
Brokering accreditation in Kenya's National Hospital Insurance Fund: Lessons learned from Marie Stopes Kenya's AMUA social franchise network

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African Health Markets for Equity (AHME) is a six year programme funded by the Bill & Melinda Gates Foundation and Department for International Development. The six-year project aims to deliver high quality primary health care, particularly to the poor, through the private sector in Kenya and Ghana. The AHME partnership is led by Marie Stopes International in collaboration with Population Services International and PharmAccess Foundation.

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Photo: AMUA clinic

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Project Summary

The African Health Markets for Equity (AHME) project, funded by the Bill & Melinda Gates Foundation and the UK Department for International Development, aims to deliver high quality primary health care, particularly to the poor, through the private sector in Kenya and Ghana. The six-year project seeks to improve the functioning of the health system in terms of quality, access, security of supply, sustainability and equity in ways that benefit the poor. The AHME partnership is led by Marie Stopes International (MSI), with Population Services International (PSI) and PharmAccess Foundation (PAF) as sub-contracting partners.¹

The AHME partnership identified five conditions that must be met for markets financed through national health insurance schemes to work for the poor. These five conditions underpin AHME's intervention strategies (Figure 1):

Figure 1: AHME conceptual framework



1. The poor are enrolled in government health insurance schemes. To increase enrolment of the poor, AHME focuses on improving targeting mechanisms and community engagement.

2. Key primary healthcare services are covered. AHME has championed the inclusion of primary healthcare services in the benefit package offered by government health insurance schemes and advocated reforms in how primary healthcare services are purchased in order to create an incentive for providers to deliver high quality services cost-effectively to all who need them.

3. Accessible facilities are contracted. AHME works directly with smaller, low-cost private providers to assist them with empanelment and is exploring ways for franchisors to serve as intermediaries between the insurer and a network of private providers.

4. Accessible providers offer quality services. AHME partners are working to measure and improve the quality of services offered by franchised providers.

5. Providers run viable businesses. AHME partners are supporting providers to improve their business skills as well as gain access to credit to grow their businesses.

This brief describes the experience of Marie Stopes Kenya (MSK) in its pursuit of condition 3: Accessible facilities are contracted. It looks specifically at how MSK has evolved the network function of the Amua social franchise to broker franchisee accreditation into Kenya's National Hospital Insurance Fund (NHIF). This process was considered quite complex and bureaucratic for franchise providers as it involves a number of steps and requirements. It considers how Amua's value proposition has evolved in the process, for franchisees as well as the health system. It highlights some of the teething pains involved in working with evolving universal health care (UHC) schemes as well as the value of field experience to inform advocacy (as part of MSI's "advocacy by doing" approach).

MSK's experience will be relevant to other organizations and governments embarking on domestic financing and seeking to overcome obstacles in linking private providers into UHC.

Background

Kenya is one of several countries in sub-Saharan Africa to invest in national health insurance. Kenya started early, shortly after independence, with the establishment in the 1960s of the National Hospital Insurance Fund (NHIF). The scheme, as its title implies, was initially focused on in-patient care through hospitals, mainly for formally employed urban residents. As a result, coverage in the scheme remained low. However, in recent years there has been renewed effort to expand coverage of the scheme as part of Kenya's commitment to UHC. In addition to in-patient coverage, the NHIF now covers primary and preventive care, as out-patient out-of-pocket expenditure is expensive and has a larger effect on health outcomes.

While NHIF membership is compulsory for all formal-sector workers² and voluntary for the informal sector,³ effort is being made to include the poor through the Health Insurance Subsidy Programme (HISP), introduced in 2014. A low-cost product, SupaCover, was introduced in 2015 to increase voluntary enrolment of the informal sector. It has been estimated that in 2012 approximately 25% of the population of the country was enrolled in the NHIF.⁴ As of early 2017, the NHIF had 1,635 health facilities accredited – 727 government hospitals, 682 private hospitals and 164 faith-based facilities.⁵

Marie Stopes Kenya (MSK) is one of the largest sexual and reproductive health NGOs in Kenya. MSK currently operates through an extensive service delivery infrastructure that consists of 23 MSK clinics, one obstetric centre, 15 dedicated outreach teams and a social marketing team. MSK coordinates the Amua social franchise under the leadership of the Ministry of Health (MoH), which is a network of approximately 360 private clinics throughout Kenya.

