Unlocking sustainable access to medicines in emerging markets through innovative financing solutions

How pharmaceutical companies can leverage financing ecosystems to enable access to high-cost therapies and drive sustainable growth

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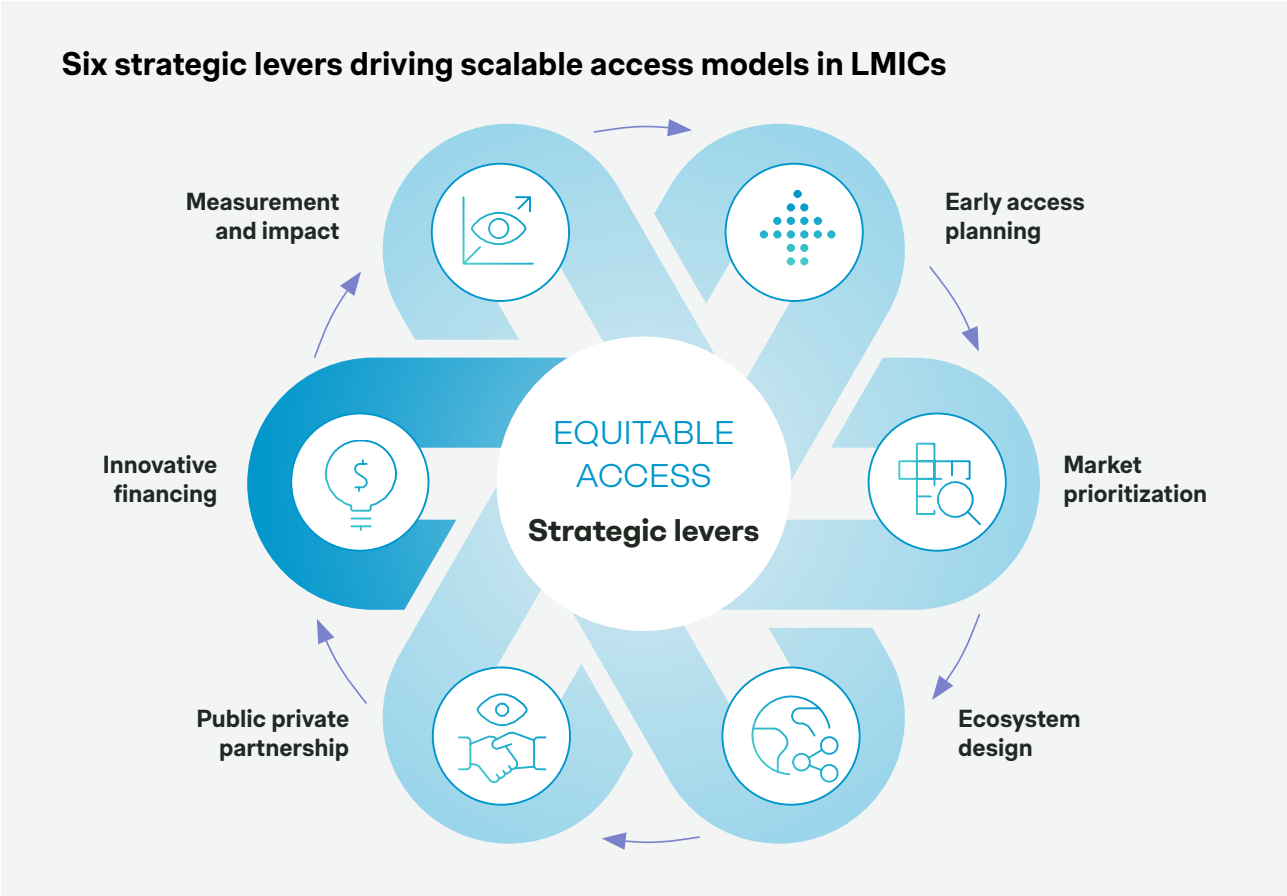
Executive Summary

Access to high-cost therapies is increasingly constrained not by clinical value, but by how healthcare is financed. In many emerging markets, high out-of-pocket (OOP) burden, limited coverage, and fragmented payer systems continue to limit patient access to innovation.

Globally, more than one billion[1] people face catastrophic out-of-pocket health spending, reinforcing that affordability is a structural access barrier rather than a marginal issue. The WHO and the World Bank also report that progress toward universal health coverage has stalled, with financial hardship from OOP payments worsening in many countries.

