Health Insurance Fund

Annual Accounts 2020

1 July 2021

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Management Board Report

1. Introduction

Twenty twenty has been a year like no other in testing our resolve to achieve universal health coverage (UHC). Over two million people have lost their lives, and many more their livelihoods as a result of the COVID-19 pandemic. The virus and containment measures have resulted in one of the worst global economic shocks in history. The World Bank estimates 71-100 million people will be forced into poverty, pushing many governments around the world to reassess their commitments to the Sustainable Development Goals (SDGs) as they battle to resuscitate their economies.

In Africa, the health sector has been dealt a harsh blow by the pandemic as financial and operational challenges have stalled and delayed many development initiatives. This amplifies the necessity to implement bold economic policies and interventions, including stronger health systems, private sector development and innovations, not only to reach those who are financially excluded but also in terms of pandemic interventions and preparedness.
Over the past year, Health Insurance Fund through PharmAccess has pursued working towards making inclusive health markets work. We have continued to provide loans to healthcare providers through the Medical Credit Fund (MCF) whilst many financial institutions closed up shop. In some cases, MCF restructured loans so that struggling health facilities could remain open during the pandemic. In Nigeria, the Kwara State Health Insurance Scheme started enrollment in September, whilst in Lagos almost 300,000 people have registered for the state's health insurance scheme. In Kisumu County, Kenya and Zanzibar, Tanzania the groundwork was laid for a real shift towards more sustainable, social insurance-based models for reaching UHC.

In these difficult times we have seen that there is a growing demand for health insurance, and the urgent necessity to improve quality of care, like patient safety and infection control. With that in mind, SafeCare has moved to a next phase, exploring how it can expand the adoption of quality standards and certification to grow its impact beyond Africa by starting in Afghanistan and India.

Our 'affiliated' organizations, who were initiated by PharmAccess but are now governed and financed independently, have also made important progress. The Joep Lange Institute (JLI) has been advocating for digital health and responsible data use, and their work done in Cameroon on Hepatitis C is an example of how outcome-based payments for health facilities can play an important role in driving quality healthcare in the future. Meanwhile, our partners CarePay and Safaricom received recognition for their joint work on M-Tiba, with the latter ranked 7th by Fortune for companies that are 'changing the world' in 2020.

As vaccine roll out early 2021 has raised hopes for recovery throughout Europe and the West, the cost of financing such a vaccine in hard hit African economies as well as the complex planning and logistical operation to deliver it will mean the continent may need to wait longer before pandemic restrictions are fully lifted. We must ensure equitable access to vaccines so that everyone at risk, anywhere in the world is protected. In the meantime, we have implemented technology-driven interventions to cope with the rapidly unfolding crisis.

The novel coronavirus has reinforced the need for African countries to strengthen their health systems to ensure the delivery of basic quality health care services, address the impact of COVID-19 and prepare effectively for future pandemics. Health Insurance Fund is dedicated to strengthening health markets with digital technology so that people can access better services, lead healthier lives, and reach their full potential. Our work echoes the global call for universal health coverage, and we do this by mobilizing private and public resources, to reach those in even the most remote areas with affordable healthcare they can trust.

A brief history

The early work of PharmAccess partnering with the private sector on HIF treatment workplace programs revealed the broader financing and systems challenge in Africa. In 2006, PharmAccess, the Dutch Ministry of Foreign Affairs (MinBuZa) and several other multinationals created the Health Insurance Fund, tapping into private sector potential to better healthcare in Africa. PharmAccess acted as the implementing agency, while its sister organization AIGHD/AID conducted operational research. In 2015, following the positive evaluation by the Boston Consulting Group, MinBuZa refinanced the partnership for a further seven years.

Five Strategic Objectives were developed to guide our efforts in making inclusive markets work. In interventions spanning this period we will continue to:

1. accelerate health financing,
2. strengthen the quality of health services,
3. match demand and supply,
4. increase investment in healthcare, and
5. measure impact with research, evaluation, and advocate

Envisioning a virtuous cycle

At the Health Insurance Fund, a longstanding contextual analysis guides our Theory of Change. We believe that providing healthcare is a semi-public good where governments can meet the health needs of society. The reality remains, though, that only about half the world's population can access essential health services — which is why the private sector must play a role in delivering healthcare. This is especially true in Africa, where the private sector already delivers approximately 50 percent of health services.

Governments play a critical role in health sector development as only they can intervene at the required scale to enforce financial synergies, risk pooling, strategic purchasing and regulation. However, sub-Saharan Africa countries face challenges to finance, regulate, and enforce health policies. As a result, a large segment of the population, like those at the bottom of the pyramid, are on their own. So called 'free public healthcare' does not exist and there is little in the way of health insurance. Where insurance is available, the low quality and uncertain availability of health services discourage people from pre-paying for health. Pre-payment is still a challenging concept in the region, and many families face competing priorities for their limited resources. Because of this, most people pay out-of-pocket when they need care, and so millions risk being pushed into poverty due to unpredictable healthcare costs.

The high proportion of out-of-pocket expenditure combined with little trust in the health sector has led to low and unpredictable revenues for providers, which in turn prevents them from investing in the quality, scope, and scale of their services. Almost everything is post-paid. The resulting limited exchange and high transaction costs mean that banks and investors are generally unwilling to invest, especially at the lower end of the market. This leaves the healthcare sector with limited or no access to the capital required for inclusive growth. Therefore, the market remains stuck in a vicious cycle of low demand and poor supply.

PharmAccess and our partners (both public and private) aim to break this pattern by moving toward a virtuous cycle of trusted, inclusive markets that use private sector development to benefit low and middle-income groups. Through mobile technology and data, we are strengthening our interventions for better results and impact. The costs and time involved with administrating healthcare programs has been significantly reduced, and recent pilots have shown that fragmented sources of health financing can be unified through mobile health platforms. At the individual level, families and households can now be supported directly through their devices and smartphones — and can be reached at low marginal costs.

The approach

HOLISTIC: We believe in systems strengthening, while working on interventions at both the demand and the supply side of the market. To work towards the virtuous cycle, we support, through PharmAccess the development of public private social insurance schemes and aim to increase willingness to pre-pay for healthcare through risk-pooling mechanisms and to pave the way for investments in healthcare. With MCF to provide loans to the broad range of healthcare providers and companies in the health sector, SafeCare to develop quality standards for hospitals, and the AIGHD to conduct impact and operational research.

PARTNERSHIPS: Our implementing partner PharmAccess acts as a catalyst and enables local entities to do the same. For many activities, PharmAccess works with local implementers, including the private sector, technical assistance partners, banks, Insurance and telecommunication companies, medical equipment providers and pharmacy distributors. Our partnerships with governments, including national and state health insurance agencies and regulators, are fundamental to our ambitions and the sustainability of our impact.