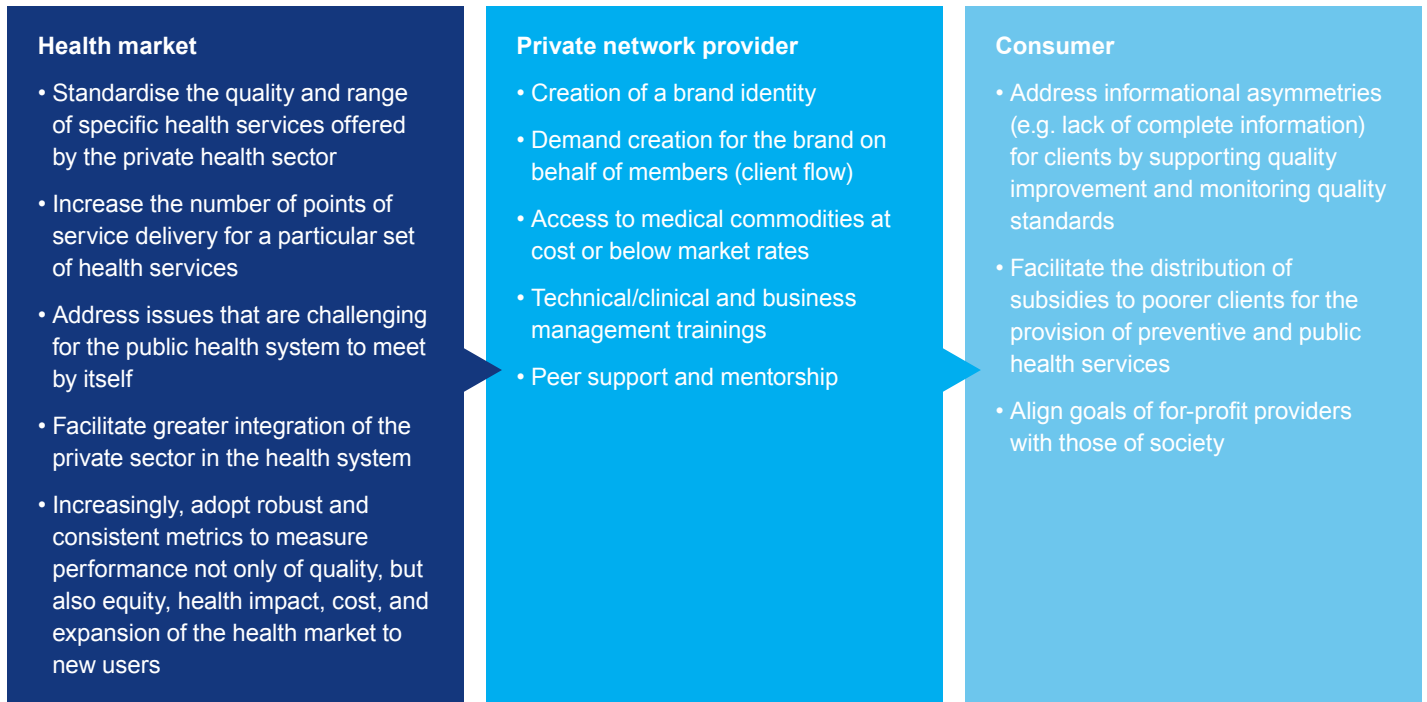
Health insurance and social franchising are synergistic. The extreme fragmentation of the private sector in many countries, including Kenya, is in itself a barrier to entry for large-scale insurance schemes. To operate effectively, such entities need to navigate efficiently through, of then complex, strategic purchasing of health care, something that is difficult to do without organised provider networks. Social franchising is an effective vehicle for organising the private sector. Additionally, given that health insurance reduces out-of-pocket payments at the point of use, having social franchising providers accredited by insurance schemes, particularly those that are 'pro-poor', extends access to consumers and may improve utilisation of services and prompt healthcare seeking.

