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REPUBLIC OF GHANA

NHIS
NATIONAL HEALTH INSURANCE SCHEME

Health Finance & Governance
Expanding Access. Improving Health.

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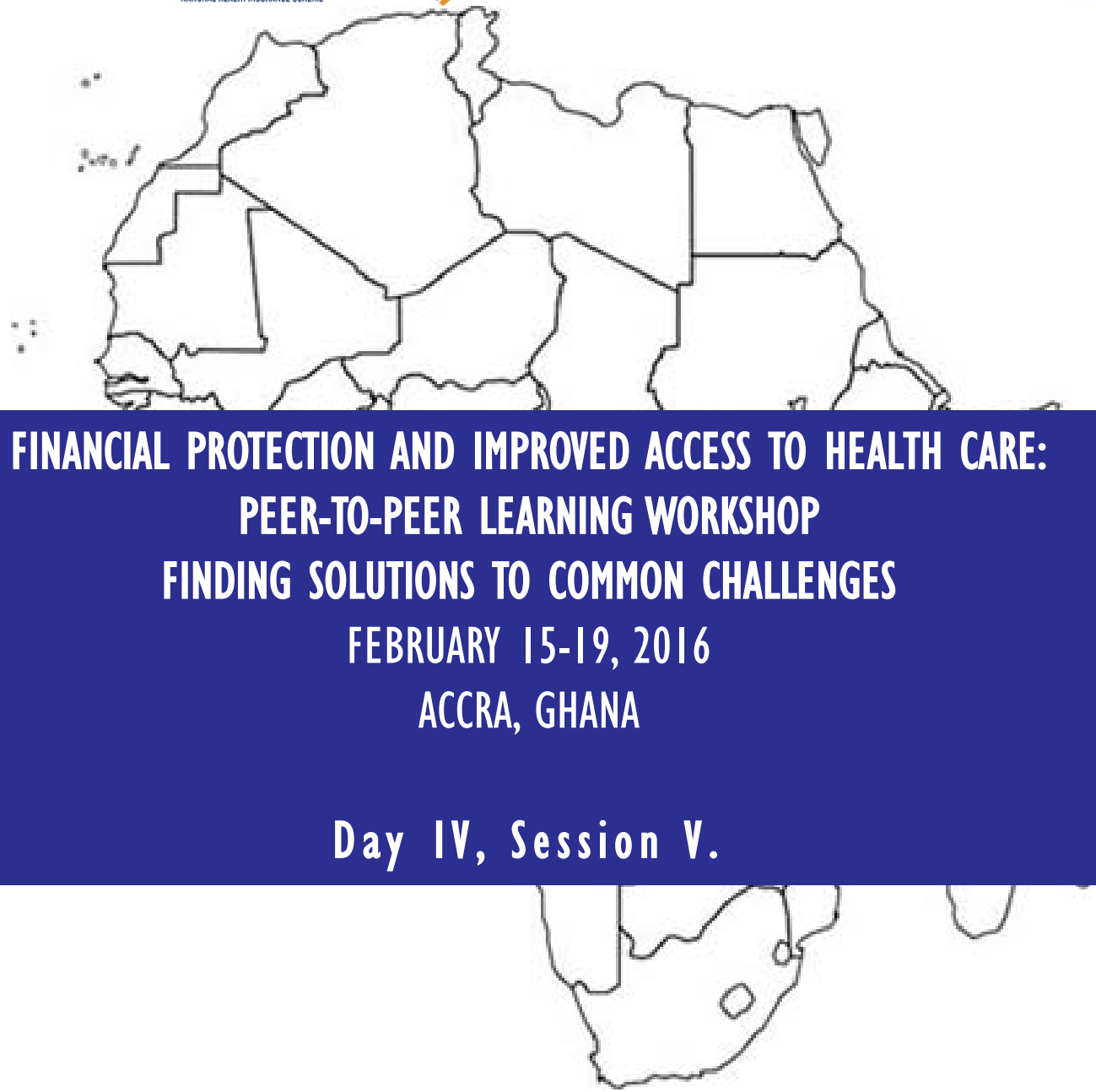


FINANCIAL PROTECTION AND IMPROVED ACCESS TO HEALTH CARE:
PEER-TO-PEER LEARNING WORKSHOP
FINDING SOLUTIONS TO COMMON CHALLENGES

FEBRUARY 15-19, 2016

ACCRA, GHANA

Day IV, Session V.

