

## Interview with Organization 06

*This transcript has been anonymized to not have the organization 06 and the interviewees identity be known. Also any information regarding other companies that is not regarded of importance for this research has been deleted or anonymized.*

Interviewer: Nienke van der Kooij [NK]

Interviewee: James Smit [JS]

22/01/2021, Microsoft Teams, 11.00

[NK]: Hi.

[JS]: Hi, how are you?

[NK]: Good, how are you?

[JS]: Good, good.

[NK]: Thanks that you could make the time to talk with me!

[JS]: Sure, sure.

[NK]: I've already started the recording just so that I don't forget.

[JS]: Alright.

[NK]: So yeah. Did you read the interview protocol that I sent you?

[JS]: No, unfortunately... look, I did not have the time, so I'd rather just... Let's go through, you know, how can I help? Whatever questions you have and then, yeah?

[NK]: Yeah. So, in short, I'm doing research into barriers for adoption for medical technology at GOAL3. And I have interviewed a couple of companies regarding their strategies on maintenance, user training and organizational and behavior changes that could either help or be a barrier for adoption. And so, for me, it is always helpful to start off with a little bit of a company profile from your side.

Just in short, like in two minutes, what do you do and how did you start?

[JS]: Absolutely. So did I send you a presentation?

[NK]: No, not yet, no.

[JS]: Okay, so in a nutshell. We are in markets which are very very fragmented, from a healthcare perspective. So I mean, think, imagine if you're not in the Netherlands, or if the Netherlands would have 20.000 small GP practices instead of having 5000 or 2000, right. And then, all of them would be too small, too poor, too little, not enough patients. No education of the clinicians and no access to medical devices. That's kind of the picture, right? So, in that scene, you know most of the emerging markets function in the same way where basically you have massive fragmentation in primary care. So we're not... I'm talking at the primary care level.

[NK]: Yeah.

[JS]: Uhm, and the... Usually those practices are run by nurses, not by doctors, because there are not enough doctors, right? So there is no problem of access to care as such. You step out of

your place, and you have, you know, ten small clinics and all of them are the same. A nurse maybe studied some kind of nursing school 10 years ago, she doesn't know much. She's going to look at you and say Nienke, let me give you some antibiotic and goodbye.

[NK]: Ok.

[JS]: Yeah, so and what we do... There is no laboratory, so it's not... there's no access to, I mean the labs are located in the cities for the one/two percent insured people. Most of the individuals are not insured for, you know they're not covered, so they pay out of pocket.

[NK]: Yeah.

[JS]: They pay maybe 70 – 80 dollars per year. In the whole healthcare system so very, very little compared to a Dutch or French or whatever, who pays 6 to 7000 dollars/euros per year, right? So kind of this scale.

So what we do, we go to those small practices and we give them a diagnostics, one or more diagnostic devices in the shape of you know, can be a portable ultrasound, can be a cholesterol analyser, can be a small device or so small machines with a couple of you know metabolic markers which can be like hemoglobyn 1C for diabetes. So we're looking to the kind of the 80/20 of the markers which help identifying the basic diseases of what people suffer. And those are not the that the standard HIV, malaria, blah blah blah, because also things that have been dealt with for the past 60 years right? So we talk about things that most of the people suffer now in those markets which are metabolic diseases, right? Heart like heart diseases, diabetes or just a condition. Like a pregnancy, needing pregnancy scans right?

[NK]: No, no yeah.

[JS]: Um, so we have about 10... So we bring those machines from around the world. So we've scouted the world to look at, you know, the most innovative start ups building those devices, which can each of them do one or two or three markers bring them into Kenya until then, now also South Africa, Cape Town. Um, we connect them so we find ways to... You know, we built kind of an IoT platform to connect those devices together into one system, into one middleware, and we lease them. We place them into those practices. We don't really sell them because those small practices don't have money to buy, they can't buy something for 1000-2000 dollars, but they can pay every month. They can perform diagnostics, they can charge the patients and I can pay on time, or sometimes over time.

So, and there are about 1000 of those of the 10,000 private small clinics in Kenya, we are in about 1000 of them, and we just went into South Africa with a similar model. And we also when we see the opportunity to bring more machines into a medical practice, which is bringing in more slightly bigger machines, and we can't sell mini laboratories like you'd see in your doctor practice in Rotterdam, Amsterdam, wherever you are. And imagine that that Doctor will tell you instead of just sending it to a laboratory or drawing the blood, into the lab and you wait for a couple of days. The doctor will do the test immediately and... That's literally our value proposition.