Methodology and Conceptual Framework

Methodology: The methodology employed to develop the "lessons from the field" was a participatory process conducted jointly with MSK and MSI's Health Financing Team (HFT) based in London. This included mapping the empanelment process by MSK (this map did not exist within the NHIF). This was further informed by subsequent interviews with franchisees and NHIF branch managers, conducted by MSK in February 2016.

Network value proposition: Networks exist in all health systems. They are a useful form of organisation, particularly when the private sector is prominent in a health market. They can serve as important intermediaries between governments and a 'disorganized' private sector. Disorganisation can occur when the private sector is atomised. Atomisation may be geographical, hierarchical or economic, or it may occur as a result of training or specialisation. Atomisation, as the term implies, does not make aggregation of providers easy. As a result, establishing networks often features as part of health reform agendas. Provider networks allow for programmatic changes of all kinds to spread more rapidly and efficiently than among un-networked, atomised providers. This conceptual understanding of health provider networks has informed the MSK franchise value proposition, presented in Figure 2. This illustrates the value that the social franchise function brings to the health market broadly and to providers and consumers.

Figure 2:
Conceptual framework for Social Franchise
value proposition



Findings

Findings are presented according to the steps for provider engagement with NHIF identified by MSK in the empanelment process.

Step 1: Contract fit

There are currently two contract types – in-patient and out-patient – included under the NHIF scheme. These are presented in Box 1 along with the positioning of family planning methods within the two contract types.⁶ As noted by MSK, providers do not always have the information or business skills to make the best choice of NHIF scheme for them. For example, they may prioritize large margins from per member capitation payments over volume, taking insufficient account of the demographics of their catchment area that would mean small per member margins still provide a good income. Such misunderstandings may lead to disillusionment on the part of the providers. Franchisees also tend to opt for the contracts which they perceive to be more expedient. In both instances, this may lead to franchisees opting out due to poor decision making. MSK is supporting franchisees to make informed decisions on contract fit.

The NHIF is in the early stages of UHC reform; experience from other contexts suggests that reform measures should result in aggregation in order to improve overall performance of the scheme (who is covered, what is covered, how much is covered) as well as reduce administrative burden. Fragmentation is costly⁷. While measures are being taken to address NHIF efficiency, MSK is working closely with providers to find the “best match” for franchisees and contract schemes.

Box 1: NHIF contract options

Out-patient service contract: Outpatient services are offered on a capitation basis. The health facility signs a contract to provide a defined benefit package for a pre-determined number of people. The health facility is paid in advance and is expected to treat the patients for an unlimited number of visits. The outpatient contract itself has five different categories; the rates given below are for faith-based and private health facilities, while public facilities receive a slightly lower rate.

- National scheme contract – capitation amount of Ksh 1,400 (~US\$13.60)
- Civil servant and disciplined forces contract – capitation amount of Ksh 2,850 (~US\$27.70)
- Health Insurance Subsidy Programme – capitation amount of Ksh 1,400 (~US\$13.60)
- Elderly and disabled programme contract – capitation amount of Ksh 1,400 (~USD 13.60)
- Job Group L–T – fee-for-service

In-patient service contracts: There are three possible contracts available.

- **Contract A:** Healthcare providers offer comprehensive care without co-payment for both medical and surgical procedures for in-patient members and their declared dependents.
- **Contract B:** Healthcare providers offer a comprehensive package, as in contract A. This contract has no co-payment requirement. However, members may be required to make a co-payment of up to Ksh 15,000 (~ US\$145.70) in surgical cases only.
- **Contract C:** A daily rebate system applies, and the member is required to pay any amounts over and above the daily rebate. The out-of-pocket top-up is made in case of a deficit after deduction of the NHIF rebate from the total bill.

Family planning – long-acting reversible contraceptives and short-term methods – are not well defined under the capitation model, while surgical (i.e., permanent) methods are under in-patient contracts and are reimbursed on a fixed fee-for-service basis.

