

Opening the Door to Health Insurance Programs

Experiences of small and medium private providers



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Over 214 million women of reproductive age in developing regions want to avoid pregnancy, but are not using a modern contraceptive method. This unmet need for family planning is due to many reasons, including lack of access to quality and affordable family planning services. At the same time, countries worldwide are working to achieve universal health coverage (UHC)—the ability to obtain health services, including family planning, without financial hardship. Regardless of the pathway to UHC a country chooses, it is likely to confront many challenges. In emerging markets, these often include inadequate financing and infrastructure for health, inconsistent or poor quality services, and insufficient numbers of providers.

Private health care providers are an important resource in a health system, and their potential to help countries achieve UHC is generating global interest. A substantial share of private health care providers are small and medium private providers (SMPPs). While there is no uniform definition, this brief considers SMPPs to be solo practitioners as well as those who practice in groups comprising several practitioners. SMPPs include doctors, nurses, midwives, clinical officers, and pharmacists. They mainly offer services at the primary level, whereas larger provider organizations often offer secondary or tertiary services, including inpatient care. Many practitioners who are considered an SMPP or part of an SMPP practice in low-income communities and may themselves be members of these communities.

SMPPs play an important role in extending family planning and other health services by reaching poor and underserved groups, yet they remain underrepresented in health sector policies and programs. They are fragmented and their number, distribution, and capacity are not well known by country decision makers. Many



A private provider counsels a female patient in Senegal.

Photo: Javier Acebal

providers lack resources, including sufficient capital, and business skills. Despite these challenges, they are increasingly seen as a valuable partner by governments that seek to scale up health financing programs. SMPPs can help expand access to health services and relieve pressure on public facilities, often at a lower cost than would be required to invest in new infrastructure.

Administrators of health financing programs (insurance, conditional cash transfer programs, and voucher programs) purchase services such as family planning on behalf of their clients from health care providers, including SMPPs. Typically, providers enter into a legally binding contract with the health financing program (which may also be referred to as the purchaser, payer, or sponsor) to provide covered services to clients enrolled in the program. Once a contract is in place, a provider is said to be *participating*.

A program administrator may ask a provider to satisfy multiple requirements and accept various terms and conditions before it executes a contract authorizing the provider to deliver covered services to clients. For example, the provider may be required to meet criteria specified by the program related to quality, payment terms, and other conditions such as submitting claims or conducting patient encounters by a certain time and in a certain format, or agreeing to treat clients equitably (Figure 1). This process varies by program and context.

Figure 1. Common requirements to participate in a health financing program



The requirements and processes for SMPPs to participate in health financing programs, and the ease (and pitfalls) of doing so have not been well documented. These providers often have fewer resources and sometimes the participation process can be arduous and costly. This brief documents the experiences of SMPPs offering family planning and other priority health services who participate in health financing programs, particularly government-sponsored insurance programs, and the challenges they face.

Various terms, one concept

Various terms are used to refer to the process of establishing provider participation in health financing programs, or to steps in the process. Terms such as *accreditation*, *certification*, *contracting*, *credentialing*, and *empanelment* are often used. Use of these terms vary by speaker, context, and location. However, they generally refer to the same concept: meeting standards that qualify a provider to participate in a health financing program. Providers, once participating in health financing programs, may be referred to as *contracted*, *empaneled*, or *in-network* providers—or simply as *participating* providers.

Given the variation in terms and their use, it is important when discussing an individual program to confirm which terms are used, and how they are defined. In Kenya, the process of meeting standards to participate in the country’s National Hospital Insurance Fund (NHIF Kenya) is described as completing a *declaration*; sometimes the terms accreditation or empanelment are used instead. Ghana’s National Health Insurance Scheme (NHIS) uses another set of terms and definitions to refer to the provider participation process (Figure 2).

Figure 2. How providers participate in Ghana’s National Health Insurance Scheme



Private providers applying to participate in the NHIS must first work at a facility that is accredited by the Health Facilities Regulatory Agency (HEFRA), an independent regulatory body established in 2012. Since 2012, the National Health Insurance Authority (NHIA), which oversees the NHIS, has relied on HEFRA to register, license, and monitor all private facilities. Public providers may also fall under HEFRA’s purview in the future. Applicants submit the appropriate forms, payment, and business registration, and pass an onsite inspection as part of the accreditation process.

Following HEFRA accreditation, providers are credentialed by the NHIA (made eligible) to be empaneled (contracted to participate) in the NHIS. Applicants submit the appropriate forms and payment, and complete onsite inspections as part of the credentialing process. The process is paper-based, though the agency hopes to migrate to an electronic format in the near future.