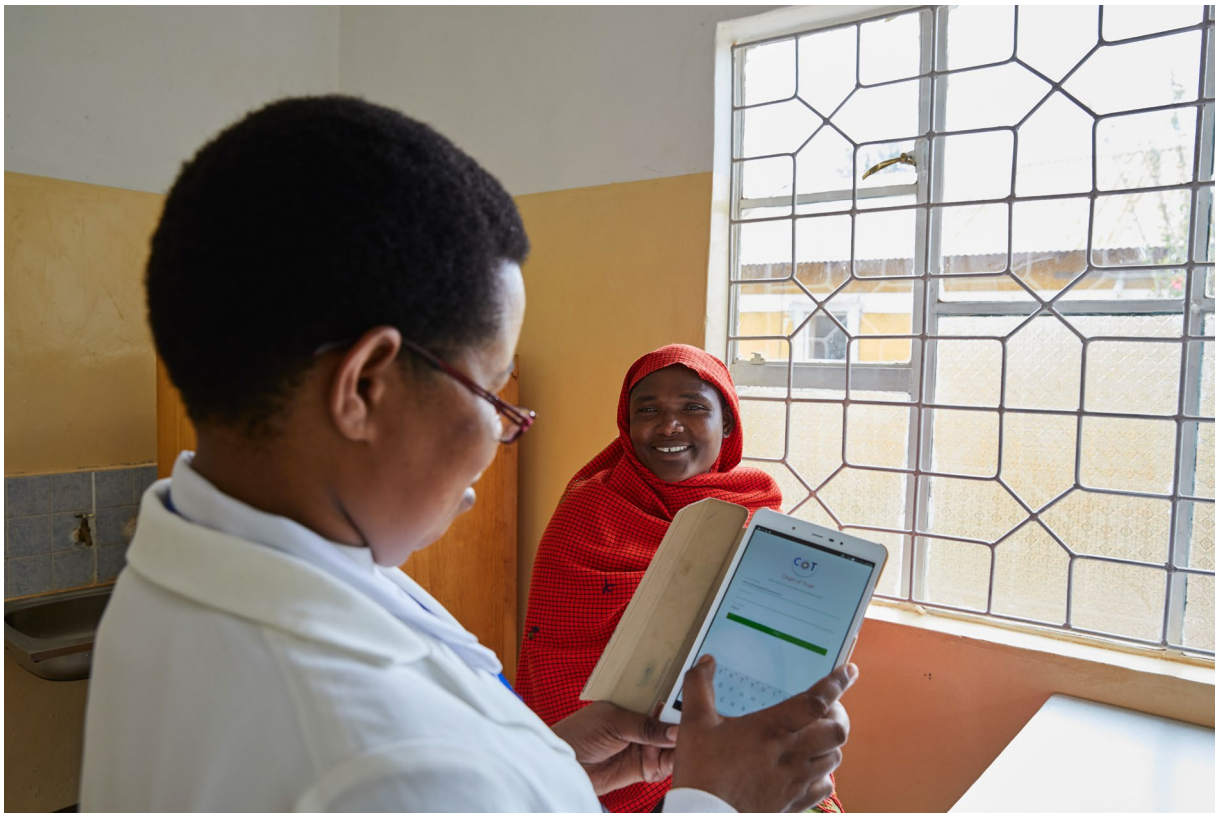
STARTING PRIVATE, GROWING PUBLIC: Strong partnerships are essential for making programs efficient and sustainable. Although health is a public responsibility, the private sector complements public efforts by providing innovative products and services, additional capacity, and financing for healthcare. We partner with the private sector to develop and test new approaches and initiatives to improve both healthcare financing and delivery. At the same time, we partner with the public sector to replicate and scale such innovations. Well-functioning PPPs in health are the basis for successfully attaining Universal Health Coverage.

INNOVATE: Mobile technology enables efficient pooling of financing and scaling of insurance at a low cost as well as providing data to improve healthcare delivery and outcomes. On the supply side, the services can be tracked to ensure quality standards at affordable prices which, in turn, increases public trust and drives demand. Information generated by electronic transactions improves transparency for all

stakeholders and allows healthcare providers to better understand their customers' needs. Digital health will empower citizens to take control of their own health.

Sustainable Development Goals

The 2030 Agenda for Sustainable Development was adopted by all United Nations member states in 2015 to provide a set of goals to end poverty, protect the planet and ensure prosperity for everyone. Health Insurance Fund contributes to these targets, especially (but not exclusively) Goal 3 on good health and Goal 8 on economic growth, by innovating with state-of-the-art technology and novel partnerships to create inclusive health markets in sub-Saharan Africa.



Our COVID-19 response

The coronavirus pandemic has amplified the fragility of sub-Saharan Africa's healthcare system. Most health posts, clinics and hospitals, already dealing with HIV, tuberculosis, and malaria as well as an increasing amount of non-communicable diseases, cannot withstand the onslaught of such a rapidly evolving public health emergency. They lack essential equipment like safety masks or personal protective equipment (PPE), approved test kits, and qualified staff to undertake effective triage and ensure infection control.

National lockdowns to contain the spread of the virus have been effective, but they have also created an additional barrier to accessing healthcare. The corresponding drop in patient numbers and revenue for private health facilities, which serve half of Africa's population, has meant many have had to scale down the services they provide or shut down altogether. This disproportionately affects the poorest and most vulnerable in society, further adding to their struggle to find quality healthcare that does not put them out-of-pocket.

To respond to the pandemic in Africa, Health Insurance Fund supported PharmAccess in devising a rapid deployment plan based upon our approach, which engages the public and the private sector and innovates using the latest communications technology.

The Medical Credit Fund (MCF), our impact loan fund, has responded to the cash crunch faced by many healthcare providers due to increased expenditure for COVID-19 (e.g., PPE) on top of working capital expenditure, despite the fall in income. MCF has offered on average 100 new loans per month during the pandemic. In 2020, MCF disbursed $30 million of COVID-19 loans, providing lenders with more flexible repayment terms in these challenging circumstances. Digital loan products like MCF's 'Cash Advance' that do not require face-to-face contact have an important role to play in maintaining services at such exceptional times.

Digital solutions have also helped us bring together patients and doctors when movement has been restricted. Together with Luscii, a Dutch technology company, PharmAccess implemented CovidConnect, a mobile service in Ghana, Nigeria, and Kenya. It enables individuals to assess their risks for COVID-19 and provides home monitoring and support from remote medical staff. Meanwhile, in Kenya, our MomCare service, a care analytics platform for pregnant mothers, has been adapted to cater for the pandemic.

In terms of infection prevention and control, we have built on our SafeCare service, a stepwise certification process to improve quality of health. The SafeCare4Covid mobile app prepares staff and facilities in coping with the COVID-19 pandemic. The app describes an approved triage protocol, gives detailed information on prevention and control, and provides training resources. All the materials are available online. To date, SafeCare4Covid has been downloaded in 765 facilities in all our four core countries and many others, some as far afield as Peru. The app may be adapted quickly for future pandemics, conflicts, or natural disasters.

Objective 1: Accelerating health financing

Trust is the key ingredient for creating demand in the health sector and achieving universal health coverage (UHC). By showing people that their health system can provide quality and affordable care we can increase the willingness to participate in health insurance schemes, and thus reduce the out-of-pocket costs that so often lead to financial ruin on the African continent, and around the world. Health Insurance Fund supports such risk pooling mechanisms, where participants receive care for a pre-payment by themselves or (with) third parties such as government subsidies, remittances, employers, or donor funding.

Mobile phones can help reach more people at lower marginal costs, and the data generated by such technology can be used to identify gaps in and improve services, while ensuring that nobody is left out. This increased transparency and information builds trust, which is further strengthened when combined with SafeCare standards *(see 'Strengthening the quality of health services')*.

In Nigeria, Health Insurance Fund supported several states – Lagos and Kwara, and Adamawa – in designing, developing, and implementing statewide health insurance schemes. In Lagos State, almost 300,000 people have been enrolled since December 2019 and in Kwara State, the Kwara State Health Insurance Agency (KW-HIA) began enrolling an initial group of 8,000 indigents to its state health insurance scheme. Success in Lagos, the most populous state shows the possibility of scale, whilst success in Kwara, one of the poorest states, shows the viability of such interventions in rural, informal work sector settings.

In Ghana, we are supporting the National Health Insurance Authority (NHIA) to improve upon its operational efficiency, sustainability, and coverage. By supporting the rollout of the CLAIM-it app — a digital system within the provider panel of NHIA — we assist in digitizing more claims, support an efficient, transparent process, and help shape a blueprint for what UHC can look like in a 'Ghana Beyond Aid'. We are also assisting with the analysis of three years of claims data to provide insights and generate policy briefs and research publications for management decision-making.

In Kenya, to support the Kenyan government's UHC agenda, a partnership has been set up with the County Government of Kisumu (CGK) to develop and set up the Marwa Solidarity Health Scheme. The Scheme aims to demonstrate how UHC may be achieved by passing required legislation, establishing governance and financing structures, by fully digitizing administration and by introducing innovative financing models.

