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AHME AFRICAN HEALTH MARKETS FOR EQUITY

Aggregating providers to more effectively engage in health markets: Lessons from Population Services Kenya

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Photo: Nurses outside Tunza St. Mary's Medical Clinic in Kibera slum, Nairobi. Credit: Population Services International.

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Contents

List of acronyms

AHME	African Health Markets for Equity	PSI	Population Services International
CMS	Clinic Management System	PS Kenya	Population Services Kenya
GPO	Group Purchasing Organisation	NMO	Network Management Organisation
NHIF	National Hospital Insurance Fund	TSE	Tunza Social Enterprise
PHC	Primary Health Care Services	UHC	Universal Health Coverage

Introduction

Figure 1: AHME 5 Market Conditions Framework

The African Health Markets for Equity (AHME) project, funded by the Bill & Melinda Gates Foundation and the UK Department for International Development (DFID), aims to deliver high quality primary health care through the private sector in Kenya and Ghana. The 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.

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):

1. **The poor are enrolled**
2. **Key primary healthcare services are covered.**
3. **Accessible facilities are contracted.**
4. **Accessible providers offer quality services.**
5. **Providers run viable businesses.**

This case study describes the experiences of Population Services Kenya (PS Kenya) with the development of an aggregator model, as part of longer-term plans to develop a fully-fledged Network Management Organisation (NMO). An NMO, for the purposes of this case study, is an organization that aggregates healthcare providers into a structured network and represents this network to payers and healthcare consumers. The NMO/insurance aggregator work is part of a wider sustainability model that PS Kenya is developing for its health social franchise, and aims to strengthen the private sector's contribution to Universal Health Coverage (UHC) by addressing gaps in the insurance market in a way that consolidates strategic purchasing. This case study is relevant to other organizations and governments seeking to overcome obstacles in linking private providers into UHC.

Background

The classic approach to social franchising requires sustained donor financing to enable franchisors to provide ongoing support to franchisee clinics. Population Services International (PSI) seeks to disrupt this model and determine whether franchisors, such as PSI, can move social franchising from a donor-reliant model towards a sustainable model by decreasing the need for donor financing. To test this proposition, PSI launched the *Tunza Social Enterprise* (TSE) network (in Kenya, this is referred to as Tunza Platinum). In addition to Kenya, PSI is also testing the TSE model in Uganda and Malawi. Regional branding and testing has generated efficiencies and cross fertilization of learning.

