Health Insurance Fund
PROGRESS REPORT 2019
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In 2019, through collaboration with (local) governments, the private sector and communities across sub-Saharan Africa, new policies and legislations have been implemented and our interventions have evolved and scaled—increasing the potential for delivering better healthcare to 50 million people in Ghana, Nigeria, Tanzania and Kenya.

Dear friends,

In this report, we proudly present highlights and the impact of our 2019 activities. Achieved through the collaboration with (local) governments, the private sector and communities across sub-Saharan Africa, where new policies and legislation have been implemented and our interventions have evolved and scaled—increasing the potential for delivering better healthcare to individuals across Ghana, Nigeria, Tanzania and Kenya.

The results reflect not only raw statistics, but share the strategies behind our principle mission of bringing better healthcare to countries in sub-Saharan Africa (SSA) and the stories of how our work have catalyzed change and impacted people’s lives.

At the time of publishing, the COVID-19 virus has spread around the globe destroying trillions in wealth in a matter of months. Affecting everybody everywhere, and making us realize that the world will only be safe when we are collectively able to stop the pandemic everywhere. In these unprecedented and uncertain times, universal health coverage (UHC) and the need to build stronger and more transparent health systems has become more evident and necessary than ever.

The countries where we work have adopted UHC, where national and state governments, despite budget constraints, are expressing their commitment to partly subsidize health insurance for low-income people. In Tanzania, the National Health Insurance Fund (NHIF) has been able to disburse of over USD 20 million in 2019. This success is partly driven by our digital loan product in Kenya, the Cash Advance. Clinics can access small, fast loans from our private sector partners, and stakeholders with data for informed decision-making, while complementing the work with the thousands of public and private clinics that belong—with more control, at the center of their own healthcare journeys.

In terms of Quality Improvement, we made important strides in 2019 by investing in a SafeCare digital quality platform that better connects providers and stakeholders with data for informed decision-making, while complementing the work with the thousands of public and private clinics that participate in the program to improve their quality levels.

Through the Medical Credit Fund we have financed more clinics with more loans than in any year before, with a total disbursement of over USD 20 million in 2019. This success is partly driven by our digital loan product in Kenya, the Cash Advance. Clinics can access small, fast loans from their mobile phone without the collateral requirements and burdensome administrative procedures. This in turn helps to improve the availability of primary healthcare to serve people in their everyday lives.

To address a fragmented supply chain that often delivers substandard or even fake medications in Ghana, we worked closely with partners to initiate a digital platform for procuring pharmaceuticals—so that people in Ghana can trust the medicines they buy, and at a lower cost.

None of our work would be possible without the collaboration with our highly valued partners, and the continued support of the Dutch Ministry of Foreign Affairs, the Nationale Postcode Loterij and many other donors and investors.

As we look forward, no single intervention or organization can solve the healthcare problems facing our world. If anything, the COVID-19 pandemic has reminded every one of us that health systems can be fragile, and that we must continue to strive to ensure that every individual has access to dependable care.

We believe that the availability of data and mobile platforms has the potential to completely change healthcare financing and delivery in Africa and facilitate better, more patient-centered healthcare services. African countries cannot afford lockdowns. Technology offers an opportunity to build more transparent and resilient health systems, that can help contain this pandemic and can be sustained for the future. Making health markets work for all is what drives us at PharmAccess, and we are confident that with political will, through public-private partnerships and the use of technology this can be achieved.

Monique Dolfing-Vogelenzang
CEO PharmAccess Group
Health Insurance

How can access to quality care for low and middle-income families in Africa be improved?

The Health Insurance Fund, launched by the Dutch Ministry of Foreign Affairs, aims to develop inclusive health markets in order to increase access to affordable and quality healthcare for low- and middle-income populations. It does so through the use of technology and introduction of innovative financing mechanisms, such as health insurance, mobile health wallets, blended investments and the improvement of healthcare quality.

Launch Medical Credit Fund

With a lack of trust between health SMEs and banks, how can health SMEs grow their business and invest in quality? Since its launch, MCF has proved, with over 4,000 loans, and more than $170 million disbursed and an average 97% repayment rate, that lending to health SMEs makes business sense and contributes to UHC by strengthening primary and secondary care.

Launch SafeCare

With international care standards out of reach for most health facilities in Sub-Saharan Africa, how can quality be improved?

With SafeCare’s stepwise quality process health facilities carry out assessments with 91% improved their quality. Assessments provide investors and donors with a benefit-risk analysis, turning them into attractive investment opportunities.

Launch MemCare

How can care be organized around the patients’ needs?

With MemCare, mobile data is leveraged to offer evidence and value-based care, which puts patients and their health outcomes at the center of the decisions about allocating scarce resources.

Launch mTIBA

How can mobile reshape healthcare?

Over 4 million patients can now access healthcare from 1500+ facilities directly on their mobile thanks to an affordable health exchange. mTIBA facilitates access to care for low-income groups whilst distributing funds in a healthcare system in a smarter and equitable way, something that refers to equity/social redistribution, demonstrating that UHC can be achieved at low marginal cost.

Mobile Health Financing

Innovations

2001

2003

Launch first Risk Equalization Fund for HIV/AIDS

It is impossible to cover an HIV/AIDS patient for only $340 per month? The Vitality Daniels, a basic medical fund in Namibia, showed the way.

2009

Launch Medical Credit Fund

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2010

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2015

States in Kenya and Nigeria launch their first Health Insurance scheme with support of the Dutch Ministry of Foreign Affairs and a public/private partnership including PharmAccess

MCF wins OER Impact Award for Access to Finance. KwaZulu Health Insurance program won:
- Finalist for the OECD AC Prize for Taking Development Innovation to Scale
- Saving lives at Birth Award
- Selected as model for scaling access to care by the World Economic Forum

2016

Dutch Ministry of Foreign Affairs relaunches the HIF for 7 years

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- Saving lives at Birth Award
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2017

mTIBA launches in Ghana

AWARD

mTIBA wins Financial Times/VC Transformational Business award Partnership with National Health Insurance Fund Kenya

HealthConnect launched to enable direct and fully transparent peer-to-peer funding through mobile.

2018

Diabetes and hypertension care pilots launched in Kenya with social partners

KwaZulu, Nigeria, launches mandatory Health Insurance for all using mobile to enroll the population

2019

Financial Times Future of Healthcare conference

Med4All launches in Ghana
These advances provide enormous opportunities to address the challenges that have thwarted the efforts of governments and the private sector to deliver health for millions of underserved populations. Using available funds more effectively and building sustainable health systems are critical to our work, as well as harnessing data to strengthen these systems, and in ways that send the benefits back to society.

To promote a strategic dialogue on these issues, PharmAccess organized the Financial Times Future of Health Coverage Conference in May of 2019, along with the Dutch Ministry of Foreign Affairs, the Joep Lange Institute (JLI), and the private sector in both Africa and Europe. The conference was opened by Her Majesty, Queen Maxima, UN Secretary-General’s Special Advocate for Inclusive Finance for Development. Sigrid Kaag, the Dutch Minister for Foreign Trade and Development Co-operation and Yaw Osafo-Maafo, the Senior Minister of Ghana, attended.

Key stakeholders discussed multiple strategies: for using mobile technology and data to enhance the financing and delivery of healthcare and private sector investments; advocacy for legislation on mobile payment services to expand financial services to millions of people in Africa without a bank account; and partnerships for scaling and learning from digital solutions for inclusive health coverage in developing countries. The value of health data was another recurring theme, as was a discussion on the risks and need for data solutions that serve everyone.

As a direct result of the conference – and the underlying advocacy – the Global Fund signed a partnership agreement with PharmAccess to support African countries in accelerating progress toward UHC by harnessing digital technology. Relying on a solid base of local and international public-private partnerships, and with the support of international stakeholders including the Dutch Ministry of Foreign Affairs, we will embrace the challenge.

