

The Use of Patient Capital as a Funding Mechanism in Health Sector Initiatives

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Introduction

The end of the twentieth and the beginning of the 21st century has been characterized by an unprecedented rate of growth and rise in wealth in the world. This changing economic landscape has exacerbated and increased the divide between rich and poor, causing 3 billion people, half of the world's population, to not share in the economic benefits of the global economy. The bottom of the pyramid (BoP) refers to the world's poorest population who are often neglected from the aid policies and initiatives undertaken by global development institutions. This global imbalance is worrisome for many reasons and it is becoming more apparent that innovation and alternatives to the current aid architecture are imperative for establishing more inclusive aid policies that do not omit the world's most needy populations.

The alleviation of global poverty continues, today, to be one of the most fundamental goals of international institutions and global civil society. The first of the eight Millennium Development Goals, set in 2000, is to eradicate extreme poverty and hunger. More specifically, the first target is to halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day (UN Summit: MDGs Fact Sheet, 2010, p.1). The number of people living under the international poverty line of \$1.25 a day declined from 1.8 billion to 1.4 billion people between 1990 and 2005. However, even if these positive trends continue, in 2015, there will still be roughly 920 million people living under the international poverty line of \$1.25 a day, as adjusted by the World Bank in 2008 (UN Summit: MDGs Fact Sheet, 2010, p.1). The world community has pledged to support large investments in infrastructure to meet the Millennium Development Goals. At the same time, investors, operators and lenders – local as well as

international – have become more risk-averse than they were ten years ago (Winpenny, 2005, p. 12). The usual sources of development finance are unlikely to expand enough to cover the large sums involved, and will need to be supplemented by non-conventional means. Successful approaches rely on community management, inclusive institutions that pay particular attention to disadvantaged groups, and cross-cutting approaches that coordinate budgets and mechanisms across government agencies and development partners (UNDP: Summary Human Development Report 2011, NYC, p.ii). Our world system has not provided the support and possibility for growth that so many low-income people require to sustain their livelihoods.

The failure of neo-liberalism to address structural problems of poverty and social exclusion has led many governments to look closely to civil society initiatives in the social economy as solutions to these challenges. In many cases, these initiatives are rooted in their societies (Mendell and Nogales, 2009, p. 93). Now, more than ever, there is a call from these local actors, often called social entrepreneurs, for alternatives. These alternatives can be understood in the ways development projects are organized, funded, and managed in order to transform the development landscape into one of greater social impact. Today, most agree a step in the right direction has been taken as we see a shift towards more sustainable development and the establishment of projects emerging at the grassroots level, as opposed to a top down approach.

This paper explores an innovative approach to development financing, which combines the best that pure charity and the market has to offer. Patient capital is a funding mechanism used in international development that has shown to deliver real results, with greater and more efficient social impact than traditional development

financing. It can be understood as an investment that places social impact at the center of its approach. It is a long-term, thus, a ‘patient investment’, that expects below-market returns. Patient capital is a new method of funding and investment in development projects and has proved to yield positive results when measuring widespread social impact. It has been used in a variety of sectors in the developing world and has proved that it is an innovative and effective mechanism in a new era of development. More specifically, it is particularly useful in the health sector. Due to its affinity to long timelines, and its focus on long-term sustainability and social impact, patient capital is an appropriate social financing mechanism for health sector initiatives. For the sake of this paper, one particular case study will be examined to effectively illustrate the use of patient capital in the health sector, particularly in the treatment and care of individuals living with HIV/AIDS in sub-Saharan Africa.

As a new topic in the area of social financing in international development, this paper represents a systemic review of literature on the concept of patient capital in order to provide an accurate picture of this funding mechanism and how it is being used within the social economy. Based on these findings, it makes the argument that patient capital is an effective financing tool for creating sustainable development projects that contribute to increased social impact and better health sector results.

In order to properly demonstrate the success of patient capital financing, this paper will begin with a discussion on traditional aid. By presenting the traditional financing tools, most still commonly used today, it can provide a clearer picture of where patient capital fits in the perspective of development financing. Next, a discussion on the growing need to include social considerations in financing mechanisms are addressed as

it becomes apparent that the traditional range of development actors and financing mechanisms of the past struggle to produce results for beneficiaries, precisely because they take on a capitalist approach, to social problems. From here, concepts such as social entrepreneurship and the social economy are defined and explored as a basis for the discussion on patient capital.

In chapter three, the concept of patient capital will be defined and further explored. Through an illustration of Acumen Fund, the organization credited for giving patient capital its name, it will examine how using patient capital when investing in local entrepreneurs can have a long-lasting social impact for beneficiaries. From here, the ways in which it is possible to measure the success of patient capital will be addressed by looking at two particular examples related to measuring social impact: Expected Return Analysis and the Impact Reporting and Investment Standards (IRIS). These tools are important when describing successes in sustainable development for the BoP. Finally, a brief discussion on the practical and theoretical impacts of patient capital will conclude this chapter.

In the last chapter, patient capital will be examined in the context of the health sector. As a lack of proper access to healthcare persists in sub-Saharan Africa, it is a priority to focus on new and innovative ways of finding solutions to healthcare needs for the BoP. Through a discussion of the key characteristics of the health sector, it will demonstrate how patient capital offers an effective way for addressing long-term health problems. Addressing the HIV/AIDS epidemic in sub-Saharan Africa is currently on the global agenda as one of the most important health initiatives of our time. Thus, a case study, BroadReach Healthcare, will be used to demonstrate how patient capital is

effectively addressing previously unmet healthcare needs for HIV/AIDS patients in South Africa. Due to its success, this particular patient capital model is also being copied in other regions in sub-Saharan Africa. The BroadReach Healthcare model will be further discussed in order to broaden the context and examine how it may be used in other sectors. This will serve to demonstrate how patient capital is an effective tool, more generally, in development financing. Finally, this chapter will conclude with a discussion on the role of financial guarantees and how they relate to the patient capital model. The strengthened use of public guarantees and better Official Development Assistance (ODA) accounting for them is likely to get increased support as guarantees can unlock considerable private capital (OECD Report: Financing Development, 2007, p. 17). In development financing, guarantees are one of the greatest, most underdeveloped tools that can be used to deliver positive impact on healthcare in Africa. These types of guarantees allow local actors to be protected from numerous types of risk, which often are debilitating in developing countries. Thus, by incorporating guarantees into the discussion of the patient capital model, a valuable contribution can be made on the usefulness of this type of financing in a wide array of development initiatives.

The discussion of all these concepts; traditional financing, the social economy, patient capital and health sector initiatives, helps to make the case for patient capital as a financing tool in improving health in developing countries. This is why it matters. Patient capital offers the answers as to how socially oriented enterprises can use market-mechanisms and an innovative financing instrument to deliver affordable, basic goods and services to those who have been excluded from the opportunities of globalization.

Chapter 1 – The Limits of Traditional Financing Tools

Introduction

Traditional approaches to development have struggled to provide lasting change to issues of poverty. In the past 60 years, more than \$1.5 trillion has been distributed as aid-based grants and donations to developing countries, with very little improvement in poverty measures (Kennedy, Novogratz, 2010, p.46). There are various arguments made in the attempt to explain this failure, but one overarching aspect that cannot be denied is that the top-down approach of traditional aid has simply failed in reaching all individuals in the most vulnerable communities. William Easterly, Dambisa Moyo, Robert Calderisi, and many others have argued that traditional top-down development programs, while well intentioned, inevitably fall short of their goals because they neglect individual incentives, create opportunistic behaviour, and fail to tap into the innovative potential of citizens in recipient countries (Kennedy, Novogratz, 2010, p.46). This chapter will provide an overview of the traditional actors and tools in development financing and highlight the limits of this framework. It will then discuss the emerging social economy and a new set of actors that are working to achieve social means through entrepreneurship, thus changing the development landscape to one with a greater focus on “social” financing. Finally, it makes the case for these new actors, who are able to bridge the public-private divide, as important and effective agents of change in a new era of development.

1.1.1 Traditional Financing for Development: Tools and Actors

Traditional approaches to development have often focused on the very poor,

proceeding from the assumption that they are unable to help themselves and thus, need charity or public assistance (Hammond et al., 2007, p.6). They also tend to address unmet needs for healthcare, clean water, or other basic necessities by setting targets for meeting those needs through traditional financing tools, such as direct public investments, subsidies, or other handouts. These goals may be worthy, but the results have been strikingly unsuccessful (Hammond et al., 2007, p.6). Traditional approaches to development have lacked appropriate focus and have too often failed at providing sustainable solutions. Traditional tools for financing development have also faced serious limits as we have witnessed countless dollars wasted in attempts to reach the world's poorest communities with Official Development Assistance (ODA).

For fifty years, the Organization for Economic Co-operation and Development (OECD) has been the home of data collection, analysis and discussion regarding development assistance and financing tools used within the context of international development. After declining in the 1990s, ODA has increased in the twenty-first century, following the adoption of the Millennium Development Goals (MDGs). However, a closer look at these recent aid increases reveals that a large proportion of these dollars can be attributed to debt relief and special-purpose grants (Zimmermann and Drechsler, 2006, p.8). Special-purpose grants are crucial for disaster reconstruction and do not necessarily target the achievement of development goals, as outlined in the MDGs. Similarly, debt relief, under the Heavily-Indebted Poor Countries Initiative or Multilateral Debt Relief Initiative, does not automatically free up money for development, and has only benefited a small number of countries. (Zimmermann and Drechsler, 2006, p.9). Thus, aid figures can often be skewed by this “debt relief bubble” (Zimmermann and

Drechsler, 2006, p.9). This “bubble” must be considered when examining the OECD’s data on ODA and the impact that these traditional flows of aid dollars have on development.

Since the beginning of development assistance, donor countries have used many forms of traditional financing tools for providing assistance to developing countries in the Global South. Most of these tools are still the most common today for disbursing donor countries’ official development assistance dollars. Four different types of flows are the most important as financing tools in international development (see table below): 1) official development assistance (ODA), 2) other official flows, 3) private flows and market terms and finally, 4) net grants by NGOs (OECD: Development Co-operation Report, 2010, p. 176). There are numerous types of tools that also fall under these broad categories:

Traditional Financing Tools

Official Development Assistance (ODA)	Other Official Flows	Private Flows at Market Terms	Net Grants by NGOs
Bilateral grants and grant-like flows	Bilateral	Direct investment	
Bilateral loans	Multilateral	Bilateral portfolio investment	
Contributions to multilateral institutions		Multilateral Portfolio investment	

		Export credits	
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(Source: OECD Development Co-operation Report, 2010, p.176).

The challenges of traditional financing become more apparent when we witness some of the ignorance of fundamental components of any successful funding initiative. When an investor undertakes a development project, three critical mechanisms are needed in order to ensure its success: (1) assessment of the ongoing social program; (2) prediction of the return on the mission investment; and (3) planning long-term program strategies (Brest, Harvey, Low, 2009, p.51). These mechanisms have often been set aside in the traditional framework, as fast results were the ultimate goal. Many traditional development programs are characterized by short-term horizons. A renewed focus on accountability among bi- and multi-laterals has led to the proliferation of three-year funding cycles for many development projects, including project ramp-up, wind-down, and evaluation (Kennedy and Novogratz, p.49). This short time frame is the exact opposite of what is needed to create long-term sustainable solutions to poverty. It leaves somewhere between 18 and 24 months for the “real development work” to be completed. Furthermore, one of the greatest issues developing countries face in furthering its own social development is the budget ceiling. This is one of the greatest impediments to proper social and economic development, and while there is rationale for these ceilings, these types of policies illustrate the need for alternative financing tools that work outside of the traditional development framework. This is especially true in the health sector, the area of focus of this research paper.