In Tanzania, the government has adapted the improved Community Health Fund (iCHF) program supported by Health Insurance Fund and piloted by PharmAccess in partnership with the National Health Insurance Fund (NHIF) and the local District Councils in the Kilimanjaro and Manyara regions in the north of the country. This fund has been rolled out to all 26 regions of the Tanzania mainland. At the end of 2020, more than 1.3 million people were enrolled across Tanzania.

Objective 2: Strengthening the quality of health services

Some 5 million people die every year because of poor quality of healthcare, causing more deaths than from malaria, HIV and tuberculosis combined. SafeCare is a standards-based, stepwise certification approach which rates, improves and recognizes providers' business and quality performance. Qualified SafeCare assessors visit a facility for an assessment, where compliance against the quality standards is measured. This generates an assessment report, and providers are given a tailor-made quality improvement plan to address their gaps and challenges, with transparent and achievable goals, and tools that guide them down a motivating and manageable path to improvement.

Accredited by the International Society for Quality in Healthcare External Evaluation Association (IEEA), SafeCare has three products that evaluate a facility's performance. The first, SafeCare Self-Assessments, is a digital self-assessment tools that allow facilities to self-evaluate against a set of criteria, designed around a specific topic such as COVID-19 preparedness, pharmacy, or MNCH. The second, SafeCare STEPS, is a quick assessment tool that rates facilities on a scale of 1 (lowest) to 5 (highest). The third, SafeCare ACCREDITATION, recognizes excellence in performance.

The three-assessment products feed into the SafeCare Quality Platform, which allows healthcare providers to use their assessment scores and benchmark against other facilities, learn about best practices and uses gamification approaches to stimulate quality improvement activities. The Quality Platform can also be accessed by third parties such as governments who can access the data for informed decision making and resource allocation. Investors and banks can access the information for investment risk reduction purposes. In 2020, 88% of the 875 participating facilities have improved in quality. Most were able to move from SafeCare level 1 and 2, to SafeCare levels 3 and 4.

The digitization of SafeCare makes quality assurance and improvement more scalable and sustainable. This is further supported by its embedding within the other initiatives, which allows us to develop and test new health care delivery models that incentivize standards compliance and continued improvement.

Objective 3: Matching demand and supply

Mobile technology is changing the way health care is organized and paid for, especially in Sub-Saharan Africa, where 10% of transactions are done via phone payments (compared to 2% in Europe and the US). PharmAccess develops innovative care models that use mobile data to prioritize vulnerable patient groups and processes. In Kenya and Tanzania, we provide 'care bundles' to pregnant women and in Ghana we connect doctors to possible COVID-19 patients. In Kenya we identify malaria hotspots to streamline operations, whilst in Nigeria we screen for tuberculosis, both of which are poverty-linked diseases. It is this combination of creativity in solutions and rigorous data analytics that has the best chance of identifying solutions that can be scaled or replicated.

Care bundles

The MomCare bundle is designed around the expecting mother; empowering her to access the care she requires throughout her pregnancy 'journey' - no matter what complications may arise. Some 200,000 women die every year giving birth in sub-Saharan Africa. In the first visit, the healthcare facility sets out the recommended path, which includes ante-natal care and delivery. The expectant woman agrees to the care program (currently covered by a combination of social health insurance, donors, and co-payments) at the clinic directly through her mobile phone; ensuring treatment data is captured and checked according to medical protocol and her risk status.

This service is powered by an underlying care analytics platform, a set of digital tools that helps process clinical and operational healthcare data. That same powerful medium, supports the mother throughout the pregnancy journey outside of the clinic, providing care information, appointment reminders, and giving her a voice in care satisfaction and outcome reporting. This transparency builds trust. And the valuable data collected during each touch point of the journey helps care providers to mitigate risks for their patients, moving towards better health outcomes for mother and child. To date, we have enrolled over 25,000 women in 42 clinics in Kenya and Tanzania.

The data-driven approach supports providers to continuously measure and improve the quality of their services. In addition, the predetermined costs of the care bundle offer a reliable income to the care provider that is often lacking. This can be used to invest in his or her business. Moving toward evidence- and value-based care not only helps clinics spend their time where it counts; it also helps payers, insurance, donors, and policymakers make more informed decisions. With near-real time data, the impacts of investments and interventions become clear and fully transparent, which appeals to payers, whether they be international donors or private.

The same care analytics platform that underpins MomCare can be adapted for other healthcare conditions such as HIV/AIDS, or even non-communicable diseases (NCD).

Connected diagnostics

The ongoing coronavirus pandemic has uncovered new opportunities for more patient-centered health care as provision moved from 'onsite' to remote only. Digital care models had not been fully appreciated before, but now many clinics found cell phones to be the only way to keep track of their patients' health. As experts in digital health, we have been able to support clinics with patient information (e.g., lists of high-risk patients to reach out to), financial solutions (e.g., room to purchase more hypertension drugs in one visit to reduce the need for travel) and digital tools (e.g., home measurement of blood pressure).

'Connected Diagnostics' (ConnDx), the use of smart phones to diagnose patients and channel funds conditional to the diagnostic result, allows you to upload rapid diagnostic test results into the cloud and target payments using mobile health platforms such as M-TIBA. In Kenya, we identified hotspots of malaria in semi-real time and could indicate which people suffered most from this disease (gender, age, geo-location, socio-economic status). We recorded and quantified over prescription behavior of doctors, performance of lab technicians and how patients vote with their feet with respect to visiting certain providers and certain (rush) hours and did this in semi-real time. This information could be used for significantly improved targeting of funds to the poor in the context of UHC. Moreover, it provided essential information for markedly improved management of malaria patients service delivery.

When the pandemic struck, we quickly adapted our technology to identify coronavirus hotspots, so interventions could be put in place to disrupt transmission. This shows that no matter what the ailment, diabetes, hypertension, malaria, tuberculosis, HIV, dengue, schistosomiasis, or COVID-19, if diagnostics are digitizable, ConnDx can play a role in identifying patients, targeting interventions, and bringing together private and public sector capacity and funding streams to respond accordingly. ConnDx also allows for 'horizontalizing vertical funds' while keeping track of the specific condition the vertical fund is interested in, critical if we want to reach UHC by 2030.

Objective 4: Increasing investments in healthcare

In sub-Saharan Africa, healthcare providers struggle to obtain financing to grow their businesses and hence improve the quality of care they deliver. This is partly due to banks with limited knowledge of the health sector, high collateral requirements and the difficulty in assessing credit risk for these micro-, small- and medium-enterprises (MSME). As over 50% of Africa's population is served by the private health sector, this can have a significant impact on reaching universal health coverage.

The Medical Credit Fund (MCF), is a loan impact fund which helps health MSMEs access loans so they can buy equipment, expand their facility, pay bills, remunerate staff, or as seen recently, to pay for personal protective equipment and other coronavirus containment measures. Essentially, this avoids clinic closures and ensures not only that smaller businesses are financially included, but also that people with lower income, who these clinics often serve, can continue to have access to good quality healthcare.

In 10 years, MCF has disbursed some USD 100 million in local currency loans to over 1,800 healthcare providers, of which 22% are female entrepreneurs. These loans were not only to the private sector, but also to not-for-profit and faith-based organizations. The repayment rate has been 96% leading up to the pandemic and 94% during, providing further proof of our lending model that has mobile technology at its heart. The clinics that are supported by MCF have around 365,000 visits per month across the six sub-Saharan countries.

In 2020, MCF disbursed 1,440 loans with a total loan volume of around USD 35 million (60% more than in the same period in 2019). And despite the closure of most financial institutions in the wake of the pandemic in Africa, at least for new loans, MCF has continued to provide over 100 loans per month, the same as before the pandemic.
MCF offers a unique combination of loans and technical assistance. The latter includes linking clinics to SafeCare to improve the quality of care delivered, as well as providing business support such as training of staff through business courses like we have in Kenya and Nigeria. Providing capacity building is crucial for improving the treatment of major diseases such as HIV/AIDS, and non-communicable illnesses like diabetes or hypertension, as well as for strengthening essential primary care services that provide the foundation for health systems everywhere.

