, studies showed a significant reduction in the purchase of taxed beverages. In the first year, there was a 6% decline in purchases, which increased to 12% by the second year. The reduction in sugary drink consumption is expected to lead to long-term health benefits, including lower rates of obesity and diabetes, within the country. Additionally, the tax generated substantial revenue, which was earmarked for health programs, including initiatives to provide clean drinking water in schools.

POOLING FUNDS

Digital Health Insurance (Insurtech)

How it works: Using digital tools, like artificial intelligence, big data analytics, blockchain, and machine learning, to deliver insurance products for health. This includes using digital tools to shop for insurance, purchase insurance, pay premiums, submit claims, and receive reimbursements, among others.[21] This supports the uptake of existing financial instruments and insurance plans.

Stakeholders:

1. **Insurance Companies:** Traditional insurers that partner with or invest in insurtech firms to innovate and improve their services.
2. **Insurtech Companies:** Startups and tech firms that develop new technologies and business models for the insurance industry.
3. **Venture Capital Firms:** Investors that provide funding to insurtech startups, driving innovation and growth in the sector.
4. **Regulatory Bodies:** Government agencies that oversee and regulate the insurance industry to ensure compliance and protect consumers.
5. **Consumers:** Individuals and businesses that purchase insurance products and benefit from improved services and lower costs due to insurtech innovations.
6. **Technology Providers:** Companies that supply the technological infrastructure and tools needed for insurtech solutions, such as cloud services, AI, and data analytics.

What if Offers:

1. **Customer Experience**: Insurtech can enhance the customer experience by leveraging digital tools to shop for insurance, increase options for engagement (calling a representative or accessing resources online) and customize insurance plans based on individual's needs.

2. **Improves Efficiency** Insurtech also improves efficiency by eliminating the need to go to brick-and-mortar insurance locations; increases flexibility with more insurance offerings that can be custom, short-term, transferable, etc.; and reduces overall operating costs that may impact the customer.

Case Study: Sami: An Insurtech and Primary Health Care Company[22]

[21] Gresenz, Carole Roan; Hoch, Emily; Eibner, Christine; Rudin, Robert; Mattke, Soeren, "Harnessing Private-Sector Innovation to Improve Health Insurance Exchanges", RAND Corporation, 2015.

[22] Roosa Tikkanen, Robin Osborn, Elias Mossialos, Ana Djordjevic, George A. Wharton, "Brazil", The Common Wealth Fund, https://www.commonwealthfund.org/international-health-policy-center/countries/brazil#:~:text=Nearly%2025%20percent%20of%20Brazilians%2C%20mostly%20middle-%20and,health%20insurance%20to%20circumvent%20bottlenecks%20in%20accessing%20care.

In Brazil, roughly 25% of the population seeks private insurance to supplement the country's universal health coverage. Sami, launched in 2019, is a Brazilian insurtech and primary care company with the objective of making healthcare more accessible and affordable by connecting patients directly with doctors, hospitals, laboratories, and companies. Sami also directly hires medical care professionals to support its customers through their entire healthcare journey, along with providing physical and mental health apps and personalized therapeutic plans. About 95% of Sami's primary care work happens digitally — via text messages, video calls, or through the app.[23] However, the business also has one brick and mortar store for customers that would like to speak face-to-face.

Customers can pay for their health insurance via credit card, authorized direct debit (DDA), pix (a new payment method in Brazil, with no fees for those who pay) or boleto bancário[24]. Coverage includes consultations, exams, surgeries, hospitalizations, and other procedures listed under the Brazilian Agency of Supplementary Health (ANS).

Sami generates revenue by actively working to lower hospital admission rates through effective clinical intervention.[25] Companies like Sami make healthcare more accessible by reducing wait times, reduces hospital admission rates, and offers tailored health plans and real-time support.

[23]https://www.axios.com/pro/fintech-deals/2023/06/02/sami-brazilian-insurtech-gets-18-million

[24] Using a unique code, businesses can send invoices via email, text, or social media that customers can use to pay online within a set period, usually between 3–15 days. Customers have the option of paying in full immediately or in installments.

