African healthcare needs markets, not philanthropy

Philanthropy has long been a protagonist in Africa's healthcare system. Why is that problematic? For decades, Africa's healthcare system has been sustained by donor aid and philanthropy.

Temps de lecture : minute

7 August 2024

This article was originally published by *The Realistic Optimist*

The AIDS crisis and the ensuing Western initiatives, such as George Bush's *PEPFAR program*, are emblematic. This led to money being plowed into treating very specific diseases. But African patients are more than a single disease. They also have hypertension and diabetes. You can't have a healthcare system that only works for specific ailments.

This reliance is fragile. Even with the best intentions, people's focus moves on. Three years ago, COVID was all the rage. Now, it's barely an afterthought (for most of us). When philanthropy shifts its attention to something else, donor-dependent infrastructure crumbles. Philanthropy (or subsidies) doesn't build holistic or solid healthcare systems.

Take this anecdote gleaned from conversations I had with Ethiopian pharmacists. For years, the Ethiopian government has subsidised insulin, a diabetes drug. They subsidised it so much that private actors couldn't compete, so they abandoned that market. Now, the Ethiopian government is *facing* a currency crunch and can't buy any insulin. Unfortunately, there aren't any alternatives because private sector producers aren't there anymore. Good intentions are not enough to build sustainable markets.

mPharma is built around pharmacies. Why?

Consumers are smart. If there's free medicine, they'll take it. But if you take philanthropy out of the equation, consumers will go where the cost-to-quality ratio of care is best. In most cases, that is the local pharmacy.

The reason is simple. If you go to the hospital, you have to pay for the consultation and the prescribed medication. If you go to the pharmacy, you can ask the pharmacist a couple of questions and just pay for the medication. Neighbourhood pharmacies also enjoy high levels of trust. The question becomes: how do you expand the breadth and quality of care that these pharmacies provide?

This isn't an African phenomenon. In England, the NHS has been *proactive* in making pharmacies more than mere retailers. This eases pressure on the "hospital" healthcare infrastructure and personnel.

Talking about mPharma's pharmacies. Do you own or franchise them?

We fully own 25% of them, and the rest are franchised via our QualityRX program. We could've been a marketplace where African pharmacies bought medicine online, but that would have limited us. The problem with African B2B e-commerce is that margins are low while competition and distribution costs are high. We decided to go the other route, "take over" the actual pharmacies and create a managed marketplace.

For our QualityRX pharmacies, we enter a 5-year management contract with the owner and open a joint bank account. We provide them with the medicine and enter a profit-sharing agreement. Essentially, we only make money when they sell medicine. This forces us to deeply understand purchasing data to adequately supply pharmacies, managing expiry dates and stock-outs. This comprehension is useful for our health subscription

product, which we'll touch upon later.

Don't pharmacy owners object to mPharma taking over their business?

Yes, and it isn't easy to convince them. They are generally conservative and don't want to be first movers. That's why our expansion strategy has focused on *buying* local pharmacy chains outright, refurbishing them, equipping them with our tools and showing other pharmacy owners the power of mPharma's model.

The majority of Africans don't have private health insurance. The figure *stands* at around 1% in Ethiopia and 13% in South Africa. Why is that and what does it imply?

For a simple reason: most African private health insurance schemes are attached to an employer and the vast *majority* of Africans work in the informal sector. They don't have an "official" employer. So they don't have private health insurance.

Out-of-pocket is the predominant form of healthcare financing in sub-Saharan Africa. Government healthcare schemes exist, but they are lackluster. In Ghana for example, the government pays so late that healthcare providers often refuse that mode of payment.

From a business standpoint, this is a problem for us. There's a large cap on how much our pharmacies can sell if we are limited by people's immediate purchasing power, which in Africa is *low*.

So you venture into health insurance. How do you build a health insurance offer for people on $2/day?

Health insurance is not just a premium collection business, it is also a cost to deliver care challenge. Insurance providers make money on the delta between the premiums they charge and the cost of care they dish out. Logically, the higher the cost of care, the higher the premiums need to be. Our challenge is that we can't charge high premiums because our customers have little money. So we have to reduce the cost of care.

