
Digitizing and Contracting Private Practices to Sustain Family Planning

Lessons from Kenya



Summary

Private providers in Kenya, including numerous small and medium practices, have the potential to attract and retain clients, increase revenues, operate more efficiently, and contribute to universal health coverage by digitizing operations and participating in health financing programs. Both actions aim to sustain scaled-up provision of health services, including family planning, in the private health sector while reducing financial barriers for clients. This brief focuses on the transition from paper, cash-based operations and limited individual contracts with payers, to digital solutions that enable more efficient contracts between multiple providers and payers. The Sustaining Health Outcomes through the Private Sector Plus project examined effects from two reinforcing interventions in which an intermediary supported a network of 33 practices to (1) install and build use of a digital clinic management system, and (2) contract with health financing programs such as the National Hospital Insurance Fund (NHIF), individually and as a network. The COVID-19 pandemic affected implementation of both interventions, as did learning that the NHIF requires legal reform before it can contract with an intermediary that represents multiple private providers. The intermediary succeeded in contracting the network with a private health insurance scheme for low-income households, and digitized the clinical and administrative operations of 10 new network members. Looking ahead, donors can support governments, in collaboration with private stakeholders, to enact reforms that enable contracting between programs like the NHIF with intermediaries representing multiple practices. Donors can also assist intermediaries to develop and deliver a sustainable value proposition. Done right, these efforts can enable private practices, especially smaller ones, to sustainably increase access to family planning and other essential health services.

Keywords: digital health, family planning, health financing, health insurance, Kenya, universal health coverage

Photo: NHIF

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Digitizing and Contracting Private Practices to Sustain Family Planning: Lessons from Kenya

Households in low- and middle-income countries pay out of pocket for more than half of all the health care they use; every year, more than 100 million people fall into poverty due to the cost of health care. Out-of-pocket payments limit access to quality services, including the full range of family planning methods, especially more costly long-acting family planning methods. Reducing out-of-pocket payments is critical to increasing access to quality health care and reducing financial hardship resulting from the cost of care (SHOPS Plus 2021a).

In 2012, the global family planning community, through Family Planning 2020 (FP2020), set stretch goals and committed to reach 120 million new users by the year 2020. As of 2019, there were 53 million new users of family planning (FP2020 2020a). Globally, the number of women with access to modern contraceptives has increased. However, the total population of women of reproductive age is also increasing. The FP2020 partnership has defined an updated vision, now under FP2030, of “a future where women and girls everywhere have the freedom and ability to lead healthy lives, make their own informed decisions about using contraception and having children, and participate as equals in society and its development” (FP2020 2020b). This necessitates sustained efforts by family planning stakeholders to maintain gains and close remaining gaps. A look at past and projected funding for family planning reveals that donor funding for family planning has been stagnating or decreasing (FP2020 2020c). In 2021, the UK government announced cuts to foreign assistance programs including for sexual and reproductive health. For example, funding provided to the United Nations Population Fund (UNFPA),

which supplies low-cost family planning commodities globally and receives 60–70 percent of its annual budget from the UK government, was reduced by 85 percent (MSI 2021). If total spending by donors, governments, and clients were to remain at current levels, growing demand for family planning in low- and middle-income countries would create a funding gap for contraceptive commodities of approximately \$1.17 billion over the next five years (2021–2025) (RHSC 2019).

Globally, the private health sector is an important source of family planning products and services, especially for clients seeking short-acting methods (Ugaz et al. 2016). FP2020 tracking indicators and Demographic and Health Survey data showed that in 2016 more than 106 million women in the world's 69 poorest countries relied on the private sector for their modern method of contraception (Weinberger and Callahan 2017). Many low- and middle-income countries such as India, Kenya, Nigeria, and Tanzania have large and growing numbers of for-profit and nonprofit private providers (Box 1). However, these providers generally operate independently. This lack of organization, especially among small and medium private providers (SMPPs), prevents them from partnering with donor and government-supported health financing programs.

Box 1. The range of private providers

- Private providers include individuals who are trained doctors, clinical officers, midwives, nurses, and pharmacists.
- They work as solo practitioners and in group practices providing primary or specialty care, and in hospitals with inpatient facilities, mobile medical units and pop-up clinics, pharmacies, drug shops, and laboratories.
- Private providers may be affiliated with social franchises, other networks, or workplace programs.
- Small and medium private providers are a subset of private providers who practice at facilities ranging in size from a single practitioner up to a small group with several providers, or, for an inpatient facility, up to 10 beds.

In Kenya, privately run facilities represent the majority (53 percent) of health facilities and warrant deliberate strategies for inclusion in health financing interventions (Ministry of Health 2021). Convening and organizing large numbers of private providers is essential to take donor investments to scale.

