

Networking Private Providers in Mixed Health Systems – How AHME inspired changes in social franchising

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Photo: Tunza provider providing family planning counselling.
Credit: Population Services International

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List of acronyms

AHME	African Health Markets for Equity	MSI	Marie Stopes International
CME	Continuous Medical Education	MSK	Marie Stopes Kenya
DHIS2	District Health Information System	NHIF	National Hospital Insurance Fund
HISP	Health Insurance Subsidy Program	PAF	PharmAccess Foundation
HNQIS	Health Network Quality Improvement System	PSI	Population Services International
KQMH	Kenya Quality Model for Health	PS Kenya	Population Services Kenya
LARCs methods	Long Acting Reversible Contraceptive methods	QA	Quality Assurance
MOH	Ministry of Health	QUIC	Quality Information Centre
MCF	Medical Credit Fund	SFN	Social Franchise Networks
		UHC	Universal Health Coverage

New approaches are emerging to engage providers in mixed health systems with the goal of achieving Universal Health Coverage (UHC), a system that provides health care and financial protection to all citizens. Population Services International (PSI) and Marie Stopes International (MSI) lead two of the largest private sector social franchise networks globally, offering an opportunity to increase access points to care. The African Health Markets for Equity (AHME) project (2012–2019), supported by the Bill & Melinda Gates Foundation and Department for International Development, sought to increase access to high quality primary health care through social franchising networks (SFN) amongst the poor by addressing five key market conditions necessary to create health markets for the poor: primary care covered by the National Hospital Insurance Fund (NHIF) schemes; facilities contracted to the NHIF; quality services available at contracted facilities; viable businesses among contracted private providers; poor enrolled in NHIF coverage to access services at accredited clinics. This resulted in significant changes to PSI and MSI's approach to social franchising in Kenya, and positive spillover effects to other supported networks.

In Kenya, AHME:

- Expanded the depth and breadth of quality support to franchisees by introducing tools and technologies that improved adherence to quality standards while simultaneously reducing costs (quality services available)
- Facilitated empanelment of private providers under NHIF and enrollment of new clients in NHIF products, demonstrating the government's willingness to pay for private provider services (facilities contracted)
- Leveraged Population Services Kenya (PS Kenya) and MSK networks to increase the number of poor enrolled in NHIF and accessing social franchise networks (poor enrolled)
- Initiated targeted advocacy efforts to create an enabling environment for private providers, clients, and payers in a mixed health system (primary care covered)
- Highlighted the complementary nature of quality and business operations by exploring strategies to augment franchisee profitability (viable provider businesses)

These insights were shared globally with PSI and MSI's networks, spurring further change. PSI's regional business model in East Africa, Tunza Social Enterprise— including Kenya, Malawi, Uganda, Burundi, and Somaliland— was developed from AHME learnings in Kenya and offers broad support across key primary care market functions. The Tunza Social Enterprise has a four-pillar value proposition (improved business systems, quality improvement, increased demand, and affordable, quality products). It is complemented by a fifth pillar in Kenya to offer insurance aggregation to providers and payers, which will generate learnings that can be applied to Uganda, Tanzania, and Malawi as ongoing conversations around the rollout of national health insurance schemes continue. In Asia, PSI is piloting two strategic purchasing models for primary care services (Myanmar) and family planning (India).

MSI's new success model (known as SUMO) pulls from best practices from MSI's social franchise programs globally to provide operational and strategic guidance on the fundamental requirements for a successful franchise network. AHME lessons helped shape SUMO guidance on improving reach of poor clients, improving data management systems, understanding the value proposition to the networks, and integrating health financing and market assessments. This guidance is rolled out globally to all countries implementing a social franchise or designing one.

These meaningful changes to how PSI and MSI have approached social franchising demonstrate that with further commitment and investment from the community of practice and funders, we can tackle the complexity of mixed health systems and continue to move toward UHC.

Background: the role of the private sector in mixed health systems

Countries are exploring new ways to engage with mixed health systems – where public and private providers operate side-by-side to deliver health services and products¹ – in order to achieve UHC, a system that provides health care and financial protection to all citizens. In order to increase the total number of healthcare users in a mixed health system, PSI, MSI, and others have worked for decades to design solutions to more effectively engage with the private sector, where they are a significant provider of care. Social Franchising – the organization of small, independent health care businesses into quality-assured networks² – quickly emerged as one promising approach to supporting private providers. PSI works with over 10,500 franchisees in 24

countries, while MSI works with 2,400 private providers across 14 countries. While PSI and MSI successfully increased quality and coverage of specific health services (i.e. family planning), social franchising needed to evolve to sustainably and holistically support delivery of primary care services by private providers in mixed health systems.

