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Entrepreneurial models to promote healthcare access for underserved populations

Learnings from the Swiss Re Foundation's Entrepreneurs for Resilience Award portfolio

A study by



With the support of



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To the partners and users of these ventures who generously shared their experiences and time with us, we wish to say:
 Your deeply appreciated contributions will be instrumental in advancing healthcare for low-income communities.

Introduction

Accessible, affordable and quality healthcare is an imperative

Whether it is a child receiving a basic vaccine, an expectant mother receiving prenatal care or an elderly man needing preventive care for chronic conditions, access to quality medical care is a human right as well as a moral and practical necessity. Nonetheless, around half of the world's population does not have access to essential health services. These individuals experience worse health outcomes as preventable and treatable conditions can escalate into serious illnesses, premature death and a spiral of indebtedness.

For instance, an expectant mother dies from preventable causes every two minutes¹, and 17m people die prematurely due to chronic diseases each year, with 86% of those deaths occurring in low- and middle-income countries (LMICs)². Moreover, untreated health issues reduce overall workforce productivity and increase long-term public healthcare costs: it is estimated that poor health reduces global GDP by 15% each year³.

Healthcare inequality is particularly marked in developing countries, where the average number of hospital beds per 1k inhabitants is just 0.7 (six times fewer than the 5.6 beds in high-income countries⁴), while most Sub-Saharan African countries record less than 3 doctors per 10k inhabitants (vs. 25 in developed countries)⁵. As a result of these gaps, public facilities are underfunded and overcrowded, and the quality of care may be compromised.

These challenges are even greater for rural and remote areas in LMICs, which are home to 45% of the world's people⁶. Over half of them (ie over 2 billion people) have limited or no access to essential health services because the distance to the nearest facility, coupled with poor and/or unaffordable transportation, constitutes a significant barrier to accessing care⁷. As a result of this double disadvantage (having a low income and living in a rural area), children in developing countries who are born in rural areas are almost twice as likely to die before the age of 5 than those born in urban areas⁸.

Even when healthcare services are available, they are often unaffordable, particularly in the case of private providers. These providers frequently represent the only option for quality treatment, as public hospitals are typically overcrowded and under-resourced. High treatment costs are particularly challenging when patients must pay out of pocket (on average, only 8% of the population in low-income and 27% in lower-middle-income countries is covered by health insurance⁹). The lack of financial solutions and protection against health shocks pushes many people (381m in 2019)¹⁰ into heavy debt and extreme poverty when faced with medical emergencies.

¹ <https://sdgs.un.org/goals/goal3>

² [https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases#:~:text=Noncommunicable%20diseases%20\(NCDs\)%20kill%2041,%2D%20and%20middle%2Dincome%20countries](https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases#:~:text=Noncommunicable%20diseases%20(NCDs)%20kill%2041,%2D%20and%20middle%2Dincome%20countries)

³ [https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases#:~:text=Noncommunicable%20diseases%20\(NCDs\)%20kill%2041,%2D%20and%20middle%2Dincome%20countries](https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases#:~:text=Noncommunicable%20diseases%20(NCDs)%20kill%2041,%2D%20and%20middle%2Dincome%20countries)

⁴ https://data.worldbank.org/indicator/SH.MED.BEDS.ZS?most_recent_year_desc=true

⁵ [https://www.who.int/data/gho/data/indicators/indicator-details/GHO/medical-doctors-\(per-10-000-population\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/medical-doctors-(per-10-000-population))

⁶ [https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases#:~:text=Noncommunicable%20diseases%20\(NCDs\)%20kill%2041,%2D%20and%20middle%2Dincome%20countries](https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases#:~:text=Noncommunicable%20diseases%20(NCDs)%20kill%2041,%2D%20and%20middle%2Dincome%20countries)

⁷ <https://iris.who.int/handle/10665/328913>

⁸ https://www.unicef.org/media/50076/file/UNICEF_SOWC_2016-ENG.pdf

⁹ <https://pubmed.ncbi.nlm.nih.gov/35537761/#:~:text=Mean%20health%20insurance%20coverage%20was,in%20upper%20middle%2Dincome%20countries>

¹⁰ <https://unstats.un.org/sdgs/report/2023/goal-03/>

As governments struggle to ensure universal healthcare access, many non-profit organisations and social impact ventures have stepped in to contribute to providing healthcare to millions of underserved patients. Thanks to the development of innovative models and products, market-based social impact ventures have the potential to sustainably contribute to healthcare equality, eg by expanding healthcare coverage through innovative financial protection products, improving healthcare accessibility through telemedicine and addressing the rising burden of non-communicable diseases by promoting preventive care at the last mile.

About this study

Improving access to healthcare for underserved populations has long been a priority for the Swiss Re Foundation. With the support of LeFil Consulting, the Foundation devoted five of the last six editions of its **Entrepreneurs for Resilience Award** programme to identifying and fostering social entrepreneurs with the most promising approaches to improving low-income people's access to quality healthcare in LMICs through infrastructure, digital tools and/or financial innovation.

Each edition of the Resilience Award starts with a rigorous screening of hundreds of applicants to select the top 12 candidates. After extensive phone interviews, the six most promising ventures undergo in-depth in-person due diligence. The award jury, composed of Swiss Re experts and external advisors, then selects three winners, which receive grant funding and technical assistance to support their growth and success over the next two years.

Since 2019, the Swiss Re Foundation and its partner LeFil Consulting have thus accumulated a large amount of quantitative and qualitative data on dozens of healthcare ventures operating in over 30 countries. Given the learning opportunity this wealth of data on health-focused social ventures presents, the Swiss Re Foundation decided to share it back with the sector at large to advance health and inclusive finance practitioners' understanding of innovations in this space. To this end, it mandated LeFil to conduct a comprehensive analysis of top E4RA contenders to:

- Examine the various models the ventures are using to enhance the accessibility, affordability and quality of healthcare for low-income populations, and identify clusters of ventures with similar underlying models
- Illuminate the key characteristics, strengths and challenges of each cluster
- Compare the impact and financial performance of each underlying model
- Develop recommendations for donors and investors on how best to support ventures in each cluster.

Executive summary

Overview and methodology

Improving access to healthcare for underserved populations has been a priority for the Swiss Re Foundation since its inception. In five of the six most recent editions of its Entrepreneurs for Resilience Award (E4RA) programme, the Foundation has recognised ventures that make healthcare more accessible and affordable to low-income populations.

Since the E4RA was launched, more than 1k ventures operating in over 30 countries have been screened and analysed to select the award finalists. As extensive information is collected and verified from the top 12 candidates in every edition, the Swiss Re Foundation and its partner LeFil Consulting now have access to a trove of data on healthcare ventures that target the underserved.

Leveraging this evidence base, LeFil Consulting conducted an in-depth study to take stock of the field, identify emerging trends and commonalities in ventures' approaches and models and shed light on the key characteristics, strengths and challenges of ventures that follow specific approaches and models. From a donor's or investor's standpoint, this analysis offers insights into the potential trajectory of different kinds of ventures and how best to support them.

The study is based on detailed data collected from 26 health-related ventures (61% based in Africa, 19% in Asia, 12% in the Americas and 8% global), of which 13 were among the top three candidates, and 13 were among the top six candidates in their respective E4RA editions. For each venture, the dataset includes over 150 data points on six key dimensions: product and value proposition, users and impact, scale and scalability, financials, fundraising and challenges and needs¹¹.

Given that the purpose of this study is to leverage this wealth of data in a synthetic and comparative manner, four key dimensions were prioritised for the clustering and analytics: users and impact, scale and scalability, financial sustainability and additionality of support. These reflect the typical concerns of impact investors as well as philanthropic donors with a strong concern for (financial) sustainability, such as the Swiss Re Foundation. For each of these dimensions, the study builds on a large array of indicators, most quantitative but in some cases also qualitative, which together provide a multifaceted understanding of the strengths and weaknesses of each cluster, beyond how each cluster fares on individual metrics.

¹¹ Overall, the dataset spans the years 2016-2023. For most ventures, at least three years of data were available, including a 2023 update on key metrics.

Venture categorisation

The ventures analysed in this study offer a wide diversity of solutions addressing different elements of the healthcare ecosystem. Within this broad portfolio, we identified three categories, or “clusters”, of ventures, each with its own unique characteristics:

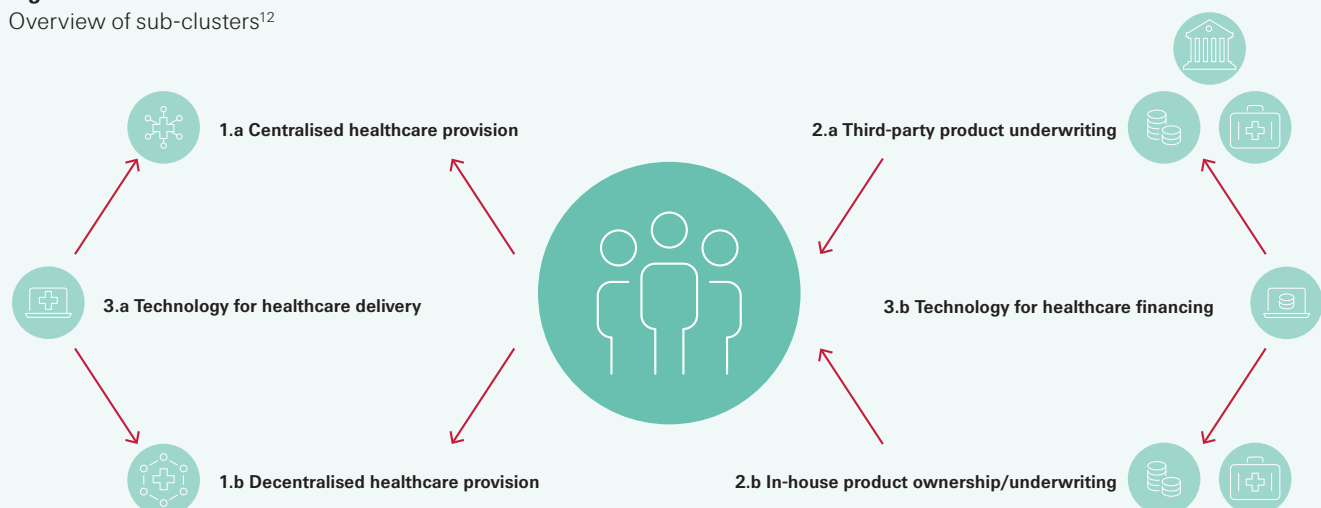
Cluster 1. Affordable and accessible healthcare provision: ventures within Cluster 1 focus on addressing the shortage of affordable medical infrastructure in their target areas. They combine physical assets, medical staff and, often, technology to improve accessibility and care quality for underserved populations and can be further split into two sub-clusters:

- **Sub-cluster 1.a: Centralised healthcare provision:** ventures that mainly offer their services through a network of physical clinics, often located in higher-density population areas
- **Sub-cluster 1.b: Decentralised healthcare provision:** ventures that mainly deliver their services as close as possible to patients by leveraging mobile clinics, telemedicine and/or home visits

Cluster 2. Financial solutions for healthcare: ventures in Cluster 2 aim to reduce the financial burden of healthcare for patients. They offer financial products that enable access to healthcare, providing a safety net against catastrophic health expenses and improving health outcomes by reducing foregone and delayed care. They can be further split into two sub-clusters:

- **Sub-cluster 2.a: Third-party product underwriting:** ventures that design and distribute insurance products (usually micro-insurance) underwritten by partner insurers
- **Sub-cluster 2.b: In-house product ownership and/or underwriting:** ventures that develop and fully own financial solutions for healthcare, including microinsurance, savings wallets, micro-loans, etc

Figure 1
Overview of sub-clusters¹²



¹² See Appendix for descriptions of the ventures in this study and assigned to each (sub-) cluster.

Cluster 3 Technology solutions for the healthcare ecosystem: ventures in Cluster 3 leverage technology to enhance the capabilities of existing healthcare or healthcare financing providers, thereby reducing costs, increasing efficiency and/or improving service accessibility. They can be divided into two sub-clusters:

- **Sub-cluster 3.a: Technology for healthcare delivery:** ventures that provide software solutions to facilitate healthcare provision (eg electronic medical records, telemedicine, screening tools, etc)
- **Sub-cluster 3.b: Technology for healthcare financing:** ventures that provide software solutions to digitalise operations of insurers and other healthcare payers (eg registration, billing, claims management, etc)

Key features by cluster

Each cluster plays an important role in addressing different aspects of the healthcare ecosystem and, ultimately, in improving healthcare accessibility and quality for end users: Cluster 1 advances the direct delivery of affordable healthcare services to patients, Cluster 2 provides patients with essential financial services enabling them to consume healthcare and Cluster 3 drives technological advancements to expand the capabilities of and decrease costs for medical and financing providers. Each cluster demonstrated more or less high levels of performance across the four dimensions listed above. The analysis focused on average trends; exceptions within clusters are possible.

Cluster 1 stands out for its high impact on healthcare affordability, accessibility and impact on health outcomes. While all ventures in this cluster target underserved segments, those with a more decentralised approach (ie sub-cluster 1.b) have a higher proportion of users living in rural areas and informal urban settlements (55% vs. 34% and 39% vs. 10%, respectively). Ventures in this cluster also generate the highest average net additional value (NAV)¹³ per user, or USD10 on average¹⁴, and those with a decentralised delivery model (sub-cluster 1.b) generate an even higher NAV of USD11.5.

Ventures in this cluster operate on a medium scale, serving an average of 106k users yearly, with large differences between sub-clusters: ventures with a decentralised approach (sub-cluster 1.b) recorded 170k users served in the last years of data collection¹⁵, compared with 53k for ventures with a centralised approach (sub-cluster 1.a). This cluster also shows the lowest rate of growth in the user base, averaging 46% yearly. The growth rate is particularly low for sub-cluster 1.b (22%), possibly due to the peak in demand during the COVID-19 pandemic and the sudden decline afterward.

¹³ NAV is a measure of the average net monetary benefits a venture generates per user per year. Essentially, it is computed as the amount of savings or additional earnings generated for the user, minus any price paid by the user for the product or service provided. For ventures offering health insurance, it is computed as the average claim payout, adjusted for the proportion of subscribers who made successful claims, minus the average premium paid.

¹⁴ The average NAV for Cluster 1 is USD10 excluding the outlier (a venture with an NAV of USD412.5) and USD55.8 including it.

¹⁵ The total number of users served in the last year of data collection in sub-cluster 1.b ranges from USD3k to USD675k.

In terms of financial performance, these ventures record the highest annual earned revenue, with an average of USD1.3m¹⁶. The COVID-19 pandemic boosted sales in sub-cluster 1.b, thanks to these ventures' decentralised approach, allowing 60% of them to reach breakeven at some point¹⁷ (although only 20% maintained this after the pandemic). In comparison, only 20% of sub-cluster 1.a ventures managed to break even. Similarly, the post-pandemic return to "normality" dampened the growth in the earned revenues of the ventures in sub-cluster 1.b to the lowest rate of all sub-clusters (average of 83% yearly).

There are also large disparities in the amount of external funding that these ventures need to sustain their operations and growth. Those in sub-cluster 1.a raised a cumulative average of USD3.6m¹⁸ (roughly USD453k per year), while the figure was USD1.2m¹⁹ (USD227k per year) for sub-cluster 1.b.

Ventures in **Cluster 2** play a crucial role in increasing the financial resilience of the low-income segment while having a medium impact overall. On the other hand, they have the lowest average NAV per user (USD-7). This figure is especially low for ventures in sub-cluster 2.b, which have in-house financial product ownership or underwriting (NAV of USD-17.2)²⁰.

With a yearly average of only 24k users served in the last year of data collection, these ventures are the smallest in scale. As they start from (very) low outreach levels, however, they enjoy relatively high user base growth rates, with a 3-year compounded annual growth rate (CAGR) of 94% (excluding outliers)²¹.

Lastly, this cluster's financial sustainability lies above average. Despite having the lowest average annual revenue (USD166k), half the ventures have already reached breakeven at some point (although only 17% maintained it, likely due to the impact of COVID-19 and the high levels of investment required for continued growth). These ventures also have the weakest fundraising track record, raising a cumulative average of USD1.1m²² (USD201k per year), possibly because they are among the youngest in the portfolio (particularly sub-cluster 2.b, with an average of three years in operation).

¹⁶ The earned revenue in Cluster 1 ranges from USD14k to USD7m.

¹⁷ Out of the 26 ventures analysed, only 15% were profitable at the time of data collection. Their average net margin was -161%.

¹⁸ The total amount of funds raised per venture in sub-cluster 1.a ranges from USD6.8k to USD12m.

¹⁹ The total amount of funds raised per venture in sub-cluster 1.b ranges from USD33k to USD2.9m.

²⁰ Cluster 2's negative average NAV mainly reflects the dynamics of insurance models, whereby most users incur small losses while a few receive large payouts.

²¹ The average 3-year CAGR for ventures in Cluster 2 is 94% excluding the outlier (a venture with a 3-year CAGR of 6567% due to rapid expansion following its pilot stage) and 1172% including it.

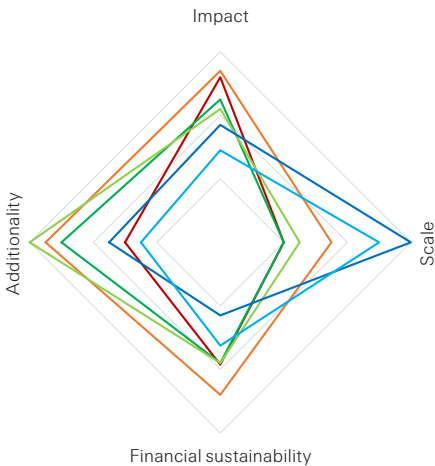
²² The total amount of funds raised per venture in Cluster 2 ranges from USD0 to USD3.5m.

