



Emerging analysis and ideas

DFI health investments as a Covid-19 response

The need for more risk-taking and innovation

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May 2020

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Key messages

- Current discussion around significantly scaling up investment by Development Finance Institutions (DFIs) in response to the Covid-19 crisis should be accompanied by discussion about whether, alongside changes to their balances sheets, DFIs' objectives, business models and tools need to change to take on more risk and include a focus on high social return investment, including health. This discussion becomes necessary as much of the scaled investment is likely to be counted as official development assistance (ODA).
- ODI analysis indicates that DFI investment in the health sector is low and is largely directed towards infrastructure and pharmaceuticals in upper-middle income and lower-middle income countries, with a significant concentration in Turkey and India.
- This pattern of investment is not inevitable. There are examples of high risk-taking and innovative approaches which demonstrate that investment need not be concentrated in infrastructure and a few MICs. The use of pooled investment vehicles, volume guarantees, first loss guarantees and Development Impact Bonds (DIBs) demonstrates the potential of DFI investment to act as a catalyst for market development, especially in health supply chains.
- These examples show that DFIs can move beyond a narrow focus on job creation and focus on other impacts that can be truly life-changing. Critically, these examples also show that financial returns are compatible with high social returns, and that issues of affordability and access can be addressed by DFI investment.

About this article

The authors would like to thank Mark Miller, Anne Buffardi and Dirk Willem te Velde of ODI for insightful comments on an earlier draft. Any errors are the authors' own. The authors gratefully acknowledge the generous financial support of the Bill & Melinda Gates Foundation, which has made this research possible.

1 Introduction

Covid-19 is a truly global pandemic: a virus that will leave no country untouched by its direct and indirect effects on health systems, societies and economies. While the world is still in the midst of the crisis, it is clear that these effects will not be felt equally. Advanced economies are much better placed to weather the health and economic storm than developing countries, where the economic, social and health effects will be most profound and long-lasting (Miller et al., 2020).

From past crises we can expect a large exit of external capital from developing countries, eroding already fragile fiscal and balance of payment positions with further devastating consequences for development and growth (IMF, 2020). Development Finance Institutions (DFIs)¹ can play an important role in countering this outflow of capital and provide much-needed investment to kick-start economic growth. Much has already been written on this, focusing on the provision of working capital and trade finance to preserve jobs (Bilal et al., 2020; Lee, 2020) – an echo of CDC Group (n.d.b) and the International Finance Corporation (IFC)'s (n.d.a) investments in response to the Ebola crisis in West Africa. With DFI proponents² calling for significant capital injection or funding³ and increased DFI investment to accelerate growth and 'build back better' (EDFI, 2020), it is timely to pause, take stock and reflect on the future role of DFIs.

Providing the background to this discussion are two salient, interrelated points: 1) governments have already supported the increased capitalisation of DFIs; and 2) these capitalisations and DFI investments can now be counted as official development assistance (ODA).⁴ For many DFIs, the expansion of their balance sheets has come at very low cost to themselves, and provides an opportunity for them to alter their objectives and business models. If DFI business models were performing well before these changes to their capitalisations and accounting rules, increased cheap capital should allow more flexibility to pursue investments that have higher financial risks, but may also have higher development returns. The following discussion of investments in innovative financing mechanisms for health interventions is therefore timely as it acknowledges, both these shifts within DFIs, and the immediate challenges facing developing countries.

This note seeks to stimulate and inform debate around how, by changing their own risk-return profiles, DFIs can take advantage of their unique capacities to help strengthen health markets, and in doing so enhance the resilience of developing countries to health shocks and support the

¹ For our purposes, the private sector window operations of multilateral and regional development banks (MDBs and RDBs) are included in this classification of investments.

² See <https://www.ft.com/content/9143d05c-906d-11ea-9b25-c36e3584cda8>.

³ Bilateral DFI donors may choose to count capital injection or increased funding of their DFIs as ODA under the provisional OECD DAC reporting arrangements for private sector instruments. There is also ambiguity as to how multi-donor trust funds and other hybrid bi-/multilateral channels used to blend are accounted for.

⁴ For bilateral DFIs.

formation of human capital. By providing a link in the financing chain between grant-based, highly concessional capital and commercial capital, DFIs can not only create jobs, but also help create health markets and support healthy workforces. The US International Development Finance Corporation's recently announced Health and Prosperity Initiative, seeking to invest \$2 billion and catalyse \$3 billion in private financing (Saldinger, 2020), recognises the importance of resilient health structures, and the role that equity and debt, political risk insurance and technical development can play in financing these goals. To date, however, other DFIs have remained quiet on fashioning a response to Covid-19 that meets this specific issue.

