THE BROOKINGS INSTITUTION

WEBINAR

OUTCOMES-BASED FINANCING: POSSIBILITY AND PROMISE IN GLOBAL HEALTH

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OPENING REMARKS:

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GUFSTASSON-WRIGHT: Good morning, good afternoon and good evening to everybody joining us from around the world. Welcome to this webinar on the possibility and promise of outcomes-based financing for global health. For those of you who don't know me, I'm Emily Gustafsson-Wright. I am an economist and senior fellow in the Global Economy Development program at the Brookings Institution, based in Washington, DC. I lead our work at Brookings on innovative, and outcomes-based financing and have been researching impact bonds and outcomes funds for over a decade now. Prior to that, I spent, decade doing research on the impacts of innovative health financing initiatives, including low cost, community based health insurance schemes, primarily on the African continent.

Today's webinar features a wide range of experts, who have been involved in outcomes-based financing or similar mechanisms for health on different continents. The webinar is a follow up to a one day workshop that we held in Zurich in March, in which we brought together some of the world's experts on outcomes-based financing and global health, to discuss their lessons learned and ambitions for the future. I'd like to thank the PharmAccess Foundation, Joep Lange Institute and Achmea Foundation for their close partnership. This event and the previous work, these organizations and the Lego Foundation provide generous support to the center for Universal Education at Brookings, which helps to make the work we do possible. I'd like to reiterate Brookings' commitment to independence and underscore that the views expressed today are solely those of the speakers.

So our goal today is to illuminate the experiences, to date, and to collectively engage in the challenging question of if, how and where outcomes-based financing may help to address the myriad health challenges faced globally today. Including the rise in premature deaths from non-non-communicable diseases. The failure to reach targets on such diseases and malaria and TB. The compounding global crises weighing on the most marginalized populations, including climate change, geopolitical instability and displacement. So I after I, provide some background, on outcomes-based financing and share, some data from the global landscape of outcomes-based financing, we'll hear from Nicole Spieker, who is the CEO of PharmAccess Foundation, who will also share a summary of the insights from our workshop in Zurich.

And note that we recently published a blog post summarizing that event, which can be found on the Brookings website. After Nicole, we'll hear from our esteemed panelists. And that will be followed by an opportunity to ask questions to the panelists. If you have questions, please submit them to by emailing events@brookings.edu. Or you can also use X or Twitter, by using the hashtag #OBF, the number 4 and global health. So that's hashtag #obf4globalhealth. All right, so with that, we'll dive into, a bit of, a background on, on outcomes-based financing just to make sure that we are all on the same page. All right. So I'd like to place, outcomes-based financing in the broader, landscape of innovative financing mechanisms. So on the in, in, in innovative financing, we have both innovative sources, funding as well as innovative, innovative ways of delivering that funding.

So, on the left hand side of this table, you can see such things as syntaxes, airline taxes, carbon auctions, those are examples of innovative sources. And then on the right hand side, we have innovative delivery mechanisms which includes non-contingent disbursements and contingent disbursements. and non-contingent disbursements includes things such as bonds and notes, guarantees for risk mitigation, unconditional cash transfers. On the right hand side we have the broader category of results based financing. And just to note in each of these categories, you can also have public private partnerships and blended finance that, that include elements of these different types of mechanisms. So we're focusing on results based financing. And what is results based financing. So in terms of financing, funding depends upon the achievement of pre-agreed and verified results. There are lots of different types of results based financing, and the way that they differ is primarily by who it is that holds the financial risk or the contingency for the payments.

So in the left hand column, you can see, that this includes, this can be national governments, local government service providers, investors or beneficiaries. And the middle column is the broader instrument category. And on the far right, the RBF instrument. What we'll be focusing on today is outcomes-based financing, which includes social impact bonds, which also is called pay for success contracts, outcomes contracts, development impact bonds. Environmental impact bonds. Outcomes funds. And, for this, category of results based financing. The, the entity that holds the financial risk or immediate financial risk, direct financial risk, contingency for payment, is the investors.

So how does this work? Investors provide a risk capital to service providers to deliver services to a population in need. And then an independent evaluator, verifies whether, the service provider has, agreed, has achieved some pre-agreed, impact metrics, and then the outcome funder, in the case of a social impact bond, as government in the case of a development impact bond, and primarily focused in low and middle income countries, could be a, third party sets, such as a donor or, a foundation, for example. Note that there are also social impact bonds. Today in, in middle income countries. So development impact ones, are not the only type of impact bond that can exist in a lower middle income country. So the investor provides the risk capital. There's a verification whether or not some agreed upon outcomes have been achieved.

And then if outcomes have been achieved, the outcome funder pays the investor, back their principal, plus some return or partial return, depending upon, whether or not found outcomes have been achieved or no return or no principal back if outcomes have not been achieved. So, globally today, based on our Brookings database of, verified projects. So all the projects in our database are verified by, the projects themselves. So that includes, nearly 260 projects, of which 203 are social impact bonds. And 18 are development impact bonds across 40 countries. The majority of those are in the United States, and the UK and the UK first, and the United States, Portugal. And the Netherlands. So which sectors are these projects, do these projects that exist in? Overall, if you look at the whole landscape across the entire globe.

The majority are in the social welfare sector, followed by the employment sector. Health and education, have the same amount and then followed by criminal justice and then finally, environment, and agriculture and, but in lower and middle income countries that it looks a little bit different. There are 11 in the education sector, followed by ten in health, eight in employment, and one in the environment sector. So today we're talking about health. And as you can see, there aren't as many as one might think, in the health sector. How are these, distributed? The majority of them, are in the UK and Japan, which, that have the most, most in the health sector, as you can see, from this graph, those are, but that's why those dominate, those regions. And here is a breakdown by, health impact bonds, by health area. So you can see that the majority are for non-communicable diseases.