[25] https://www.insurtechinsights.com/brazilian-insurtech-sami-raises-us18-million-in-series-b-round/

Complementary Insurance

How it Works: Complementary insurance is designed to cover costs that are not fully covered by a primary health insurance plan. This can include out-of-pocket expenses such as copayments, deductibles, and services that the primary insurance does not cover, like dental or vision care.

In many countries primary health insurance might cover basic medical services, but complementary insurance can help pay for additional services or higher levels of care. This type of insurance is particularly useful for reducing the financial burden on individuals by covering the gaps left by their primary insurance.

Stakeholders:

1. **Policyholders:** Individuals or entities that purchase complementary insurance to cover additional healthcare costs not covered by their primary insurance.
2. **Insurance Companies:** Providers of complementary insurance policies. They design, market, and manage these insurance products.
3. **Healthcare Providers:** Hospitals, clinics, and individual practitioners who deliver healthcare services. They interact with both primary and complementary insurers for reimbursement.
4. **Government Agencies:** Regulatory bodies that oversee the insurance market, ensuring compliance with laws and regulations.

What if Offers:

- **Coverage for Additional Services**: It can cover services not included in primary insurance plans, such as dental, vision, and alternative therapies.

- **Reduced Out-of-Pocket Costs**: It helps pay for expenses like copayments, deductibles, and coinsurance, reducing the financial burden on policyholders.

- **Access to Specialized Care**: Complementary insurance can provide access to specialized treatments and medications that might not be covered by primary insurance.

- **Financial Protection**: It offers a safety net against unexpected medical expenses[26].

Case Studies: Across Latin America

[26] National Center for Complementary and Integrative Health. Paying for Complementary and Integrative Health Approaches. U.S. Department of Health and Human Services, June 2016, www.nccih.nih.gov/health/paying-for-complementary-and-integrative-health-approaches

Chile[27]: The Chilean health system includes a mix of public and private insurance. The public system, FONASA, covers a significant portion of the population, but many people also purchase complementary insurance from private providers to cover additional services and reduce out-of-pocket expenses.

Brazil[28]: In Brazil, the public health system (SUS) provides universal coverage, but there is also a substantial private health insurance market. Many Brazilians opt for complementary insurance to access private healthcare facilities and services not fully covered by SUS.

Mexico[29]: Mexico's Seguro Popular program aims to provide universal health coverage, but many individuals still purchase complementary insurance to cover services not included in the public system. This additional insurance helps cover costs for specialized treatments and medications.

[27] Roman-Urrestarazu, A., Yang, J.C., Ettelt, S. et al. Private health insurance in Germany and Chile: two stories of co-existence, segmentation and conflict. Int J Equity Health 17, 112 (2018). https://doi.org/10.1186/s12939-018-0831-z

[28] The Commonwealth Fund. Brazil. International Health Policy Center, www.commonwealthfund.org/international-health-policy-center/countries/brazil

[29] José E Urquieta-Salomón, Héctor J Villarreal, Evolution of health coverage in Mexico: evidence of progress and challenges in the Mexican health system, Health Policy and Planning, Volume 31, Issue 1, February 2016, Pages 28–36, https://doi.org/10.1093/heapol/czv015

AMERICAS RISE for HEALTH
RESILIENT • INCLUSIVE • SUSTAINABLE • EQUITABLE

PURCHASING HEALTH SERVICES AND MEDICAL DEVICES

Managed entry agreements (MEAs)

How it works: An arrangement between a pharmaceutical manufacturer and healthcare payer that allows for coverage of new medicines, limiting uncertainty around one or more of the following challenges: clinical evidence, cost-effectiveness, budget impact, price, eligible patient population.[30] Managed entry agreements can also provide a mechanism to introduce new drugs into the healthcare system while addressing concerns related to cost-effectiveness, efficacy, and safety. Managed entry agreements can take many forms, including:

- **Financial-based agreements**: Payment for a new drug based on specific financial conditions, such as how many patients use the drug or the total cost to the healthcare system. This type of agreement helps manage the financial risk of introducing expensive new treatments, promoting affordability and accessibility while controlling costs.

- **Performance-based agreements**: Agreements that tie the price, level, or nature of reimbursement to the actual performance of the medical product or service in real-word conditions. Such agreements can be challenging and need very robust data systems to be able to measure certain outcomes.