The note is structured as follows. Section 2 reviews the current landscape of DFI investment in health. Section 3 looks at DFI investments showcasing the possibilities, and section 4 offers insight into approaches that could help scale and replicate health investment, and act as a catalyst for market development. Section 5 concludes the note.

2 A snapshot of DFI health investment

At the outset we acknowledge that the potential of DFI investment in the health sector is complex, depending on DFI capacity, the strength of the host country's health system and the host country investment climate. The issue is also vexed as shareholders and civil society have strong views about health provision as a public good, and equity concerns.

Notwithstanding these issues, the private sector plays an important role in most countries' health systems regardless of the model of provision. It is estimated that about 50% of healthcare services in Africa are provided by the private sector (Convergence, 2019). Initiatives such as GAVI have demonstrated that private investment, if done right, can be additive to public finance, and that public development finance can successfully crowd in private investment to scale transformative initiatives. Here, we briefly set aside public/private ideological debates to explore how DFIs can support health systems, while remaining mindful of equity concerns.

Data overview

The following analysis is based on ODI's DFI commitment database, which covers the period 2013 to 2018.⁵ The analysis looks at eight DFIs: the Asian Development Bank, the European Investment Bank (EIB), the IFC, the Multilateral Investment Guarantee Agency (MIGA), the World Bank International Development Association's (IDA) funds, Agence française de développement (AFD) and Proparco, the CDC Group and the United States International Development Finance Corporation (DFC). These eight DFIs accounted for almost 70% of the total private finance mobilised by DFIs in 2017 and 2018, as reported to the OECD (OECD, 2020a).⁶ As such, the analysis offers a fair snapshot of the state of DFI investment in health.

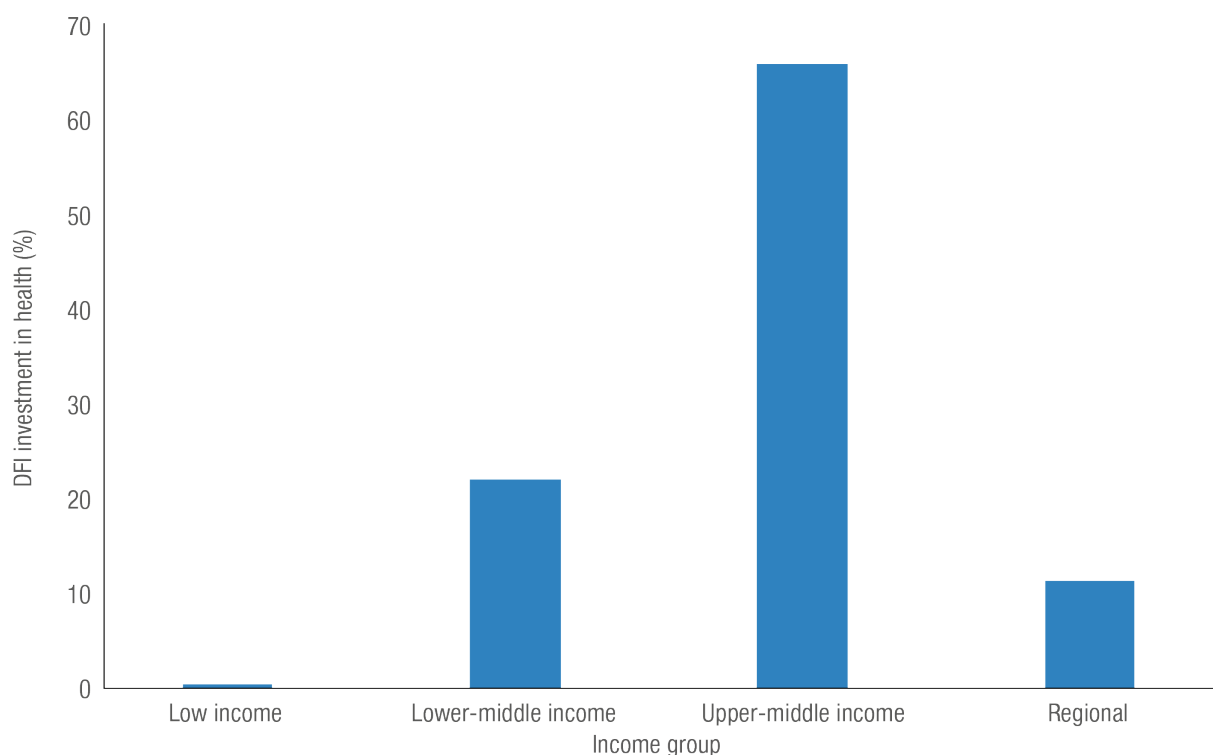
⁵ For a summary of data intricacies, see Annex 1.

⁶ Our DFI commitment database covers investments made by 11 institutions accounting for 73% of the total private finance mobilised by DFIs from 2017 and 2018. The three DFIs excluded from this analysis did not have identifiable health investments.