As part of the credentialing process, onsite inspections are conducted by teams comprising a doctor, nurse, pharmacist, and health administrator from the Ghana Health Service. Each provider who is assessed receives a letter that documents the provider's score, which can range from A (highest) through F (failure). Importantly, the letter identifies any gaps in meeting specified quality standards. Providers given a D grade or higher receive a certificate good for an initial period of five years. Re-credentialing is required every two years thereafter.

The NHIA estimates that approximately 10 percent of first-time applicants receive an F on their onsite assessment; most (around 70 percent) receive a grade of C or D. The NHIA observed that providers often improve their scores over time, since the assessment shows specific improvement areas (Addo-Yobo and Wiafe 2017, Opoku-Boateng 2017).



A nurse in Accra, Ghana. To participate in Ghana's National Health Insurance Scheme, a facility must be accredited through the Health Facilities Regulatory Agency and its providers credentialed by the National Health Insurance Authority.

Photo: Elizabeth Corley

Benefits of participating

Participating in health financing programs has benefits for private providers. It can help them attract and retain clients, increase revenues, and operate their practices more efficiently—and ultimately it can promote sustainability of their practices.

For midwives in the Philippines, participation in PhilHealth, the country's national health insurance scheme, has been a game changer. PhilHealth refers to a participating provider as an accredited provider. Given the high population coverage of PhilHealth (92 percent), participating in the scheme is widely viewed by providers as the norm; to not participate is a perceived disadvantage. Generous payments from PhilHealth have given independently operating, participating midwives a sustainable source of clients and revenue. To its advantage, PhilHealth increased the number of accredited (participating) providers to expand its capacity to serve growing numbers of clients. Today, the scheme provides broad access to health services. It accredits nearly all public and private hospitals licensed by the Department of Health. At the close of 2015, more than 2,550 outpatient clinics covering 99 percent of local government units were accredited to provide primary care service packages that were offered to indigent members (PhilHealth 2015).



Gertrudes Luderico, a private midwife and clinic owner in the Philippines who is part of the Well-Family network. "I run my practice such that every day, if the Department of Health arrives to perform an inspection, it will go well," says Luderico.

Photo: Jeanna Holtz

In Kenya, participation in NHIF has improved the reputation of providers affiliated with Amua, a social franchise network established by Marie Stopes Kenya in 2004.¹ As a result, Amua network providers participating in NHIF Kenya have seen increases in client volume and service use (Owino 2017). In Ghana, when the NHIS included additional private providers (specifically clinics and pharmacies) in its provider network, it expanded geographic access to health services (Lampthey et al. 2017).

¹ More than 270 SMPP clinics are affiliated with Amua. Most are owned and operated by a licensed nurse, and staffed by additional health workers (Center for Health Market Innovations 2018a). As of June 2016, Amua providers accounted for approximately 10 percent of all private providers empaneled in the NHIF (HANSHEP/African Health Markets for Equity 2016).

Challenges for providers

Despite the benefits that private providers derive from participating in health financing programs, the requirements and conditions to do so may be challenging or even unfeasible to meet, especially for SMPPs with limited size and resources. Box 1 describes challenges that SMPPs faced in India and the Dominican Republic. Although this brief focuses on SMPPs' participation in government-sponsored health insurance programs, similar findings are noted with other health financing programs, including with public sector vouchers, cash transfers, and private sector insurance.

This section discusses common challenges providers face when participating in health financing programs: prohibition of certain types of providers, exclusion due to a provider's proximity to a larger facility, cost, licensing and legal agreements, processing time, and operational challenges.

Box 1. Challenges of participating in conditional cash transfer and private health insurance programs in India and the Dominican Republic

The Janani Suraksha Yojana program, launched in India in 2005, is a conditional cash transfer program that encourages the use of safe motherhood services through cash incentives for clients and providers (Bredenkamp 2009). The program contracts private providers for safe delivery services such as antenatal care and institutional delivery. A recent study found that key barriers that discourage private providers from participating in Janani Suraksha Yojana are financial and administrative: anticipated insufficient payments for services, payment delays, an unclear application process, and a lack of trust and previous unpleasant experiences with government officials (Yadav et al. 2017).

