Snapshot 11 | Social Franchising and Equity

AHME is a partnership focused on equity, committed to helping private providers deliver quality health services to poor people. Social franchising is a key AHME intervention, providing an opportunity to measure equity in the private sector. Our data is disappointing – how are we using this knowledge?

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Summary

This snapshot outlines AHME's approach to measure equity in social franchising, and considers how findings have informed social franchising models used by AHME partners.

Intervention

AHME works in Nigeria, Ghana and Kenya, and represents more than 1,500 clinics in five franchises. To assess if the franchises were reaching the poor, MSI's client exit interviews were modified to gather data on relative poverty measures across the networks, in addition to standard practice of measuring absolute poverty (e.g. US$ 1.25/day).

Comparison was made between clients who used franchised clinics with national wealth quintiles (using DHS data, and following methodology developed by the social franchising metrics working group).

Findings from this analysis were surprising, and disappointing. Very few clients came from the lowest two wealth quintiles, and many came from the wealthiest quintile. This was counter-intuitive as 'no AHME franchisors work with up market clinics'.

In response, AHME looked carefully at the data and compared client populations to sub-national quintiles (given the uneven spread of the private sector and geographic concentrations of poverty, which do not always overlap.)

Each analysis shifted the results a little, particularly by reducing the proportion of clients in the wealthiest quintile. But there was no radical change; the overall picture remains the same – few clients are amongst the poorest, even when we consider regions in which we franchise.

AHME came to the conclusion that:

1. We were not serving the poorest through social franchising
2. We were not even serving the poorest people from the areas in which social franchise facilities are located.

AHME partners responded by reviewing the social franchising models they were using to make markets work for the poor.

In response to the equity analysis, AHME partners reviewed the theory of change underpinning the programme and made adjustments to their approach. A decision was taken to reduce emphasis on scale and scope and focus on provider location and subsidization of services for the poor in order to facilitate access to quality primary health care in social franchised facilities.

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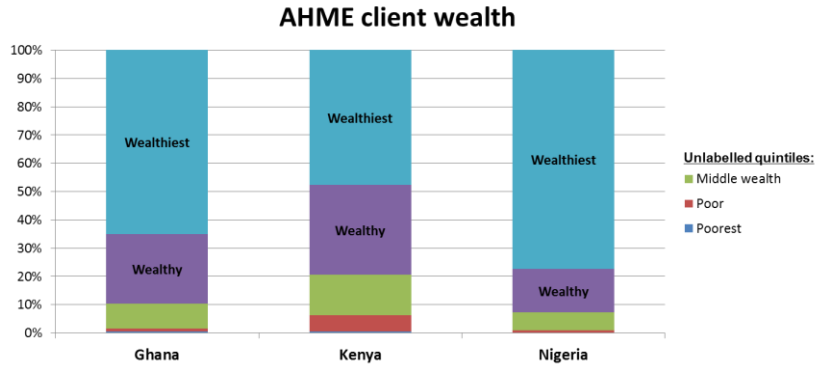
Evidence

AHME exit interviews demonstrated that, absent interventions targeting the poor, franchisees rarely serve those in the lowest wealth quintiles. Follow-up data in the Social Franchising Compendium confirmed this mediocre reach to the poor is common across franchisors and countries.



Result

Following the insights on equity, AHME franchisors have focused increasingly on midlevel providers in an effort to ensure facilities are co-located with the poor. These characteristics have been included in revised guidelines for franchisee selection.

AHME franchise networks have focused on the empanelment of their providers in national health insurance (NHI) programmes. AHME is also working to support the enrollment of poor households into NHI schemes, including Kenya's Health Insurance Subsidy Programme (HISP).

Lessons Learned

In order to reach the poor through private sector providers, it is imperative to work with those in poorer, more rural areas, and to incorporate financing of services for poor clients.

Providers who serve poor communities are likely to be less well qualified and run smaller, simpler clinics. This potentially has implications for quality and cost per DALY.

Political considerations can often factor in how the poor are identified and where they are supported to enrol in NHI. There is need to ensure:

- Areas with enrolment activities contain a significant proportion of poor households;
- Tools validated to identify the poor are utilized; and
- Provider empanelment activities are overlaid with enrolment areas to link pieces critical to make markets work for the poor.