Objective 5: Measuring impact with research, evaluation, and advocacy

Research, and evaluations

Evidence-based work is at the heart of our approach, hence our investment in independent research to evaluate and improve our products and services. Our own operational research has been published in peer-reviewed scientific papers, policy briefs, case studies and disseminated through workshops and conferences. Increasingly posting on social media has meant we could engage the next generation of thinkers to tackle the challenges of inclusive health care in Sub Saharan Africa. In 2020, the coronavirus pandemic stole all the headlines and delayed our projects through closure of universities and the halting of international travel. Despite the challenges, we still provided powerful new insights in achieving quality health care for all.

Key findings (highlights)

Poor quality care is a significant cause of mortality and morbidity worldwide. Our research found that improvements in care quality measured using the SafeCare standards over an 18-month period were related to significant increases in patient numbers and staff in 491 facilities studied in Tanzania, Ghana, Kenya, Nigeria, amongst other countries. These facilities were of public, private, and faith-based ownership and were dispensaries, healthcare centers and primary hospitals. The results underline how providing quality care translates into better business performance, which in turn incentivizes facilities to stay on the path to better quality.

Staying on the topic of quality of care, our research in Tanzania used SafeCare data to analyze how well-prepared primary and secondary private healthcare facilities were to respond to pandemics. We looked

at infection prevention and control, patient and staff safety, hand washing and personal protective equipment. Our research found that most facilities were grossly under-prepared in the event of a pandemic. The data from our research in Tanzania was critical in informing the design of our SafeCare4Covid app, free of cost and globally available for healthcare providers with practical support on COVID-19 protocols in low-resource settings.

In Nigeria, our research found that as in other sub-Saharan African countries, informal medicine vendors are an important provider of health services for rural and low-income populations, even for households who are covered by insurance. Patent and proprietary medicine vendors (PPMVs), as they are known, are rarely included in insurance schemes therefore adding to households' out-of-pocket health expenditures. In addition, they also often provide lower quality healthcare. Our published research shows that to reach UHC, the position of PPMVs within the primary healthcare system and within health insurance schemes needs to be reconsidered and quality management systems require further development.

Finally, last year saw a major review of our Medical Credit Fund (MCF) in Kenya, by SEO Amsterdam Economics. It showed that health SME's were struggling to secure loans from banks, especially during COVID-19, and that MCF helped to fill that gap. In making a success of it, MCF lead the way for other banks to follow in health care financing. Two further evaluations were completed by the London School of Hygiene and Tropical Medicine as well as University College Berkeley on our SafeCare initiative. More details on the outcome of those studies can be found in our Progress Report.

Advocacy

Our advocacy has focused on creating an enabling environment and policy change for innovations, private sector participation and scaling of our successful interventions in digital financing, health insurance and quality improvement in Ghana, Nigeria (Lagos and Kwara States), Tanzania and Kenya (Kisumu County). These countries have adopted UHC, where governments, in spite of budget constraints, have expressed commitment to partly subsidize health insurance for poor people. This commitment marks a shift in the way that healthcare is financed for millions of underserved populations. The need for greater domestic ownership in financing for health is not only about government financing but also highlights the importance of individual contributions to augment the public efforts to achieve UHC.

The strength of our advocacy lies in the quality of our relationships. Over the years, PharmAccess has built unique expertise in bringing diverse partners together. Whether it be public or private, national or global, patients or provider, advocacy is critical in building these partnerships to create an enabling environment for the development of inclusive health markets, emphasizing the benefits of using private sector capacities and investments, and the digitalization of health financing and delivery. We also use the capacity of the public sector and the international community to bring our interventions to scale.

Building partnerships

The Netherlands Ministry of Foreign Affairs (MFA) has been a committed and long-term funder of PharmAccess. It has led the way in the policy dialogue on the 'Aid and Trade Agenda', and its embassies have been instrumental in providing political leverage and strategic advice in the countries where we operate. For example, MCF launched a new partnership with 7.5 million Euro support from MFA, to continue the supporting private healthcare provision in sub-Saharan Africa.

In all our advocacy efforts, we always seek to include the private sector. In sub-Saharan Africa, the private sector provides 50% of health services. Engaging them in this digital era boosts innovations in health, complements the services of the public sector and contributes to access to better care and increased coverage. For example, we collaborated with Africa Health Business and FMO to connect African and Dutch health entrepreneurs at the Annual World of Health Care held by the Dutch Task Force Health Care.

Government ownership is critical for creating enabling environment for scaling and providing funding to ensure that the poorest get served. PharmAccess builds partnerships at local, state, and national level to facilitate health insurance and ensure that health facilities deliver care according to agreed standards. For example, in Nigeria, Kwara and Lagos began the roll-out of the health insurance scheme, illustrating the need for health systems strengthening to address COVD-19 and achieve UHC.

Together with the Joep Lange Institute (JLI), we engaged I-DAIR (International Digital Health & Artificial Intelligence Research) on the digitalization of health financing and delivery. PharmAccess and JLI have also become core members of two global digital health coalitions. The Transform Health Coalition unites organizations and institutions across sectors who are committed to achieving UHC by harnessing digital technology and data to benefit all, including women and young people. The Digital Connected Care Coalition (DCCC), which we co-initiated with Philips and Dalberg, brings together over 20 cross-disciplinary organizations to form a networking-and-action-platform to support efficient partnerships for the digital transformation of health for UHC in LMICs.

2. Financial

In 2020, total realized program expenses were EUR 9,237,157 (2019: EUR 11,142,141).

The financial statements reflect all the activities of the Health Insurance Fund. The actual implementation of the programs is done by PharmAccess for which it has offices in Tanzania, Kenya, Nigeria and Ghana. The financial statements have been prepared in accordance with the Guideline for annual reporting 640 “Not-for-profit organizations” of the Dutch Accounting Standards Board. Contrary to the Guideline for annual reporting 640 the budget on overall level has not been included. Control is performed on project level. Financial risks are limited since Health Insurance Fund holds cash on dedicated bank accounts. Health Insurance Fund does not work with ‘embedded derivatives’ and ‘hedge accounting’ and all larger programs are prefunded.

The foundation has been incorporated for the sole purpose of running the activities along the lines of the objectives as mentioned in the management board report. The foundation has no objective to gain reserves.

Given the nature of the organization risk assessment is addressed on regular basis. The monitoring and managing of risks take place on the level of the Foundation and its implementing partners. Risks have been categorized and prioritized on possibility and impact. The most significant risks which have been identified are:

- Financial risks - continuity of funding; (successfully) mitigated by business development and submitting proposals for new funding.

- Personnel risks - health and safety of staff; mitigated by establishing a travel policy.
- Personnel risks - fraud; mitigated by establishing a code of conduct and by sound financial management (segregation of duties, dual level authorization).
- Performance risks - management capacity of the implementing partners and their local project partners; mitigated by capacity building activities.
- Legal / Privacy - mitigated by implementing a data policy and involving specialist monitoring.
- IT related risks – security breaches and loss of data; mitigated by assigning responsibilities and implementing procedures.
- Reputational risks - mitigated by attention for external communication and advocacy.

SOLVENCY SUPPORT

Due to increased solvency requirements in 2012 one of the partners in Kenya, AAR Insurance Holdings Limited (AAR) was challenged by these new regulations for Health Maintenance Organizations (HMO's) which needed to register as licensed insurers and were demanded to hold increased solvency capital. In accordance with the Dutch Ministry of Foreign Affairs the Health Insurance Fund provided a 5-year solvency loan of EUR 8 million to AAR to accommodate this transition and to be able to continue its activities as partner to the HIF. The loan period is extended until 31 December 2021. Repayment capacity of AAR is largely depending on a planned future sale of shares (see note 1 and 7 to the financial statements).