Project Summary

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):

This paper demonstrates how AHME evolved social franchising in Kenya, and how these changes spurred a positive spillover effect in PSI and MSI social franchise networks globally.

In particular, we explore the situation of family planning within capitation, as an example of an important preventive primary health care (PHC) service.

- 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.**

Figure 1: AHME conceptual framework





Quality services available

In Kenya, AHME expanded the depth and breadth of quality support to franchisees by introducing tools and technologies that improved adherence to quality standards while simultaneously reducing costs.

Building on decades of experience in quality assurance approaches, PS Kenya and MSK worked to deepen the quality support provided to each franchisee. Both organizations introduced new technologies to more efficiently assure quality among an expanded range of health services. In 2015, PS Kenya incorporated paper-based Ministry of Health (MOH) supervision checklists into a PSI-developed electronic tablet system, called the Health Network Quality Improvement System (HNQIS) to improve targeting, routing, and impact for clinics that most need quality support. A precursor to HNQIS was developed under a UNITAID project for malaria, which was expanded to a range of health services (16 in total) through SIFPO and tested in Kenya. PS Kenya has seen improvement in quality scores across numerous service offerings through use of this tool in conjunction with supportive supervision and trainings. For example, in one year (2016 to 2017), PS Kenya increased the percentage of their franchisees meeting the minimum quality score (85%) in Family Planning services from 65% to 83%. For those clinics that consistently meet the 85% minimum score, the frequency of supervision visits required by a Quality Assurance Officer declines as well, thereby introducing cost efficiencies and better targeting support to clinics that most need improvement.

MSK introduced the quality assurance app Quality Information Centre (QUIC) in 2016, which feeds into ORION, their central repository for their quality assessment data generated by Social Franchise Coordinators and Quality Advisors, taking learnings from PSI's experience globally in launching HNQIS in transitioning from paper-based assessments to a technology approach. Kenya and Ghana were the first two countries to pilot this approach for MSI. Both HNQIS and QUIC were linked to an open-source reporting platform used by over 60 countries called the District Health Information System (DHIS2) to improve the ease of data sharing with internal teams and external partners, such

as the Ministry of Health. Improved data analysis allowed MSK to better target support to Amua clinics that most needed it, and allowed the Quality Assurance team to tailor support to clinic-specific needs. Data was also used in segmentation of providers for de-franchising if high quality standards were not met. MSK applied MSI's channel quality assessment system to assess the quality of services in the franchise network by an external assessor. The system allowed for better analysis of a facility's quality performance, and aided in the prioritization of visits as well as the selection of providers for Continuous Medical Education (CME) trainings.

Additionally, PS Kenya and MSK applied SafeCare stepwise structural quality improvement standards to position franchisees for accreditation for empanelment with the National Hospital Insurance Fund (NHIF). Clinics progress through 5 levels, and after level 2, the franchisors found that their facilities were much more likely to be accredited. Both organizations conducted capacity-building trainings for their Quality Assurance Officers so they would be able to implement both SafeCare and HNQIS/QUIC concurrently in one visit, rather than hire specific staff to conduct SafeCare assessments. This offered cost and time efficiencies by reducing staffing needs and strengthening insight into all dimensions of quality for each clinic by one individual.

As new quality tools were adopted and tested under AHME in the private sector, the Ministry of Health took notice, and began to incorporate key elements into their Kenya Quality Model for Health (KQMH). One component of the KQMH framework is a Joint Health Inspection Checklist (JHIC), which includes much of the content of SafeCare and combines minimum requirements of multiple regulatory bodies into one checklist for use in both the public and private sectors. While HNQIS and QUIC will continue to be used to assess clinical quality of care, Quality Assurance Officers from both organizations will transition from AHME-funded SafeCare structural quality assessments to the KQMH framework as AHME funding comes to a close – an important step in moving toward sustainable QA in a mixed health system.