Common ways of organizing the private sector include (Callahan et al. 2017):

- Working through **professional associations** that bring together people with similar qualifications to pursue a common purpose, usually advocacy and information sharing.
- Setting up **cooperative businesses** that are jointly owned and operated by members who oversee operations and share profits and losses.
- Forming **federations** that organize disparate, homogenous groups under the leadership of a central body.
- Establishing **provider networks** that affiliate private providers under a larger umbrella structure.

Health financing programs present benefits and challenges for SMPPs. Private providers may contract with financing schemes sponsored by employers, public or private insurers, or voucher programs that target specific populations to increase access to health services such as family planning. Participating in health financing programs can help SMPPs attract and retain clients, increase revenues, and operate their practices more efficiently (Holtz and Sarker 2018a). This ultimately improves sustainability of SMPP practices. Yet SMPPs also find participation in health financing programs challenging. Across countries, a variety of barriers limit the number of SMPPs participating in health financing programs. For example, SMPPs may be excluded from health financing programs that do not recognize their cadre, or if their practice is located near larger, full-service facilities that also contract with the program. Other barriers to participation in health financing programs include costs associated with participating, licensing, and legal agreements; processing time; and operational challenges (Holtz and Sarker 2018a). In Kenya, SMPPs find accreditation and contracting with the National Hospital Insurance Fund (NHIF)—the largest government-sponsored health financing program—complex and challenging (Sieverding, Onyango, and Suchman 2018; Suchman 2018). Further, some SMPPs, particularly smaller, female-run clinics and nursing homes, report discrimination from the NHIF, through such tactics as delayed accreditation and claims processing (Appleford and Ramarao 2018).

Similarly, purchasers of health services, also called third-party payers, find partnering with SMPPs valuable but challenging. Payers recognize that partnering with SMPPs can expand geographical coverage of health financing programs and increase points of access for clients. Project experience shows that contracts with SMPPs can also yield cost savings relative to agreements with larger facilities. However, payers struggle to partner with SMPPs, as it is difficult to identify them and to be sure about the range of services and quality

they provide (Holtz and Sarker 2018a). Global experience suggests that it is an expensive and tedious process to contract with individual SMPPs. In the Philippines, PhilHealth Corporation noted that staff need substantial training and better coordination to efficiently contract with SMPPs. Likewise, in Nigeria, third-party payers do not directly support private providers to become accredited because of the substantial time and resources required to institute the right systems (Ishtiaq 2019).

In 2019, the world confronted the emergence of the COVID-19 pandemic, with negative effects on the availability, quality, choice, and affordability of family planning supplies and services. Social distancing and other strategies to reduce transmission of the virus have limited the ability of couples to use contraception. Disruptions to global manufacturing and supply chains have reduced the availability of contraceptive commodities (UNFPA 2020). Closure of health facilities has reduced availability of medical staff to provide family planning, and reluctance of clients to visit health facilities due to concerns about COVID-19 has also limited access to contraception. UNFPA estimates that health service disruptions during a nine-month lockdown period could prevent approximately 18 million women seeking modern contraception from being able to obtain the method of their choice (UNFPA 2020).

This brief presents lessons learned by the Sustaining Health Outcomes through the Private Sector (SHOPS) Plus project from two mutually reinforcing interventions to improve sustainability of family planning provided by SMPPs and access to the full range of family planning methods for clients in Kenya.

1. **Digitizing health facility clinical and financial operations:** SHOPS Plus helped digitize clinical and financial data within SMPP practices. These data are used to support contracts with health financing programs, for example, to submit electronic claims and manage patient information.
2. **Contracting through an intermediary:** SHOPS Plus tested a model whereby an intermediary—sometimes referred to as an aggregator—aims to contract multiple providers with a payer under one negotiated contract with uniform pricing and terms. Contracting through intermediaries has the potential to streamline operations for payers and providers while scaling up and managing service access points available to covered clients.