This paper builds on Simon-Kucher's six-lever framework for equitable access in LMICs, as outlined in the whitepaper Equitable Access in emerging markets, and positions innovative financing as a focused deep dive within the broader access agenda. The six levers, market prioritization, ecosystem design, public-private partnership, innovative financing, early access planning, and measurement, provide the foundation for scalable access models in LMICs.

1. https://www.who.int/news/item/18-09-2023-billions-left-behind-on-the-path-to-universal-healthcoverage



Healthcare funding is evolving. Public budgets are under pressure, while private-sector funding, private health insurance, providers, employers, and financial intermediaries are increasingly becoming part of the access equation. This means that the financing challenge can no longer be framed as a single payer decision. It must be understood as an ecosystem design challenge.

At its core, innovative financing addresses two questions: who pays and how we pay. The first question focuses on expanding the pool of payers beyond traditional reimbursement systems. The second focuses on restructuring payment so that innovative therapies become more affordable, predictable, and reach the intended patients.

This paper focuses primarily on private sector financing models, while recognizing that these models often interact with public systems. Within the private sector, private health insurance (PHI), alternative funding mechanisms, and partnership models are emerging as key access levers, particularly in markets where public reimbursement is limited or incomplete.

For pharmaceutical companies, the strategic implication is clear: access strategy must move beyond pricing alone toward financing ecosystem orchestration focused across care pathways. Companies that can engage insurers, providers, financial intermediaries, and public stakeholders will be better positioned to unlock access and shape the future of healthcare financing.

1. The access gap: why high-cost therapies remain out of reach in LMICs

Pharmaceutical innovation is advancing rapidly, particularly in specialty care including **oncology, rare diseases and gene therapies**. These therapies offer transformative clinical outcomes, but their cost structures challenge the way healthcare systems have traditionally been financed.

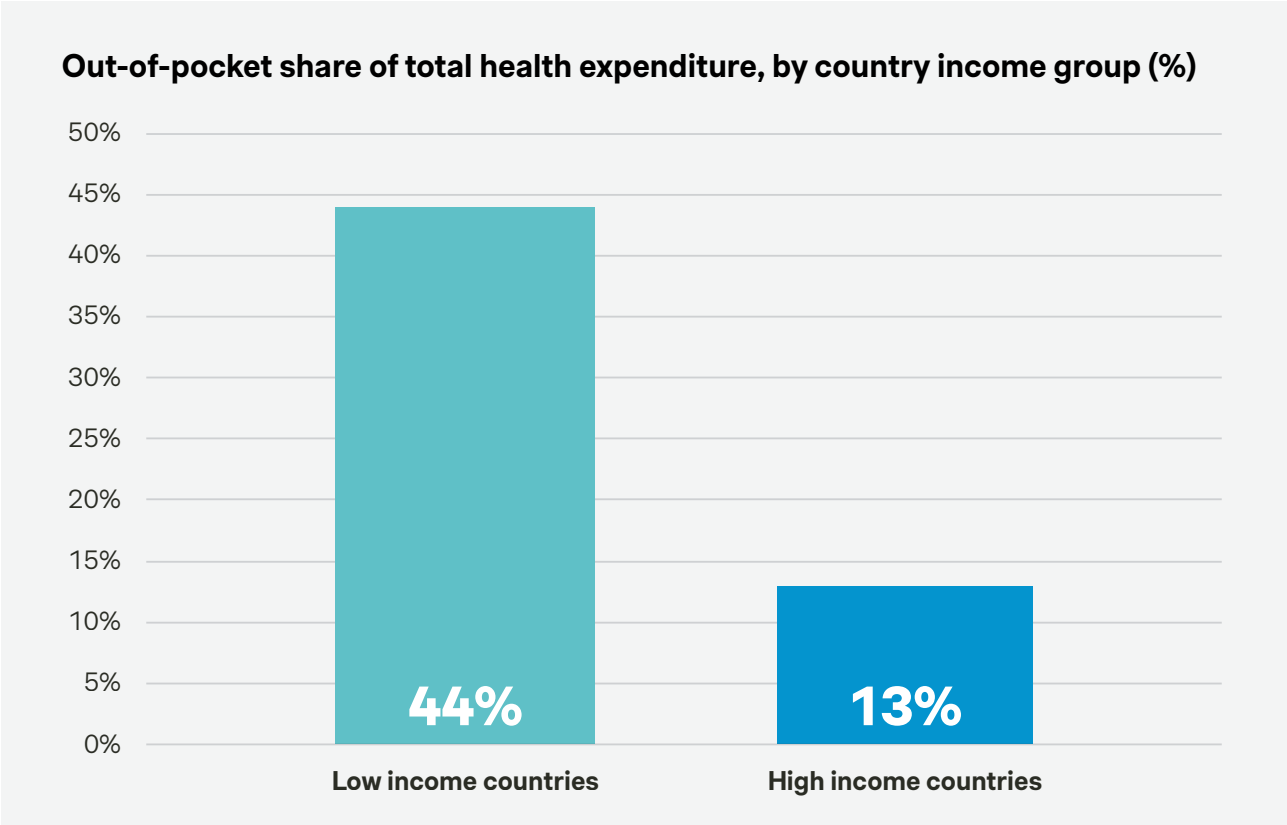
The issue is not simply that these therapies are expensive. The deeper challenge is that their **costs are often high and upfront**, while their value is realized over years through improved survival, reduced complications, avoided hospitalizations, or long-term disease control. This creates a mismatch between **when costs occur** and **when value is captured**.