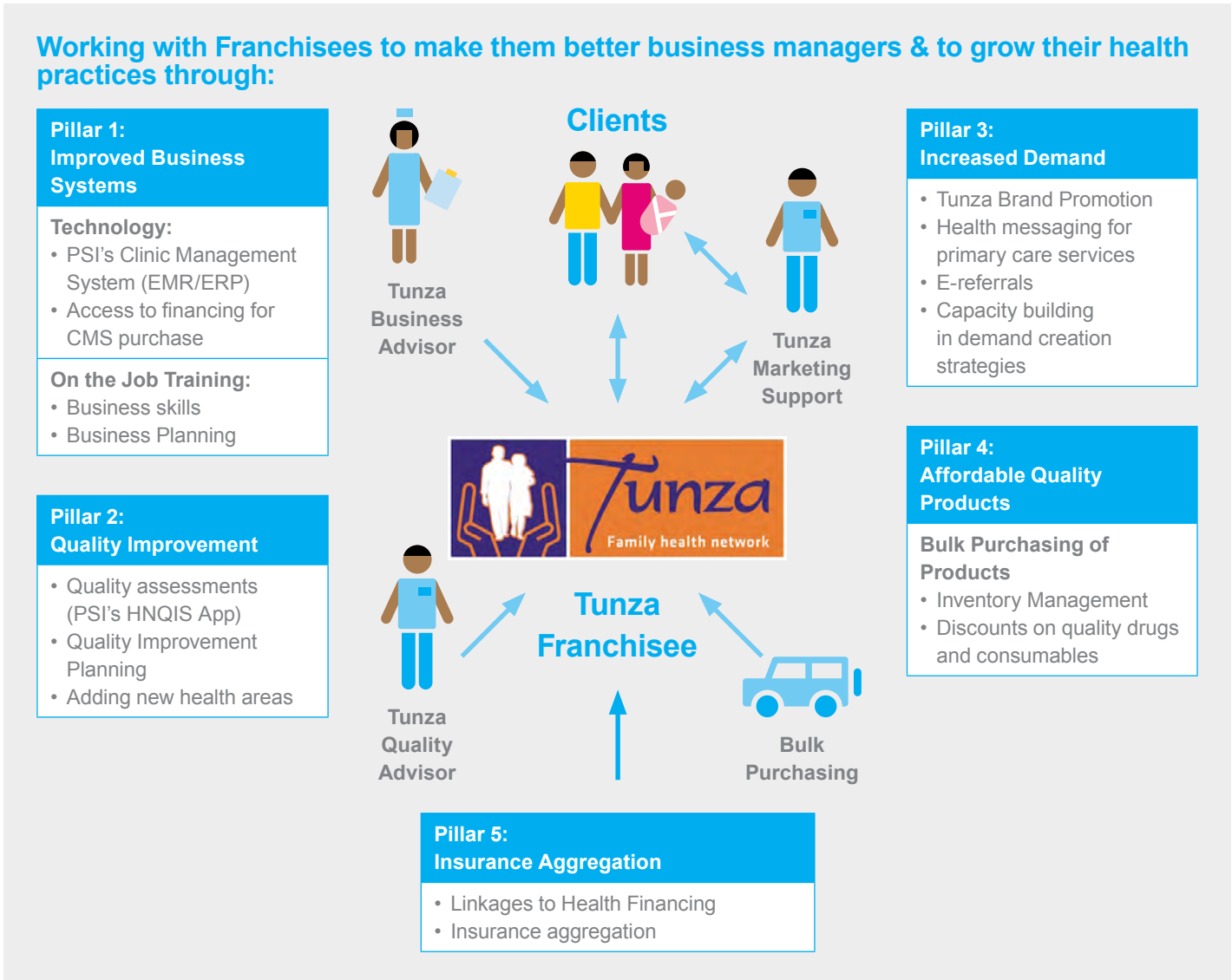
The Tunza Platinum value proposition has five pillars: improved business systems; quality improvement; increased demand; affordable quality products; and insurance aggregation. The value proposition is intended to deliver:

- To customers - access to a panel of quality providers, lower premiums or lower out-of-pocket costs
- To providers - increased client volumes (profitability and accreditation)
- To insurance providers - healthcare services which meet a pre-defined set of standards, and lower administration fees

Figure 2 provides an overview of the five pillars as well as planned interventions under each of these in Kenya. The case study focuses on pillars 1, 4 and 5, given that these are unique to the NMO model.

The ultimate aim of the Tunza Platinum value proposition is to support UHC by expanding access to affordable, quality Primay Health Care (PHC) services. This includes broadening the offer from coverage of vertical health areas to include a more holisitc approach to supporting private providers. The revamped value proposition was based upon research with over 500 clinics in East Africa.

Figure 2: Tunza Platinum value proposition



Purpose and methodology

The purpose of the case study was to collate learning from the aggregator pilot in Kenya over the period September 2017 to March 2019. The case study drew on primary and secondary data sources. Secondary data included PS Kenya programme documentation as well as published studies. Primary data was collected through key informant interviews conducted in February 2019 with PS Kenya and PSI staff involved in the aggregator pilot. Findings have been organised around key themes related to organizational arrangements, interventions and plans for the future.

Above: A Quality Assurance Officer visits a clinic in Juja, Kenya. Photo credit: Population Services International.

Findings

Organizational arrangements

As part of establishing Tunza Platinum, franchisee clinics (415 in total) were segmented into bronze, silver and gold health facilities. This was based on:

- Client flow: silver facilities have 450-600 clients/month while gold facilities have greater than 600 clients/month
- Service offer: silver facilities can provide a range of PHC services while gold facilities offer these in addition to more specialized services such as dentistry (12 facilities have this status).