Above: Cyrus Mandela (PS Kenya QA Officer) conducts quality improvement assessment with Tunza provider using HNQIS. Photo credit: PSI

Global implications: PSI and MSI are expanding these approaches and tools to other social franchise networks. PSI's HNQIS is now active in 23 countries and is being piloted in the public sector in Zimbabwe, Mozambique, and Somalia. This public-private collaboration ensures that the government has access to private sector data, in many cases for the first time. This visibility into how clients engage with the health system, regardless of sector, offers a true contribution toward achieving UHC. In Uganda, PSI also worked with PharmAccess to roll out SafeCare to its ProFam network. MSI's ORION has been rolled out to four MSI country programmes, with arrangements in place to roll out to at least ten additional country programs with social franchise networks in 2019.

Recommendation: Just as HNQIS, QUIC, and SafeCare were first piloted within PS Kenya and MSK's social franchise networks, the private sector can take the lead in developing innovative technologies and tools for improved quality assurance, that can be then fostered and incubated within the MOH for wider adoption and scaling across both public and private sectors. Social franchising organizations working with the private sector can be well-placed to co-create tools with the public sector that improve efficient, cost-effective decision-making to further strengthen mixed health systems and lead to more sustainable national QA systems.



Figure 2: Tunza Platinum Business Model

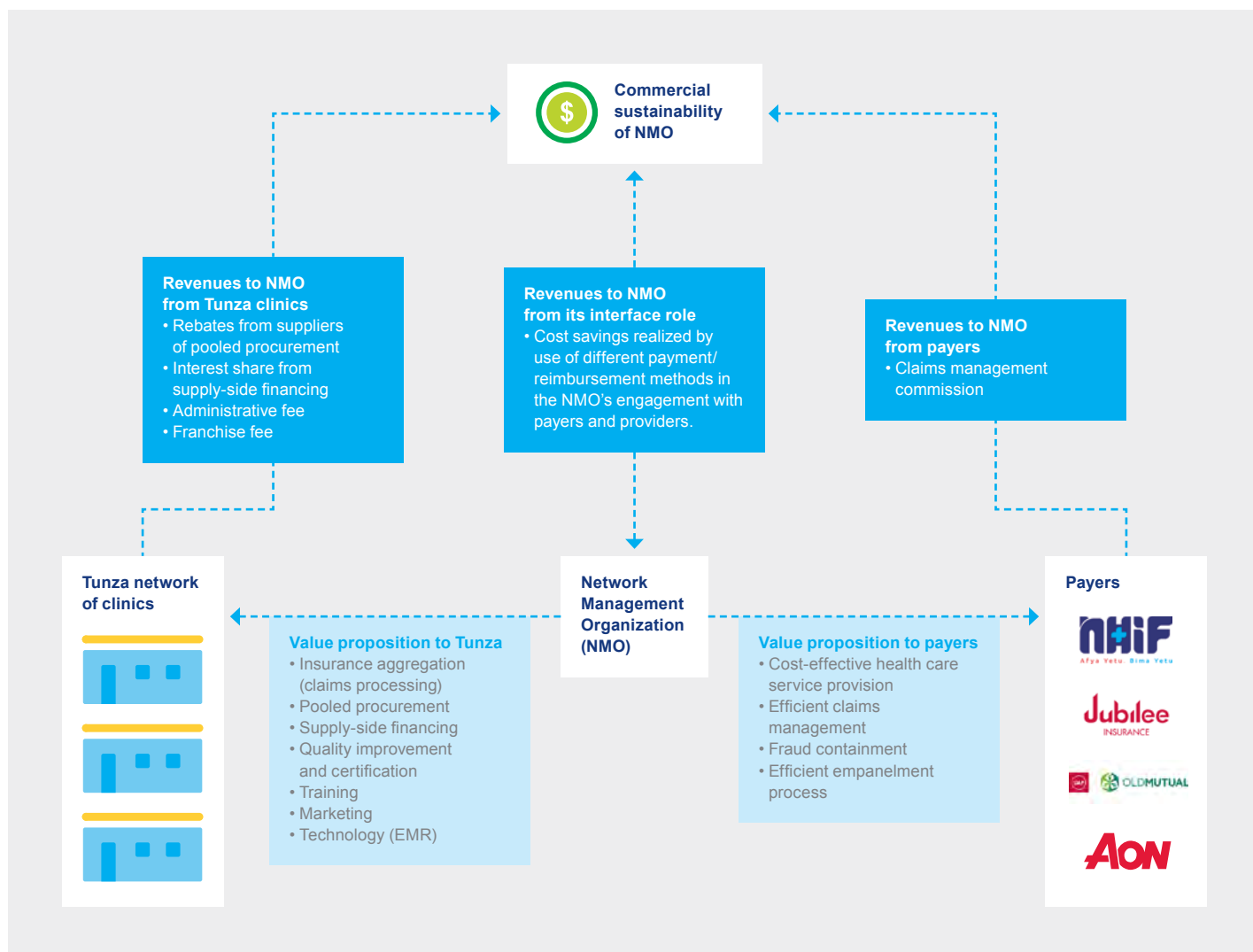
Facilities contracted

In Kenya, AHME facilitated empanelment of private providers under NHIF, increasing choice and accessibility for clients enrolled in the scheme

Access is a key determinant of uptake, particularly for preventative services, and for the poor. For this reason AHME prioritizes working with many small, local providers over a few larger, more centralized providers. However, this brings inevitable compromises in terms of efficiency and service quality, and NHIs in AHME countries have tended to prioritize administrative efficiency and (structural) quality over access. Many challenges remain for smaller providers to contract with NHIs, and this is one reason why AHME's work to leverage the power of networks as intermediaries is so important. Social franchising plays an important brokering role, lowering high transaction costs for providers and national health insurance agencies.

AHME first strengthened the geographic coverage (breadth) of quality assured services available in the private sector by successfully driving an increase in the number of access points for clients to obtain these health services nationwide. PS Kenya's Tunza Social Franchise expanded from 295 to 371 clinics during the project period, with growth across all regions, most significantly in Rift Valley and Central. MSK's Amua Social Franchise likewise expanded its network from 257 to 360 franchisees, adding Embu to increase regional coverage, and with highest franchisee growth in Machakos and South Coast. These new locations offered more convenient options for clients to access quality care by supporting a largely unregulated private sector to meet international standards in service provision across more private facilities nationally.