Photo: Jeanna Holtz

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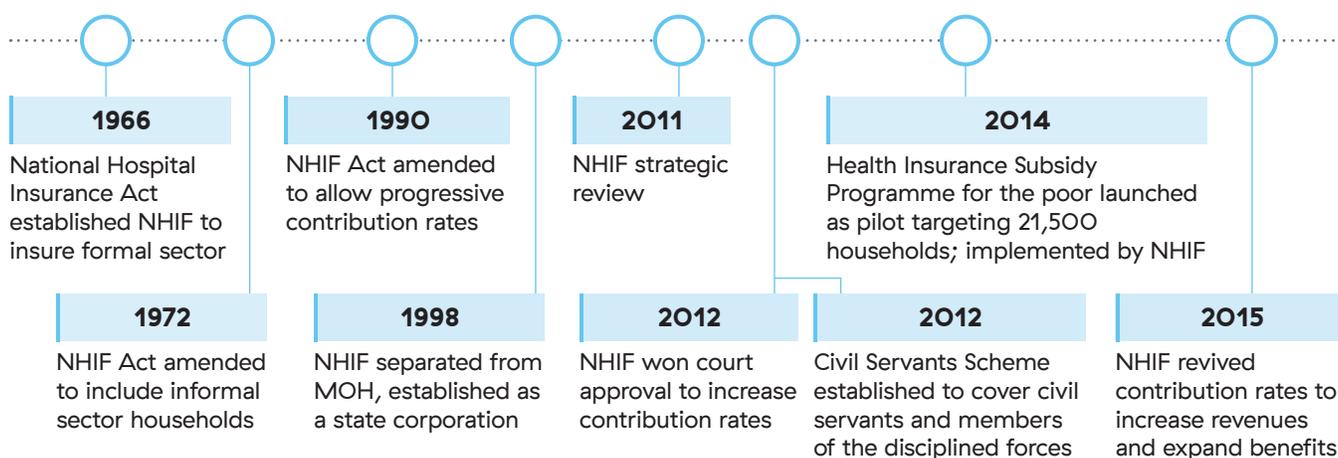
Kenya landscape

NHIF is a major health financing program that supports universal health coverage

The NHIF was established by the National Hospital Insurance Act of 1966 to provide health insurance to formal sector employees, but the populations covered, the number and types of schemes available, and the contribution rates have evolved (Figure 1). Under NHIF's flagship national scheme, commonly called Supa Cover, enrollment is mandatory for formal sector employees. They pay the full premium, with no contribution from employers. This differs

from the shared contributions between employers and employees typically paid to social health insurance programs in middle-income countries (Dutta et al. 2018). Enrollment in NHIF is voluntary for those not in formal employment. The fund has registered 9 million principal members out of 47 million Kenyans, of whom 3.2 million are not in formal employment (Box 2) (NHIF 2021). NHIF members employed in the informal sector pay a fixed monthly premium of KSh 500 (approximately \$5), while premiums for formally employed members are calculated on a graduated scale of KSh 150–1,700 (approximately \$1.5–17 per month) (NHIF 2018).

Figure 1. Key milestones in the history of NHIF



Source: Adapted from Dutta et al. (2018)

Box 2. NHIF by the numbers (2020)

- Kenya population: 47 million
- NHIF principal members: 9 million, of whom 3.2 million are not formally employed
- Contracted health facilities (public and private): 8,000

Source: NHIF (2021)

The NHIF operates six schemes (Table 1). It purchases services from accredited health facilities in both the public and private sector. The Supa Cover scheme includes all family planning methods in its benefit package.

Table 1. NHIF schemes

NHIF product	Target market	Membership*	Payment mechanism**
National scheme (Supa Cover)	Formal and informal sectors	Approximately 3.6 million members***	Outpatient: Capitation Inpatient: Fee for service, case-based rates and per diems
Edu Afya	Secondary school students in public schools	2.7 million students (2019)****	Outpatient: Fee for service Inpatient: Per diem
Civil Servants	Civil servants	600,000 civil servants and dependents***	Outpatient: Capitation Inpatient: Fee for service and case-based rates
Linda Mama/free maternity service	Poor mothers	395,918 women	Case-based rates
Health Insurance Subsidy Program	Poor community members	181,415 households**	Outpatient: Capitation Inpatient: Fee for service, case-based rates and per diems
Older Persons and Persons Living with Severe Disability	Older persons and people living with severe disability	42,000 households	Outpatient: Capitation Inpatient: Fee for service, case-based rates and per diems

* NHIF (2018)

** Dutta et al. (2018)

*** Barasa et al. (2018)

**** Appleford and Mbuthia (2020)

Private providers are a significant player in the health system

Approximately half of all registered facilities in Kenya’s health system are private. However, the quality of services they deliver is uneven, and they are irregularly supervised (WHO 2020). A look at health-seeking behavior shows that 52 percent of urban and 32 percent of rural populations visited a private provider for outpatient services in 2013 (Dutta et al. 2018). Among modern contraceptive users, 38 percent sourced their method from the private sector.

Within this group, utilization varied based on economic status. In the bottom two wealth quintiles, 24 percent of users sourced their method from the private sector. In contrast, 50 percent of modern contraceptive users in the top two wealth quintiles sourced their method from the private sector (SHOPS Plus 2021b). It is likely that these users paid for their family planning method out of pocket, with a small minority accessing benefits through a health financing mechanism.