Ventures in **Cluster 3** generate impact for users indirectly. That is, they enable other ecosystem players to deliver services more cost-effectively, which may (or may not) translate into better service and/ or lower prices. Ventures in this cluster have a low average NAV per user, at USD1.2, and a very low proportion of users from informal urban settlements (5%). The results are even more modest for ventures providing technology for healthcare financing (sub-cluster 3.b), which have an average NAV of USD-0.5 per user and a very low proportion of users living in rural areas (6% vs. 93% in sub-cluster 3.a). In terms of outreach, this cluster stands out, with an average of 1m users served (though mostly indirectly)²³ and a 3-year CAGR in user growth of 230%²⁴. Ventures in sub-cluster 3.a (providing technology for healthcare provision) stand out for their large scale, serving an average of 1m users (mostly indirectly though) in the last year of data collection and showing high user base yearly growth (193%).

On the financial side, this cluster records high annual revenue growth, with an average of 284%, but only medium annual revenues (USD610k²⁵). It includes both the highest proportion of profitable ventures (25%) and the ventures recording the largest net losses (average of USD-550k), resulting in the lowest net margin of all clusters (-250%). Finally, these ventures require the most external funding per year, or an average of USD518k. This result is driven mainly by ventures in sub-cluster 3.b, which provide technology for healthcare financing and require on average USD670k yearly to operate and grow.

Figure 2
Overview of sub-clusters' performance across selected dimensions

- 1.a Centralised healthcare provision
- 1.b Decentralised healthcare provision
- 2.a Third-party product underwriting
- 2.b In-house product ownership/underwriting
- 3.a Technology for healthcare delivery
- 3.b Technology for healthcare financing



²³ The number of users served in the last year of data collection by ventures in Cluster 3 ranges from USD 21k to USD2.8m.

²⁴ The average 3-year CAGR in Cluster 3 is 230% excluding the outlier (a venture with a 3-year CAGR of 2750% due to a very low starting point) and 513% including it.

²⁵ The earned revenue in the last year of data collection in Cluster 3 ranges from USD67k to USD2.7m.

²⁶ The impact dimension was assessed based on three criteria, each rated on a 3-point scale: inclusivity (consisting of the following metrics: share of users living in rural areas, share of users living in informal urban settlements), relevance (consisting of the following metrics: impact on accessibility and affordability of healthcare) and benefits (consisting of the following metrics: impact on health outcomes and financial resilience and NAV).

The scale dimension was assessed based on two criteria, each rated on a 3-point scale: number of users served per year and the 3-year CAGR in the number of users served per year.

The financial sustainability dimension was assessed based on four criteria, each rated on a 3-point scale: earned revenue, 3-year CAGR of earned revenue, profitability (net margin, number of years needed to break even since inception and share of ventures that historically reached breakeven) and share of grants over total revenue.

The additionality of support dimension was assessed based on three criteria, each rated on a 3-point scale: number of years in operation, total amount of funding raised and amount of external funding needed per year.

Conclusions and recommendations for donors and investors

The ventures analysed in this study are filling gaps in healthcare infrastructure and medical personnel, reducing financial barriers to paying for healthcare and leveraging technology to enhance service delivery. By focusing on underserved populations, they contribute to more equitable healthcare systems and improve health outcomes for millions of people who would otherwise be left behind.

Based on the findings of this study, donors and investors who seek to improve healthcare accessibility should keep the following considerations in mind, depending on their own priorities and strategy:

- **Sub-cluster 1.a: Centralised healthcare provision:** records high impact but demonstrates limited potential in scaling outreach and financial sustainability. These ventures might require a constant stream of external funds to operate and grow, making them suitable for donors who prioritise deep impact over financial performance.
- **Sub-cluster 1.b: Decentralised healthcare provision:** scores highest in terms of impact and financial sustainability. These ventures achieve significant impact, scale and revenue while maintaining above-average financial sustainability and relatively low dependence on external funding, indicating a high potential for additional investments to improve their trajectory.
- **Sub-cluster 2.a: Third-party product underwriting:** records medium levels of impact and relatively small user bases, although the ventures in it have operated for 7 years on average. On the other hand, this sub-cluster boasts the best net margins of all sub-clusters in the study. Historically, these ventures have raised relatively little external funding and demonstrate relatively strong sustainability, possibly calling for more support in breaking a pathway to scale.
- **Sub-cluster 2.b: In-house product ownership and/or underwriting:** counts the youngest ventures in the study, which in turn record the smallest user bases but promising user growth rates. Overall, these ventures display a medium impact and sustainability performance. They also stand out for raising the least external funds, indicating a high potential for additional investments to fuel innovation and growth.
- **Sub-cluster 3.a: Technology solutions for healthcare delivery:** achieves the biggest outreach and the highest user growth rates. On the other hand, as these ventures mostly reach end users indirectly, their impact is also indirect. These ventures also show limited financial sustainability and thus relatively high dependence on external funding. As such, they could be targeted by patient-capital investors who prioritise outreach over depth of impact.
- **Sub-cluster 3.b: Technology for healthcare financing:** also records significant outreach and user growth rates. However, impact is limited and indirect, and financial sustainability uncertain. Yet these ventures raised the most funding, on which they are highly dependent. It may be that investors prioritising such ventures are more mainstream and tech-focused.

Finally, while ventures within a cluster share overall approaches and intervention models, there may be differences among ventures within a given cluster on specific dimensions. This is particularly true of ventures in Clusters 2 and 3, which show high performance variability, pointing to a need for thorough due diligence to identify those with the most potential. In contrast, Cluster 1 is more homogenous (except for a few positive outliers in sub-cluster 1.b).

Comparative overview of intervention models adopted by ventures

Venture categorisation

The ventures analysed in this study offer a wide diversity of solutions addressing different elements of the healthcare ecosystem. Within this broad portfolio, we identified three categories, or “clusters”, of ventures, each with its own unique characteristics:

Cluster 1. Affordable and accessible healthcare provision: ventures within Cluster 1 focus on addressing the shortage of affordable medical infrastructure in their target areas. They combine physical assets, medical staff and often technology to improve accessibility and care quality for underserved populations and can be further split into two sub-clusters:

- **Sub-cluster 1.a: Centralised healthcare provision:** ventures that mainly offer their services through a network of physical clinics, often located in higher-density population areas
- **Sub-cluster 1.b: Decentralised healthcare provision:** ventures that mainly deliver their services as close as possible to patients by leveraging mobile clinics, telemedicine and/or home visits.

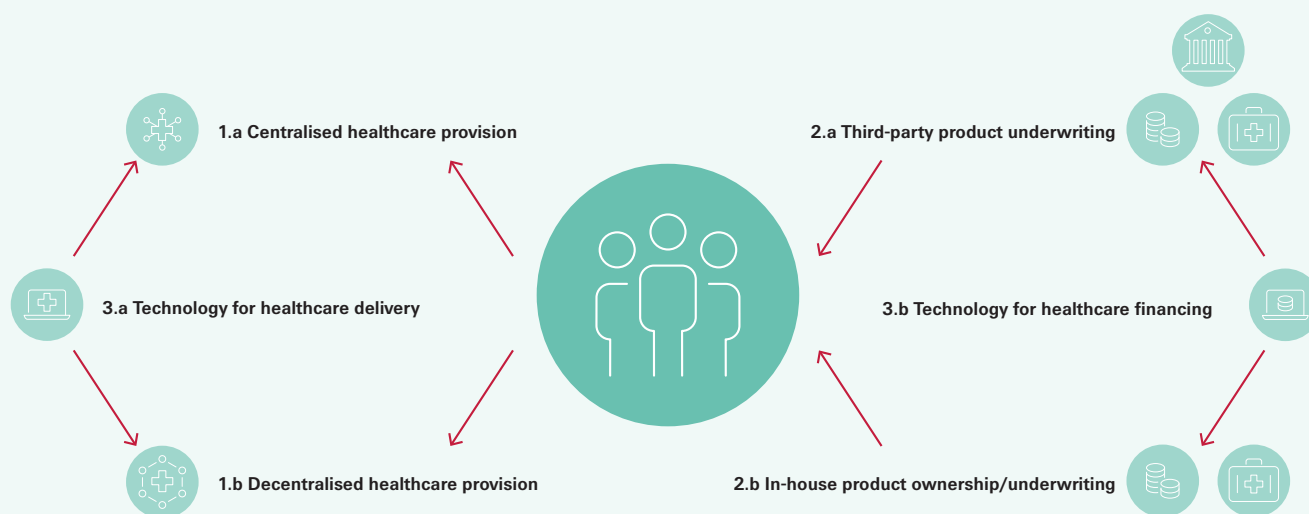
Cluster 2. Financial solutions for healthcare: ventures in Cluster 2 aim to reduce the financial burden of healthcare for patients. They offer financial products that enable access to healthcare, providing a safety net against catastrophic health expenses and improving health outcomes by reducing foregone and delayed care. They can be further split into two sub-clusters:

- **Sub-cluster 2.a: Third-party product underwriting:** ventures that design and distribute insurance products (usually micro-insurance) underwritten by partner insurers
- **Sub-cluster 2.b: In-house product ownership and/or underwriting:** ventures that develop and fully own financial solutions for healthcare, including micro-insurance, savings wallets, micro-loans, etc.

Cluster 3. Technology solutions for the healthcare ecosystem: ventures in Cluster 3 leverage technology to enhance the capabilities of existing healthcare or healthcare financing providers, thereby reducing costs, increasing efficiency, and/ or improving service accessibility. They can be divided into two sub-clusters:

- **Sub-cluster 3.a: Technology for healthcare delivery:** ventures that provide software solutions to facilitate healthcare provision (eg electronic medical records, telemedicine, screening tools, etc.)
- **Sub-cluster 3.b: Technology for healthcare financing:** ventures that provide software solutions to digitalise operations of insurers and other healthcare payers (eg registration, billing, claims management, etc).

Figure 1
Overview of sub-clusters²⁷



²⁷ See Appendix 1 for descriptions of the ventures featured in this study and assigned to each sub-cluster.

These clusters and sub-clusters were analysed and compared with respect to four dimensions²⁸:

Users and impact:

- Inclusivity: geographic and sociodemographic characteristics of end users (the proportion of users from rural areas and informal urban settlements)
- Relevance: affordability²⁹ and accessibility of service or product provided³⁰
- Benefits created: health outcomes³¹, NAV³² and financial resilience³³
- Usage: engagement, retention and satisfaction levels of end users

²⁸ The earned revenue in the last year of data collection in Cluster 3 ranges from USD67k to USD2.7m.

²⁹ Affordability was assessed based on three criteria, each rated on a 3-point scale: price competitiveness, price level appropriateness for low-income segments and level of control over pricing.

³⁰ Accessibility was assessed based on three criteria, each rated on a 3-point scale: focus on underserved segments, expansion of range of services available to underserved segments and level of sustainability in provision of healthcare services.

³¹ Health outcomes were assessed based on three criteria, each rated on a 3-point scale: quality of healthcare services, range of healthcare services and level of control over healthcare delivery.

³² NAV is a measure of the average net monetary benefit a venture generates per user per year. It is a measure widely used in the development sector to understand whether and how much the end users' situation improves (or not) financially; an important concern when working with vulnerable populations. Essentially, NAV is computed as the amount of savings or additional earnings generated for the user, minus any price paid by the user for the product or service provided. NAV may include savings on the price of medical services, travel expenses avoided or income loss avoided thanks to shorter waiting times. For ventures offering health insurance, it is computed as the average claim payout, adjusted for the proportion of subscribers who made successful claims, minus the average premium paid. While a positive NAV is easier to achieve for some clusters than others, there are still important differences in NAV across ventures within a cluster. For instance, ventures offering insurance-like products often struggle to deliver positive NAV, due to the very nature of insurance, which is to protect a few users against catastrophic losses at the "expense" of users who make no claim over that period. Yet some such ventures manage to deliver a positive NAV by, for example, offering value beyond the insurance product (eg free screenings or telemedicine consultations), by shifting to savings-based products or by designing products that offer only modest monetary payouts but cover common health conditions (eg malaria in Africa).

³³ Financial resilience was assessed based on three specific criteria, each rated on a 3-point scale: scope of financial solution (if any) provided or enabled, value of medical services enabled through the financial solution and range of authorised healthcare providers where the solution can be applied.

Scale and scalability:

- Outreach: yearly number of end users served and geographical coverage
- Outreach growth: 3-year CAGR in number of end users served
- Scaling and user acquisition strategy

Financial sustainability:

- Revenue model and diversification
- Earned revenue levels
- Revenue growth: 3-year CAGR in earned revenues
- Profitability/ financial viability: net margins, number of years to reach breakeven (projected) and proportion of ventures that (historically) reached breakeven and cost dynamics
- Reliance on grant funding: proportion of total revenue consisting of grants

Additionality of support³⁴:

- Number of years in operation
- Fundraising track record: cumulative funds (including grants) raised
- Reliance on external funding: the yearly need for external funding to operate and grow
- Financial and non-financial needs of venture

Key features by cluster

Each cluster plays an important role in addressing different aspects of the healthcare ecosystem and, ultimately in improving healthcare accessibility and quality for end users: Cluster 1 advances the direct delivery of affordable healthcare services to patients, Cluster 2 provides patients with essential financial services enabling them to consume healthcare, and Cluster 3 drives technological advancements to expand the capabilities of and decrease costs for medical and financing providers. Each sub-cluster demonstrated more or less high levels of performance across the four dimensions listed above. The analysis focused on average trends; exceptions within clusters are possible.

Users and impact:

Cluster 1 stands out in terms of impact. Thanks to the variety and quality of healthcare services provided, ventures in both its sub-clusters drive the highest improvements in health outcomes for end users. Thanks to practices such as telemedicine or simply low margins, these ventures also have the highest impact on healthcare affordability and accessibility and – at USD10³⁵ – the highest average NAV per user, which is over 7 times higher than the highest NAV in the two other clusters. The impact is even greater among ventures delivering healthcare using a decentralised approach, with a NAV of USD11.5 and the highest impact on accessibility and affordability.

³⁴ The earned revenue in the last year of data collection in Cluster 3 ranges from USD67k to USD2.7m.

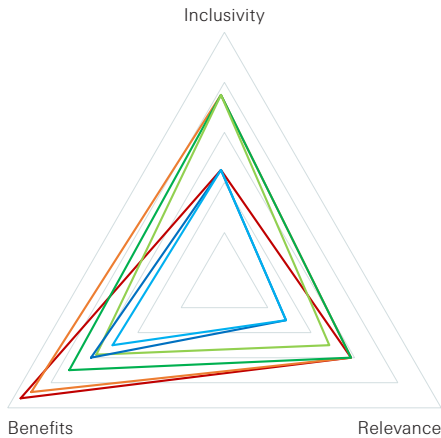
³⁵ The average NAV for Cluster 1 is USD 10 excluding an outlier (a venture with a NAV of USD412.5) and USD 55.8 including it.

As most of the ventures in **Cluster 2** do not provide healthcare services to end users, their impact is more indirect. Nonetheless, thanks to their provision of financing solutions enabling previously underserved end users to access healthcare, they record a medium impact on health outcomes, affordability and accessibility of healthcare. Their strong focus on accessibility is visible in the high average proportion of users living in informal urban settlements (46%)³⁶. Moreover, ventures in both its sub-clusters demonstrate the highest impact on the financial resilience of end users. On the other hand, since the benefits of insurance-like models are inherently unevenly distributed (with the majority of users incurring small losses and only a minority receiving larger payouts in a given year), ventures in Cluster 2 record the lowest average NAV (USD-7), albeit ventures in sub-cluster 2.a, which use third-party product underwriting, achieve a positive NAV (USD3.2).

Since ventures in **Cluster 3** mostly provide solutions supporting other actors in the ecosystem and only marginally provide benefits to the end users directly, this cluster has the lowest impact as well as the lowest proportion of users living in informal urban settlements (5%). It also has the lowest impact on health outcomes, affordability and accessibility of healthcare. It is worth noting that the ventures focusing on solutions for healthcare delivery demonstrate a higher impact on health outcomes, affordability and accessibility than their counterparts focusing on healthcare financing provision and record the highest proportion of users living in rural areas of all sub-clusters (93%). They also have a higher NAV (USD4.3 vs. -USD0.5 per user) than the other sub-cluster, lifting the average for the cluster to USD1.3 per user.

Figure 2
Comparison of impact dimensions across clusters and sub-clusters

- 1.a Centralised healthcare provision
- 1.b Decentralised healthcare provision
- 2.a Third-party product underwriting
- 2.b In-house product ownership/underwriting
- 3.a Technology for healthcare delivery
- 3.b Technology for healthcare financing



³⁶ The share of users living in informal urban settlements was calculated using a limited dataset, as this information was available for only 50% of the ventures included in the study.

Scale and scalability:

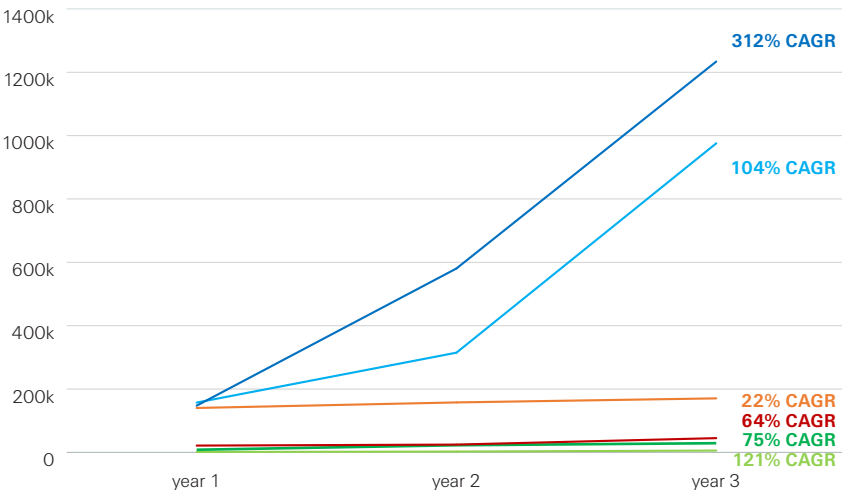
As technology products have relatively low marginal scaling costs, the ventures in **Cluster 3** significantly outperform the other clusters in terms of number of users reached, with an average of 1m users served in the last year of data collection³⁷ – although their definition of users tends to be broader and more indirect than for ventures in other clusters. These ventures also exhibit the widest geographical coverage (67% of them expanded internationally) and the highest 3-year CAGR in the number of end users (193%³⁸).