At the United Nations General Assembly on UHC, David Malpass, the President of the World Bank, spoke about the effectiveness of the mobile health platform M-TIBA in delivering digital health insurance. His words to speak to how digital and mobile technology is revolutionizing healthcare, especially in Africa.

PharmAccess 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. We have country offices in Kenya, Tanzania, Ghana and Nigeria, and a head office in the Netherlands. By the end of 2019, we employed a multidisciplinary team of 213 professionals, of which 70% are based and operate in our African country offices.
Establishing PharmAccess

At one point, in challenging the healthcare status quo, Joep Lange declared, “if we can get cold Coca Cola and beer to every remote corner of Africa, it should not be impossible to do the same with drugs.”

In 2001, his first objective after founding PharmAccess was to push groundbreaking scientific research on triple combination drug therapy into action by bringing HIV/AIDS treatment to regions where it had previously been unavailable. As an initial step, PharmAccess partnered with Heineken to design workplace healthcare programs for their employees and dependents who were based in Africa – a practice to be followed by many other companies. These programs laid the foundation for international action by proving that treatment in Africa was viable and that the delay in delivering care was a political choice.

The work also highlighted the financing challenge in Africa: the need for affordable, social health insurance that would include coverage for communicable disease like HIV. As a result, several multinational companies, the Dutch Ministry of Foreign Affairs and PharmAccess decided that more needed to be done to provide people in Africa with access to better healthcare. A working group was formed to discuss possibilities for including the private sector, which led to the creation of the Health Insurance Fund in 2006 and the signing of a long-term partnership with the Dutch Ministry of Foreign Affairs. Consequently, the Health Insurance Fund contracted PharmAccess as its implementer and AIGHD/AID to conduct impact and operational research.

After a positive evaluation of the first funding term by the Boston Consulting Group in 2015, the Ministry renewed the partnership for another 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. Develop private pre-payment mechanisms, risk pooling structures, and mobilize resources for organized demand.
2. Strengthen, benchmark, and certify clinical and business performance for healthcare providers.
3. Improve efficiency, effectiveness and transparency to better match demand and supply of healthcare transactions.
4. Mobilize capital into the health sector.
5. Conduct research on interventions and advocate those that are successful.

Envisioning a virtuous cycle

Several longstanding propositions guide our work. 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. In Africa, the private sector delivers approximately 50 percent of health services.

At the same time, governments play a critical part as well – as only they can intervene at the required scale to enforce financial synergies, risk pooling and regulation. However, in SSA, governments may lack the capacity to finance, regulate, and enforce health policies. As a result, a large segment of the population – especially those at the bottom of the pyramid – are on their own. The low quality and uncertain availability of health services discourage people from pre-paying for health. Pre-payment is also a relatively new concept for the region, and many families face competing priorities for their limited resources. Because of this, most pay out-of-pocket when they need care.

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.
Starting private, growing public

Strong partnerships are essential for intensifying impacts and making programs efficient and sustainable. PharmAccess partners with the private sector to develop scientifically evaluated proofs of concept that deliver data and can later be adopted by the public sector. And we work with the public sector to provide insights and data for more informed decision making.

In terms of the private sector, in 2019 PharmAccess launched the SafeCare Quality Improvement Program with the Christian Health Association of Ghana (CHAG). As part of the partnership, SafeCare will facilitate the training of 20 medical professionals on local quality improvement standards such as the importance of handwashing to fight infection. These individuals will then support all 330 CHAG hospitals which service millions of low-income Ghanaians – to scale up SafeCare while at the same time providing more Ghanaians with quality healthcare. Critically, CHAG providers get income from NHIA, making the financing of quality care more feasible and sustainable.

In Nigeria, the CarePay digital platform has been chosen by Lagos state to run its mandatory health insurance scheme. The platform has also been featured prominently in the international and Kenyan news media, including CNBC.

In terms of collaborating with the public sector, in Tanzania we worked with the NHIF and regional authorities to integrate iCHF into the national health insurance program. In Nigeria, we partnered with the Global Fund and CarePay to scale digital innovations for UHC and quality improvement models within the Lagos State health insurance scheme. And, in every country we support, PharmAccess has actively participated in national policy dialogue, debates and expert meetings organized by policy makers.

In Kenya, a mobile registration app that had been developed on M-TIBA was used to assist the Kenyan government with mass household registration for the UHC pilot in three countries.

Our partnership with Ghana’s NHIA is a particularly important example. Ghana has adopted a “Beyond Aid” economic policy for relying on its own resources, technology, and the private sector to deliver prosperity to more Ghanaians. The mandate asserts that each agency must address its financial sustainability issues and operational inefficiencies to contribute to the government’s agenda of self-reliance.

NHIA covers nearly 40 percent of the Ghanaian population – including low-income groups – and represents a best-practice example for public insurance across the region. Yet the agency faces the challenge of ensuring the scheme’s financial sustainability while also increasing enrollment and improving the effective coverage of services so that more Ghanaians can access care.

Recognizing this as an opportunity to contribute, PharmAccess offered to serve as a technical advisor to help the NHIA analyze all membership and claims data, with the aim of developing data-based insights and reducing costs. The goal for NHIA is to digitally transform into an insurer capable of making more informed, evidence-based decisions. PharmAccess began analyzing NHIA data in 2019, with key insights expected in 2020.
ACCELERATING HEALTH FINANCING

Most developing countries lack institutionalized solidarity mechanisms, and the total per capita health spending is very low.

Healthcare financing sources are highly fragmented, and the system suffers from distrust issues.

Quality challenges and uncertain availability of health service delivery discourage people to pre-pay for health.

Mobile technology enables efficient and equitable demand side health financing approaches.

**BARRIERS**

- Most developing countries lack institutionalized solidarity mechanisms, and the total per capita health spending is very low.
- Healthcare financing sources are highly fragmented, and the system suffers from distrust issues.
- Quality challenges and uncertain availability of health service delivery discourage people to pre-pay for health.
- Mobile technology enables efficient and equitable demand side health financing approaches.

**THIS IS WHY WE...**

- Partner with public and private payers to pioneer and roll-out social health insurance schemes specifically for low-income groups.
- Use mobile technology as an enabler to create public-private risk pools for healthcare at low transaction costs.
- Empower households and individuals, based on their identified socio-economic status to receive, copay or save for health entitlements and to access services.

**CONTEXT:**

11 million people in Africa are being pushed into extreme poverty because of out-of-pocket costs.

36% of health expenditure in SSA is out of pocket, compared to 22% in the rest of the world.

SSA is the fastest growing region of unique mobile subscribers.

456 million unique mobile subscribers, an increase of 20 million over the previous year.

Sub-Saharan Africa struggles with a health system that has very low health expenditure per capita and limited risk pooling. The problem has multiple sources – insufficient funding, highy fragmented and limited funds, and poor access to quality healthcare services. PharmAccess is partnering with local governments and the private sector to roll out insurance plans that address health financing – and support the momentum for UHC. The potential for digital technology and mobile health financing platforms are central to this approach.

As we increasingly work with local governments, political challenges in the countries we support can affect the implementation of health financing initiatives. Elections were held in Nigeria which ushered in new state governments – including both Lagos and Kwara – requiring that we intensify our advocacy efforts to ensure the continuity and consolidation of governmental policy on health financing.

