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Leveraging Digital Financial Services to Advance Universal Health Coverage

Local Health System and Sustainability Project (LHSS)



Moderator



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Objectives

1. Discuss USAID's interest in establishing an evidence base on digital financial services for health
2. Share the global evidence review findings and recommendations
3. Share programmatic case studies' findings and recommendations
4. Discussion and participant questions

Digital in USAID Visions and Strategy

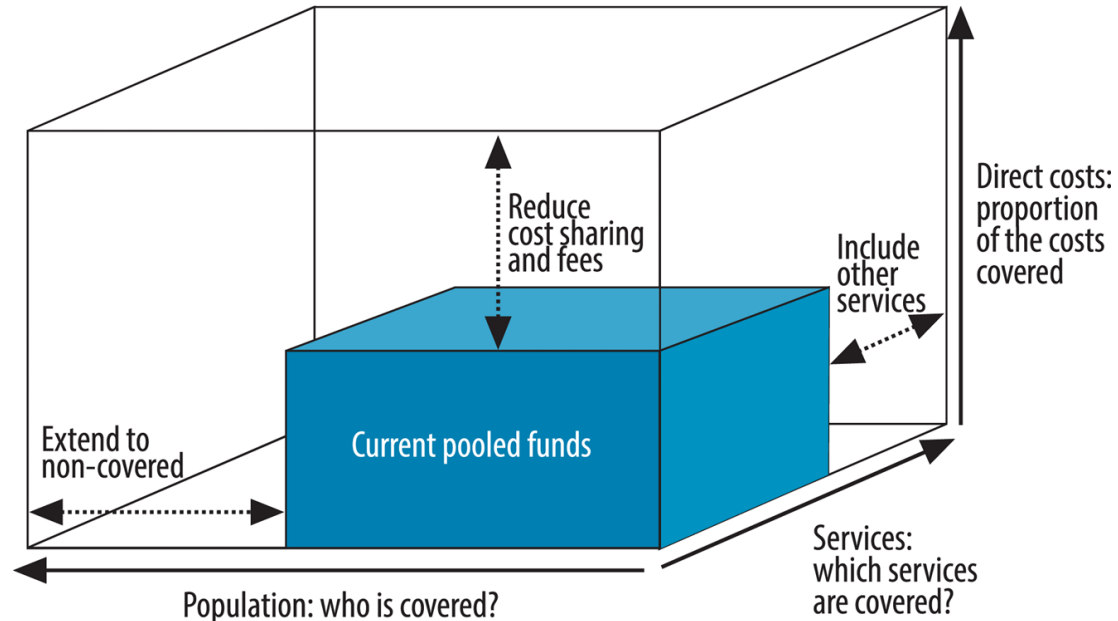
Recent USAID documents concerning the use of digital technologies, include the **USAID Digital Strategy** and **USAID Vision for Action in Digital Health**. Within the **USAID Vision for Health System Strengthening 2030**, it details the important role health system digitization can play in working toward health equity, quality, and resource optimization.



Digital Financial Services (DFS) for Health

Financial transactions, including payments, savings, loans, credit, insurance, remittances, and transfers, **through digital channels** such as mobile phones, USSD, electronic cards, computers, and other electronic instruments **in a health systems context**.

Dimensions of universal health coverage (UHC)



Growing the DFS for Health Evidence Base

Building on the 2019 publication **The Role of Digital Financial Services in Accelerating USAID's Health Goals**, USAID's Office of Health Systems commissioned reports on the role of DFS in the context of efforts to advance financial protection and support improved health system performance and to better understand the factors that make solutions successful.

- **Digital Financial Services for Health: A Global Evidence Review.** USAID Local Health System Sustainability Project, Abt Associates Inc. March 2021
- **Digital Financial Services for Health Programmatic Case Studies: Experience from Kenya and Rwanda.** Management Sciences for Health through Digital Square.



