Short Report 2

Market Condition 3: Facilities Contracted

Background:

The African Health Markets for Equity (AHME) project seeks to make quality, affordable private health services accessible to low-income populations in Kenya and Ghana. AHME aims to achieve this goal by offering private providers enrollment in a franchise network; access to the SafeCare quality improvement program; and access to Business Support and Medical Credit Fund (MCF) loans. In addition, AHME is assisting franchised providers to become accredited with National Health Insurance schemes in both countries: the National Hospital Insurance Fund (NHIF) in Kenya and the National Health Insurance Scheme (NHIS) in Ghana. To increase client access, AHME is assisting poor communities to become enrolled in the NHIs so that they are able to receive care at accredited franchised facilities. This work with NHIs is meant to be the "glue" that binds AHME's supply (high quality providers) and demand (patients) components. NHI Accreditation brings the two aspects of care together and, ideally, also supports providers to grow their business.

This short report examines opportunities for providers once they are accredited; the challenges providers face once they are accredited and how they manage these challenges; and the extent to which the integrated package of AHME interventions helps providers to mitigate challenges and take advantage of opportunities.

Methods:

Data was collected from private providers in 2013, 2015, and 2017. Working under the guidance of the AHME Qualitative Evaluation Team at the University of California, San Francisco (UCSF), Innovations for Poverty Action (IPA) field staff in Kenya and Ghana conducted interviews with providers to learn about their experiences with the AHME interventions. After each round of data collection, the research team at UCSF used an open coding approach to code and analyze interview transcripts using Atlas.ti qualitative data analysis software. The coding process indicated that data saturation was reached.

Results:

There are three main reasons providers become accredited with the National Health Insurance in both countries (1) grow their business, (2) stay competitive, and (3) serve low-income populations.

Providers stated that they saw joining NHIF in Kenya and NHIS in Ghana as an opportunity to grow their business. Providers felt that by accepting NHIF/NHIS they would attract new patients, increasing their client load, which would increase their revenue. However, it is unclear if providers actually saw an increase in revenue as a result of joining an NHI scheme. Although providers regularly mentioned that their client load did increase as a result of accepting NHI coverage, they also complained of delayed payments and low reimbursement rates. This was especially true in Ghana, where a number of providers had waited up to one year to be paid by the NHIS. As a result, it was unclear whether providers ultimately realized any meaningful financial gain. Some providers shared that they joined the NHIs to remain competitive. They saw other private providers in their community becoming accredited and worried that they would lose clients if they did not also do the same. This worry of lost competitiveness was amplified as provides reported an increase in demand from patients to accept NHI. These providers were concerned they would not be able to stay in business if they did not become accredited. Finally, a number of providers shared that they became accredited with NHI to serve low-income patients. Many providers discussed how their community and the patients they treated were very poor and by accepting NHI they were able to serve these clients.

After becoming accredited providers faced a number of challenges. The most significant challenges were: (1) delays in payments, (2) processing claims, (3) patients' misunderstanding of the insurance programs.

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Providers in both Kenya and Ghana discussed payment delays, but this was a much larger issue in Ghana, where delays were longer and resulted in providers having problems stocking drugs and paying staff. Some providers said they had to buy drugs on credit, while others used their personal funds to cover basic clinic expenses. In addition, some providers in both countries mentioned charging patients for services covered by NHIF/NHIS, believing they couldn't sustain their business in the face of NHI payment delays without additional income. Processing of claims was also an issue in Ghana. Providers struggled to complete claims forms accurately, particularly given the number of restrictions placed on drugs and services that small private providers are allowed to claim for reimbursement. This resulted in a back-and-forth with the NHIA office that further delayed payments. Due to restrictions on drugs/services, low reimbursement rates, and delays in payment, providers in both countries sometimes treated patients who had NHI coverage differently from patients who pay for services out of pocket. This often translated to limiting services or drugs given to clients using NHI coverage. Finally, providers in both Kenya and Ghana discussed that patients often did not understand what services are covered by their insurance and expect everything to be free of charge. This was particularly relevant under a capitation system and confusion often extended to providers as well. As a result of misunderstanding how NHI coverage works, providers sometimes felt that patients who visited the clinic frequently were purposefully taking advantage of the system. In some cases, this lack of understanding also led to providers placing a "cap" on the services they provide under NHI. All outpatient services under the NHIF in Kenya are covered under a capitation system. The Ghana NHIS has piloted capitation for all services, but has yet to roll out this system across the country.

Participating in AHME helped private providers mitigate some of the challenges they faced under the NHIs: (1) navigating accreditation process (2) understanding requirements and (3) addressing quality gaps

Providers in Kenya remarked that becoming accredited is often a very long and difficult process, which the franchisor helped them navigate. The franchise provided information on the requirements to become accredited, helped providers prepare for the assessment, and helped them move the process along. In addition, most providers said that SafeCare specifically prepared them for the NHIF assessment. These providers found that the SafeCare assessment was similar to the assessment required for NHIF. By addressing the gaps identified by SafeCare beforehand, providers faced fewer challenges in the NHIF accreditation process. Finally, although the AHME partnership had anticipated that the MCF loans program would give providers access to the capital necessary to meet equipment and facility requirements for NHI accreditation, this program has not been very popular among providers. While a handful of providers benefitted from MCF loans, most were distrustful of bank loans and, particularly in Ghana, reluctant to take on debt when their clinic's financial status was so uncertain.

Conclusions:

Providers in Kenya and Ghana are finding that accepting NHIF/NHIS is necessary to remain competitive and operational. However, because these systems were designed with a focus on the public health sector, accepting NHIF/NHIS can be very challenging for small private providers who are only beginning to be engaged with the national insurance system. The AHME interventions are helping to mitigate challenges by providing assistance in navigating NHIF/NHIA processes. However, systemic issues such as payment delays and low reimbursement rates remain. In the face of these high-level challenges to providers' financial sustainability, and with such low uptake of the MCF loans, it will be particularly important for the AHME franchisors to fully integrate business planning and support into their work with providers. Providers' own lack of clarity around whether or not they were financially benefitting from NHI accreditation suggests an insufficient understanding of basic business practices, which, if corrected, could help them better manage their finances and realize financial gains going forward.

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***Data Sources**: Provider interviews (2013, 2015, 2017); Patient interviews (2013, 2017); community member FGDs (2013); Sieverding et al. 2015; 2017 AHME Qualitative Evaluation Midline Report*

To learn more about the AHME Qualitative Evaluation:
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