And much of those are in high income countries followed by behavioral health. And then, we have, geriatric or end of life care, sexual reproductive health, maternal and newborn health, disability and communicable diseases. So I think this is very interesting for a conversation to, to think about, you know, where the opportunities are, where we have seen the projects, so far. So with that, I'm going to turn over to, to Nicole. Nicole, as I said, is the CEO of, the PharmAccess Foundation, which is an international non-for-profit organization dedicated to strengthening, health systems in sub-Saharan Africa. With over 20 years of experience on the ground in Africa. Doctor Spieker has focused on developing and scaling innovative models for quality health care. She's also the Founder of Safe Care, which is an initiative to improve clinical quality using transformative digital solutions in resource limited settings. So with that, I'll turn it over to you, Nicole.

SPIEKER: Great. Thanks so much. Emily, and I hope you can all hear me. Okay. Really excited to be joining this, this webinar today. As, Emily said, my name is Nicole Spieker. I work for PharmAccess. PharmAccess is a transformative organization that's really aims to reduce out-of-pocket expenditure and come up with innovative financing solutions to improve better health care on the African continent. So why are we so extremely interested in blended financing models? 15% of the global population is on the African continent at the moment, and that number is rising. I think at the moment India is the most densely populated, well, country, continent, but Africa is expected to take over that pole position in the next few years. 21% of the global burden of diseases. So if you're born on the African continent, you simply fall ill more often than if you're born. For example, in the Netherlands, like, I was and then 2% of the global expenditure of healthcare.

So health systems in low and middle income countries, specifically those on the African continent, is not poor because people don't know how to do health care. It's poor because there's not enough money into the system. And this is actually a moving target. Despite all the progress made during, to achieve universal healthcare coverage and the advocacy and the global movement to, put more money onto the African continent, including local resources. What we've seen is that the economic crisis that's hit almost all of us in the past couple of years, combined with the impact of climate change, where we're actually seeing disease is rising, means that if we don't do something different, we're just chasing and moving targets, and we need to be smarter about this.

And the interesting part, as Emily also alluded to, is if you do impact bond financing, you're able to create a blended financing models where investors are actually willing and able to take the risk, as we've heard during, the, the, events in Zurich of a few weeks ago where we put 30, experts in the same room, and we started addressing, various initiatives that have been done, in healthcare throughout, the world. But we've also and I'm sure we'll be hearing that from our panelists today. We see that investors are actually willing and able to put up that risk money with, with a new, innovative way so that, global institutes and governments have to pay for the outcomes, but they don't have to pay for the risk of setting up, these, healthcare systems. So it's actually a great way to move, into a much more smart, use of healthcare financing, bringing public and private partnerships together and doing the Zurich events.

There was, various models discussed, which are also described in the blog. That's Emily in Brookings Institute, published. But just to give you an example of, the work that we've been engaged in together with a partner organization, up Langer Institutes in Cameroon, which was supported by Mayo Foundation, is an outcome based, financing mechanism where we introduced, hepatitis C treatments, which for those of you who are familiar with it, is actually now a curable disease. You can give people, a medication measure three months later with, a simple test, and you are actually able to cure 96%, of the people that were before with a disease that comes with a lot of, morbidity and often ends with mortality, and you're really able to keep, you know, give people their lives back. But we also discussed other bonds, just noticing, the one in, in, in which case, I hope I pronounce it the right way in India, where, the improvement of quality of care actually saved 30,000 lives.

So it's interesting to see that these models are working, that investors are willing to, pick up the risk that you're able to spark efficiency, value and impact. And that's, in fact, you're sometimes able to save lives permanently from, a chronic disease. But one of the things that we noticed during the learnings of the workshops is that the buying of the government is crucial. Evidence is needed, beyond just the savings, implemented. Next slide please. Can I have the next slide, please?

GUFSTASSON-WRIGHT: All right, just one second. It's frozen.

SPIEKER: So I'll just keep talking while we a while we get to the to the next slide and apologies for some of the technical glitches. What we see very often in these proof of principle projects is that it is one investor willing, to able to, to invest in an outcome based, financing mechanism. But it takes a lot of time to set it up. And in fact, some of the partners, won't mention any names said that the people that benefited most were probably the legal people because of all the contracting and everything that's had to be done in the back. And that sets up a lot of time and difficulties. The M&A framework in low and middle income countries, it's very difficult to collect data, especially when it comes to health outcomes. We've shown you the example of Hepatitis C, which was a simple, test at the end of the treatment. But we've worked, for example, also with outcome payments for maternity care, where you can imagine that the complexities during a maternity journey are much more complicated.

And to measure progress, doing to its better outcome is a more complicated situation where actually the cost of setting up a mini framework and then collecting the data is, difficult, and then attracting the outcome payments. One of the things we learned when we set up the Hepatitis C bonds is despite the overwhelming evidence that this was working, and we could actually bring people and their lives back, was that the cost of this treatment was about $1,500 a patient to treat them. Now, you would argue that that was a very low cost. That should be worth it. But in a healthcare system where universal healthcare coverage is very limited and often the available financing to treat a family for a very year for general health care is somewhere between 50 USD. You can imagine that this is relatively expensive, and that because it's very often unclear what is actually the cost of not treating these patients, the economic burden, the morbidity before mortality sets in is not known.

It is difficult for governments to then take up that, a, a balanced decision, to take up these new payment, models. So we've seen a lot of proof of principles, but we haven't seen the high uptake yet. Next slide please. Now. Why should we worry about this? I actually stole this file from Stefan Larsson at a conference in Amsterdam at the moment. And he's walking around, and I think it's a very good slide because it shows where, where, heading, in the world with universal health care coverage. We have a value crisis. There's not enough money in the system to treat everyone. And as I mentioned earlier, we have a moving target, but we also have an evidence crisis.