In comparison, the ventures in **Cluster 1** operate at a more modest scale, serving an average of 106k users in the last year of data collection. Although this cluster ranks second in terms of outreach, its average 3-year CAGR in number of users (46%) is the lowest of all clusters, indicating that these ventures grow slowly and achieve higher outreach because they have typically been operating for a longer time. This more gradual growth may be attributed to the fact that their expansion is more resource-intensive and less scalable than for technology-driven or financing solutions.

Ventures in **Cluster 2** have the smallest scale, reaching an average of 24k users served in the last year of data collection. This translates into a comparatively high average 3-year CAGR in the number of users (94%³⁹). This growth rate is even higher among ventures with in-house product ownership and/or underwriting, where the growth rate is 121%⁴⁰. These patterns can be explained by the fact that this dynamic sub-cluster includes the most recently established ventures across all clusters.

Figure 3
End users reached per sub-cluster

- 1.a Centralised healthcare provision
- 1.b Decentralised healthcare provision
- 2.a Third-party product underwriting
- 2.b In-house product ownership/underwriting
- 3.a Technology for healthcare delivery
- 3.b Technology for healthcare financing



³⁷ In Cluster 3, the number of users served in the last year of data collection varies significantly, from 21k to 2.8m.
³⁸ The 3-year CAGR for Cluster 3 is 193% excluding an outlier (a venture with a 3-year CAGR of 2750% due to a very low starting point) and 513% including it.
³⁹ The 3-year CAGR for Cluster 2 is 94% excluding an outlier (a venture with a 3-year CAGR of 6567% due to rapid expansion following its pilot stage) and 1172% including it.
⁴⁰ The 3-year CAGR for the In-house product ownership/underwriting sub-cluster is 121% excluding an outlier (a venture with a 3-year CAGR of 6567% due to rapid expansion following its pilot stage) and 2270% including it.

Financial sustainability:

When it comes to financial performance, none of the clusters significantly outperforms the rest, as most of the ventures are not yet profitable.

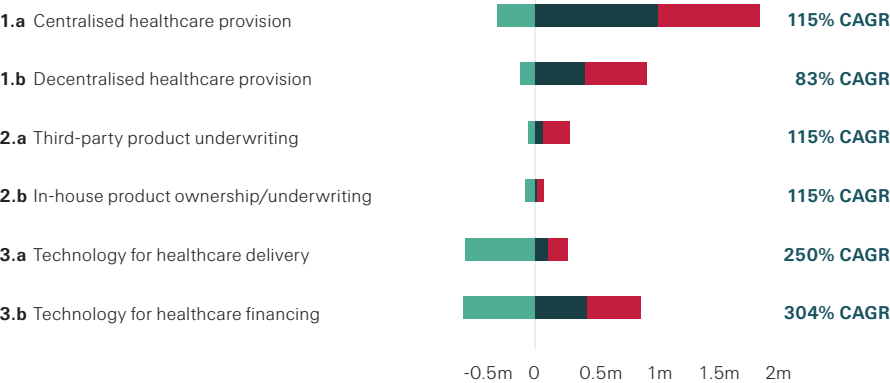
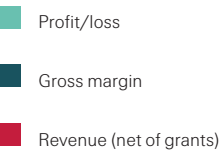
Cluster 1 stands out in terms of having the highest average yearly earned revenues (USD1.3m⁴¹) and the highest average gross margin (50%). That said, grants play an important part for these ventures, amounting to 26% of total revenue on average. At the sub-cluster level, the ventures delivering healthcare using a centralised approach achieve by far the highest earned yearly revenues of all sub-clusters (USD1.75m), while the ventures using a decentralised approach have by far the least negative net margin (-52%). Cluster 1’s performance on the other financial metrics ranks between Cluster 2 and Cluster 3.

Cluster 2 records the lowest average yearly revenue (USD166k) of all clusters. Grant funding also significantly supplements the earnings of these ventures, contributing 22% of total revenue. On the other hand, this cluster shows strengths, such as a less negative net margin (-100%) than other clusters, the highest proportion of ventures that historically reached breakeven (50%, although only 17% were still profitable at the time of data collection) and the shortest projected time to reach breakeven since inception (5 years). Within Cluster 2, the ventures with third-party underwriting perform better than those with in-house ownership and/or underwriting, having higher yearly earned revenue (USD268k vs. USD66k), gross margins (22% vs. 18%) and net margins (-77% vs. -122%). On the other hand, grants played an important role for this sub-cluster (amounting to 34% of earned revenue).

While **Cluster 3** records by far the lowest share of grants in total revenue (10%) and the fastest rates of revenue growth (3-year CAGR of 284%), it exhibits the lowest profitability levels across all clusters, with a high overhead ratio (351%), the most negative net margins (-250%), the lowest proportion of ventures that have historically reached breakeven (25%) and the longest projected time to reach breakeven since inception (6.5 years).

While certain clusters excel on specific metrics – such as Cluster 1, which leads in earned revenue – none dominates across dimensions. Cluster 2 shows the highest metrics in several profitability-related areas, but its results closely align with those of Cluster 1. For instance, the proportion of ventures that have historically reached breakeven is only 10 percentage points lower in Cluster 1 than in Cluster 2 (40% vs. 50%). Additionally, the average net margin for Cluster 1 is just 26% lower (-126% vs. -100%). In contrast, Cluster 3’s profitability metrics diverge somewhat from those of Clusters 1 and 2. The proportion of ventures in Cluster 3 reaching breakeven is only 15 percentage points lower than in Cluster 1 (25% vs. 40%), but the average net margin is 124% lower (-150% vs. -126%).

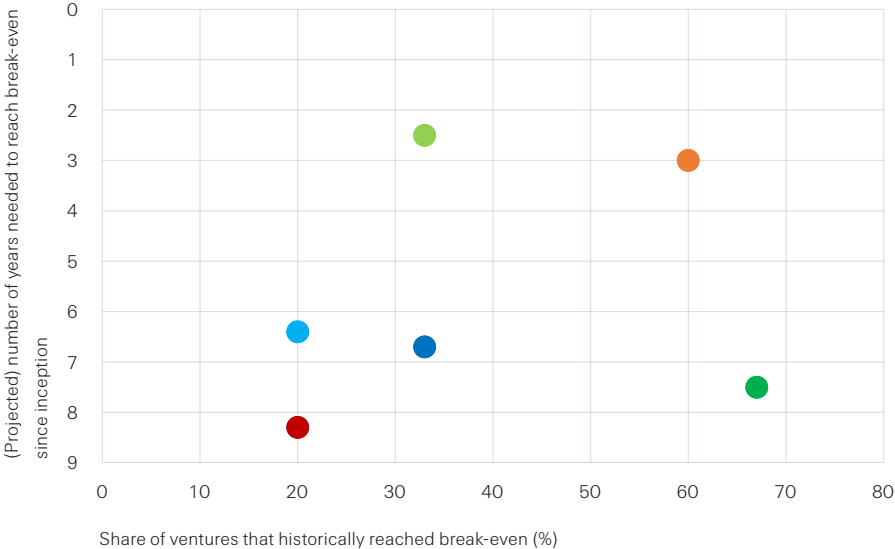
Figure 4
Revenue (net of grants), gross margin, net profit/loss (USD) and 3-year revenue CAGR



⁴¹ The earned revenue in the last year of data collection for Cluster 1 varies significantly, from USD14k to USD7m.

Figure 5
Overview of profitability metrics:
average (projected) time needed to reach
break-even since inception (in years) and
share of ventures that historically reached
break-even (%)

- 1.a Centralised healthcare provision
- 1.b Decentralised healthcare provision
- 2.a Third-party product underwriting
- 2.b In-house product ownership/underwriting
- 3.a Technology for healthcare delivery
- 3.b Technology for healthcare financing



Additionality of support:

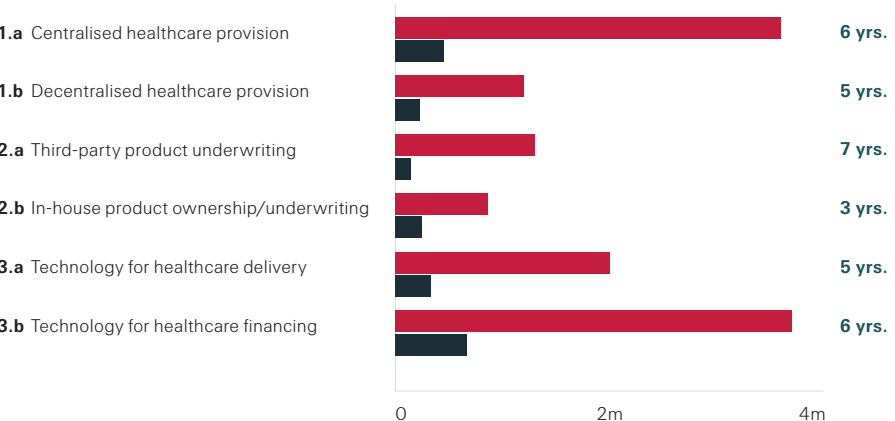
Cluster 2 displays the lowest need for external financing out of all clusters. Besides having raised the least cumulative amount of funds (USD1.1m, on average⁴²), ventures in this cluster also require the least external funding per year to finance operations and growth (USD201k on average). In particular, ventures with in-house product ownership and/or underwriting raised the very least funding, likely also because they are the youngest of all ventures studied.

On average, ventures in **Cluster 1** have moderate needs in terms of external financing. Nonetheless, there are large differences between the sub-clusters. The ventures using a centralised approach have raised the second-highest amount of cumulative funding (USD3.6m on average⁴³) and record the second-highest amount of external financing needed to operate per year (USD453k on average). In contrast, ventures following a decentralised approach have lower financial needs, like those in Cluster 2, with an average of USD1.2m raised cumulatively⁴⁴ and USD227k of external funding needed per year.

Finally, **Cluster 3** has the highest financial needs of the three clusters. On average, ventures in this cluster raised the most funding cumulatively (USD2.9m⁴⁵) and require the most external funding per year (USD519k). However, as in Cluster 1, there are significant differences between its sub-clusters. The averages are driven by the ventures offering technology solutions for healthcare financing, which record the highest amount of total funds raised cumulatively (USD3.7m) and require the most external funding to operate and grow (USD670k per year).

Figure 6
Average cumulative funding raised,
external funding required per year
(USD) and average number of years in
operation

- Total amount of funds raised cumulatively
- External funding required per year



⁴² In Cluster 2, the total amount of funds raised varies significantly, from USD0 to USD3.5m.

⁴³ In sub-cluster 1.a, the total amount of funds raised varies significantly, from USD6.8k to USD12m.

⁴⁴ In sub-cluster 1.b, the total amount of funds raised varies significantly, from USD33k to USD2.9m.

⁴⁵ In Cluster 3, the total amount of funds raised varies significantly, from USD15k to USD9.6m.

Summary

Cluster 1 shows the most impact on patients, particularly in terms of improving health outcomes and healthcare affordability and accessibility. Additionally, it records the highest NAV among all clusters. The ventures following a decentralised approach are the most impactful sub-cluster in the study, with the highest NAV and impact on affordability and accessibility. That said, the high impact of Cluster 1 is delivered to a relatively limited user base that is growing more slowly than those of Cluster 2 and Cluster 3, showing more limited scale and scalability potential. On the financial side, Cluster 1 generates by far the highest earned revenue and achieves above-average results overall, especially in terms of gross margins and share of grants in total revenue. Notably, the decentralised delivery sub-cluster displays better profitability than the other sub-clusters. Finally, in terms of additionality of support, the sub-cluster using centralised delivery is the one most reliant on external financing of all, while the decentralised delivery sub-cluster is among the least reliant on external financing.

Cluster 2 generally delivers less direct impact than Cluster 1, but it stands out thanks to the improvements in end users' financial resilience and the focus on serving users living in informal urban settlements. On the other hand, this cluster records the lowest NAV in the study, mostly due to the specifics of insurance models. The ventures with third-party underwritten solutions are more impactful in that they record higher NAV and a slightly higher impact on financial resilience, affordability and accessibility. In terms of scale and scalability, although the average user base in this cluster is the smallest in the study, it is also the fastest growing, especially in the in-house product ownership and/or underwriting sub-cluster. On the financial sustainability front, despite generating the least earned revenue, Cluster 2 displays relatively strong financial performance thanks to having the highest proportion of ventures that have historically reached breakeven, the shortest time needed to reach breakeven since inception and the best net margins.

Finally, in terms of additionality of support, this cluster records the least reliance on external funding and has raised the least funding cumulatively so far. In particular, ventures with owned solutions demonstrate the highest additionality of all sub-clusters, having raised the least financing and being the youngest in the study.

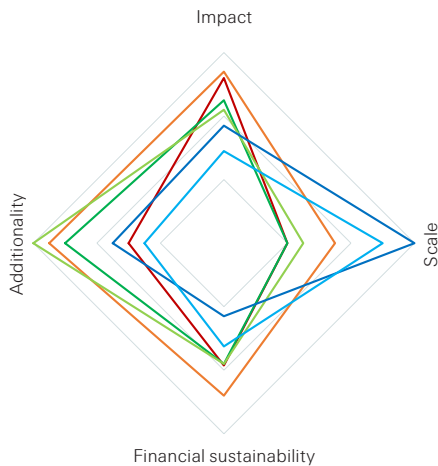


Cluster 3 displays the least impact. Besides recording the smallest share of users from rural areas, it also has very limited impact on health outcomes and healthcare affordability and accessibility. That said, the sub-cluster offering solutions for healthcare delivery displays better results on all these metrics than its counterpart. In terms of scale and scalability, Cluster 3 stands out thanks to its massive scale and the highest user base growth rates. However, in terms of financial performance, it records the most negative net margins, the smallest share of ventures that have historically reached breakeven and the longest time needed to reach breakeven since inception. Lastly, in terms of additionality of support, the two sub-clusters differ considerably: of all the sub-clusters in the study, the technology for healthcare delivery sub-cluster is among the least reliant on external funding, and the technology for healthcare financing sub-cluster is among the most reliant on it.

A table with the values of selected quantitative metrics used to create the below chart can be found in Appendix 2.

Figure 7
Sub-cluster performance
comparative overview⁴⁶

- 1.a Centralised healthcare provision
- 1.b Decentralised healthcare provision
- 2.a Third-party product underwriting
- 2.b In-house product ownership/underwriting
- 3.a Technology for healthcare delivery
- 3.b Technology for healthcare financing



⁴⁶ The impact dimension was assessed based on three criteria, each rated on a 3-point scale: inclusivity (consisting of the following metrics: share of users living in rural areas, share of users living in informal urban settlements), relevance (consisting of the following metrics: impact on accessibility and affordability of healthcare) and benefits (consisting of the following metrics: impact on health outcomes and financial resilience and NAV). The scale dimension was assessed based on two criteria, each rated on a 3-point scale: number of users served per year and the 3-year CAGR in the number of users served per year. The financial sustainability dimension was assessed based on four criteria, each rated on a 3-point scale: earned revenue, 3-year CAGR of earned revenue, profitability (net margin, number of years needed to break even since inception and share of ventures that historically reached breakeven) and share of grants over total revenue. The additionality of support dimension was assessed based on three criteria, each rated on a 3-point scale: number of years in operation, total amount of funding raised and amount of external funding needed per year.

Cluster 1: Affordable and accessible healthcare provision

Challenges addressed

Ventures within this cluster aim to alleviate the acute lack of medical infrastructure and staff in the areas where they operate. While public healthcare facilities in the countries where they operate are often free, they are typically understaffed, resulting in poor quality, very long waiting times and drug shortages. On the other hand, private facilities require payment. Given the low penetration of healthcare insurance in these countries, healthcare expenses are unaffordable for most low-income people. Consequently, people often delay care, avoid it altogether, self-diagnose or rely on the advice of traditional healers or similar.

Solution offered

While all ventures in this cluster have developed solutions to make primary and/or preventive healthcare more affordable and accessible, they can be distinguished into the ones following a more centralised approach to care (ie offer a majority of their services through a network of physical clinics, often located in higher-density population areas) and the ones following a more decentralised approach, focusing on delivering healthcare services close to patients through mobile clinics, telemedicine or home visits. This approach is particularly important to reach patients in remote (rural) areas or those with limited mobility (eg women).

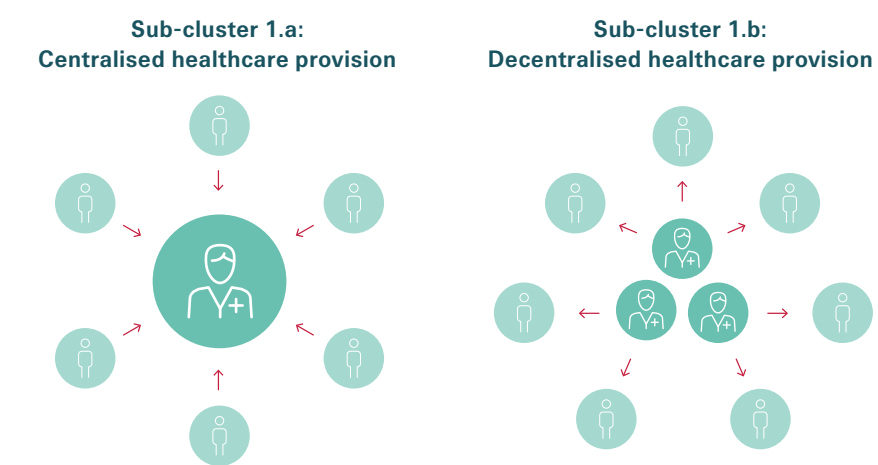


Most of the ventures also put great emphasis on providing high-quality care and offer health prevention and education activities. As they usually focus on primary care, none offer inpatient services. The ventures with a more centralised approach usually have large(r) pharmacies attached to their facilities, which enable them to offer lower-priced drugs to patients. As a result, provision of affordable drugs is more common in this sub-cluster (67%) than in the decentralised sub-cluster (40%).