In Lagos State, PharmAccess has assisted the Lagos State Health Management Agency (LASHMA) with the design and operational set-up of the Lagos State health scheme (LSHS). During 2019, PharmAccess supported the enrolment and registration of formal and informal households in the scheme. LASHMA employs CarePay’s mobile health financing platform to, as well as register households, mobilize funds for financing and managing care. PharmAccess has supported LASHMA and the CarePay collaboration with technical support (setting scheme rules and parameters, user acceptance testing, marketing planning and agent training). The aim is to ensure that LSHS is prepared for a rollout to the citizens of Lagos in 2020. In Kwara State, preparations have been ongoing to launch the Kwara State Health Insurance Scheme (KwSHIS). With the Kwara State Health Insurance Agency (KwSHIA) established, healthcare providers recruited across the State and indigent households identified and registered for activation, the first phase of the program is set to commence during the first half of 2020. This will be followed by a rollout to formal and informal households across the State.

In Ghana, by supporting the rollout of the Claim-it app – a digital system within the provider panel of the NHIA – we aim to assist in digitizing more claims, support an efficient, transparent process, and help shape a blueprint for what UHC can look like in the context of sub-Saharan Africa. NHIA is a mandatory scheme, and the outcome of our collaboration has the potential of extending access to care for 30 million people in Ghana. NHIA now covers about 11 million people.

In Tanzania, by the end of 2019, NiCHF covered more than 650,000 people. PharmAccess continues to support the scheme, both operationally and in refining the design. One critical element is the inclusion of the private sector, especially faith-based clinics – as in Tanzania, more dialogue is required to ensure the active participation of both private sector health facilities and insurance companies – for pushing towards UHC.

In Kenya, UHC remains a major objective of the ‘Big Four’ development agenda announced by President Kenyatta in 2017. To support this push, PharmAccess and its technology partner CarePay were contracted to organize and register 2.6 million people for healthcare in three of four pilot counties. Collecting health-visit data in approximately 45 county facilities was essential. Based on the data, relevant insights will be given back to local and national stakeholders concerning patients’ facility selection, medicine prescription practices and overall disease patterns.

While realizing UHC in Kenya depends on political and policymaking decisions yet to come, PharmAccess has refined an agreement with Kisumu County to provide UHC support there, beginning with the indigent population, and using the mobile health financing platform M-TIBA.

Unifying financing streams

M-TIBA was developed in partnership with CarePay and the telecommunications company Safaricom and powers a digital ‘health wallet’ on mobile phones that allows for the mobilization and earmarking of private and public resources, including insurance benefits. This can ensure that individuals access healthcare at a lower cost and help protect them against health expenses. M-TIBA connects patients to outpatient clinics, hospitals, payers, insurers and donors. M-TIBA can also receive and store subsidies to help people cover future healthcare expenses. Put simply, through this mobile health platform we can put the individual at the center and enable two-way, real-time interactions which can include the exchange of information with providers.

When a person uses the wallet in a clinic, the patient’s claims data is uploaded to the platform (GDPR compliant). This information offers key insights to funders and payers (both public and private) about how specific target populations have been reached, but also on problems and inefficiencies that may have occurred. It also generates valuable data for healthcare providers, data that better informs them on their financing and patient case loads. Ultimately M-TIBA will help promote efficient health financing and service delivery with greater transparency.

Strategies for directing subsidies

To improve the efficiency of existing funding, and to increase funds for UHC, African governments must design social insurance schemes that pool existing funds and ensure upfront, individual contribution – so that the costs of health risks can be spread across all communities. Identifying the households that both can and cannot afford to contribute to their own health insurance costs is essential to designing sustainable schemes. Equipped with this data, the government and national health insurers can develop policies to ensure that subsidies and funds are channeled equitably to benefit the most vulnerable groups without crowding out contributions from those who can pay.

As part of the Kenya pilots, a socioeconomic ‘poverty mapping tool’ called dPMPT was deployed during the enrollment period to help assess socio-economic status. Integrated into the mobile registration tool, dPMPT capitalizes on recent advances in machine-learning and adheres to advanced statistical methods to estimate whether a household falls above or below the Kenyan National poverty line.

After obtaining consent to use this information for allocating subsidies, community volunteers conducted interviews about poverty in the households we registered before sharing the data with the Ministry of Health as part of an effort to help national and local governments make evidence-based decisions about developing subsidies for low-income families. PharmAccess is investing in this tool as a standard element of digital healthcare. By incorporating dPMPT into the UHC enrollment process, the interviews can be performed at a low marginal cost – as household details must be gathered, regardless, during the UHC registration.

Collecting the data through a tool that runs on a digital platform will also allow for the direct allocation of subsidies using the same platform that collected the information.
Alongside our work in the pilot counties, PharmAccess also digitally enrolled nearly 36,000 pregnant women, women with young children and their households for health insurance with the NHIF. This program, the Innovative Partnership for Universal Sustainable Healthcare (i-PUSH), was developed with Amref Flying Doctors and funded by The Dutch Postcode Lottery – to create a pathway to better healthcare for key populations and develop insights for reaching UHC.

Solovina Nanjila, who sells vegetables at a market in Kenya, has six children. Last spring, she signed up for i-PUSH. In a 15-minute session, an enrollment assistant asked questions about her family, her vegetable business, and her clinic preferences. Being able to register with a mobile phone was important to her. “It would have been impossible for me if I had to go all the way to the city to register.”

As part of i-PUSH, she was given a year of insurance coverage at no cost but was encouraged to use the M-Tiba wallet to deposit and save funds for premium payments that would be used to pay for a second year of NHIF.

Behavioral economic techniques from the Center for Advanced Hindsight at Duke University were put in place to encourage her to set aside funds for future copayments. The reinforcement exercises were simple: she was given a paper calendar with behavioral prompts and asked to practice making deposits with M-TIBA.

At one point, her eldest son developed a serious breathing problem. She took her phone with her to the clinic, he received treatments, and all costs were reimbursed through the coverage.

“I was overjoyed that all costs were indeed covered. Thanks to this insurance, me and my family are finally having access to good care. I’m much less stressed now because I no longer [have] unforeseen care expenses.”

Building on the first year of i-PUSH, PharmAccess analyzed the findings to help guide the public sector in designing insurance schemes with attractive payment schedules.

- Using the personalized paper calendar with illustrated stories about health events and prompts to save for insurance increased the percentage of those saving over time from 14 to 54 percent.
- Overall, 15 percent of the women who participated in the program saved the full amount and transitioned to the second year. In 2002, we see that percentage growing.
- Instead of setting aside money on a daily, weekly or monthly basis, low-income families save when they have funds available. Families who may not be able to afford payment every month, could still set aside funds over the course of a year to reach the required premiums.
- Households with a positive clinic experience during the first year where three times more likely to transition to the second year than families who did not visit a hospital within that year.
- Having a spouse registered for insurance more than doubles a family’s chances of transitioning to year two. Women in their thirties and forties, with covered children, tended to renew the insurance more often than women in their twenties.
**2019 IMPACT**

**PHARMACCESS: A TRUSTED PARTNER TO ACHIEVE UHC**

PharmAccess partners with local governments and the private sector to leverage the potential of mobile payment platforms, roll-out technological interventions, provide data analysis, and develop models and policies to achieve UHC. During 2019, the PharmAccess programs helped support Social Health Insurance schemes that have enrolled:

11,8M across Ghana, Nigeria, Kenya, and Tanzania

**DIFFERENT APPROACHES IN EACH COUNTRY TO ACHIEVE UHC**

**Ghana**

Our data analysis helps the NHIA to gain insights and make informed decisions on strategic matters like population reach and financial sustainability:

- Dependent and informal sector show very high renewal rates compared to other groups, validating its value for vulnerable groups.

**Kenya**

- M-TIBA continues to grow with 4.4M individuals registered across three counties.
- With increased adoption of M-TIBA, for example, in Kisumu County, the digital health wallet enabled 30,000 visits to healthcare facilities to access care.

**Nigeria**

By supporting the Lagos State Government kick-start its mandatory health insurance program using the CarePay mobile payment platform, PharmAccess galvanized the State to commence the registration of 350,000 residents to set-up the risk pool.