[00:08:35]

[NK]: Okay, yeah, so and that's actually connected to the first theme of interest from my research, because one of the points I'm researching is how companies handle the maintenance part of their devices and since you do a leasing contract...

[JS]: It's not really maintenance... let me ask you a question, how many times in your life have you gone in to fix your iPhone.

[NK]: To what? To check my iPhone?

[JS]: To get your iPhone fixed.

[NK]: Maybe like once or twice, yeah.

[JS]: Almost never. Exactly, that's exactly what happens. I mean, those devices are run....

It's not... there's no parts, so I think... we're not talking anymore about the big laboratory devices. Think about a photocopy machine compared to your phone, which can scan a paper. The photocopy machine, it's big, it has parts, has wheels, etcetera. Your scanning device, like your camera, doesn't have anything right. That's exactly with these of them, most of those machines are purely digital. There's nothing really to fix. Yeah, it can break, because the doctor, the clinician throws it on the floor or whatever, and then it can break. And then we go and change it, replace it. Nothing really happens often... just nothing we need to maintain. We have a team of 30 people.

[NK]: Ah, so you replace it then?

[JS]: Yeah, I mean our maintenance is more about, our customer relationship is more about how do we help those clinicians to increase the utilization of those devices. Because if they don't use them enough they can't pay, they can't. They don't make money, they can't pay our tax. We really work with them on how to help them getting more patients, explaining them the meaning of a certain test because they're very very low educated medical professionals. They need to explain to the patients the tests and then do this.

[NK]: So you do like a training programme on how they can use the devices.

[JS]: Exactly.

[NK]: Ok, so what kind of training is that?

[JS]: But we even go farther than just the devices. We train the clinicians on, you know, what are the precursors of diabetes, for example, what are the precursors of a certain, you know heart disease right? So... because they don't know. So and then, then by doing this medical training you know we get to the point of saying well then you need to use this procedure, this specific test. You know to identify and then they're going to use advice.

[NK]: Yeah, and did I do you also train them on like how to treat the diseases then as well.

[JS]: I mean we do part of the training, but obviously... we do. That's kind of putting... finally they have access to meds, you know, they give meds. That's kind of what they know, they just struggle to identify the disease. And you know.

I don't know... The number is horrible, but it's something like 1810 cases in heart diseases here are misdiagnosed, most of the patients are misdiagnosed, and then obviously the doctor tells you you have whatever... A bacterial infection, take antibiotics, but maybe it's a viral infection, right? And there's no point to be taken antibiotic or no one tells you...

It has happened to me. You know, sitting there they said I had Malaria. And obviously I don't have Malaria, I just have like a digestive infection or something.

[NK]: So they do have the ability or the medicine to be able to?

[JS]: Yeah, I mean they have meds. Obviously low quality meds... No brands, not branded. Ironically that is where they make most of their money, they're rather keen on selling medications.

[NK]: And how? How do you guys train them? Do you guys go and visit every clinic or do you video call them or?

[JS]: There's like 70 people. No, forget about video calls. No it's pretty much door to door, we have 70 people going to the field every day. We got back record devices, we've got [inaudible]. Mapping, we map those locations and we identify... Pre-identified clinics, we may call them, but not really by video phone. They barely know how to use a phone.

[NK]: Yeah yeah, cause that you do have the people then to go everywhere cause if you run like 1000 clinics and you have to set them all up...

[JS]: Very human, very human intensive.

[NK]: OK, so this I've spoken to persons actually doing training via video calls or maybe instructional videos and stuff. But in your opinion, that doesn't work.

[JS]: So we have videos that we give them, we watch half those videos... It's just very difficult to get someone over the video call and explain because of the limited skills of those individuals. So you need to... And also, a lot of countries who are kind of, face to face contact is very very important in the relationship and you need to be face to face.

[NK]: Yeah, yeah, so you have like a personal relationship with these clinics then... Which is also I guess good for if something on the device breaks and they contact you.

[JS]: Exactly.

[NK]: Yeah... And because, if something breaks, you replace it, you said.

[JS]: Yeah.

[NK]: Yeah okay, and that works well? Because you have been running since 2019 right?

[JS]: Yeah, begin of 2019 yeah.

[NK]: Yeah, so that's it... That has been working for you, just the replacement model, yeah?

[JS]: Yeah, yeah.

[NK]: OK, um, and did you because you said you started in Kenya? Did you have a lot of knowledge on Kenya to say that you knew what kind of training each nurse or each doctor would need?