Cluster 1 ventures typically operate under a “brick and click” model, combining physical presence, such as fixed or mobile clinics, with digital tools like telehealth or AI-based algorithms that facilitate diagnosis and triaging of patients. That said, there are large disparities between ventures taking a centralised versus a decentralised approach. The latter tend to be more tech-driven, with 80% employing telemedicine, 60% connected diagnostic devices and 40% AI-based algorithms for diagnosis and treatment. These ventures have to leverage technology to drive quality and consistency of care at the last mile, including for more complex cases, as they often deliver care through nurses or community health workers (CHWs) rather than doctors.

Lastly, 67% of ventures in this cluster also offer financial solutions, such as health plans that bundle discounted or free services or credit and micro-insurance options. This is particularly prevalent among ventures following a centralised approach. These must maximise the utilisation of their facilities and staff by building longer-term relationships and loyalty with patients, driving footfall to the clinics while offering additional value relative to other providers in the area (eg preventive health visits, additional check-ups, discounted services).

Figure 8
Intervention models in Cluster 1



Overall assessment

Cluster 1 ventures stand out for delivering significant impact directly to those most in need. By providing direct healthcare services, adopting practices like telemedicine and standard medical protocols and maintaining low margins, these ventures achieve the greatest impact on healthcare affordability, accessibility and health outcomes. This is particularly true among ventures using a decentralised approach, which has the highest impact on the affordability and accessibility of healthcare. The high impact of Cluster 1 is additionally highlighted by the highest average NAV per user of USD10.

In terms of size, Cluster 1 ventures operate at a modest scale, serving an average of 106k users in the last year of data collection per venture and reaching a limited geographical area as only 9% of the ventures expanded internationally, and only 18% offer their services country-wide. Additionally, the average 3-year CAGR in number of end users served per year is the lowest among all clusters (46%). This more gradual growth can be attributed to the fact that expanding physical clinics is more resource-intensive and less scalable. At the sub-cluster level, ventures applying the decentralised approach are more likely to expand internationally (20% vs. none in the other sub-cluster) and serve more users per year (170k vs. 53k in the other sub-cluster), while the other sub-cluster records a slightly better 3-year CAGR (64% vs. 22% in the other sub-cluster).

In terms of financial performance, Cluster 1 boasts the highest average yearly revenue among all clusters, generating USD1.3m in the last year of data collection. However, these ventures also have the lowest average 3-year revenue CAGR (101%). Despite the modest growth rate, this figure is still impressive, given the substantial revenue already earned. Profitability-wise, Cluster 1 performs relatively well, with the highest average gross margin (50%) and a less negative net margin (-126%). Historically, 40% of these ventures have reached breakeven, and projections indicate they should achieve profitability an average of six years after inception. Neither sub-cluster clearly outperforms the other. Ventures with a centralised approach tend to have higher yearly revenue (USD1.75m vs. USD873k), faster growth rates (115% vs. 83%), higher gross margins (55% vs. 45%) and a lower reliance on grant funding (24% vs. 33%). In contrast, ventures with a decentralised approach perform better in other key areas as they record better net margins (-52% vs. -200%), have a higher proportion of ventures that historically broke even (60% vs. 20%) and reached breakeven faster (in 3 vs. 8 years).

On average, the ventures in Cluster 1 have been in operation for around five years. They raised, over that period, significant funding (USD2.5m cumulatively), as they require around USD350k in external funding annually to operate and grow. However, there are significant differences between the sub-clusters: ventures with a centralised approach have raised cumulatively USD3.6m and require an average of USD453k in external funding per year. In contrast, ventures with a decentralised approach raised only USD1.2m cumulatively, with an annual external funding requirement of USD227k.

Users and impact

Inclusivity:

The ventures in this cluster typically target informally or self-employed people, who fall within the low- to middle-income range. Women make up a significant portion of the user base in general, reaching 80% of all patients in some cases, as taking care of children’s and family’s healthcare often falls on them. In general, the ventures serve patients of all ages, albeit those ventures catering to a specific health condition, such as diabetes, may serve more elderly patients. Notably, ventures that adopt a decentralised approach record a higher proportion of users from rural areas (55% vs. 34%) and a higher proportion of users living in informal urban settlements (39% vs. 10%). This can be explained by the fact that their delivery model specifically targets remotely located populations, which generally have lower incomes.

Figure 9
End users’ profiles



Relevance:

Affordability: All the ventures in Cluster 1 offer services tailored to the low-income segment at prices lower or significantly lower than similar competitors in the area. To keep prices low, they rely on standardisation of processes and operations and bulk purchasing from drug suppliers.

Accessibility: The ventures increase accessibility of healthcare by reducing the need for long-distance travel, time lost in travel (and corresponding income loss) and travel costs, which can be significant. They often do so by providing telemedicine (64% of the ventures) or apps with medical information (45% of the ventures). Overall, 67% of the ventures greatly increase the accessibility of healthcare services for their target population. While ventures that follow a decentralised approach typically score higher on this impact dimension (as they rely, for example, on mobile clinics or teleconsultations), the ones that follow a centralised approach need to balance proximity to target populations with the need to be located in high-traffic areas with enough footfall to ensure higher utilisation.

Benefits created:

Health outcomes: To ensure high-quality services, the ventures rely on standardised care protocols, data-driven improvement processes and regular staff training. A vast majority rely on electronic medical record (EMR) software to streamline patient data management, driving better continuity of care across patients’ visits, while around half utilise connected devices to improve diagnostics in limited-resource settings (such as connected mobile ultrasound machines, which enable physicians to perform imaging in the field). Nonetheless, only 18% of the ventures leverage artificial intelligence (AI) to support diagnosis and choice of treatment. Overall, the ventures adopting a more centralised approach tend to offer more services as their fixed location allows them to deploy deeper and broader medical capabilities. As a result, the ventures in the centralised sub-cluster have on average a slightly higher impact on the health of their patients (83% highly improve patient health vs. 80% in the decentralised sub-cluster). Many ventures in this cluster also focus on prevention and early detection to support better health outcomes.

Net additional value (NAV): Thanks to the ventures’ various benefits for patients, they generate a high average NAV of USD10. This is particularly true for ventures that adopt a decentralised approach, as these are typically priced low and help patients save on the cost of transport (NAV of USD11.5 vs. USD8.6 for the ventures offering more centralised services).

Financial resilience: Most of these ventures (73%) also offer some kind of financing solutions for healthcare expenses, such as flexible payment options, microloans or health plans. However, since these financial products often exclude inpatient services and allow redemption of services only within the venture’s network, their impact on the financial resilience of patients is moderate for 45% of the ventures and low for 45% of the ventures.

Usage: On average, patients are highly satisfied with services provided, albeit ventures often struggle with low utilisation and retention. This might be due to the health-seeking behaviour of the targeted populations, which often lack funds and awareness of the importance of healthcare, especially when it comes to prevention.

Figure 10
Overview of performance across
impact dimensions

— 1.a Centralised healthcare provision

— 1.b Decentralised healthcare provision



Scale and scalability

Outreach and outreach growth:

The ventures in this cluster tend to grow in a linear but slow fashion; they also tend to have limited geographical coverage, usually focusing on one or a few areas within a country. Only 18% managed to reach country-wide coverage, and 9% expanded internationally. On average, the ventures served 106k users⁴⁷ in the last year of data collection. Ventures using a more decentralised approach typically reach many more users than their counterparts with centralised infrastructure (170k⁴⁸ vs. 53k) as they rely on more flexible deployment channels, such as telemedicine. For the same reasons, they also achieve wider geographical coverage. Nonetheless, the speed at which ventures in this sub-cluster add users is higher among the more centralised ones (3-year CAGR of 64% vs. 22% among the decentralised ones). The slower growth rate of ventures using decentralised approaches may be attributable to the unusual increase and decline in demand for non-physical interactions during and after the COVID-19 pandemic.

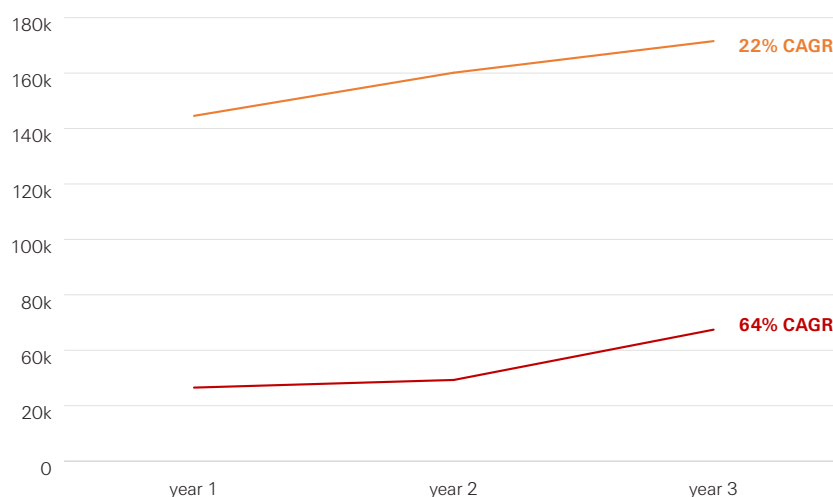
Scaling and user acquisition strategy:

To reach and recruit new patients, ventures typically use business-to-customer (B2C) go-to-market strategies, such as positioning flagship clinics in high-traffic areas, door-to-door visits, promotional events (eg free basic screenings or information sessions) and social media. To diversify away from winning one patient at a time, some also serve business-to-business (B2B) clients, delivering services to the workforces of corporates, small- to medium-sized enterprises (SMEs) or non-governmental organisations (NGOs). Lastly, a minority of the ventures pursue business-to-business-to-customer (B2B2C) channels, partnering with community-based organisations, local clinics, NGOs, micro-financing institutions, saving groups or the like to gain access to their users or members, with mixed success. The user acquisition costs of the ventures range from USD4 to USD72.

Figure 11

Average number of end users served per year, over three years

- 1.a Centralised healthcare provision
- 1.b Decentralised healthcare provision

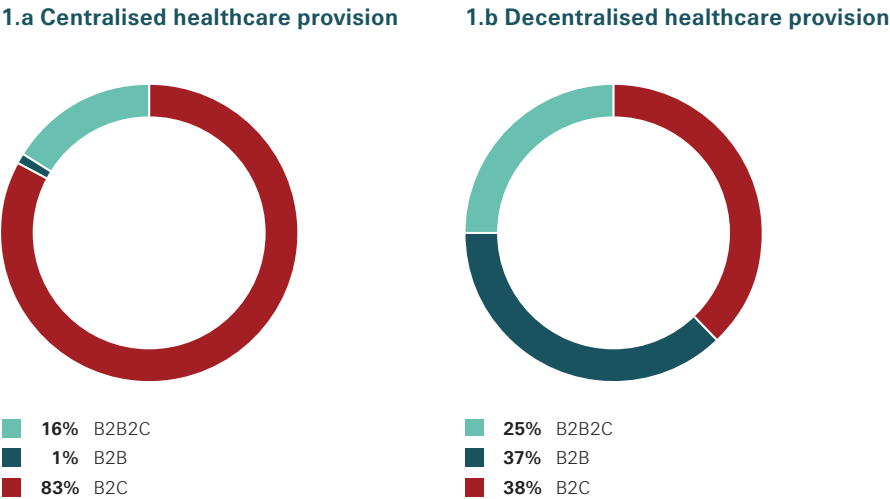


⁴⁷ Users are defined as people who used the ventures' services, typically medical services (in-person and/or remotely). In one case, users are defined as people participating in health screenings organised by the venture.

⁴⁸ In sub-cluster 1.b, the total number of users served in the last year of data collection ranges from USD3k to USD675k.

On average, 65% of the users in this cluster come from the B2C channel, 20% from B2B2C and 15% from B2B. The averages hide big differences between sub-clusters, however: centralised ventures manage to sign proportionally many more B2C patients (83% vs. 38% for the decentralised ventures), while the decentralised ventures compensate by trying to serve B2B clients (37% vs. 1% for the centralised sub-cluster) and B2B2C partners (25% vs. 16% for the centralised sub-cluster). This can be explained as follows: as the latter ventures typically do not have established physical locations, their customer base is widely dispersed, making the B2C channel more challenging. In contrast, B2B2C and B2B partnerships ensure access to a broader customer base and help validate the venture, overcoming potential resistance to non-traditional healthcare delivery.

Figure 12
Average proportion of users acquired by outreach channels



Financial sustainability

Revenue model and diversification:
Of the ventures in this cluster, 72% are for-profits, 18% adopt hybrid models and 9% are non-profits. Non-profits are excluded from the financial sustainability analysis below due to their distinctive mission-driven focus and financial structures, which could skew the results and complicate comparisons with other clusters.

The 10 remaining ventures generate 66% of their revenue by selling healthcare services, including physical consultations, teleconsultations, diagnostics, screenings and drug sales. This revenue stream is crucial for the ventures adopting the decentralised approach as it constitutes, on average, 92% of their total revenue (vs. 39% for the ventures in the centralised sub-cluster). About half of the ventures also sell financial solutions, such as health plans, albeit this typically represents a tiny share of revenue (28% on average). Notably, this proportion is much higher for the ventures in the centralised sub-cluster (53% vs. 2% in the decentralised sub-cluster). These ventures also tend to offer a wider range of products, which might stem from efforts to increase utilisation rates to cover high fixed costs. The remaining 6% of the revenue is derived from activities unrelated to direct healthcare services, such as selling products tailored to the needs of specific patients (eg shoes or specialised foods), collecting franchising fees, offering space for advertisements or software sales.

Revenues’ split per channel typically differ between ventures adopting a centralised vs. decentralised approach. The ventures following the centralised approach generate their revenue from B2C (59% of total revenue vs. 43% in the other sub-cluster) and B2B channels (41% of total revenue vs. 38% in the other sub-cluster). As ventures that adopt the decentralised approach must rely on more diversified acquisition strategies than the centralised ones, they also utilise the B2B2C channel, which brings the remaining 19% of revenue (vs. 0% in the centralised sub-cluster).

Earned revenue levels and growth:

The ventures in the centralised sub-cluster generate more revenues and do so faster: while, on average, the ventures in Cluster 1 generate USD1.3m in yearly revenue (net of grants), more centralised ventures record USD1.75m (vs. USD873k for decentralised ones) and 3-year revenue CAGR of 115% (vs 83% for more decentralised ones).

Profitability/financial viability:

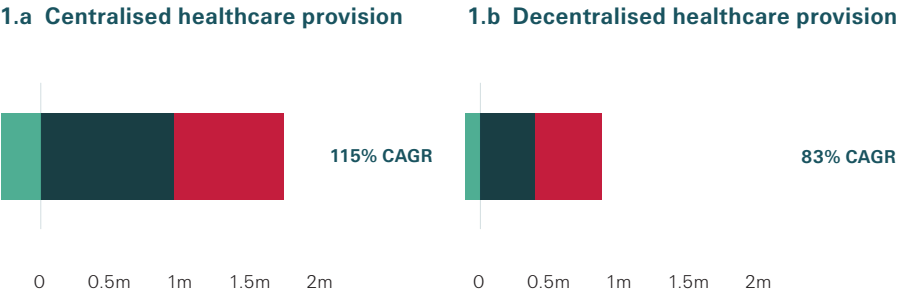
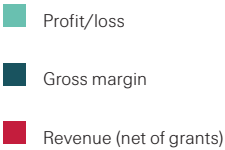
Along with higher revenues, the ventures in the centralised sub-cluster also record overhead costs almost four times higher than in the decentralised sub-cluster (247% vs. 71%). As a result, these ventures have worse net margins (-200% vs. -52%) and record higher losses (USD-335k vs USD-110k). On the other hand, the gross margins are similar, with an average of 50%, showing that decentralised ventures do not necessarily lower the cost of healthcare delivery relative to their more centralised counterparts at this stage of the sub-cluster’s maturity.

In terms of net profit, more of the ventures adopting a decentralised approach reached breakeven at some point than the centralised ones (60% vs. 17%), but did not necessarily maintain it over time (20% of decentralised ventures are currently profitable vs. none of the centralised ones), as these ventures mostly rode on a pandemic-driven increase in demand for their services. Also, reaching breakeven takes longer for ventures adopting a centralised approach (8 years vs. 3 years) as they require a larger scale (USD258k users vs. USD91k users among decentralised ventures) and bigger sales (USD5.2m vs. USD3m) to pay for their overhead costs.

Reliance on grant funding:

As a result, grant funding is essential for a vast majority of the ventures, amounting to 19% of total revenue in the centralised sub-cluster and 33% in the decentralised sub-cluster.

Figure 13
Revenue (net of grants), gross margin, net profit/loss (USD) and 3-year revenue CAGR



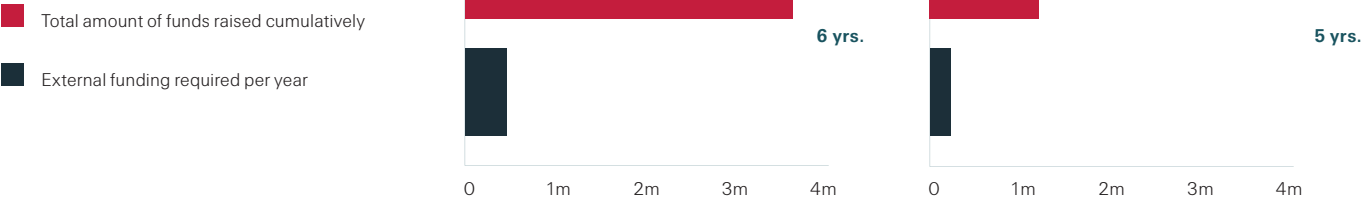
Additionality of support

Years in operation:
Ventures in Cluster 1 have already gained considerable experience, with the average time in operation being six years in the centralised sub-cluster and five years in the decentralised sub-cluster.