Stakeholders:

1. **Government Agencies**: These bodies, such as health ministries and regulatory authorities, oversee and regulate MEAs to ensure they align with public health goals.
2. **Pharmaceutical Manufacturers**: Companies that develop and produce new medicines and enter into MEAs to facilitate market access under specific conditions.
3. **Healthcare Payers**: Entities like insurance companies and national health services that negotiate MEAs to manage the financial risk associated with new, often expensive, treatments.
4. **Healthcare Providers**: Hospitals, clinics, and healthcare professionals who administer the treatments covered by MEAs and collect data on their real-world effectiveness.
5. **Patients**: Individuals who benefit from early access to new treatments through MEAs, often under conditions that monitor and evaluate the treatment's effectiveness.
6. **Health Technology Assessment (HTA) Bodies**: Organizations that assess the clinical and cost-effectiveness of new treatments and provide recommendations for MEAs.
7. **Non-Governmental Organizations (NGOs)**: Groups that may advocate for patient access to new treatments and monitor the implementation of MEAs.

[30] Organisation for Economic Co-operation and Development. Performance-Based Managed Entry Agreements for New Medicines in OECD Countries and EU Member States. OECD, www.oecd.org/en/publications/performance-based-managed-entry-agreements-for-new-medicines-in-oecd-countries-and-eu-member-states_6e5e4c0f-en.html

What it Offers:

1. **Reducing Cost Pressures**: MEAs create an option to provide expanded access within a finite budget. Reducing the cost pressure for health services can allow coverage for the maximum number of patients and a predictable budget for medications. It can also improve budget predictability and give the healthcare system more time to allot necessary funding so they can continue to expand access in a controlled manner over time.

2. **Early or Improved Access**: MEAs can give patients early or improved access to innovative medicines and can help drive towards better disease management by improving overall health standards.

Case Study: National Resources Fund in Uruguay[31]

In 1981 the National Resources Fund (FNR), a non-state public entity, was created to provide universal financial coverage for highly complex procedures, and high-cost devices and medicines to all individuals with health coverage by the Nationally Integrated Health System (SNIS). The FNR is administered by an Honorary Commission made up representatives from the Ministry of Public Health, Ministry of Economy and Finance, the Social Security Bank, the Collective Medical Assistance Institutions, and the High Specialized Medical Institutes.

Procedures financed by FNR are performed at Highly Specialized Institutes of Medicine (IMAE) and Specialty Centers, and FNR negotiates and buys the medicines for the treatments under coverage, which are mostly dispensed in the pharmacies of the comprehensive providers where the patients are affiliated.

Financing

The majority of FNR's income comes from Uruguay's National Health Fund (FONASA). For each contributor to FONASA, the Social Security Institute (BPS) transfers a fee to the FNR, regardless of the age and sex of the contributor. This fee is generally increased once or twice a year, depending on the annual budget.

In the case of patients who do not contribute to FONASA but are affiliated with the State Services Administration (ASSE), the Ministry of Economy and Finance (MEF) reimburses the FNR for the expenses incurred for the procedures performed and the medicines delivered. And for those who do not contribute to FONASA but are beneficiaries of the Armed Forces Health, it is the Ministry of National Defense that reimburses the FNR.

[31] Fondo Nacional de Recursos. ¿Qué es el Fondo Nacional de Recursos? FNR, www.fnr.gub.uy/que-es-el-fondo-nacional-de-recursos/

Value Based Care

How it Works: Helps improve efficiencies and deliver better health with existing resources. In this model, the amount health care providers earn for their services is based on the results they deliver for their patients, such as the quality and equity of care. Value based care programs aim to hold providers more accountable for improving patient outcomes while also giving them greater flexibility to deliver the right care at the right time.[32]

Some key elements of value-based care (VBHC) include:

- **Patient-Centered Outcomes**: Focuses on achieving the best possible health outcomes for patients. This includes not only clinical outcomes but also patient-reported outcomes such as quality of life and satisfaction with care.[33]

- **Cost Efficiency**: Emphasizes the relationship between the costs of healthcare services and the outcomes achieved. It aims to reduce unnecessary spending by eliminating ineffective treatments and focusing on interventions that provide the most value.[34]

- **Integrated Care:** Promotes coordinated care across different healthcare providers and settings. This integration helps to ensure that patients receive comprehensive and continuous care, which can improve outcomes and reduce costs.[35]

- **Performance Measurement**: This includes robust data collection and analysis to measure performance. This includes tracking clinical outcomes, patient experiences, and cost data to identify areas for improvement.[36] This can also include a health technology assessment (HTA) or value-based framework used to determine high value services (e.g., vaccination, screening) and help ensure emphasis on those high-value services instead on services that may be outdated or less effective.