These - sometimes sudden - changes of regulation influencing our private sector partners may also occur in other countries where the HIF is building capacity for health insurance programs eligible for low income and currently insured groups. Monitoring of regulatory developments and potential solutions for local partners will continue to be a priority.

INVESTMENT

In April 2019, in accordance with the grant decision of the Minister for Foreign Trade and Development Cooperation for *'CarePay, a basic mobile health contract for everyone'*, the Health Insurance Fund purchased shares for a total amount of EUR 19.6 million (2020: 33,9%) in CarePay International B.V..

TRANSPARANCY AND ACCOUNTABILITY

The programs are designed to ensure transparency and accountability to all stakeholders. The PharmAccess Group Foundation Supervisory Board, governing the Health Insurance Fund holds quarterly meetings to discuss the status and progress of the program. In addition, the Supervisory Board keeps yearly formal and informal track of the program standing and development which includes bi-yearly visits to local operations. Financial program audits covering all main stakeholders including the local implementing partners are carried out by an external auditor every year.

3. Outlook 2021 and beyond

The COVID-19 crisis is a wake-up call, a reminder that resilient healthcare systems are essential for economic and social prosperity, and international security. It has demonstrated that health is a global responsibility that requires cross-sector collaborations for universal health coverage. It has also driven wide-spread acknowledgement that digital technology and data form a core pillar of healthcare, with effective innovations being deployed for prevention, infection control and mitigating spread, including track and trace apps, telemedicine, symptom trackers and dashboards as well as tools to build capacity and improve delivery.

In the wake of COVID-19, an opportunity has emerged for African countries to build stronger, more resilient data-driven healthcare systems which are better prepared for the next pandemic and can deliver basic quality healthcare for all citizens. The increasing penetration of mobile technology and digital platforms in Africa will be key for fast-tracking health system transformation, allowing all individuals to be digitally connected, covered and empowered to access care. Technology provides real-time data, thus ensuring transparency in the delivery, utilization, and costs of care to guide decision making for patients, healthcare providers and governments.

This has proved vital during the crisis when it has been critical to both address the outbreak and to commit resources to other healthcare needs. Health Insurance Fund will continue to support PharmAccess to capitalize on digital technology to improve the financing and delivery of health care. For example, we will further develop smart contracting and value-based care interventions for mother and child healthcare and HIV, expanding services to support vulnerable socioeconomic groups. With lifestyle diseases, on the rise in Africa, we will also develop digital services for NCD care as well as platforms and tools, including online health information to empower people to take better informed decisions about their health and healthcare.

Given the limited and fragmented nature of healthcare funding in the countries that we support, and with donor funding on a downward trend, mobile technology also brings the opportunity to combine scarce funding sources while reducing transaction costs. By increasing efficiency and transparency, it can ensure that more marginalized individuals are covered while paving the way to implement new pay for performance models which generate data to guide governments in resource allocation. In the years ahead, we will support the integration of vertical programs into a more horizontal and integrated healthcare approach.

Further investments in healthcare quality remain crucial. We will continue to support SafeCare and MCF in scaling up, which proved critical throughout the pandemic. MCF's flexible and digital loans have offered much need support for health SMEs during the crisis with SafeCare helping to ensure infection prevention and control, while prioritizing staff and patient safety in clinics. Going forward, we will continue to use digital technology and data to improve the quality standards of healthcare facilities as well as share our expertise and lessons learnt with new countries. MCF will focus on digital lending to health SMEs, enabling them to overcome the requirement of a collateral security that impedes their access to financing.

4. Institutional development

Since January 2017, in line with a request of The Ministry of Foreign Affairs, the governance structure of Health Insurance Fund has been revised. The statutory responsibility for Stichting Health Insurance Fund and all PharmAccess group entities (i.e. Stichting PharmAccess International, Stichting Medical Credit Fund, Stichting SafeCare and Stichting HealthConnect) is vested with PharmAccess Group Foundation (PGF), represented by its executive board (statutair bestuur) under the supervision of one Supervisory Board, the PGF Supervisory Board.

As per January 1, 2020 Christiaan Rebergen (Treasurer-General of the Dutch Ministry of Finance) and Mirjam van Praag (President of the Vrije Universiteit, Amsterdam) joined the Supervisory Board. The other Supervisory Board members (Pauline Meurs (Chair a.i.), Willem van Duin, Ben Christiaanse, Ruud Hopstaken, Peter van Rooijen and Lidwin van Velden) stayed in their position.

Monique Dolfing-Vogelenzang and Jan Willem Marees stayed in their role of resp. CEO and CFO of the Executive Board.

Signing of the Management Board's report

Amsterdam, 1 July 2021

J. W. Marees
Director

Stichting PharmAccess Group Foundation
Represented by:

M.G. Dolfing-Vogelenzang

J.W. Marees

Financial statements

- Balance sheet
- Statement of income and expenditure
- Cash flow statement
- Notes to the financial statements

Balance sheet as at 31 December 2020

(After appropriation of result)

	Note	31.12.2020	31.12.2019		Note	31.12.2020	31.12.2019
		EUR	EUR			EUR	EUR
Assets				**Equity and liabilities**			
Financial fixed assets:				**Equity**			
Loans	1	9,388,571	9,203,987	Continuity reserve	6	3,753	3,753
Participating interests	2	19,600,000	19,600,000				
				Long-term liabilities			
Current assets				Deferred income concerning solvency support	7	9,180,285	9,023,389
Other receivables	3	175,261	167				
Advance payments	10	-	111,042	**Current liabilities**			
Debtors	4	-	53,390	Creditors	8	272,976	53,683
				Deferred income	9	33,194,812	20,041,203
Cash	5	22,488,009	10,113,886	Liabilities projects	10	3,842,798	-
				Other liabilities and accrued expenses	11	5,157,217	9,960,444
		51,651,841	**39,082,472**			**51,651,841**	**39,082,472**

Statement of income and expenditure for the year 2020

	Note		2020		2019
			EUR		EUR
Income	12		9,237,157		11,142,141
Operating expenses:					
Direct project costs	13	9,178,710		11,067,366	
Personnel expenses	14	26,445		42,765	
Other operating expenses	15	32,002	9,237,157	32,010	11,142,141
Result			**0**		**0**
Appropriation of the result:					
Continuity reserve			0		0
			0		**0**

Cash flow statement for the year 2020

(Based on the indirect method)

		2020		2019
		EUR		EUR
Operating result		***0***		***0***
Adjustments for:				
Changes in working capital:				
- movements operating accounts related to receivables and projects	3,832,136		3,447,038	
- movement deferred income concerning solvency support	(27,688)		(27,071)	
- movement deferred income	13,153,609		(705,943)	
- movements other current liabilities	(4,583,934)	12,374,123	9,764,463	12,478,487
Cash flow from business activities		12,374,123		12,478,487
Interest received/paid		0		0
Cash flow from operating activities		12,374,123		12,478,487
Investments in other financial fixed assets	-	-	(14,650,000)	(14,650,000)
Cash flow from investing activities		-		*(14,650,000)*
Net cash flow		*12,374,123*		*(2,171,513)*
Cash as per 1 January		10,113,886		12,285,399
Cash as per 31 December		22,488,009		10,113,886
Movements in cash		**12,374,123**		**(2,171,513)**

Notes to the financial statements

GENERAL

Foundation

Stichting Health Insurance Fund is a not-for-profit organization based in Amsterdam, the Netherlands. The foundation was founded on 6 October 2005. Health Insurance Fund is registered with the Trade Register at the Chamber of Commerce under number 34234456.

The financial statements have been prepared in euros.

ACCOUNTING POLICIES

General

The financial statements have been prepared in accordance with the Guideline for annual reporting 640 "Not-for-profit organizations" of the Dutch Accounting Standards Board ('Raad voor de Jaarverslag-geving').

The financial statements have been prepared using the historical cost convention and are based on going concern. Income and expenses are accounted for on accrual basis. Profit is only included when realized on balance sheet date. Liabilities and any losses originating before the end of the financial year are taken into account if they have become known before preparation of the financial statements.