Connecting people to better healthcare

Cees Hesp & Maxwell Antwi

Accra, 18 February 2016

PharmAccess FOUNDATION

Health Insurance Fund

MEDICAL CREDIT FUND AFRICA

SafeCare BASIC HEALTHCARE STANDARDS

PHARMACCESSGROUP

Kenya

Stuck in a vicious circle

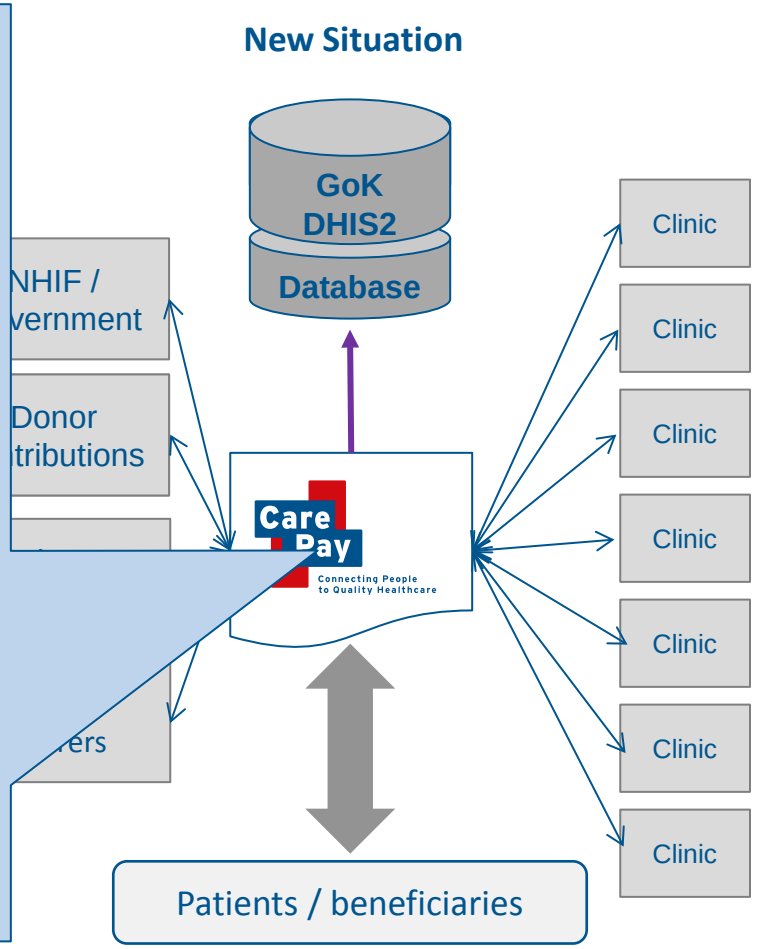
- Low demand & poor supply of healthcare
- No quality standards
- Mortality under 5 is 108K
- Maternal deaths 5.5K at birth
- Gvt. health expenditure $17 per capita
- OOP $21 per capita (donors $19 per capita)
- 43% of population live below poverty line
- Institutional environment is weak
- Little enforcement
- 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

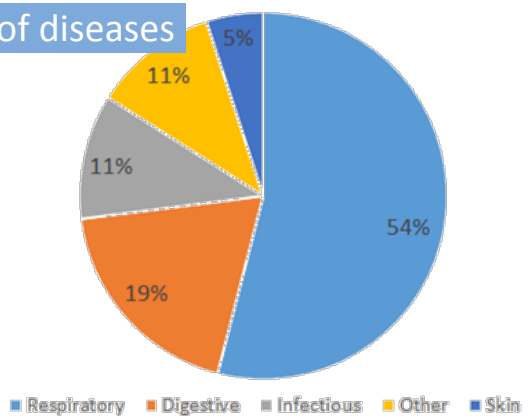
Partnerships
- MOU with Vodafone and M-PESA Foundation
- Merchant Aggregator agreement with Safaricom
- PharmAccess is partner for product development
- SafeCare is partner for quality standards
- Medical Credit Fund is partner for facility financing