Fundraising track record:
Most of the ventures in this cluster managed to raise significant external funding, with an average of USD2.5m per venture (USD3.6m among decentralised ventures vs. USD1.2m among others).

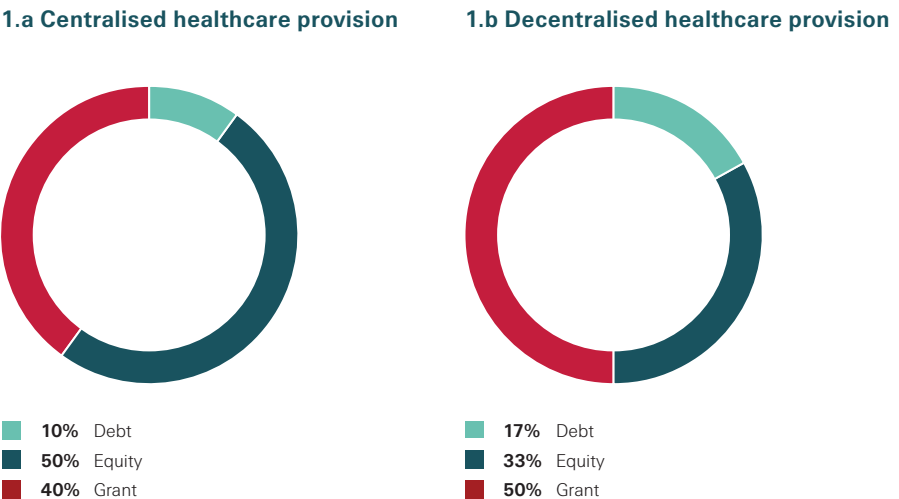
Reliance on external funding:
On a yearly basis, however, ventures adopting a centralised approach “burned through” more external funding (USD453k vs USD227k for decentralised ventures), perhaps owing to the considerable manpower and capital required to run physical clinics.

Figure 14
Average cumulative funding raised so far, external funding required per year (in USD) and average years in operation



For both of the sub-clusters grants and equity are the most common type of funding raised, while debt constitutes a minor share. Notably, ventures using a centralised approach raise the biggest share of their funding in the form of equity (50%), while the ventures using a decentralised approach rely more on grants (50% of funding raised).

Figure 15
External funding raised cumulatively (on average) by type of funding



Financial and non-financial needs of ventures:

Key investment areas for the ventures in this cluster include geographic expansion and technological advancements (in particular, the development of interfaces with patients and the use of AI to drive quality delivery). Some ventures also strive to enhance their data management capabilities and operational efficiency.

To realise their ambitions, 91% of the ventures seek grants or hybrid financing, while almost half also seek equity. Only a few are interested in debt financing. They typically report struggling to fundraise due to difficulties in identifying the right investors, lacking experience in the investment process or lacking bandwidth to engage in fundraising (including in providing the required financial documentation). Their relatively slow growth curve may also pose challenges in their effort to attract equity investors.

Besides funding, many ventures seek expertise in the development of financial products, especially regarding pricing and risk management. Many of the ventures also aim to expand their technological capabilities and look for assistance in introducing AI-powered tools (eg algorithms for clinical decision-making), user interfaces (app or chatbot) or smart diagnostic devices. Data collection and utilisation is another field in which ventures seek support.

Considering the metrics where this cluster performs less well than the others, it would be important to offer these ventures support on the following topics:

For the cluster at large:

- How to increase scale and scalability, notably using technology, to drive outreach and revenue growth
- How to offer better financial solutions to users, beyond limited health plans at selected facilities

For ventures in the sub-cluster using a centralised approach:

- How to improve inclusion, that is, serve more users from rural and informal urban settlements, notably using technology
- How to improve profitability and decrease reliance on external funding by adding more “click” elements to the “brick” ones

For ventures in the sub-cluster using a decentralised approach:

- How to improve profitability and decrease reliance on grants by developing more appropriate and sustainable revenue models

Lastly, most ventures could use expertise and resources to enhance their impact measurement and management practices.

Cluster 2: Financial solutions for healthcare

Challenges addressed

Ventures in this cluster aim to address the low penetration of healthcare financing or protection products in low-income countries. These ventures usually operate in countries where there are no public health insurance schemes or such schemes' penetration or coverage is severely limited. Similarly, private insurance is typically out of reach for most of the population due to the high premiums charged. Therefore, patients mostly pay out-of-pocket and are vulnerable to health-related financial shocks when they cannot afford their medical expenses. Low-income patients' lack of resources to pay for healthcare leads many to delay or avoid care, resort to unqualified local healers, self-diagnose and/or self-medicate, resulting in poor healthcare outcomes.

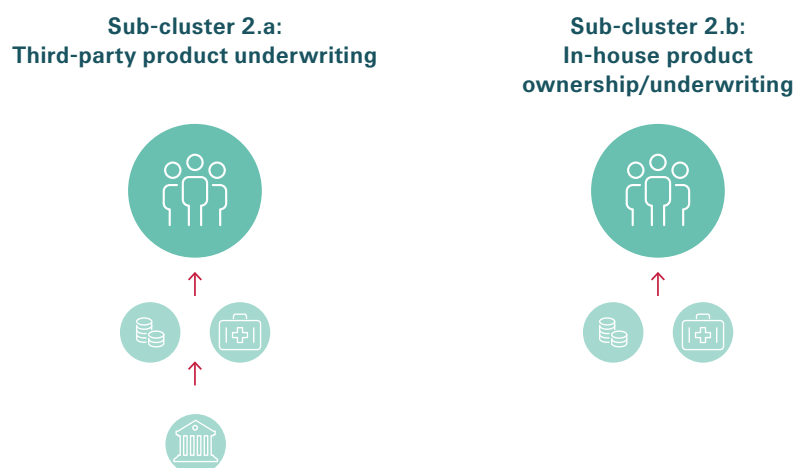
Solution offered

Ventures in this cluster create value for their users by facilitating the payment of medical expenses and protecting them against financial health shocks. They can be split into ventures that design and distribute financial protection products (typically health microinsurance), which are then underwritten by third parties, and ventures that develop, distribute and underwrite/manage their financial product in house (including microinsurance, collective health plans, savings wallets and microloans).

Although the main focus of these ventures is the provision of financial services, around half of them offer complementary healthcare services, such as telemedicine consultations (mostly through a network of outsourced doctors) or prevention services such as screenings, while one venture also offers a whole range of in-house medical services. Provision of healthcare is more common in the sub-cluster with owned financial solutions (67% of ventures vs. 36% in the other sub-cluster).

About two-thirds of the ventures in this cluster operate purely digitally. The remaining third deploy staff or CHWs for outreach, promotion or medical service provision. Most leverage technological solutions to optimise their own operations (eg software to digitalise users' registration or claims processing, digital payment facilities). Lastly, in the sub-cluster with externally underwritten solutions, two-thirds of the ventures can integrate their solution with the systems of other ecosystem players (eg partner microfinance institutions, underwriters or medical providers).

Figure 16
Intervention models in Cluster 2



Overall assessment

These ventures record high levels of inclusion in terms of end users residing in informal urban settlements (46%), but the lowest level of all clusters for rural users (40%). While microinsurance provides valuable support, it does not necessarily lead to better health outcomes, especially in areas lacking quality healthcare providers or where coverage is limited. As a result, these ventures have a medium-sized impact on the health outcomes of their users and on healthcare accessibility and affordability. While they achieve the highest impact on users' financial resilience, ventures in Cluster 2 record a comparatively low NAV of USD-7 per user because insurance benefits tend to be unevenly distributed, with most users incurring minor losses while a few benefit from larger claim payouts in a given year. Ventures using third-party product underwriting perform better, recording a NAV of USD3.2 per user and a higher impact on financial resilience, affordability and accessibility.

Ventures in Cluster 2 operate at a comparatively small scale, reaching an average of 24k users per venture in the last year of data collection and rarely expanding country-wide. However, their small scale translates into a comparatively high average 3-year CAGR in number of users (94%). In this cluster, ventures with externally underwritten solutions tend to serve more users annually (37k vs. 12k in the other sub-cluster) and achieve broader geographical coverage (with 67% expanding country-wide compared to 0% in the other sub-cluster). Meanwhile, ventures with in-house product ownership and/or underwriting grow faster, at a rate of 121% (vs. 75% in the other sub-cluster). These patterns typically reflect differences in levels of maturity between the sub-clusters, as the ventures with third-party underwritten solutions have, on average, operated for seven years and the ventures with in-house solutions only three years.

This cluster displays moderate financial performance. Although it records comparatively low levels of yearly earned revenues (USD166k), its 3-year CAGR in revenue is robust (115%). Looking at profitability, this cluster displays among the least negative profit margins (-100%), and 50% of the ventures have historically reached breakeven (while only 17% were still profitable at the time of data collection). These ventures also require the least time to reach breakeven, with only 5 years since inception on average. The ventures with third-party underwriting perform better than those with in-house ownership and/or underwriting, with a higher average revenue (USD268k vs. USD66k), better gross margins (22% vs. 18%) and better net margins (-77% vs. -122%). These differences might stem from the sub-clusters' different levels of maturity. Additionally, the ventures with underwritten solutions receive more grant support, with grants constituting 34% of their total revenue in the last year of data collection (vs. 10% in the other sub-cluster).

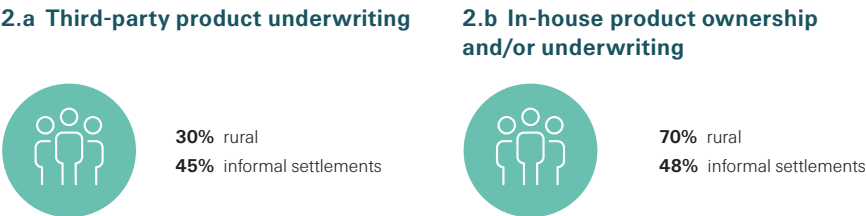
Lastly, although on average these ventures have a similar maturity level to those in other clusters (5 years in operation), they have raised the least external financing cumulatively (USD1.1m per venture). They therefore require the smallest amount of external funding per year to support operations and growth, with an average of USD201k. Notably, ventures with in-house product ownership and/or underwriting are the youngest in the study, with an average of just three years in operation, and have raised the lowest amount of funding cumulatively (USD868k).

Users and impact

Inclusivity:

Target users are typically self-employed or formally employed, have a family and fall within the low-income range. More specifically, 40% of users live in rural areas, and 46% in informal urban settlements. Notably, the ventures with in-house solutions have a higher proportion of users living in informal settlements and rural areas (48% and 70%, respectively, vs. 45% and 30% in the other sub-cluster). This difference may stem from the fact that ventures distributing underwritten microinsurance typically have very low margins and elect to operate in more densely populated areas to achieve some scale and penetration. In contrast, ventures that develop and own tailored financial products other than micro-insurance often tailor those to the needs of specific underserved segments of the population and do not necessarily need large, diversified pools of users to manage risk.

Figure 17
End users' profiles



Relevance:

Affordability: 67% of these ventures offer services tailored for low-income users at prices significantly lower than similar competitors, while the others charge prices similar to or slightly lower than market rates. Many intentionally design their products to guarantee lower premiums or interest rates. Most ventures also utilise technology to reduce their cost to serve, which might translate into lower prices for the end users (although no evidence of this effect was identified).

Accessibility: These ventures typically strive to offer their financial products where mainstream financial players and insurance fail, for instance, by using CHWs or by partnering with community-based organisations to reach underserved populations. Moreover, they deploy technology to allow for online registration, online access to medical records or telemedicine. As a result, 83% of them have a high impact on the accessibility of healthcare for their end users.

Benefits created:

Health outcomes: While one might expect insured patients to be more likely to avail themselves of care, the quality and presence of accredited providers and the extent of cover are limiting factors. As 50% of the ventures offer limited coverage or do not enforce quality assurance measures in selecting providers, their impact on the health outcomes of their end users is relatively low. On the other hand, 50% of the ventures perform more extensive due diligence before adding a provider or providing some level of complementary medical services themselves (notably primary care, prevention and education). In this case, the impact on the health outcomes of their end users is higher.

Net additional value (NAV): Given their less direct impact and the prevalence of microinsurance solutions, the ventures generate an average NAV of USD-7. Nonetheless, the sub-cluster with externally underwritten solutions records a higher average NAV of USD3.2 compared to an average NAV of USD-17.2 in the sub-cluster with owned financial solutions.

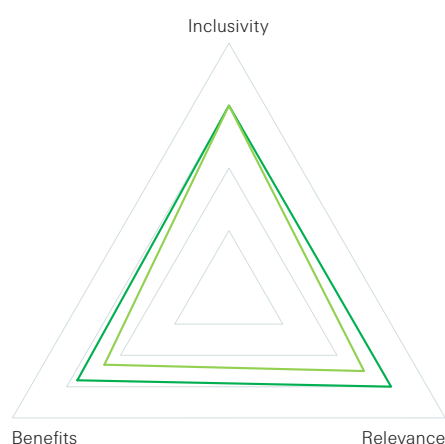
Financial resilience: All the ventures in the cluster provide financial solutions for healthcare expenses, such as microinsurance, affordable loans or saving products that are designed specifically for uninsured populations. They therefore greatly increase the financial resilience of their users (compared with the status quo).

Usage: Although ventures in this cluster rarely measure the satisfaction of their clients, those that do report positive feedback. When it comes to retention, however, there are large differences between the sub-clusters: the ventures with externally underwritten financial solutions report much lower retention rates than the ventures with their own financial solution. This may be due to the specificity of the products offered by the latter sub-cluster, which the ventures try to differentiate from insurance or any financial design that requires users to pay upfront without getting tangible value and benefits in return.

Figure 18

Overview of performance across impact dimensions

- 2.a Third-party product underwriting
- 2.b In-house product ownership/underwriting



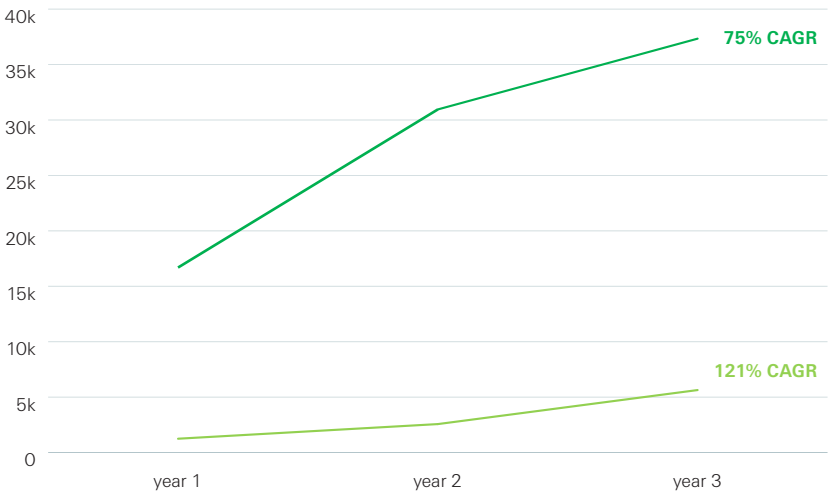
Scale and scalability

Outreach and outreach growth:

Almost all ventures in this cluster grow in a linear but almost flat fashion and serve a modest number of users, with an average of 25k⁴⁹ served in the last year of data collection. However, the sub-cluster with externally underwritten solutions records three times as many users as their peers with in-house owned/underwritten solutions (37k vs. 12k). The same is true when it comes to geographical coverage as 67% of the former ventures expanded country-wide, while none of the other ventures did. This is because the ventures with in-house owned/underwritten solutions are still relatively young, which also explains their higher growth rates (3-year outreach CAGR of 121% vs. 75% for the externally underwritten solutions)⁵⁰.

Figure 19
Average number of end users served per year, over three years

- 2.a Third-party product underwriting
- 2.b In-house product ownership/underwriting



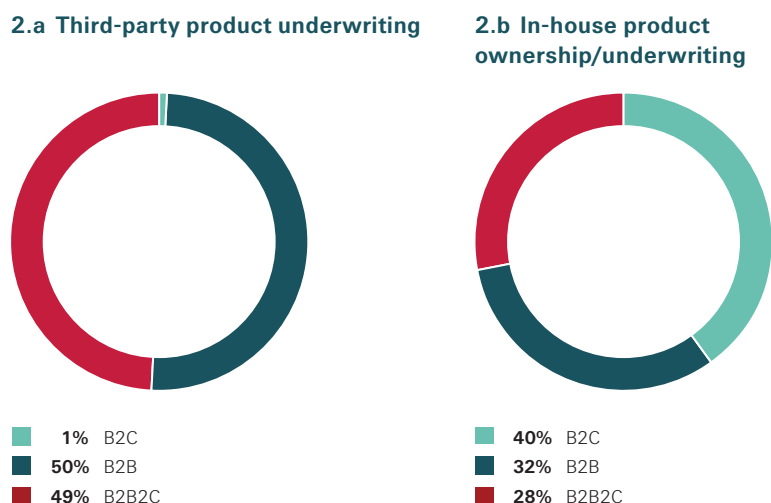
Scaling and user acquisition strategy:

In this cluster, ventures enrol end users directly through partnerships with healthcare facilities, health camps or field agents. Some ventures also use B2B with corporates and SMEs to enrol their employees or B2B2C channels by partnering with various service providers (eg MFIs or mobile phone operators) that promote the venture’s services among their own customers. On average, 40% of the users in this cluster come from the B2B channel, 37% from B2B2C and 23% from B2C. Notably, B2B2C and to some extent B2B strategies are (much) more prevalent in the externally underwritten solution sub-cluster: 49% B2B2C vs. 28% in the other sub-cluster and 50% B2B vs. 32%. In contrast, B2C was more prevalent in the in-house owned/underwritten sub-cluster (40% vs. 1% in the other sub-cluster), perhaps reflecting that the novelty of their products (and their young age) obliges these ventures to demonstrate market pull before convincing institutional clients or partners. As a result of the wide range of strategies used, user acquisition costs vary considerably across ventures, ranging from USD 0.2 to 9⁵¹.