In a case involving private health insurance, PSI established one of its model clinics in the Dominican Republic to offer primary care at an affordable price. PSI planned to replicate the model via social franchising. Although the model did not initially serve patients covered by private insurance, the clinic later decided it would seek to participate in private health insurance programs. While PSI could readily adapt its systems to support the clinic to operate in private health insurance provider networks, it encountered challenges. In particular, the time for the insurance companies to complete the contracting process was lengthy. In one instance, it took up to 16 months. During this period, it was unclear how, or with whom, to follow up at the insurance company. Additionally, the private insurance companies were selective about which providers they would contract with. For example, they focused on those who would fill a geographic or service gap within the network. They would not contract a provider if there was an existing contracted provider nearby. Finally, understanding how to transition from input-based payments (such as a grant for operations) to outcome-based payments, such as being paid a set fee per service or group of services delivered, was also a challenge for the clinic (Hardin 2017).

Exclusion of provider types

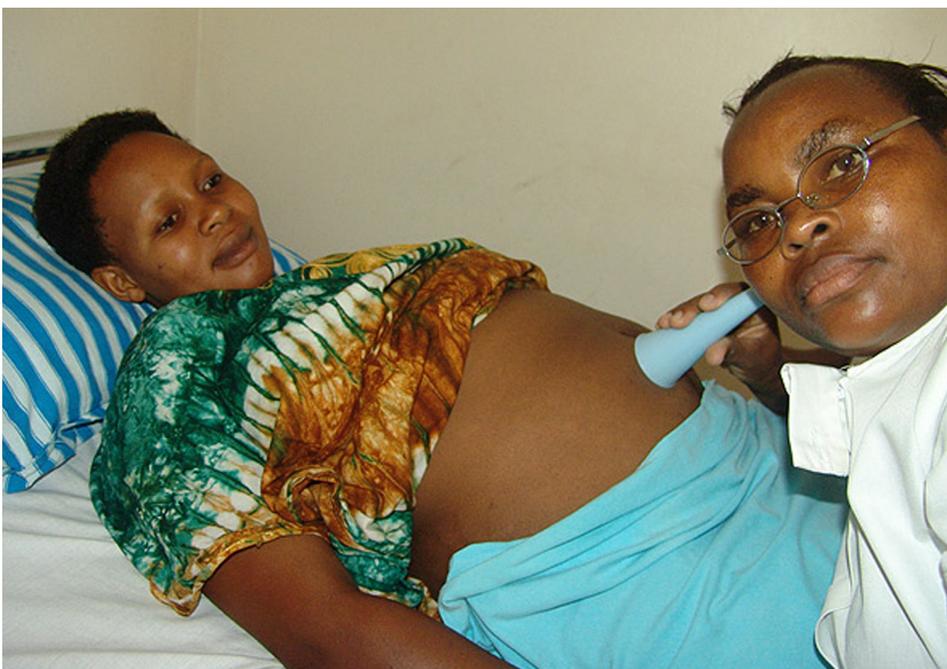
Sometimes, a health financing program lacks procedures to recognize a particular type of provider, thus excluding the type from participating. Until recently in Tanzania, both midwives and nurses were unable to operate health facilities. After a change in policy, the Private Nurses Midwives Association of Tanzania (PRINMAT) began operating a network of maternity homes; this network now includes 100 maternity homes that deliver a range of maternal and reproductive health services, including family planning. As a grassroots organization, it aims to deliver affordable, quality health services to people who otherwise lack access.

Current National Health Insurance Fund (NHIF Tanzania) guidelines exclude maternity homes from eligibility as NHIS participating providers. This means that clients cannot access NHIF Tanzania benefits at the maternity homes—they must instead seek services at higher-level health facilities that may be outside their communities and that may be more costly for the scheme. Alternatively, if clients seek services at a maternity home, they must pay out of pocket. PRINMAT is currently advocating for

maternity homes to become eligible to participate in NHIF Tanzania (Ogada-Ndekana 2017).

Proximity to larger, full-service facilities

Health financing programs sometimes prefer to contract larger facilities that offer a wide range of health services. Such “one-stop shopping” is more administratively efficient for the program, in contrast to the numerous contracts that would be required if the program worked with multiple SMPPs—even if those smaller, more limited facilities are an important source of services in low-income communities. For instance, in Tanzania, proximity to a larger facility influences whether NHIF Tanzania will agree to contract a facility to participate in the scheme. A smaller facility such as a dispensary will typically offer a limited number of services. If there is a larger facility that offers a wider range of services nearby, the NHIF Tanzania may elect not to contract with the smaller facility. The consequence is that SMPPs can be excluded from the scheme, even when they are providing much-needed and often more affordable services to the community.