Stakeholders:

1. **Payers**: Can include both public and private health insurance companies. These stakeholders are responsible for financing healthcare and creating value-based payment arrangements that incentivize high-quality, cost-effective care.

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[32] Centers for Medicare & Medicaid Services. Value-Based Care. CMS, www.cms.gov/priorities/innovation/key-concepts/value-based-care

[33] Chisholm-Burns, Marie, et al. " Does value-based healthcare support patient-centred care? A scoping review of the evidence." BMJ Open, vol. 13, no. 7, 2023, e070193, bmjopen.bmj.com/content/13/7/e070193

[34] Chisholm-Burns, Marie, et al. " Does value-based healthcare support patient-centred care? A scoping review of the evidence."

[35] van Egdom, Linda, et al. "Value-Based Healthcare from the Perspective of the Healthcare Professional: A Systematic Literature Review." ResearchGate, Jan. 2022, www.researchgate.net/publication/357837272_Value-Based_Healthcare_From_the_Perspective_of_the_Healthcare_Professional_A_Systematic_Literature_Review/fulltext/61e3bb0c8d338833e371123d/Value-Based-Healthcare-From-the-Perspective-of-the-Healthcare-Professional-A-Systematic-Literature-Review.pdf f

[36] Michaela, Bissett, et al. "A Comparative Analysis of Value-Based Healthcare in European Countries." European Journal of Public Health, vol. 31, no. 4, 2021, pp. 676–681, academic.oup.com/eurpub/article/31/4/676/6306804?login=false

2. **Providers**: This group encompasses hospitals, health systems, physician groups, and other healthcare professionals. Providers are tasked with delivering care that meets the quality and cost targets set by payers.
3. **Purchasers**: Includes entities that fund health insurance, such as employers and government agencies. They advocate for cost-effective healthcare solutions and often push for the adoption of VBHC models to reduce healthcare spending.
4. **Patients**: Recipients of healthcare services, patients benefit from more coordinated and personalized care under VBHC models.
5. **Industry Partners**: Includes pharmaceutical companies, medical device manufacturers, and digital health firms. They provide products and services that support the goals of VBHC by enhancing care quality and reducing costs.

What it Offers:

1. **Holistic Care**: Value based care puts an emphasis on addressing a patient's physical, mental, behavioral, and social needs. This type of care can potentially reduce medical costs and improve the quality of care for patients.

2. **Collaboration**: Such programs can also promote collaboration across healthcare teams and encourage providers to spend more time on services that wouldn't normally be covered under fee-for-service, such as counseling or screening for social needs.[37]

Case Study: Cuenta de Alto Costo (CAC) in Colombia[38]