**Tanzania**

- The i-CHF insurance model provided access to healthcare in Kilimanjaro and Manyara, covering:
  - 670,000 people
  - 18-22% of the regional population
- The model became the blueprint for the national health insurance scheme reaching many more Tanzanians.
STRENGTHENING THE QUALITY OF HEALTH SERVICES

BARRIERS
• LMIC governments have limited capacities to perform inspections
• Shortage of objective standards and data on healthcare quality
• Healthcare providers struggle how to improve quality
To achieve UHC, healthcare in LMICs needs improvement. Improvement requires transparency of quality care.

CONTEXT:
5 million DEATHS PER YEAR CAUSED BY POOR HEALTHCARE
3.6 million DEATHS CAUSED BY LACK OF ACCESS TO HEALTHCARE

In low and middle-income countries, 10% of patients hospitalized can expect to acquire an infection during their stay.

Casualties related to healthcare

5 million DEATHS PER YEAR CAUSED BY POOR HEALTHCARE
3.6 million DEATHS CAUSED BY LACK OF ACCESS TO HEALTHCARE

This is why we...
• Develop international standard for transparency and benchmarking purposes
• Support facilities to improve quality and safety with step-wise improvement programs
• Collect data on quality of care, enabling informed decision making by institutes, donors and government
• Build local capacity

Ensuring the right to health is impossible without providing quality healthcare services, and sub-Saharan African governments have a responsibility for providing equitable, affordable and high-quality services for all citizens. But the challenges of enforcing quality standards in facilities on the ground are daunting. Medication stock-outs, lack of sterilization equipment, no proper waste management, shortage of skilled midwives and other professionals; the shortcomings in hospitals and clinics in SSA are plentiful and do not compare easily with quality problems in high-income countries. In these emerging countries, ten percent of hospitalized patients will come down with an infection while they are being treated—a figure three percent higher than in higher-income countries.

Therefore, access to healthcare alone cannot guarantee the effectiveness of care. Studies in eight high-mortality nations show that only 28 percent of antenatal care services and 21 percent of sick-child care are treated—a figure three percent higher than in higher-income countries.

SafeCare is an initiative that empowers providers like Dr. Lirhunde by helping them measure, monitor and improve their services using innovative solutions. Accredited by the International Society for Quality in Healthcare External Evaluation Association (IEEA), SafeCare evaluates clinics by conducting an assessment against a set of standards that provides a clear, objective view of the facility’s performance, identifying the gaps in service and challenges that must be addressed. Two products evaluate facility performance: SafeCare STEPS, a quick, one-day assessment tool that rates facilities on a scale of 1 (lowest quality) to 5 (highest quality); and SafeCare ACCREDITATION, which recognizes excellence. The latter product will be launched in 2020.

Based on the assessment report, providers are given a tailor-made quality improvement plan with transparent and achievable goals, and tools that guide them down a motivating and manageable road to improvement. Typically, facilities work on infection prevention measures, waste management, the development and implementation of guidelines and standard operations but also financial topics such as audit and procurement processes. The aim is to have a medically and financially healthy organization, which translates into patient and staff safety, better health outcomes and more investments in (insurance) contracting.

In 2019, SafeCare made progress by investing in the Quality Platform, an online model developed to support the quality improvement processes of facilities. Features on the platform include weekly QI challenges, connection to best practice examples, chatbots, benchmarking, and others. Human Centered Design workshops with healthcare facilities were used to develop a minimal viable product in 2019, which will be rolled out to scale in 2020. The platform will also be made accessible to governments, NGOs, provider networks, medical associations, insurance companies and other organizations in the health sector.

To expand locally and internationally – and ensure the institutionalization of the methodology with public and private partners – SafeCare has also introduced a licensing model. The latter will allow partner organizations to use the SafeCare methodology and brand under a licensing contract, making it possible for more providers, payers and patients to benefit from SafeCare. The licensing contract is also available under a white label for public institutions.

Western-style quality standards are not always applicable or achievable because the challenges faced by these facilities are very different. Health facilities in LMICs therefore need local solutions on the certification and accreditation of healthcare provision combined with innovative, cost-effective quality improvement support.

Improving the availability, affordability, and quality of pharmaceuticals with Med4All

Throughout SSA, the problem of fake and substandard medication presents an enormous challenge for both providers and patients. The combination of a fragmented, poorly regulated market with insufficient quality control measures, inefficient procurement and inventory management means that providers cannot always purchase quality supplies and patients cannot be sure that those medications are safe and effective.

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Partnering with the Public Sector

Lagos State is the most populous state in Nigeria, with an estimated 24 million people and an annual growth rate of 3.2 percent. The financial and economic center of the country, Lagos attracts an influx of people from other Nigerian regions as well as from sub-Saharan Africa.

To help achieve UHC, the state government launched the mandatory Lagos State Health Scheme (LSHS) in December 2019. Through the plan, enrollees can access healthcare from both public and private healthcare facilities.

However, high costs and limited resources present major barriers. Both factors alone would have the potential to damage the credibility of any health insurance scheme.

Therefore, LASHMA made the decision to adopt SafeCare Standards. The agency needed to focus on strengthening the regulation and capacity building for state officials working on quality assurance and improvement. SafeCare was there to support the effort.

Strengthening regulatory systems

The first step for improving a health system is establishing a strong regulatory backbone. Lagos State has the highest number of private facilities in Nigeria. PharmAccess conducted a GIS mapping of 2,800 facilities, jointly developed a quality inspection tool with State representatives, facilitated the development of the State Quality Policy for the Health Sector and conducted an organizational capacity assessment of the Lagos State Health Facility Accreditation Agency (HEFAMAA) to identify gaps in the system. The licensing inspection tool sets the minimum requirements for a facility to operate.

As a result, PharmAccess supported the development of a website and portal for registration to help improve the Agency’s operational efficiency with licensure processes. Registering new health facilities and annual renewals have been done electronically since the launch of the portal in July 2019.

Strengthening health services

To be empaneled under the scheme, healthcare providers must first apply to LASHMA. After being contracted and assigned individual patients, the provider then must participate in a mandatory quality improvement program that draws upon the SafeCare Standards. The SafeCare standards guide the facilities toward excellence, building on the minimum standards set by the inspection tool.

The facility undergoes a baseline quality assessment that uses the SafeCare Tool. A Quality Improvement Plan is put in place for 18 months, during which LASHMA supports the provider on their quality improvement journey with periodic audits, a yearly renewal of empanelment for high performing providers and follow-up quality assessments every 18 months.

Institutionalizing the program in Lagos has required training state officials and agencies on the Standards, so they can serve as assessors and conduct provider appraisals. Lagos State now has a Quality Team of 20 assessors who lead the assessments and 45 Quality facilitators who mentor the teams in implementing the improvement plans.

Better allocating resources

As a result of the partnership, health providers in Lagos will be trained to understand and comply with the treatment protocols and quality standards that can help fight infection and deliver better health outcomes.

Performance ratings will also be used to clarify gaps and challenges in the health sector and provide the government with actionable data, insights that can help allocate limited resources.

Crucially, the Lagos State Employment Trust Fund will also offer providers access to low-interest loans, an important and innovative strategy designed to deliver much-needed investments for utilizing these resources. Made possible only through a broader public-private partnership, the program will give other stakeholders access to critical information – and marks another important step in helping providers invest in improving the quality of their healthcare.

Partnering with the Private Sector

Quality assurance (QA) and improvement (QI) programs in LMICs are often fragmented and linked to vertical programs that treat specific diseases and conditions, such as HIV/AIDS or maternity. Benchmarking across programs and facilities is not possible, and institutionalizing is complex, especially as countries move toward UHC. A strong healthcare system is one that has an institutionalized quality assurance policy and embeds QA into the contracting approaches of (national) insurance bodies, lending and investment institutes. This would send the information back to patients, so that they can make informed choices when selecting a provider. In line with UHC, the focus must be on primary and secondary providers.