Franchisee providers in the silver and gold segments were approached to join Tunza Platinum. In the first wave, 63 franchisees signed the letter of intent and paid the assessment fees of Ksh 6,000/USD 60. In addition to collecting information on the functionality of clinic systems, the assessment included understanding the clinic owner's geographic location, growth objectives, entrepreneurial spirit, and willingness to test and iterate models.

Interventions

While Figure 2 outlines the range of interventions conceptualized under the aggregation model, in practice, a phased approach was taken with three interventions prioritized for implementation. Prioritization was done based on potential for financial impact. Through financial modelling, insurance aggregation and pooled procurement were prioritized, underpinned by data automation, through a clinic management system (CMS).

Improved Business Systems (pillar 1). PS Kenya successfully introduced a CMS in 33 of the assessed Tunza Platinum clinics. The number of clinics was limited due to constraints on access to finance for the CMS. The system costs in the range of USD 5,000-15,000, depending on the size of the clinic and the number of system users and includes software, hardware, networking and connectivity costs. This is expensive for clinics and signals willingness on the part of owners to invest in their businesses. PS Kenya has been able to subsidize some of the costs through AHME and is considering offering other co-financing options such as private capital made available through a centrally managed investment fund, donor catalytic funding, as is done in Uganda, or a loan mechanism.

The CMS has given providers, and PS Kenya, greater visibility into facility operations and business performance and improved reporting into the DHIS2. Providers have generally found it easy to adjust to the clinical aspects of the CMS while the financial management functions have been more challenging. As a result, PS Kenya has provided on-going business support, given that this skill set takes time to embed, and is constrained by staff turnover in the some of the facilities. This constraint has also been addressed by PS Kenya, which has provided support with the development of human resource policies in order to improve staff retention. PS Kenya has also initiated champions within facilities so that these individuals can train up new staff. Already the CMS investment has paid off as it has given clinic owners new visibility into their operations including issues such as wastage and pilferage.

Affordable, Quality Products (pillar 4). In Kenya, the mark up for drugs and supplies within the private health sector is tremendous, with the lowest priced generics costing over three times the international reference prices.[1] Even with large mark-ups, the quality of drugs supplied to small private facilities is still not guaranteed, with 10.5% of products in circulation estimated to be fake.[2] Given low volumes of medicines ordered by Tunza providers, franchisees are unable to negotiate for bulk pricing of pharmaceuticals, estimated at 45% of the overall outpatient costs. This affects affordability for clients and profitability for providers. In response, PS Kenya sought to develop a pooled procurement arrangement for Tunza providers. Initially this arrangement was negotiated with one Group Purchasing Organisation (GPO), however there were some challenges with this. Tunza providers found that over half of the medicines that they normally order, were not available through the GPO which stocked more expensive original rather than generic brands. The GPO also did not provide a more affordable price than what providers could get on the open market. PS Kenya is currently working with another organisation, which has agreed to bulk purchasing of pharmaceuticals and non-pharmaceuticals with a three percent profit share arrangement with PS Kenya, a similar arrangement that they have with another social franchise. The contract is currently under review with procurement to commence in the first half of 2019. Unlike the other interventions, this is open to all franchisees and not just those in Tunza Platinum.

Insurance Aggregation (pillar 5).
The National Hospital Insurance Fund (NHIF) is considered the main vehicle for UHC in Kenya, however membership in the scheme remains uneven and limited (approximately 20% of the population), across and within Kenya's 47 counties. With AHME support, PS Kenya had initiated client membership drives in partnership with Tunza providers and local NHIF branches. This saw over 57,585 individuals registered on NHIF over the last 18 months facilitated through event days and home visits. PS Kenya continues to engage with NHIF for Quintile 1 and Quinitle 2 coverage to facilitate delivery of quality services to low income groups.

PS Kenya lanched the insurance aggregation pillar to facilitate the private sectors' contribution to UHC and provide evidence that the national insurance scheme and private payers can benefit from an aggregator that makes accreditation and empanelment easier. If contracting is easier, more low income clients will access the health services they need through complementary offerings in the public and private sectors.