Step 2: Readiness assessment

MSK works with a subset of the 360 providers in its franchise network to assess their readiness for contracting with the NHIF. In 2016 MSK focused on 50 franchisees, while 35 are in the process of being registered and 63 are already participating in the scheme. Readiness is assessed primarily on the basis of performance, with a specific focus on quality. Franchisees are categorized based on MSI's internal Quality Technical Assistance (QTA) scores as well as SafeCare level, where this process is being implemented.⁸ MSK also prioritises franchise facilities based on their level of interest and geographic location, focusing on those in underserved areas or considered marginalised by the NHIF. Geographic mapping and prioritization also takes into consideration "traction" with NHIF branches (explained below).

Step 3: Sensitization meeting

MSK subsequently organises a sensitization meeting for franchisee providers that are ready to join the NHIF. This meeting is held by region (MSK has assigned franchisee facilities to regions). The NHIF branch manager for that county/region is invited to attend the sensitization meeting. During the meeting s/he walks potential franchisees through the accreditation process as

well as the checklist that NHIF uses during accreditation site visits. The NHIF representative also answers any questions from the potential franchisees. Common issues raised include:

- The length of time for NHIF contracting
- Concerns related to capitation rates
- Costs of meeting registration requirements and possible penalties for non-compliance
- The minimum score on the NHIF checklist needed to qualify for accreditation
- What the NHIF checks for during inspection.

In addition to specific concerns, the meeting provides an opportunity for building rapport and trust between parties – franchisees and NHIF branch managers – and reinforces the brokerage role of MSK. The importance of this rapport should not be underestimated. In the last year the NHIF has undergone significant internal restructuring to improve transparency and increase public trust. Additionally, with an increase in mandatory NHIF contributions,⁹ there are mounting consumer and provider expectations of the NHIF. Tensions among the parties may be part of the growing pains that mark progress in UHC schemes (Box 2).

Box 2: Pathways to universal health care

Savedoff et al. (2012) review historical evidence and identify four patterns in the way countries achieve universal health coverage:

- Social movements play a key role in pressing for universal health coverage
- Government is deeply involved in managing or regulating health financing
- the contingent nature (e.g. non linear) of public policy-making and
- progress is incremental.

Source: Savedoff et al., 2012. Transitions in health financing and policies for universal health coverage: final report of the Transitions in Health Financing Project, Washington, D.C., Results for Development Institute, p. 16.

“NHIF people came and went without uttering a word. They just looked at the facility and did not give us a feedback on whether we have passed or not. They just left.” (Amua franchisee)

“I have waited for four years to get accredited. MSK coming to assist us on this is a blessing.” (Amua franchisee)

Step 4: Compliance preparations

There are a number of preparations for licensure compliance that franchisees must navigate. All providers have their practitioner’s license (this costs approximately US\$150 for initial registration and thereafter \$60 annually to maintain membership). However, many providers, particular those with smaller facilities, do not have the Kenya Medical and Practitioners and Dentist Board (KMPDB) license. This license is not required for nurses and clinical officers, but it is required for participation in NHIF schemes. This license ranges in cost from US\$60–\$210 for registration to US\$50–\$800 for annual renewal depending on the level of facility. Providers also must ensure that they and their staff members are registered with the NHIF as beneficiaries.

Step 5: Pre-inspection

MSK facilitates the pre-inspection of franchisee facilities, a dress rehearsal for NHIF inspection. This is done using the NHIF checklist. Based on pre-inspection, providers are deemed “ready” or “not ready”. Those that struggle with readiness cite costs as the limiting factor, since, in addition to licenses, they often need to address infrastructure and documentation requirements. The former may include partitioning and painting, while the latter is likely to include contracts with pharmacies or laboratories (NHIF requires these functions to be available on site or contracted in). MSK assists at this stage with patient charters (e.g. patient rights), contract templates, etc. It can take health facilities two to three months to prepare for inspection once the pre-inspection has been completed. As this effort can be resource-intensive, the process depends on the franchisee’s ability to finance facility improvements. The business component of AHME is able to support this with loans, should a franchise provider wish to do so.