Actually, a lot of the treatment that is given to patients are not supported by this data. We are not really sure if they align to medical protocols that should be given to this patients, and especially where we see more and more the complex environment where people have multiple, morbidities, it's that we get really confused on how to treat the patients. And in fact, one of the biggest discussions also here at the conference today is the purpose crisis, where more and more doctors are getting frustrated and nurses are getting frustrated with the work. The COVID pandemic caused a lot of mental issues and people are leaving the professions. So we need to be smarter and we need to do this well. Next slide please. Now. Should we all be depressed about it? No, because the results of these, these, case studies that we discussed in Zurich and I encourage you to reach up.

But also, I'm sure the panelist will talk a lot about it is that these models actually work. They bring in blended financing. They're bringing new ways of partnerships, and they're promoting better health outcomes. But we have seen that the developments of this space are difficult. The learnings are that you need to bring in government involvement from the start. But even the. A guarantee. And I already gave you the example of the government of Cameroon that simply has to struggle with choices of where to put the money into health care prevention and health care treatment. So we have to advocate evidence building through use cases, not only showing what happens when you do the right things, but also what the cost of care is when we're not doing anything. And because that is so often hidden, we don't know what the burden of disease is because a lot of patients are actually not showing up on the hospitals. It's difficult to measure that. We're not really showing the evidence that we're actually better off economically. And from a health perspective of bringing in patients for early treatment and other disease management.

Now there is a huge opportunity ahead of us. As I mentioned earlier in my talk, the cost of actually collecting the data has been immense and often by far outweighs the cost of implementing these treatment programs. And they've also prevented a lot of these programs to scale. But the reality is that the world is changing. We are rapidly seeing the progression of the adoption of mobile technology and mobile phones throughout, especially lower middle income countries, where more than 90 to 95% of the people are now collected through a mobile phone, which means that the cost of connecting to them asking, for example, that patient reported health outcomes measurements has become much

more lower, as much more real time. But interesting enough, you can now create models where patient journeys actually start with the individual, rather than just starting with, the health care provider. And this allows you to monitor patient journeys in a much more natural collection of information, because patients are already going to the health care facilities. The facilities are already paid through claims management, are already collecting information through my system, and with the promotion of open data standards, we should be able to tap into this information and reuse that information for new financing mechanisms in much more transformative ways than we have to being able to do up to now where we needed to add complicated data, capturing systems that were often also perceived by doctors and nurses as adding to their workload rather than reducing the workload.

So we really need to think, moving forward with these new financing mechanisms, how do we tap off the digitalization of the healthcare data? And then maybe my last point, before I like to hand it over to Emily and the panel, because I very much look forward to the discussion, is how do we bring in the big institutes? Because showing by doing. We need to start bringing these models to scale and also demonstrate how we can start reducing efficiencies and effectiveness in setting up also the administrative bones behind these, innovative financing models. And as governments are a bit hesitant and hesitant to bring in that next step, could we actually also start out some of our amazing, big initiatives that have already shelved, save so many lives in HIV treatment and malaria treatments and see if we can bring some of the learnings of these innovative financing models and see how we can capture that into these big, initiatives, hopefully also then leveraging the money that the governments themselves put on the table to treat people better. So with this thoughts, I headed back to Emily, and I really look forward to the stimulating panelist panel discussion. Thank you very much.

GUFSTASSON-WRIGHT: Thank you so much for Nicole for that excellent summary and for highlighting some of the opportunities as well as some of the challenges. I would now, like to introduce, the panel and, if you all can, turn on your cameras, I'll introduce you. Thank you all for joining. So this panel will be moderated by John Fairhurst, who is the head of private sector engagement at the Global Fund to Fight Aids, Tuberculosis and Malaria, where he drives catalytic impact initiatives through engaging private sector resources, philanthropy and innovative finance.

Prior to his work at the Global Fund, John was director at UBS Optimists, where he led the team developing new products, and innovative financing instruments. We're also joined by Doctor Fareed Abdullah, who is the director of the Office of Aids and TB Research, South Africa, at the South African Medical Research Council. He is, a medical doctor and a specialist in public health medicine. He also holds a part time appointment as an HIV clinician in the Division of Infectious Disease at the Steve Biko Academic Hospital in Pretoria. And he also serves as an honorary professor of public medicine at the University of Pretoria in 2022. Doctor Abdullah was appointed the as Knight of the French National Order of Merit by President Macron. I guess that means we should be calling you Sir Doctor or Doctor, Sir?

And, we're also joined by Dia Martin, who is managing director on the social enterprise finance team at the US International Development Finance Corporation, where she originates debt financings across multiple emerging markets. She also leaves the portfolio for impact, an innovation program which focuses on financing scalable, earlier stage projects, with significant social impact. Prior to her position, she was, in Germany for three years, for the finance in motion, JMB and was recipient of the Robert Bosch Foundation Fellowship with a focus on development finance. We are also joined by Jane Newman, who is the International Director at Social Finance, which, where she leads the work to develop and support international, the International Network of Social Finance Collaboration Partners and works with intermediaries, foundations and others in many countries to support the development of impact investing and outcomes-based social finance approaches. She was previously director of governance and company secretary at the Social Investment Business, which is a leading UK social investor. We are also joined by Doctor Yaw Opoku-Boateng, who is a medical doctor, public health practitioner and has degree in health economics policy and management from London School of Economics. He has been working with the National Health Insurance Authority in Ghana since 2017 and has held several portfolios. He is currently the head of data analytics at the National Health Insurance Authority and the lead person in the pilot phase of the value-based care implementation at the National Health Insurance scheme.