If not indicated otherwise, the amounts of the accounts are stated at face value.

As from 2020 the foundation is confronted with the consequences of the corona virus. Although the consequences of the corona virus are uncertain in the long term, the foundation does not expect any consequences for the continuation of the activities.

Balance sheet

Financial fixed assets

Upon initial recognition the receivables and loans are valued at fair value and then valued at amortised cost, which equals the face value, after deduction of any provisions.

Receivables

Upon initial recognition the receivables are valued at fair value and then valued at amortized cost. The fair value and amortized cost equal the face value. Provisions deemed necessary for possible bad debt losses are deducted. These provisions are determined by individual assessment of the receivables.

Cash

The cash is valued at face value. If cash equivalents are not freely disposable, then this has been taken into account upon valuation.

Current liabilities

Deferred income

Deferred income consists of subsidy prepayments related to projects to be carried out less the realized costs of these projects, taking into account foreseeable losses on projects.

Other current liabilities
Upon initial recognition, liabilities recorded are stated at fair value and then valued at amortized cost.

Principles for the determination of the result
Statement of income and expenditure
Income and expenditure are recognized as they are earned or incurred and are recorded in the financial statements of the period to which they relate. Overhead expenses are excluded from program expenses and recorded in the operating expenses.

Income
Income from 'Realized income related to projects' is recognized in proportion to the completed project activities rendered on active projects, based on the cost incurred up to balance sheet date. The costs of these project activities are allocated to the same period.

Other income relates to other non-project related items.

Direct project costs
Direct project costs consist of expenses directly related to projects (out-of-pocket costs) excluding staff costs.

Recognition of transactions in foreign currency
Transactions in foreign currencies are recorded at the exchange rate prevailing at the transaction date. At year-end, the assets and liabilities reading in foreign currencies are translated into euros at the rates of exchange as per that date.

Financial instruments
Financial instruments include both primary financial instruments, such as receivables and liabilities, and financial derivatives. Reference is made to the treatment per balance sheet item for the principles of primary financial instruments. The foundation does not use derivatives and there are also no embedded derivatives.

The foundation does not apply hedge accounting.

Principles for preparation of the cash flow statement
The cash flow statement is prepared according to the indirect method. The funds in the cash flow statement consist of cash and cash equivalents. Cash equivalents can be considered to be highly liquid deposits.

Cash flows in foreign currencies are translated at an estimated average rate. Exchange rate differences concerning finances are shown separately in the cash flow statement.

Notes to the specific items of the balance sheet

1. LOANS

	2020	2019
	EUR	EUR
Balance as at 1 January	9,203,987	13,973,516
CarePay International B.V. - Convertible loan:		
- transferred	-	4,900,000
- converted	-	(9,850,000)
Interest to be received	184,584	180,471
Balance as at 31 December	**9,388,571**	**9,203,987**

	2020	2019
Total disbursed to AAR Insurance Holdings Limited	8,000,000	8,000,000
Total accumulated interest to be received	1,388,571	1,203,987
Balance as at 31 December	**9,388,571**	**9,203,987**

AAR Insurance Holdings Limited - Solvency support loan

The Health Insurance Fund issued in 2012 a 5-year solvency support loan of EUR 8 million to AAR Insurance Holdings Limited. The full amount has been disbursed. The interest rate on this solvency loan is 2% per annum on the disbursed amount and is added to the deferred income concerning solvency support. The final repayment date has been, with approval from the Ministry of Foreign Affairs, extended to 31 December 2021. Repayment capacity of AAR is largely depending on a sale of shares planned to take place. The default risk (of not repaying the loan by AAR) is covered by the pre-received subsidy of the Dutch Ministry of Foreign Affairs, included under the deferred income concerning solvency support on the balance sheet. Therefore, the loan is not subject to an impairment.

2. PARTICIPATING INTERESTS

	2020	2019
	EUR	EUR
Participating interest – CarePay International B.V.	19,600,000	19,600,000
Balance as at 31 December	**19,600,000**	**19,600,000**

In accordance with the grant decision of the Minister for Foreign Trade and Development Cooperation for 'CarePay, a basic mobile health contract for everyone', the Health Insurance Fund invested a total amount of EUR 19.6 million in CarePay International B.V. The Health Insurance Fund has a total of 196,000 shares.

The investment is valued at the purchase value.

Based on the participating interest percentage of Health Insurance Fund in CarePay International B.V. the net asset value (NAV) amounts to EUR 8,328,883 (33.86%) per year end 2020 (2019: EUR 12,558,800 (37.66%)). The net asset value has been calculated on the CarePay International B.V. draft annual accounts 2020 (dated May 30th, 2021).

3. OTHER RECEIVABLES

	2020	2019
	EUR	EUR
Other receivables	175,261	-
Interest to be received	-	167
Balance as at 31 December	**175,261**	**167**

The other receivables relate to rent and service costs to be charged out.

4. DEBTORS

	31.12.2020	31.12.2019
	EUR	EUR
Related foundation: PharmAccess Foundation (PAI) - accounts receivable	-	53,390
Balance as at 31 December	**-**	**53,390**

5. CASH

	31.12.2020	31.12.2019
	EUR	EUR
ABN-AMRO MeesPierson - General - charity savings account	14,947,174	9,991,875
ABN-AMRO MeesPierson - General - MCF2	7,500,000	-
ABN-AMRO MeesPierson - Global Health Membership	40,835	122,011
Balance as at 31 December	**22,488,009**	**10,113,886**

The year-end balance of 2020 includes advance payments, which has been received from the Ministry of Foreign Affairs for the year 2021 and beyond.

Funds are available in line with the different program objectives.

6. CONTINUITY RESERVE

	31.12.2020	31.12.2019
	EUR	EUR
Balance as at 1 January	3,753	3,753
Result	0	0
Balance as at 31 December	**3,753**	**3,753**

In accordance with the subsidy agreements, the operating expenses are funded by the different donors. The continuity reserve is available to use in line with the described objectives of the foundation as stated in article 2 of the Articles of Association.

Result appropriation for the year

No provisions of the Articles of Association deal with result appropriation. The result for the financial year 2020 amounts to nil and therefore no movement has been processed in the continuity reserve.

7. DEFERRED INCOME CONCERNING SOLVENCY SUPPORT

	2020	2019	Realized in 2020
	EUR	EUR	EUR
Cumulative payments from Dutch			
Ministry of Foreign Affairs	8,000,000	8,000,000	-
Deferred income before interest	*8,000,000*	*8,000,000*	
Cumulative interest to be received:			
- AAR	1,180,285	1,023,389	156,896
Total interest to be received	*1,180,285*	*1,023,389*	*156,896*
Deferred income after interest	**9,180,285**	**9,023,389**	

This long-term deferred income position with the Dutch Ministry of Foreign Affairs relates to a loan for solvency support which has been made available to AAR Insurance Holding Limited (AAR) in 2012. The solvency support agreement between Health Insurance Fund and AAR has been extended to 31 December 2022. The deferred income represents the pre-received subsidy from the Dutch Ministry of Foreign Affairs. In the event of a default of AAR on the loan agreement the deferred income is recognized as income to cover for the impairment costs. The Health Insurance Fund has the obligation to report to the Ministry on the status of repayment by AAR.

The interest added to the deferred income position is calculated on the disbursed amount.