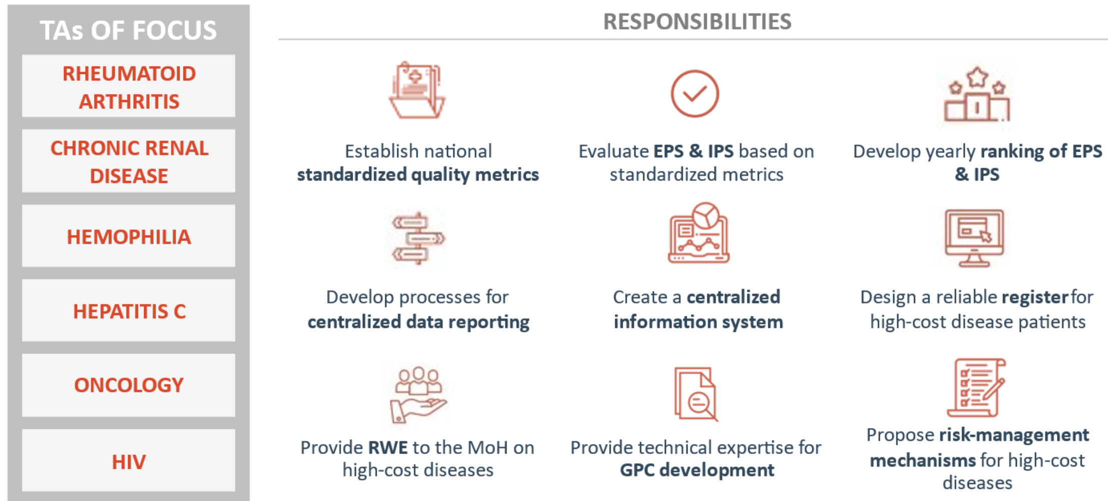
Background

In 2007 Colombia passed decree 2699 which provided a national standardized approach to the management of health information to accelerate the improvements of patients with high-cost diseases and evaluates the performance of the entities providing care. Cuenta de Alto Costo supports numerous high-cost diseases, including rheumatoid arthritis, chronic renal disease, hemophilia, hepatitis C, oncology, and HIV.

[37] The Commonwealth Fund. Value-Based Care: What It Is and Why It's Needed. 2 Feb. 2023, www.commonwealthfund.org/publications/explainer/2023/feb/value-based-care-what-it-is-why-its-needed

[38] Cuenta de Alto Costo. ¿Quiénes Somos? Cuenta de Alto Costo, www.cuentadealtocosto.org/quienes-somos/

CAC provides a national standardized approach for data collection and reporting in selected high -cost diseases.



Source: 1) Cuenta de Alto Costo
HIV: Human Immunodeficiency Virus; EPS: Entidad Promotora de Salud; IPS: Institucion Prestadora de Servicios; RWE: Real World Evidence; GPC: Guia de Practica Clinica; CAC: Cuenta de Alto Costo; TA: Therapeutic Area

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Results

Since its inception, CAC has seen a reduction of the cost of treatment in dialysis therapy for patients - saving the health system approximately $900 billion pesos in 5 years (US$450 million). In the 4 years since this disease has been tracked, approximately 5,169 cases have been prevented from entering Renal Replacement Therapy, which means a saving for the health system approximately 600 billion pesos.

Patient Affordability Solutions

How it Works: Programs designed to reduce the financial burden on patients, making healthcare more accessible and manageable. For example, patient affordability solutions can support out-of-pocket payments through:

- **Cost-Sharing Assistance**: Programs that help cover copayments, deductibles, and coinsurance can make treatments more affordable by reducing the immediate financial impact on patients.
- **Predictable Costs**: Programs that make out-of-pocket costs more predictable, ensuring that patients are not surprised by unexpected expenses. This can include setting caps on out-of-pocket spending.
- **Medication Assistance Programs**: Programs that provide financial aid specifically for prescription medications, ensuring that patients can afford their necessary treatments without financial strain.
- **Income-Based Support**: Programs that include sliding scale fees or subsidies based on income, making healthcare more accessible to low-income patients.
- **Negotiated Savings**: Sharing negotiated savings with patients at the pharmacy counter to lower costs of medications.

Patient affordability solutions can also leverage digital financial services in many ways through:

- **Digital payments**: Instead of traditional payments using hard currency, digital payments are made through online platforms, portals, or applications.
- **Ethical, digital credit/lending and alternative risk scoring**: Lending through financial technologies offer balance sheet consumer lending, where the platform company takes on the risk.[39] Platforms also enable peer-to-peer lending, where consumers are connected to directly to lenders. In addition to traditional risk scoring metrics that use debt balance, and payment of bills; alternative risk scoring uses other data such as digital footprints and proof of income to provide a holistic assessment of and individuals risk to provide them loans.[40]
- **Digital savings/wallets**: A digital wallet enables the storage of financial information and facilitates payments via an online application or portal on an electronic device. It securely stores information and provides easy access, allowing users to make electronic payments wherever accepted. It simplifies savings and does not require a formal bank account.[41]

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[39] Asian Development Bank. Fintech and Digital Health in Indonesia, the Philippines, and Singapore. 2022, https://www.adb.org/sites/default/files/publication/800276/fintech-digital-health-indonesia-philippines-singapore.pdf.