And then last but not least, Sietse Wouters is program director of innovative finance for the UBS Optimus Foundation, where he works closely on the design, structuring, and contracting of the Quality

Education India development impact bond the Maternal and Newborn Health impact, development impact bond. And prior to his current role, he worked within UBS and Society, an umbrella platform within UBS Group to grow the bank into a leader in the sustainable banking sector as well as within strategy development at UBS Asset Management. So with that, I will turn it over to John first to moderate this conversation.

FAIRHURST: Thank you very much, Emily, and also Nicole for that fantastic introduction. It's always slightly daunting to be moderating a panel where it takes sort of 10 minutes to introduce people's bios, but I, I hope it, it gives you a sense of the expertise that we have in front of us. So, really want to move to, to talking to the panelists and get their inputs, but please do, ask questions. This is very much for people to get what they need out of the conversation, as well.

I mean, I think, you know, Emily and Nicole set this up incredibly well. What we see is a huge amount of promise and possibility for outcome based financing for these kind of mechanisms. But I think we recognize that we haven't yet fulfilled that promise. And there's many of the learnings that came out of Zurich that will help us build and scale, this. I think we know this isn't a solution to every problem to, and one of the key things I think, is about understanding you know, where this is the right model. You know, where this solves a problem with the right structure, the right financing structure? As well. So in order to leverage the efficiencies that Nicole spoke about, you know, how do we understand the experience of these instruments? And what we've learned in order to make sure that we use them in the most effective way with all the stakeholders that we have at table. So with that, Jane, I'd like to maybe come to you first, if that's okay. Social finance, was really the founding of, of this concept. And, you've supported a number of these instruments, both in, in the UK in high income settings, but also in low middle income countries. I'd be really interested to hear your perspective. You know what? What is the value proposition? Where, what's the evidence of the benefits of this kind of model of contracting from your experience?

NEWMAN: Thank you, John. And hello, everybody. Thanks also to Emily and the Brookings team and all the members of the panel. It's really good to speak to you today. Yeah. So, just to set that up, social finance has worked extensively on outcomes-based finance in the UK, but also internationally.

And I'm going to focus my, my comments on, projects that we've done in the middle income countries and, use that as a sort of, use case it effectively of economies. But I think in terms of looking at how they can work in a mature, health system, we are really starting to feel that we have a means of engaging with our National Health Service around particular models to understand exactly how to insert, an outcomes-based approach into their programing in a way that resonates with the sort of constraints that they would they work with. But that's not for today. I'm going to talk a little bit about, a program that we, help support.

Also in Cameroon, actually, which was focused on infant, reducing infant mortality and, preterm, low birth weight babies as, as an example of how, some of the learnings that, that we see in the benefits of this kind of commissioning, this program was called, for convenience, kangaroo, Mothercare, the intervention model was based on skin to skin contact and breastfeeding for, for, for new mothers. And it was an evidence based, from another set in Colombia, but hadn't been used in an African setting that was had been identified by the W.H.O., was as a highly promising model. To do it had the potential potentially should be implemented in other settings. So, so, so the, the advantage perhaps three points really I want to make, or to highlight or the benefits or the use of outcomes-based, models in this context. One is, is the flexibility. People talk a lot about flexibility for impact bonds. But I'll talk about how that benefited us in this case.

Secondly, the partnership, amongst the stakeholders, which is a really important way in which people come together and drive, you know, they focus, shared focus towards outcomes. And thirdly, the really important role in government, as Nicole was saying, if you're really going to try and impact this for the long term. So very briefly on the flexibility, I think, being able to come together around a clear focus on specific outcomes in a context where, you understand in KMC case what the essence of the model was, but you have no idea really how it will, how to operationalize it in a different context. Having a model which enables you to, focus on the outcomes and as you implement it, learn, adapt and change with, with rapid learning cycles.
So in that particular case, we were setting out the measurement points of every quarter. But that gave us rapid feedback and a quick opportunity to, to understand, try and understand what was working, what wasn't working and how to work, how to adapt. At the second, when there was the partnership

with the stakeholders, we had a governance structure that brought the government, the outcome payer, the investor, the implementer around the table with quarterly review meetings, looking at progress. And that meant that from the beginning, everyone was focused on the endpoint and was working well, working together, on challenges and adaptations, as, as they came along. So, so it enabled us, as I say, to, to, to, to operationalize but also adapt.

And we were better at sort of troubleshooting when, when there were some issues always emerge on any program. But we had a shared objective in finding solutions and that really sort of showed, showed its strength really when, when COVID hit. Because obviously the biggest period in program was responding to COVID. But the fact that the governance group were already working together in that way meant that people thought straightforward. But it was surprisingly, surprisingly, surprisingly possible to, to implement something as close as possible to business as usual. And we managed to continue to adventure out of it. And last one was just on the government and absolutely right that that government should be, if possible, be brought in at the beginning. I'll go with this was to think, to think about this program in terms of how it could be embedded in the Cameron system for the future as a sort of health system strengthening kind of approach. So government had to be part of it.

And they were an outcome funder, but they had backed funding from the global finance facility. So we had quite a complicated contracting structure. I just to technical point, but that did mean that, I think it's quite challenging with the program, which is sort of piloted outside government. And then you hand it over and say, here, this works, that by involving the government from the beginning, what we were seeking to do was to have to have them own the benefits and the learnings, of the system and start the process of, transition into, into the government system as early as possible. So for the last year of the of the delivery period, we were continuing to implement the bond. We were really focusing on how it might sustain beyond the end and end of the program and, getting budget lines into, into, into the next year's budget. And, I've got lots to say, but I will stop there because I know others have lots to say as well.