Innovations in quality support to franchisees eased the empanelment process with NHIF, as the inspection



checklist heavily emphasizes high quality standards. To complement quality assurance supportive supervision visits, PS Kenya and MSK sensitized franchisees on the application processes for NHIF products, and MSK conducted “dress rehearsals” with their clinics to assess readiness for NHIF inspection and give tips on areas for improvement. The strategy worked. PS Kenya helped 198 of 415 Tunza clinics to become empaneled, and MSK supported 152 of 360 Amua clinics. MSK additionally empaneled 69 clinics into the NHIF’s Linda Mama free maternity scheme, while PS Kenya empaneled 80. From AHME learnings, PS Kenya confirmed the need for continued support to franchisees on empanelment, and identified additional gaps in insurance processing at the franchisee level. For example, insurance companies reject many claims for minor errors and sometimes take up to 6 months to repay franchisees, which can be detrimental to clinic cash flows. As a result, they designed and launched a new ‘Tunza Platinum’ Model. Through this model, both franchisees and payers are expected to benefit from efficient empanelment, and insurance aggregation leading to faster claims processing, reductions in claims rejections, and negotiations with payers on mutually beneficial capitation rates, fraud management, and more (see Figure 2). Tunza Platinum is also moving toward financial sustainability through the introduction of revenue streams, a lean budget, and economies of scale, in order to continue support to franchisees and payers beyond the life of the AHME project.

Global implications: PSI is exploring empanelment models in Myanmar and India. Since March 2017, PSI Myanmar has been implementing a strategic purchasing pilot in two peri-urban townships of Yangon to demonstrate the capacity of private general practitioners in its Sun Quality Health social franchise network to offer a basic package of primary care services to the poor while reducing financial barriers. Early results indicate that contracting the general practitioners with capitation system can reduce out of pocket expenditures without jeopardizing satisfaction levels of the clinic’s services. In 2015, PSI designed a strategic purchasing model of family planning services in Uttar Pradesh (UP), India which accounts for 26% of India’s FP2020 commitment to address unmet need. PSI acts as an intermediary to enable private provider accreditation, empanelment, and reimbursement. From 2016–2018 the government reimbursed \$5.1 million to private facilities for family planning services through a new online system; from 2015–2017 the number of private facilities accredited to offer family planning services increased from 10 to 750.

Following AHME, MSI is incorporating a health financing and market assessment as an essential component to developing its engagement strategy. In Pakistan, this revealed opportunities to link private providers to a community-based health insurance program. Where relevant MSI is also incorporating support to franchisees to enroll in national health insurance into its franchise value proposition.