Presenter – Global Evidence Review



Emily Mangone

Senior Technical Advisor for Digital Health and Transformation, Local Health Systems Sustainability Project (LHSS)

Research Questions

1. Do DFS **increase financial protection** in low resource settings?
2. Do DFS **increase demand for and/or utilization** of health services in low resource settings?
3. Do DFS **impact health system performance** in low resource settings?
4. What **factors contribute** to the success or failure of the implementation of DFS in health?



Methods

1. Systematic Literature Review

- 991 documents from 12 sources, resulted in 34 included documents

2. Key Informant Interviews

- 36 key informants from 26 organizations with insight into DFS in the health care context

Results



I. Do DFS increase financial protection?



- Mobile money accounts and digital loans help smooth health and non-health expenditures.

I. Do DFS increase financial protection? (2)



Image Source: ILO Impact Insurance Facility
<https://www.youtube.com/watch?v=cF1vUOQ0ukg>

- Digital platforms can facilitate scale of and participation in national health insurance.

I. Do DFS increase financial protection? (3)



- DFS facilitate health saving for health emergencies, particularly among female, rural, and less educated mobile money users

2. Do DFS increase demand for or utilization of healthcare in low resource settings?



- Mobile money and digital conditional cash transfers facilitate health care use in low-resource settings.

2. Do DFS increase demand for or utilization of healthcare in low resource settings? (2)



- Pairing insurance and telemedicine increases health care engagement and perceived tangible value.

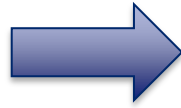
2. Do DFS increase demand for or utilization of healthcare in low resource settings? (3)



- Access to digital credit decreases the likelihood that households will forgo health services due to a health shock.

3. Do DFS impact health system performance in low resource settings?

1. Payments to health workers
2. Health facility accounting and financial management systems
3. Health insurance enrollment, renewal, and payment



- Transparency
- Accountability
- Speed of transaction
- Efficiency/cost-savings
- Increased revenue
- Provider satisfaction
- Protocol adherence

4. What are the barriers/enablers of DFS in health?



Political and Regulatory Environments

- Clear regulations on digital banking, mobile money, and insurance protect customers and create opportunities for new products.
- A political mandate can expedite DFS implementation.

4. What are the barriers/enablers of DFS in health? (2)



Digital Infrastructure and Ecosystem

- Digital infrastructure can be a barrier to equitable uptake of DFS in health.
- Interoperability and digital payment ecosystems are key to expanding DFS.

4. What are the barriers/enablers of DFS in health? (3)



Health System Maturity and Facility Readiness

- Digitization of parallel and upstream systems facilitate DFS implementation.
- Digitizing the claims process of a national health insurance program incentivizes digitization at the health facility level.

4. What are the barriers/enablers of DFS in health? (4)



Financial Infrastructure and Culture

- Labeled accounts and transaction fees can deter social appropriation and improve self-control.
- Consumer understanding of the value of financial protection products is still low.

Key Takeaways



DFS in health are
nascent but gaining
momentum.