FAIRHURST: Yeah. Sorry, Jane. I know it's really fascinating and it leads a little bit into my next question because I think, you know, one of the, the criticisms of, of these instruments is that they take

a long time, to build and, and the comment about lawyers, being the biggest beneficiary, tend to hang around. But I, you know, I think there was there are many kind of intangible pieces that are built through, you know, the construction of the kind of stakeholder partnership that you talked about that, are not always built in the same way by other mechanisms. So Fareed, interesting for me, I know and we've obviously work together closely on this, that you've had experience of, the time it takes to develop these instruments. I wonder if you could just tell us a bit about that experience, of building it? And is there anything you learned in that design process, that you think people on the call should or should know, from a well.

ABDULLAH: Good morning. Good afternoon everybody. Thanks, John. Emily, for asking me to say a few words. It's always a little embarrassing to, to be, mopped up as someone who took long to put a transaction together. But the understanding that is that these transactions do take a long time to put together. In our case, it was as long as four years. So, so quickly, just to remind you what that transaction is. It's an impact on the Social Impact Fund. To address the needs of young women for HIV and reproductive health. And, you know, we set forth targets linked to antiretroviral treatment, pre-exposure prophylaxis, contraception and early antenatal care. Ambitious targets.

And the transaction was put together by the Medical Research Council, which is where I work. It's a kind of. Government institution with a little more leeway than an independence than a government department. So that's the, the setting. I think a couple of important. There's a few important lessons to learn. One is that. Being a research organization, we both invested in researching the problem. You know, we spent quite a lot of money and a lot of time, scoping all the data, but also commissioning our own research. And, you know, I think one must be careful about. Entering into transactions with the data gaps. And areas where you're not really aware of what the latest evidence is. In our second transaction, which we're putting together now.

We you know, we learned lessons from that by, just doing a simple literature review and, harmonization of data. And, you know, in a few months, we have a good understanding of what the second one, which is on multidrug resistant TB should be. So, so that's the first thing, is that you can spend a lot of time researching the subject, researching your baselines and counterfactuals and,

figuring out the digital health, the reporting systems. So good to, start with programs where there's sufficient information and knowledge about how to do these things. The second thing I'd point out is that we took a long time to firm up the outcomes funding, even though we had a budget.

And the MRC became moved kind of from an intermediary role, putting the transaction together into an outcomes funding role. But there's a lot of complexity in government systems to allocate funds. And, you know, we, we made the mistake of not, forcing our treasury to issue a guarantee. So there was a lot of instability on the government side, for this funding. We now have firmed that up. But, if you don't have the outcomes, funds firmed up and you know the place and the role and the commitment of government, you know, your entry, you're opening up a whole new category of risk. So I think, you know, one must be, aware of that. It takes a long time to put these things together, but also, they have to be done. I think the third risk is that each of our regulatory environment is complex, and in our case, in South Africa. We don't really have a pathway to get approval, regulatory approval for this transaction and, for a government agency.

You know, this looks like a loan, and you can imagine the rules that have to be followed, the approvals you need to get if you want to borrow money from the markets. And it became even more complicated when you wanted to borrow money for which you already had a budget. You know, people couldn't really understand why you needed to borrow money. And of course, you know, the, the, the returns, and the reimbursement of the capital is variable because it depends on the achieving the outcomes. And unless your regulatory environment, you know, Treasury or all your, committees giving you approvals, understand what it's about. So we took a long time. It took as long as eight months just through the Treasury to process this transaction until now. Journal.

And by saying that that here in lies a bit of complexity. You know, you bring the implementer and investor on board before you have the ultimate funding road. Do you have that kind of funding first? I think we went around in circles really a little bit there. And now, we know that the two pathways here, one is. If you have the kind of spending, the security, you running the transaction, you know, then start determining what you want and committing the project to intimate partner with an investor. That's a very different route to putting this transaction together. So figure those things up where you go. I'll

stop there just to say that I hope we have different versions of the next transaction. We'll take between 12 and 18 months. There's complexity here, so it's going to take a long time to get it to plan. I don't think you can put this transaction together in six months, at least not in a country like ours. Thanks.

FAIRHURST: You know, that's really helpful. And I mean, I. It sounds like a simple lesson to say to understand your context. But I, I think it's really key that the, you know, the regulatory piece can take, a long time, particularly if it's sequential. But I think to go back, you know, to what Jane said, I think, you know, building this around evidence, I mean, understanding the data, the drives, and that the solution that you're, implementing or the outcomes in driving is really key. And you very conveniently mentioned the investor. And where do you start with the investor? So, if it's okay, I'm going to move to, to Dia, from the US. And you, you were an investor in, in, in, in, in, in Cameroon that I and some worked on cataract surgeries and I think delivered something like 18,000 surgeries over five years. So, you can tell us whether that, was a success from your perspective. But, I just interested, you know, listening to also to for each perspective of why that why you made that investment, what made it attractive. And, and what's your perspective on that? That idea about, you know, needing outcome funding. So first before investors, as well. Thanks very much.

MARTIN: Sure. I think there's a lot of nuggets in this conversation and just want to build on that. And, and, actually, the Cameroon-Cadillac Bond is still in progress. To date, we have, made over 13,000 surgeries and met all of our social impact targets. For the first check in point. The second and final check in point will occur in 2025. And hopefully at that time we will get to the 18,000 surgeries. But, very excited about this project. And I can tell you for us, this was DFCs at the time OPEC's first development impact bond. And so for us it was a matter of having a real conviction around investing in this transaction.