There is a desperate need to expand healthcare infrastructure in both urban and rural settings. The investments that countries make in their healthcare system are very

expensive and usually only “pay off” in the long term with the economic development that stems from a healthy, productive work force. However, in the short term, many countries are prevented from expanding their budgets to allow them to hire more health workers or accept grants for healthcare expansion due to the budget ceilings required under the International Monetary Fund (IMF) inflation reduction and deficit reduction targets. This issue of budget ceilings proves to be an important factor in the development of health systems in sub-Saharan Africa.

A budget ceiling represents the limit a country must put on its budget in order to keep spending low enough to reduce deficit and inflation. The IMF imposes these limits so that these countries can be eligible for loans and grants from the World Bank and other international and regional development banks. Budget ceilings have been found to be a problem in many countries of the Global South precisely because the ceilings are too low to allow adequate spending on healthcare infrastructure and health supplies. The IMF sets its inflation targets and deficit reduction targets significantly lower than many other economists believe is necessary to achieve long term economic growth¹ (IMF: The Budget Ceiling). The result is that countries aren’t able to adequately address HIV and AIDS, as well as other health crises in their countries. In recent years, the IMF has shown increasing flexibility in some countries, but continues to apply excessively tight monetary policies in countries with high rates of HIV and AIDS infection.

It remains true that while every country must determine a budget ceiling that works for it, it is clear that it does not need to be nearly as low as it is under IMF conditions (IMF: The Budget Ceiling). Health spending in many countries in the Global

¹ Retrieved July 9th 2012 from: http://www.healthgap.org/camp/hcw_docs/IMFBudget.pdf

South is restrained and governments find themselves unable to address significant issues of health due to these constraints. Increased investment is needed in this area in order to begin to effectively address the HIV/AIDS crisis in sub-Saharan Africa.

While many policies and stipulations put forth by institutions such as the IMF have been criticized, there is no doubt that many of these policies and initiatives have lead to increased economic and social development in the Global South. Development practice has come a long way in the last forty years and there are many successes we can highlight throughout the past thirty years. There has been the eradication of smallpox, the campaign against malaria, the near eradication of polio, the increase in measures of family planning, global initiatives to fight HIV/AIDS, and mobile phone revolutions in a number of developing countries (Sachs, 2005, p.264). In hard numbers, the evidence from the last 25 years unequivocally demonstrates that the developing world has made dramatic advances on many fronts. Being born in the developing world in 1995, rather than 1970, has added 10 years to one's life expectancy (Stiglitz and Squire, 1998, p. 138). It is also true that per capita annual incomes are fifty percent higher (Stiglitz and Squire, 1998, p. 138). There has been considerable progress in our knowledge and understanding of development. Its agenda has been broadened to include democratic, equitable, sustainable development that raises living standards on a widespread basis. Furthermore, a wide set of instruments have been brought to bear: not only sound macroeconomic policies and trade liberalization, but also strong financial markets, enhanced competition and improved public services (Stiglitz and Squire, 1998, p. 150). There have been many successes in development and it is important to acknowledge their significance in the lives of the beneficiaries, as well as how the various traditional financing tools worked in

these diverse, and often difficult, contexts. Thus, much as been learned through various approaches and traditional financing tools in development's short history.

The successes in development witnessed up-to-date are meaningful but must also be the focus of lessons learned and areas for improvement. Traditionally, the development architecture was shared between public, private and mixed actors. Short time frames, budget ceilings, changing political priorities, divergent calendars of funding phases and short time frames have all contributed to a lack of cooperation in development initiatives and clearly demonstrate that our traditional ways of financing development must be supplemented by other actors and mechanisms. These include a new kind of actor, working in a new "social economy": social entrepreneurs, "philanthrocapitalists", impact investors, and many more are new actors in social financing where the focus is as much on social and environmental impact, as it is on any financial consideration.

1.1.2. Adding the "Social" to Development Financing

The traditional range of development actors and financing mechanisms of the past struggle to produce results for beneficiaries precisely because they take on a capitalist approach, to a social problem. The combination of capitalist means, for achieving "social" ends, can simply not work. Similarly, development practices based on charity and grants, cannot sustainably work in a capitalist world economy. While development financing has been working within this dichotomy, the social and the economic, it hasn't properly developed the tools to effectively navigate this complex relationship. The recent emergence of new actors, social entrepreneurs, working within a "social economy" can serve to better illustrate how the social and economic aspects of a new era of

development financing fit together in a harmonious and productive way.

Development financing has focused on social impact, often without much consideration for the formal economy. Similarly, businesses work towards their bottom line, profit, without much consideration for the social ramifications of their enterprise. In innovative development financing, the two must meet somewhere in the middle. A market-based approach to poverty reduction is important to address in the development community and can help frame the debate on poverty more in terms of enabling opportunity and less in terms of aid (Hammond, Kramer, Katz, Tran, Walker, 2007, p.6). Furthermore, a charitable approach must consider the workings of a country's formal economy. An innovative financing approach starts from the recognition that being poor does not eliminate commerce and market processes, as mostly all poor households trade cash or labor to meet many of their basic needs. The focus is thus on people as consumers and producers, and on solutions that can make markets more efficient and inclusive, so that the Bottom of Pyramid (BoP) can benefit from them (Hammond et al., 2007, p.6). This approach continues to look for solutions in the form of new products and new business models that can provide goods and services at affordable prices. These solutions may involve market development efforts with elements similar to traditional development tools—hybrid business strategies to include education; microloans, consumer finance, or cross-subsidies among different income groups; franchise strategies that create jobs and raise incomes; partnerships with the public sector or with nongovernmental organizations (NGOs) (Hammond et al., 2007, p.7). These types of hybrid solutions are the basis for better understanding patient capital financing as an alternative way of funding development projects and creating sustainable solutions.

Currently, many types of innovative financing are making increasingly important contributions to international development. Often, they are characterized by new partnerships between public and private entities. Within the health sector, two major international funds that combine public and private contributions have made a deep impact in meeting global health challenges: the Global Alliance for Vaccines and Immunizations (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria. These funds took advantage of the upsurge in private philanthropy for development and have themselves become the drivers of further innovation (OECD: Development Co-operation Report, 2010, p. 27). In addition, UNITAID is a global organization, housed at the World Health Organization, which seeks to develop innovative financing mechanisms to address health critical health issues in the Global South. It is the first global health initiative to work through market interventions to make life-saving products better and more affordable. UNITAID uses innovative approaches to increase access to treatments and diagnostics for HIV/AIDS, malaria and tuberculosis in low-income countries.² All of these organizations have made a huge impact by coming up with innovative ways of addressing development finance. The Global Fund has developed its own scheme for mobilizing debt relief, UNITAID created a system of small levies of private and public purchases, and various forms of guarantees and insurance have been considered by the Pilot Group on Innovative Financing for Development (OECD: Development Co-operation Report, 2010, p. 27). A “weather insurance” have been trialed, where donors put up funds to buy an insurance policy that triggers indemnity for farmers if and when stipulated rainfall or other thresholds are met (OECD: Development Co-operation Report,

² Retrieved July 10th 2012 from: <http://www.unitaid.eu/who/vision>

2010, p. 27). The role of guarantees is further discussed in the last chapter of this paper as it plays a crucial role in innovating financing for development.

The newly evolving international development finance architecture addresses many of the social issues needed to properly address the needs of beneficiaries. Social financing, in most of its forms, including the patient capital framework discussed in the following chapter, addresses three critical factors for any development initiative: 1) time, 2) the needs of beneficiaries and 3) the capacities of individuals. It allows for an appropriate time frame, adjusts to the evolving needs of the beneficiaries and can adapt as the capabilities of the individuals, both investor and beneficiary, develop in changing environments. These new forms of social financing require new actors, participating in the formal economy in a way that is different than before. As witnessed by most social financing initiatives in development, entrepreneurs are at the heart of developing innovative financing mechanisms for development. These are the people thinking outside the box when it comes to development. As new actors, they work within the social economy to reach both economic and social ends. This creates a whole new framework in how we discuss business and social goals in entrepreneurship.

1.2. Defining Social Entrepreneurship and the Social Economy

Social Entrepreneurship

Entrepreneurship aimed at economic ends is how we traditionally think of entrepreneurs and their businesses. While entrepreneurial phenomena with a purely economic focus has received a great amount of scholarly attention, entrepreneurship as a

process to foster social progress has only recently attracted the interest of researchers (Mair and Marti, 2006, p.36). Similar to entrepreneurship, which even today, continues to lack a unifying paradigm (Shane & Venkataraman, 2000), the term “social entrepreneurship” has taken on a variety of meanings (Mair and Marti, 2006, p.36). The concept of social entrepreneurship means different things to different people. However, for the sake of this paper, it is necessary to briefly explore this theoretical discussion and land on a definition that is most pertinent to the topic of social entrepreneurship within the context of international development.

Social entrepreneurship as a concept has been defined in various ways by various authors in the short time that it has been explored academically. Some researchers refer to it as not-for-profit initiatives in search of alternative funding strategies, or management schemes to create social value (Austin, Stevenson, & Wei-Skiller, 2003; Boschee, 1998). Others understand it as the socially responsible practice of commercial business engaged in cross-sector partnerships (Sagawa & Segal, 2000; Waddock, 1988). A third group views social entrepreneurship as a means to alleviate social problems and catalyze social transformation (Alvord et al., 2004).³ Premier organizations such as Ashoka and the Skoll Foundation, who invest in social entrepreneurs for systemic change, identify social entrepreneurs as society’s change agents: pioneers of innovation that benefit humanity (Neck, Brush and Allen, 2009, p.14). We see that in most definitions, a social entrepreneur is associated with terms such as innovation, social problems and solutions. It is important to note conceptual differences in all the terms surrounding social entrepreneurship. *Social entrepreneurship* typically refers to a process of behaviour;

³ This brief review of literature on social entrepreneurship can be found on p. 37 of “J. Mair, I. Marti. *Journal of World Business*. 2006. 41: 36-44.

definitions of *social entrepreneurs* focus instead on the founder of the initiative; and definitions of *social enterprises* refer to the tangible outcome of social entrepreneurship (Mair and Marti, 2006, p.37). Clarifying these terms will allow for a more comprehensive discussion of the concept of social entrepreneurship in innovative financing.

Social entrepreneurs matter for the same reason that other entrepreneurs matter: because they generate new, disruptive models for organizing human activity (Auerswald, 2009, p.51). This is particularly true when we examine the role of social entrepreneurship in creating innovative solutions to the alleviation of poverty. Due to the innovative nature of social entrepreneurship within this context of international aid, it is useful to broaden the domain of inquiry from social entrepreneurship to also include “social innovation”. Thus, a comprehensive definition of social entrepreneurship that will be used as a basis for this paper can read as follows:

“Social entrepreneurship is the process of finding a novel solution to a social problem that is more effective, efficient, and sustainable, or just than existing solutions and for which the value created accrues primarily to society as a whole rather than private individuals” (Auerswald, 2009, p.52).

Social value can be further explained by defining it as “the creation of benefits or reduction of costs for society – through efforts to address societal needs and problems – in ways that go beyond the private gains and general benefits of market activity” (Auerswald, 2009, p.52). The operative concept here is the reference to benefits that “go beyond market activity”. This is key to the role of social entrepreneurs in finding solutions to issues of health, education, infrastructure, that extend beyond traditional economic benefits in development financing.