Purchasing Arrangements Vary by Payer and by Product

A range of public and private actors purchase health services in Kenya at public and private health facilities. For example, the government mobilizes funds for health care through taxes. It uses these funds to finance services provided by public health facilities and provide subsidies for low-income or target populations to enroll in programs such as EduAfya, a scheme sponsored by the NHIF for secondary school students. The NHIF mobilizes funds from premiums paid by individuals in the case of Supa Cover, and employers for other medical schemes such as the one for civil servants. Private health insurance programs mobilize funds from premiums paid by employers, employees, and, in some limited instances, individuals who buy individual coverage. Private employers may sponsor programs to enable employees to access health care including family planning with company funds, and/or from contributions or user fees collected from employees. In parallel, and often as a default, private households also often purchase services out of pocket.

Health insurance premiums and benefit packages vary by product and market segment. For example, the Supa Cover scheme defines a comprehensive benefit package that includes outpatient and inpatient care, surgery, maternal care, reproductive health including all family planning methods, imaging, and treatment for chronic illnesses (Figure 2). In comparison, the Civil Servants scheme is more expansive. It covers all the Supa Cover benefits and, in addition, fertility services, as well as dental, vision, and funeral expenses (Dutta et al. 2018).

Figure 2. NHIF Supa Cover benefits



Benefits Package:

- + Outpatient Services
- + Maternal Care
- + Renal Dialysis
- + Cancer treatment
- + Rehabilitation for drug & substance abuse
- + All surgical procedures including transplants
- + Emergency Road Evacuation Services
- + Inpatient Services
- + Reproductive Health Services
- + Overseas treatment
- + Radiology Imaging Services

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The NHIF contracts with health facilities on a scheme-by-scheme basis, with Supa Cover as the first scheme providers must qualify for. Subsequently, facilities must separately apply and qualify for additional schemes; they would need to hold six contracts with the NHIF to participate in all six schemes the NHIF currently operates. This places an administrative burden on the NHIF and the private providers with whom it contracts. The challenge of managing multiple contracts with NHIF and other programs is amplified by different benefit packages and provider payment mechanisms across schemes. A more efficient approach would be for providers to contract with multiple NHIF schemes using a common contract. To the extent possible, this contract could consolidate and rationalize terms and conditions pertaining to service mix, quality assurance, payment rate and method, and other administrative functions, while specifying scheme-specific differences such as membership eligibility and benefits.

The interventions

Support sustainable service delivery using digitization and contracting through an intermediary

This intervention contributes to a growing body of knowledge generated by SHOPS Plus and other organizations, including the African Health Markets for Equity project, about opportunities and challenges with integrating family planning into financing programs that have the potential to advance family planning and other health goals.

SHOPS Plus noted an opportunity for SMPPs to generate and use better data (Holtz and Sarker 2018b). Those data support efficient contracting, and digitization enables data collection. Accordingly, SHOPS Plus developed a theory of change to test two reinforcing interventions to improve the sustainability of family planning provided by SMPPs and access to the full range of family planning methods with reduced financial barriers (Figure 3). The theory of change envisions sustainable service delivery of a full range of quality family planning for increased client satisfaction that leads to an increased modern contraceptive prevalence rate. This goal is more achievable when providers and payers efficiently contract and work with each other in health financing schemes that increase client flows and revenues for family planning SMPPs.