A nurse in Tanzania examines a pregnant patient.

Photo: PRINMAT

Cost

Many SMPPs have limited financial resources, which bars them from participating in health financing programs. Additional costs that can be problematic for SMPPs to cover range from application fees to required investments in facility renovations or training.

For example, as of 2018 birthing centers in the Philippines (typically operated by SMPPs) are required to hold a license to operate, which is issued by the Department of Health. The license is needed to maintain accreditation with PhilHealth and costs ₱300 (\$6). It stipulates that each center have a minimum of 50 square meters of total space per bed. Midwife informants estimate that approximately half of licensed birthing facilities have obtained a license to operate. Yet, for midwives who own and operate smaller spaces, it may be too costly to renovate the spaces to meet the minimum space requirement or, for those who rent small spaces, unfeasible to relocate for financial or other reasons (e.g., distance from their existing client base).

Moreover, in focus group discussions, private midwives expressed concern about the cost and accessibility of training required to participate in PhilHealth, particularly when staff turnover can be high. Indeed, the biggest challenges for midwives appear to be paying for required training and maintaining all professional credentials. For example, basic emergency obstetric and neonatal care training can cost ₱20,000–25,000 (\$384–481). Applying to participate in PhilHealth costs ₱3,600

(\$69) for birthing centers (renewable every three years) and ₱1,500 (\$29) for individual midwives (renewable every year).

Licensing and legal agreements

Another challenge for SMPPs is to obtain and maintain required licenses and agreements. For example, NHIF Kenya requires participating providers to be licensed with the Kenya Medical Practitioners and Dentists Board. This means that nurses, who are licensed by the Nursing Council, must obtain an additional (and more expensive) license from the Medical and Dentistry Board (Wanderi 2017). In Ghana, providers sometimes do not realize that to participate in the NHIS they must complete and maintain individual certifications (i.e., registration in professional bodies) in parallel with facility accreditation. In the case of pharmacies, medicine prescribers must hold a license from the Pharmacy Council. Failure to maintain all required licenses for facilities and providers practicing at those facilities can result in suspension of providers' participation with the NHIS (Addo-Yobo and Wiafe 2017).

Attaining legal agreements can also be a challenge for some SMPPs. In Kenya, most providers tend to have an informal agreement with a nearby laboratory, but NHIF Kenya requires providers to have written service level agreements with a third party for laboratory services. Providers affiliated with the Tunza social franchise network run by Population Services Kenya (PSK) get help in establishing formal service level agreements (Wanderi 2017).²

² Tunza is a fractional franchise founded in 2008 comprising 84 clinics throughout Kenya staffed largely by nurses (Center for Health Market Innovations 2018b).

Processing time

In Ghana, credentialing (Figure 2 on page 3) by the NHIA works reasonably well for the government authority and participating providers, but it is a time-consuming process. The target established by the NHIA to complete credentialing is 90 days, but the process is often delayed, sometimes by months, due to a backlog of onsite inspections. For example, small over-the-counter medicine sellers may experience a 6- to 12-month wait for their site inspection from HEFRA. Prior to 2012 and the establishment of HEFRA, approximately 10,000 medicine sellers were accredited by Ghana's Pharmacy Council. Now, with HEFRA overseeing accreditation, only a few hundred medicine sellers have been accredited. While the NHIA reports that backlogs are decreasing, the length of time to complete credentialing is still a challenge for providers and the NHIA (Addo-Yobo and Wiafe 2017).

Operational challenges

Payment mechanisms

Often the greatest challenge SMPPs face is not the process of becoming a participating provider in a health financing program but the operational aspects of being one. For many providers, moving from input-based or fee-per-service payments to another payment method can be difficult; operating successfully under the new payment mechanism usually requires providers to change the way they do business. Examples of payment approaches that may present challenges to providers are case rates, which pay a fixed amount for a group of services expected to produce a given health outcome, or capitation, which pays a fixed amount per person, per period to deliver a defined set of services. NHIF Kenya makes a quarterly capitation payment, based on the number of clients enrolled with the provider, regardless of clients' use of the services. In effect, the capitation payment establishes a budget under which the provider must manage

care of all enrolled clients. This gives participating providers a financial incentive to deliver care more efficiently. In addition to helping providers manage capitation-based payments, PSK encourages social franchisees who are part of its Tunza network to seek a diversified mix of clients and payment arrangements (Wanderi 2017).