PS Kenya also worked with franchisees to reduce barriers to NHIF accreditation. Once accredited, provider reimbursement became a concern given delays in claims processing by the NHIF. Given the level of expressed provider need for ongoing support with NHIF claims management, this became a focus for aggregation. On the side of providers, PS Kenya proposed a more formalised claims management function, for which providers would pay a small proportion of their reimbursement to PS Kenya as a service fee. PS Kenya also envisages a role as a third-party quality assurer for the NHIF, as a means of reducing the transaction costs of engaging with small and medium sized health care enterprises and ensuring quality services for NHIF members. While the NHIF is supportive of these roles in principle, policy and procurement obstacles have delayed advancement of this value proposition.

As conversations progress with NHIF, PS Kenya is moving forward with insurance aggregation with several key private insurers in Kenya, which enabled PS Kenya to continue building the infrastructure needed for insurance related accreditation, which will in the future benefit NHIF. To date, this proposition has progressed with two private insurers, Jubilee and Britam. Negotiations are at an advanced stage: Jubilee provided a contract late in 2018, while Britam shared a contract in February 2019, both of which are under legal review. The proposition is unique in both instances:

- Jubilee is providing a tailored package on a fee for service basis for aggregated Tunza Platinum providers.This insurance product will target the 'working middle', defined as members who can afford insurance but are looking for a more portable option than what is currently provided for under the NHIF. This means that under the Jubilee scheme, members may use any provider in the aggregated network whereas with NHIF the member must select a primary facility.
- Britam has developed a capitation model with a group of 600,000 farmers and their families in five regions in Kenya. Tunza Platinum providers in these regions will be contracted through PS Kenya to provide services on behalf of Britam.

With both insurance companies, PS Kenya will reduce costs and information asymmetry enabling private insurers to mitigate risks, such as over servicing under a fee-for-service model, while providing a better premium and quality service experience for members. To support this, PS Kenya is working to automate claims management and is currently working with an e-claims company to develop an e-claims module that will link invoice and payment processes between the CMS (provider) to the insurance companies. Once operational this will bring efficiency to claims management as well as reduce on fraud. PS Kenya is additionally exploring the development of microinsurance products to target low-income clients at Tunza facilities.

The aggregator model will consolidate a fragmented insurance market by bringing NHIF and private payer contracting and claims management under one network, that will simultaneously increase availability of services and enroll low income clients in the NHIF and affordable private payer schemes to improve access to affordable, high quality healthcare.

Conclusion and looking forward

AHME support has enabled co-financing of the CMS and supported background research and negotiations with external entities on the other interventions. However, except for the CMS, planned aggregation interventions have yet to be launched. Despite delays, lessons have been learned from aggregation, some of which have been documented in companion briefs. Investment in the CMS will be used to enhance or redesign the Tunza Platinum value proposition pillars.

As a "first mover", PS Kenya is building a body of knowledge and experience in aggregation: *"we learn from our mistakes as opposed to learning from others"*. Looking to the future, PS Kenya plans to register an NMO as a separate entity to allow for testing of profit-making functions, which are incompatible with PS Kenya's non-profit status as an non-governmental organisation. The plans are to incubate the NMO functions within PS Kenya for the next two years.

NMO viability requires that the aggregator offer is financed, by the Tunza Platinum providers on one hand and external third parties on the other. Tunza Platinum providers have not had to bear the additional costs of the Platinum value proposition as the joining fee for the first two-years was waived to allow for proof of concept testing. However, from 2020, providers will be required to pay a joining fee of US$1,000, and an annual fee of US$250. These rates are significantly higher than what the franchisees pay under the current agreement (US$25 per annum).

Given the level of investment expected, it is important for the "first wave" of providers to be satisfied with the Tunza Platinum value proposition. A concern expressed by PS Kenya respondents was that the offer needs to look and feel different than what is currently provided under the traditional social franchising model. It is important the Platinum-branded products and services are valued by providers. As one PS Kenya respondent noted, *"If we get it right with the few, the others will follow."*

References

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