[JS]: I mean, I've been in Africa for 13 years between Kenya and South Africa. And I was in venture capital before and I've been in a few other companies. I hope you know I had, you know... A fairly good understanding of the market but not that deep. Um, so it took me a while, so it took me a year. Before even I launched [organization 06] in the year, so to research the market and pick clinicians and go to the field and...

[NK]: Yes, so you did a lot of field research to know what they needed and what kind of knowledge they had. Okay, and is it comparable to South Africa? Now you're moving there like or...

[JS]: Nah, I mean look, I mean, it's interesting. I mean I, I'm not sure if you've ever been to Cape Town, right? But Cape Town is becoming... South Africa is a very interesting country because you have... You know you have a country that looks a lot like the South of France or like whatever like Nice or Monaco on one side, but you have 14 million people living under par, for like \$4 or \$5 a day, right? So and you don't see them. I mean, you're in Cape Town is like you living in San Francisco? But if you go 20KM south of the town, you're going to see massive townships, right? That's where most of the people live.

South Africa is very different from this point of view. It's different from one perspective is that there is a working medical or healthcare system, but which helps only 15-20% of the population. So if you're rich, but even for the poor, then they have access to some kind of medical insurance, so there is a payer. So things are, there is also a massive market, but we need to go farther into the townships to be able to get what we want.

[NK]: Yeah, and um, one factor I'm also looking into is that some devices require quite a behaviour or habitual change of the receiver, the end user. And I think with what you explained, it is quite a change in the way the nurses work within their clinics. So you do anything to support that.

[JS]: We train, I mean we train the nurses. I mean... the thing is, look at look at US right. 60% of the Americans are overweight and 40% are obese right? And this is gonna grow by 2025 or 2030 to 80% overweight and 60% obese, right? That's what the stats look like. Horrible right? And that's US, so what do you expect? You'd expect Americans to be... You know, better to understand better.

Whereas, we're in South Africa, right? Those people don't have money. They drink coke everyday. Or they drink something. They don't, they don't move, and they eat fried whatever. Their state of health is horrendous. So we see it. We look at the numbers, you know 50-60% of the blood test that we do show that you know their precursors of diabetes or pre cursors of heart disease. So people are extremely sick. Do they understand now that, unless you tell them? No. Uh, can they pay for tests? Very difficult, so? So yes, we need to educate, but also need to make sure that we lower significantly the cost of those diagnostics to tell someone you need to do this test, because what we look we see you may have actually something which is killing in the next five years.

[NK]: Yeah, and do you think you would be able to do that or is it only possible if more... Uhm if more patients will come into the offices to be tested.

[JS]: So people are interested and let you identify this when people come. You can't do it otherwise, right? People still need to step into a clinic. It's not like you have someone you know... You would have a kit home and you do your own tests. You know, those people leave shocked. They barely have homes.

[NK]: Okay, and then I think one also interesting things for your, like kind of model is consumables. Do the devices need a lot of them or...

[JS]: Some of them do, some of them are purely digital, like imaging. Some of them need consumables. We supply those consumables.

[NK]: Oh, so you just supply them. And that works. Cause I've heard kind of like um... difficulties with consumables because of the costs. But that goes within the leasing price then.

[JS]: Exactly, and then the devices that we find, that we place... That's why I spend so much time scouting for those devices, because technology is not always cheaper than the old fashioned. So I'll give an example. It can do urine analysis... Resolve massive issues in urinary track infections, right? So urine analysis, you can do it with 50 cents strip with a drip. People do it in a pharmacy. It's not precise, but I mean it kind of works right? Or you can step into a booth in London or into a whatever pharmacy in Europe. Which is really cool, it's an app, it costs you 5 dollars or euros. So 50 cents or 5 euros for the same type of test. One is much more accurate and easier and profitable, but cost 20 times more so. For people... Those markets are still priced entities, that we need to find the device which is cheaper than their traditionally training and way of doing those tests.

The same for cervical cancer. They distill with vinegar. It's horrible. Yeah you can do it with portable corpus cops with cameras and artificial intelligence models to identified the lesions. But those machines cost, you know, a thousand/two thousand dollars so. The question isn't always like yes great, but is that priced well enough to be able to be affordable?

[NK]: Yeah, but I did read that you guys do integrate with AI your devices, right?

[JS]: Yeah.

[NK]: So how do you? What's your approach on that? Do you just do you get like that the diagnostics or?