The SafeCare licensing approach empowers local organizations to own and institutionalize a quality assurance program that measures quality healthcare comprehensively, with the ability to deep-dive into specific conditions or disease profiles.

As part of an initiative to support employees worldwide, the Heineken Corporation currently funds 70 healthcare clinics in LMICs. At these facilities, free healthcare is available to Heineken employees as well as their spouses and children.

In 2006, Joop Lange persuaded Heineken to commit to offering workplace healthcare and treatment for those living with HIV/AIDS in Africa. This marked the first of many public-private partnerships that have enabled PharmAccess to contribute to improving health systems in Africa.

Now, Heineken is the first multinational corporation to adopt the SafeCare standards.

By contracting to use SafeCare, Heineken has committed to providing transparency and quality improvement at their health facilities.

For SafeCare, the partnership with Heineken expands our reach outside the African continent and gives us an opportunity to connect with clinics in regions such as Papua New Guinea and Asia—with scalable, affordable packages that deliver real impact on Quality of Care.
2019 IMPACT

SAFECARE REACH
Number of active facilities and patients reached in 2019

1,130 facilities

<table>
<thead>
<tr>
<th>Country</th>
<th>Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya</td>
<td>435</td>
</tr>
<tr>
<td>Tanzania</td>
<td>323</td>
</tr>
<tr>
<td>Nigeria</td>
<td>247</td>
</tr>
<tr>
<td>Ghana</td>
<td>99</td>
</tr>
<tr>
<td>Other</td>
<td>568,000</td>
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<tr>
<td></td>
<td>487,000</td>
</tr>
<tr>
<td></td>
<td>362,000</td>
</tr>
<tr>
<td></td>
<td>151,000</td>
</tr>
</tbody>
</table>

1.6 million patients

In 2019, SafeCare designed two models for expansion. Digital offerings for healthcare facilities have been tested to support faster and more cost-effective quality improvement. Whilst, a licensing model allows more providers, payers and patients to benefit from SafeCare.

QUALITY INCREASE
% of facilities with increased score in 2019

81%

Average score at first and second assessment
1st 45
2nd 55

WAY OF WORKING

Digital solutions have been tested by:

45 facilities in 4 countries.

Helping improve quality quickly and cost-effectively.

DIGITAL SOLUTIONS

New digital solutions have been tested by:

SCALING SAFECARE
Collaborating with partners supports the growth of quality care.

For example, Heineken now uses SafeCare under a licensing model, extending our reach to new Heineken facilities:

Government bodies incorporate SafeCare as the quality standard:

For many of their client health SMEs, Heineken uses SafeCare to support the growth of quality healthcare:

2018 2019 2020

13 40 40

Kenya Zanzibar Nigeria

572 558 789

61%
Despite the growth in overall government spending on health, SSA still holds...

*Context:*

Despite the growth in overall government spending on health, SSA still holds...

There is a mismatch between the demand and supply of healthcare:

- Many millions of people suffer and die from conditions for which there exist effective interventions
- Available resources are not allocated to the most effective interventions and do not reach the poor

Supporting the rural and urban poor in their ‘great escape’ from poverty depends significantly on reducing the high risks and costs that they face in accessing healthcare. The digital revolution offers the potential to reach previously excluded people at much lower costs.

**Barriers**

There is a mismatch between the demand and supply of healthcare:

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- Available resources are not allocated to the most effective interventions and do not reach the poor

Supporting the rural and urban poor in their ‘great escape’ from poverty depends significantly on reducing the high risks and costs that they face in accessing healthcare. The digital revolution offers the potential to reach previously excluded people at much lower costs.

**Sources:**
Improving a health market that is deeply fragmented depends on doing more than just increasing the availability of funds and enhancing the quality of medical services. In LMICs, vulnerable groups – such as expectant mothers – may experience something like chaos during their pregnancies because available services are not organized around patient needs. We believe that the availability of data and mobile exchange platforms has the potential to completely change healthcare financing and delivery and facilitate better, more patient-centered services. By leveraging real-time mobile data, PharmAccess is working to offer evidence- and value-based care, which puts patients and their health outcomes at the center of decisions about allocating scarce resources.

Together with several strategic partners, PharmAccess is now using mobile technology to address the full patient journey and its outcomes. After joining forces with Sanofi and CarePay, we have begun working to break access and awareness barriers for diabetes and hypertension treatment in Kenya.

The result of this collaboration is Ngao Ya Afiy (“Shield for Health” in Kiswahili): a digital service model for NCD-care that combined direct financial support and access to care for low-income patients while stimulating quality of care and generating real-time medical and financial data insights for doctors and healthcare payers.

This digital tool was designed with a view to developing a scalable service model that optimizes cost of care and efficiency, while leveraging available funds from patients and payers in one wallet. If successful, the pilot will be scaled and replicated by healthcare payers and providers in Kenya as well as other African countries.

Every year, roughly 300,000 women die as a result of a preventable complications during a pregnancy. This statistic is 14 times higher than in high-income countries, and sub-Saharan Africa accounts for 66 percent of these deaths.

For pregnant women in LMICs, navigating the health system comes with specific barriers. Home births may be the standard. Prenatal care could involve additional costs that are impossible for the household. Even if an expectant mother has “free” healthcare, getting a clear picture of the treatments, and the costs, can still seem murky. What type of doctor should she go to see first? Will insurance cover the visit? Some clinics only get paid if they deliver the baby. So, if she has a complication, like an ectopic pregnancy, will the doctor refer her to another facility for surgery, or just try to deliver the baby anyway? What about faith healers? Plenty of people go to faith healers.

“Those who have no insurance, they come late. Maybe they come once. There are some who come at the ninth month. Then they deliver. If there is a problem, you will diagnose later.”
By enrolling expectant mothers on a digital payment platform, it becomes possible to contractually offer these women a better ‘deal’. For example, the MomCare package in Kenya and Tanzania covers the full journey of care and includes all providers whose services could be needed during that journey. Because the contract is digital, it can be transparent about the specific care and treatments expectant mothers are entitled to receive. SMS surveys following doctor visits empower these women to evaluate medical services and the mobile platform makes it possible for them to have smart contracts that create an accountable care journey that they can trust.

The product draws upon well-documented interventions such as timely antenatal care visits and assisted birth deliveries and enforces the clinical guidelines that are essential to keeping mothers and babies healthy.

First piloted in Kenya, MomCare uses a trusted platform and begins by better connecting mothers and providers. Before the first consultation, both agree to a path of maternal care—at a predetermined cost and quality.

For the mother, knowing the specific treatments she is entitled to can help her manage the risks in her pregnancy, and save for her portion of premium costs, if any. She will know that she is entitled to an ultrasound, even if the sonographer is temporarily unavailable. She will understand exactly what she can expect from her provider and be encouraged to report on each medical experience, and outcome.

Mobile technology also allows for better communication between mother and doctor. The technology sends triggers to both doctor and patient to enhance their interactions and ensure that every step in the nine-month journey is addressed according to clinical guidelines.

MomCare benefits providers in other ways. The predetermined costs offer reliable income, which the provider can then use to invest in his or her business. Critically, the real-time data drawn from each mobile interaction offers providers a fuller, dynamic picture of the pregnancy itself, making it easier for them to identify prenatal risks and complications and increase the quality of care.

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Smarter contracting for enabling value-based care

Moving toward evidence- and value-based care not only helps clinics spend their time where it counts; ultimately, value-based care also helps payers, donors and policymakers make more informed decisions. With near-real time data, the impacts of investments and interventions becomes clearer. How changes in policies or programs affect outcomes can be tracked between clinics, regions, risk and income groups almost from the point of implementation. This allows for a more efficient organization of health plans and programs where learnings and innovations can be evaluated and scaled (or discontinued) much earlier than previously thought possible. PharmAccess’ objective in introducing smart contracts for pregnancies or NCD’s is to demonstrate that this type of data-driven resource allocation is possible today—and in most LMICs.