At the same time, payer systems remain structurally constrained. Many operate under **short-term budget cycles**, with limited ability to absorb large expenditures. Funding responsibilities are often fragmented across stakeholders, meaning that the actor paying for treatment may not be the one capturing the long-term benefit. This is particularly relevant for advanced therapies, where durable value may extend beyond the immediate payer's budget horizon.

These challenges are particularly acute in emerging markets. Public reimbursement is often limited, private insurance penetration remains uneven, and patients frequently rely on **OOP payments**. In low-income countries, the uninsured population remains extremely high, significantly increasing reliance on direct patient payments.[2]

Out-of-pocket spending represents approximately 44% of total health expenditure in low-income countries, compared with around **13% in high-income markets**, highlighting the structural financing gap that innovative models must address.

2. https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS



This dynamic creates a widening gap between **innovation and access**. Patients may delay treatment, discontinue therapy, or never initiate care. Providers may face cash-flow constraints when treatment costs precede reimbursement. Payers may restrict access because they cannot absorb high upfront costs or manage uncertainty.

Pricing alone cannot solve access. Pricing remains foundational, but the real bottleneck increasingly lies in **how healthcare is financed**. This is why innovative financing must be treated as a core access lever, not a late-stage workaround.

2. Conceptual framing: Who pays vs. how we pay

To bring structure to a complex landscape, innovative financing should be framed around two fundamental questions: **who pays** and **how we pay**.

The first question, "**who pays**", focuses on expanding and diversifying the pool of stakeholders contributing to healthcare financing. Historically, pharmaceutical access discussions have focused on public payers. But in many emerging markets, public systems alone cannot absorb the cost of innovation. New access models increasingly require participation from **private health insurers, employers, providers, financial intermediaries, reinsurers, digital platforms, and hybrid public-private structures**.

The second question, "how we pay", focuses on restructuring payment. Rather than relying solely on large upfront payments, new models seek to spread costs over time, link payment to outcomes, cap financial exposure, or pool risk across stakeholders. These approaches include **installments, annuities, outcome-based agreements, subscription models, budget caps, and financing partnerships**.

This distinction is important because many traditional categories are not fully mutually exclusive. **Outcome-based agreements** are also a form of **risk sharing**. **Subscription models** can be viewed as a payment structure. **PHI models** may include riders, reinsurance, annuity-like features, or outcome-linked coverage. Rather than forcing models into rigid buckets, the **who pays / how we pay** framework reflects how access decisions are made in practice.

Rethinking who pays … and how

Payer diversification: "Who pays"

- Public payers
- Private health insurance (PHI)
- Employers
- Reinsurers
- Providers
- Financial intermediaries
- Hybrid schemes

Payment restructuring: "How we pay"

- Installments
- Annuities
- Outcome-based models
- Subscriptions
- Budget caps
- Patient financing

This framework also links directly to stakeholder needs. **Payers** face budget impact and affordability constraints. **Patients** face OOP affordability barriers. **Providers** face cash-flow and reimbursement delays. Effective financing models are those that target the specific constraint, rather than simply introducing a novel mechanism.

This is also where the private sector becomes particularly relevant. In markets where public reimbursement is incomplete, private funding ecosystems can play a meaningful role in closing the access gap — if they are designed around the right stakeholders, incentives, and market conditions.

