Connecting people to better healthcare
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Kenya

Stuck in a vicious circle

- Low demand & poor supply of healthcare
- No quality standards
- Mortality under 5 is 108K
- Maternal deaths 5.5K at birth
- Gvt. health expenditure $17 per capita
- OOP $21 per capita (donors $19 per capita)
- 43% of population live below poverty line
- Institutional environment is weak
- Little enforcement
- Lack of trust
- Low level of investments due to high risks
- Lack of reliable data & information
Kenya’s health system: coordination is needed

**Newly established social enterprise**
- 2,100 facilities contracted
- Focus on lower market segments
- Focus on informal sector
- Low premium, low administration costs

**Partnerships**
- MOU with Vodafone and M-PESA Foundation
- Merchant Aggregator agreement with Safaricom
- PharmAccess is partner for product development
- SafeCare is partner for quality standards
- Medical Credit Fund is partner for facility financing

**Advantages of platform approach**
- Payment & utilization data collected in real-time
- Allows for introduction of new health financing types
- Mobile data used for segmentation & targeting
Advantage #1: real-time actionable data

**Prevalence of diseases**
- Respiratory: 54%
- Digestive: 19%
- Infectious: 11%
- Other: 11%
- Skin: 5%

**Malaria diagnoses**
- Githogoro: 1
- Kayole: 38
- Kibera: 166
- Komarock: 1
- Mathare: 30

**Transactions per hour**

**Transactions per day**

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Advantage #2: introducing new financing types

Out-of-pocket cash
Out-of-pocket Lipa na M-PESA
Health wallet post-paid
Risk-pooling via shared wallet
Hybrid bundled product
Health wallet pre-paid
Insurance with premium financing
Insurance pre-paid

Five new health financing types are created of which three are based on prepayment
Advantage #3: mobile-data segmentation

1. Slum dwellers (15.6%)
   - Slum population living hand to mouth from day jobs and hawking

2. Rural indigents (16.7%)
   - Subsistence farmers living hand to mouth off a small plot of land or small live stock, and day laborers

3. Household workers
   - Household workers at wealthy families (guard, cleaner, nanny, driver)

4. Nomadic communities
   - Nomadic people living of herds. Substantial health risks due to living conditions, small support network

5. Small scale farmers & traders
   - (Upper) low-income small scale farmers living off the land (substance & cash crops), livestock and small trade

6. Employees medium businesses
   - Owners willing to finance health insurance for their employes

7. Employees large scale farms
   - Large-scale farmers, taking care of one to hundreds of employes

8. Owners small businesses (9.2%)
   - Entrepreneurs of SMes such as M-Pesa shop or boda boda driver. Low to upper low income

9. Caretakers (18.4%)
   - Ambitious with urban jobs, middle to high income, supporting relatives

10. Chama members (28.6%)
    - Social/ member driven groups with purpose of saving with each other

11. SACCO members (9.1%)
    - Members of bigger savings and credit cooperatives, owned and managed by its members

12. M-Shwari and KCB customers
    - Economically active and engaged in entrepreneurship. Some receive financial support (M-shwari 1.0%)

13. Women at reproductive age (22.7%)
    - Women aged 15-44 yrs

14. Girls at risk of teen pregnancy (3.2%)
    - Girls at risk of teen pregnancies, living in rural, traditional locations

15. People living with (at risk of) HIV/AIDS
    - HIV living with HIV, and people living at risk lifestyles (sex workers, truck drivers)

16. Poor children < 5 (13.0%)
    - Children < 5 at risk of childhood diseases in indigent, lower to upper lower income households

17. Households in disease prone areas (74%)
    - Households living with animals, sleeping in cooking areas and often in high-malaria prevalence areas

18. Orphans (2.7%)
    - Orphans living with uneducated, low-income to indigent caretaker

19. Elderly > 65 (2.7%)
    - Elderly, prone to arthritis, hernia, hypertension, diabetes, rheumatism

20. Chronically ill (>25.6%)
    - Chronically ill (hypertension, diabetes), limited exercise, limited education on risks

- Segments composed from different parameters, e.g. vulnerable groups, economic & financial behavior, health risks
- Segments not mutually exclusive and some yet to be quantified (work in progress by Safaricom and PharmAccess)
- Donors/payers are invited to design their own mobile wallet propositions for target segments (e.g. vouchers)
MTiba

- Launched in March 2015, to test platform end-to-end at scale
- Tested with 44 clinics and 5,000 mothers in slums of Nairobi
- 80% of respondents expressed willingness to save for health

**Interest from key players in the health sector**

Field visits from large pharmaceutical companies, BMGF, MoH, IFC / World Bank, Global Fund, NHIF, private health insurers, and many others
Lessons Learned

• Using mobile data to segment the market is easy, but mobile enrolment is not
• Agent model works better than SMS
• Women like the wallet as a means of saving for health, also because it keeps the money safe from their husbands
• Wallet allows for “vertical” programs (e.g. separate funding for HIV/AIDS & malaria), but this is difficult to explain to patients and providers
• High staff turnover at facilities means continuous training is needed
• Mobile payments increase safety

Call to action

• Funding raised to scale to 300,000 wallets in 2016, meaning 1.5 mio beneficiaries
• Much more is needed for “network” effect
Appendix
Origins in Amsterdam Medical Center, University of Amsterdam

- **1995**  Mother-to-child transmission studies in Africa
- **2000**  PharmAccess Foundation: treatment in Africa
- **2002**  Initiated HIV treatment programs: Heineken, Shell, Celtel, Diageo, Unilever, Coca-Cola
- **2005**  HIV/AIDS program for armed forces in Tanzania (PEPFAR program)
- **2006**  Health Insurance Fund (150 mio USD public fund)
- **2007**  Research: Amsterdam Institute for Global Health & Development
- **2008**  Private equity: Investment Fund for Health in Africa, largest health fund in Africa
- **2009**  Largest loans fund for doctors and pharmacies in Africa (MCF)
- **2011**  Medical standards: first accredited quality standards for Africa
- **2013**  Mobile health: partnership with Vodafone, M-PESA and Safaricom
- **2015**  Access-to-treatment initiative: kick-start Hepatitis-C Treat & Cure

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