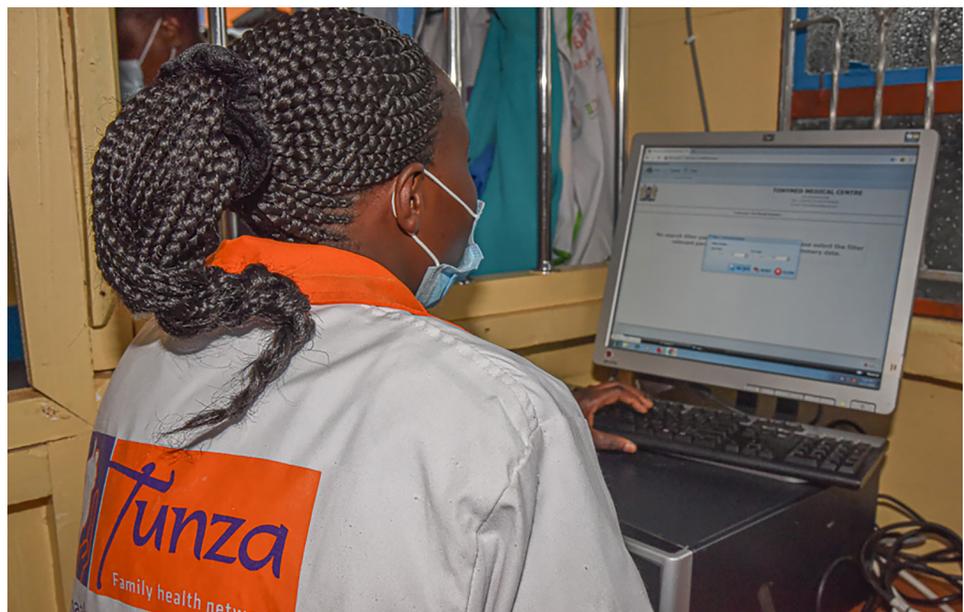
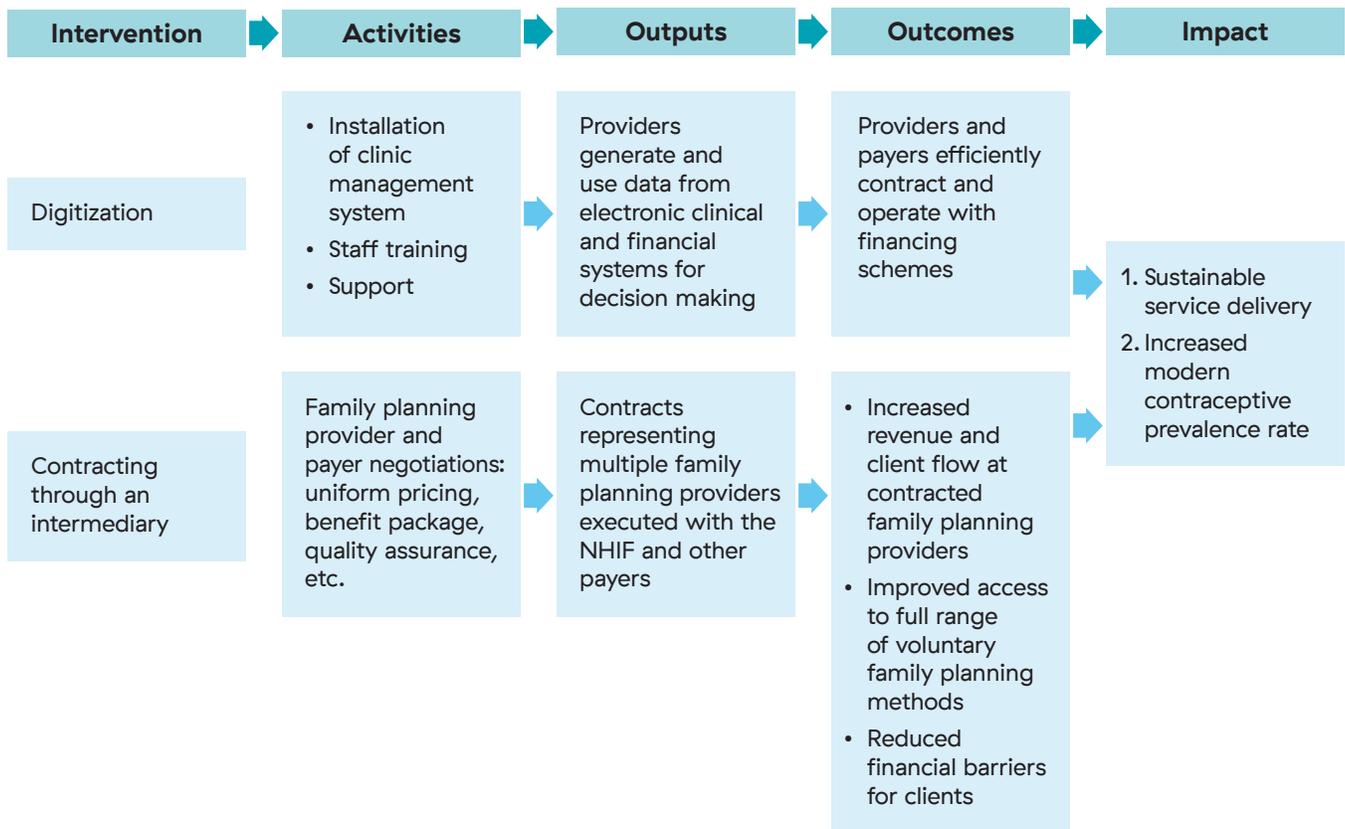


Photo: PS Kenya

Figure 3. Theory of change



Context: Manual operations and record keeping inhibit data collection and analysis, which in turn hinder establishing and sustaining contracts with health financing programs. In general, digitized health facility operations support data collection and decision making, thereby enabling health providers to contract and operate within health financing programs and deliver quality services. By reducing reliance on paper-based records, an electronic clinic management system (CMS) should improve the efficiency and transparency of clinical and administrative operations at a health facility.

A CMS can support scheduling and patient communications, medical record documentation, billing and payments, quality assurance, inventory management, human resource functions such as payroll, and external reporting (e.g., to a supervisory body or a third-party payer). Data generated by the CMS can inform decision making as well. Providers can use data to assess clinical and business performance and trends pertaining to service statistics, and payment methods and amounts. They can better track invoices and receivables, clinical and service quality, inventory management, human resources, and other components relevant to the facility.