And that stood out because of the deep developmental impact, the idea that we would be providing high quality cataract surgeries and a business model that supported all aspects of the population. And one of the key social impact targets for this bond is, is to work with low income and rural populations. So the idea is to have a cross-subsidy business model that, provides for upper middle income, middle income individuals to be able to pay a fee for service that allows, the hospital to subsidize the cost for

lower income populations. And that's actually part of our social impact metric, so that the developmental aspect of it was really important to us. I think, to Fred's point on the outcome, funders versus the investors, we came in after the outcome, funders and the service implementer had coordinated and had their discussions, and we were really excited about the commitment of the outcome, funders and also their flexibility there.

There was a little bit of changes or adaptation to work with us, but that really stood out and the implementer was very knowledgeable and had had a much larger vision. And we just want to implement this project. I think their vision for building out the space, integrating with the community really stood out to us. Also, as I mentioned, there was the innovative business model, but investing in a Dib was an innovative product offering, and at the time, we could see that this would be a way for us to invest in, development in ways that we couldn't invest with a commercial loan or equity or even maybe a more concessionary loan. Right? I think with Dibbs and with results based financing, you can create investment opportunities that would not necessarily be there with a with a more straightforward product.

So this for us was, as Nicole mentioned, a demonstration of that. So we wanted to make this investment as a demonstration effect for dips in the market, but also for us as DFC. And we've gone on to make other investments. But this fit well as far as timing and size to make the investment through our portfolio for Impact and Innovation program. And then I'd say another key aspect was the social impact metrics. Not only did we deal with number of surgeries, as you mentioned, John, quality of surgeries. But one of our metrics is that the hospital is sustainable. And that's really important, as Jane mentioned, to see that sustainability long term after the life of the bond.

So we wanted to see that they would still be able to impact that the community and the country. I think, if we if I go really quickly to lessons learned, one of the things I think is really key. Whoever you bring in first, whether it's the investor or the outcome funder or it's an implementer that has an idea for a new way to do business, is bringing all the partners together as early as possible. That's something that after this first transaction, I've always mentioned as we've discussed other transactions, and I

think it's very beneficial in terms of timing, but also flexibility and ensuring that everyone is able to achieve their goals and work within the constraints of their operating system.

I also think it's really important to have an intermediary that is a driver of moving through the process and has a clear understanding of what all the parties want to achieve. That's been essential, for us and the investments that we've worked in. And then I just end by saying, DFC is really excited about these types of opportunities in the future. We've actually created a new department, our Office of Catalytic Investments, where we want to catalyze and build markets. And I think that results based financing or outcomes-based financing is a real critical areas. We look at health care as a sector as well as climate and others employment, education as well. So I'll pause there.

FAIRHURST: I'm happy to hear now, I think really exciting and exciting that you did have a proof of concept and it's built, the enthusiasm for it. If we get time, there's a lot of questions about kind of financing sustainability. So just to warn you, I might come back to you but end with some questions on that. But, just so we move on because I know time's running out, but yeah, everybody has mentioned the importance of, of government, in these and the centrality of, engaging government, but also the challenges, you know, around, regulation and systems. I know you haven't been involved in outcome-based financing exactly. But, but you are running a very interesting program on value-based health services, which has many similarities, I think, with, with, you know, the goals of, outcome-based financing. So be really interested to understand in what is value-based care. And, and you know, what was the motivation to, to pilot that in Ghana as well.

OPOKU-BOATENG: All right. Thank you, John. And, thanks, everyone, for giving me the opportunity to talk about our story on Value Biscayne going on. Basically, I would say that value based care is new to us as a country and probably to the continent of Africa in general. Largely, I think a couple of few countries, maybe South Africa is probably, practicing value based care. So, value based care came into the program or the structure of Ghana health care system when, National Health Insurance Authority, which is the main financier of health in Ghana, saw an increasing rise or increase in the number of non-communicable diseases, especially hypertension. And data also showed us that less than 15% of hypertensive patients that are going into the facilities, health care facilities are getting

the, hypertension levels controlled, which means all their investments that the National Health Insurance Authority is doing does not complement, with the, outcomes that we are getting in terms of the health care of the patients.

Therefore, we need to re-strategize because the investments that we need to see results. That is where the value B.Sc. care option came in, where we're using hypertension as a pilot to study the efficiency of the health care that is that we are doing in Ghana. So with the hypertension cases we kind of studying. Number of patients within, some health care facilities. We are in a pilot phase now, and we started in August, where we are monitoring the values of these patients for a considerable time to be able to see how the patterns are going. And then based on that, we would be able to, make a meaningful, outcome out of it. Maybe I would go in a bit into what we've seen so far, and that is where we see the value that we are seeing in the program that we, we are doing.

Yes. For some time now, we realize that, the number of patients that we are doing a pilots do, the national statistics shows that we are having about 15% of the patients attending health care facilities getting the IDP controlled, the patients that are within the value based care. Pilots. We are having close to 50% of them having diabetes value DP values control, which means there is a significant increase in the value based care that we are practicing. And that is There is an edge for the authority and probably government at large, to be able to implement the value. But like I said, we are still in the pilot phase. We are now kind of doing the outcomes measurements, and it's based on that that would be able to make, projections into the future. However, this has not come, easy. There are a lot of, challenges that came with it.

Some of the challenges include that, with the healthcare facility, they had challenges in terms of the time that they need to spend with the patients, because the value based care puts the patient at the center of the care, and therefore, education of the patient needs to come in. The patient needs to be aware of the condition that is being or she or she is being treated for, and that would definitely encourage the cooperation of the patients in terms of the management of the disease. Therefore, the time spent at the facility level or the healthcare provider level. It's quite a lot and that is the challenge that we have. And another aspect is the human resource. Also a challenge because we need the

number of health personnel to be able to do health education, and all other aspects of the health care chain. And that puts because we have limited human resource. It makes the work a bit more, difficult in achieving the volumes that we need to achieve within a certain period.