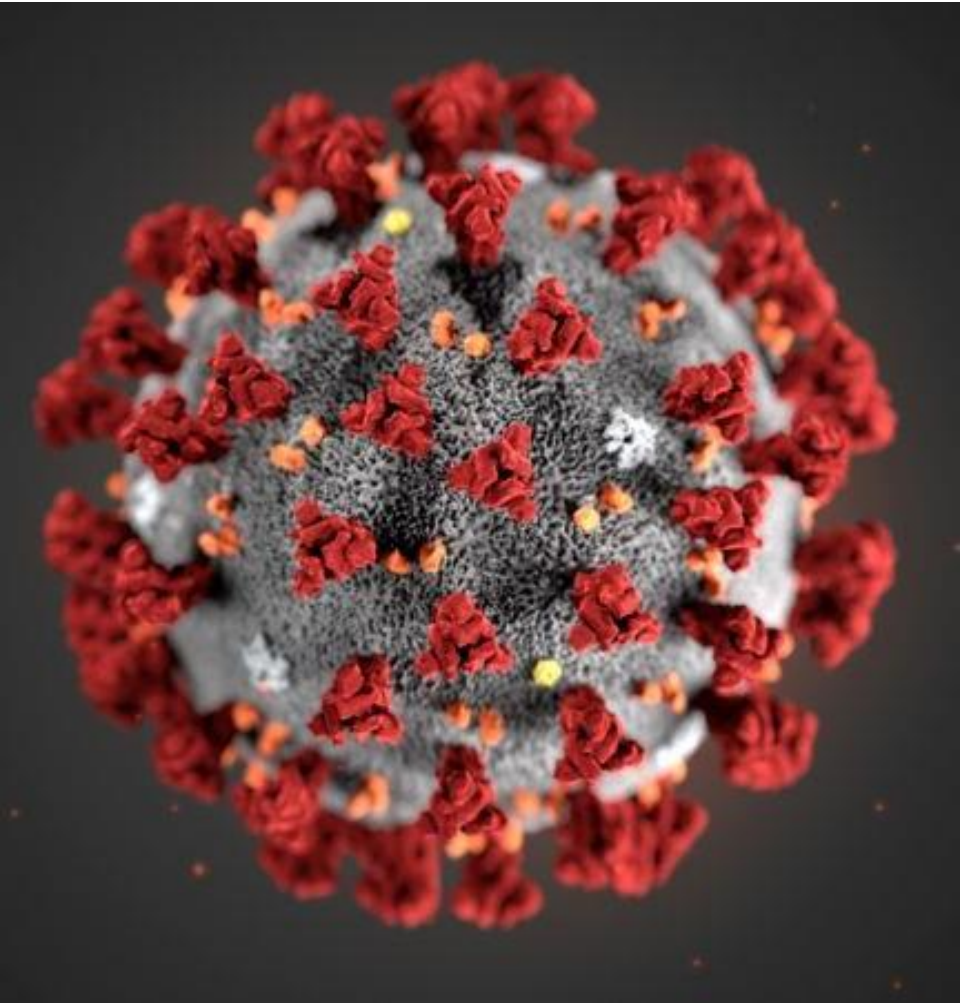
Mobile money is not necessarily financial protection.



DFS do not yet
bridge the digital
divide.



Global pandemic is an opportunity to accelerate DFS in health.



Go to LHSSProject.org
to download the full
report.





Digital Financial Services for Health: Programmatic Case Studies from Kenya and Rwanda

MSH, PharmAccess, RSSB



Presenters



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Security Board



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Kenya



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Programmatic Case Study Methodology

Research questions:

- 1) What is the experience in implementing the program, specifically:
 - Facilitators and barriers to successful implementation
 - Program adaptations
 - Pandemic-related changes
- 2) How is the program perceived to influence health system performance?
- 3) What has been the client/beneficiary experience of the program with regard to:
 - Financial protection
 - Service demand/utilization

Programmatic Case Study Methodology

Methods:

Qualitative key informant interviews:

- Rwanda: 9 DFS implementers, 18 beneficiaries
- Kenya: 7 DFS implementers, 26 beneficiaries

Primary interview data analyzed using a data-charting approach

Secondary data on trends in enrollment, service utilization, etc. analyzed using Excel and QGIS