Outlook

We believe that ultimately, franchising the right providers, and linking them to government strategic purchasing to remove financial barriers, is the way that Social Franchised will fulfil its promise of providing quality services to the poor. More than that, adding value to both providers and governments will ultimately ensure the sustainability of franchising, and this success will catalyse market change, as others crowd in to follow where social franchising organizations have led. AHME will continue to push this agenda and to carefully and honestly evaluate what works, and what doesn't .

Snapshot 12 | NHIF contracts and provider business – Kenya

MSK has supported AMUA social franchise providers with empanelment in the National Health Insurance Fund (NHIF). This snapshot explores implications of contracts and capitations on provider businesses.

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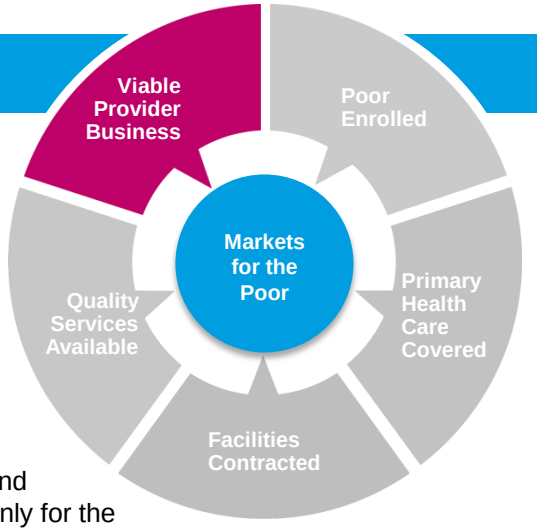


Background

Kenya invested early in national health insurance, with the establishment of the National Hospital Insurance Fund (NHIF) in the 1960s. The scheme, was initially focused on in-patient care through hospitals in urban areas, mainly for the formally employed and civil servants. However, with renewed effort to expand coverage of the scheme as part of Kenya's commitment to UHC, the NHIF now covers primary and preventive care through an out-patient contract.

Context and Intervention

Approximately one quarter of Kenyans are covered under the NHIF. While the NHIF still relies on voluntary premiums for the general population, effort is being made to include the poor through the Health Insurance Subsidy Program (HISP) and the availability of a low cost product for the informal sector. Outpatient services are offered on a capitation model, where the health facility signs a contract for 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 visits. The outpatient contract categories and annual capitation rates are outlined in Table 1.

Table 1. Outpatient services

Contract	Capitation
National scheme	Ksh 1,200 (~USD 11.65)
Civil servant and disciplined forces	Ksh 2,850 (~USD 27.70)
HISP	Ksh 1,200 (~USD 11.65)
Elderly and disabled programme	Ksh 1,200 (~USD 11.65)
Job Group M-T	Fee-for-service

MSK has supported private providers in the Amua social franchise with empanelment in the NHIF. At present 108 providers are empanelled with another 50 in process. Amua franchisees, tend to be "mid-level providers" – nurses and clinical officers who own and operate clinics. Most of these providers have not worked with capitation before.

Many perceive the NHIF tariffs to be low, a concern at time of empanelment. Unlike the public sector, which receives equal capitation tariffs, private providers have structural and operational costs to cover such as consumables and staff salaries.

MSK is working with providers to better understand the implications of different out-patient contracts and capitation tariffs on the "bottom" line" of their businesses. MSK devised a tool for data collection and trained Amua providers on this. In total 41 providers collected data on the civil servants scheme and 35 on the national out-patient scheme. This considered the number of patient visits under capitation and estimated profit and loss based on the price that would have been charged by providers had services been paid for out-of-pocket (OOP).

The results were complex (see Table 2). Providers in the civil and national schemes both recorded profits, including nearly a quarter with surpluses of more than $20,000. However, 27% of those under the civil service scheme were functioning at a loss, as were 20% under the national out-patient scheme.

Snapshot 12 | NHIF contracts and provider business – Kenya

MSK has supported AMUA social franchise providers with empanelment in the National Health Insurance Fund (NHIF). This snapshot explores implications of contracts and tariffs on provider businesses.

Results

AHME's analysis for a sub-set of empanelled providers found that 74% of social franchise providers under the civil service outpatient scheme were breaking even or making a profit, with 41% making the equivalent of more than USD10,000, and 19% reporting profits equal to USD30,000 or more. Fully 80% of outpatient providers in the national out-patient scheme were profitable. The study did not reveal which factors influenced the profitability or loss of various clinics.