[JS]: So we don't build our own. We try to find devices which have an AI model behind or are high tech enough, and we just connect them. Just a more data perspective on collecting the data.

[NK]: Yeah, and do you... Because I have heard people can be very... They have different statements on the technology acceptance of people in more lower resource settings. You said your devices are very digital. Do you get any? Struggles there or...

[JS]: Yeah, obviously when we started. When we placed the first portable ultrasound with an iPod or an iPhone the clinicians were like: no we need one to see the babies on the big screen. Big screen is when you buy a \$50000 ultrasound, not a \$2000 ultrasound. And then, there's a lot of patients who do not come... Women will not come, because they want to see it on the big screen. Is that a real blocker? We were told that that is a blocker. Well, there's no blocker. So it's very much the adoption of technology happens, right? I mean, my grandma uses an iPhone. It took her years to do it, but finally people change and they can... You know they adapt. Or maybe they are scared in the beginning but then they adapt.

[NK]: Yeah, do you think it's also kind of? Maybe because, um... If it's the only thing available in the clinic, they are going to have to use it to be more efficient or...

[JS]: Yeah, obviously efficiency is super important because... Efficiency, the thing is that in the Western world, the biggest problem with doctors is actually the time right? Now because the doctors sits, and writes on the computer and then tells you goodbye. And then next patient, next patient. In those markets like South Africa is more like Europe, but Kenya and the rest they don't have no patients. So the time is not as important because there's no patient. They, maybe they have one patient per hour.

But understanding of their financials, how much money they made. Being able to get the loan from the bank if they don't have anything documented, they don't have systems they can't get financing and then they can't buy so, so that's kind of the efficiency we're talking about more than just do it faster.

[NK]: Yeah, and do they, if you give them like digital solutions, do they have like an electronic patient record as well or?

[JS]: Yeah, we build an in house electronic medical records and billing platform.

[NK]: Yeah, and do you guys plan on like scaling that up towards like the connectivity with the hospitals as well or.

[JS]: We connect to the devices, but we're not in hospitals. We are only in primary care.

[NK]: Yeah, but can your devices like the medical records that you create, can they be send to like hospitals?

[JS]: It's a very simple, so we build it for primary care because there's nothing really in primary care. There are plenty of platforms serving hospitals. Now that's way too many, but there's nothing... It is very little staff working for the simple process flows in a clinic with one clinician right. The hospital is... to have a flow in the hospital, you need 2 wings, you know, X rays. You need different flows in hospitals, right? People can go from department to department. You know, one room cleaning. There's one floor, right? People come get recorded at reception, maybe pay and go to see the doctor / the clinician and then have maybe a laboratory that's it.

[NK]: Yeah, and do you do any internal developments with the AI that you use? Like the data that you gather for like assisting of diagnostics and stuff?

[JS]: We analyse the data but no AI for now. Just for now we analyse the data ourselves and then maybe in the future. I mean to use AI you need a lot of data and so now there's no need for this. But yeah I see a clear model in the future where we're going to have millions and millions of data points. Then we can predict stuff.

[NK]: I ran over it pretty quickly, but also because the maintenance is very straightforward for you guys and I've talked to people that have very big devices that needs quite a lot of preventive maintenance like check ups every week or something.

[JS]: Right?

[NK]: So but yeah, so do you think that your devices need to be like... do they need to be cleaned regularly to be able to work or anything?

[JS]: Not really. I mean, going back to the example of a phone. Do you really need to clean your phone to work? Not really. I mean there's a bit of maintenance, but nothing to major. It's not like the older... kinda the machines working with parts right when you clean them and.

[NK]: Yeah, you need to take them apart and stuff.

[JS]: Yeah.

[NK]: Yeah, and you guys ever get that you need to send like a spare part so like a little bit of a machine to someone to be able to fix it? Or is it just replacing the whole thing or?

[JS]: Exchange machine completely. Yeah, you replace it if needed, but very rarely and it is so rare that we don't really do it.

[NK]: Yeah, and for the success of the model that you implemented, do you think that the amount of field research that you had to do was important or how long you guys...

[JS]: Absolutely, because we need to go and first define what the problem is, right? So the problem is, I mean then... and what the problem is. And is there a problem? There are so many problems, right? It's either one of the... Can you solve profitably one of those problems, right? There are plenty of problems in the world, but a lot of them cannot be sold profitably, unfortunately. So you can't build a venture capital fund adventure on solving a problem in a non-profitable way.

So, the field research I did for over a year while still doing my venture capital work. Was you know, there's so many issues in healthcare what that single issue or couple of issues where we can build something [inaudible].