Findings

From 2013 to 2018, our sample of DFIs invested almost \$5.6 billion in the health sector, or less than 3% of their total investments over that period. Of this, almost \$5.4 billion (96%) was invested by five DFIs: IFC (\$2.3 billion), US DFC (\$1.3 billion), MIGA (\$780 million), EIB (\$460 million) and CDC Group (\$550 million).

Figure 1 Income group shares of DFI investment in health, 2013–2018⁷



Source: Authors' calculations based on ODI dataset.

Given previous research (Attridge and Engen, 2019), the data in Figure 1 was unsurprising in that the majority, \$4.9 billion of the \$5.6 billion invested by DFIs, went to countries that were classified as upper-middle income and lower-middle income, whereas low-income countries received only four investments, totalling \$16 million.⁸ Within the upper-middle income and lower-middle income classifications, much of this investment was in Turkey and India. Investments in Turkey accounted for 62% of the total in upper-middle income countries and 41% of total investments by DFIs in health, while India received 67% of the investment in lower-middle income countries, 15% of the global total. Whereas investments in India were diverse with respect to the investor and the type of investment being made, DFI investments in Turkey were concentrated in projects to build new hospitals and refurbish older ones under the government's Health Transformation Program (HTP). Investments of this type were made by IFC, EIB, US DFC and Proparco, aided by investment guarantees provided by MIGA (Box 1).

⁷ Investments classified as 'Regional' are those for which there are multiple countries of investment or the geographic location of the investment is reported as a continent.

⁸ From 2013 to 2017, low-income countries received 7% of total DFI investment.

Box 1 Turkey's PPP hospitals: financial innovation and improved health access

As Turkey's economy grew during the 1990s and early 2000s, it was evident that the country's healthcare system was not keeping pace. To address this, the government created the Health Transformation Programme and, with the support of the World Bank and the EBRD, developed the Integrated Health Campuses PPP Programme. The programme aimed to build 29 new hospital facilities to house 42,000 high-quality hospital beds. As of June 2017, 11 hospitals had reached financial close.

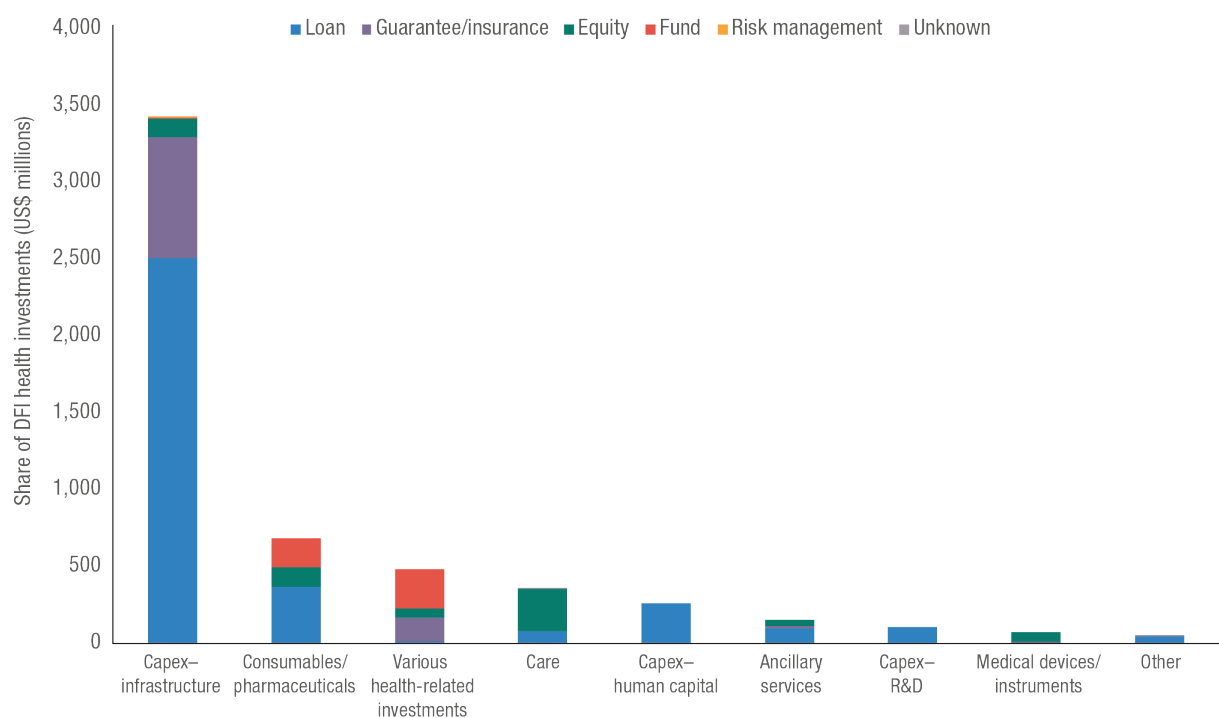
The PPPs are structured as design, build, finance and maintain agreements whereby private consortiums provide these services for 28 years, but core medical services remain the responsibility of the Ministry of Health. In the case of the Elazig hospital, the €360 million project was financed via €288 million in senior debt, split between three bond issuances, and €72 million in equity. One bond, the €80 million, 20-year senior secured A2 bond, was purchased by the IFC. The other two bonds, an €83 million 18-year senior secured A1A bond and a €125 million 20-year senior secured A1B bond, were provided political risk insurance guarantees by MIGA and a revenue support facility by the EBRD that would cover debt service and other costs in the event that the Ministry of Health could not make the bond payment. These provisions improved the A1 bond ratings and made them investment grade, two notches higher than Turkey's sovereign rating (GIH, 2017).