3. Innovative private sector financing models

3.1 Private health insurance: expanding who pays

Private health insurance is becoming a critical lever in expanding access to high-cost therapies. However, PHI should not be viewed as one single model. It is a broad ecosystem of products, stakeholders, and mechanisms that can address different access barriers.

A stronger categorization of PHI models includes standalone insurance products, riders and add-ons, preventive and diagnostic-linked coverage, inclusive or microinsurance, value-based or risk-sharing coverage, and ecosystem partnerships. This more granular view better reflects the diversity of models emerging across markets.

Standalone PHI products

Standalone PHI products include **critical illness plans** and **disease-specific insurance plans**, such as oncology-focused coverage. These products are designed to provide targeted financial protection for specific conditions or therapy areas. They are particularly relevant where standard public or private coverage does not include innovative therapies.

For patients, these plans can reduce catastrophic OOP exposure. For insurers, they create differentiated products that can attract customers seeking protection against high-cost conditions. For pharma, they can create a new access channel for therapies that may not yet be included in public reimbursement.

Riders and add-ons to existing plans

Riders and add-ons extend existing insurance coverage. For example, an insurer may add coverage for non-reimbursed cancer drugs or high-cost specialty medicines on top of a base plan. These models can be easier to implement than standalone plans because they build on existing insurance infrastructure.

They also allow insurers to test demand, manage risk exposure, and offer differentiated coverage to specific customer segments. In emerging markets, riders may be particularly relevant for middle-income and urban populations with existing private insurance but incomplete specialty drug coverage.

Preventive and diagnostic-linked coverage

Preventive and diagnostic-linked PHI models focus on earlier identification and intervention. These models may link coverage to screening, diagnosis, adherence, or disease management. They are especially relevant for conditions where early detection can reduce downstream costs or improve treatment outcomes.

For pharma, these models can support earlier diagnosis and improve patient flow.
For insurers, they can reduce long-term claims costs by shifting care upstream.

Inclusive and microinsurance models

Inclusive and microinsurance models aim to expand coverage among underinsured populations through low-premium, modular insurance products. These may be supported by employers, NGOs, digital platforms, community organizations, or public-private partnerships.

These models are not always designed for the highest-cost therapies, but they can play an important role in expanding financial protection and building insurance literacy in underinsured markets.

Value-based and risk-sharing PHI coverage

Value-based PHI models link coverage or payment to outcomes, utilization, or cost drivers. These models may involve shared risk between insurers, manufacturers, and providers. They require strong data infrastructure, clear patient cohorts, and measurable endpoints.

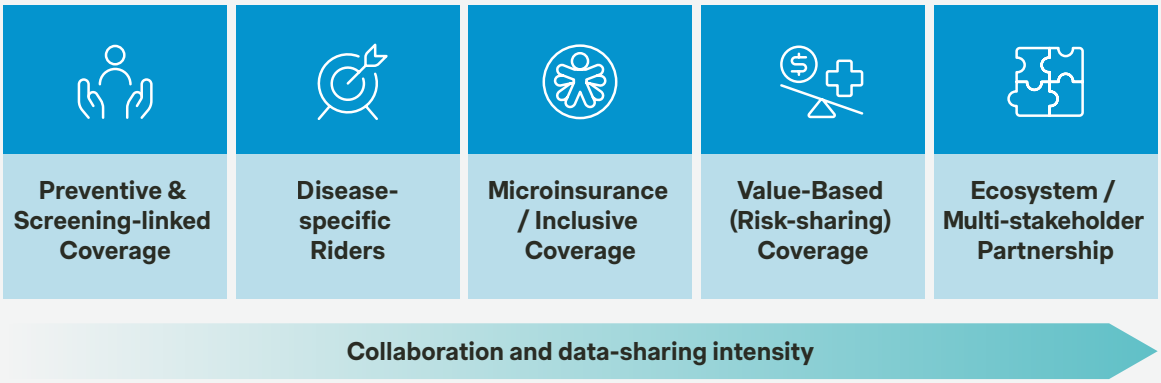
Thess models are particularly relevant where insurers need confidence that covering an innovative therapy will translate into measurable value, such as reduced hospitalization, avoided disease progression, or improved treatment persistence.

Ecosystem partnerships

The most advanced PHI models go beyond reimbursement. They integrate **insurers, providers, pharma, digital platforms, diagnostics, and patient support** into an end-to-end access pathway. These partnerships may include screening, patient navigation, treatment access, adherence support, and outcome tracking.