Timeliness of payment

Providers also encounter challenges in receiving timely and complete payments from health financing programs, in particular insurance schemes. In Ghana, the NHIS has struggled to make timely payments to contracted providers. The national scheme has faced difficulties securing adequate funding from the government, processing claims on time, and controlling claims costs. Similarly in Kenya, payments for inpatient services often exceed the maximum turnaround time of 21 days stated in the program's standard operating procedures.



A health clinic in Kisumu, Kenya supported by Afya Research Africa—a private health enterprise.

Photo: DDC International

The purchaser's perspective

While this brief focuses on challenges that SMPPs face in participating in health financing programs, the converse also happens—program purchasers face challenges in engaging the providers. These include having an accurate census of private providers with locations; understanding the range of services and quality they provide; and having adequate resources, regulations, and know-how to oversee their performance. Box 2 describes the difficulty encountered by Ghana's NHIA in trying to accurately assess providers' qualifications to deliver NHIS services.

Box 2. Purchaser challenges: Preventing fraud and misrepresentation in Ghana's provider inspections

In Ghana, the NHIA discovered a weakness in its approach to inspecting providers: its scheduled inspections result in some providers “borrowing” staff or equipment from other providers to meet minimum standards or to improve an inspection score. This is particularly a problem with SMPPs, which often cannot afford to meet all inspection criteria. In the future, the NHIA would like to do unannounced inspections. Also, inspectors ideally should be from other regions to minimize collusion or favoritism; this, however, will require greater logistical planning and cost (Opoku-Boateng 2017).



A provider weighs a pregnant woman in the Central African Republic. Small and medium private providers can help expand access to health services and relieve pressure on public facilities, often at a lower cost than would be required to invest in new infrastructure.

Photo: © ALIMA/Nanna Kreutzmann



Allowing various types of providers to participate in health financing programs can help the programs to extend their reach.

Photo: © WHO Afghanistan/S. Ramo

Certainly, the process used by health financing programs to engage SMPPs to participate is dynamic. It will evolve as requirements and assessment techniques change, and programs make adjustments to eliminate barriers and improve their processes. For instance, application fees used to be a challenge for providers, especially SMPPs, seeking to participate in NHIF Kenya. To remove this financial barrier and increase the number of participating providers to deliver services, in 2016 NHIF Kenya eliminated the application fee of KSh 50,000 (\$496) for faith-based health facilities and

KSh 100,000 (\$991) for other private facilities along with other participation requirements (Otieno 2016). In Ghana, the NHIA would like to explore the potential of offering NHIS participating providers financial incentives that are directly linked to the quality of the services they deliver (Opoku-Boateng 2017). Additionally, the NHIA sees potential in using facility mapping to target providers who are located in underserved areas for participation in the NHIS. This may be of particular benefit to SMPPs, including those who provide family planning and other primary care services.

Program administrators recognize that allowing new types of providers, whose members are often SMPPs, to participate can help programs efficiently extend their reach. For example, in the Philippines, PhilHealth recently decided to contract standalone family planning clinics that can be staffed by nurses, most of whom are likely to be SMPPs.

Ideas to improve the process and requirements to participate in health financing programs for all parties can be based on feedback solicited from SMPPs. In the Philippines, midwives suggested that PhilHealth synchronize the date of accreditation for facilities and individual providers, for example, placing them both on a three-year cycle. They also identified opportunities to improve consistency in policies and standards issued by the Department of Health and PhilHealth. For example, PhilHealth requires midwives to hold a memorandum of understanding with a physician who provides clinical back-up, whereas the Department of Health does not.

Support for small and medium private providers

A third party can play an important role in helping SMPPs navigate the process of becoming a participating provider in a health financing program. This intermediary role³ is exemplified by social franchisors that support SMPPs. In effect, the franchisor trains the franchisee to satisfy regulatory and other requirements to participate in health financing programs and provide quality, efficient services. An intermediary may offer additional benefits, such as peer learning and bulk purchasing to lower a SMPP's costs, or refresher training for provision of family planning or other services. Provider associations and third-party administrators of health financing programs are examples of other potential intermediaries.

Well-Family Midwife Clinics and BlueStar Philipinas are two social franchise networks in the Philippines that have helped midwife franchisees become participating providers with PhilHealth. Participation in PhilHealth requires meeting equipment and infrastructure requirements, which may ultimately require capital. Both networks offer grants and low-interest loans, as well as facilitate access to loans through local banks. PhilHealth also has facility layout requirements; both networks offer a basic blueprint to guide construction and renovation. In some cases, the networks supervise new construction or renovation themselves. They also help midwives execute a memorandum of understanding with a referral physician who can

prescribe medications and provide clinical back-up when needed to satisfy another requirement of PhilHealth. Both networks provide virtual or in-person administrative support to midwife members, including sending reminders to franchisees to renew their participation in the scheme (Viswanathan and Avanceña 2015).