As is the case with most paradigms, there are constant challenges put forth to the definitions of social entrepreneurship. If it is understood that entrepreneurs identify and exploit opportunities, social entrepreneurship more specifically identifies and exploits innovative solutions to social problems. In practice, therefore, this definition is said to imply conflicting challenges. How does an entrepreneurial initiative pursue both social and economic goals, and achieve performance in both areas? Economic theory suggests entrepreneurial ventures need to exploit opportunities in an innovative way, and must primarily pursue economic goals (profit) in order to overcome competing market forces and survive over the long term (Neck, Brush and Allen, 2009, p.14). While it is true that social entrepreneurs must maintain a certain level of profit in order to create and maintain a sustainably viable social enterprise, it is by no means the most important, nor the motivating factor, behind the venture. Moreover, the pursuit of economic and social goals cannot be understood as a zero-sum game where one suffers in the pursuit of the other. As social entrepreneurs have consistently demonstrated, both social and financial goals can simultaneously and significantly be achieved when the mission of the social enterprise is clearly defined, both in its social goals and business model. It is true that numerous variations of enterprise exist and can be further explored in terms of the donors and beneficiaries, as well as the vision behind the social enterprise. By considering the mission and objectives, with some enterprises placing more importance on the social, others on the financial, we can better understand the variations of social enterprise.

Social Economy

Social entrepreneurs have begun to address many issues facing the poor in the Global South by working within the relatively new “social economy”. It is true that there

are no more market-oriented individuals than those living in desperate poverty in many developing nations around the world. Every day, these individuals must navigate markets and make dozens of micro decisions to make their way in the world (Novogratz, 2007, p.19). However, if one single catastrophic health problem impacts themselves or a member of their family, they can be pulled back into poverty, perpetuating an evil cycle of insecurity. It is for this reason that both the market, and traditional aid, are needed for sustainable solutions to poverty alleviation: thus, the development of a social economy.

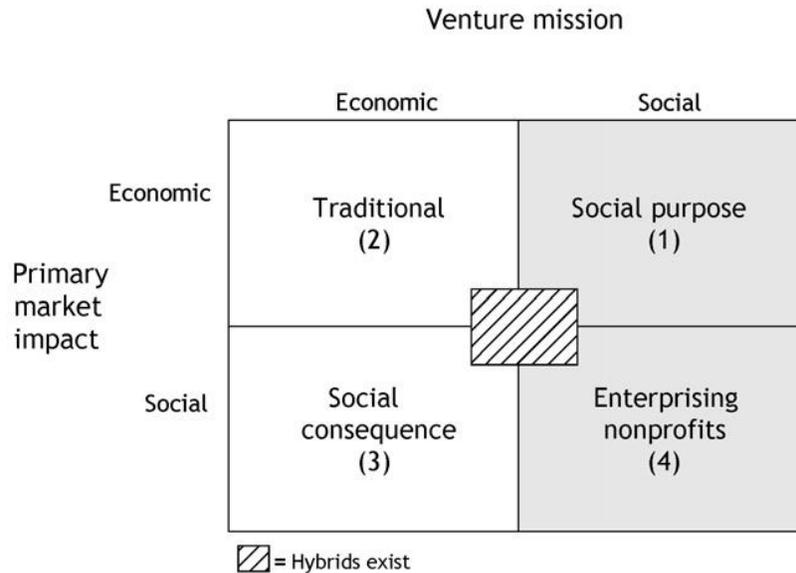
In recent years, the social economy has emerged as an important topic within the context of international development. This relatively new area of study refers to a new age in economics where businesses, organizations and enterprises are no longer solely motivated by profit. There are many forms of social enterprise, however, the most viable will be designed with a sustainable business model that puts an onus on social impact. Two complementary developments are transforming how we think about international development. First, a new group of “philanthrocapitalists” has taken an interest in global poverty alleviation. This includes organizations such as the Gates Foundation, Omidyar Network, Google.org and Virgin Unite. Unlike traditional development institutions, they insist on the adoption of business tools and techniques, using private capital organizational forms to get incentives right, pushing for efficient and effective use of resources and insisting on rigorous measurement (Kennedy and Novogratz, p.46). A second development, as discussed earlier, is the rise of “social entrepreneurs”, which are individuals who create innovative organizations to address social needs (Kennedy and Novogratz, p.46).

Recently, many organizations that have emerged from the social economy have used innovative ways of financing key development initiatives in order to build capacity amongst poor, local populations. One of these innovative financing mechanisms is patient capital. Patient capital is a type of funding mechanism in international development that is often used by social enterprises. As a social financing tool, it bridges the gap between the efficiency and scale of market-based approaches and the social impact of pure aid. It is an innovative financial product for developing markets aimed at realizing externality benefits and thereby significantly accelerating growth of viable enterprises in a given sector. The particularities of patient capital will be further explored in the following chapter.

1.2.1. Social Financing: Donors and Beneficiaries in the Social Economy

Many forms of social financing have emerged in recent years, which has led to numerous and varying social enterprises that identify with different priorities and models for “doing business”. The figure below demonstrates four types of entrepreneurial ventures that can emerge based on the underlying goals of an organization. The first quadrant (Social Purpose Ventures) represents a venture that has an explicitly social goal, yet has more of a perceived economic impact on the market. The second quadrant (Traditional Ventures) represents ventures with a clear economic mission and impact. The third quadrant, (Social Consequence Ventures) have social outcomes but they are an outcome of doing business, they are not the reason for the firm’s existence. Finally, the fourth quadrant (Enterprising Nonprofits) represents ventures that have a primarily social goal, but have income earning activities and focus on growth and economic sustainability

for the sole purposing of continuing to fulfill their social goal. Finally, there are hybrid forms that have a combination of characteristics and behaviours that are found in more than one type (Neck, Brush and Allen, 2009, p.16).



(Source: Neck, Brush and Allen. 2009. *The landscape of social entrepreneurship*. Business Horizons: 52, 13-19.)

For the purpose of this paper and the examination of patient capital as an innovative funding mechanism in healthcare initiatives, we find ourselves in the fourth quadrant. The goal is explicitly social, improved health, and the financial goal is only a means to an end of more efficient and effective healthcare distribution. These entrepreneurs are working within the social economy and are looking to create both social and financial value, typically in this order. Not only are they finding innovative solutions to most important global problems, by working within this newly defined social

economy, they are looking to confront the societal challenges that are keeping three billion people worldwide in abject poverty.

1.2.2. Limits of the Social Economy in a Traditional Development Framework

As demonstrated above, aid alone will not solve the problems of global poverty. It is essential to bring in new actors and sources of development finance. In many areas in the Global South, this is already happening. By understanding aid as just one of several finance flows and calling for the private sector to become more involved in development, the Monterrey Summit on Development Finance in 2002 (leading to the Monterrey Consensus), and the Earth Summit in Johannesburg leading to the Johannesburg Declaration (2002), symbolize a shift in consciousness about international development finance (OECD Report: Financing Development, 2007, p.11).

Loans, investments and remittances have emerged as a major source of capital to developing countries. Obviously, these funds are not always coming from traditional development institutions. With more actors becoming involved in development, the distinction between public and private financing is becoming increasingly difficult to define. NGOs exemplify organizations that bridge the divide between public and private finance. Some provide autonomous financing raised, others act not as finance sources but as implementing agencies or service deliverers in projects financed by the public sector, including ODA (OECD Report: Financing Development, 2007, p. 15). The public-private divide is also straddled by global funds and public-private partnerships that have been set up to spark action around specific global challenges, such as health and education. The Global Fund and the GAVI Alliance have been extremely active in the health sector.

However, their funding is largely composed of conventional bilateral and multilateral ODA. (OECD Report: Financing Development, 2007, p. 15).

These types of changes in the international development finance system may not be easily grasped, neither statistically nor analytically. This has been the case in recent years as more actors have emerged in this new social economy, yet there remains no clear understanding of how these types of actors affect the development finance system. They have major implications for policy makers in developing countries, who must make the most out of new funding opportunities, as well for donors, who must reposition themselves within the system (OECD Report: Financing Development, 2007, p. 16). Furthermore, they prove difficult to calculate, as there is missing a common language for development practitioners to discuss social impact in relation to the social economy. The share of non-aid flows from around the world is increasing and sub-Saharan Africa, in particular, may still rely more on official flows than the rest of the Global South, yet it also attracts almost as much FDI as a share of GDP as other developing countries (OECD Report: Financing Development, 2007, p. 16). Thus, a new system must be developed in order to be able to properly to calculate, analyze and discuss the impact these new forms of social financing have on the aid architecture, in both social and economic terms. It has become apparent that traditional tools for financing development must be supplemented by other means within the social economy. The deadline for the Millennium Development Goals (MDGs) is fast approaching and OECD governments can fulfill their pledges for increased aid in only three ways: through full accounting as ODA of debt relief granted to poor countries, through increasing ODA appropriations in ordinary budgets, and through innovative forms of development finance, which also needs to be

able to be fully accounted for as ODA (OECD Report: Financing Development, 2007, p. 17). As debt relief will not contribute a great deal to ODA in the near future and seeing as budgetary pressures in donor countries are growing, the search for innovative funding mechanisms will necessarily become the main priority.

Conclusion

There are many questions that remain unanswered in the practice of development, and there are no easy answers. The past has seen many successes in bringing aid to the world's most vulnerable populations, and it is important to focus on what worked within these solutions. However, many of the world's poorest people are not reached by important aid initiatives due to the lack of sustainable solutions and the political agendas witnessed by donor countries. Within a new era of social entrepreneurship and the social economy, individuals all over the world are motivated to increase social impact and provide a more equitable future for all. An inclusionary market-based approach may prove to yield more sustainable and inclusive development results for communities at the BoP. Thus, innovative social financing, including the patient capital framework, is worthy of further examination as it seeks to provide the long-lasting solutions needed to sustainably alleviate global poverty.

Chapter 2 – Patient Capital: An Instrument for Financing Development

Introduction

As a new tool within the social economy, patient capital is an innovative instrument for financing development. It serves to bridge the gap between traditional financing mechanisms that rely on the market alone, and charitable donations. Patient capital provides the vehicle for supporting sustainable development for the Bottom of the Pyramid (BoP), and has the ability to increase access to basic goods and services for low-income populations. This chapter will serve to define and further elucidate the concept of patient capital within the context of international development and will provide an illustration of an organization that uses patient capital to finance development projects around the world. In the second part of this chapter, the challenge of measuring social impact will be discussed and two tools in calculating these social externalities will be further explored. Finally, patient capital will be investigated within the context of the social economy and how it is able to offer sustainable solutions to the world's poorest populations. It will conclude by offering a brief discussion of the practical and theoretical impacts of patient capital as a whole, and how this is important in the evolution towards a new era of development.

2.1.1. Patient Capital Defined

Patient capital is a new instrument for financing international development initiatives. One of the most important outcomes of “philanthrocapitalism” and social entrepreneurs is the emergence of a new “patient capital” sector – a set of intermediaries with private capital structures who direct their energy toward creating social returns

(Kennedy and Novogratz, p.46). In general terms, patient capital is equity funding with return requirements that are delayed in time or lower in profitability than normal commercial thresholds (Patient Capital Initiative, p.3). A base assumption is that financial return is not the motivating factor driving donor interest; instead, social impact is the most important determining factor in the investment (Patient Capital Initiative, p.3). Patient capital has all the discipline of venture capital, demanding a return (and therefore rigor in how it is deployed), but expecting a return that is more in the five to ten percent range, rather than the thirty-five percent that venture capitalists expect (Novogratz, 2007, p.20). The investments that drive this market-based approach have the ability to grow, as long as they are well-suited to the type of development project. The ultimate goal of a business model based on a patient capital investment is that it will generate a “patient” return on the investment which will allow it to remain sustainable, recycling the returns into covering the costs incurred in running the development project. It also fills a gap that exists in developing financing in the Global South as it works between microfinance initiatives, investments typically up to \$10,000, and commercial financing, investments that are typically \$2 million or more.

Patient capital is an interesting new trend in development precisely because it asks the question whether or not this model can, in fact, change the way the world looks at international aid (Batavia, Chakma, Masum, Singer, 2011, p.66). It has emerged and gained popularity based on the fact that development, in the past, has seen many failures due to issues of sustainability. Failures in all sectors continue to have terrible consequences for low-income people. When social entrepreneurs work with patient capital, they can have a transformative effect on many sectors in the BoP markets –

housing, water, sanitation, agriculture and healthcare. Patient capital social entrepreneurs create new solutions, identify the best ideas, help build organizational capabilities and provide the capital to scale (Kennedy and Novogratz, p.47).