However, efforts are being made to, do that. One component on the in there, on the part of the healthcare provider is cost. And I think cost as across all the various in terms of the health care, should the healthcare provider, the patient himself, and then the insurer or the parent as well, because they need to increase their human resource to be able to. Compensate or commiserate with the volume of patients that are available. They need to have more health care personnel, and that increases their costs. More resources come in and therefore puts a toll on their on their budgets. So that is one area that a challenge that, healthcare providers are facing greatly in terms of -- sorry.

FAIRHURST: Sorry to cut you off because it's really fascinating, but a conscious of time. But. I mean, I think, you know, one of the interesting things that, you know, you're saying is how, in essence, the focus on outcome actually drives the different thinking about how you get to the outcomes in terms of increasing human resources. It kind of reveals that, you know, maybe the old way of working isn't as effective and therefore you need to work differently, which I, I do think is one of the powerful elements of outcome-based funding, is that it puts the emphasis to your point on things like patient-centric care, and patient-centered care means doing things differently, maybe to service-based care. So really fascinating. I would love to hear more. But I'm afraid I need to just move on to say Sietse, we might not give Sietse time to speak. But, thank you very much for that.

So, Sietse, just, you know, you've. And even as Optimus has been also at the beginning of many of a number of different, outcome based, funding instruments. The equity problem, obviously a significant one. You know, working on, maternal newborn health in that system. I'd be interested, if you could, to share some of the lessons you learned from building that one particularly, but also from the other ones that, ultimately the work.

WOUTERS: Thanks, John. And, I think, a lot of lessons are actually similar to the lessons that Jane spoke of and, key lessons that I really kind of run the flexibility and, and, continuous improvement of

the, of the model and, echoing as well. But what Jane was mentioning around, around COVID, during the COVID, pandemic, we really saw how, the model was really able, to work in these times of uncertainty. And, and actually, it's overachieved on results, within the time period. And, and, both within earthquakes, but also, for example, in the education debate that we did at the same time in India and how that flexibility really displayed, for example, with the education schools being closed, we actually were able to, to still educate children the same for the, it would correspond we were still able to move these clinics to higher quality levels.

And I think that that that's, that's really been a fantastic result and really shows the strength of the model, which I think is then great for the next step as a way how we can think about scaling, because I think we've had such great results. We've really been able to prove out how this structure works fantastically, and the challenge on us as a space is really now, how can we scale this, going forward? And how can we think about, embedding new ways of working to work also in the longer term? Because a lot of what we've done has actually been only 2 or 3, 4 or 5 year program that what we're trying to do is make sure we can, you know, enable systemic change that allows for ten years, 20 years and continues to get those improvements and work with sustainable funding streams, work with government to see how we can redirect maybe some of these, these, sustainable funding streams to keep focusing on outcomes, rather than redoing these 3 to 5 year programs where you will have the same kind of set up, problems. So rather set and set it up once and then see how we can run it ten years within, let's say, a government context with sustainable donor funding streams.

FAIRHURST: Yeah. Fantastic. Well, yeah, I think it's been a great example of, you know, one of the larger buttons, over time. And, I know Optimus, is this safe, remarkably optimistic about, the potential of these, but would just like to move to a few questions, if that's possible. We've had so many questions. I'm not quite sure where to start, but, at that there's definitely a number around the sustainability. And I think the challenge here that, you, you create an investment vehicle that, is creating change. And I think we've seen, you know, from, from there, from situation and I think also from you and for retail, these kind of mechanisms, create kind of impact change. But I guess the question, like any of these kind of financing mechanisms is, is after that financing period is over, after the five years, that's finished in Cameroon or, or, also about just, how do these, how are they

sustained, you know, how and is it necessary for further financing to continue? Would be interested maybe. Yeah. Just to start with you because you referenced it and then perhaps also to come back to you, Sietse, just to talk about, how do you see that sort of longer term, success, of these instruments?

MARTIN: So, so just, just short response. I think in the first one in the, in the Cameroon project that we discussed, it is implied within our social impact metrics that the, Africa Eye Foundation is sustainable. So one of the metrics is, around operations and, and then being EBITDA positive by the time we exit our investment. And the idea is the hospital will be, self-sustainable and able to continue operations in the future, I think in other transactions. And I'm thinking of another transaction that we worked on that was the development impact on a lot of it was about the thesis of the organization we were supporting, which was a nonprofit, and their view to move towards more sustainable impact linked financing versus reliance on donor funding.

So I think the sustainability, question is very difficult, but it can be addressed in different ways depending upon the project. And, and something I saw to just one other note, sometimes the sustainability could not necessarily be operating on their own for cash flows, but being able to move, if you're a profit to a model where you can have longer term kind of donor funding or financing to really implement change versus short term one year funding, where you can't really do a lot of the strategic planning.

FAIRHURST: Right. Thank you. And Sietse, you do have any thoughts on the sort of long term sustainability.

WOUTERS: Yeah, absolutely. I think we need to take a step back and think a little bit about, you know, what really are the needs. The governments have, you know, have this dialog with governments, insurers, what are their needs? One of their priorities. What do they want to fund? Because these are also the areas that they'll have money available for, longer term, pay for results and then see how their, you can work on, pay for results structures and really focusing on the price per outcome and working with beneficiaries on structures that can really be in place for the long run, where they really create continuous improvement for the beneficiaries.

And of course, at the end of that, of course, if there are investors needed, that would be interesting for us, will be great. But I think if we keep focus on that, as we've done in the, you know, the pilots will be very technical about it. We focus a lot on how great our structures are and all the investors, blah, blah, blah. I think we need to take a step back and look at what is the value we're creating here for the for patients was a value we were creating for, for governments. How can we sustain that in the long run, and how would we then solve that with the structure behind? But focus less on the structure. We know now how that can work. That's kind of a boring story. Now. Now we need to focus back on, on the results for the, for the beneficiaries and improving those and implementing, this kind of way of working.