In this context, PHI becomes more than a funding source. It becomes part of the **access ecosystem**.

Out-of-pocket share of total health expenditure, by country income group (%)



3.2 How PHI models work in practice

Working with PHI is not only about enabling short-term access, but about building sustainable healthcare ecosystems that ensure long-term patient access to innovation, while remaining financially viable, operationally feasible, and scalable across healthcare systems.

PHI models are effective when they align the incentives of **patients, insurers, providers**, and **pharma** within a coherent system. This goes beyond simply including a therapy in a benefit package. It requires a structured approach that defines the eligible population, manages risk exposure, supports diagnosis, facilitates treatment pathways, and enables ongoing value tracking.

Crucially, working with PHI is not only about enabling access in the short term. It is about building sustainable healthcare ecosystems today that can support patient access to innovation in the future.

These models must therefore be designed with a long-term perspective, ensuring that they are financially viable for insurers, operationally feasible for providers, and scalable across patient populations.

One example is China's Huiminbao-type insurance model, which has expanded rapidly as a low-premium supplementary insurance approach. These schemes are typically city-level, commercially administered, and designed to complement basic public insurance, allowing broader segments of the population to access higher-cost therapies. Huiminbao-type schemes in China have scaled to cover more than 100 million individuals, demonstrating the potential of large-scale, affordable insurance models to expand access in a sustainable way.

Another example comes from insurer–pharma partnerships in oncology. In these models, pharmaceutical companies contribute epidemiology data, disease education, and support for benefit design, while insurers and reinsurers structure coverage and manage financial risk. These collaborations enable insurers to assess whether a high-cost therapy can be sustainably integrated into coverage.

Recent Simon-Kucher work also highlights models where private insurers and third-party administrators (TPAs) combine insurance benefits with patient support programs. These approaches extend access to high-cost oncology treatments while improving treatment continuity and patient outcomes, demonstrating that PHI can be integrated with affordability tools and managed care infrastructure, rather than operating as a standalone reimbursement mechanism.

Across these examples, the common denominator is the shift from isolated funding mechanisms to integrated access ecosystems, where financing, care delivery, and patient support are coordinated to ensure long-term sustainability

For these models to succeed, pharma must move beyond a clinical value narrative toward a financial value narrative. Insurers do not only assess whether a therapy works; they evaluate whether it improves claims experience, reduces downstream costs, enhances customer retention, and strengthens product differentiation.

In practice, leading pharmaceutical companies differentiate themselves by proactively co-designing insurance solutions with payers, providing real-world evidence to support underwriting and risk modeling, and aligning pricing structures with insurer economics, rather than acting solely as product suppliers.

This represents a critical shift. Pharma must translate clinical value into insurer-relevant outcomes, including risk reduction, claims impact, premium competitiveness, patient retention, and long-term cost avoidance.

3.3 Alternative funding models beyond insurance

Private sector financing is not limited to PHI. In many emerging markets, particularly those with high OOP burden, alternative funding models are emerging to make care affordable even when reimbursement is incomplete.

These models refer to financing arrangements that sit outside traditional public reimbursement and conventional private insurance, but still help patients access care by reducing the immediate cost they must pay themselves. While the structure of these models varies by market, their common purpose is to bridge affordability gaps, spread costs over time or across a wider group, and expand access for patients who would otherwise delay, forgo, or discontinue treatment because of cost.

A prominent example is **installment-based financing**. These models allow patients to convert high upfront costs into manageable monthly payments. They are often enabled by partnerships between providers, fintech companies, banks, or specialized healthcare financing players.

Our recent work highlighted multiple market examples, including large healthcare installment ecosystems in **Egypt**, hospital-led installment offerings in **Malaysia and Vietnam**, and fintech-enabled healthcare marketplaces in **Mexico**.

These models do not solve every access barrier, but they can be highly practical where the primary constraint is immediate affordability. They are particularly relevant for patients who have some ability to pay but cannot absorb the full cost upfront.

Alternative funding models may also include employer-supported access, patient financing platforms, digital health marketplaces, and provider-led affordability programs. Their common feature is that they mobilize non-traditional funding sources to reduce reliance on OOP lump-sum payments.