The patient capital sector is still relatively new, but it is growing rapidly and even more importantly, having a significant impact. A patient capital organization that runs a social enterprise serving the BoP community is much more complex than simply importing successful business ideas from the top of the pyramid (ToP). Social enterprises serving the BoP often require nontraditional financing and for this reason, are well-suited for patient capital. This is due to the fact that these types of initiatives usually take time to pilot, develop and grow (Kennedy and Novogratz, p.48). It is important to note that patient capital is not a grant, it is an investment intended to return its principal plus interest, which may be at or below the risk-adjusted market rate (Kennedy and Novogratz, p. 48). As previously stated, it does not seek to maximize financial returns to investors; rather, it seeks to maximize social impact and to catalyze the creation of markets to combat poverty. On the spectrum of capital available to both social enterprises and regular enterprises, patient capital sits somewhere between traditional venture capital and traditional philanthropy. Comparatively, it also sits between development aid and foreign direct investment (Kennedy and Novogratz, p.48).

There are four main differences in how patient capital organizations differ from traditional capital providers:

- 1 – **A longer time horizon:** Patient capital is appropriate for BoP initiatives because the investor must usually be willing to tie up money for ten years or longer. This is also in sharp contrast to the short time horizon of many traditional development aid programs (Kennedy and Novogratz, p.48).

2 – A willingness to forego maximum financial returns in exchange for social or environmental impact: Various social enterprises will approach this trade-off very differently – as seen in the quadrant of the various types of social enterprise and their primary goals in chapter two. Some will begin with expectations of market rates of return and will subsequently forego some return for high social and environmental impact. Others will work in the opposite way, seeking to maximize social returns with some lower bound on acceptable returns. These social enterprises strive to break-even on a commercial basis, with the primary goal being maximum social impact (Kennedy and Novogratz, p.49).

3 – A greater tolerance for risk than traditional investors: Often, the source of patient capital may be philanthropy, investment capital or a combination of the two. Due to this, there may be no expectation that the initial capital is returned and thus, allows for greater experimentation with the knowledge that many investments may not succeed but will still lead to lessons that benefit the entire sector. When an investment does succeed, the money is returned to the fund and becomes available for future investments. For many social investors the opportunity cost of *not* investing is perceived to be high. As their aim is social change, this lends itself towards experimentation and action, as opposed to conservation of capital (Kennedy and Novogratz, p.49).

4 – Capital is typically bundled with intensive support for social entrepreneurs as they grow their enterprises: This is especially important if the social entrepreneur is a local actor that may need significant financial and non-financial support. This assistance can take on many forms, such as formal training programs, information mentoring of executives, assistance with writing business plans or obtaining financing, technical advice on manufacturing, sourcing, and distribution, and sponsorship for conferences and exchange programs. It is more

common for patient capital investors to spend more time and effort nurturing their investee organization than on simply providing the financial capital (Kennedy and Novogratz, p.49).

It must be emphasized that patient capital is not “easy capital.” A social entrepreneur makes the investment because he or she believes in an initiative’s ability to become self-sustaining and to serve low-income markets at scale. There is an expectation of accountability and repayment on an agreed-upon schedule. Depending on the type of social enterprise, repayment is part of a social contract that helps avoid the tension that can arise when local, low-income entrepreneurs are expected to repay well-off investors. This may not always be the “patient capital relationship”, however, as many of today’s social enterprises act themselves as intermediaries, connecting funders from richer countries to entrepreneurs in poorer countries, one can understand how this tension may arise. However, local entrepreneurs understand that when they repay the patient capitalist, they are enabling the patient capital investor to support other social entrepreneurs serving the poor (Kenney and Novogratz, p.50). In order to better illustrate this relationship and the mechanism of patient capital at work in the real world, I will highlight one organization that has been using patient capital since 2001, using a successful business model for investing in local entrepreneurs, and is the organization given credit for coining the term ‘patient capital’.

2.1.2. Illustration: Acumen Fund

Established in 2001, Acumen Fund is a nonprofit venture capital fund for the poor, which was created with the goal of helping to build a world in which all individuals

have access to quality, affordable critical goods and services. This social enterprise reflects the growing interest in using markets to solve the toughest problems of poverty. It has invested in 46 organizations with \$40+ million in approved investments, which range from \$200,000 to \$2 million in both debt and equity vehicles (Kennedy and Novogratz, p.50). Acumen Fund is supported by over 200 individuals, foundations and corporations from all across the world who are seeking higher social returns, including the recycling and leveraging of capital, on their philanthropic funding (Novogratz, 2007, p.19).

Acumen Fund raises charitable funds, which it then invests equity and loans in both for-profit and non-profit social enterprises that deliver affordable healthcare, water, housing and energy to low-income people (Novogratz, 2007, p.20). It takes chances on business models proposed by local entrepreneurs that see a basic need that has yet to be filled within their community. Therefore, in addition to providing capital, the organization supports local entrepreneurs with talent (management assistance, strategic planning and on-ground support) and knowledge by bringing best practices and lessons to influence on specific business models and metrics (Novogratz, 2007, p.20). With this combination of social and financial goals, Acumen Fund sits at the center of the “blended value” concept. This term, coined by Jed Emerson, is the idea that the value that organizations create is a non-divisible mix of economic, social and environmental components (Novogratz, 2007, p.20). Acumen Fund is a prime example of an organization whose value is not easily divided between the economic and the social, although its ultimate goal, and the driving force of its investments, is clearly defined as social impact.

Acumen Fund is a non-profit social enterprise that seeks charitable donations in order to invest in private enterprises from which it expects a reasonable, but often below-market financial return on the capital invested (Novogratz, 2007, p.20). It measures success both by its social impact on target markets, as well as its own ability to be repaid on obligations outstanding. Acumen Fund uses the financial returns as indicators of the potential these local enterprises have to attract private capital, which is the ultimate end goal as this is much more plentiful than aid or philanthropic funding and can better address the needs of the majority of the global population (Novogratz, 2007, p.20).

The organization only invests in social enterprises with strong leaders that can promise long-term financial sustainability (revenues covering costs) and scale (the aspiration to reach 1 million customers over time). As it continues to grow, and has the opportunity to invest in many great social enterprises, Acumen Fund is currently exploring a “high-risk, low-return” fund for its longstanding partners in which investors would be repaid principal and modest interest (approximately 3%) after 8-10 years provided additional grants injected to cover the costs of providing essential management assistance (Novogratz, 2007, p.21). This would represent a great opportunity for growth of Acumen Fund’s investment activities, leading to an even greater social impact on the BoP communities these investments serve all around the world.

Acumen Fund’s investments have helped create more than 20,000 jobs worldwide and delivered much needed services to tens of millions of BoP customers. This has opened up a whole new world for these individuals who previously had limited or no access to markets. This approach has been successful due to the fact that it recognizes the

need for patient capital and continues to focus on developing an efficient and effective system for measuring and reporting on social impact.

2.2.1. Measuring Impact: Expected Return Analysis

In a new era where the emergence of the social economy has pushed many to focus on measuring social impact as well as the metrics of the regular economy, we find ourselves faced with the challenge of speaking a common language when it comes to social impact. Purely financial investors may differ in their risk preferences and desired time frames, but they are a common metric – dollars – for assessing the returns on their investments (Brest, Harvey, Low; Calculate Impact; 2009, p. 52). Social enterprises, philanthropists, NGOs, private donors all work within the social economy, yet lack a common currency. They continue to struggle with effectively communicating social impact for dollars spent. Necessarily, donors want to ensure their dollars are spent effectively and thus, seek to estimate the social return on their investment.

Expected Return Analysis is a tool used by various social enterprises to properly analyze the cost of an investment in relation to its expected social benefit in its target population. The concept of expected return implies that a cost is justified to the extent (but only to the extent) that it contributes to the net benefit (Brest, Harvey, Low; Calculate Impact; 2009, p. 56). The equation used in Expected Return Analysis reads as follows:

$$\text{Expected Return} = \frac{\text{Outcome} \times \text{Probability of the Outcome} \times \text{Contribution/Investment}}{\text{Cost}}$$

When it comes to a one-time mission investment of patient capital, an organization would use this equation to see whether or not this investment is likely to outperform the *Best Alternative Charitable Option* (BACO). To further build on the earlier illustration, Acumen Fund uses BACO comparisons to determine whether or not its investments are likely to deliver more social output per dollar than conventional grantmaking alternatives (Brest, Harvey, Low; Calculate Impact; 2009, p. 53).

Acumen Fund's loan to a Tanzania based company called "A to Z Textile Mills" can serve as a good illustration of a BACO comparison. Acumen Fund sought to help a local firm produce long-lasting insecticide-treated bed nets (LLITNs) to protect people against malaria, with a \$325,000 loan. These types of nets last twice as long as conventional insecticide-treated bed nets (ITNs). The BACO for this particular investment in A to Z Textile was a hypothetical \$325,000 grant to an international nongovernmental organization (NGO) that would use the money to distribute the more common ITNs. Their analysis consisted of three steps: 1) calculate the expected return of the BACO, 2) calculate the expected return of the investment in A to Z; and 3) compare the expected returns of the two options (Brest, Harvey, Low; Calculate Impact; 2009, p. 53). The result of plugging in the necessary figures into the equation⁴, the numbers indicate that investing in A to Z Textile is approximately 24 times more cost-effective than donating to the BACO. Furthermore, if A to Z Textile pays the annual interest on the loan, as well as repaying the principal, the loan/BACO ratio increases substantially. Additionally, if A to Z Textile defaults entirely, but still manufactures the bed nets, the

⁴ For further details on these calculations see p.53-54 "Calculated Impact" by Paul Brest, Hal Harvey and Kelvin Low. *Stanford Social Innovation Review*; Winter 2009; 7,1.

ratio falls to four, which is still a better deal than the BACO (Brest, Harvey, Low; Calculate Impact; 2009, p. 54).

Undertaking these types of calculations is just as much about the process than the result. Necessarily, a social enterprise like Acumen Fund wants a clearer idea of the return on investment when providing patient capital financing. And although comparisons to BACOs may have a large margin of error, they serve to inform a social enterprise's due diligence process (Brest, Harvey, Low; Calculate Impact; 2009, p. 53). As noted by Acumen Fund's chief investment officer, the value of the analysis "is not in the number that is spit out at the end, but in forcing the team to think through the marginal analysis of whether or not we really are generating significantly more social impact for our dollar than prevailing approaches" (Brest, Harvey, Low; Calculate Impact; 2009, p. 56).

2.2.2. Impact Reporting and Investment Standards (IRIS)

The growing need for reporting and investment standards for measuring social impact has also led a group of pioneering impact investors to begin to address critical barriers for measuring social and environmental impact. In 2008, the Rockefeller Foundation brought together a team of social impact investors to discuss the lack of transparency and credibility in how funds are defined, tracked and to report on the social and environmental performance of their capital.⁵ The scarcity of consistent, credible, non-financial performance information continues to prevent fair comparisons between impact

⁵ Accessed June 26th, 2012 from <http://iris.thegiin.org/history>

investing opportunities, social and environmental performance benchmarks, and other aggregate industry analyses.⁶

To address all of these challenges, three groups (Rockefeller Foundation, Acumen Fund and B Lab) came together to initiate the “Impact Reporting & Investment Standards (IRIS)” initiative, which seeks to create a common framework for defining and reporting the performance of impact capital.⁷ “IRIS was developed to provide a common reporting language for impact-related terms and metrics”.⁸ Through standardization of the manner in which organizations communicate and report their social and environmental performance, IRIS aims to increase the value of non-financial data by enabling performance comparisons and benchmarking, while also streamlining and simplifying reporting requirements for companies and their investors.⁹ IRIS provides value to many key stakeholders in the impact investing industry, including investors in funds, direct investors, companies and member organizations and intermediaries.