Intervention: SHOPS Plus supported 10 practices to digitize operations by installing an electronic CMS, with assistance from Population Services Kenya (PS Kenya), the network management organization (NMO) acting as the intermediary (Box 3). The project wanted to observe whether and how an in-house team from the NMO could oversee installation and use of the CMS. It was expected that, if used effectively, the CMS would support SMPPs to contract with health financing programs by enabling them to operate their facilities more efficiently and effectively. This could include producing accurate billing and reports, managing working capital and receivables, adhering to clinical and service quality standards, and complying with supervisory reporting.

Box 3. Tunza Platinum Network

PS Kenya, working as an affiliate of Population Services International, has operated the Tunza Family Health Network since 2008. The network comprises 415 private for-profit independently owned health facilities serving low- to middle-income and underserved communities in Kenya. The Tunza Family Health Network is a fractional social franchise network—meaning only a portion of a franchisee’s services are subject to franchise terms and standards. PS Kenya contracts with health providers to deliver a defined package of services in accordance with franchise standards under a common brand, Tunza.

In 2017, PS Kenya, operating as an NMO, partnered with a subset of high-capacity, high-potential Tunza facilities to form the Tunza Platinum Network. This network included facilities committed to entrepreneurship and growth. The NMO selected providers based on qualitative and quantitative aspects, including average monthly client flows, quality scores, primary care services offered, interest in modernizing and adaptability, willingness to invest in an electronic CMS, and commitment to build business, marketing, and inventory management skills. As of September 2020, the Tunza Platinum Network comprised 33 facilities.

The NMO manages network facilities under a new intermediary model in Kenya designed to increase the quality, scale, and financial sustainability of private health facilities, and to contribute to universal health coverage. Network facilities pay additional fees to the NMO in return for more expansive support and services. This includes having the NMO represent them as an aggregated unit to payers for contracts with health financing programs and supporting them to improve their clinical and operational performance.

Results

The results attained by the project's efforts to digitize practices and facilitate aggregate contracting are summarized here. They were more limited than hoped. The main reasons for this are discussed in the lessons learned section.

Digitization

SHOPS Plus set out to use digitization to generate and use data from electronic clinical and financial systems for decision making by network facilities and the NMO. To facilitate learning in a step-wise fashion and working with available resources, the project installed the CMS, trained users, and provided information technology (IT) support at 10 network facilities. Out of 33 network facilities, 30 (91 percent) reported consistent, complete, and accurate data with the CMS. However, the reporting period (16 months, ending September 2020) was shorter than planned due to effects from the COVID-19 pandemic. During this time, implementation slowed and nearly all support was virtual.

Box 4. Computer management system components

- Hardware (server, computers, cabling, network)
- Software
- Training
- Licensing fees
- User support
- Internet

PS Kenya, in its capacity as an NMO or intermediary, assessed member needs and options for digital systems, and brought experience from organizing and partnering with larger numbers of SMPPs. It supported member facilities to install and use the CMS by providing training, troubleshooting, and sharing lessons learned across installations. The cost to install a CMS varied based on the size of the facility, which in turn influenced the configuration and amount of hardware, software, and user support needed (Box 4). At the time of the installations, costs ranged from approximately \$5,000 to \$6,200. In earlier CMS installations funded by other projects, the NMO provided short-term subsidies for network members to offset some installation costs (e.g., internet or software costs). After learning that providers were generally prepared to

pay installation fees, the NMO reduced operating subsidies with installations supported with SHOPS Plus funding and covered only licensing fees. This allowed the NMO to reduce its installation costs and encouraged network members to take ownership of their system.

Contracting through an intermediary

SHOPS Plus set out to pioneer contracting SMPPs through a single contract representing multiple SMPPs with the NHIF and other payers. The NMO was unable to contract the network with the NHIF through a single contract due to a regulatory limitation. Currently, the NHIF must comply with legal requirements stipulated by the *Quality Improvement Checklist for Contracting of Health Facilities* under the NHIF Act of 1998. Under the act, the NHIF can only contract with health facilities holding a Kenya Medical Practitioners and Dentists Board facility license. There is no provision in the act that allows the NHIF to contract with an NMO or intermediary representing individual providers if the board does not recognize that entity as a

health facility. The act would require a major reform to enable contracting between the NHIF and intermediaries. However, the NMO did execute a contract on behalf of the network with one private health insurer.

Over the 16-month (May 2019 through September 2020) implementation period, efforts to facilitate contracting of multiple facilities under a single contract made less progress than initially expected. Given the regulatory barrier for the NHIF to contract with an intermediary, the NMO focused on contracting with private health insurance schemes. After soliciting interest from eight private health insurance programs, the NMO executed its first contract with a fully commercial insurance scheme for a new outpatient product targeting low-income households called AfyaPoa—Amani (Box 5). The payer reported that the process of contracting through an intermediary was positive. For example, working with the NMO allowed the payer to identify, recruit, and train providers more efficiently than if it had contracted directly with individual providers.