Recommendation: The MOH in Kenya has demonstrated through its NHIF products that they are committed to inclusive insurance schemes – this is a great start in ensuring that the poorest have access to affordable care. More support is needed from franchise organizations in Kenya to aid clinics in the NHIF empanelment process, and to link enrolled clients to the most convenient access points to care for them. Additionally, gaps at the provider-payer level – including high claims rejection rates, slow reimbursement processes to clinics, and fraud – must be addressed to incentivize providers to become empaneled in private and public insurance schemes. As other countries in East Africa continue conversations around the launch of their own national health insurance schemes, they can turn to Kenya for best practices in engaging with the private sector to empanel private providers, and to improve access to affordable, high quality health services.



Poor enrolled

To complement the evolution of their supply-side approaches to Social Franchising in Kenya, PS Kenya and MSK leveraged their networks to increase the number of poor enrolled in NHIF and accessing social franchise networks

With additional private clinics contracted to offer NHIF products (increased supply), PS Kenya and MSK worked to enroll new clients in NHIF and link them to Amua and Tunza clinics so they could access affordable, quality health services (increased demand). Alongside PharmAccess Foundation (PAF), PS Kenya and MSK supported NHIF in marketing their newly branded Supa Cover, designed to be affordable to the general population at 6,000 KES per annum. In 2016, this new marketing campaign contributed to the registration of over 300,000 households for Supa Cover nationwide, nearly 30,000 of which were directly registered through PS Kenya support. Clients enrolled in Supa Cover were then linked to Tunza and Amua clinics for their health service needs. A second NHIF product, the Health Insurance Subsidy Program (HISP), was rolled out when the MOH realized that the poorest were still unable to afford Supa Cover. HISP leveraged World Bank funding and was 100% subsidized for eligible indigents. As with the Supa Cover, both AHME partners worked to identify and enroll eligible clients into HISP as well, which resulted in 23,500 new households accessing health insurance. MSK is already mobilizing resources to support the continuation of this activity post-AHME, and PS Kenya will include client enrollment in their Tunza Platinum offering.

HISP was conceived out of the necessity for products that are inclusive of the poor, and inspired an important conversation around equity within Kenya – but have clients with access to subsidized or free health services actually gone to Tunza and Amua clinics? To answer this question, PS Kenya and MSK applied two different tools, the Equity Tool—initially conceived by PSI and the SF Metrics Working Group— and the Poverty Probability Index (PPI), to track the wealth breakdown of their franchisees’ clientele. Part of the conversation spurred by AHME included the best approach to measuring equity, and PS Kenya and MSK diverged in their approaches to measuring equity. The Equity tool looks at a basket of goods affordable for populations within

five wealth quintiles, while the PPI draws on District Health Systems data to assess the proportion of the population above and below the poverty line served by franchisee clinics.

PS Kenya and MSK were surprised by the annual reports in AHME years 2 and 3 when data indicated that there were not significant changes in the percentage of clientele in the lowest wealth quintiles who were accessing the AHME franchised clinics. The organizations discovered that, while those enrolled in HISP qualified as vulnerable orphans, they might not have been in the lowest wealth quintiles. PS Kenya was able to increase the percent serviced in the lowest wealth quintile from 0.5% in 2013 to 3% in 2018, and MSK had some success in increasing this percentage from 0% in 2013 to 4.5% in 2018 in Amua clinics. To improve reach to the most vulnerable, both social franchise networks would need to be more targeted in their expansion to geographic regions where they could best reach the poor in Kenya. PS Kenya and MSK gained insight into the clientele reached, and learned that more targeted approaches to geographic expansion must be pursued in order to effectively reach the poorest.

AHME additionally demonstrated that market facilitators could advocate on behalf of private sector clinics and their clients. After the AHME successes in enrolling new clients in HISP, PS Kenya and MSK organized meetings with several Kenyan counties to advocate for the allocation of millions of dollars to support this NHIF product over the next several years. MSK engaged four counties to commit resources to the continuation of HISP and were pleased to see Vihiga pledge \$1 million for 2018–2022, and Kwale another \$100k from 2018–2019. PS Kenya is currently in discussions with three counties – Bungoma, Kakamega, and Siaya – to commit financial resources to HISP as well. This engagement is key to unlocking sustainable financing for inclusive insurance schemes, such as HISP or UHC.