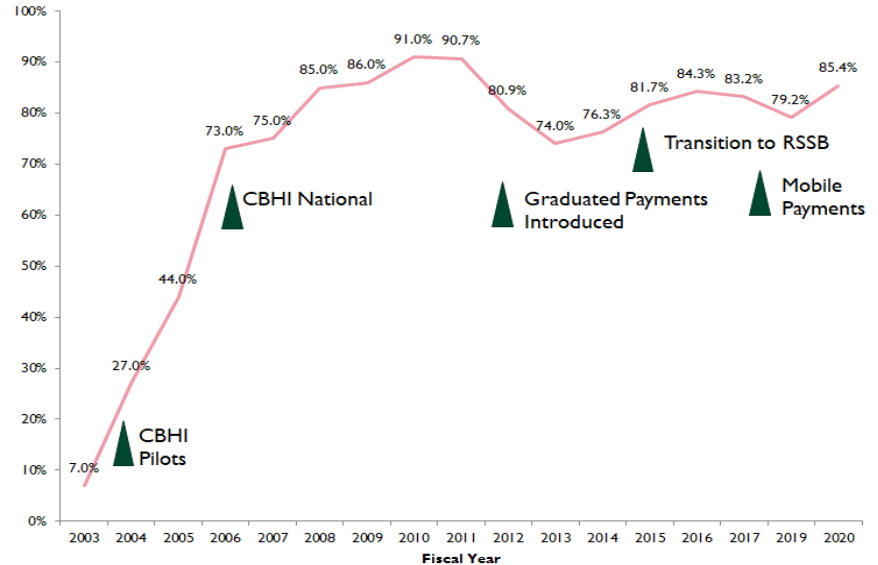


Rwanda Community-Based Health Insurance

DFS addressed the following challenges:

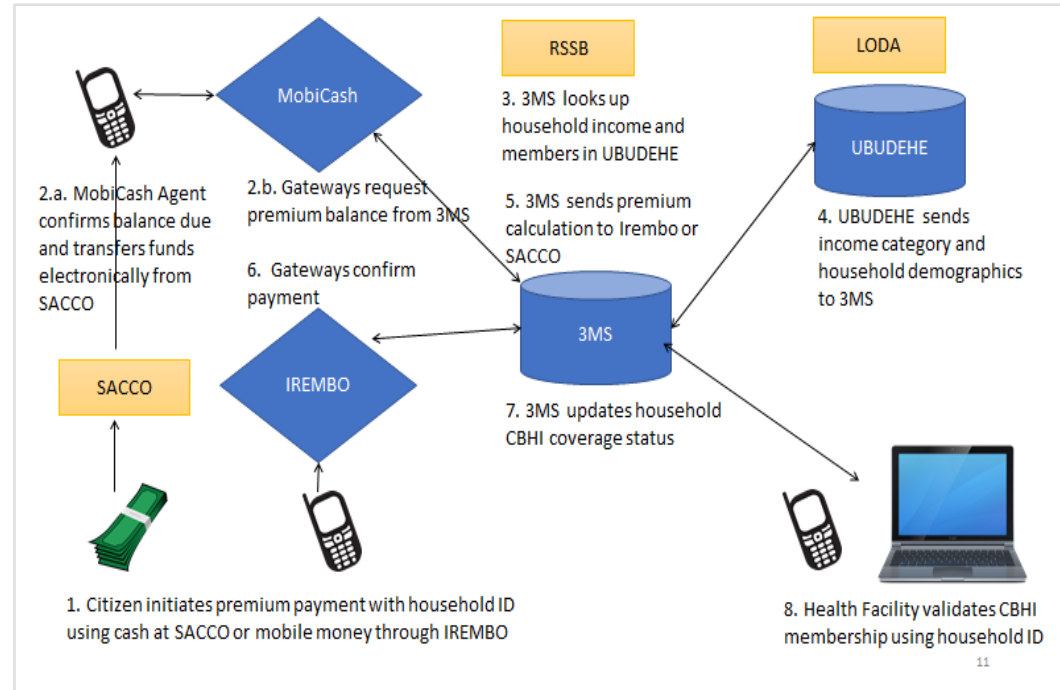
- High volume of financial/membership transactions with paper-based system
- Long delays in paying providers
- Complex manual process for collecting household health insurance premiums
- In-person bank payments and re-enrollment process at local community-based health insurance (CBHI) section were barriers in rural areas

Rwanda CBHI Coverage Rate Over Time



Mutuelle Membership Management System (3MS)