In terms of replicability and scalability, key factors in the success of the Elazig project was the government's support of the PPP process, robust contractual frameworks and a recognition among ratings agencies of the value of multilateral mitigation products (Jordan-Tank and Kanchi, 2017). However, it must be noted that the major DFI parties in the Elazig transaction were those with large balance sheets enabling them to participate in this large project and to serve that catalytic function.

The significant share of investments in hospitals, clinics and other health centres, captured as investment in infrastructure, compared to the rest of the health portfolios of DFIs is also illustrated in Figure 2. Both Figure 2 and Box 1 highlight DFIs' preference for investing in projects that have large ticket sizes to minimise relative transaction costs,⁹ and for investments for which the return curve is familiar. The Elazig project described in Box 1 also demonstrates DFIs' capacity to create innovative financing packages for an output in health infrastructure that is likely to perform similarly to other DFI infrastructure assets. It speaks more to DFIs altering the market for financing, and less about altering the market for healthcare. This celebrated financing structure, and the favouring of investments in infrastructure, signals the subsectors of health in which DFIs are willing to invest, based on the risk/return profile of infrastructure investment and how these investments match the risk/return profiles of existing DFI portfolios. However, as noted above, the risk/return composition of DFI investment portfolios should change to carry more risk given these institutions' increased access to cheap capital. This shift should also be reflected in the type of future health investments.

⁹ For 60 DFI investments classified as 'Capital Expenditure-Infrastructure', the median investment was \$30.3 million. See Annex 2 for more information.

Figure 2 DFI health investments, 2013–2018



Source: Authors’ calculations based on ODI dataset.

One factor that needs to be kept in mind in any discussion of portfolio reallocation is development impact. The data suggests that DFI investments are rarely explicitly cited as targeting low-income clients. In fact, only \$102 million, or 2% of health investments, specifically mentioned targeting poor or low-income clients in their project descriptions. One example is CDC Group’s \$48 million investment in Narayana Health, which aimed to deliver quality healthcare to more than 2 million patients in underserved parts of central and eastern India. According to CDC Group (n.d.a), around half of patients receive financial support for treatment, either from Narayana or through government schemes. As discussed in section 3, DFIs can and do seek to address equity issues in their investments, but more transparent reporting regarding who accesses and is impacted by health investments would shed light on the importance of these investments. It would also go beyond simplistic impact analysis linked to how many jobs are created by a DFI investment.

Some investment descriptions also provide information on the type of health issue the investee tackled. In many cases, the investee was an integrated health campus or hospital that addressed a variety of ailments. Anecdotally, there were numerous specialised investments in maternal and children’s health facilities, cancer care facilities and diagnostic centres and eye-care clinics, as well as investments targeted towards other non-communicable diseases. However, as mentioned, investment volumes were predominantly directed to large-ticket projects that had multiple health targets.¹⁰ While increasing the resilience of a healthcare system requires investments in multiple causes, the transaction costs involved mean that DFIs are likely to favour larger investments in large, multi-targeted projects, rather than specialised, targeted interventions that may require smaller investments, but a similar level of investor due diligence. Nevertheless, innovative

¹⁰ For data on average investment size, see Annex 2.

financing mechanisms offer DFIs opportunities to invest at different volumes and at different risk levels. In other words, they offer an opportunity to err on the side of action over worrying about transaction costs.

3 Innovative examples as opportunities for the future

A review of DFI health investment at the individual investment level and the track record of global health initiatives reveal an appetite, not only on the supply side of finance (both public and private), but also on the demand side (from developing country governments, businesses and patients) for blended and innovative finance to mobilise additional private investment in health. It also demonstrates that DFI investment need not be concentrated in infrastructure; there are opportunities across the health value chain¹¹ and across the financing chain where DFIs can take on a variety of roles according to their mandate and business models. The examples below showcase approaches that could: 1) help scale and/or replicate health investment; and 2) act as a catalyst for market development. Not all examples will be applicable to all DFIs, but they do demonstrate the various investment sizes and subsectors available to DFIs if they are willing to rise to the challenge the current crisis presents.