IRIS is available as a free, public good and provides a library of standardized social, environmental, and financial performance indicators designed to be applied across diverse sectors and regions (IRIS Data Report, 2011, p.2). IRIS indicators allow social entrepreneurs to speak the same language, helping them in communicating the performance of their organization, which thereby helps in receiving and seeking impact investment capital. Where possible, IRIS aligns itself with widely accepted sector-specific reporting standards, such as the microfinance performance indicators used by MIX (IRIS Data Report, 2011, p. iv). In sectors where there are no commonly-accepted

⁶ IBID

⁷ IBID

⁸ Accessed June 26th, 2012 from <http://iris.thegiin.org/about-iris>

⁹ IBID

performance indicators, the IRIS team works with industry experts to develop the most comprehensive indicators (IRIS Data Report, 2011, p. iv). It is important to note, however, that IRIS does not provide prescriptive guidelines for reporting, value judgment, certification or performance rating (IRIS Data Report, 2011, p. iv). The three main components of the IRIS initiative are to 1) develop and refine the IRIS standards, 2) promote the adoption of the IRIS standards, and 3) enable voluntary contribution of anonymous IRIS performance data through data collection partners in order to establish an expansive evidence base of the industry's performance (IRIS Data Report, 2011, p. iv).

IRIS represents one of the innovative ways social entrepreneurs in the 21st century are seeking to solve problems related to measuring social and environmental impact in social financing. Expected Return Analysis proves to be a good tool for assessing impact per dollar for investors looking to make the most effective socially-conscious investments. Historically, investors have had to rely on fragmented information, have implemented proprietary measurement systems or have relied on anecdotes alone (IRIS Data Report, 2011, p. i). These tools have contributed to the great strides made in recent years for creating a common language in measuring social and environmental impact. As social entrepreneurs are consistently looking for additional funds from impact investors, these tools are imperative for effectively communicating their successes to key stakeholders. When social impact can be more clearly communicated, it becomes easier for social entrepreneurs to extend their goods and services to poor people all over, including the most needy BoP communities.

2.3.1. Sustainable Development for the BoP

The patient capital model works in unique contexts where most often, social enterprises are exploring new markets and dealing with some of the world's poorest populations. This reality can present challenges that differ greatly from the issues they have dealt with in other contexts. BoP markets differ from ToP markets in important ways and therefore, require unique solutions (Kennedy and Novogratz, p.47). Five key factors affect the way social enterprises must undertake their ventures for BoP markets:

1 – **Unaddressed needs:** There are many unaddressed needs at the BoP, usually because government isn't fulfilling its mandate or because people are perceived as too poor to buy (healthcare, housing).

2 – **Poor infrastructure:** Poor infrastructure leads to inadequate distribution networks and poor access to vital goods and services. This can also mean that a low-income customer generally has poor access to education and information, which makes a company's market and service delivery different from a company's approach to ToP customers (Kennedy and Novogratz, p.47).

3 – **Corruption:** In these contexts, corruption is often rampant, sapping economic value from the system and adversely affecting those who follow the rules.

4 – **Low purchasing power:** This makes it difficult for new products and services to enter the market. BoP communities are also subject to a "poverty penalty" whereby they pay significantly more for products and services than their middle-income counterparts (sometimes, up to forty times more).

5 – **Lack of equity capital:** This is mostly due to the fact that these investments are risky. Traditional capital providers tend to bypass BoP entrepreneurs because they are perceived as highly risky.

When one combines all of these factors, it becomes apparent how the BoP markets differ greatly from the ToP markets (Kennedy and Novogratz, p.47). Most ventures must operate very differently in each market where they exist, adjusting the products and services they offer and their business processes. Most successful BoP ventures must adopt innovations and social entrepreneurs must continue tailor their strategies to BoP communities. Four innovations¹⁰ can be highlighted, and successful social entrepreneurs adopt often more than one. Briefly stated, these are:

- Introducing radical cost reductions in entrepreneurial activities
- Building a BoP-centric management team; which consists of constantly rebalancing the will to serve the poor with the more traditional business skills needed to build a successful business
- Implementing human-centric design thinking to the creation of products and services
- Establishing trust with the BoP community in order to create and grow markets.

These four innovations, when used individually and together, are conducive to successful social ventures in BoP markets. When it comes to lowering costs, a common misconception is that quality must also be lowered. This is simply not the case for many social enterprises. An example of quality, inexpensive care is seen in Aravind Eye Hospital, based in Madurai, India. Aravind has succeeded in lowering the cost of cataract

¹⁰ It should be noted that the framework presented here draws on several years of these particular experts' experience working with and learning how to nurture and grow BoP ventures. It is not the outcome of structures hypothesis testing or of extensive data gathering and analysis (Kennedy and Novogratz, p.52).

surgeries from approximately \$3,000 to somewhere between \$50-\$75 per surgery. They have done so through a radical restructuring of the hospital's workflow. Aravind performs more than fifty times the surgeries than the U.S.' leading eye hospital, employs hundreds of low cost orderlies and junior nurses to perform routing monitoring and care services, and relentlessly focus on optimizing resources (Kennedy and Novogratz, p.53). While Aravind successfully keeps costs low, its quality measures are equal to or exceed those of U.S. hospitals. Surgical residents from around the world come to Aravind to gain high quality, and a high quantity of experience in a short amount of time. It is these types of cost reduction innovations that allow Aravind to provide affordable high quality eye care to low-income people in India.

The second innovation, building a BoP-centric management team, is critical for the success of BoP ventures. Top management teams require two distinct skill sets: the *will* and *imagination* to create solutions for BoP communities and the *skill* to manage a meaningful business (Kennedy and Novogratz, p.54). The real challenge is staying in tune, and being able to properly balance these needs as the venture matures in size and in scope. Organizations' success creates new management needs, which can prove challenging in a social enterprise. Social entrepreneurs rarely have the functional skills necessary to run large, complex organizations. Similarly, skilled functional executives are not always available for the salaries and circumstances that BoP ventures require (Kennedy and Novogratz, p.54). Consequently, balancing these needs can be a very interesting challenge.

Implementing human-centric design thinking relates to the challenges BoP organizations have in providing products and services to their customers. These products

and services must be a) valued by BoP consumers, b) must be affordable and c) must be able to be delivered efficiently (Kennedy and Novogratz, p.56). Thus, in order for a BoP venture to be properly designed, it is imperative that a social entrepreneur must understand the local context, as well as the consumers' needs and usage patterns in order to achieve a "human-centric design". The goal, here, is to better understand the way people think, feel, and live at the BoP before, during, and after designing products and services (Kennedy and Novogratz, p.57).

Finally, the last innovation – establishing trust – may be the most important component of any successful social enterprise. In the commercial sector, it is often the BoP that bears the brunt and is left out of the world's new advancements. Local communities constantly hear promises from politicians, development organizations and even charities whose funding and organization promises prevent them from following through on their commitments. The result is skepticism on the part of local people of the solutions being offered to them. If you combine this with the fact that understandably so, the poor are more risk-averse than other segments of the market, a perfect recipe emerges for customer resistance. It becomes easy to see that establishing trust with BoP communities is imperative in creating and growing markets catered to these very important customers. Trust requires time, and as we have seen, the patient capital model offers this particularly important long time frame.

2.3.2. Practical and Theoretical Impacts of Patient Capital

Patient capital investors and the social entrepreneurs they support are moving beyond the artificial separation between aid and the market; creating a new path to

prosperity for BoP communities (Kennedy and Novogratz, p.52). As one looks across the BoP landscape, an emerging set of approaches to innovation (and innovative approaches to funding) are emerging that can be employed across a range of BoP-oriented businesses (Kennedy and Novogratz, p. 74). Increasingly, social entrepreneurs are approaching low-income communities as *customers* and *partners*, rather than mere objects of charity. Success in social financing has occurred using patient capital precisely because it is well-suited to be working within the social economy. As a funding mechanism, patient capital has demonstrated success as an innovative funding mechanism at both practical and theoretical levels.

In practice, patient capital offers the time, flexibility and sustainability required by development initiatives. Theoretically, it fills the divide between the world of the formal economy and social impact. It is a funding mechanism that can effectively navigate the complex relationship between the economic and the social and succeeds in providing real benefits to the BoP. It acknowledges the need for a market-based approach, the sustainability that this offers, while simultaneously maintaining focus on the ultimate goal of social impact. As a form of social financing, patient capital offers the necessary tools for succeeding in creating real social impact while working within a capitalist economic framework. This is why it is an important tool. While the global economic framework is unlikely to change, it can evolve to better support ethical business practices and a more prominent social economy. An increasing number of people around the world are more aware of global, social inequalities and understand that in our globalized world, these issues are not far removed from their own lives. As these inequalities becomes more apparent, and better understood, a greater number of socially-

motivated individuals are focused on putting an end to these gross disparities in wealth, and become adamant agents of change. The patient capital framework is important precisely because it is an effective tool that is well adept within this context of greater social change.

Conclusion

This chapter has demonstrated how patient capital is an effective funding mechanism for various development projects. As a new form of financing, it has been shown how patient capital is a flexible tool in a wide range of contexts, and can be counted on for delivering increased social impact. For this reason, it is important to consider how this form of social financing can be applied in specific sectors. Improving health is one of the most important goals put forth by the development community, as witnessed through the Millennium Development Goals (MDGs), and a state of good health is valued deeply by any individual, in both the developed and developing world. The following chapter will explore the role of patient capital in the health sector and how it can be used as an effective funding mechanism in the prevention and treatment of individuals living with HIV/AIDS in sub-Saharan Africa.

Chapter 3 – The Use of Patient Capital in the Health Sector

Introduction

Good health is one of the most valued possessions of any individual, rich or poor, and is a state that most people attach great value to gaining and keeping. Health has an impact on every component of an individual's every day life: family life, ability to earn an income, leisure, and much more. Sadly, whether or not an individual has access to adequate to healthcare is largely determined by where he or she has had the fate of being born. Many countries in the Global South are faced with extreme challenges in providing healthcare services through their national systems. Moreover, increased strains on these healthcare systems persist due to high rates of long-term diseases and infections. The status of one's health generates externalities for many other aspects of one's life and thus, is the basis for living a valuable and productive life.

This chapter will explore the use of patient capital financing in the health sector, more specifically in HIV/AIDS prevention in sub-Saharan Africa. By using a case study, BroadReach HealthCare, it seeks to demonstrate more tangibly, how the patient capital model can be used to improve health, and health systems in the developing world. Furthermore, by broadening the context to the role of official development assistance, patient capital will be examined in terms of how distribute, analyze and calculate ODA in a new era of social financing. Finally, the role of financial guarantees will be discussed as an important tool in expanding the use of patient capital as we evolve towards a new era of development. As one of the greatest, most underdeveloped tools in international development, financial guarantees can be used to deliver positive impact on healthcare in Africa. By understanding how all these components works together in the health sector,

the practical role of patient capital as an alternative to traditional financing will be further clarified and supported.

3.1.1. Key Characteristics of Health Sector

In the last decade, health in sub-Saharan African has largely been monitored in terms of meeting the MDGs. In this regard, the World Health Organization's (WHO) World Health Report 2008 asserts that any progress towards meeting the goals in several sub-Saharan African countries has “stagnated or even lost ground”(UNAIDS, 2008, p. 4). There has been some progress in the fight against malaria, however, the number of people living with HIV/AIDS continues to grow (UNAIDS, 2008, p. 4). Sub-Saharan Africa a new issue, the so-called ‘double health burden’, where continuing high rates of infectious diseases are combined with growing rates of chronic disease including cardiovascular diseases, diabetes, cancer, chronic respiratory disease and mental illness (MacLean & MacLean, 2009, p.363). Thus, health solutions in international development must consider the longer term in order to have a positive effect on health in the Global South.

