Private health care in Africa

A middle way?

Insurers have spotted an opening for no-frills but life-saving health care

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Waiting for the state-paid doctor

SITTING in the shade outside the Avenue hospital in Kenya's capital, Nairobi, Stephen Ombedho plays on his smartphone while his wife is inside being treated for a chest infection. After three years of private health insurance, he is still getting used to the perk. But he remembers the wait at public hospitals, where the queuing can be measured in days.

The 38-year-old driver and his family are covered by his employer, a dairy firm, at a cost of about $200 a year. The package does not offer much in the way of frills. The wooden waiting area in the hospital car park is little better than a shed. But the care on offer is markedly better than in most of its state-run counterparts. A friend of Mr Ombedho died last year only hours after being discharged from one of them. The doctors, he said, had "no time or money" to give his friend proper treatment.

Until recently Kenya was typical of most of sub-Saharan Africa in having, in effect, a two-tier health system. At the top end, the rich generally went to one of two exclusive private hospitals, while the poor majority had to put themselves at the mercy of an often dysfunctional state sector. That has left a huge gap in the middle, says Diana Patel, who

heads Avenue Group, which runs small private hospitals and outpatient clinics. “As soon as we started to fill that gap,” she says, “we’ve been overflowing.”

Its low-cost model relies on keeping medical tests to a minimum and ensuring that doctors do not waste time on tasks that nurses can do. A handwritten sign in Mrs Patel’s office reads “Recognise nurses’ aides”, a plea to staff to let those on the lowest pay grade fulfil unskilled tasks such as emptying bedpans. She describes the Avenue’s approach as “giving patients everything they need and nothing more.”

East Africa’s improved investment climate persuaded the group to expand. In the past three years Avenue has doubled its number of outpatient clinics to 13; earlier this year it opened a second 70-bed hospital in Kisumu, western Kenya’s largest city. In the next three years it aims to open similar-sized hospitals in neighbouring Uganda and Tanzania.

In 2011 a London-based firm, Aureos Capital, later bought out by one of the Middle East’s biggest private-equity firms, the Dubai-based Abraaj Group, invested $2.5m in Avenue. Shakir Merali, a fund manager with Abraaj, sees it as part of a future pan-African network of affordable private health-care providers meeting an “unmet demand for a need that is recession-proof.”

By 2016 the market for health care in sub-Saharan Africa will be worth $35 billion, according to a report by McKinsey, a consultancy. But a skills shortage is constraining it, since the continent is reckoned to host a quarter of the world’s disease burden but has only 3% of its medical workers. The World Bank reckons an additional 90,000 doctors and 500,000 nurses will be needed in the next few years.

It is even harder to see how people can pay for health insurance, especially since few Kenyans work in the formal sector, where they might build up a fund. So far some 600,000 Kenyans out of 43m are estimated to have bought policies or been given workplace insurance.

Half of Africa’s health expenditure is thought to come from out-of-pocket payments, known to health-care pundits as OOPs, with the sick paying over the counter. In Kenya OOPs account for $77 out of every $100 spent on private health care, says the World Bank. Millions of people are pushed into a poverty trap by a sudden health crisis. Moreover, the cash economy has been a breeding ground for quacks, counterfeit medicines and unlicensed dispensaries whose owners play hide-and-seek with sparse health inspectors.

The only sensible system, argues Onno Schellekens, who runs the Investment Fund for Health in Africa, a private-equity fund based in the Netherlands and Mauritius, is pre-paid private health insurance. Most Kenyans already agree informally among friends and relations to pool medical costs in times of need. Mr Schellekens's fund began work in September with Safaricom, Kenya's leading telecoms company, which pioneered a hugely successful mobile money system, M-Pesa. PharmAccess, a Dutch foundation that aims to bring affordable health care to Africa, is running three pilot schemes that formalise this pooling of risk. It hopes to find the right mix of price and product to persuade people at the market's bottom end to buy in.

"Telecoms have proved that Africans will pre-pay for a service that works," says Mr Schellekens. Safaricom now also offers health cover with a local insurer, Britam. Its "Linda Jamii" ("Protect the Family") plan provides basic inpatient and outpatient annual cover for two parents and an unlimited number of children for $140 a year. Sven Byl, who works on health care in Africa for KPMG, a consultancy, predicts that private equity will "remake health care" for the continent.

Some international donors and health-care experts, ideologically attached to the well-endowed systems they are used to at home, resist the onset of private health care for the new middle class. But a decent free system for everyone is not yet affordable. The World Health Organisation reckons a basic system costs $34-40 per head. Kenya currently spends $11, at the latest count, in 2011. African governments, Mr Byl argues, should not waste time "copying unaffordable models from the West".

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