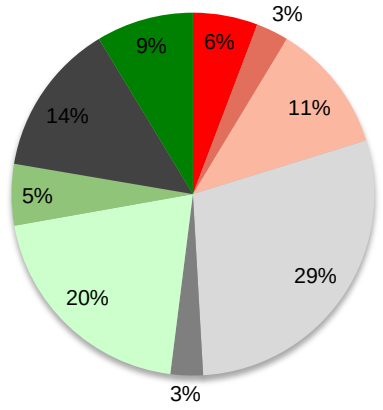
Lessons Learned

Most AMUA providers were not keeping track of how they were performing financially under either the civil servant or national out-patient scheme, and assumed that higher capitation rates for civil servants would result in higher profits for providers. But results were more mixed. Civil servants may have higher and more pricey service expectations (e.g., no generic medicines) due to their longer experience with NHIF coverage.

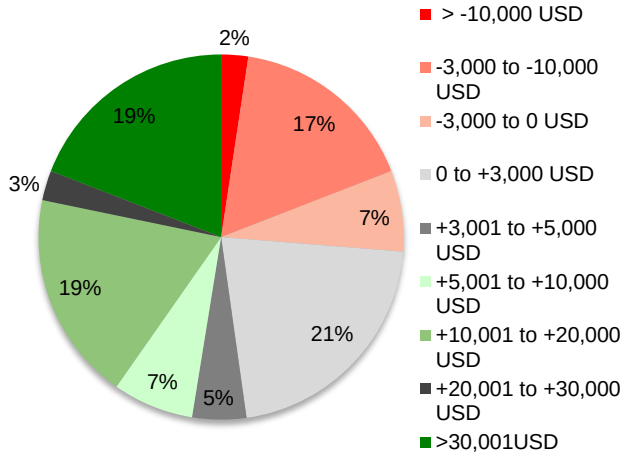
Further research is needed to understand the factors influencing provider performance under capitation. In addition, care must be taken to understand if business profitability is coming at the price of access or quality, such as under-treatment or selecting out patients who are perceived to need more care.

There may be a possibility to negotiate increased capitation rates for providers who are using the SafeCare quality improvement plan and standards, with higher payments as they rise from one SafeCare level to the next.

Surplus/Deficit under NHIF national out-patient contract



Surplus/Deficits in Civil Service Scheme under NHIF Capitation



Outlook

The Government of Kenya has proposed replacing NHIF with a consolidated national social health insurance fund (NSHIF) to provide one basic benefit package for all, based on available resources. It will eliminate the distinctions between coverage for civil service employees and others.

MSI is planning to analyze data on costs and NHIF visits within franchise facilities to develop a clearer understanding of factors such as service utilization, behaviours, and costs under capitation that can inform provider business under the new NSHIF.

MSK plans to build the business management capacity of franchisees through the development of a financial health management information system (MIS) to ease the tracking on usage of the capitation funds.

Snapshot 13 | Consolidation of Quality Assurance Activities – Kenya

Population Services Kenya (PSK) combined its vertical approach to quality assurance (QA) with SafeCare's horizontal one to create a single, integrated QA system, meant to be more holistic and drive cost efficiencies.

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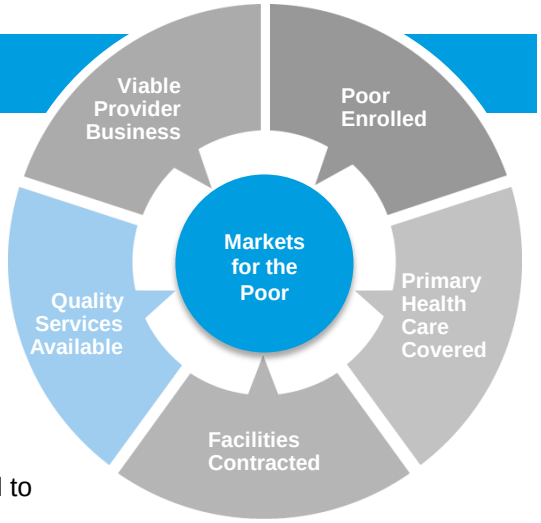

There is a great deal of interest in methods for consolidating quality assurance standards within healthcare provider organizations in ways that are both reliable and practical. This snapshot looks at how PSK has worked to merge its quality assurance approach with the globally recognized SafeCare standards and improvement program. It reviews key steps, challenges, and lessons learned from the process.