Step 6: Accreditation application

Once the facility decides that it is ready, it needs to complete an application form. MSK provides a sample of a completed application to show providers how to do this. Increasingly, MSK is also encouraging clusters of providers to submit group applications; this reduces transaction costs for the NHIF and introduces economies of scale. Group applications can be challenging, however, when individual providers are at different stages of readiness. MSK is encouraging clusters to move at the same pace and reports that peer support is very effective motivation, as is testimony from local peer providers who are already empanelled.

Step 7: Facility inspection

Upon successful submission of the application, NHIF inspection can take place at any time and is unannounced. Providers report that they are unaware of the criteria being used in assessment (although it does follow the checklist). Nor are they informed of their performance upon completion of the checklist; the NHIF branch officer does not communicate this. MSK has recommended to providers to make photocopies of the completed checklists (which they must sign), as NHIF has been known to lose them. The NHIF branch officer, for his or her part, is expected to enter the assessment findings into a database and submit this to Nairobi. There is a tracking system. However, follow-up in person (by MSK) at the NHIF office in Nairobi is still required. As noted by the MSK Health Financing Officer, ‘The NHIF does not have an online accreditation tracking system. We at MSK leverage on the established relationship with the various NHIF offices country-wide to support our social franchisee network. Field experience has shown that the average time required to move from this level to the next level is reduced when we play the role of “middle men”’.

Step 8: Approval

Tracking approval also is labour-intensive, and there have been cases where approval has been given but the provider was not informed. Therefore, MSK also plays a proactive role in tracking the approval process, checking regularly with the NHIF.

“If you have good relationship with the branch managers, you will make a lot of income. In fact, if it were not for NHIF, my facility would not be where it is currently in terms of health Infrastructure.”
(Amua franchisee)

Step 9: Gazettement

Once NHIF gives approval for contracting, this information goes for gazette to the Attorney General’s office. This step of the process falls outside of the NHIF and is, therefore, difficult to monitor or influence in terms of the time it takes.

Step 10: Facility coding

Once gazetted, the facility is given a code. Again, there have been cases of facilities not learning that this had taken place, and so MSK’s proactive follow-up is required.

Step 11: Contracting

The provider is not required to pay for the outpatient contract. In contrast, the in-patient contract costs approximately US\$1,000. This is usually a one-time lump-sum payment; however, if the franchisee has a good relationship with the NHIF branch manager, often an agreement can be made to pay the amount in instalments. Reimbursement rates for specific contracts are noted in Box 1. The amount of the rebate¹⁰ is linked to quality. This linkage is not defined and appears to be at the discretion of the NHIF. The rebate amount for each facility is decided by the NHIF Board; facilities have no option but to accept the amount offered under a given contract. As a result, some facilities receive higher rebates than others under the same contract. For in-patient services in health centres and hospitals, rebates range between Ksh 600 and 4,000 (US\$5.80 and \$38.80).¹¹

Step 12: Client demand creation

To justify the effort and expense of contracting with NHIF, providers must promote their services to potential clients. In some instances they may be the only NHIF-accredited provider in the area, but, increasingly, as empanelment rates improve, there should be competition among providers – from both the public and private sectors – to register clients/patients. This is potentially good for clients; it improves choice and drives competition to deliver the contracted package of services comprehensively and with quality. MSK franchisees are experimenting with registering clients for NHIF services through Community Health Volunteer (CHV) networks. CHVs are a recognised function under the Government of Kenya’s Community Health Strategy and, as such, are a logical extension or linkage between facilities and communities. Franchise providers are accustomed to working with CHVs and, in some instances, hire them or find other means to recognize their work.

Step 13: Monitoring client utilisation

Efforts have focused – and will continue to focus – on provider empanelment, given the lengthy, labour intensive processes involved (as outlined in the steps above). However, MSK is turning to “what next” – what NHIF accreditation means to franchised clinics in terms of client traffic. Providers and clients both need to benefit from the NHIF. This remains a challenge to monitor, as data need to be collected from individual providers. MSK has designed tools that are being used to collect NHIF data from empanelled facilities.

