

From: David Grosf [REDACTED]
To: Jeffrey Epstein <jeevacation@gmail.com>
Subject: Re: gates to me
Date: Sun, 03 Apr 2011 11:14:26 +0000

Wow, thank you.

I am glad he agrees with us on the critical importance of (1) partnering in developing regions with the largest and most effective organizations (our favorites are Aravind, LV Prasad and VisionSpring) and (2) targeting the level just above the base of the pyramid for launch and learning the market: namely, urban and town working class people, not the very poorest and most rural. The urban and town working-class markets are, I understand, the target markets for the Mexican firm Farmacias de Similares, which has become highly profitable making basic healthcare goods and services affordable and attractive, and is profitable in direct competition with free government clinics. How do they make money in competition with "free"? Farmacias de Similares saves its "customers" waiting time vs. the government clinic, and the customer experience is designed by a customer-centric organization, so not only their service-time but also their dignity and entertainment needs are addressed...in return for cold, hard cash.

Five other quick points for now.

1. VisionSpring is the renamed Scojo Foundation and partnered with BRAC. I am not sure what has happened with that particular relationship and I am seeking an update from the head of VisionSpring.

2. Adaptive spectacles, that involve self-adjustment, have been opposed by Establishment optometry figures and also were initially championed in a sloppy and stupid way. I think that due to some new data and a new product, Establishment resistance is about to weaken. Nonetheless, the adaptive specs are likely still going to be more expensive, unattractive and vulnerable to loss than ordinary lenses...and their failures either to correct for astigmatism or to work on small children will hinder uptake in competition with more traditional spectacles. In short: these might be suitable for schoolkids with near-work-onset myopia above age 8.

I identified a former employee of the AdSpecs group who is a consultant in Southern California that I am itching to hire to prepare a re-analysis; our clinical advisor Bruce Moore of New England College of Optometry is also very much on top of current efforts with adaptive specs. I suspect that their glasses will be quite expensive and unless left in school overnight may not have a suitable product lifetime with children. I am also skeptical of their aesthetics, but I am open to convincing.

3. OptiOpia's is a more traditional approach than the others described in the email, with the exception of VisionSpring, which has carefully chosen frames and materials to provide first-rate reading glasses (and only reading glasses)..

Because our means of refractive error measurement is suitable for young children as well as adults, ours addresses the whole population. We both enhance existing optometry and ophthalmology capabilities and facilitate de-skilling of refractive services in regions where practitioners are scarce. Our lenses are exactly like developed-country acrylic CR-39 lenses -- the developed world's most popular lens material! -- and can be cut to fit in any frame. Appearance is as important to the poor as to the well-to-do, and in some regions poor people show off with fashion eyewear. I like to say, "Eyeglasses should not be birth control." OptiOpia is ready to help people both see well and look good.

[Technical clarification: Our lens molder can't make every lens you can get at LensCrafters -- it makes single-vision acrylic plastic lenses for near and far-sightedness and astigmatism. The molder we want to build will not make high-refractive index, photochromic, prism, or progressive advanced lenses.]

4. The existing operational economics of front-line clinics at the Aravind and LV Prasad systems in India, which more-or-less break-even based on positive cash flow from sale of eyeglasses, indicate that those organizations

can reach and profitably sell to even the poorest, at province-wide scale (25 clinics). More on that later. The significance of the fact that *everybody makes money selling eyeglasses, including charities*, can scarcely be overestimated. Where you have that business incentive, you have repair services and shops. *The big bottleneck is measuring refractive error to get the right prescription*, and that's why the autorefractor is our lead product. Where refractive error measurement has been bad, dispensed glasses have yielded an unsatisfactory experience and has severely limited market confidence and scale.

5. I have not disclosed how to supplement the objective refraction technology of the autorefractor with what Gates may be referring to as "self-programmable" perhaps subjective refraction methods. Existing objective refraction methods can be made "self-programmable" for many, but my information from people with decades of experience in delivering care has made us prioritize an assisted device like OptiOpia's autorefractor. Note that getting the right prescription involves getting three numbers right, but the adaptive specs get only the first right: spherical lens power, cylinder lens power and cylinder axis. Some technology is needed to automate what is called subjective refraction ("Is it better with lens 1 or lens 2?") efficiently and accurately. The methods are at hand or are nearly at hand. More on that later. [Clarification: an objective refraction method measures the eye's optics without needing an assessment of visual quality from the patient; however, it does require stabilization of the shape of the variable lens of the eye, which is called the accommodative state. Eye drops can force the relaxation of the lens but are not particularly suitable for vision screening and have their own operational and clinical challenges.

David

PS I recently helped a Gates Foundation consultant friend of mine update the Foundation staff on eyecare!

At 02:18 AM 4/3/2011, you wrote:

Thank you for sending this information along. I have seen at least five similar proposals in almost as many years. Note that nright one of these gentleman are MDs and neither have experience in implementing programs in the developing world. Their business model is based on a billion people being willing to pay \$5 each and I am not sure that would be realistic.

We supported a similar program a few years ago, since the strong argument can be made that if people can see better (either near/far sighted correction) they can be more productive. There were a few lessons:

1. Standalone technologies and items (cookstoves, toilets, etc) - with cel phones being the big exception - do not typically catch on in the developing world. Even if they improve quality of life. In my evaluations, it seems that the marketing just didn't reach the poorest, the financing packages were not available to make the items affordable (even if there was demand), there were no places to get repairs, and small things (like glasses, bikes, etc) were frequently lost or stolen and unreplaceable (parents didn't see value in product for their children if it could be easilly lost).

2. Here are some of the now dewfunct similar efforts - some have even been presented at TED:

-Scojo Foundation <http://www.fastcompany.com/social/2008/profiles/scojo-foundation.html> ;

-AdSpecs (Centre for Vision in the Developing World) <http://www.vdw.ox.ac.uk/2minuteintro.htm>

-Focus on Vision (really cool and for \$4, check out how they do it...no machines needed) http://www.focus-on-vision.org/index_en.php

-Adaptive eyewear (uses water!) <http://www.visionforanation.org/> and <http://adaptive-eyewear.org/>

There are many more - just google "low cost eyeglasses" AND "developing world"

Where there was a short term bump, was when a program like this was imbedded into a larger organization that could not only utilize this as an entry point, but also had the reach and ability to market and finance the glasses. BRAC (www.brac.net) is the world's largest NGO and they tried to bring cheap glasses (under \$3) to the poor (<http://www.changemakers.com/node/1249/images>) a few years ago. It worked for a few months. I think what happened was that the middle classes and "richer" poor bought glasses but the truly poor weren't biting.

While ideas like this could in theory put developed world glasses makers out of business, rich people don't mind paying more for stylish lenses and somehow are comforted by all the big machines used to assess refractive error.

In the developing world, these guys are unlikely to succeed unless they link up with a large organization already implementing health/vision programs or can find a way to work directly with governments to include their products into national health care planning. For ideas on groups that are active in the developing world, a good place to start might be

above. If they want to take a national government approach, I would suggest countries where public health reaches the poor effectively, like Peru - Mexico, Thailand, Turkey or even Botswana. The latter seems like the most viable option for scale since there is also the possibility of cross-subsidy from those who can afford to pay (payor mix).

I think the future of this type of thing in the developing world would probably be closer to some of the ideas above. A box full of fully self-programmable (though low tech) spectacles that can be readjusted as needed and requiring only you and your own brain to make them work.

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