[40] SEON. "Alternative Credit Scoring: How to Score the Unscorable." SEON, https://seon.io/resources/guides/alternative-credit-scoring/.

[41] ACCESS Health International and MetLife Foundation. Fintech for Health: Breaking the Health-Poverty Trap - How Fintech Can Improve Access to Healthcare in Asia. April 2021, https://fintechforhealth.sg/wp-content/uploads/2021/04/Fintech-for-Health_Breaking-the-health-poverty-trap-How-fintech-can-improve-access-to-healthcare-in-Asia.pdf f

To note - not all countries have digital tools or payments that are accessible to the broader population, so some country methods still use credit card or cash for patient affordability solutions and initiatives.

Stakeholders:

1. **Patients**: The primary beneficiaries who need affordable access to medications and healthcare services.
2. **Healthcare Providers**: Doctors, nurses, and other medical professionals who prescribe treatments and advocate for patient access to affordable care.
3. **Pharmaceutical Manufacturers**: Companies that produce medications and may offer patient assistance programs to reduce costs.
4. **Insurance Companies**: Payers that design and implement coverage plans to make healthcare more affordable for patients.
5. **Government Agencies**: Entities that regulate healthcare and may provide subsidies or support programs to enhance affordability.
6. **Pharmacies**: Retailers that dispense medications and may offer discount programs or work with manufacturers on affordability initiatives.

What it Offers:

1. **Ensure Access**: Patient affordability solutions provide tools and services to facilitate access to healthcare services and products.

2. **Reduces Corruption**: Using digital financial services can reduce corruption and fraud.

Case Studies

- **Mobile-Based Health Insurance Wallets**[42]: In Kenya and Pakistan, the use of mobile-based health insurance wallets, like M-Tiba in Kenya and Easypaisa in Pakistan, allow users to send, save, and spend funds for medical treatment through mobile transactions. M-TIBA also provides some direct funding such that users receive additional funds for healthcare beyond what they strictly save on their own. These digital wallets have significantly improved access to healthcare by providing a secure and immediate way to pay for medical services. They have been successful due to features like streamlined enrollment, government disbursements, and reduced regulatory requirements, making healthcare more accessible, especially for the unbanked population.

[42] Wooldridge, Lisa, et al. "Building Community-Based Health and Medical Preparedness: Utilization of a Systems Approach to Strengthen Community Resilience." Disaster Medicine and Public Health Preparedness, vol. 16, no. 1, 2022, pp. 180-186. National Center for Biotechnology Information, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8645240/

- **The Regional Public Good (RPG) "Digital Transformation in Health to Mitigate the Effects of COVID-19 in Latin America and the Caribbean" (LACPASS)[43]:** The LACPASS initiative, supported by the Inter-American Development Bank (IDB) and part of the RACSEL network, aims to bridge digital health disparities in Latin America and the Caribbean. It collaborates with strategic partners like Pan-American Health Organization (PAHO) and HL7 and supporting entities such as Global Alliance for the Development of Blockchain in Latin America and the Caribbean (LACChain), Integrating the Healthcare Enterprise (IHE), and National Center for Health Information Systems (CENS). The project's first phase focused on implementing digital vaccination certificates, aligning with European Union (EU) and World Health Organization (WHO) interoperability standards. The second phase will further develop COVID certificates and enhance the IPS profile for cross-border health interoperability, including moving certificates to digital wallets.

[43] RACSEL. "RPGLACpass: Latin America and the Caribbean Digital Identity Interoperability Framework." RACSEL, https://racsel.org/en/rpglacpass/.

Performance-Based Financing (PBF)

How it Works: Payments to healthcare providers that are based on performance and measured by service quantity. These payments often cover facility costs and staff incentives. Performance-based financing (PBF) schemes usually include verification processes to confirm the accuracy of provider reports on quantity, quality, and community perceptions.[44]

There are different types of performance-based financing. They can be at the service level (e.g., provider payment models aimed at promoting use of high-value services as defined by a value-based care approach); institution level (e.g., designed to improve population coverage of high-value, often preventive services like vaccination and screening); at the product level (e.g., like managed entry agreements); or to catalyze/test new interventions and programs by using blended financing / private financing and measuring performance as in social impact bonds or development impact bonds.