Global implications: PSI is employing the Equity Tool to more effectively measure relative equity and adjust client recruitment/targeting plans accordingly. In Myanmar, the Equity Tool was used as an ex-post assessment of the effectiveness of PSI's approaches to target poor households in its strategic purchasing pilot. It found that more than 98% of the identified households fell in the two lowest socioeconomic quintiles in one of the targeted peri-urban township; while two-thirds of the identified households fell in the two lowest socioeconomic quintiles in the other township. PSI Myanmar is determining whether this targeting strategy can be scaled up to other sites. MSI Uganda has adopted a similar approach to MSK and MSI/Ghana, by recruiting clinics in more remote areas. As a result, the BlueStar network in Uganda doubled their reach of poor clients: the proportion of clients who live on <\$1.25 increased from 8% in 2015 to 15% in 2016; <\$2.50 proportion increased from 39% in 2015 to 56% in 2016.

Recommendation: While it is clear that more work must be done to link the poorest to health services – either through the private or public sectors – equity measurements offered visibility into who is served by social franchise networks, and ignited critical discussion about the inclusion of the poor in health insurance schemes. Outside of AHME programming, NHIF is now piloting a new mechanism, named 'Universal Health Coverage', in 4 test counties in Kenya to provide healthcare to everyone, irrespective of ability to pay, and if this program expands to all 47 counties, it will be critical that PS Kenya and MSK work to link clients with empaneled Tunza and Amua clinics to increase access points for care and focus on supporting franchisees in areas easily accessible to poor communities. Poverty targeting tools used must be carefully designed, locally adapted and periodically updated to ensure that they identify the poorest households.

Below: Facility owner and Doctor Patrick at Jamii Vipawa Hospital in Kariobangi North, Nairobi.





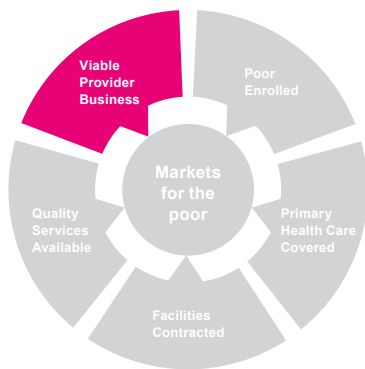
Primary health care covered

In Kenya, AHME initiated targeted advocacy efforts to create an enabling environment for private providers, clients, and payers in a mixed health system

While Kenya already has a fairly comprehensive capitation package for Primary Health Care, MSK is promoting a change in the reimbursement method for Long Acting Reversible Contraceptive methods (LARCs) from capitation to case based payment due to their relatively higher cost than short acting contraceptive methods. Providers cannot cover the cost of service provision with the current rates, which presents a risk that that private sector isn't incentivized to provide LARCs, as it would negatively impact their profitability. Family Planning advocacy efforts are still underway and are critical to ensure affordable coverage within the NHIF insurance primary care package.

Global implications: PSI is increasingly facilitating engagement between private sector actors and the government to support coverage of a range of health services at a rate that incentivizes private providers to offer quality care. This is particularly important in countries with nascent and/or developing national health insurance schemes, such as Uganda and Tanzania. MSI is considering expanding support to franchisees to offer integrated primary health care in countries like Kenya and Ghana, where clinics are linked to national health insurance mechanisms. MSI is also looking to build on experience gained from AHME to develop its advocacy around health insurance benefits packages.

Recommendation: Kenya is on a strong path toward UHC with investments in products catering to the poor, such as HISP and UHC pilots. Continued focus on mutually beneficial reimbursement terms between providers and public insurance schemes will strengthen Kenya's mixed health system, and allow for more clients to access affordable, quality care. PS Kenya and MSK will both continue to advocate for improved capitation rates and blended payment mechanisms with NHIF and other private payers through the Tunza Platinum model, and lessons learned will be shared with the community of practice to improve national health insurance models globally.