Advantages of platform approach
- Payment & utlization data collected in real-time
- Allows for introduction of new health financing types
- Mobile data used for segmentation & targeting

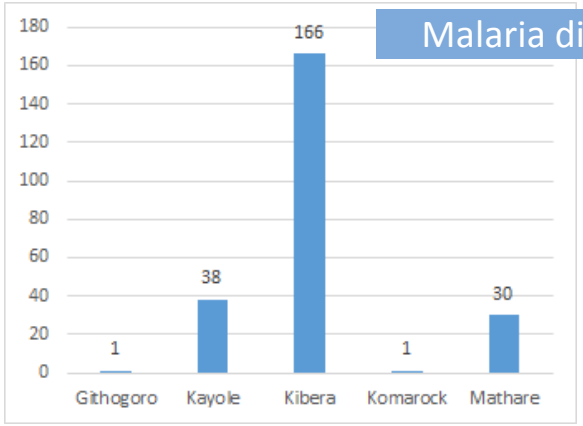


Advantage #1: real-time actionable data

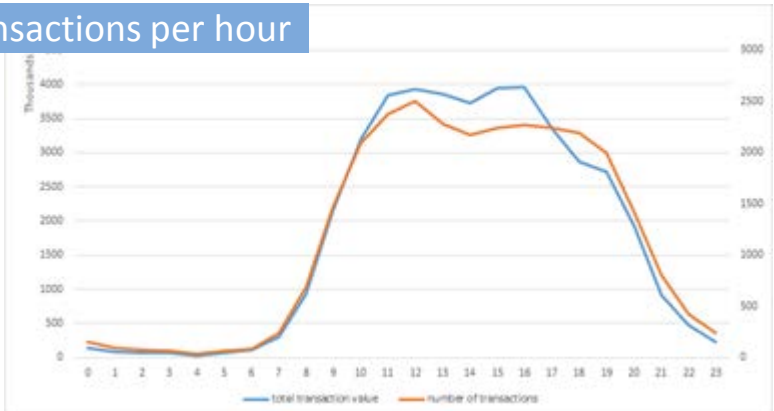
Prevalence of diseases



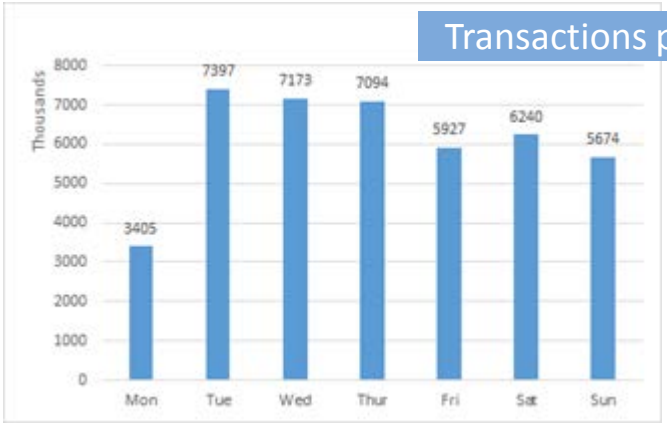
Malaria diagnoses



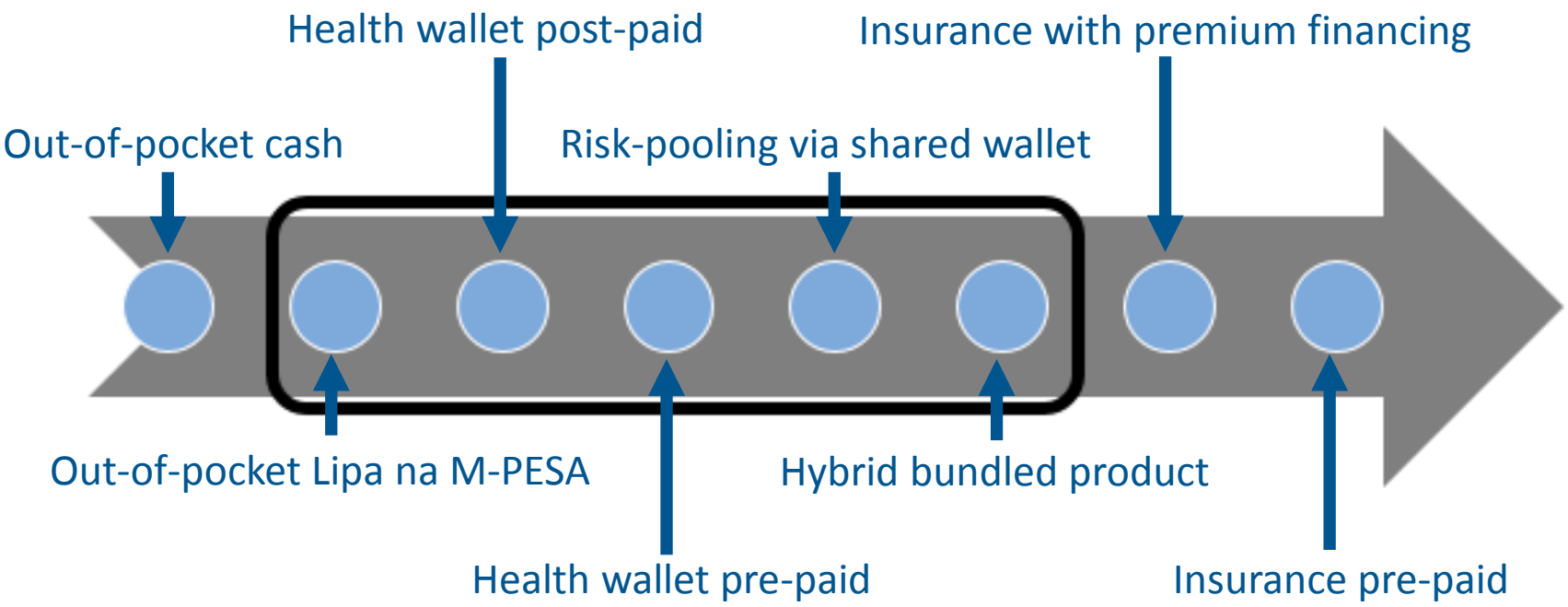
Transactions per hour



Transactions per day



Advantage #2: introducing new financing types



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 (subsistence & cash crops), livestock and small trade

6. Employees medium businesses

Owners willing to finance health insurance for their employees

7. Employees large scale farms

Large-scale farms, taking care of one to hundreds of employees

8. Owners small businesses (9.2%)

Entrepreneurs of SMEs such as M-Pesa shop or bodaboda driver. Low to upper low income

9. Caretakers (18.4%)

Ambitious with urban jobs, middle to high income, supporting relatives

10. Chama members (28.0%)

Social/ member driven groups with purpose of saving with each other

11. SACCO members (9.1%)

Members of bigger savings and credit co-operatives, owned and managed by its members

12. M-Shwari and KCB customers

Economically active and engaged in entre preneurship. Some receive financial support (M-shwari 10%)

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

6% 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%)

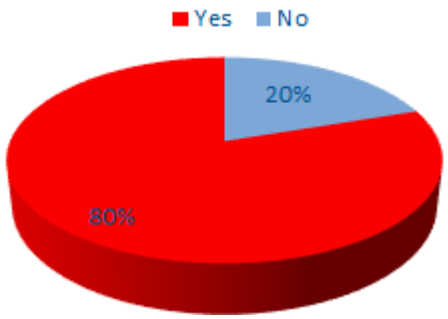
Chronically ill (hypertension, diabetes), limited exercise. limited education on risks

- 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)

First product: MTiba mobile health wallet

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

In conclusion

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

PharmAccess FOUNDATION

Health Insurance Fund

MEDICAL CREDIT FUND AFRICA

SafeCare BASIC HEALTHCARE STANDARDS

PHARMACCESS GROUP

PharmAccess

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

2000

2011

2014