Regardless of whether we own or franchise a pharmacy, mPharma controls the distribution of medicine. We buy the medicine, we purchase the diagnostics, we employ the doctors and we handle distribution logistics. This gives us a precise understanding of the cost of care.

We identified that roughly 70% of people who seek care in a pharmacy do it for one of 14 diseases. We decided to build a health subscription plan for these 14 diseases only. From there, we could precisely calculate how much it costs to diagnose and treat those 14 diseases. We reduced the cost of treatment by enacting a "generic drug only" policy. We concluded that it would cost, on average, $3.45 to treat the basket of 14 diseases.

Then you get into insurance math. If 100 people subscribe to my $2/month plan, what is the maximum number of people that can "redeem" their care before I stop making my margin? These calculations culminated in the launch of our *mutti+ plan*, a health insurance plan for low-income customers.

The value proposition seems crystal clear.

Why do you have a hard time convincing people?

Apathy remains our number one enemy. What we are asking people to do is: pour a day's earnings into a health subscription plan that you might not even use. From their point of view, they are foregoing eating today for a healthcare expense they're not even sure they'll have. Many fail to see the point. In economics, this is known as *present bias*.

Paradoxically, it's much easier to convince people who are already sick. But those are the people who will incur higher healthcare expenses. If all of the people paying for your health insurance are sick every month, your math won't work.

This is the crux of the issue: sick people are willing to pay but they make you lose money, while healthy people don't want to pay, but they make you money.

We have another challenge where a healthy person will subscribe, not fall sick and not renew their insurance for the following month. If you look at our cohorts, we have great adoption in the first month but we suffer a fair amount of drop-off (from healthy people) when the 9th month comes along.

One of your largest markets, Nigeria, suffers from a twin crisis: inflation and currency depreciation. How does this affect your insurance product?

Both terms can be conflated but they aren't the same. And they have different consequences on our business.

First, let’s take inflation. This is when the price of tomatoes and gas increase from one week to another. Inflation has many causes, including but not limited to the government printing more money. Inflation has a pernicious effect if prices increase but salaries don’t increase with them. This reduces people’s purchasing power.

Nigeria has suffered inflation rates of over *30%* this year. People’s salaries get them less stuff. Since everything is more expensive, our drugs get more expensive and less people can afford them. This decreases our sales.

People have to make cruel choices: I once asked a diabetes patient why she hadn’t refilled her treatment that month. This put her at serious risk. She told me that she knew very well what halting her treatment meant, but that she would die today if she didn’t eat while she would die later if she forwent her treatment.

One way we’ve tried to manage this is selling food at wholesale prices in our pharmacies, 15% cheaper than in supermarkets. Our hope is that clients will come to our pharmacies to buy the food (on which we don’t make any money) and spend the money they saved on their medications (on which we make money).

Onto *currency depreciation*. This is when the value of your currency falls compared to others. For various reasons, including the Central Bank’s decision to “float” the Naira (ie: let the market instead of the government determine the exchange rate), the value of the Naira has tumbled. As of February, it had lost *230%* of its value against the $ during the past year.

This makes our life hard for yet another reason. Our customers pay us in Naira, but we often buy our medicine in USD. Let’s say we bought a drug for $1, which used to be 450 Naira. Now, that same $1 drug is worth 1,600 Naira. That’s more than a 3x jump. This means that, to stay afloat,

we need to increase our health insurance subscription price by 3x as well. This leads to less consumer spending.

During all of this, we still have salaries to pay and we need to augment them to follow inflation. See the vicious circle?

There's ways to manage it, like buying medicine in local currency in bulk and letting the importer take on the currency risk (this means you pay more of course, but you have some stability). We also doubled down on deals with local manufacturers, who are still rare. But the recent months' spiral has been infernal and what used to be decent hedging tactics haven't been enough.

These compounding financial conundrums is in large part why we had to let *150 people* go a couple of months ago.

Africa's healthcare needs to be market-driven for it to be sustainable and attend to the needs of all African patients. Market-driven implies building for the markets we operate in. These are tough and forging economically-sustainable businesses is harder than distributing free medicine.

That's the price of independence.

Gregory Rockson is the founder of mPharma, a Ghana-based healthtech startup. In 2022, mPharma raised a $35M Series D round and served around 2 million patients.

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