Stakeholders:

1. **Government Agencies**: These bodies design, implement, and regulate performance-based programs to ensure they align with public health goals.
2. **Healthcare Providers**: Hospitals, clinics, and individual healthcare professionals who deliver care and are evaluated based on performance metrics.
3. **Patients**: Individuals who receive care and benefit from improved quality and efficiency in healthcare services.
4. **Non-Governmental Organizations (NGOs):** Groups that advocate for patient rights and monitor the implementation and impact of performance-based solutions.
5. **Regulatory Bodies**: Agencies that ensure compliance with healthcare standards and regulations in performance-based programs.

What it Offers:

1. **Improved Health Outcomes**: By linking financial incentives to specific health outcomes, PBF encourages healthcare providers to improve the quality and efficiency of their services. This can lead to better patient care and overall health improvements.

2. **Enhanced Accountability**: PBF systems often include rigorous monitoring and evaluation mechanisms. This helps ensure that funds are used effectively and that healthcare providers are held accountable for their performance.

3. **Increased Efficiency**: By focusing on results rather than inputs, PBF can help streamline healthcare delivery and reduce waste. This can lead to more efficient use of resources and better value for money.

[44] Díaz, Alba, et al. "Impact of a Web-Based Educational Tool on Health Literacy: A Pilot Study in Patients with Hypertension and Diabetes." PLOS ONE, vol. 18, no. 2, 2023, e0305698, https://doi.org/10.1371/journal.pone.0305698

4. **Data-Driven Decision Making**: PBF programs typically require robust data collection and analysis. This can improve the availability and quality of health data, which can be used to inform policy decisions and improve health system management.

Case Study: Argentina's Plan Nacer and SUMAR[45]

In 2004 Argentina implemented a series of reforms to support universal health coverage for the uninsured. The Plan Nacer program, supported by the World Bank, provided financing for a maternal and child health service for eligible health beneficiaries, consisting of uninsured pregnant and lactating women, as well as uninsured children under six. After the implementation of Plan Nacer, an additional program, SUMAR, served as its successor. SUMAR emphasized preventive health care services for the uninsured, while additionally mandating the inclusion of predefined quality standards for the services provided. While SUMAR built upon Plan Nacer's work, it also included new population groups, including uninsured children aged 6 to 9 years, uninsured youth aged 10 to 19 years and uninsured adults aged under 65. Health care interventions supported under SUMAR (such as maternal and child health services) were also expanded to include cancer prevention, sexual health, and prevention of noncommunicable diseases, as well as interventions to support the federal network for treating congenital heart disease. SUMAR retained the results-based financing mechanisms that had been implemented under Plan Nacer at the provincial government and health care providers levels.

Results:

Between 2010 and 2019, the SUMAR saw the following results:

- The proportion of eligible children, youth and women aged 19-65 with effective health care coverage increased from 7% to 50.4%;
- The proportion of eligible pregnant women receiving pre-natal check-ups before the 13th week of pregnancy increased from 15% to 41.5%;
- The proportion of eligible children under 10 years of age receiving complete health check-ups according to protocol increased from 15% to 69.8%;
- The proportion of eligible women between 25 and 64 years of age with at least one cervical cancer screening every two years increased from 5% to 25%;
- The proportion of eligible men with effective health care coverage increased from 0% to 13.4% (between 2014 and 2019); and
- A total of 8,000 public health providers and all 24 provincial jurisdictions participated in the SUMAR program.

[45] World Bank. "Universal Health Coverage (UHC): Sumar Program in Argentina." World Bank, 29 June 2020, www.worldbank.org/en/results/2020/06/29/universal-health-coverage-sumar-program https://www.worldbank.org/en/results/2020/06/29/universal-health-coverage-sumar-program

About Americas RISE for Health

Americas RISE for Health (RISE) is a public-private, multisectoral forum that harnesses the collective strengths of the region's private sector and civil society in partnership with the region's governments to build sustainable health economies and ecosystems. Its mission is to identify, catalyze, and accelerate multisectoral collaborations that can be pursued on a voluntary basis to help bring about the resilient health ecosystems and economies that the Americas deserve.

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