⁴⁹ Users are defined as people who use the respective venture’s services. This typically means people who have bought a policy or who have deposited money in savings accounts.
⁵⁰ One of the ventures from the sub-cluster with in-house solutions recorded an unprecedented growth of its user base, from 26k in the last year of data collection to over 1m active users as of mid-2024, suggesting that there may be “unicorns” in this cluster. This venture was such an extreme outlier that it was excluded from the average analysis for this dimension.
⁵¹ This data was available for only half of the ventures in this cluster.

Figure 20

Average proportion of users acquired by outreach channel



Financial sustainability

Revenue model and diversification:

While all the ventures in the cluster are registered as for-profits and earn revenue through the sale of financial solutions, their business models differ. In the underwritten financial solutions sub-cluster, the ventures typically generate revenue from commissions on the sale of microinsurance products, which – given the very low-priced covers they offer and the low awareness of insurance in these markets – is a thin reward for a challenging job. To diversify income, they may additionally earn revenue from the sale of medical services, drugs, commissions from medical providers or the sale of software. On the other hand, the owned solutions sub-cluster displays a wider variety of revenue streams, including full premiums paid by health plan holders, commissions from various partners, interest on deposited funds and fees for loan top-ups.

The revenue streams are thus vastly different between the two sub-clusters: while ventures in the underwritten solutions sub-cluster usually generate 100% of their revenue through B2B2C and B2B, those in the in-house owned solution sub-cluster derive 41% of their revenue from B2B, 33% from B2B2C and 26% from B2C.

Earned revenue levels and growth:

On average, the ventures in this cluster generate USD167k in yearly revenue (net of grants), with ventures using external underwriting generating USD268k (vs. USD66k for the others). On the other hand, revenue in both sub-clusters grows at the same pace, with a CAGR of 115%.

Profitability/ financial viability:

Besides higher revenue, the third-party product underwriting sub-cluster also records less negative net margins than the other sub-cluster (-77% vs. -122%), while gross margins are similar for both sub-clusters (20%, on average). The higher profitability of ventures in this sub-cluster may be a result of their higher revenue (possibly due to them being more mature) and the fact that the share of uncompressible overhead at their smaller, younger counterparts is higher (the overhead ratio for ventures with in-house solutions is 171% and only 50% for ventures with externally underwritten solutions).

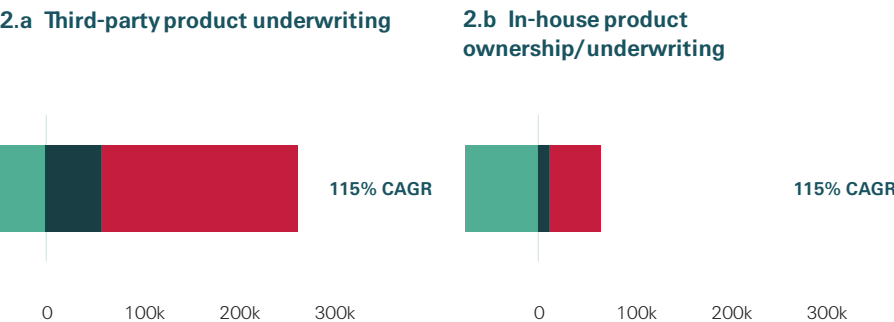
While 67% of the ventures that use external underwriters turned profitable at some point, all of them recorded a loss in the following year(s), either due to increased investment in growth or the impact of the COVID-19 pandemic. In contrast, among ventures that own their solution in-house, only 33% managed to break even, but all remained profitable over time. Also, these ventures are projected to reach breakeven faster, after just 2.5 years of operation (vs. 7.5 years for the venture using third-party underwriters).

Reliance on grant funding:

Lastly, the ventures with in-house owned/underwritten products appear to be disadvantaged on the philanthropic fundraising front. Grants represented only 10% of their revenue (vs. 34% for the other sub-cluster), despite the fact that these ventures are in an earlier stage.

Figure 21
Revenue (net of grants), gross margin, net profit/loss (USD) and 3-year revenue CAGR

- Profit/loss
- Gross margin
- Revenue (net of grants)



Additionality of support

Years in operation:

The ventures in the in-house solutions sub-cluster are the youngest across all sub-clusters, with an average time in operation of just three years. In comparison, the ventures in the other sub-cluster are active for an average of seven years, making them the “oldest” in the study.

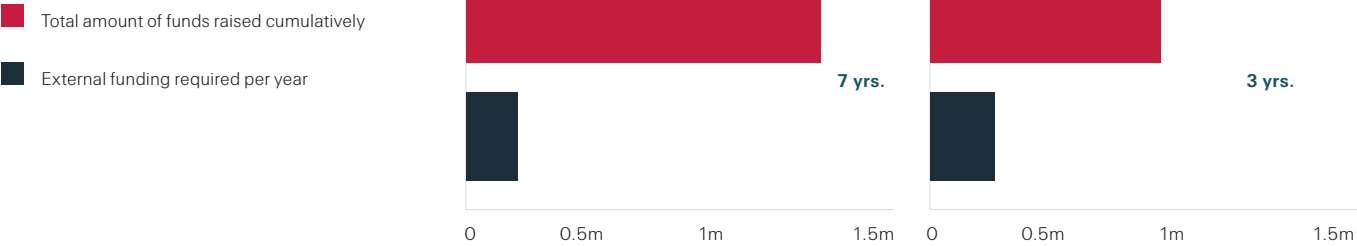
Fundraising track record:

The fundraising efforts of the ventures in the cluster were relatively unsuccessful, with an average of USD1.1m cumulatively raised (USD1.3m in the underwritten solutions sub-cluster vs. USD868k in the owned solutions sub-cluster).

Reliance on external funding:

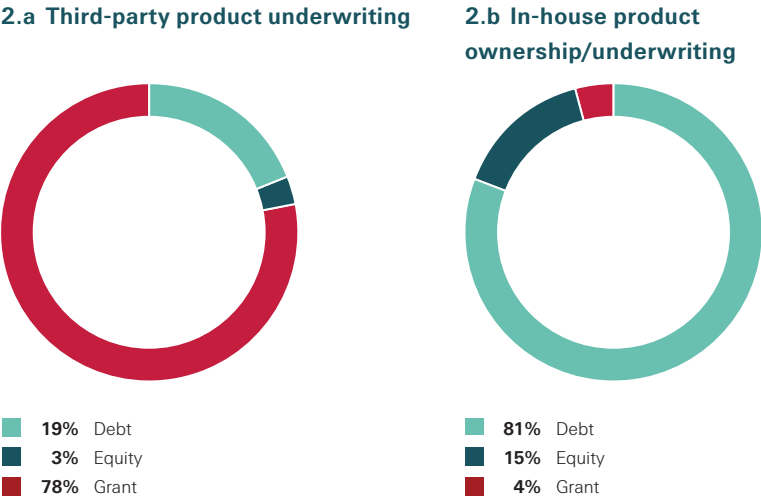
Looking at the amount of external funding needed per year to sustain and scale operations, the ventures in the sub-cluster using external underwriting require more funding than the others (USD252k vs. USD146k).

Figure 22
Average cumulative funding raised so far, external funding required per year (in USD) and average years in operation



There are even more marked differences in the type of funding raised so far: historically, the sub-cluster with external underwriting raised mostly grants (78% of total funds raised vs. 4% in the other sub-cluster). Instead, the latter ventures rely on debt funding (81% of total funds raised), suggesting that they are leveraging debt to finance the products they offer (eg microloans).

Figure 23
Split of external funding raised cumulatively (on average) by type of funding



Financial and non-financial needs of ventures:

As most of the ventures in the cluster have a small user base, their key objectives revolve around accelerating outreach, enrolment and geographical expansion. Some ventures also seek to introduce new financial or technological products.

To achieve their goals, they prefer external financing, in the form of grants or equity, over debt. Like those in Cluster 1, these ventures report that fundraising is challenging due to difficulties in identifying the right investors and their lack of experience in the investment process.

Regarding non-financial assistance, they typically seek support with the development and deployment of new financial products, improvement thereof (eg actuarial expertise or, in the externally underwritten solutions sub-cluster, integrating advanced algorithms for claims processing) and innovative marketing strategies to accelerate the adoption of insurance-like products.

Considering the metrics where this cluster performs less well than the others, it would be important to offer these ventures support on the following topics:

For the cluster at large:

- How to increase the NAV, by rethinking the design of insurance-like products (eg by covering more widespread conditions), by offering more systematic, tangible and immediate value to users (eg free screenings or telemedicine support) or by leveraging savings schemes
- How to enhance user acquisition for acceleration of both outreach and revenue
- How to rethink the revenue model, to improve gross margins

For ventures in the sub-cluster offering underwritten products:

- How to break free from the very low commissions negotiable with underwriters and capture more value from the design and distribution of policies, to reach breakeven faster while reducing reliance on grants

Lastly, most ventures in this cluster could use expertise and resources to enhance their impact measurement and management practices, especially given that their models make measuring impact more challenging.

Cluster 3: Technology solutions for the healthcare ecosystem

Challenges addressed

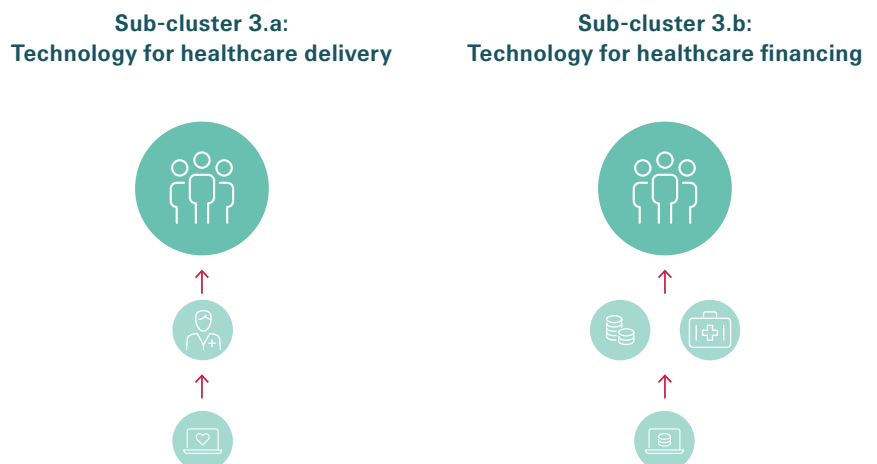
Ventures in this cluster offer technology solutions to support various players in the healthcare ecosystem that try to serve lower-income and/or more remote populations but struggle with poor connectivity and infrastructure as well as with the high cost of enrolling and serving patients. When the solution aims at improving healthcare delivery, it revolves around alleviating issues such as lack of healthcare infrastructure or the poor quality of care available. When the solution aims at facilitating healthcare financing, it focuses on addressing other challenges, such as decreasing the costs of distributing or serving insurance and other financial products.

Solution offered

The ventures in this cluster offer technological solutions to ecosystem players that decrease the cost-to-sell or cost-to-serve, increase outreach, facilitate access and/or improve the quality, reliability or effectiveness of their clients' services. The cluster thus encompasses a broad palette of solutions, reflecting the range of purposes and players served. The ventures can be divided into technological solutions for healthcare delivery and technological solutions for healthcare financing.

Ventures that exclusively serve healthcare financing players offer software that optimises the operations of their B2B clients, such as user registration, billing, payment, policy management and claims processing. Some are (more or less) integrated with medical providers to ensure a seamless payment flow and/or offer apps that allow patients to check the status of their plan or access their medical data. On the other hand, ventures that serve medical providers display a broader range of solutions, such as EMR (100% of the ventures), telemedicine (50%), AI-based algorithms for diagnostics (50%) or software-optimising operations like booking appointments or ordering drugs (50%). As technology providers, ventures in this cluster operate mostly digitally, albeit a third of them (and all in the sub-cluster serving healthcare providers) also leverage CHWs to recruit users, to introduce them to the venture's technology or to deliver basic care.

Figure 24
Intervention models in Cluster 3



Overall assessment

Cluster 3 ventures offer solutions primarily for various healthcare ecosystem players. Since they only occasionally and/or marginally serve end users directly and healthcare ecosystem players are rarely located in informal urban settlements, they report by far the lowest proportion of users living in such settlements (5%). As the solutions' benefits are intended for the B2B clients, with the expectation that they will be somehow passed on to end users, these ventures rarely track the extent to which this happens. Consequently, their impact ranks relatively low on health outcomes and affordability, with a medium impact on financial resilience and a low NAV (USD1.3 per user). That said, ventures providing technology solutions for healthcare delivery register more impact because they interact directly with end users more frequently, allowing them to bring benefits closer to patients. As a result, their NAV is higher (USD4.3 vs. -USD0.5 for the other sub-cluster), as is their impact on health outcomes, affordability and accessibility. Ventures serving healthcare providers also show a higher proportion of users from rural areas (93% vs. 6%) and informal settlements (7% vs. 0%).

As technology products have relatively low marginal scaling costs, the ventures in Cluster 3 significantly outperform the other clusters in terms of number of users reached, with an average of 1m users served in the last year of data collection per venture (although their definition of users tends to be broader than for ventures in other clusters). They also have significantly greater geographical coverage, with 67% of the ventures within the cluster expanding internationally. Finally, these ventures exhibit the highest 3-year CAGR in users reached (193%). In terms of scale, ventures serving healthcare providers outperform the other sub-cluster, with larger scale (1.2m vs. 975k) and higher growth rates (312% vs. 104%).

Along with outreach growth, Cluster 3 ventures demonstrate strong financial growth, achieving a very high 3-year revenue CAGR of 284% and a moderate yearly earned revenue of USD610k in the last year of data collection. That growth comes at the cost of profitability, which is dampened by a very high overhead ratio (-351%) and negative net margin (-250%). This challenge is also visible in the low percentage of ventures that have historically reached breakeven (25%), though all those that did have maintained it. Additionally, these ventures have the longest projected timeline to breakeven, averaging 6.5 years from inception. Differences between the sub-clusters are negligible: the sub-cluster focusing on healthcare financing achieves higher revenue (USD824k vs. USD255k in the other sub-cluster) and growth rates (304% vs. 250%), whereas the sub-cluster serving healthcare providers shows better net margins (-216% vs. -270% in the other sub-cluster) and a higher percentage of ventures reaching breakeven (33% vs. 20%).

Lastly, while these ventures average five years in operation, they exhibit the highest financial needs of all. On average, ventures in this cluster have raised USD2.9m funding cumulatively and require USD519k in external funding yearly to operate and grow. Here, however, there are significant differences between the sub-clusters: ventures offering technology solutions for healthcare financing significantly skew the averages by recording much higher amounts of total funds raised cumulatively (USD3.7m vs. USD2m in the other sub-cluster) and a need for more external funding yearly to operate and grow (USD670k vs. USD330k).

Users and impact

Assessing the impact of ventures in Cluster 3 is more challenging than for the other clusters because they are further removed from end users. They primarily benefit B2B clients, and the extent to which those benefits are passed on to end users is not measured.

Inclusivity:

While the clients of ventures in this cluster are organisations, the end users are the people served by those organisations. In this section, we look at the end users' profiles. First, one sees some notable differences in terms of socioeconomic status. The ventures offering solutions to healthcare operators indirectly serve more users from rural areas and informal settlements (93% and 7% of end users, respectively, vs. 6%⁵² and 0% respectively in the other sub-cluster). This can be explained by the fact that higher-end, urban medical providers are already well served and the ventures in this study specifically aim to offer bespoke solutions to medical providers operating in rural or low-income areas. On the other hand, users living in informal urban settlements constitute a marginal share of end users in both sub-clusters.

Figure 25
End users' profiles



Relevance:

Affordability: The impact on the prices of healthcare services or financial products for the end users differ per sub-cluster. While 60% of the ventures offering technology for healthcare financing have a medium impact on the prices paid by the end users, 50% of ventures focusing on technology for healthcare delivery have a high impact on prices as they often provide services to end users for free, with the costs covered by external funders (eg screenings).

Accessibility: The ventures improve healthcare accessibility by enabling access to insurance, telemedicine, screening events, campaigns and messaging interfaces or by partnering with community-based organisations to reach underserved populations. A third of them (all in the sub-cluster serving healthcare operators) also leverage CHWs to engage patients and/or connect them with the technological interface. As a result, 75% of the ventures serving medical operators improve accessibility significantly, while the same is true for only 20% of the ventures in the other sub-cluster.

⁵² This data was only available for 40% of the ventures in this sub-cluster, making it less representative.

Benefits created:

Health outcomes: 75% of the ventures serving medical providers have a moderate impact on health outcomes (vs. none in the other sub-cluster), notably thanks to the provision of basic healthcare (often through CHWs), technology resulting in better medical records management, streamlined care protocols or better drug stock management.

Net additional value (NAV): Since the ventures in this cluster rarely provide direct, tangible benefits to end users, they achieve a low average NAV of USD1.3. Nonetheless, as some also provide healthcare services directly to end users, the average NAV of the ventures offering technology solutions for healthcare delivery is higher, reaching USD4.3 (vs. USD-0.5, on average, among the ventures offering technology solutions for healthcare financing⁵³).

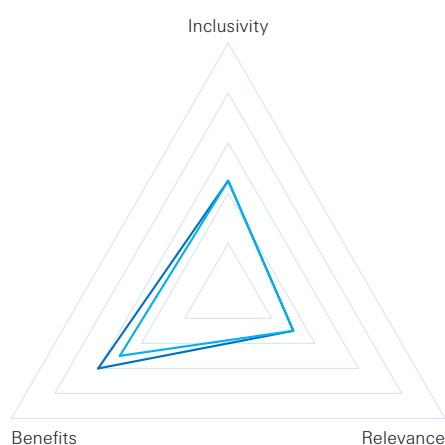
Financial resilience: The impact on the financial resilience of end users depends on the sub-cluster: 40% of the ventures offering technology for healthcare financing increase the financial resilience of end users (vs. none in the other sub-cluster), as they often improve the accessibility and cost-effectiveness of financial solutions or provide their own insurance-like products.