Box 5. AfyaPoa—Amani

AfyaPoa—Amani is an insurance product launched in 2019 by Sanlam, in partnership with an administrative partner, Insurance for All. AfyaPoa targets Kenya's low-income earners in the informal sector. This innovative insurance product includes benefits for family planning and a free wellness check. Clients make small daily premium payments using a digital platform. They have access to savings and loan products that complement the insurance. The overall aim is to offer clients greater financial protection against health risks they face.

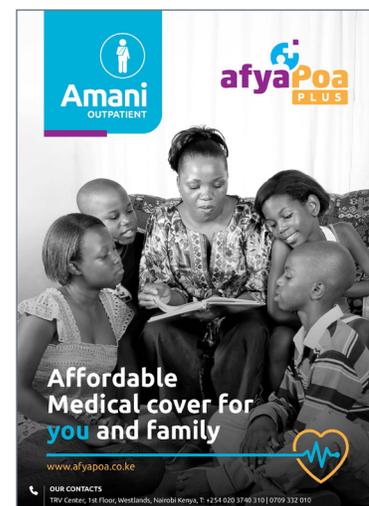


Photo: Jeanna Holtz



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Lessons learned

This experience generated lessons to inform future initiatives that strengthen the ability of the private health sector to transition from paper-based operations and individual contracts to digital systems and contracts representing multiple providers with payers.

Digitization

1. Intermediaries have the capacity to help SMPP practices digitize.

An intermediary can help SMPPs transition from the use of a manual, paper-based system to a digitized operation. Some SMPPs attempted to digitize their practices previously but were not successful largely because they did not fully understand system and non-system inputs such as the human resources required to set up, maintain, and use the CMS. Some purchased systems that lacked sufficient technical support and then struggled to operate the system successfully.

2. There is a learning curve to understand the effects of a CMS on providers and clients.

CMS installations took place over 16 months. The system provides real-time statistics, but a larger volume of transactions, over a longer period and from additional practices, will improve understanding of the full potential and limitations of a CMS.

However, anecdotal experience suggests that a CMS may improve client experience, health outcomes, and operational efficiency of the provider's practice. Early feedback indicates that the CMS supported providers to contract with and participate in health financing schemes such as the NHIF. For example, facilities with a CMS reported increased capacity to conduct financial tracking and forecasting using past performance data. Some reported that the CMS helped them compile and manage claims more accurately and efficiently, and to conduct cashless transactions that are efficient and faster.

The CMS generates client information that can support continuity of care for family planning and other health services. Some providers reported reduced commodity stockouts when using the CMS to track drug movement and generate notifications when stock levels are low or about to expire. Providers also began to use the CMS for patient scheduling and to manage patient flow. Some observed that the CMS could help reduce wait time for clients and provide information on when and how to triage patients based on the care required.

3. **Growth-minded practices are more likely to adopt digital solutions.**

Network facilities expressed varying levels of interest in adopting a CMS. The project observed several characteristics that may predispose a practice to successfully adopt and use digital solutions (Box 6). For example, successful adopters of a CMS demonstrated a vision for business growth. They understood the business case for digitization and saw value in digitizing their practices. Other characteristics also appeared to support adoption and use of the system. A dedicated CMS champion in the facility helped navigate and support IT and non-IT aspects of implementation. Owner-operated facilities used the CMS more and adopted it faster. Female-owned facilities performed better than non-female-owned facilities. Location was another enabler of installing and using a CMS. Providers in urban and peri-urban areas fared better due to better internet connectivity that eased data transmission and back-up. It was also noted that when facility owners are comfortable with data transparency and know how data are used, they tend to adopt a CMS more readily.

Box 6. A facility archetype for CMS

- Business growth mindset
- Champion(s) for CMS on site
- Female owned
- Strong internet connection/urban location

4. **Digitization is foremost an investment in technology, but also requires changes in user behavior and supporting processes.**

Digitization requires investment in more than the technology alone; there is a need to invest in people and processes. For example, one practice migrating data from existing systems and paper-based records into the new CMS had a rocky transition. The effort was more difficult owing to missing records, which delayed the launch of the CMS in some facilities and required additional support to rectify.

Users responded to digitized information once it was available in a variety of ways. Not surprisingly, some staff were reluctant to use the CMS. They would revert to the previous way of doing things (e.g., maintaining paper records) when they were uncertain about how to use new digital processes, and more familiar with established manual processes. Several other examples were more unexpected and infrequent. In one case, the increased transparency of financial

information (i.e., income) by the CMS presented a disincentive to some staff to use the CMS. Increased financial transparency also raised concerns about potential tax implications in some facility owners. Another facility owner was reluctant to generate digitized financial information that could be more accessible to staff, family members, and/or business partners. At one other facility, staff expressed concern about the possibility of the facility owner using the CMS to monitor employee productivity or whereabouts.