MomCare grew substantially in 2019. By the end of 2018, 1,092 women had enrolled for MomCare in Kenya and Tanzania, and 222 had given birth. In 2019, more than 7,000 expectant mothers signed up for digitally tracked mother journeys — and the resulting births have given us crucial data that we must use to support more effective, efficient mother journeys in LMICs.

To lower both the physical and financial costs, we are looking for patterns in the MomCare data.
**SUPPLY AND DEMAND**

**PEOPLE REACHED**

MomCare enrollments:

7,274 Mothers

- Kenya: 4,785 (4.6% teenagers)
- Tanzania: 2,489 (8.3% teenagers)

**BENEFITS FOR ALL**

- **Mothers** agree their care journey upfront with funds made available to support her.
- **Facilities** have live insights on high-risk cases, care provision, patient care experiences and health outcomes.
- **Donors** see how funds are used to support mothers and how health outcomes improve.
- **Governments** can benchmark facilities and make decisions based on trends.

**2019 IMPACT**

Over the past years we (co-) developed new approaches to link demand and supply to improve health outcomes, with an initial focus on the pregnancy journey, non-communicable diseases (NCD’s) such as hypertension and diabetes and Malaria. In 2019, our main focus has been pregnancy care, with a program called MomCare.

**MOMCARE RESULTS IMPROVED OVER THE YEAR**

<table>
<thead>
<tr>
<th></th>
<th>Ave. number of check-ups</th>
<th>% Women with 4+ check-ups</th>
<th>% Skilled deliveries*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya</td>
<td>2.6</td>
<td>14%</td>
<td>24%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>11</td>
<td>0%</td>
<td>20%</td>
</tr>
</tbody>
</table>

**DATA AND INSIGHT SNAPSHOTS**

- **Mother**
  - Hana, your next appointment is at...
  - Were you satisfied with the service? 11.7% 2.1%
- **Donor**
  - Facility
  - Cost overview, Kenya
  - Satisfaction survey results
  - 91% of funds support women that act to manage their risk
- **Facility**
  - Ultrasound
  - Diagnosis: infection of genitourinary tract
  - ANC consultation

*Percentage of women over 43 weeks of pregnancy

**SUPPLY**

<p>| |</p>
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<tr>
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<tbody>
<tr>
<td>Demand</td>
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**DEMAND**

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<tr>
<th></th>
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<tbody>
<tr>
<td>Supply</td>
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</table>
INCREASING INVESTMENTS IN HEALTHCARE

$25-$30 billion investment is needed to meet its healthcare demand.

CONTEXT:
Sub-Saharan Africa suffers from a lack of quality healthcare.

50% of healthcare in Africa is provided by private sector facilities.

BARRIERS
- Private health facilities need capital to grow and improve their health services.
- African banks have little interest in financing health SMEs. The health sector is perceived as non-transparent.
- The private health sector in Africa is suffering from chronic under investment. Investors need to be triggered in to providing loans to the sector.

THIS IS WHY WE...
- Provide access to capital to health SMEs.
- Combine loans with capacity building to improve quality and to grow their business.
- Partner with, and support African financial institutions with which we co-invest.

INVESTMENT IS NEEDED TO MEET ITS HEALTHCARE DEMAND

INCREASING INVESTMENTS IN HEALTHCARE

Small and medium size health clinics in Africa have received more than 4,000 loans amounting to USD 71 million from the Medical Credit Fund since 2009. In 2019 alone, more than USD 20 million in loans were disbursed. These funds have helped clinics purchase better equipment, grow their businesses and improve the overall quality of their healthcare services. Loan repayment stands at 96 percent. The clinics have around 450,000 patient visits per month across the six countries.

In sub-Saharan Africa, the public sector faces major financial and management challenges in delivering quality services to everyone who needs healthcare. This applies to the treatment of major diseases such as HIV/AIDS, and non-communicable illnesses like diabetes or hypertension, as well as the essential primary care services that provide the foundation for health systems everywhere.

Consequently, most Africans rely on private healthcare facilities.

Supporting healthcare providers directly

Meanwhile, the private small and medium size health enterprises (health SMEs) that provide primary and secondary care services to the lower income groups in Africa are struggling. They often lack the financing to invest in their infrastructure or purchase the equipment they need to provide quality services. Compounding the problem, commercial banks tend to shy away from lending to SMEs in general, and health SMEs in particular — as they perceive these facilities to be high-risk. MCF is the first and only impact investing initiative dedicated to providing loans combined with technical assistance to health SMEs in sub-Saharan Africa — to enable them to strengthen their businesses and improve health care quality. The Fund works both directly and with a wide network of financial partners to serve clinics with the loans and technical assistance they need to offer more people better healthcare services.

Delivering fast, effective digital loans for Primary Care

Small loans can make a tremendous difference to clinics in the countries we support, but these loans also face a high bar for approval. While collateral is a major barrier for SMEs, small loans present a challenge for banks—in that issuing small loans can be costly and time-consuming. To perform due diligence, a loan officer must understand a customer’s needs, circumstances, and liabilities. The earnings on these loans are limited, but the administrative burden remains the same regardless of loan size. As a result, most banks prioritize larger loans to corporate clients or investments in capital markets.

The Fund has decided in 2019 to start lending directly to health SMEs — to better serve its customers. While more of the portfolio remains held with financial partners, 10 percent of disbursements were made through direct lending in 2019.

Recognizing this challenge as well as the unmet demand for loans, MCF has a mandate to co-lend with local financial institutions. Despite a solid track record—we had 19 financial partners and USD 22.6 million in loans outstanding with them in 2019 — MCF has also encountered challenges in getting banks to disburse funds. Collateral requirements remain an obstacle that SMEs must overcome to qualify for bank loans. In Kenya, which holds the largest share of the portfolio, a continued interest rate cap has reduced the banks’ appetite to lend to SMEs.

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Borrowers apply for Cash Advance loans with a mobile phone. The healthcare providers often need short-term loans to cover expenses like rent, salaries, and medicines. These smaller loans are critical to bridging the gap for providers between buying necessities like pharmaceuticals and being paid for their services — especially given the frequent and lengthy delays of health insurance payments.

Repayments are automatic, drawn in daily installments as a percentage of income from the mobile revenues of digital bills. If a clinic’s earnings increase or decrease, repayment adjusts proportionately, based on what the healthcare provider can pay.

Ultimately, once a healthcare provider has repaid a digital loan, they can easily take out a new Cash Advance to close another gap between expenses and reimbursements; and grow their business as a result.

MCF launched the product in 2016, processing 11 digital loans in that year. In 2019, 844 Cash Advance loans have been disbursed with an average amount of KES 760,000 (USD 7,500). Total Cash Advance disbursements stand at USD 9 million. Around 70 percent of clients enter into repeat loans, indicating high customer satisfaction.
Empowering businesswomen

The Zamzam Medical Center has a sign out front that reads your choice for quality care. Located right across from the Seventh Day Adventist Church by Chali Plaza in Ngong, Kenya, Zamzam has another sign on the roof, and one on the road, that both point inside with red arrows that read, “Open 24 hours” – including Sundays and public holidays.

This health SME takes up a quarter acre. Inside the redbrick building, there is a furnished reception area. The phone is always ringing. There are consultation rooms, a pharmacy, a laboratory, a procedure room, observation and ultrasound rooms, the wards, and the office.

Mrs. Esther Muthoni Karaya owns Zamzam. A registered nurse and midwife, she is a healthcare warrior. Her dream was to own a modern health center, but after she was evicted from the center’s previous location, that dream seemed distant. Eventually, she did what needed to be done, and she converted a family home into Zamzam.