8. CREDITORS

	2020	2019
	EUR	EUR
Accounts payables	272,976	487
Related foundation: PharmAccess Foundation (PAI) - accounts payable	-	53,196
Balance as at 31 December	**272,976**	**53,683**

9. DEFERRED INCOME

	2020	2019
	EUR	EUR
Dutch Ministry of Foreign Affairs: 2016 - 2022 *'making inclusive health markets work, activity number 28079'*	10,994,812	10,160,839
Dutch Ministry of Foreign Affairs: 2018 - 2021 *'CarePay; A basic mobile health contract for everyone, activity number 4000001129'*	14,700,000	9,850,000
Dutch Ministry of Foreign Affairs: 2020 - 2030 *'Medical Credit Fund; financing the future (MCF2), activity number 4000004301'*	7,500,000	-
Global Health Membership	-	-
HealthConnect	-	30,364
Balance as at 31 December	**33,194,812**	**20,041,203**

Deferred income Dutch Ministry of Foreign Affairs: 2016 – 2022

	2020	2019	Realized in 2020
	EUR	EUR	EUR
Cumulative payments from Dutch Ministry of Foreign Affairs	65,745,000	55,715,000	10,030,000
Cumulative realized expenses:			
- Organisational	9,149,136	7,393,253	1,755,883
- Demand Side Financing	11,848,603	10,903,212	945,391
- Supply	11,101,838	9,907,354	1,194,484
- Investments: Financing & Access to Credit	8,840,050	6,868,204	1,971,846
- Data & Technology	3,538,486	1,986,182	1,552,304

- Advocacy	4,967,990	4,240,071	727,919
- Resource Mobilisation	1,912,517	1,359,980	552,537
- Research & Learning	3,024,640	2,528,677	495,963
- New Initiatives	426,924	426,924	-
Total realized expenses	*54,810,184*	*45,613,857*	*9,196,327*
Deferred income before interest	*10,934,816*	*10,101,143*	
Cumulative interest received:			
- interest income Health Insurance Fund	44,442	44,192	250
- interest income PharmAccess	15,554	15,504	50
Total interest received	*59,996*	*59,696*	*300*
Deferred income after interest	**10,994,812**	**10,160,839**	

Deferred income Dutch Ministry of Foreign Affairs: 2018 – 2021

	2020	2019	Realized in 2020
	EUR	EUR	EUR
Cumulative payments from Dutch Ministry of Foreign Affairs	14,700,000	9,850,000	4,850,000
Cumulative realized expenses:			
- Reported expenditures for the year	-	-	-
Total realized expenses	*-*	*-*	*-*
Deferred income before interest	*14,700,000*	*9,850,000*	
Cumulative interest received:			
- Reported interest for the year	-	-	
Total interest received	*-*	*-*	
Deferred income after interest	**14,700,000**	**9,850,000**	

In accordance with the grant decision of the Minister for Foreign Trade and Development Cooperation for *'CarePay, a basic mobile health contract for everyone'*, the Health Insurance Fund invested a total amount of EUR 19.6 million in CarePay International B.V. As per year end 2020 HIF has received three installments from the Ministry of Foreign Affairs for a total amount of EUR 14,700,000. The remainder, which amounts to a total of EUR 4,900,000, is scheduled to be received from the Ministry of Foreign Affairs in January 2021. After receipt of the installments these funds will be directly disbursed to CarePay International B.V. in line with the 'Share Purchase Sale Agreement'.

Deferred income Dutch Ministry of Foreign Affairs: 2020 – 2030

	2020	2019	Realized in 2020
	EUR	EUR	EUR
Cumulative payments from Dutch Ministry of Foreign Affairs	7,500,000	-	7,500,000
Cumulative realized expenses:			
- Reported expenditures for the year	-	-	-
Total realized expenses	-	-	-
Deferred income before interest	*7,500,000*	-	
Cumulative interest received:			
- Reported interest for the year	-	-	
Total interest received	-	-	
Deferred income after interest	**7,500,000**	**-**	

In accordance with the grant decision of the Minister for Foreign Trade and Development Cooperation for *''Medical Credit Fund; financing the future (MCF2)*, the Health Insurance Fund received a grant to grant to invest as common equity in MCF2. As per year end 2020 HIF has received an installment from the Ministry of Foreign Affairs for a total amount of EUR 7,500,000.

Deferred income Global Health Membership

	2020	2019	Realized in 2020
	EUR	EUR	EUR
Cumulative payments from private donors	380,279	339,450	40,829
Cumulative realized expenses:			
- General program/project management	37,801	31,862	5,939
- Contribution to Health Insurance Programs	342,478	307,588	34,890
Total realized expenses	*380,279*	*339,450*	*40,829*
Deferred income	**0**	**0**	

10. LIABILITIES RELATED TO PROJECTS / ADVANCE PAYMENTS

	2020	2019
	EUR	EUR
Deferred income to PharmAccess regarding MoFa	3,858,352	(95,537)
Prepaid in total to PharmAccess on projects	*3,858,352*	*(95,537)*
Interest revenue PharmAccess regarding MoFA	(15,554)	(15,504)
Balance as at 31 December	3,842,798	(111,042)

11. OTHER LIABILITIES AND ACCRUED EXPENSES

	2020	2019
	EUR	EUR
Other liabilities	4,900,000	9,750,000
Accrued expenses	246,472	210,444
Accrued interest	10,745	-
Balance as at 31 December	**5,157,217**	**9,960,444**

Other liabilities

In accordance with the grant decision of the Minister for Foreign Trade and Development Cooperation for '*CarePay, a basic mobile health contract for everyone*', the Health Insurance Fund invested a total amount of EUR 19.6 million in CarePay International B.V. The investment was partially financed via the execution of the outstanding convertible loan of EUR 9,850,000. The remainder, which amounts to EUR 9,750,000, will be paid to CarePay in two tranches (III and IV). From this amount EUR 4,850,000 has been paid in 2020 (Tranche III) and the final tranche (IV) ad. EUR 4,900,000 is expected to be settled in January 2021.

Contingent assets and liabilities

Regarding the current project portfolio Stichting Health Insurance Fund received from donors' commitments for grants for an amount over EUR 103.1 million (2019: EUR 95.6 million). Of this amount approximately EUR 87.9 million (2019: EUR 65.9 million) has been received. Stichting Health Insurance Fund has the obligation to make use of these promised grants according to the contracts with donors.

Financial instruments

For the notes to financial instruments reference is made to the specific item by item note.

The main financial risks the foundation is exposed to are the currency risk, the liquidity risk and the credit risk. The foundation financial policy is aimed at mitigating these risks by:

Currency risk

The currency risk is mitigated by holding the received foreign currency pre-payments on ongoing foreign currency contracts as long as possible in the contracted foreign currency and only convert into the functional currency (EUR) based on commitments.

Liquidity risk

The liquidity risk is mitigated by monthly monitoring of the work in progress portfolio and closely monitoring and steering the deferred income position per contract.

Credit risk

The credit risk is limited as the current programs are prefunded. For the partners, the credit risk is mitigated by providing only a rolling advances.

Non-recognised assets and liabilities and contingent assets and liabilities

In December 2016 a ten-year operational lease agreement was signed for the premises - AHTC buiding, 4th floor, Tower C and D - located at the Paasheuvelweg 25 in Amsterdam, the Netherlands. The yearly operational lease amount amounts to EUR 402,185. The first two years are free of charge, year 3: 60%, year 4: 73,3%, year 5: 86,6% and year 6 -10: 100% of the yearly operational lease amount.

Notes to the specific items of the statement of income and expenditure

12. INCOME

	2020	2019
	EUR	EUR
Realized income related to projects	9,196,327	11,098,018
Other income	40,830	44,123
	9,237,157	**11,142,141**

The 'Realized income related to projects' consists of:

	2020	2019
	EUR	EUR
Dutch Ministry of Foreign Affairs: 2016 - 2022	9,196,327	10,798,018
Dutch Ministry of Foreign Affairs: 2019 - Revolutionizing Health Financing	-	300,000
Dutch Ministry of Foreign Affairs: 2018 - 2021	-	-
	9,196,327	**11,098,018**

The 'Other income' consists of:

	2020	2019
	EUR	EUR
Global Health Membership	40,830	44,123
	40,830	**44,123**

13. DIRECT PROJECT COSTS

	2020	2019
	EUR	EUR
Ministry of Foreign Affairs 2016 - 2022	9,137,880	10,723,243
Dutch Ministry of Foreign Affairs: 2019 - Revolutionizing Health Financing	-	300,000
Global Health Membership	40,830	44,123
	9,178,710	**11,067,366**

Direct project costs related to Ministry of Foreign Affairs: 2016 - 2022

	2020	2019
	EUR	EUR
Health Insurance Fund	18,880	11,192
PharmAccess	9,153,890	10,750,391
Global Health Membership *	(34,890)	(38,340)
	9,137,880	**10,723,243**

*) This amount reflects the Global Health Membership (GHM) contribution to the Ministry of Foreign Affairs program.