The NMO also found that staff turnover posed a challenge to maintaining continuity in the use of the CMS at facilities, because it resulted in a need to invest in training new staff.

Aggregation and contracting

1. It is important to understand legal parameters for contracting.

An intermediary in Kenya and elsewhere should understand and keep abreast of regulations, procedures, and current provisions and practices for contracting between health providers and financing programs. Currently, due to the legal barriers outlined previously, the NHIF can only contract with health facilities holding a Kenya Medical Practitioners and Dentists Board facility license. It is not authorized to contract with an intermediary representing individual providers that does not hold a board facility license. Changing this requirement will entail major reform of the existing legal framework.

2. There is an opportunity for intermediaries to add value for clients and private providers in capitated health financing programs.

The NHIF's schemes pay for outpatient services on a prospective basis using capitation. Clients are required to register at a primary care facility for outpatient care. This presents challenges for clients, providers, and the NHIF when the client is in another location and requires outpatient services at a different facility than where he or she is registered. The project's exploratory discussions with the NHIF indicated that an intermediary could help coordinate referrals for capitated outpatient services within the intermediary's network. The intermediary could also pool payments within its network, and then pay out funds where services are delivered. This could allow clients to access family planning and other services more easily from multiple points of access—not just the one where they are registered. This opportunity can be explored further in future initiatives and may provide a point of entry for an intermediary to provide services on behalf of its members to the NHIF.

3. Intermediaries need sufficient authority to act on behalf of their members.

The legal scope of the intermediary and its authority to represent network facilities will define the extent to which the intermediary can engage in contracting, as noted previously with the NHIF. Private health insurers confirmed they seek to partner with an intermediary that has full legal authority to contract on behalf of its members. This means that the intermediary would have legal authority to negotiate terms and conditions of the contract on behalf of members. These terms should include payment mechanisms and rates, billing and reporting requirements, a dispute resolution process, handling of payments, and terms for termination.

The existing agreements between the intermediary and network providers fell short of this. As fractional franchisees, network members cede limited legal and enforceable authority to their intermediary and retain their own fee schedules. This prevented the NMO from negotiating a uniform rate across all facilities in a single contract with the payer. PS Kenya needed to negotiate with network members to establish a common fee schedule members would abide by in a contract with the insurer. The lack of uniformity in fees was a main reason that some larger private health insurers preferred to “wait and see,” and deferred contracting with the NMO. A full franchise that can influence all services and prices offered under a common contract may be an eventual model for fractional franchises, such as PS Kenya, interested in operating as an intermediary.

4. Private insurers are experimenting with how to expand market share, cautiously.

Private insurers are experimenting with digital innovations to deliver insurance products that are more affordable and convenient for clients. In Kenya, private health insurers are leveraging digital technologies to expand insurance coverage into rural areas (Kariuki 2020) while others are developing digital-enabled insurance products (Muchira 2020). However, private insurance companies are cautious about contracting with an intermediary without a more substantive demonstration case (proof of concept).

Insurers are risk averse by nature and training

“One insurer told us, ‘Look, we want to wait and see how this works with other insurers first, so you sign up with other insurers, let them work, then we’ll see.’ ”

— PS Kenya Manager

Recommendations

While SMPPs often provide substantial amounts of care in lower- and middle-income countries, they struggle with empanelment and effective participation with health financing programs. Governments and other private payers also seek reliable, quality health care providers whom they can work with at scale. Although SMPPs are not homogenous, one way for SMPPs with growth and entrepreneurship potential to overcome challenges of working with health financing programs, such as the NHIF in Kenya, is to work with an intermediary such as a social franchise or association that aggregates and organizes them. Recommendations for intermediaries, providers, and donors with an interest in strengthening private sector engagement in health include:

1. **Support legal reforms that enable government-sponsored health insurers to hold contracts with intermediaries who represent multiple health providers.**

Donors can support governments to initiate and support legal reforms to allow contracting multiple SMPPs through an intermediary. Done right, these contracts can enable SMPPs to sustainably increase access to health services, including family planning.

2. **Help intermediaries define their role and value proposition, then identify and organize providers whose objectives and capabilities align.**

Intermediaries can play a variety of roles to support SMPPs. These can include supporting accreditation, contracting, contract management, pooling of capitated funds across a network of facilities, and quality improvement. Intermediaries should determine their value proposition based on the needs of providers and other stakeholders (clients, payers, donors, or investors). This will help them partner with providers who align with their objectives and develop scalable business models that support health goals, including universal health coverage.

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