Scaling investment: catalysing private company investment via volume guarantees

Example: MedAccess

In 2017, CDC Group seeded MedAccess with \$200 million, creating an entity offering volume guarantees that reduce the commercial risk to medical suppliers and accelerate supplies into new markets at affordable and sustainable prices. By reducing commercial risk, suppliers are more willing to commit their own resources to increasing production. For example, in 2019 MedAccess partnered with the Bill and Melinda Gates Foundation (BMGF) to provide a four-year guarantee to BASF to bring innovative mosquito nets to malaria-endemic countries. The agreement enables BASF to better plan its long-term resources as sales volumes are guaranteed, allowing it to reduce the costs of the new nets by 40% (MedAccess, 2019). MedAccess has also partnered with the Clinton Health Access Initiative and Hologic, a global diagnostic supplier, on a volume guarantee agreement to reduce the price of viral load testing and extend the scope of testing to include HIV, Hepatitis B, Hepatitis C and Human Papilloma Virus (MedAccess, 2018). In both cases, MedAccess and its partners have been able to alter the market conditions for medical supplies, increase access for vulnerable populations and have these private companies increase their investment dedicated to these issues.

DFIs can also take smaller positions in smaller initiatives. A clear example, and one that could be replicated by DFIs, was a \$225 million guarantee to Bayer AG to supply 27 million contraceptive implants over a six-year period, provided by the Swedish International Development Cooperation Agency (SIDA), the Norwegian Agency for Development Cooperation (Norad), BMGF and CIFF. Since the guarantee meant that Bayer knew how many implants to supply and, essentially, ignore concerns about demand, it was able to offer the implants for \$8.50 per unit, down from \$18. Merck, the only other manufacturer of the implant,

¹¹ From research and development of new health products and technologies to strengthening the physical health infrastructure and health supply chains, developing and growing the health workforce through training and development and reducing barriers to accessing healthcare through the provision of insurance.

reached a similar agreement to provide 13 million units. As with the MedAccess examples, the volume guarantee releases private capital towards a significant health issue facing women.

Scaling investment: pooled investment vehicles can diversify risk inherent in health investment

Example: Global Health Investment Fund

The Global Health Investment Fund (GHIF) is a \$108 million pooled social impact investment vehicle that supports the research and development of drugs, vaccines and new technologies for neglected diseases, which disproportionately affect developing countries, focusing on late-stage innovations. Anchored by a \$10 million equity investment by IFC, the GHIF also benefits from a partial guarantee provided by the BMGF and SIDA. Under the guarantee, viewed as essential in attracting a diverse group of investors including commercial capital (AXA, J.P. Morgan), BMGF and SIDA assume the full risk of first loss up to 20% of invested capital. Once the 20% is exhausted, BMGF and SIDA share 50% of the losses with investors, essentially guaranteeing 65% of the entire fund (IFC, 2017).

The GHIF's investment mandate is to fund health companies with products that have a high probability of successful commercialisation within two or three years. Of greatest interest to GHIF are products with 'dual market' potential: i.e. that will have a clear impact on public health in developing countries, but also have value in high-income countries. GHIF investee companies are legally required, through Global Access Commitments, to make their products available to the developing world at an affordable price. These commitments remain in force if the investee is acquired, compelling investees to either adopt a low-price, high-volume business model, or find alternative revenue streams. In 2017, GHIF estimated that, by 2025, the products in its portfolio would save the lives of 140,000 people and improve the lives of 10.9 million people suffering from malaria, HIV, tuberculosis, cholera, onchocerciasis (river blindness) and pregnancy-related conditions.

Example: Medical Credit Facility

The Medical Credit Facility (MCF) is the first and only debt fund entirely focused on the injection and mobilisation of private finance into the SME healthcare sector in sub-Saharan Africa. The facility supports increased access to finance via direct and indirect lending through local financial institutions and the provision of technical assistance to improve the quality of healthcare services and strengthen business sustainability (Convergence, 2019). The facility is a blended structure, with the first loss capital funded by USAID and debt financing provided by three DFIs (OPIC, CDC and IFC) and impact investors. The MCF's success has attracted more 'impact-orientated commercial' capital in later financing rounds to join the original capital provided by 'impact-first funders' – a clear example of how each investor sees itself in different funding iterations based on their risk and return appetites.