Because if it is not working, if it is not adopted by the market then it is not gonna work because you can't find funds that can be drawn forever, right? I mean, look at the healthcare, the healthcare in Africa is destroyed because for 50 years you know Europe and the US gave money to governments and then where do you know... This money didn't go to solve their healthcare problems? So you can't.... You can build something that is this thing is adopted by small entrepreneurs, that are building businesses around the issues and certain people.

[NK]: Yeah, do you think that for every country that you want to expand to, you need to do the field research in some measure again? Or do you think it's comparable enough too?

[JS]: The thing is, you know, healthcare is very different and that's interesting because... There's some, there are a lot of factors that are pretty similar like [inaudible] in Kenya, Tanzania, Uganda, electricity tariffs are basically the same. Saying like whatever building supermarkets is similar. Health is very different because it evolves separately and you know if you look at Netherlands, France, UK and Germany, four countries, completely different healthcare systems right? Where you know, in payer, insurance, private, non private etcetera. So unfortunately I don't really see how we can stand in other markets without researching.

So I was just saying, you know last year four months have been to Cape Town, Johannesburg and the outskirts to try and understand the market. Speaking to every person in the sector I choose so I'll understand what the problem is.

[NK]: Yeah, that's very interesting. Yeah, we went over it pretty quickly, but it's good for me because, um, I think so... You're active and I think Kenya and South Africa for now and then and then. Your intended users are mainly the nurses. But also I think general practitioners if they have them.

[JS]: Exactly.

[NK]: And how many persons work within [organization 06]?

[JS]: 130.

[NK]: Yeah, and so your main office is? That I know like that their country of origin for the comparison of the company for interviews.



[JS]: We have kind of... We have teams and semi-offices in Nairobi, in four cities in Kenya, and in Cape Town.

[NK]: Yeah, okay. Yeah, and then your personal experience within the field that you said you've been there for 13 plus years doing other ventures in Africa, right?

[JS]: Exactly.

[NK]: And that's just my own frame, because I'm going to compare the companies that I talked to. Also, unlike on like an upper level, and if you have... Do you have like any sales brochures or something that you can send me, that you maybe give to the doctors...

[JS]: I can send you, yeah I can. I can show this.

[NK]: Yeah, that would be great, okay, and then for your knowledge. I don't know if you've read through it, but I'm gonna anonymize this interview transcript. Send it to you so you can cheque it and then use them in the analysis for my thesis which will be published in the end of March.

[JS]: Also, how many companies are you talking to?

[NK]: I've been talking to six companies. And then with the knowledge I gather from that, I'm going to try to build a framework within the themes that I've identified. I'm going to validate through... I've got one company, which I'm going to talk to an engineer to doctors and some people that are performing the training. Um, which are going to help me give some other perspectives on the problem. And then talk to some experts in the field as well after that so.

[JS]: And it's part of grad school, PhD or?

[NK]: So this is my master thesis, so the like the final projects for my Masters degree.

[JS]: From which Masters degree is it, in in what?

[NK]: Complex systems engineering and management from there the TU Delft. Yeah, but I've done...

[JS]: We work with a company based in Delft which is called Delft by the way, which does imaging. They build those portable X ray machines as the size of a binoculars.

[NK]: *[company 03]*?

[JS]: Check them out, just go check them out. I mean they are based in Delft, I mean they are called Delft, *[company 03]*.

Very interesting, someone that's kind of one example of other potential supplier of hours, right? You know companies which builds superinnovative tech, you know that your X ray machine which is inside the room now becomes something which is the size of the binoculars. So it is low radiation, you don't need anymore the led walls, and then you put a patient you know against the wall and then you do pulmonary X rays for example. And then you identify TB.

[NK]: I've talked with our CEO and their Managing Director of Ghana. Yeah, very cool company.

[JS]: Right, pretty, but very quick.

[NK]: They have very good products, but they're very expensive.

[JS]: So that's why we couldn't do much because you know they're cheapest machines are still €50,000 euros. Which is great, but it is still very expensive for us.

[NK]: Well, but there they are very good at what they do, but they are... Comes with a little price tag cause well, yeah.

[JS]: Well, let me know if I can help you anyways, I'll also just got on my side. I'm looking continuously for smart entrepreneurial people who want to work with us. So if you know anyone in your network who wants to do something cool in African healthcare, let me know.

[NK]: Yeah, I will okay, thank you for your time. Have a nice day. Bye bye.