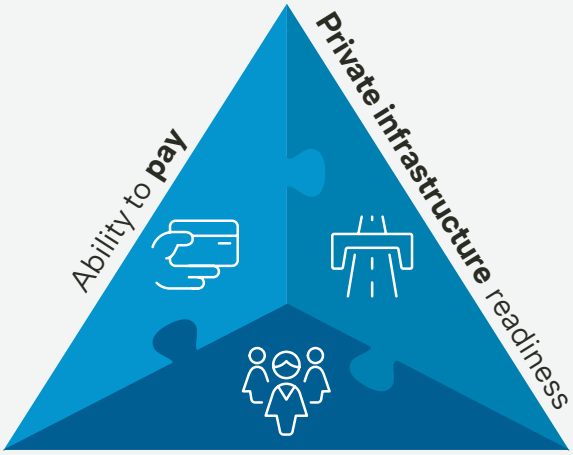
4. What it takes to scale

Designing an innovative financing model is only the first step. Scaling it requires market readiness, operational simplicity, partner alignment, data infrastructure, and effective governance.

The first question is whether the market has sufficient ability to pay. This does not only mean GDP per capita. It includes household income, employer coverage, insurance penetration, private provider infrastructure, and willingness to pay for healthcare protection.

The second question is whether the necessary private infrastructure is in place. Markets with organized private insurers, provider networks, fintech players, third-party administrators, and digital platforms are more likely to support alternative financing models.

The third question is whether the policy environment allows these models to operate. Insurance regulation, data privacy, pharma compliance rules, and reimbursement policies can all determine whether a model is feasible.



Partnership models: Moving from funding to access ecosystems

The most sophisticated models combine funding with care delivery. These partnership models involve pharma, insurers, providers, digital platforms, financial intermediaries, and sometimes public stakeholders.

For example, a pharma–insurer partnership may integrate screening, diagnosis, benefit design, treatment access, and follow-up support. A pharma–provider–financing partnership may combine installment payments with patient navigation. A digital health platform may support patient identification, affordability screening, and adherence tracking. Successful models also share several operational characteristics. They target clearly defined patient cohorts, use measurable outcomes or cost drivers, and keep enrollment and claims processes simple. They align incentives across pharma, insurer, provider, financing partner, and patient. And they are designed with clear compliance guardrails.

These models are powerful because they solve more than one barrier at once. They expand who pays, restructure how payment happens, and improve how patients move through the care pathway.

Successful implementation depends on orchestrating a coordinated approach across **multiple stakeholders**, rather than relying on a single payer or a single access lever.

For pharma, the role is not to become an insurer or lender. The role is to act as an **ecosystem enabler**, **co-developer**, and **integrator**.

This shift requires new capabilities. Companies need to understand insurance economics, financing structures, partner incentives, and implementation realities. Traditional market access capabilities remain important, but they are no longer sufficient on their own.