The MCF offers several loan products of different sizes and tenors to health SMEs. With loan amounts ranging from \$1,000 to \$2.5 million and maturities up to 10 years, the MCF is a viable financing partner for a multitude of companies. Specifically, the MCF increased loan sizes and tenor lengths to support larger companies such as pharmaceutical firms and equipment suppliers, which need large amounts of capital to expand their operations. To date, the MCF reports disbursing 4,471 loans in sub-Saharan African countries for a total volume of almost \$77 million, with an average loan value of \$17,163. As of 2017, issued loans had a 96% repayment rate.

Evidently, the MCF is meeting a need among health SMEs for access to small amounts of capital to upgrade and expand services quickly.

Market development: Development Impact Bonds can crowd in additional private finance and deliver strengthened health outcomes

Example: Cameroon Impact Bond

Development Impact Bonds (DIBs) are innovative performance-based payment contracts for the provision of services in developing countries. DIBs have not been widely used in development finance yet offer the potential to crowd in private investment to secure improved health outcomes and establish sustainable health financing models. To date three DIBs have focused on health: the Utkrisht Impact Bond (maternal health), the Humanitarian Impact Bond (physical rehabilitation) and the Cameroon Cataract Bond (CCB). The CCB is especially noteworthy and instructive for three reasons: 1) it is the first and only DIB with a DFI as the main investor; 2) it has a financial sustainability performance target, whereby the hospital (the Magrabi ICO Cameroon Eye Institute (MICEI)) should become financially self-sustainable at the end of the five-year investment period; and 3) it has an equity target whereby 40% of surgeries must be provided to the very poorest.¹²

In 2017, US DFC made an anchor debt investment of \$1.75 million in the CCB, alongside a \$250,000 investment by the Netri Foundation. The bond supports the MICEI to provide quality affordable cataract treatment. The hospital employs a cross-subsidisation model where wealthier patients subsidise treatment for low-income patients at low or no cost. After five years the investors are paid back their investment by the outcome funders,¹³ who also pay a return based on how well the hospital has met its performance targets. There is no risk to US DFC, an unusual set-up in existing DIBs, as the loan has 100% capital protection; the risk of non-performance is shared between the outcome funders and the service provider (MICEI). This latter point is particularly important as the service provider is incentivised to meet targets.

Once fully operational, it is expected that treatment capacity in Cameroon will be increased by up to 50%, enabling 60,000 patients to be treated annually, including patients from remote communities who will be given transportation for treatment. The first-year results are encouraging and suggest that the initiative is on track to meet its performance targets.¹⁴

Market development: DFI health investments can integrate equity concerns

Example: USDFC debt investment in the Aga Khan Hospital, Karachi

Like the CCB, US DFC's \$30 million loan for the expansion of the Aga Khan Hospital and Medical College in Karachi is an example of an investment in an institution operating a cross-subsidisation model. The investment was to fund the construction of a new ambulatory care building, a neonatal, medical and paediatric intensive care unit and other facilities. The hospital's innovative Patient Welfare Programme cross-subsidisation scheme helps ensure that the infrastructure investment has greater health impacts for vulnerable populations. According to the hospital's 2017 annual report, 710,000 patients received patient welfare, up from 94,000

¹² Defined as individuals belonging to the bottom two wealth quintiles of the population of Cameroon.

¹³ The Conrad N. Hilton Foundation, The Fred Hollows Foundation and Sightsavers.

¹⁴ <https://www.africanews.com/2019/06/07/cameroon-cataract-bond-records-successful-first-year/>.

recipients in 2012 and accounting for over 34% of the patients served by the hospital. According to the hospital's valuation this welfare was worth \$24 million in 2017, and cumulatively worth almost \$161 million since its inception in 1986 (AKU, 2017). US DFC's investment seems to have expanded services to all clients, enabling Pakistanis to enjoy more equitable access to important health services.

Example: GHIF and the US Food and Drug Administration Priority Review Voucher

As discussed above, the GHIF legally requires investee companies to make their products available to developing countries at an affordable price. However, it has also found an innovative way to ensure that medicines can be donated for free to the poorest and most vulnerable populations using the US Food and Drug Administration (FDA) Priority Review Voucher (PRV) System. The scheme allows pharmaceutical companies that develop drugs for neglected tropical diseases to earn a PRV if their drug is approved. The PRV allows the holder to seek FDA approval on a fast-track basis, and can be auctioned off (IFC, 2017). GHIF investee Medicines Development for Global Health (MDGH) has been developing a new drug, Moxidectin, to treat and possibly eradicate river blindness. As MDGH has undertaken to deliver the drug on a cost-recovery basis, and if the drug is approved by the FDA, MDGH intends to auction its PRV and use the proceeds to donate large quantities of the drug to the poorest and most vulnerable.