14. PERSONNEL EXPENSES

	2020	2019
	EUR	EUR
Contracted services related to Facility Agreement	25,932	42,252
Other personnel expenses	513	513
	26,445	**42,765**

15. OTHER OPERATING EXPENSES

	2020	2019
	EUR	EUR
Auditing fees	18,864	18,653
Representation/marketing/communication	514	11,226
Other	12,624	2,131
	32,002	**32,010**

Other notes

NUMBER OF EMPLOYEES

The average number of employees during the financial year was nil (2019: 0).

REMUNERATION OF MEMBERS OF THE BOARD

Throughout 2020, the board of the Health Insurance Fund consisted of two board members. J.W. Marees and PharmAccess Group Foundation. The PharmAccess Group Foundation is resprsented by M.G. Dolfing-Vogelenzang and J.W. Marees. With reference to the WNT, two natural persons are recognized as board member.

2020

	M.D. Dolfing-Vogelenzang CEO	J.W. Marees CFO	Total
	EUR	EUR	EUR
Total remuneration WNT	0	0	0
Period of engagement:			
Engaged from	01.01.2020	01.01.2020	
Engaged to	31.12.2020	31.12.2020	
Scope of services	N/A, no actual employment	N/A, no actual employment	

2019

	M.D. Dolfing-Vogelenzang CEO	J.W. Marees CFO	Total
	EUR	EUR	EUR
Total remuneration WNT	0	0	0
Period of engagement:			
Engaged from	01.01.2019	01.01.2019	
Engaged to	31.12.2019	31.12.2019	
Scope of services	N/A, no actual employment	N/A, no actual employment	

The Health Insurance Fund is in compliance with the WNT as no payments were made to the Members of the Board.

SUBSEQUENT EVENTS

There are no subsequent events to report.

Signing of the financial statements

Amsterdam, 1 July 2021

J.W. Marees
Director

Stichting PharmAccess Group Foundation
Represented by:

M.G. Dolfing-Vogelenzang

J.W. Marees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25Kg
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Other information

Independent auditor's report

The independent auditor's report is recorded on the next page.

Deloitte.

Deloitte Accountants B.V.
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Independent auditor's report

To the Management Board of Stichting Health Insurance Fund

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS 2020 INCLUDED IN THE ANNUAL ACCOUNTS

Our opinion

We have audited the accompanying financial statements 2020 of Stichting Health Insurance Fund, based in Amsterdam.

In our opinion the accompanying financial statements give a true and fair view of the financial position of Stichting Health Insurance Fund as at 31 December 2020, and of its result for 2020 in accordance with Dutch Accounting Standard 640 'Not-for-profit-organizations'.

The financial statements comprise:

1. The balance sheet as at 31 December 2020.

2. The statement of income and expenditure for 2020.

3. The notes comprising a summary of the accounting policies and other explanatory information.

Moreover, we are of the opinion that in all material aspects the 2020 financial statements comply with the WNT requirements regarding financial regularity, as laid down in the WNT Audit Protocol of the 'Beleidsregels toepassing Wet Normering bezoldiging Topfunctionarissen publieke en semipublieke sector (WNT)'.

Basis for our opinion

We conducted our audit in accordance with Dutch law, including the Dutch Standards on Auditing. Our responsibilities under those standards are further described in the "Our responsibilities for the audit of the financial statements" section of our report.

We are independent of Stichting Health Insurance Fund in accordance with the Wet toezicht accountantsorganisaties (Wta, Audit firms supervision act), the Verordening inzake de onafhankelijkheid van accountants bij assurance-opdrachten (ViO, Code of Ethics for Professional Accountants, a regulation with respect to independence) and other relevant independence regulations in the Netherlands. Furthermore, we have complied with the Verordening gedrags- en beroepsregels accountants (VGBA, Dutch Code of Ethics and the 'Beleidsregels toepassing Wet Normering bezoldiging topfunctionarissen publieke en semipublieke sector (WNT)', including the audit protocol WNT).

We believe the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Deloitte.

Emphasis on the valuation

We draw attention to note 1 (loans), note 2 (PARTICIPATING INTERESTS) note 7 (Deferred income concerning solvency support) and note 9 (deffered income), as presented in the financial statements, where additional information is included on the valuation of loans and participating interests . Our opinion is not modified in respect of this matter.

REPORT ON THE OTHER INFORMATION INCLUDED IN THE ANNUAL ACCOUNTS

In addition to the financial statements and our auditor's report thereon, the annual accounts contain other information that consists of:

- Management Board's Report
- Other Information

Based on the following procedures performed, we conclude that the other information:

- Is consistent with the financial statements and does not contain material misstatements.
- Contains the information as required by the Dutch Accounting Standard 640 'Not-for-profit-organizations'.

We have read the other information. Based on our knowledge and understanding obtained through our audit of the financial statements or otherwise, we have considered whether the other information contains material misstatements.

By performing these procedures, we comply with the requirements of the Dutch Standard 720. The scope of the procedures performed is substantially less than the scope of those performed in our audit of the financial statements.

Management is responsible for the preparation of the other information, including the Management Board's report, as required by the Dutch Accounting Standard 640 'Not-for-profit-organizations'.

DESCRIPTION OF RESPONSIBILITIES REGARDING THE FINANCIAL STATEMENTS

Responsibilities of management for the financial statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with the Dutch Accounting Standard 640 'Not-for-profit-organizations' and the 'Beleidsregels toepassing Wet Normering bezoldiging topfunctionarissen publieke en semipublieke sector (WNT)', including the audit protocol WNT). The executive board is likewise responsible for preparing the financial statements in compliance with the WNT requirements regarding financial regularity as laid down in the WNT Audit protocol of the 'Beleidsregels toepassing Wet Normering bezoldiging topfunctionarissen publieke en semi-publieke sector (WNT)'.

Furthermore, management is responsible for such internal control as management determines is necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

Deloitte.

As part of the preparation of the financial statements, management is responsible for assessing the foundation's ability to continue as a going concern. Based on the financial reporting framework mentioned, management should prepare the financial statements using the going concern basis of accounting unless management either intends to liquidate the foundation or to cease operations, or has no realistic alternative but to do so.

Management should disclose events and circumstances that may cast significant doubt on the foundation's ability to continue as a going concern in the financial statements.

Our responsibilities for the audit of the financial statements

Our objective is to plan and perform the audit assignment in a manner that allows us to obtain sufficient and appropriate audit evidence for our opinion.

Our audit has been performed with a high, but not absolute, level of assurance, which means we may not detect all material errors and fraud during our audit.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. The materiality affects the nature, timing and extent of our audit procedures and the evaluation of the effect of identified misstatements on our opinion.

We have exercised professional judgement and have maintained professional skepticism throughout the audit, in accordance with Dutch Standards on Auditing, ethical requirements and independence requirements. Our audit included e.g.:

- Identifying and assessing the risks of material misstatement of the financial statements, whether due to fraud or error, designing and performing audit procedures responsive to those risks, and obtaining audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtaining an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the foundation's internal control.

- Evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- Concluding on the appropriateness of management's use of the going concern basis of accounting, and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the foundation's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the foundation to cease to continue as a going concern.

- Evaluating the overall presentation, structure and content of the financial statements, including the disclosures.

- Evaluating whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

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We communicate with Management Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant findings in internal control that we identified during our audit.

Amsterdam, 1 July 2021

Deloitte Accountants B.V.

Signed on the original: S. Kramer

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