Snapshot 05 National Health Insurance and Social Franchising – Lessons from Kenya

AHME seeks to link private health facilities in social franchise networks into universal health care schemes (UHC). Marie Stopes Kenya (MSK) has evolved the "network function" of the AMUA social franchise to broker franchisee empanelment into Kenya's National Hospital Insurance Fund (NHIF).

The accreditation process for health facilities to qualify for empanelment into Kenya's NHIF is complex and time-consuming, requiring 12 different steps. This snapshot highlights the processes and lessons from the field regarding the MSK experience of brokering NHIF empanelment of AMUA franchise clinics.

Intervention

MSK conducted an initial assessment of social franchise network members to evaluate their readiness for contracting with Kenya's NHIF. Both quality performance and geographic location were included as key indicators to ensure a focus on equity. From the assessment, 50 of the 420 franchisees in the AMUA social franchise network were selected for intensive support to help them qualify for NHIF empanelment. In collaboration with regional NHIF branches, sensitisation meetings for the selected facilities were held to walk them through the empanelment and accreditation process, which includes an NHIF checklist. The meeting also served to build trust between franchise providers and NHIF branch managers.

MSK and NHIF branch officers guided franchisees on compliance requirements, such as the need for a certificate of business registration, a practitioner license with the relevant medical board, employer registration with NHIF to obtain a compliance code, and formal application for inspection. MSK brokered the process to ensure that individual providers were not intimidated or overwhelmed. MSK facilitated a pre-inspection of franchisee facilities as a 'dress rehearsal' for the NHIF inspection, using the NHIF checklist.

In addition to the licenses, there is often a need to address infrastructure and documentation requirements. It can take health facilities 2-3 months to prepare for inspection once the pre-inspection has been completed. The pre-inspection includes a set of minimum quality standards, and the facilities need to obtain a score of 60 to qualify for the inspection application. Those falling below the minimum score were supported to initiate a quality improvement process. MSK guided facilities through the next step, completing and submitting the application form, by giving them a sample template of a completed form. Increasingly, MSK is encouraging clusters of clinics to submit group applications, as this reduces transaction costs for the NHIF and introduces economies of scale.

Upon successful submission of applications, NHIF conducts unannounced inspections, the results of which are submitted by the NHIF branch manager to NHIF Nairobi. MSK tracked applications to reduce the waiting time through regular check-ins with the NHIF, as this process is currently not automated. Once NHIF gives approval for contracting, it goes to gazettement at the Attorney General's office, which falls outside of the NHIF and is difficult to monitor or influence. Following approval, the provider is issued with a unique code, based on its capacity and range of services. After successful empanelment, MSK continues to support franchisees with community mobilisation and contract monitoring, as it is important for providers to match the contract with their patient based and service capacity.

Snapshot 05 | National Health Insurance and Social Franchising – Lessons from Kenya

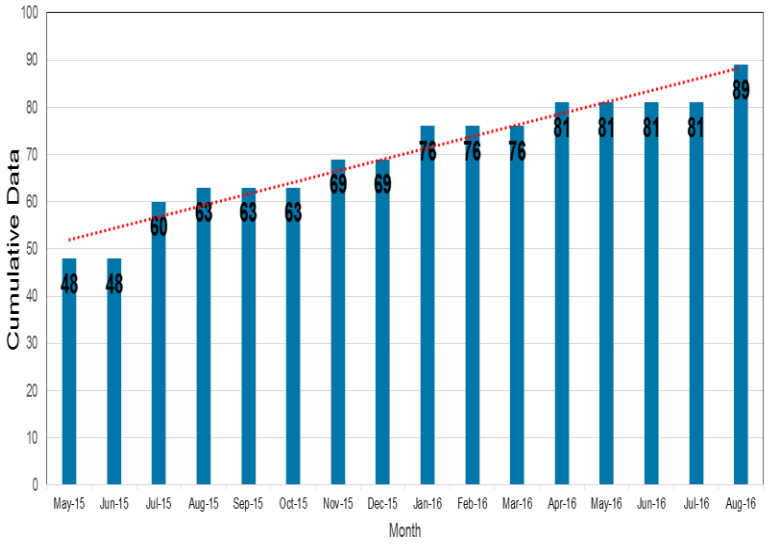
AHME seeks to link private facilities in social franchise networks into universal health care schemes (UHC). Marie Stopes Kenya (MSK) has evolved the "network function" of the AMUA social franchise to broker franchisee empanelment into Kenya's National Hospital Insurance Fund (NHIF).

Result

Since providing intensive support from July 2015, the number of AMUA providers accredited into NHIF has increased from 35 to 89. This figure represents approximately 10% of all empanelled private providers in the NHIF (as of June 2016). On average there are just over 3,000 beneficiaries enrolled with each AMUA empanelled provider.

MSK successfully convinced NHIF to eliminate the payment fee for in-patient accreditation through policy change advocacy and feedback to the NHIF.

Figure 1: AMUA Empanelment Trend – Cumulative



Examples and Evidence

The evolved "network function" has strengthened MSK's social franchise value proposition. Providers have been quoted as saying, *"I have waited for four years to get accredited. MSK coming to assist us on this is a blessing."* (Amua Franchise).

Lessons Learned

The inclusion of mid-level providers as part of strategic purchasing under national health insurance is critical to UHC, especially to ensure equity of access. High transaction costs for both mid-level providers and national health insurance schemes can be brokered through social franchises.

Social franchises can also facilitate greater understanding to the NHIF of the differential rate requirements for private providers given that salary and medicines tend not to be covered through other funding mechanisms, such as budget support, as in the case in the faith-based and public sector providers.

Outlook

Efforts will continue to focus on provider empanelment given the lengthy, labour intensive processes involved. However, providers and clients both need to benefit from the NHIF. This remains a challenging area to monitor as data needs to be extracted from individual providers. MSK has designed tools that are being used to collect NHIF data from empanelled facilities. This will inform risk mitigation measures in relation to the capitation model. Registration is still a paper based bureaucratic process. ICT and the transparency it would allow around empanelment is still a considerable gap in this process.