Market development: health insurance can reduce the barriers to healthcare access

Example: MicroEnsure

In 2012, as part of a larger capitalisation programme, IFC invested \$2.2 million in MicroEnsure, a company bringing insurance coverage to people at the bottom of the pyramid. MicroEnsure works as an insurance broker and offers back-office support to microfinance institutions and sales partners that offer its products. Other partners include mobile network operators, agricultural suppliers, health clinics, non-governmental organisations, faith-based networks and associations. While it offers over 200 types of insurance, its primary health offering is a hospital cash product. Some members of MicroEnsure's distribution network cover basic insurance premiums for clients based on the amount of airtime purchased from a network provider, or the amount deposited with a financial institution. IFC's capital arrived at a point where MicroEnsure was transitioning from grant-based support of its business growth to growth based on equity and debt investments. IFC's project disclosure (IFC, n.d.c) indicates that MicroEnsure was operating in five countries and offered insurance products to 4 million people. MicroEnsure (n.d.) now reports serving 40 million customers in 20 countries, 85% of whom had never previously had an insurance product.

Example: Intellicare

IFC has also invested in Fullerton Health, which owns and operates an extensive network of health clinics in the Asia-Pacific. To enable it to expand in the Philippines and diversify its operations, IFC (n.d.b) provided Fullerton Health with a \$40 million loan to acquire a 60% controlling stake in Intellicare, a Filipino health organisation. Intellicare works with corporate and SME clients to provide health benefits to their employees. Between 2000 and 2016, coverage offered by Intellicare (n.d.) rose from 100,000 individuals to 1 million. While this investment only serves people in employment and may not have the same impact as MicroEnsure, it is nevertheless helping to grow a business providing health insurance to people who, presumably, did not have it previously. Nine hundred thousand more Filipinos have health insurance because

Intellicare was able to expand its operations; an expansion that was enabled by Fullerton's acquisition of Intellicare and financially supported by the IFC.

4 Key insights for future DFI investment

Scaling investment

- Scaling investment by attracting private capital can be done at different levels. Volume guarantees can convince private companies to dedicate more resources to a specific health provision. Pooled investments attract commercial financiers via risk diversification. Financial guarantees for large-scale projects can mobilise institutional investors seeking to diversify their alternative investment portfolios.
- Co-investments and pooled investment vehicles are mechanisms through which DFIs with limited capital can remain flexible regarding investment volumes and investment risk. These investments also allow DFIs to 'scale down' and participate in investments for which their own transaction costs would make the investment prohibitive.
- On risk, DFIs may face trade-offs regarding their risk appetite and the ability of their capital to mobilise private finance. Key to attracting private investment to the health sector has been the use of grant funding, often provided by donors (USAID, in the case of the MCF), which has funded first loss tranches or guarantees (issued by donor agencies and/or philanthropic agencies, as was the case for BMGF and SIDA for the GHIF). DFI investment has sometimes been complementary by following this grant funding and taking subordinated positions (subordinated debt and/or equity), which provides investment vehicle endorsement and comfort to other, private investors. This evolution in the financing structure highlights how different investors with different risk and return appetites can collaborate over time and work towards increasing the participation of more commercially focused investors in later stages.
- First loss guarantees (to date mostly funded by donors and/or philanthropies) offer great potential to attract private finance. However, these powerful financial tools only accounted for 8% of the transactions and 16% of the invested volumes in our DFI health investment data, and mainly related to large infrastructure investment. Prudent employment of these tools in the right markets can attract large-scale private financing by altering the risk/return profile for private investors.

Market development

- Innovative, performance-based payment contracts such as DIBs can leverage private investment to deliver significant social returns. They can integrate impact targets into private investment, incentivise innovation and strengthen the delivery of health services, while creating sustainable funding models.
- Investing in health providers that employ cross-subsidisation models, where services provided to wealthier clients subsidise services provided to poorer ones, broadens the client base of health providers and increases access among vulnerable populations. The example of the CCB also indicates that cross-subsidisation models can be financially sustainable and allow original investors (i.e. DFIs) to exit when appropriate.
- By diversifying risk and incentivising product development, DFIs investing in pooled funds can support the research, development and market penetration of new health products to underserved markets without the risks associated with being a sole investor.

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- Working with investees to find alternative sources of revenue via government programmes such as the FDA's PRV can enhance impact, and demonstrates the development additionality that DFIs can bring to an investment.
 - Given the prevalence of private healthcare, DFI investments in health insurance schemes allows these operations to expand their footprint and reach and retain clients who had previously been uninsured and vulnerable to costs associated with catastrophic health events.

5 Conclusion

As shareholders and donors reflect on the future role of DFIs and blended finance in supporting developing countries to 'build back better', it is necessary to revisit their mandate, objectives and business models. We know the 'return to normal' will be a return to a different 'normal', where developed and developing countries engage differently. This future presents an opportunity for DFIs to broaden their investment theses to focus more on high-impact, transformative investment as their balance sheets expand. An increase in development capital will be accompanied by increased expectations.