FAIRHURST: Yeah. Fantastic. I and I think what you what you both said I think is, is really you need to design the sustainability. And if, if you already see the through the, you know, intervention then clearly like any intervention, like any funding it's up to sustainability. There's no question about that. It's come up and, and we've mentioned the kind of centrality of, of government. And it's a question which is. Which may be to you Fareed, is how do you convince governments to take these on? You know, whether it's value based care or the impact on the you let you know what's the key that you make that convinces governments to make the kind of investment in, in these new kind of mechanisms? How would you articulate that for me to maybe first and then? Yeah.

ABDULLAH: Yeah. Thanks for the great question. I think one has to pull back on. From the sort of. Bottom up pressure, preschool pressures that the Treasury's are facing. There's more and more interest now in, in, you know, using government money that, certainly in our context and I think across the continent, you know, and the kind of economic effects of the pandemic have really highlighted this.

And what's happened is that the people in the Treasury who are interested in making sure that every round is stretched to as far as it can get. Through these sorts of contracts. Showing interest. But what's interesting is midway through our transaction, you know, we broke the records on the provision of contraception. And overachieved by 250%, of the target. And that has led to, widespread interest from the education department, the schools department, the health department, because they've

never seen a result like this, you know? So I think there's. These are the sorts of things that, get governments interested. The hard part is to get the first transaction through in the pilot, which is what we're all doing. Right? But if we could show results, that certainly attracts the attention of the decision makers. I mean, the links back to the sustainability show, which is we've had our education department come forward saying we're not interested in the other three outcomes, but this pregnancy in schools is the big problem for us. You know, can we can we talk about scaling that aspect up? Thanks for conducting.

FAIRHURST: Yeah, so I guess it's results ultimately. But you know you know, Yaw, you obviously implemented those starting to implement its value based care. What how did you make the case.

OPOKU-BOATENG: Yeah. Thank you. John. Like I really said, you realize that. Costs was on the rise in terms of, non-communicable diseases, which is led by more or less hypertension and as because of scarce resources, we did put in measures so that we would be able to make, effective utilization of the resources that we have available. And that is one of the mechanisms that we can put in place to ensure that the scarce resources that we have, been put to effective use. The data was presented to the healthcare providers that you are sent to these patients. But this is what the data shows. You are achieving only less than 15% of the, results that need to be achieved, therefore, which shows that we are reinvesting you at a rate at which you do not deserve.

And therefore, if we do not achieve the results, that we may need to put in measures to be able to, maybe lower your level of care which attracts a higher tariff or give you, at a slower tariff so that you would be able to, compensate for it. So based on that, they understood the concept that we were trying to implement and therefore bought into it. And we hope that as we get some more results to show them.

They would be egged on. But one challenge that probably I couldn't talk about was that. Financial be their investment package of value based care. Like I said, I think the front out now therefore has not gone far ahead to be able to see how their investments is going to be done. But we are working in that process with support supporting pharmacies. We are working on it and we hope together to get the right tariff to commiserate with the care that is being provided.

FAIRHURST: Thank you. Well, I really look forward to hearing more about the pilot. And then, I hope Emily will give me one more minute is to wrap up again. I did not ask you to summarize the panel. But I don't know if you have any kind of final thoughts on either the sustainability or, you know, the government engagement problem. And then, really, thank you to everybody for a fantastic panel. Fantastic information, I think, because there's a real nugget in, in the conversation. So hopefully with Jane, just for the last word. Let me hand over to you.

NEWMAN: Oh, thank you. I mean, I think this is an incredibly interesting panel. Thank you. John. I think my last word is that I always think of, the impact bond as being a sort of a really powerful instrument of change. But what we're trying to do also is, to change systems. They might be large systems or small systems. And I think that it's really important when you sort of enter into your transaction to think about what's next. So you sort of think about what that leads to sustainability or what comes next or you know, what is the next step or routine or sort of system change model. The outcome, so I think that that's probably one of the most important reflections we've had at social finance that we realize that we are using instruments for a purpose, and we need to think about the broader system in which that, that. But the way we're implementing that is the best model.

GUFSTASSON-WRIGHT: Wonderful. Thank you. Thank you, John, for moderating this excellent panel. And, to all of you, for, joining from various corners of the world. I know some of you are at high level conferences, that you have stepped out of, to be able to join us, today with your, with your expertise, clearly, you know, in an hour and change, it's hard to get to all of the issues, but I feel like, we've covered some of the main, topics today. Jane, I think you summarized, precisely what I was going to say, which is that, at the end of the day, this is really about, you know, not some fancy financial instrument, but it's really, a pathway to, to systems change for longer term sustainability, which really puts patients, at the center.

And, with that. So, as a follow up to, our Zurich workshop, we felt that that was, kind of a kickoff to a community of practice, around outcomes-based financing. Clearly, there's more sharing that needs to be done, more learning, for, to really take, this agenda forward. So I'm going to share now a QR code.

We're really curious to know, if those of you, who have joined us today, would be interested in joining a community of practice on outcomes-based financing for health. And, so you can take a shot of this Of this QR code. If you are interested in joining, you're also welcome to email us at obs@brookings.edu. If you're interested in joining or if you have any thoughts, about today's conversation, or, about, about the future of outcomes-based financing, and global health. Please do, fill out the survey. And, with that, again, I would like to thank, all of, the panelists for your, excellent comments. And to Nicole, for your introduction. Really look forward to taking this conversation forward. So much work to be done given, the challenges that we face, today, in the globe. So thank you.