Investment in health is one of the most expensive expenditures in development financing. With little to no pay-off in the short-term, limited national budgets, imposed budget ceilings, it is often difficult for governments to heavily invest in improving their health systems. Governments do not have the ability to set aside the large amount of funds needed up-front to invest in a strong national healthcare system. A huge investment is needed from the outset, and in addition, upkeep and costs associated with the health sector are particularly high. Salaries of medical professionals, equipment, training, advances in technology, infrastructure, healthcare provision in rural areas: it is obvious

that investing in health is a heavy burden on any national system.

To affect action, three areas are to be targeted for improving health systems in the Global South: surveillance and evaluation of health needs and policy impacts, national health systems and underlying political economy. These multi-dimensional objectives will require novel approaches to governance involving “civil society, governments and global institutions” (MacLean & MacLean, 2009, p.364). For sustainable health solutions to emerge, the focus must be on building capacity of national health systems. Patient capital financing in health is well-positioned to address the many needs of the sector by offering an innovative approach that leads to sustainable solutions for health equity.

3.1.2. Patient Capital Financing in Health Sector

The use of patient capital as a social financing mechanism in the health sector is an innovative advancement in how we can go about solving global health inequalities. Household demand for healthcare is sensitive to price (negatively) and quality (positively), whether public or private, and it is always poor households that show the strongest demand response. Simply offering a service to the poor does not suffice to ensure a corresponding demand, and charging fees for services is incompatible with the reduction of inequality unless the poor are exempt from these fees. Even without fees, these services still entail some costs (medicine, transport), and the most efficient way to increase the demand of poor households is to reduce these costs (OECD Development Centre Policy Brief No. 19, p.15-16). By using innovative business models, patient capital financing is often able to absorb these fees for the poorest individuals in the system by offsetting costs in other ways. This ensures that demand remains central to the

health systems and the needs of the BoP are being addressed.

The supply approach in health used in developing countries since the 1950s is not well suited to the BoP. Provision of health services should not be based on an abstract, general notion of equal rights to health care for all, but should be structured instead according to the specific needs and behaviour of BoP households (OECD Development Centre Policy Brief No. 19, p.15). For instance, rural and urban areas may have different needs. Moreover, even when medical care is provided free, households bear part of the costs (including loss of the income from hours not working). While these costs are negligible for higher- income households, they are significant for the BoP. It is therefore necessary to reason in terms of both supply and demand in order to adapt health services to the needs of the poor, even when supply is not affected by market forces because these services are provided free of charge (OECD Development Centre Policy Brief No. 19, p.16).

The erosion of public health services has been especially devastating to sub-Saharan Africa. These struggling services include monitoring of a population's health, disease surveillance and prevention, response to emergency health threats, setting and maintaining standards for air, water and food security as well as for workplace health and safety, health education and promotion; and research and evaluation of health services and issues (MacLean & MacLean, 2009, p.365). Many experts are worried that the skewed emphasis on pharmaceuticals versus health systems has been exacerbated by the inordinate influence that philanthropic and business actors now exert on the global health agenda. The recent massive infusion of external funds through private actors and PPPs, especially related to the fight against AIDS, is that it can allow a set of external actors to

set the terms of health care in sub-Saharan Africa. This may cause further eroding of the already fragile health systems. Finally, health systems may be further stressed by a lack of coordination among PPPs and between them and other health actors (MacLean & MacLean, 2009, p.366).

While there are significant criticisms on these models, a patient capital framework would ideally work with the mindset of traditional financing, but with greater efficiency and sustainability. It is not private sector development precisely because its bottom line is focused on social impact, not on profit. PPPs are useful in that governments can invest in initiatives with private actors who fit within this new category of social enterprise, their focus also remaining on social impact. Significant efforts to improve the challenges highlighted above are underway and most experts are optimistic that global health initiatives by PPPs and others can help to strengthen health systems through such mechanisms as more direct funding, increased advocacy, and better policy dialogue and alignment with recipient countries (MacLean & MacLean, 2009, p.367). Some argue that, with such measures, PPPs have already encouraged, in some cases, an “improved policy making environment, facilitated by country-level coordinating mechanisms” (MacLean & MacLean, 2009, p.367).

The collapse of a capitalist approach for social needs lends support to calls for a new global economic model based on a “social market economy” (MacLean & MacLean, 2009, p.368). Over the last several decades neo-liberalism dominated the global economic order, exacerbating social inequalities. In order to prevent the exacerbation of the health crisis in sub-Saharan Africa, it is imperative that more support be directed at strengthening health systems, that local civil societies become more

involved in establishing these systems and that the collapsed global economic system be remodeled to promote greater social equity (MacLean & MacLean, 2009, p.368).

Equitable distribution of resources, as through policies designed to achieve health equity, will encourage social stability and security.

The use of patient capital financing fits within the policies that are designed to promote greater social and health equity. As a social investment, it seeks to fill a gap by providing the funds needed for healthcare provision to the BoP while simultaneously supporting capacity building. As a sustainable financing tool, its aim is to eventually run on its own, within the local context that the initial investment was made. The injection of money offered by patient capital, with a long-term horizon, often gives health systems the boost needed to kick-start its own capacity-building. The social entrepreneurs that are working to find solutions to health issues within their local communities are looking to make sustainable changes to their national health systems. They are working in partnership with numerous actors to make this happen. Innovative partnerships, non-traditional models of delivering health services, and creative individuals within the civil society are all part of the advances that are already underway in creating sustainable healthcare solutions for the BoP.

3.2.1. HIV/AIDS Prevention and Care in sub-Saharan Africa

Health inequalities, and the lack of access to proper healthcare, persist in many countries across Africa. While many of the issues rest at the social level, the predominant paradigm continues to support a clinical health model that privileges pharmaceutical treatment of individual diseases over supporting a broader social change that would include broadly based national health systems, as well as new international economic

structures (MacLean & MacLean, 2009, p.361). As it stands, in spite of the billions of dollars of international aid dispensed, an incredible fifty percent of Sub-Saharan Africa's total health expenditure is financed out-of-pocket payments from its largely impoverished population (Business of Health in Africa, vii). A study by the International Finance Corporation (IFC), with the assistance from McKinsey & Company, estimates that over the next decade, \$25-\$30 billion in new investment will be needed in health care assets in order to meet the growing health care demands of Sub-Saharan Africa. This includes hospitals, trained medical personnel, clinics and distribution warehouses (Business of Health in Africa, vii).

The Joint United Nations Programme on HIV/AIDS reports that 33.3 million people are estimated to be living with HIV. The region the most affected by HIV/AIDS epidemic is Sub-Saharan African, with 69 percent of all new infections (Acumen Fund Investments: Health Portfolio). In 2009, 1.8 million people died from AIDS-related causes. Across the world, there are 3 million people dying every year from AIDS and 10 million children dying from preventable and treatable diseases. As most of these deaths occur in developing countries, it is clear that these health systems are suffering. There is a severe shortage of healthcare workers – doctors, nurses, social workers, psychologists, community-based health workers – throughout much of the Global South. The shortage is the most acute in sub-Saharan Africa where experts estimate a shortfall of at least 1 million health professionals (IMF: The Budget Ceiling).

South Africa represents 0.7% of the world's population but carries 17% of the global burden of HIV/AIDS, which amounts to approximately 5.7 million people living with HIV/AIDS (Partnership Framework, 2012, p. 6). HIV prevalence amongst adults

(15-49 years) is estimated at 18% with women and girls bearing 60% of the disease burden. Despite being a middle-income country, key maternal and child health outcomes and developmental milestones have declined over the last fifteen years due to the impact of HIV/AIDS. Furthermore, South Africa is one of only twelve countries in which mortality rates for children younger than five-years have *increased* since 1990 (Partnership Framework, 2012, p.6). The reality is that most of these deaths can be prevented through proper access to healthcare treatment and antiretroviral drug therapy. It is imperative that better ways be found to deliver care to vulnerable populations and to develop infrastructure, capacity and systems crucial for rapid healthcare interventions (Acumen Fund Investments, BroadReach Healthcare, p.1).

This stark reality begs for healthcare alternatives that provide tangible health solutions. A critical role can be played by hybrid private sector models in meeting the need for higher-quality healthcare in Africa. Alternative models that are designed to use the best of both the public and private sector has to offer can foster positive advancements in providing quality healthcare to the world's poorest people. In principal, many from the public health community oppose any role for the private sector in healthcare. Many legitimate concerns can be put forth as we see that the private sector in sub-Saharan Africa is diverse and fragmented, which can result in an inconsistent quality of care (Business of Health in Africa, vii). Furthermore, the lack of regulatory and accreditation frameworks, combined with a largely uniformed patient base, can often allow an dishonest minority to prevail over responsible providers – to the detriment of the reputation of all (Business of Africa, vii). Donor and government concerns about quality and affordability may have limited the role the private sector currently plays in

HIV/AIDS care and treatment, but there are successful models that attempt to address these concerns (USAID, 2009, p.1). These are the models we must focus on. The reality is that for-profit companies, non-profit organizations, social enterprises, insurers, manufacturers and providers already account for as much as fifty percent of healthcare provision in Africa and their role continues to grow (Business of Health in Africa, vii).

The private health sector, including private providers and insurance schemes, is often overlooked in health systems strengthening (HSS) initiatives, yet has proved that it has the potential to ease the burden on public health resources and strengthen the health sector in developing countries (USAID, 2009, p.1). The creation of the World Health Organization's Commission on Macroeconomics and Health in 2000, points to the inextricable link, and the value of evaluating the many facets of the economy and the role it plays in health systems. Increasing quality care to underserved populations and creating linkages between the public and private sectors is key for building an integrated, sustainable health system. While many private sector providers pioneered the provision of HIV-related care in developing countries, these have largely been overlooked by the public sector and donor agencies seeking to create a large-scale, fully integrated system of health delivery (USAID, 2009, p.2). The next step in HSS is to build a health sector that thoroughly integrates the private sector, with the goal of improving financial viability, efficiency, and equitability.

Sub-Saharan Africa's improving economic performance translates into a further increase of demand among all sectors of society for healthcare. The IFC study estimates that the market for healthcare will more than double by 2016, going up to \$35 billion (Business of Health in Africa, vii). Smarter investments will be needed to fill this gap.

The private sector is often perceived as serving only the rich, but often, the opposite is the case. Private sector providers, including for-profit and social enterprises, fill an important medical need for poor and rural populations underserved by the public sector (Business of Health in Africa, viii). As is often the case, individual public sector workers also provide private sector services, both formally and informally, and an informal health sector of healers, midwives, and individual medicine sellers also provide care (Business of Health in Africa, viii). The private sector is usually in a position where it can provide services or products that might not otherwise be available, such as advanced medical equipment and procedures. In the example of BroadReach (case study below), it uses a patient capital model of financing in order to provide antiretroviral drugs to the poorest people who would otherwise not be able to afford them.