Intervention

Many PSK franchise providers have been using two parallel quality assurance systems: 1) the SafeCare Standards, a horizontal approach that evaluates the structure and processes guiding the delivery of healthcare, and 2) the PSK vertical approach, which evaluates processes and outcomes through in-depth assessment of specific franchised health areas. Recognizing that both approaches were important and complementary, PSK has been consolidating the two systems and assessment teams for a more streamlined, cohesive, and time/cost effective quality assurance (QA) system.

Initial implementation of the consolidation was time and resource intensive. One of the first steps was to create a single QA team from the two existing ones to improve efficiencies and expand QA reach and capacity. The organizational structure had to be changed to merge both teams, including alignment on territories and numbers of facilities to be covered by each. Trainings and refresher courses were offered to every QA team member to ensure that they had the skills to handle both systems.

Challenges: PSK QA staff experienced a steep learning curve, due to the complexity of SafeCare Standards. There were delays initially in the assessments and development of quality improvement plans (QIPs) for providers, but a designated SafeCare Coordinator and experienced assessors within the QA team addressed the backlog and provided guidance and mentorship to other QA staff.

The SafeCare Standards were initially too onerous and revised to suit small-scale health providers with fewer services. The Standards were trimmed from 834 criteria to 170 for basic assessments or 680 for advanced ones, and the complexity of both QIPs and monitoring/evaluation were reduced.

The SafeCare and PSK QA systems worked on different platforms, so PSK could not monitor and track the progress of SafeCare activities in the facilities. It had to rely instead on PharmAccess for the information. This was resolved when Population Services International (PSI) supported the hosting of SafeCare-related activities in an open source information system for health program data reporting and analysis, called **DHIS 2**.

Opportunities: Technology provided an alternative to the previous paper-based QA systems, with ways to automate and facilitate QA. PSI/PSK developed a tablet-based tool, called the Health Network Quality Improvement System (HNQIS), that will allow QA teams to assess, score, and monitor quality while providing consistent and immediate feedback to providers. The information will be uploaded into DHIS 2, which also houses the SafeCare data. For now, the system generates separate reports for HNQIS and SafeCare, but PSK is working to devise ways to generate a single report that consolidates and integrates the two sets of data.

The consolidation of the two systems is a work in progress – but should ultimately result in improved healthcare delivery for the poor. Providers should benefit from better feedback and a more holistic QA perspective to review their overall performance, and franchisors should be able to improve cost efficiencies that allow for further expansion of SafeCare and QA.

Snapshot 13 | Consolidation of Quality Assurance Activities – Kenya

Population Services Kenya (PSK) combined its vertical approach to quality control with SafeCare's horizontal one to create a single, integrated QA system, meant to be more holistic and drive cost efficiencies.

Results

Early results show a significant increase (65%) in the numbers of first or basic assessments conducted after the consolidation of both QA activities, compared to previously (see Table 1). The numbers of QIPs developed nearly trebled. Meanwhile, the numbers of QA assessors have decreased, suggesting greater efficiencies and streamlining in the QA processes.

Examples and Evidence

The integration of the two QA systems reduces the need for multiple visits of assessors to providers. It is a significant step in setting standards for a health systems approach, which is at the core of AHME.

Lessons Learned

The internal politics of quality systems are challenging, and it is important to bring out the utility from this example through succinct case studies to inform other franchises of the usefulness of an integrated QA approach.

QA needs to be part of the monthly work plan, with a set number of assessments planned each month and the days clearly set aside.

A QA approach that is integrated from the beginning is preferable to parallel systems. It needs to be owned by the franchise and by the implementation team, with a firm understanding of its value addition.

Table 1: Pre- and Post-Consolidation Comparisons

Activity	Pre-Consolidation 2015- 2016	Post-Consolidation 2016- 2017	% Increase
1st or Basic Assessments	38	63	65%
QIPs Developed	46	128	178%
Clinics with certification assessments	33	35	6%

Outlook

PSK is committed to an integrated QA strategy and efforts will continue to address challenges as it progresses. Work on consolidating and integrating the two approaches is on-going, with the aim of providing holistic quality of care and ultimately generating a single QA report and work plan. AHME is also exploring integration of vertical service audits and to add quality audits for a cross-program, cross-network process.

AHME can support the QA integration process by distributing learnings across networks and identifying and addressing gaps. AHME is working with national stakeholders to support the coordination of quality standards and to improve transparency. Our goal is to enabling strategic purchasers and clients to understand the quality of what they are buying.