Step 14: Dispute mediation

The NHIF has been fairly timely in terms of claims management. Additionally, MSK has guided franchise providers on how to complete paperwork. As a result, disputes to date have been minimal. However, this remains an important area where MSK can mediate, as relationships need to remain amicable for the system to work.

Step 15: Feedback to NHIF

MSK participates in the NHIF technical working group (TWG) in Nairobi. This allows MSK to feed back its experience supporting providers with empanelment. It is hoped that the NHIF will address some of the bottlenecks and challenges as it works to improve its systems. This is an iterative cycle, as the TWG meets quarterly.

Conclusion

Including the private sector in large-scale risk pooling schemes, such as national health insurance, benefits the entire health market. Including the private sector, particularly one that is organised and quality-assured, may serve to drive competition between sectors, leading to higher quality. Including the private sector may also promote greater efficiency – more healthcare for the same money – by allowing risk pooling entities greater choice in the strategic purchasing of health care. The full benefits of strategic purchasing cannot be realized under national health payment plans that restrict members' access to a limited set of public health facilities.

The inclusion of mid-level providers as part of strategic purchasing under national health insurance is also critical to UHC in countries such as Kenya, where their numbers are large and their reach is extensive. The high transaction costs for both mid-level providers and national health insurance schemes can be brokered through social franchises, such as those working under the AHME. An 'honest broker' such as a social franchisor can also facilitate greater understanding of the differential rate requirements for private providers, given that other financing mechanisms, such as budget support, generally do not cover salaries and medicines, as is the case for the faith-based and public sectors.

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Glossary

Accreditation: A process by which a recognised body (governmental or non-governmental) assesses and then recognises that a healthcare facility meets pre-established performance standards.

Capitation: A set amount paid for each enrolled person assigned to a provider, per period of time, whether or not that person seeks care.

Empanelment: The act of assigning specific patients to specific primary care providers and care teams, with sensitivity to patient and family preference. Empanelment is the basis for population health management and the key to continuity of care.

Health market: A health market is comprised of all the actors involved in supplying, consuming, supporting and regulating health care.

Registration: Registration is an important step for a patient to receive care at a facility. It helps a clinic correctly identify the patient and that patient's medical information. Registration includes collecting basic information from the individual patient, thus creating a medical record.

Social franchise network: A form of organised network operating under the same brand, where services are standardized by a central organizer and whose membership is comprised of independent, owner-operated health care entities.

References

- ¹ International Finance Corporation were an AHME partner until 30 April 2017.
- ² Government of Kenya. 2012. Sessional Paper No. 7 of 2012 on the policy on universal health care coverage in Kenya. Nairobi, Kenya: Ministry of Medical Services. In the sessional paper the formal sector was estimated at 20%, the informal sector at 60%, and indigents were estimated at 20% of the population.
- ³ The 1998 Amendment of the NHIF Act requires that all Kenyans have health insurance.
- ⁴ Government of Kenya. 2012. Sessional Paper No. 7 of 2012 on the policy on universal health care coverage in Kenya. Nairobi, Kenya: Ministry of Medical Services.
- ⁵ NHIF transforming health insurance in Kenya. Daily Nation, Friday, February 5, 2017.
- ⁶ Capitation rates are per household member per year.
- ⁷ Lagomarsino, G., Garabrant, A., Adyas, A., Muga, R., Otoo, N. Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. *The Lancet*, 380:933-43. September 8, 2012.
- ⁸ Pharmaccess Foundation's SafeCare is a quality framework aimed at developing and applying universal standards of service delivery in healthcare. Further information is available at <http://www.pharmaccess.org/>.
- ⁹ Monthly NHIF contributions are compulsory for formal-sector workers. Workers in the informal sector can also apply voluntarily, including those who have retired. The rates are based on a graduated scale.
- ¹⁰ Rebate is the term used by NHIF for the daily amount that a facility is supposed to claim for admission under in-patient services.
- ¹¹ Government of Kenya. March 2016. Special Issue, Kenya Gazette, Supplement 36, Legal Notice Number 48, National Hospital Insurance Fund.