5. From access challenge to financing ecosystems: the path forward

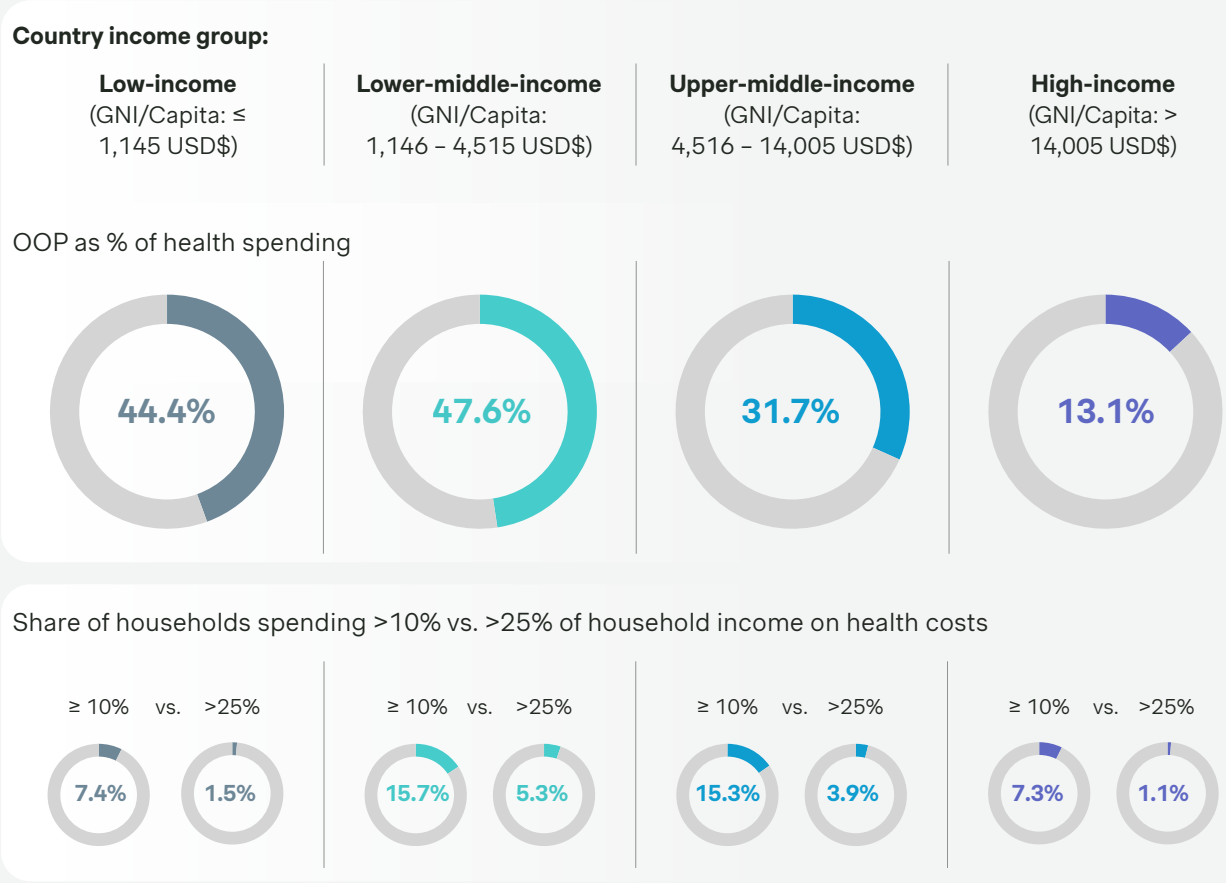
Innovative financing is becoming a key enabler of both **access and growth**. As high-cost therapies continue to reshape healthcare systems, the ability to address both **who pays** and **how we pay** will be central to unlocking sustainable access.

This is particularly relevant in emerging markets, where OOP burden remains high, public reimbursement is often limited, and private sector infrastructure is evolving rapidly. However, the relevance extends beyond emerging markets. High-cost therapies are challenging healthcare systems globally, and models developed in emerging markets may increasingly inform access solutions elsewhere.

LMICs account for the vast majority of the global population, making scalable access models essential for both patient impact and long-term growth. Previous Simon-Kucher analysis indicates tha **88% of the world's population resides in LMICs**.

Out-of-pocket health spending and share of catastrophic expenditure deviate significantly outside high-income countries

Financial burden intensity across country income groups



Catastrophic out-of-pocket health spending occurs when health payments exceed a household's ability to pay. Households in LMICs have a higher level of catastrophic health spending as illustrated by the share of the households that spend over 10% vs. 25% of income (SDG 3.8.2).

For pharmaceutical companies, the implications are significant. Innovative financing should not be treated as an optional access experiment. It should be embedded early into lifecycle planning, market prioritization, launch strategy, and ecosystem partnership design.

Companies should start by identifying where the access barrier lies: payer affordability, patient OOP burden, provider cash flow, risk exposure, or system fragmentation. They should then determine whether the solution requires expanding who pays, restructuring how payment happens, or a combination of both.

The companies that succeed will not only improve access. They will also help shape the next generation of healthcare financing, ensuring that innovation reaches patients globally.

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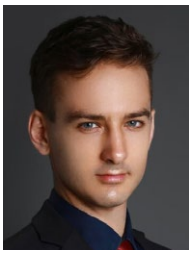

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About Simon-Kucher

Simon-Kucher is a global consultancy specializing in growth strategy, pricing, and commercialization. Within the life sciences industry, we work with leading pharmaceutical companies to design access strategies that are commercially viable, operationally feasible, and built for scale.

Our teams help clients navigate complex markets by aligning pricing, go-to-market models, and health system realities, particularly in geographies where affordability, regulation, and infrastructure shape what success looks like. With experience across Latin America, Africa, Southeast Asia, and other emerging markets, we support pharmaceutical leaders in launch sequencing, IRP management, value communication, and embedding access earlier in product planning.

We partner closely with senior teams to translate strategic ambition into actionable plans that deliver measurable impact for both patients and business.

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