To support her clinic, Esther has used MCF loans since 2013, but as a female entrepreneur, she had often struggled with getting access to larger loans – because she could not register the collateral in her name.

Cash Advance has made a difference for Esther. Digital lending has provided her with the short-term funds she needs, usually in less than 48 hours.

Because Zamzam uses a digital till to receive patient payments, she can take out small, fast Cash Advance loans, and select a percentage of the clinic’s mobile revenues to automatically repay the funds.

Accessing loans has helped her better manage cashflows – especially when insurance payments are late. It is now easier for her to deal quickly and directly with basic working capital needs like salary payments and restocking her pharmacy.

At the same time the clinic has worked with SafeCare to improve the quality of care. Zamzam has grown its client base and serves almost 17,000 patients every year.

With the opportunities of digital lending, and the commitment of the staff and owner, Zamzam Medical Center more than lives up to the promise of the sign out front.

Since 2009, MCF has disbursed USD 11 million in loans to female entrepreneurs. This figure supports Sustainable Development Goal 5 for Gender Equality – by promoting equal rights to women for economic resources, property ownership and financial services, and empowering women through technology.

Strengthening management skills

Most health SMEs are managed by healthcare professionals who have been trained to provide healthcare to patients, and are fully engaged with the daily operations of their clinic. They often lack the management skills and financial knowledge that are necessary to plan for the future and take their facility to the next level.

In 2017, MCF launched the first executive business development training in investments and management for health SMEs in sub-Saharan Africa.

In 2019, more than 100 health SME managers participated in comprehensive healthcare management courses at the Strathmore Business School in Kenya and the Enterprise Development Center in Nigeria. MCF helped coordinate these programs, along with other training programs for healthcare professionals in Ghana that are accredited by the Medical and Dental Council.

“I’ve taken out a good number of Cash Advance loans to date. Bank terms are too bureaucratic compared to the ease with which I access Cash Advance(s). I am currently working to convert my facility to fully digital...to push more than 80 percent of our transactions through the till, and the remaining percentage will be insurance payments.”
## 2019 IMPACT

### TOTAL FIGURES SINCE INCEPTION

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2018</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nr. of loans disbursed</td>
<td>4,116</td>
<td>—</td>
<td>+198%</td>
</tr>
<tr>
<td>Loan volume (*million USD)</td>
<td>204.9</td>
<td>—</td>
<td>+71.3%</td>
</tr>
<tr>
<td>Nr. of health facilities reached</td>
<td>1,669</td>
<td>—</td>
<td>+238%</td>
</tr>
</tbody>
</table>

### INCREASED DIVERSITY IN LOANS

Yearly loans disbursed by loan type (%)

- 89% Partner
- 31% Digital
- 10% Direct

Market challenges can lead to new opportunities. In 2019, MCF diversified the portfolio to include direct lending whilst digital lending products like Cash Advance continued to grow.

### HIGH REPAYMENT RATE

SMEs consistently repay loans on time

- MCF repayment rate: 96%
- African bank lending ave.: 80-91%

### LOANS USED FOR IMPROVEMENTS

Top 3 loan usage:

- 47% Medical equipment
- 36% Renovations
- 7% Fixed assets

The repayment rate for health SME’s has remained consistently about the market average. Proving that the sector is bankable.

Quality improvement: 85% of MCF funded facilities increase their quality score in 2019.

---

<table>
<thead>
<tr>
<th>Year</th>
<th>Nr. of loans disbursed (#)</th>
<th>Loan volume (*million USD)</th>
<th>Nr. of health facilities reached (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>'18</td>
<td>3,518</td>
<td>178.9</td>
<td>1,500</td>
</tr>
<tr>
<td>'19</td>
<td>4,116</td>
<td>204.9</td>
<td>1,669</td>
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<table>
<thead>
<tr>
<th>Year</th>
<th>Nr. of loans disbursed (#)</th>
<th>Loan volume (*million USD)</th>
<th>Nr. of health facilities reached (#)</th>
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</thead>
<tbody>
<tr>
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<td>3,000</td>
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<td>1,300</td>
</tr>
<tr>
<td>'17</td>
<td>3,518</td>
<td>178.9</td>
<td>1,500</td>
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<td>4,116</td>
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<td>1,669</td>
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<tr>
<td>'19</td>
<td>4,726</td>
<td>221.9</td>
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</tbody>
</table>
Research and learning is vital to improve the operations of PharmAccess and our partners, and the wider health ecosystem.

Research and evaluation requires long feedback loops, while organizational budgets focus on short-term results.

Sub-Saharan Africa’s health challenge asks for smart, innovative healthcare solutions as well as thorough research to improve credibility and translate learnings into new interventions.

• Conduct independent academic research and evaluation, made possible by long-term funding
• Facilitate access to data generated by our interventions for external scientific scrutiny
• Adopt research learnings to generate learning and improve intervention quality and advocate for proven, successful models

Limited capacity and data available on successful, cost-efficient healthcare solutions in Africa.
Evaluating SafeCare and MCF in Tanzania

Over the past four years, we have collaborated with the London School of Hygiene and Tropical Medicine and the Ifakara Health Institute to conduct a randomized control trial in Tanzania. The focus of the study was to evaluate SafeCare’s impact and assessment scores in relation to clinical quality of care. The analysis marks a first effort to evaluate the link between quality and business performance for private healthcare providers in sub-Saharan Africa.

Between 2015 and 2019, the study analyzed 237 facilities throughout Tanzania, using intervention and control groups.

The control group consisted of clinics that had taken part in standard, baseline SafeCare assessments.

The intervention group had undergone SafeCare assessments as well, but had also implemented a Quality improvement plan, business and quality training sessions, quarterly progress monitoring and mentoring – and were encouraged to apply for loans through Medical Credit Fund.

Would the intervention group – with access to extensive quality and business support – demonstrate a higher rate of improvement than facilities in the control group? And what was the relationship between SafeCare rating and impact on SafeCare scores?

To measure impacts, first, the difference in end-line versus baseline SafeCare scores was compared between the treatment and control group. Second, data was collected through IPC observations, surveys, patient exit interviews, in-depth conversations with facility staff and other stakeholders – as well as “standardized” patients.

These healthy patients would go to facilities describing symptoms of certain medical conditions – without being ill. The standardized patient would then document the provider’s response and observe whether the visit was conducted according to clinical guidelines. Did the provider perform correct tests? Were appropriate medications prescribed?

Initial results from the study show that healthcare facilities with higher quality ratings perform better with standardized patients – in terms of providers prescribing (or not prescribing) inhalers, blood tests for malaria, microscopies, or antibiotics.

Intervention group services consistently scored higher than facilities in the control group, showing that SafeCare facilities do indeed improve their healthcare through enhanced quality and business support. The evidence also implies that technical support between SafeCare and providers drives quality improvement more consistently.

Yet overall, the study showed that quality improvements still need to happen faster and reach higher SafeCare scores (level 4 was not sufficient to have perfect clinical treatment) more cost-effectively. We learned that behavioral changes matter more than just plain knowledge – especially in terms of improving infection-fighting measures, such as effective handwashing.

From a business perspective, facilities in the treatment group appeared to do better in business performance. However, additional analysis is needed as the financial data was of poor quality.

The insights derived from the study have helped drive the development of the Quality Platform, which was designed to spur quality improvement through benchmarking, reinforcement exercises and regular mobile communications between SafeCare, providers and their peers.
At PharmAccess, research is integral to strengthening successful interventions by disseminating findings across a wider network. Beyond reach, research is also crucial to developing new product offerings and improving existing ones.