If the goal is to provide all human beings access to adequate healthcare, the means to getting there is to think innovatively. Stemming from interviews with all segments of sub-Saharan Africa's healthcare community, five main imperatives emerged that create an agenda that can mobilize the responsible development of private sector healthcare in the region (Business of Health in Africa, viii):

- 1- Develop and enforce quality standards – *Financial and technical support is needed to strengthen the ability of public and private regulatory bodies to develop and enforce transparent and effective quality standards.*
- 2- Foster risk pooling programs – *such as government-funded national payment schemes, commercial insurance or community non-profit mutuelles.*

- 3- Mobilize public and donor money to the private sector – *Can help build healthcare capacity by earmarking some aid to fund private sector entities directly while also assisting local governments to expand their procurement capabilities and manage contracts with the private sector.*

- 4- Modify local policies and regulations to foster the role of the private sector – *Should streamline bureaucratic processes that limit market entry, liberalizing human resource regulations that perversely reduce the number of active healthcare workers, and reduce tariffs and other barriers that impede access to or raise the cost of health supplies.*

- 5- Improve access to capital – *By educating local banks about the true risk profile of the healthcare sector, using international financial backing to encourage local financial institutions to lend to healthcare enterprises, and developing equity-focused financing vehicles for healthcare enterprises.*

3.2.2. Case Study: BroadReach Healthcare

BroadReach Healthcare is a global healthcare solutions company that provides consulting, implementation, and program management services. This enterprise’s mission is to improve the lives of people around the world using new, innovative approaches to healthcare that combine the best of the private sector and public health (BroadReach Healthcare). BroadReach works with a wide range of partners and clients: national government, civil society, international donor agencies, pharmaceutical companies, local NGO partners and other private-sector companies. Through these partnerships, BroadReach applies its expertise across five core service areas: Distribution Networks/Product Value Chain, Health Systems Strengthening, Patient Education and

Community Mobilization, Public-Private Partnerships and Strategic Consulting (BroadReach Healthcare). The approach used across each of these service areas, combines best practices from the public sector with business efficiency and private sector discipline to address international health challenges and opportunities.

BroadReach runs one of the largest HIV/AIDS programs in South Africa. The BroadReach model identifies and takes advantages of the excess capacity of private practitioners, helping them bring on poor patients who could not otherwise pay. Each doctor is paid on a per patient basis for individuals referred by the BroadReach program. In many cases, the private practitioners operate in areas where there is no access to government clinics (Acumen Fund Investments, BroadReach Healthcare). Looking forward, BroadReach hopes to create a Medicaid model for South Africa, and, in time, expand services across the African continent. Its model also stems the drain of talent in the healthcare field by encouraging doctors to build their practices in South Africa (Acumen Fund Investments, BroadReach Healthcare).

BroadReach Approach

What BroadReach Takes from the PRIVATE Sector	How BroadReach Combines Them	What BroadReach Takes from the PUBLIC Sector
Innovative approaches to problem solving	Creating solutions that maximize impact in a sustainable way	Proven models for success in challenging environments
Experienced business talent	Using a breadth of experience across different types of businesses and organizations to grow a	NGO and non-profit expertise

		range of capabilities and best practices	
Focus on efficiency and financial discipline		Creating scalable programs and value for the public through the sound investment of time and money	Focus on improving people's lives
Private capital markets		Managing a range of funding and execution options to deliver results efficiently and effectively	Public funding and resources
Reputation for innovation and operational excellence		Developing a brand which will draw in new opportunities	Reputation for managing large scale efforts to improve healthcare

(Source: http://www.broadreachhealthcare.com/About_BroadReach)

In an interview with CNN in November 2010, Dr. Ernest Darkoh, chair and founding member of BroadReach Healthcare stated that Africa will never have enough resources to fight AIDS according to the conventions of the West and therefore, should not keep looking to conventional models that work in environments that don't match the African context (CNN, 2011). In 2001, Dr. Darkoh helped develop Africa's largest public sector HIV/AIDS treatment program, in Botswana. This project was incredibly successful and in a five-year period had considerably slowed down the number of HIV-related deaths in the country. In South Africa, BroadReach "came into being out of observations on the ground and with encouragement from groups like Merck Pharmaceuticals and the Gates Foundation" says Dr. Darkoh (CNN, 2011). He also stated "One of the principles of which we approach all of our work is to be extremely target and goal oriented and

results oriented”. As a healthcare approach, Dr. Darkoh self-describes BroadReach as a supermarket checkout approach. He further explains:

“If everybody at the checkout counter has a cart stacked full of stuff, you’ll have a big queue. And in the HIV context, everybody behind you is getting sicker, meaning that their cart is getting stacked higher and higher. So the queue grows indefinitely until you crash the capacity of your healthcare system. We created this fact checkout lane whereby those people who did not need an hour worth of care and maybe just needed five or ten minutes could come through and get all that volume through and prevent them from ever becoming sick, and those who would need intensive care would come on the other days. So we saved the lives of those who were very critical but we also prevented people getting too sick and therefore becoming this unmanageable burden on the health system”.

Dr. Darkoh’s approach is to look at how he can use partnerships to generate massive scale very quickly. In South Africa, this partnership came into fruition between the Department of Health and BroadReach Healthcare. In many rural communities in South Africa, populations have endured significant hardship caused by poverty, poor infrastructure and HIV/AIDS. In one particular community, the Dr. Kenneth Kaunda District in the North West Province, there has been a highly successful partnership between North West Department of Health and BroadReach Healthcare GP Down-Referral Program (Health 24, 2010). Established in 2005, the program is currently achieving unprecedented results. Ms. Mmope, Chief Director, Strategic Health Programs, Department of Health and Social Development states: “The GP Down-Referral Program, spearheaded by the North West Province Department of Health and BroadReach Healthcare, is an excellent example of Public-Private Partnership (PPP) and works be

leveraging private sector General Practitioners (GPs) in treatment delivery at a capitated rate” (Health 24, 2010). Some funding for the program is provided by USAID, which helps to cover critical costs including private sector training, GP consultations fees and patient education. Since the program’s inception in 2005, over 1400 HIV-positive individuals have been enrolled and the program has achieved adherence well beyond that of the African average (60% after 24 months) with 95% of the patients still on treatment after five years (Health 24, 2010).

BroadReach Model

Dr. Ebrahim Variava, Principal Specialist, Tshephong Hospital, Klerksdorp is a key supporter of the PPP model and states: “The aims of the program are simple: to initiate and maintain eligible patients on antiretroviral therapy (ART); ensure that patients adhere to their medication; support public health facilities in order to expand capacity for HIV management and to provide the highest level of care possible”. (Health 24, 2010).

Here are some of the key steps of the BroadReach model:

- 1- Initially, HIV patients are enrolled at the Wellness Centre of a public healthcare facility, where they are managed and their condition is stabilized for six months.
- 2- They are then given the choice of being down referred to a private practitioner or a clinic in their local area for continuing treatment.
- 3- Should a patient’s condition deteriorate or if they acquire an opportunistic infection, they are referred back to the Wellness Centre for management. Once they are stabilized they are again down referred to the private sector for ongoing care closer to their home (Health 24, 2010).

Partners

This public-private partnership model created a network of private sector GPs trained in HIV treatment to alleviate demands on the public health care system by down-referring stable ART patients for ongoing management. Partnerships members include: the South African Department of Health, the Provincial Hospital Complex, the Private-Sector Physician Network and BroadReach Healthcare (BroadReach Case Study: Public-Private Partnerships Treatment Model). This model is aligned with the South African Government's ARV site guidelines and BroadReach paid the capitated fee to GPs. This model addresses key bottlenecks by intervening on both the supply and demand-side of the issue:

1. *Supply-side interventions:* Government accredited training for all GPs, disease management and monitoring system identifies quality problems, monitors patient drug pick-ups and issues reports.

2. *Demand-side interventions:* All patients and treatment supporters must pass a comprehensive education program; case managers monitor adherence to patient drug pick-ups and doctor visits and reach out to patients when problems arise, confidential call center for support.

(Source: BroadReach Healthcare Case Study. Public-Private Partnerships: Treatment Model)

This North West Province GP Down-Referral program is not just a self-contained pilot project, but a cost-effective model that could possibly be replicated on a national level. The founding partners of BroadReach Healthcare have seen first-hand the impact PPPs

have on the treatment of HIV/AIDS in South Africa and hope their model can be used across all of Africa.

3.3.1. The Use of Patient Capital in other Sectors

BroadReach Healthcare runs one of the largest and most efficient HIV/AIDS programs in South Africa by providing access to consistent and quality healthcare to the country's poorest population. By working with private health practitioners across the country and by developing and deploying scalable, paradigm-shifting models, BroadReach has succeeded in extending HIV/AIDS treatment to millions of people who otherwise may not have access to these life-saving medications.

Acumen Fund, one of the main investors in BroadReach Healthcare, is also the provider of patient capital to this initiative. By providing an original equity investment of 1.75 million dollars in 2005, Acumen Fund has supported the growth and success of BroadReach healthcare through their innovative model. Through patient capital financing, Acumen Fund supports a broad range of initiatives in other sectors, including water, housing, energy, agriculture and education. They succeed by offering proper investment support to social enterprises across the four stages of firm development: blueprint, validate, prepare and scale (Trelstad and Katz, 2011, p. 3). WaterHealth International (WHI) is an innovative water treatment and distribution business that has succeeded in providing potable water to millions of poor populations across the world. This business has moved through the states of growth using a series of commercial equity capital injections, some of Acumen Fund's patient capital, and debt. Furthermore, WHI

has supplemented these efforts with innovative partnerships that often involved grants to its customers (Trelstad and Katz, 2011, p. 3).

These imaginative business solutions and partnerships supported by investors willing to take on a risk/return profile that is unacceptable to traditional financiers is possible through Acumen Fund due to its philanthropic roots. This begs the question: how can this form of social financing be used in a broader context of financing development? By approaching ODA from a patient capital perspective, aid will be disbursed more efficiently as it will be emerging from the social economy. In order to be sustainable, development projects will emerge from a need of the local community and work within both a charitable and market-based approach. The same business models used by the organizations and businesses working with patient capital, such as BroadReach, can be replicated and international donors can fill the role of investors. For this to become possible, the use of financial guarantees and PPPs are imperative. For patient capital to work in a wider context of ODA, with the investor being a donor country, the role of financial guarantees becomes extremely important. Guarantees offer the insurance against the risk that donor countries technically cannot take with their aid money due to the financial accountability they must maintain for public dollars. By looking at a development project as an investment, with the expectation of a small enough return to recycle into the project itself, ODA could become more effective and efficient. If donor countries could come to understand their role as investors in international development, social enterprises could develop and fuel their own economies and become the drivers of change.

Patient capital is enabling actors within the social economy to take risks that may otherwise not be feasible in BoP markets. Managing this risk is one of the most important components of the success of patient capital in typically high-risk communities. Thus, the next section will explore the role of financial guarantees in leveraging necessary capital flows while reducing the risks incurred by the parties involved in the social enterprise. This is the most important link in expanding the patient capital framework and being able to reconsider the way we distribute, analyze and calculate ODA in a new era of social financing.

3.3.2. Filling the Gap: The Role of Guarantees

Guarantees play an important role in mitigating risk in unstable development contexts. Political instability is one of the greatest risks in developing countries and continues to be one of the main obstacles in building infrastructure in a number of African countries. Investment in healthcare will necessitate the building and improvement of the sector's physical assets (Business of Health in Africa, ix). It is estimated that \$25-30 billion in new investments will be needed to meet the demand for better distribution and retail systems, of which \$11-20 billion is likely to come from various actors within the private sector (Business of Health in Africa, ix). Social enterprises will play a key role in investing in healthcare in coming years. There are important investment opportunities in social enterprises that, while delivering lower financial returns, can have a tremendous role in the positive development of Sub-Saharan Africa (Business of Health in Africa, ix). "Angel investors" can engage with innovative social enterprises to deliver great returns while addressing key healthcare challenges. Furthermore, "double-bottom line investors", such as development finance institutions,

foundations and hopefully one day, official development agencies, can collaborate to provide patient capital to achieve lower financial returns of the long term, while contributing to significant developmental impact (Business of Health in Africa, x). It is apparent that social enterprises can make a great contribution to the development of a responsible, sustainable and vibrant healthcare sector in Sub-Saharan Africa.

Financial guarantees in financing development are one of the greatest, most underdeveloped tools that can be used to deliver positive impact on healthcare in Africa. These types of guarantees allow local actors to be protected from numerous types of risk, which often, are debilitating in developing countries. Guarantees are based on a goal of social development as opposed to commercial motivations. They allow more resources to be given while allowing capital to be more patient, creating the obvious link with patient capital. Through guarantees, all capital becomes more patient. Guarantees are one of the key ways BroadReach Healthcare in South Africa is able to use patient capital to extend HIV/AIDS treatment to millions of people that wouldn't otherwise be able to pay for such a treatment plan.