1. Enables mobile payments for health insurance through government and private **mobile payment gateways**
2. Linked to **Ubudehe** database for household income classification
3. Enables providers to verify **enrollment status** in real-time
4. Data used to **monitor coverage** by service providers and CBHI program management



Key Findings – Rwanda 3MS

Facilitators of success

Government's digital vision: "Zero paper, zero trips"

Existing mobile networks and private-sector mobile money schemes

Existing mobile money agent network

Mature CBHI and network of public health facilities

Barriers to success

Old infrastructure not up to peak demand; spotty internet in some remote areas

Lack of electronic payment gateways and APIs to reliably connect systems managed by different actors

Low digital literacy at household level

Inadequate onboarding of CBHI and facility staff using 3MS

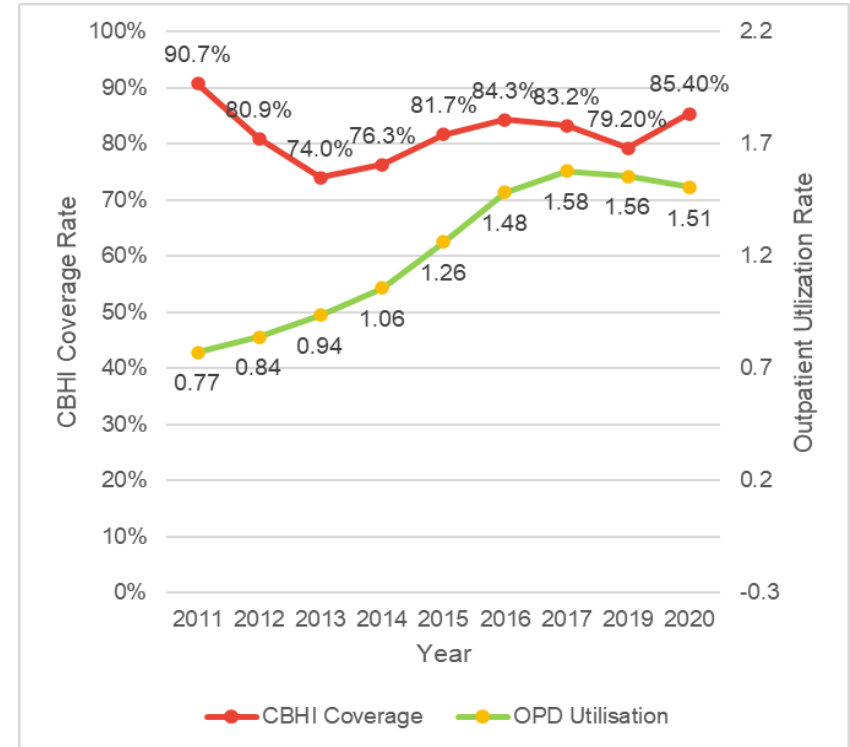
Key Findings – Rwanda 3MS Contributed to:

Financial Protection:

- DFS was one of many interventions to increase enrollment in CBHI and the trend has been positive over the last decade, with more than 85% of the target population covered
- 3MS enables third parties to easily pay premiums on behalf of households—commonly used by better-off relatives and SMEs to provide medical insurance

Service Utilization:

- Increased enrollment in CBHI has corresponded with increased per capita service utilization, but this is unlikely to be due to DFS alone



Key Findings – Rwanda 3MS Contributed to:

Health System Performance:

- Savings/cost efficiencies:
 - Fewer paper records
 - Improved patient flow
 - Task redistribution and staff reductions
- Data quality and use:
 - More accurate coverage data helped drive more data use to monitor coverage
 - Citizens could check their enrollment status
 - Heightened concern about data quality, especially Ubudehe household data

Quality of Care/Service Delivery:

- Reduced waiting time for CBHI enrollment verification
- Medical triage and enrollment verification done at the same time so those with serious complaints were seen faster
- Re-enrollment process much quicker with 3MS and can be done from home with no opportunity costs (e.g., travel, waiting in bank queues)