In Cameroon, an estimated 200,000 people are infected with Hepatitis C Virus (HCV), a chronic infection which can lead to life-threatening liver disease. In collaboration with our partners — and funded through the Joep Lange Institute (JLI) and the Achmea Foundation — we are seeking to facilitate a sustainable HCV treatment model using phased demonstration projects which will increasingly be financed by an innovative, pay-for-performance impact investment instrument. This effort capitalizes on recent advances in HCV treatment and utilizes antivirals with proven cure rates at about 95 percent in high-income countries. So far, we have completed an HCV treatment project for 161 patients — with a cure rate of 96 percent — demonstrating that decentralized treatment is feasible in Cameroon.

Another research priority in 2019 included a focus on connected diagnostics: a process where we can link diagnostic test through the cloud to digital payment mechanisms that fund only accurate medical treatments. Put simply, the process ensures that doctors only get paid for services or drugs they prescribe when a patient has actually tested positive for a certain condition, which can be verified through a simple test that has been uploaded to the cloud.

As part of a pilot in Kisumu, seven private clinics were analyzed using connected diagnostics. Nearly 12,000 people were tested for malaria, with the results uploaded to the cloud. Initial results show that the process demonstrates significant potential for decreasing the over-prescription of malaria drugs by verifying the tests, and also lowering administration costs by decreasing paperwork. Valuable, real-time data on malaria hotspots can be fed into national information systems (such as DHIS-2) to help governments allocate resources; and connected diagnostics also has the potential to empower patients, who can actively choose facilities that have a proven track record of testing accurately for disease.

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PharmAccess last year: and elsewhere were essential for advocating for the role of leading researchers in Africa, the Netherlands, and the developing world in improving health systems. JLI’s events, research, and networks in 2019 were instrumental in implementing activities across the countries we support:

- In Nigeria, JLI supported PharmAccess in engaging the new political leadership in Kwara and Lagos States to launch health insurance schemes.
- In Kenya, JLI engaged counties and the Ministry of Health to ensure the integration of digital interventions in UHC-focused activities.
- The Joep Lange Institute (JLI) applies research, innovation, pragmatism, and action to improve access to quality healthcare by building efficient and effective health systems. JLI’s events, research, and network of leading researchers in Africa, the Netherlands, and elsewhere were essential for advocating for PharmAccess last year:
  - Onno Schellekens (the Chair of JLI) was appointed Knight in the Order of the Lion of the Netherlands for his work in medical accounting, in getting capital to the poorest, and in using mobile technology to improve healthcare quality.
  - JLI, PharmAccess and other organizations worked closely with Fondation Botnar – to form a coalition supporting the advocacy, communication and accountability of AI, digital and frontier technologies in promoting the 2030 UHC agenda.
  - At the United Nations General Assembly in New York, JLI launched Global Public Investment with Helen Clark – the former Prime Minister of New Zealand – as a keynote speaker. JLI also held events on Civil Society Advocacy beyond UHC, and Health and Climate.

MEASURING IMPACT WITH RESEARCH, EVALUATION AND ADVOCACY

- At the World Health Summit in Berlin, Christoph Berr – JLI’s Director for Global Health Diplomacy – spoke at the plenary session on the Life Saving Power of Mobile Technology in Achieving UHC and Financial Risk Protection.

Strategically focusing on health and climate change, PharmAccess works to strengthen private health sector across Africa

The Africa Healthcare Federation – a platform for an Africa-wide engagement strengthening the role of private health sector – has supported the strengthening of sub-regional private healthcare associations such as the East and West African Health Care Federations. PharmAccess was one of the first strategic partners and funders of the platform. In 2019, the conference in Addis Ababa attracted participants from over 40 countries; and was pivotal in unifying African countries under a single umbrella: the Africa Healthcare Federation – to advocate for increased investment and innovation in the Africa health systems.

Recognition

PharmAccess received several important citations in 2019, including seven global awards. Our Nigeria Country Director was appointed the Commissioner on Digital Health and Artificial Intelligence by the Lancet and Financial Times Commission Governing Health Future 2030. Our Ghana Country Director was appointed to the World Health Organization’s Roster of Experts on Digital Health. Forbes Africa also named PharmAccess Nigeria as a top 50 brand making healthy returns in Africa.

In 2019, MoFA collaborated with PharmAccess in many areas, including:

- Initiating policy discussions with the World Bank’s Health in Africa initiative on digitalizing and financing healthcare for the informal sector.
- Arranging for the Director of Sustainable Economic Development to speak at the FMO-AfricInvest/PharmAccess Conference on Investments in Health Care, an event showcasing how innovation leads to healthy returns in Africa.

The Health in Africa (HiA) initiative was also pivotal in unifying African countries from over 40 countries; and was strategically focused on health and climate change, PharmAccess works to strengthen private health sector across Africa.

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When the Netherlands Minister for International Trade and Development visited Nigeria, the Lagos Governor praised the collaboration with the Netherlands government in the Lagos State Health Insurance Scheme.

Sigrid Kaag, the Netherlands Minister for Foreign Trade and International Development, visited a PharmAccess initiative in Nandi – with the goal of learning about how the Dutch government’s funding has helped deliver digital interventions to increase lending to health SMEs as well as better access to healthcare for people in the informal sector.

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The strength of our advocacy lies in the quality of partnerships, research and the lessons learned from our programs. These partnerships bring together institutional capabilities and human resources – in terms of skills, experience, and ideas for joint advocacy and for program implementation. We invest in long-standing partnerships, which require cross-cultural understanding, trust, solidarity, and accountability. Among our key advocacy partners are the Netherlands Ministry of Foreign Affairs (MoFA) and embassies, Joap Lange Institute, the World Bank’s Health in Africa Initiative and the governments and private sector entities in the countries where we work. MoFA’s long-term partnership has enabled us to strengthen and build strategic partnerships.

2019 was an important year for the advocacy that PharmAccess does with Queen Maxima of the Netherlands, the United Secretary General Special Advocate for Financial Inclusion. Queen Maxima celebrated the tenth anniversary of her work on financial inclusion which has contributed to, among other things, the Central Bank of Nigeria’s decision to license mobile operators for mobile payments for the benefit of 60 million Nigerians without a bank account. During the tenth anniversary event honoring Queen Maxima’s work in New York, she spoke of PharmAccess’ innovative use of digital mobile health to deliver insurance to the informal sector in Lagos.
In April 2020, African and European political leaders called for the urgent transformation of an international collaboration on economic and global health – to fight COVID-19 in Africa.

The virus is a communicable disease that reminds us that we are all vulnerable: within months, a disease originating in China spread around the globe and destroyed trillions in wealth. Covid-19 can strike anyone, anywhere. Wealth and power do not matter; and as such, COVID-19 works as a profound ‘equalizer’ – at a global and country level. We have all learned that the world will only be safe when we can collectively stop the impact of the pandemic everywhere.

In this interconnected world, this crisis confronts us all with daunting challenges. In this regard it is important to realize that most of the recent communicable disease crises originated in resource-poor countries. While this pandemic threatens health security and economic prospects globally, it will hit the African region even harder, and will risk excluding the African continent from aspects of the global economy if the continent cannot manage to control COVID-19. The travel bans – which have ruled out medical tourism – contribute to the political will its leaders and citizens’ support at country-level to realize UHC and the much-needed transformation of health financing and delivery.

A unique opportunity has emerged to dramatically strengthen systems for health, and at the same time build systems that are resilient and can be sustained beyond this crisis to the benefit of millions. However, given the low average health expenditures in the countries we support, this kind of genuine transformation is achievable only if we fully employ the potential of innovation. Such a system needs to reach and include ALL people interactively, through their mobile phones and networks of outpatient clinics, referral systems and connected diagnostics. Generating data at the level of symptoms, tests and treatments is crucial: in the interest of both the general public and the patient. This requires that everybody be covered and have access to a standard, basic health benefit package.

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