This note has shown that DFI health investment to date is heavily concentrated in health infrastructure and in a handful of middle-income countries. We have briefly showcased some interesting examples and innovative approaches that suggest that this pattern need not be inevitable, and which illustrate the potential of DFI investment to act as a catalyst for market development, especially in health supply chains. These should be explored to see how they can be scaled and/or replicated, as they demonstrate the life-changing impact that DFI investment can have when DFIs move beyond their comfort zones and beyond a narrow focus on traditional impact metrics. They also underscore the critical role of high-risk-carrying capital; show how financial returns can be compatible with significant social returns; and demonstrate that issues of affordability and access can be addressed by DFI investment.

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Annex 1

Detailed methodology

Investment data was collected from individual DFI websites and covered investments disclosed for the period 2013–18. To ensure accuracy, the data is compared to the annual commitment figures disclosed by the DFIs in their annual reports.¹⁵

Amount invested

All investment amounts were converted to US dollars using the OECD (2020c) conversion rates using annual average rates.

Instrument

Investments in funds were classified as ‘funds’, regardless of whether the instrument used was debt, equity or otherwise. Projects classified as risk management (at IFC) and risk participation (at CDC) were grouped into the ‘risk management’ instrument. For projects where multiple instruments were used, we applied the instrument classification used by the institution in its database.

Sector classification

To maintain consistency with previous analyses, investments were classified per the same classification as Table A5 in *Blended finance in the poorest countries: the need for a better approach* (Attridge and Engen, 2019: 70–71).

Identifying health-related investments

The following steps were taken to find health-related investments within broader sectoral classifications.

1. Filtered all investments by sector and extracted investments labelled as ‘Social sector’.
2. Visited individual project descriptions to ascertain whether investments classified as ‘Social sector’ are related to health or education investments. Retained investments related to health.
3. To find health investments which may have been misclassified, education investments and non-‘Social sector’ investments were searched again by using a text search of the project title and/or project descriptions using terms: ‘medic’, ‘hospit’, ‘bio’ and ‘pharma’. Search returns were investigated and included/excluded based on applicability.

¹⁵ The data downloaded/received differed from annual reports by more than 3% for only two DFIs.

Note: investments in funds were only included if the fund was solely dedicated to investments in health or if the amount dedicated to the health portion of the fund was indicated by the DFI.¹⁶

Note on AFD/Proparco investments

Investment data was provided by AFD. Health investments made by Proparco were identified using the same steps outlined above.

For investments made by AFD, only loans, guarantees and bond investments made to private sector entities were included in the broader blended finance investment database. Grants were mostly excluded, unless the grant was made to a private sector entity and AFD reported additional capital being mobilised by its investment.

¹⁶ For example, EIB invested in Leapfrog Emerging Consumer Fund III, a fund investing in companies that provide access to high-quality financial and health services. EIB provided a disaggregation of the investment amount between health and financial services. The amount for health was included in the health investment data. US IDFC and Proparco made investments in the same fund, but did not disclose a disaggregation in their project documents. Therefore, it could not be ascertained how much of the investment was dedicated to health. As a result, these investments were not included in health investment data.

Annex 2

Below are summaries of the average and median investment based upon different groupings.

DFI aggregation	Number of investments	Average investment size	Median investment size
Multilateral DFI aggregation	84	\$42,571,842	\$24,500,000
Bilateral DFI aggregation	37	\$53,638,937	\$19,990,932
Total	121	\$45,955,995	\$20,676,324

DFI	Number of investments	Average investment size	Median investment size
Asian Development Bank	2	\$34,640,000	N/A
CDC Group	11	\$50,234,955	\$38,812,636
European Investment Bank	8	\$57,801,839	\$40,921,129
International Finance Corporation	68	\$33,309,412	\$19,950,000
Multilateral Investment Guarantee Agency	6	\$129,883,333	\$118,250,000
US International Development Finance Corporation	18	\$69,823,004	\$8,750,921
Agence française de développement/Proparco	8	\$21,905,264	\$18,401,653
Total	121	\$45,955,995	\$20,676,324

	Number of investments	Average investment size	Median investment size
Infrastructure	60	\$57,109,295	\$30,282,333
Consumables/ Pharmacies	14	\$48,809,481	\$23,215,000
Various health-related investments	10	\$47,670,838	\$31,906,318
Care	18	\$19,800,116	\$8,140,000
Human capital	1	\$257,035,714	\$257,035,714
Ancillary services	7	\$21,562,857	\$11,110,000

Research & Development	3	\$34,770,000	\$25,000,000
Medical devices/ Instruments	3	\$21,483,333	\$2,750,000
Other	5	\$8,187,760	\$322,660
Total	121	\$45,955,995	\$20,676,324



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