Kenya PharmAccess Program

DFS addressed the following challenges:

- Low health insurance coverage, high out-of-pocket expenditures for unplanned health care, and no savings to pay for care or insurance
- Poor women of reproductive age often uninsured and most vulnerable in fee-for-service network
- Health facilities with limited access to financing for operational costs or medical equipment purchase, resulting in poor quality of care



PharmAccess Kenya DFS Technologies

1. CarePay's **m-TIBA** health wallet
2. **i-PUSH** NHIF mobile enrollment system
3. MCF's **Cash Advance** and **Mobile Asset Financing** loan apps
4. **SafeCare** digital quality improvement tools for health facilities



Key Findings – Kenya PharmAccess

Facilitators of success

NHIF was established health insurance scheme

Large network of CHWs and CHVs assist with household-level enrollment and bridge the digital literacy divide

Strong community of Kenyan software developers to manage and improve the m-TIBA platform

Effective collaboration among private, public, and NGO sectors

Barriers to success

Poor quality smart phones produce inadequate images of required certificates for registration

Poor women had too many competing demands on their limited income and no experience with savings

Service network limited to NHIF-credentialed facilities, which were sometimes far from households

Key Findings – Kenya PharmAccess Contributed to:

Financial Protection:

- Rapidly increased enrollment in NHIF, with 35,000 new households in just over 1 year; only 12% were able to save enough to cover premiums in 2nd year
- Household data collected by CHWs helped identify poor WRA for health and agricultural subsidies

Service Utilization:

- Participants reported increased access to wider array of preventive and curative services once covered by insurance

Health System Performance:

- Increased data use for evidence-based decision making by both health service providers and clients
- CA/MAF increased financial transparency and helped facilities bridge funding gaps due to delayed insurance reimbursements and COVID-19-related business downturns
- MAF loans enabled facilities to purchase equipment needed to respond to COVID-19 and offer a greater range of services to attract clients
- SafeCare program reinforced quality of care with digital checklist and access to financing



Pandemic-Related Changes



At the individual level:

- Loss of revenue caused financial hardship to many beneficiaries and led to a high dropout rate
- DFS enabled CBHI members to pay in installments without losing coverage
- Mobile payments were thought to reduce COVID-19 transmission—no need to queue up in banks with reduced hours due to lockdown
- Some individuals enrolled because they believed they were more likely to get sick

At the service provider level:

- Mobile cash advance loans helped with operating costs to bridge periods of lost revenue when the population avoided health facilities
- Mobile asset financing enabled providers to purchase specialized equipment to better respond to pandemic (e.g., respirators)



Recommendations - I

- **Use a whole systems approach to assess and build upon the existing digital landscape and stakeholders:**
 - assess of the maturity of the digital health ecosystem to establish a multisectoral ICT investment roadmap strengthen the foundation for DFS tools
 - leverage the existing service delivery ecosystem (e.g., CHWs, mobile phone agents) to make services accessible at the household level and help bridge the digital divide
 - develop trust and engage multisectoral stakeholders from the government (e.g., health and other ministries) and the private sector (e.g., financial technology, banking, mobile industries)
- **Promote opportunities to use the wealth of transactional data generated by DFS for other purposes (e.g., identifying underserved population segments, detecting fraud)**

Recommendations - 2

- **Use DFS to help expand financial protection based on the financial realities of the target populations served:**
 - connect needy beneficiaries to pro-poor funding streams
 - incorporate DFS mechanisms that make it easy for beneficiaries and third parties (e.g., relatives, small businesses, government, donors) to contribute and spread costs over time
 - facilitate health insurance premium payments to expand risk pooling and remove some barriers to UHC
- **Programs to build resilience should consider incorporating DFS into health care financing initiatives (e.g., mobile loans, electronic payments, mobile health wallets) to enhance access and efficiency**