Usage: Ventures in this cluster, especially those that provide solutions for healthcare financing, tend to struggle to quantify adoption, penetration and retention by end users of the offered technological products. This dimension is ultimately dependent on the healthcare delivery and performance of their B2B clients.

Figure 26

Overview of performance across impact dimensions

- **3.a** Technology for healthcare delivery
- **3.b** Technology for healthcare financing



⁵³ This data was only available for 40% of the ventures in this sub-cluster, making it less representative.

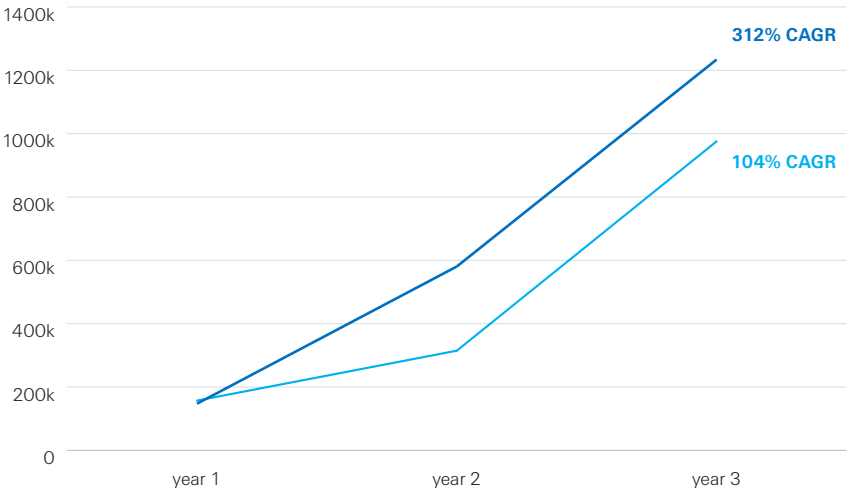
Scale and scalability

Outreach and outreach growth:

Since technology-based products require relatively low marginal costs to scale and acquire large numbers of end users by serving B2B clients, they tend to exhibit high growth in terms of end users (indirectly) served and geographical area covered. With 67% of the ventures having expanded internationally, these ventures serve 1m users per year on average and record a 3-year CAGR of 193%. However, the sub-cluster focusing on solutions for healthcare delivery serves more users per year (1.1m vs. 976k for the other sub-cluster) and shows a higher 3-year CAGR (312% vs. 104% in the other sub-cluster).

Figure 27
Average number of end users served per year, over three years

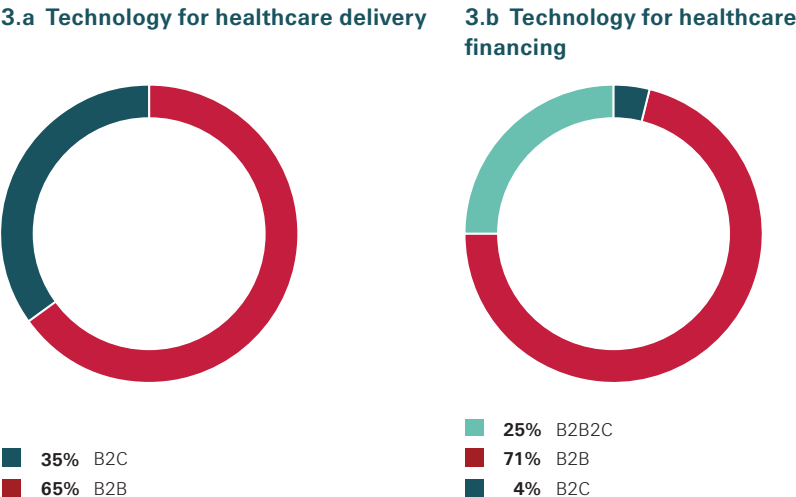
- 3.a Technology for healthcare delivery
- 3.b Technology for healthcare financing



Scaling and user acquisition strategy:

Of the ventures in this cluster, 75% rely fully on B2B channels for outreach. Some ventures also offer services to the users of their B2B clients. When they do so, they leverage B2B2C partnerships (12.5%) or CHWs to conduct door-to-door enrolment (12.5%). Thanks to their outreach model and the low marginal costs inherent to digital products, ventures in Cluster 3 have very low user acquisition costs, ranging from USD 0.4 to 1.6 per user.

Figure 28
Average proportion of users acquired by outreach channels



Most of the users of the ventures in this cluster come from the B2B channel (69%). These are the existing end users of the B2B clients and the ones that the B2B clients acquire while working with the ventures, while the remaining ones are split between B2C (17%) and B2B2C (14%). Since the ventures that offer solutions for healthcare delivery tend to have more services directly targeted at end users, they put more emphasis on the B2C channel (with 35% of users coming from this channel, on average, vs. 4% for the other sub-cluster), whereas more users of the ventures offering solutions for healthcare financing come from the B2B2C channel (25% vs. 0%).

Financial sustainability

Revenue model and diversification:

Of the ventures in this cluster, 66% are for-profits, 22% adopted hybrid legal structures and 11% are not-for-profit organisations. Non-profits are excluded from the financial sustainability analysis below due to their distinctive mission-driven focus and financial structures.

As it is often the case with technology companies, the ventures use different revenue models, such as software licensing (one-time or recurrent), commissions on services facilitated, sold or used through the platform provided or project-based revenue (eg with a corporate or donor-paying for service delivery in each area).

Most revenue comes from the B2B channel (58% of total revenue, on average), followed by B2C (25%) and B2B2C (17%), in line with the outreach strategies adopted across the sub-clusters. Solution providers for healthcare delivery earn more revenue from the B2C channel (on average, 53% vs. 12% in the other sub-cluster), while ventures in the financial services sub-cluster rely more on B2B2C channels (25% vs. 0% in the other sub-cluster).

Earned revenue levels and growth:

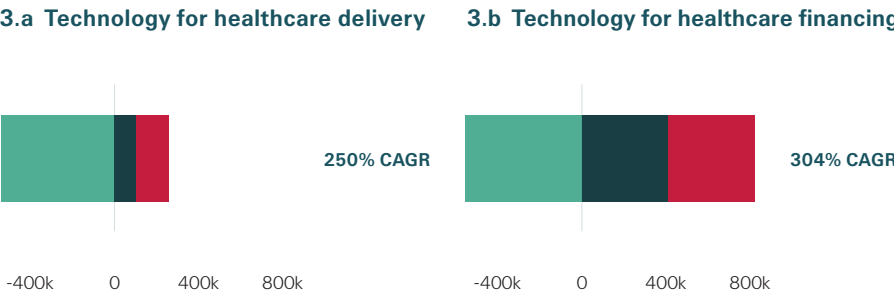
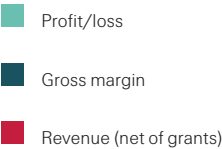
Ventures in Cluster 3 earn less than those in Cluster 1 and more than Cluster 2, with an average of USD610k per year. On the other hand, their revenue is growing fast, achieving a 3-year revenue CAGR of 284% (vs. 115% in Cluster 2). The ventures offering solutions for healthcare financing outperform the other sub-cluster, achieving a significantly higher level of revenue (USD824k vs. USD255k) and a higher 3-year revenue CAGR (304% vs. 250%), possibly driven by differences in the type of B2B clients served (medical providers like clinics and clinic chains form a more fragmented sector, constituted of smaller players, than insurance players active in the same markets).

Profitability/financial viability:

This cluster records relatively large losses (on average, USD-550k per year), despite their products’ comparatively low cost-to-serve (on average, USD0.5), given their high overhead ratio (351%). In terms of profitability, neither sub-cluster clearly outperforms the other, as the sub-cluster focusing on solutions for healthcare financing has slightly better gross margins (50% vs. 40% in the other sub-cluster), while the sub-cluster focusing on solutions for healthcare delivery records slightly better net margins (-216% vs. -270%).

A quarter of the ventures in the cluster reached breakeven at some point. This proportion is similar across sub-clusters (33% in the solutions for healthcare delivery sub-cluster vs. 20% in the other sub-cluster), and all the ventures that reached breakeven managed to maintain it. Similarly, the average time needed to become profitable is 6.5 years in both sub-clusters. Nonetheless, the scale needed to reach breakeven is vastly different across sub-clusters because ventures providing technology for healthcare delivery require on average three times as many users as their counterparts in the other sub-cluster (12m vs. 4m), as per the projections they provided.

Figure 29
Revenue (net of grants), gross margin, net profit/loss (USD) and 3-year revenue CAGR



Reliance on grant funding:

Of the ventures in this cluster, 55% received no grant funding in the years during which data was collected, and on average grants represent only 10% of their total revenue. This suggests that ventures in this cluster generally manage to finance their operations and growth through debt or equity.

Additionality of support

Years in operation:

Ventures in this cluster are relatively mature, with an average of six years in operation for the ventures providing technology for healthcare delivery and five years for the ventures offering technology for healthcare financing.

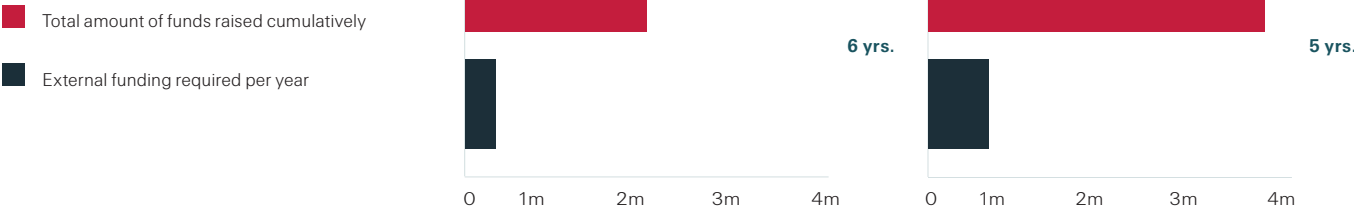
Fundraising track record:

The ventures in this cluster have managed to raise significant amounts of funding, averaging USD2.9m cumulatively per venture. However, there are big differences at the sub-cluster level, as the ventures offering technology solutions for healthcare financing raised almost two times more funding than those focusing on technology for healthcare delivery (USD3.7m vs. USD2m, on average).

Reliance on external funding:

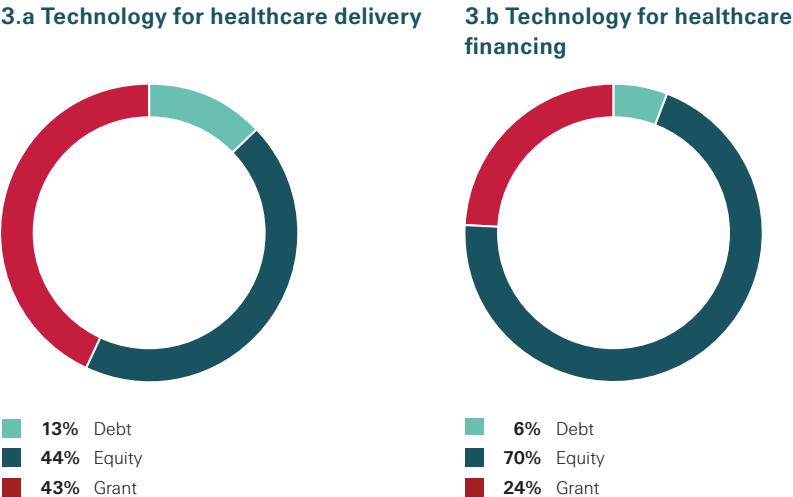
The ventures offering solutions for healthcare financing also need more external funding per year to operate and grow (USD670k vs. USD330k for the other sub-cluster).

Figure 30
Average cumulative funding raised so far, external funding required per year (in USD), and average years in operation



Equity constitutes the most common type of funding for both sub-clusters, followed by grants and debt. That said, the proportion of equity is much higher for the ventures offering solutions for healthcare financing (70% vs. 44% in the other sub-cluster). All these differences might stem from the perceived potential of fintech ventures among both impact and traditional investors.

Figure 31
Split of external funding cumulatively (on average) by type of funding



Financial and non-financial needs of ventures:

To continue growing, these ventures require a significant amount of financing every year. Typically, they look for hybrid financing, equity, or grants, and rarely for debt. Nonetheless, many report struggling to find the right investor as they are usually too established for early-stage funding but not large enough to attract larger tickets.

Since the ventures in this cluster build their business model around scale to reach profitability, these ventures usually focus on dynamic growth as their main priority and the scaling strategy to boot. In addition, around half of the ventures also aim to improve the technology (eg by incorporating AI for automatization or data analytics), introduce new products or monetize their (extensive) data sets. Among the ventures offering technology for healthcare delivery, 75% aim to also introduce healthcare financing solutions (while 25% already have such a solution), despite possibly lacking expertise in this area.

Considering the metrics where this cluster performs less well than the others, it would be important to offer these ventures support on the following topics:

For the cluster at large:

- How to improve inclusivity, by pushing distribution in rural areas or informal urban settlements or by selecting B2B clients active in those areas (eg public schemes)
- How to ensure that the benefits created for B2B clients trickle down to users, notably in terms of affordability and accessibility, by negotiating different types of partnerships with these B2B clients (eg co-designing some elements of the value proposition offered to end users)
- How to improve profitability, by rethinking the revenue model and making it less reliant on massive scale to pay back investments made in technological product development

For ventures in the sub-cluster offering technology solutions to healthcare providers:

- How to rethink the value proposition to put more emphasis on improving the financial resilience of end users

For ventures in the sub-cluster offering technology solutions to financial players:

- How to rethink the value proposition to put more emphasis on improving health outcomes of end users

Another important area of support would be impact measurement, as – despite being tech- and data-oriented – few of the ventures in the cluster convincingly track or seek to track the impact and benefits created for their immediate B2B clients and end users.

Conclusions and recommendations

The ventures analysed in this study are instrumental in filling gaps in healthcare infrastructure and medical personnel, in reducing financial barriers to paying for healthcare and in leveraging technology to enhance service delivery. By focusing on underserved populations, they contribute to more equitable healthcare systems and improve health outcomes for millions of people who would otherwise be left behind.

Based on the findings of this study, donors and investors who seek to improve healthcare accessibility should keep the following considerations in mind, depending on their own priorities and strategy:

- **Sub-cluster 1.a: Centralised healthcare provision:** records high impact but demonstrates limited potential in scaling outreach and financial sustainability. These ventures might require a constant stream of external funds to operate and grow, making them suitable for donors who prioritise deep impact over financial performance.
- **Sub-cluster 1.b: Decentralised healthcare provision:** scores highest in terms of impact and financial sustainability. These ventures achieve significant impact, scale and revenue while maintaining above-average financial sustainability and relatively low dependence on external funding, indicating a high potential for additional investments to improve their trajectory.
- **Sub-cluster 2.a: Third-party product underwriting:** records medium levels of impact and a relatively small user base, despite the ventures operating an average of seven years. Yet these ventures feature the best net margins of all sub-clusters in the study. Historically, these ventures have raised relatively little external funding and demonstrate relatively strong sustainability, possibly calling for more support in forging a path to scale.
- **Sub-cluster 2.b: In-house product ownership and/or underwriting:** counts the youngest ventures in the study, which in turn record the smallest user bases but promising user growth rates. Overall, it displays medium impact and sustainability. It also stands out for raising the least external funds, indicating a high potential for additional investments to fuel innovation and growth.
- **Sub-cluster 3.a: Technology solutions for healthcare delivery:** achieves the biggest outreach and the highest user growth rates (albeit users are mostly reached indirectly). Its impact is moderate and indirect. So far, it also shows limited financial sustainability and thus high dependence on external funding. As such, it could be targeted by patient-capital investors who prioritise outreach over depth of impact.
- **Sub-cluster 3.b: Technology for healthcare financing:** also records significant outreach and user growth rates. However, the impact is limited and indirect, and financial sustainability is uncertain. Yet this sub-cluster raised cumulatively the most funding, on which it is highly dependent. It may be that investors prioritising such ventures are more mainstream and tech-focused.

Finally, while ventures within a cluster share overall approaches and intervention models, there may be differences among ventures within a given cluster on specific dimensions. This is particularly true of ventures in Clusters 2 and 3, which show high performance variability, pointing to a need for thorough due diligence to identify those with the most potential. In contrast, Cluster 1 is more homogenous (except for a few positive outliers in sub-cluster 1.b).

Methodology

This study covers ventures that participated in the Entrepreneurship for Resilience Award programme between 2019 and 2024 and were ranked among the top 6 contenders in their respective edition. In total, 26 ventures were included (61% based in Africa, 19% in Asia, 12% in the Americas and 8% global). For each venture, our dataset includes over 150 data points across six key dimensions: product and value proposition, users and impact, scale and scalability, financials, fundraising challenges and needs.

Since the purpose of this study is to leverage this wealth of data in a synthetic and comparative manner, the ventures were first clustered according to their underlying models of intervention. For the analytics, four key dimensions were prioritised: users and impact, scale and scalability, financial sustainability and additionality of support. These reflect the typical concerns of impact investors as well as philanthropic donors with a strong concern for (financial) sustainability, such as the Swiss Re Foundation. For each of these dimensions, the study builds on a large array of indicators, most quantitative and some qualitative, which provide a multi-faceted understanding of the strengths and weaknesses of each cluster beyond how each fares on individual metrics.

Overall, the dataset spans the years 2016 to 2023, usually with three years of consecutive yearly data available for each venture, depending on which E4RA edition they participated in. As a result, the most recent data is available for ventures participating in the 2024 edition, while ventures from the 2019 edition have data that is older. In Q2 2024, we conducted a follow-up survey to collect 2023 data on key metrics from all 26 ventures covered in the study to capture their trajectory since they were selected as top 6 E4RA contenders⁵⁴.