Viability provider business

In Kenya, AHME highlighted the complementary nature of quality and business operations by exploring strategies to augment franchisee profitability

AHME encouraged holistic support to franchisees, with the goal of building both the business and quality aspects of the health practice. Empanelment was one business strategy explored by PS Kenya and MSK, who sought to understand whether NHIF empanelment led to an increase in client flows, and thus an increase in profitability of the overall health business. In analyzing the impact of NHIF empanelment on increased profitability, MSK found that most providers reported higher incomes as a result of empanelment, however 27% facilities contracted under the civil service scheme noted that they were generating less revenue under NHIF than previously due to capitation rates too low for cost-recovery. Additionally, PS Kenya and MSK introduced a one-week training on business for health to boost business acumen of franchisees and create operational efficiencies for further profitability—stronger financials allow for better client care. Business support focused on financial management, marketing, inventory management and customer service, and was delivered through group training and one-on-one coaching sessions. Specific contributing factors included: quality improvement tied to the franchising of new services (NHIF, antenatal care, maternal and child health, and laboratory), as well as the adoption of inventory management best practices, financial policies, and marketing strategies to boost client flows.

Franchising new services, improving quality structures, and physical expansion of clinic space are also tactics to increase business profitability, but require upfront investment. AHME realized this, and PS Kenya and MSK linked franchisees to financing through the Medical Credit Fund (MCF)³ so they could invest in SafeCare quality improvement recommendations. Many providers that accessed loans, from a small clinic to a large, multi-story hospital, reported positive, rapid growth of their facility allowing them to serve greater numbers of clients. Once their credit history was established through the repayment history associated with a small loan, providers could access increasingly larger loans from MCF and other banks. Early success encouraged more financial

institutions to lend to health facilities as a result of high repayment rates, proving that they are bankable.

Alongside this success, a few challenges emerged in implementing the MCF program - including the slow processing rate of MCF partner banks, despite quick MCF review, and reportedly excessive paperwork required in the application process. The interest rate cap at 14% by the Central Bank of Kenya caused banks to charge the same rate, which prevented MCF from distinguishing its loans based on lower cost. In rural areas, providers had to travel to submit loan paperwork, and many did not have accounts with MCF linked banks, which further complicated the application process. Challenges led to lower than anticipated access to loans in the health sector - for example, only 31 Tunza clinics accessed financing through MCF. The experience highlighted the importance to franchisees of accessing finance, leading them to explore alternative options, such as internal revolving funds and accessing other financing mechanisms through partnerships as part of the Tunza Platinum offering.

Global implications: Alongside other Tunza Social Enterprise countries, PS Kenya will continue to support clinics in improving their overall business operations through the provision of business skills trainings and coaching in data-driven decision making, in addition to exploring new models to link franchisees to financing in order to help them increase profitability and better serve clients. MSK learned that the provision of business skills was one of the highest value-adds to providers, and are actively fundraising to continue this support.

Recommendation: Through AHME, PS Kenya and MSK learned that quality and business acumen are deeply intertwined, and that they must look outside of the 'fractional franchise' model they have been employing to move toward a sustainable model of service delivery. Franchisees highly value access to financing and business skills trainings to catalyze quality improvement and business growth, as this more holistically meets their needs in improving their health business overall. This holistic approach must be considered by franchisors to achieve sustainability.

Conclusion

These meaningful changes to how PSI and MSI have approached social franchising demonstrate that with further commitment and investment from the community of practice and funders, we can tackle the complexity of mixed health systems and continue to move toward UHC. This requires a willingness from governments, donors, and market facilitators like PSI and MSI to work across private and public sectors to co-design interventions that address key market conditions in mixed health systems – i.e. quality services available, facilities contracted, poor

enrolled, primary care covered, and viable provider business. This also means that our community of practice should move beyond a sole focus on service delivery toward a broader approach that also address key market constraints. Donors should invest in these broader models and national policy-makers should take more responsibility for private sector integration into the health system, particularly as national health insurance schemes become active, so that all players are at the table to effectively design and deliver mixed health systems in support of UHC.

References

- ¹ Lagomarsino, Gina, Stefan Nachuk, and Sapna Singh Kundra. 2009. Public stewardship of private providers in mixed health systems: Synthesis report from the Rockefeller Foundation—sponsored initiative on the role of the private sector in health systems. Washington, DC: Results for Development Institute.
- ² Thurston, S., Chakraborty, N. M., Hayes, B., Mackay, A., & Moon, P. (2015). Establishing and Scaling-Up Clinical Social Franchise Networks: Lessons Learned From Marie Stopes International and Population Services International. *Global Health: Science and Practice*, 3(2), 180–194. <http://doi.org/10.9745/GHSP-D-15-00057>
- ³ For more information, see MSK's recent case study on MCF, "Improving access to finance for health care businesses in Kenya", by Nirmala Ravishankar and Joel Lehmann