For some time, guarantees of various kinds have been available from leading international financial institutions, national governments and private insurance companies and these products are well recognized in most markets. However, their use as tools of development, rather than commercial advantage is of more recent origin and gives rise to different considerations (Winpenny, 2005, p.12). The use of guarantees in international development, in relation to the earlier discussion on patient capital, can be understood as the link between the use of patient capital in the social economy and its use as a tool by donor governments to the developing world. Impact investors are confronted with many

risks when working in BoP communities, including political instability, terrorism, expropriation, political intervention, devaluation and restrictions on the conversion and transfer of foreign currency. Public funds must be accounted for and cannot be invested in such risky contexts, where impact may prove difficult to measure and funds may be lost. Guarantees work to protect and benefit both sides in a loan or investment transaction, or in this case between a donor and recipient country. Lenders enjoy greater security in making their loan, while borrowers are able to obtain much needed capital on better terms (Winpenny, 2005, p.14). The use of guarantees is not a new concept in international development; these schemes have been used by multilateral and bilateral development banks and agencies to stimulate local capital markets and investment in infrastructure (Winpenny, 2005, p.14). These guarantees have a primarily developmental motive aimed at improving access to finance for long-term investment by local government, firms and other institutions. Necessarily, this includes all products offered by the International Financial Institutions (IFIs) and selected schemes of bilateral development agencies. The criterion for inclusion is that the operation, if it were to have been financed directly by donors through concessional credits, would be considered as Official Development Assistance (ODA) (Winpenny, 2005, p.15). This method would allow governments, using the patient capital model, act as social entrepreneurs and succeed in using their aid dollars more effectively.

As seen earlier, new forms of development finance are crucial as we move forward in a new era of development. These new forms are often evaluated by examining revenue potential, speed of availability and political feasibility (OECD Report: Financing Development, 2007, p. 17). In this examination, guarantees have become understood as

ways to make tangible progress. The strengthened use of public guarantees and better ODA accounting for them, is likely to get increased support as guarantees can unlock considerable private capital (OECD Report: Financing Development, 2007, p. 17). Guarantees work so that both public and private parties to investment and financing decisions can benefit, on both sides of the transaction. The unqualified use of the term private financing and investment fails to recognize the vast spectrum of hybrid forms that currently exist (Winpenny, 2005, p.16). Lenders can be either private or public, and the loans they make can be from private, public or public international development banks or other financial intermediaries. Portfolio investors and equity investors can likewise be from across the public-private spectrum (Winpenny, 2005, p.14). The vehicle these types of investments often take is through PPPs, which is where we can very much see the benefit of working with guarantees through a patient capital framework. As we have seen through many social enterprises, all of these types of initiatives continue to further blur the line between the public and private.

The development of the international economy relies on sufficient movement of capital and managerial skills, interacting with the development of local capital markets and enterprise. Providing guarantees to properly mitigate investment risk is one of the ways in which international agencies and governments can support these processes in developing countries (Winpenny, 2005, p.25). There are various risks that must be taken into consideration: political, credit, exchange rate and commercial. Guarantees can offer a certain amount of protection against these types of risk and encourage investment where none previously existed. These types of guarantees include Political Risk Instruments (PRIs), Regulatory and Contractual Risk Guarantees, and Credit Risk Guarantees

(including Partial Credit Guarantees).

It continues to be difficult to obtain a comprehensive and precise portrayal of the value of guarantees in comparison to conventional aid instruments. Data on guarantees offered by IFIs has recently been collected in a one-off exercise coordinated by the World Bank (Winpenny, 2005, p.48). However, currently, most bilateral agency guarantees are not reported to the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development (OECD) and are not included in the totals of ODA used for comparing countries' performances. While the value of guarantees issued in recent years has been small in relation to conventional overseas development finance and private flows, it should be considered in these totals (Winpenny, 2005, p.48).

Guarantees have many useful traits in that they can help address the "market failure" present in certain public services, such as health. Guarantees can help in this area by enabling longer-term loans at lower interest rates. It is therefore clear how this model fits nicely within a patient capital framework. These market failures may arise because the financial returns from this kind of investment understate the full social benefits from the service, which is often the case with basic services in low-income countries (Winpenny, 2005, p.58).

Some theoretical objections to guarantees exist which must be taken into account for this discussion. There are three primary objections: 1) moral hazard, 2) adverse selection and 3) rewarding rent-seeking (Winpenny, 2005, p.60). The first highlights the chance that guarantees have of aggravating the risks they are designed to counter. As a common example, it is likely that individuals with an insurance policy may likely take greater risks than if they were without it. This would be an example of encouraging the

exact behaviour it seeks to counter. The second objection is the introduction of a bias towards bad risks. The portfolio of assets held by banks and companies can be skewed if it only attracts the more risk-prone in its insured population. Therefore, these institutions must be pro-active at maintaining a balanced portfolio (Winpenny, 2005, p.61). Finally, the third objection relates to the issue of creating unnecessary profits. When an investor would have proceeded with an investment without a guarantee, the instrument becomes redundant and may confer an unnecessary benefit to the party concerned (Winpenny, 2005, p.62). Further to these objections, guarantees may be said to distort markets, by doubling loan tenors or halving interest rates (Winpenny, 2005, p.101). However, they can also claim to correct existing market distortions and compensate for the failure of markets to value important externalities such as environmental and public health benefits (e.g. from investments in water and sanitation) (Winpenny, 2005, p.101). Describing any effect as a “distortion” implies that some ideal state exists as a blueprint for action, which simply does not exist. Therefore, guarantees can be considered a useful part of the pragmatic policymaker’s toolkit (Winpenny, 2005, p.101). These are just some of the issues that can arise with the use of financial guarantees and speak to the theoretical objections that are related these tools within the context of international development.

Guarantees are necessary for correcting market and policy failures, such as when the supply of certain public services have social, health and environmental benefits which are not reflected in the price charged. Again, this relates to some of the key issues touched upon in the discussion on the social economy. The true impact of a guarantee may well extend beyond that of the specific purpose for which it is issued. Projects supported by guarantees are probably as sound as, and probably more worthy than, those

backed by other means (Winpenny, 2005, p.81). The IFIs that offer guarantees report a low level of uptake on their products and see them as currently constrained by weak demand rather than supply (Winpenny, 2005, p.81). As the majority of host country officials prefer direct loans to guarantees, this is largely due to the fact that their understanding of the latter is limited (Winpenny, 2005, p.82). For most development agencies, guarantees are a minority component of their portfolios. There is a perception in some areas that guarantees exist to promote private investors and operators, and international rather than national finance. As we have seen, this is mistaken as there is a wide spectrum of private and public actors on both lending/investing and borrowing/host sides involved in the use of guarantees (Winpenny, 2005, p.96). The Partial Credit Guarantee acts most as the strongest stimulus as it lifts the borrower's credit rating above a critical threshold that creates the possibility of market access. This is a key component of the patient capital framework in the context of the social economy.

Conclusion

The primary rationale for the involvement of development institutions in activities for which there is an existing private market is necessarily to make a difference. By using patient capital as a funding mechanism, development institutions can have a deeper impact in the health sector. The case study on BroadReach Healthcare clearly demonstrates the great advancements made in treating HIV/AIDS in South Africa, by creating an innovative model focused on social impact. It also highlighted how this model can adapt to various contexts, with the hope of providing sustainable health solutions to a greater number of regions in sub-Saharan Africa. The role of financial guarantees is also

an important consideration when discussing patient capital. Through a patient capital framework, guarantees offer the protection needed for sustainable development initiatives to be financed by an increasing number of actors in the most difficult contexts. Thus, it would be valuable to increase the use of guarantees within international development by providing supporting evidence on how these tools can greatly contribute to sustainable financial innovation, and provide more BoP communities with the increased access to the basic goods and services they so desperately need.

Conclusion

The challenges presented by traditional financing tools for development has led development experts to think of innovative ways of shifting our approach to aid. There have been many successes and challenges in delivering effective aid over the last forty years and while great strides have been made in alleviating poverty, the reality is that when we consider the time dedicated to so many causes, and the huge amount of dollars spent, it does not represent the results that should have been achieved thus far. The emergence of the social economy and the prominence of well-intentioned entrepreneurs looking to further social and economic development has altered how we view the public-private divide. We can no longer assume a clear line exists between economic motivations and social impact. An organization's mission can vary enormously; from those focused solely on profit, to the ones seeking to contribute more deeply to overall social and economic development. There are challenges in how social impact is measured and reported on, which is currently being addressed by models such as Expected Return Analysis and the Impact Reporting and Investment Standards. Organizations such as Acumen Fund are reaching increasingly large numbers of beneficiaries as they continue to make smart investments in local entrepreneurs with life-changing ideas and innovations that benefit their local communities. Within the health sector, patient capital is an effective tool for providing long-term investment to those actors working to solve systemic problems in healthcare delivery. BroadReach Healthcare has worked creatively in order to reach millions of people who would otherwise not have access to HIV/AIDS care and treatment. This has all been due to their innovative healthcare approach and their

ability to attract the capital needed, from organizations such as Acumen Fund, in order to initiate, develop and sustain their services.

The patient capital approach has been effective in creating practical solutions to solving issues of poverty in many countries and sectors across the world. As this approach evolves, it will necessarily face challenges that will emerge as it grows into an increasingly important source of development finance. This approach has already faced issues regarding increased borrowing and can incite organizations to prematurely take on too much debt. As a new mechanism in development finance, it is also unclear as to how it will adapt and transform to the needs of the BoP when markets develop and needs change. The patient capital approach relies heavily on socially minded impact investors, which cannot always be clearly identified. The motivations of investors can become disingenuous and misleading, providing a dangerous platform to further interests of outside actors, as opposed to the target beneficiaries. Therefore, this approach regards a great deal of vigilance and altruism that are not only difficult to find, but also difficult to maintain. These challenges are significant when examining the patient capital approach and must be navigated regularly in order to effectively produce the positive social impact that has been demonstrated by the proper use of this approach within an emerging global social economy.

The use of patient capital as a mechanism for financing development is a new paradigm in international development. In the context of ODA, patient capital could ideally serve as a new model in how we think about how our governments can deliver aid to countries in the Global South. As it stands today, millions of dollars are disbursed by our governments in aid dollars, with the hope that efficient and effective results will be

attained. Transparency and accountability are also very important in reporting on our commitments of international development initiatives. The patient capital model provides a platform for greater accountability with regards to financing development. Our government, acting as an “investor” would take on a well-balanced portfolio of investments in its countries of focus, deploy patient capital in a rigorous manner that is conducive to accountability in order to create a development institution that is not only more effective per dollar spent, but is more sustainable as an entity. Patient capital allows donors to be more accountable to the taxpayers - whose dollars they are using - as well as to the beneficiaries they are seeking to help. Moreover, financial guarantees are instruments that can be used to offer more protection to our government’s investments overseas. Without a doubt, this model could serve to help greater numbers of BoP communities by putting local members of our global civil society, people who are looking to make a real difference within the social economy, in the driver’s seat of change.

Patient capital, as a relatively new area of research within the context of international development, is a concept that is in need of further exploration. Many areas are in need of further research, including a more detailed look at how this model could be used by donor countries in ODA financing. Furthermore, limits to the patient capital model is a topic that would also be worthy of further consideration in order to address in greater detail what was not possible to explore in this paper. Preliminary outcomes of development financing through patient capital have yielded positive results as it reaches a greater number of beneficiaries in a more effective way. However, there is still much to be explored with regards to the long-term effects and results of the patient capital model.

The short term results development experts have witnessed using patient capital has encouraged further investigation into this model as we transition into a new era of international development. Greater accountability, increased social impact and better access to goods and services for the BoP are all reasons why the patient capital model must be further explored by the innovative development experts of the twenty-first century.

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