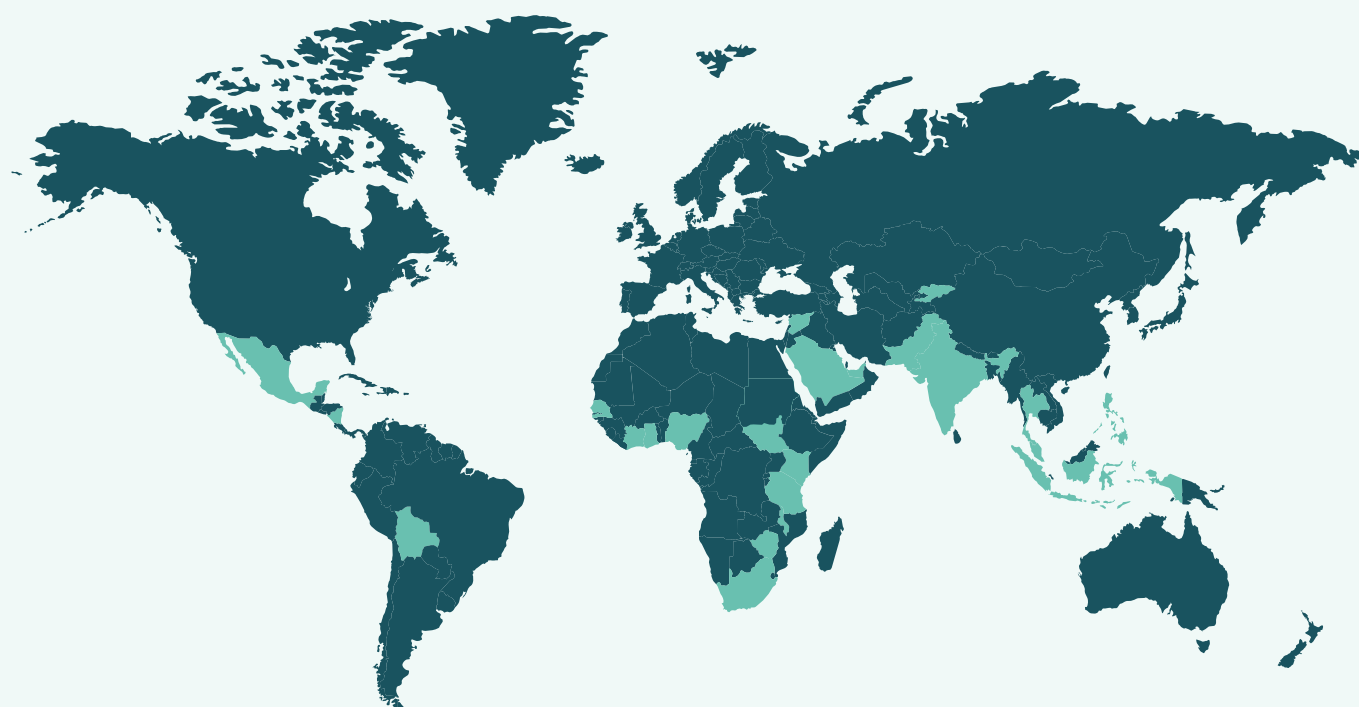
While this study is based on a rich, verified set of data, some methodological considerations need to be highlighted:

- **Sampling and representativeness:**
This analysis is based on data from 26 ventures, with high representation from Sub-Saharan African ventures (58%). Also, sub-clusters 2.a or 2.b counted only three ventures each. Finally, the ventures that reached the top six of the E4RA competition are arguably higher performing, and therefore not representative of, all ventures in the sector.
- **Clustering:**
While clustering is useful for analysis, some ventures do not fit perfectly into those boxes. This is especially true of those with holistic approaches, which could be classified as a venture offering technology for healthcare delivery or a venture providing healthcare using a decentralised approach.
- **Data consistency:**
Not all data points were available for each venture, notably on the usage and impact dimensions. In addition, Clusters 2 and 3 show higher variability in terms of performance, making the averages more difficult to interpret than in Cluster 1.
- **Temporal considerations:**
For many of the ventures, the data spans a period that includes the COVID-19 pandemic, which dramatically disrupted the healthcare sector as well as businesses in general. With this context, the long-term sustainability and adaptability of these ventures remain uncertain.

⁵⁴ 2023 data is available for 16 of the 21 ventures from pre-2024 editions (in addition to the 5 ventures from the 2024 edition).

Figure 32

Ventures participating in the study by main country of operations



Africa:

Access Afya (Kenya)
GICMED(Cameroon)
Streamline (Uganda)
CarePay (Kenya)
Inclusivity Solutions (South Africa)
Wellahealth (Nigeria)
CheckUps (Kenya)
Health Direct Global (Ghana)
ZimbosAbantu (Zimbabwe)
clinicPesa (Uganda)
MicroInsurance Services (Malawi)
Cliniva (Kenya)
NucleusIS (Nigeria)
CribMD (Nigeria)
OneDay Health (Uganda)

Americas:

Clinicas del Azucar (Mexico)
Estacion Vital (Nicaragua)
Innovasalud (Bolivia)

Asia:

Intelehealth (India)
MedoPlus (India)
Naya Jeevan (Pakistan)
Sehat Kahani (Pakistan)
Sevamob (India)

Global:

Democrance
reach52

Appendix 1: List of ventures included in the study

Sub-cluster 1.a: Centralised healthcare provision

Access Afya (<https://www.accessafya.com>) operates a network of 16 local franchise clinics catering to low-income patients in informal settlements and peri-urban areas of Nairobi, Kenya. At the clinics, patients can access a wide range of primary care services, including consultations, basic tests and medication. The venture also offers teleconsultations and self-screening services through an app and a membership plan for its patients.

Clínicas del Azúcar (<https://clnicasdelazucar.com>) runs a network of 46 specialist clinics across 20 states in Mexico. It combines clinical, behavioural and psychological interventions to provide holistic access to diabetes and hypertension care. The venture offers monthly membership plans, increasing access to specialised care for the middle- and low-income population.

Cliniva (<https://mycliniva.com>) delivers affordable, quality primary and preventive healthcare to low- and middle-income Kenyans, with a focus on women. It operates two nurse-led mini-clinics in Nairobi, providing in-person consultations, diagnostic tests, medications and teleconsultations. The venture also launched a membership plan for its patients.

Estación Vital (<https://www.estacionvital.com>) operated four healthcare kiosks in Managua, Nicaragua, offering users access to various free and paying medical preventative tests, affordable over-the-counter health products and a medical freemium app subscription, including information on a wide range of health topics and access to teleconsultations. It stopped operating in 20xx.

Innovasalud (<https://www.innovasalud.bo>) runs a network of 31 primary care clinics across 15 cities in Bolivia, focusing on serving low-income, informal workers. It puts a strong emphasis on preventive care and behaviour change. Clinics offer consultations and selected tests and medication. Innovasalud also offers prepaid health plan bundles for its patients, often distributed in partnership with microfinance institutions.

OneDay Health (<https://www.onedayhealth.org>) runs a network of 45 primary healthcare clinics in extremely remote and underserved communities of rural Uganda with the goal of facilitating access to quality healthcare. The clinics are equipped with key medical supplies, diagnostic tools and drugs. Each clinic is led by a nurse trained to follow standardised clinical protocols. The clinics offer low-cost preventative care, primary, chronic and antenatal care and family planning services.



Sub-cluster 1.b: Decentralised healthcare provision

CheckUps COVA (<https://www.checkupsmed.com>) provides affordable outpatient care in Kenya and South Sudan, through a combination of five physical clinics (delivering primary care, diagnostics and medication purchase), at-home services (eg screenings, medication delivery and consultations), telemedicine and pharmacy. The venture also offers a membership product for its patients.

GICMED (<http://gictelemed.org>) leverages innovative, context-adapted technologies to provide remote cervical and breast cancer screenings and health education to women across Cameroon. Thanks to its technology, patients' information is streamlined, enabling medical specialists to offer remote diagnostic and treatment recommendations.

Sehat Kahani (<https://sehatkahani.com>) operates a digital health platform that connects doctors with patients to provide consultations, diagnostics and medicine delivery for low-income communities in Pakistan. It leverages female doctors across 63 e-clinics (ie local nurse-led clinics equipped for online consultations, diagnostic and e-pharmacy). The clinics offer a range of primary and preventive care. Sehat Kahani also offers a telemedicine app catering to middle- and high-income users.

Sevamob (<https://sevamob.com>) offers healthcare services such as screening, triage and consultations to vulnerable populations through health camps, telemedicine services and permanent clinics. It leverages a digital disease management platform that includes AI-powered diagnostic tools for general health, nutrition, cardio-metabolic health, infectious disease and vision as well as electronic medical records and a telemedicine solution.

ZimbosAbantu (<https://zimbosabantu.co.zw>) operates five mobile clinics, catering to the stigmatised, low-income and underserved communities of informal settlements in Harare, Zimbabwe. The clinics operate out of repurposed buses equipped with basic medical equipment, powered by solar energy and staffed by trained nurses. Clinics provide a range of primary curative and preventive care, screenings, sexual and reproductive care and health education. The venture also offers health membership plans to its patients.



Sub-cluster 2.a: Third-party product underwriting

MicroInsurance Services (MIS) (<https://www.microinsurance.mw>) designs and distributes inclusive insurance products to rural, vulnerable populations in Malawi, with the goal of facilitating access to healthcare financing. The venture offers a B2C health and life insurance product through digital channels and community mobilisers (which includes payouts for malaria, childbirth, hospitalisation, disabilities and death) and a B2B2C life and health insurance product bundled with loans granted by microfinance institutions. Policyholders can request medical advice via SMS or toll-free voice calls and receive feedback from a doctor within 24 hours.

Naya Jeevan (<https://naya-jeevan.com>) distributes health insurance plans to corporations and SMEs employing low-income workers across nine cities in Pakistan. The insurance plans are customised to each client and typically cover inpatient and outpatient care. Outpatient services are delivered through Naya Jeevan's sister telemedicine company doctHERs.

Wellahealth (<https://www.wellahealth.com>) offers innovative microinsurance products for common illnesses such as malaria, which covers consultations, tests, (discounted) drugs, telemedicine and educational content. The cover is serviced through a network of over 2k partner pharmacies across Nigeria and third-party telemedicine providers.

Sub-cluster 2.b: In-house product ownership and/or underwriting

clinicPesa (<https://clinicpesa.com>) improves financial access to healthcare through an e-saving solution for medical expenses in Uganda. Its digital saving wallet can be used at over 2.7k medical facilities and pharmacies across Uganda. If the saved amount is insufficient to cover the bill, clinicPesa also offers low-interest microloans, which can be accessed directly via phone.

CribMD (<https://www.cribmd.com>) designs and provides various low-cost insurance products to underserved populations in Nigeria. The cover includes teleconsultations, home visits, drugs and outpatient and inpatient care. It also offers electronic medical records software to medical providers.

Hadiel Health Cooperative (<https://hadiel.com.ng>) designs and distributes innovation group insurance-like products for low-income populations in Nigeria, whereby individual subscribers use a portion of the collective coverage. The cover includes primary care services, teleconsultations and preventive care services.



Sub-cluster 3.a: Technology for healthcare delivery

Intelehealth (<https://intelehealth.org>) combines technology provision and on-the-ground support to strengthen telemedicine capabilities of medical providers (largely public, but also non-profit) serving remote communities of India, Kyrgyzstan and Syria. It operates an open-source, AI-powered clinical decision support system and healthcare management platform that facilitates screenings, teleconsultations and data collection between frontline healthcare workers and remote doctors.

MedoPlus (<https://medoplus.in/home>) operates a digital platform that connects rural patients with healthcare medical providers (for primary, secondary and tertiary care) in India. The platform allows users to map their symptoms, find appropriate specialists and book virtual or in-person appointments at discounted prices through digital payment. The venture works with a network of local health agents, who assist patients in navigating the healthcare system.

reach52 (<https://reach52.com>) offers health interventions (including health worker training, mass-scale health education and screening campaigns) in underserved communities of low- and middle-income countries, subsidised by businesses, governments and social organisations. It does so through an extensive network of trained CHWs, equipped with an app that allows them to collect data, track implementation and impact. It also distributes medicines in underserved communities.

Stre@mline (<https://streamlinehealth.org>) offers a healthcare management information software designed for facilities operating in low-resource, rural settings of Uganda. The software supports users with patient registration, electronic medical records, stock management and billing, along with patient safety measures and embedded medical resources. The solution also includes a module to digitalize and manage community health insurance schemes, which the venture helps design and grow.



Sub-cluster 3.b: Technology for healthcare financing

CarePay (<https://www.carepay.com>) operates a platform connecting insurers, healthcare providers and individuals in Kenya, Nigeria and Tanzania. For individuals, it offers savings wallets, which can also be funded with external contributions (eg vouchers). For insurers, it helps administer, automate and manage any type of health scheme or insurance to ensure that funds meant for healthcare are spent by the right person, for the right care, at the right place, as well as to reduce costs of administrating health schemes and insurance.

Democrance (<https://www.democrance.com>) is a global software company offering digital insurance solutions to digitalise the insurance value chain (including patients, third-party distributors and payers). It enables insurers and distribution partners to increase efficiencies, lower operational costs and make insurance more accessible across markets.

Health Direct Global (<https://www.linkedin.com/company/health-direct-global>) operates a platform that serves and connects patients, healthcare providers, and healthcare payers in Ghana. Services include: saving wallets and health insurance for end users, an electronic medical records software for medical providers, and a claim management software for payers.

Inclusivity Solutions (<https://inclusivitysolutions.com>) is a global venture that offers an AI-powered open API platform to connect the digital insurance ecosystem. It connects non-traditional distribution partners with insurance companies and digitalises client acquisition, policy administration, claims processing and marketing activities, with a view to reduce the cost of insurance. It also supports payers in developing affordable and accessible protection products for low-income populations.

NucleusIS (<https://www.nucleusisafrica.com>) offers an omni-channel digital platform to connect payers, medical providers and patients in Nigeria and Ghana, with a view to drive the adoption of healthcare financing solutions among underserved populations. It enables payers to exchange information with medical providers and patients and partly automates enrolment of subscribers as well as claim management operations. Besides the platform, the venture also piloted credit and savings schemes for both end users and medical facilities and acts as an insurance distributor for its clients' products.



Appendix 2: Overview of selected quantitative metrics per sub-cluster

	Sub-cluster 1.a Centralised healthcare delivery (6 ventures)	Sub-cluster 1.b Decentralised healthcare delivery (5 ventures)	Sub-cluster 2.a Third-party product underwriting (3 ventures)	Sub-cluster 2.b In-house product ownership and/or underwriting (3 ventures)	Sub-cluster 3.a Technology for healthcare delivery (4 ventures)	Sub-cluster 3.a Technology for healthcare financing (5 ventures)
Users and impact						
% of users living in the informal urban settlements	10%	39%	45%	48%	7%	0%
% of users living in the rural areas	34%	55%	30%	70%	93%	6%
Net Asset Value (NAV)	8.60	11.50	3.23	- 17.20	4.30	-0.50
Scale and scalability						
Number of users served per year (rounded to '000)	53 000	170 000	37 000	12 000	1 128 000	976 000
3-year compounded annual growth rate (CAGR) in the number of users served per year	64%	22%	75%	121%	312%	104%
Financial sustainability						
Earned revenue in the last year of data collection (rounded to '000)	1 752 000	873 000	268 000	66 000	255 000	824 000
3-year compounded annual growth rate (CAGR) in earned revenue	115%	83%	115%	115%	250%	304%
Net margin	-200%	-52%	-77%	-122%	-216%	-270%
(Projected) time to break even	8.30	3	7.50	2.50	6.70	6.40
% of ventures that historically broke even	20%	60%	67%	33%	33%	20%
% of grants in the total revenue	19%	33%	34%	10%	5%	8%
Additionality of support						
Total funding raised (rounded to '000)	3 601 000	1 225 000	1 293 000	868 000	1 978 000	3 656 000
External funding required per year (rounded to '000)	453 000	227 000	146 000	257 000	330 000	670 000
Years in operation	5.83	4.80	7.33	3.33	6.25	4.80

About the authors



This study is the result of a longstanding collaboration between the Swiss Re Foundation, which, through its Entrepreneurs for Resilience Award programme, has supported dozens of high-potential social ventures dedicated to enhancing healthcare-related resilience in underserved communities worldwide, and LeFil Consulting, a strategy consulting firm. The Award is a cornerstone initiative of the Foundation, aimed at identifying and nurturing innovative entrepreneurs through financial support and technical assistance. LeFil Consulting conducted the research for this study and plays a key role in identifying, selecting and providing ongoing support to the Award's winners.

LeFil Consulting is a mission-driven strategy and management consulting firm specialising in the identification, design, growth and replication of innovations that create social and economic value sustainably and at scale. LeFil works globally with start-ups, large corporations, donors, NGOs and governments. Leveraging rigorous business methodologies, top-tier consulting skills and extensive first-hand data collection, LeFil aims to solve social problems in cost-effective, innovative and focused ways. Our assignments span diverse sectors, including housing, energy, water, sanitation, financial services, health, education, retail, nutrition, economic development, job creation and agriculture, making substantial impacts in communities worldwide.

The Swiss Re Foundation is dedicated to building resilient societies by collaborating with partners and leveraging the expertise of Swiss Re employees. With a mission to create measurable and sustainable impacts, the Foundation focuses on climate risk management, natural hazards and access to health in targeted developing regions and countries where Swiss Re operates. Through evidence-based grant funding, tailored financial support and capacity-building initiatives, the Foundation empowers its partners to prototype, scale and transform how societal challenges are addressed. Its Entrepreneurs for Resilience Award programme highlights and supports innovative entrepreneurial solutions that increase healthcare accessibility for underserved populations worldwide.

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