With support from the African Health Markets for Equity⁴ partnership, Marie Stopes Kenya and PSK help franchisees participate in NHIF Kenya. Marie Stopes Kenya supports Amua franchisees' participation in the scheme as part of efforts to improve franchisees' sustainability. It does so by assisting them in acquiring necessary licenses and certificates; obtaining service level agreements for waste disposal, pharmacies, and laboratory companies; and navigating the overall process to apply to become a participating provider. Components of the application process include the NHIF Kenya Compliance Code/Certificate, board approvals, and legal registration—also known as gazettement (Owino 2017). With support from Marie Stopes Kenya, Amua facilities have increasingly become participating providers in NHIF Kenya. In May 2015, approximately 40 Amua network facilities participated in NHIF Kenya. That number increased to nearly 140 facilities by June 2017 (Owino 2017).

Similarly, PSK demystifies the process for Tunza network franchisees to participate in NHIF Kenya. Its goal is to get as many franchisees contracted and participating with NHIF Kenya as possible. PSK has

³ Intermediaries are “organizations that form networks between small-scale private providers to interact with governments, patients, and vendors while performing key health systems functions that are challenging for individual private providers to do on their own” (Results for Development Institute 2016).

⁴ The African Health Markets for Equity partnership is a six-year, \$55.6 million investment by the Bill and Melinda Gates Foundation and the UK Department for International Development that aims to improve the functioning of health systems in ways that benefit the poor in terms of quality, access, security of supply, sustainability, and equity. While African Health Markets for Equity's work in Nigeria concluded in March 2017, it will continue in Kenya and Ghana until March 2019.



A PhilHealth–accredited midwife stands in front of her clinic.

Photo: Robin Keely

a dedicated team that walks the providers through the process and shows them where they may need to make improvements to begin and maintain their participation in NHIF Kenya. In addition to helping providers with forms and obtaining the necessary licenses and documentation, Tunza also develops a quality improvement plan to improve the readiness of franchisees for participation in NHIF Kenya. Finally, Tunza serves as a link between the franchisee and the local NHIF Kenya branch office by following up on the status of contract applications and inquiries (Wanderi 2017).

Looking Ahead



Looking ahead

The range of entities—governments, development partners, implementers, and providers—that support efforts to reach UHC and to expand access to family planning have a stake in opening the door for SMPPs to participate more broadly in health financing programs.

As government-sponsored insurance schemes and other health financing programs enroll more people, particularly from lower-income households and geographically diverse locations, they will need to expand their provider networks. As their size and purchasing power increase, health financing programs will be increasingly accountable to ensure that clients receive quality, affordable care when they access services.

Purchasers of health services can do more to address factors that inhibit SMPP participation in health financing programs. In addition to addressing the challenges noted above, purchasers should:

- **Invest in reliable and current data on the total health system including private providers, particularly SMPPs.** Better data can be used to identify where SMPPs can be recruited to expand access to underserved areas and groups, such as youth for family planning services, possibly at a lower cost.
- **Incentivize providers.** Continue to align financial and other incentives to provide the right mix and level of services, including full method choice for family planning. Payment mechanisms and rates must cover the real costs of counseling and other services and be timely and reliable.

- **Be efficient.** Collaborate with other quality assurance and regulatory bodies to streamline contracting and operating processes. Work with intermediaries to help SMPPs participate in programs.
- **Be flexible.** One size doesn't fit all; participation criteria in place for larger providers can be adapted to be relevant and appropriate for SMPPs.

SMPPs should evaluate the merits of participating in a particular health financing program based on their own specific goals and circumstances. While not every program will make sense for every SMPP, the expansion of health financing programs that support UHC poses an opportunity and signals the trend toward pre-paid, pooled financing programs that purchase services more strategically. These programs offer a potential growing source of clients and revenue that can reduce reliance on out-of-pocket payments and help promote the business viability of SMPP practices. As highlighted above, participating in these programs can present challenges for SMPPs, too.

Providers and purchasers are best advised to view participation in health financing programs as an investment in quality and accountability. Successful participation requires time and resources, and ongoing collaboration and monitoring by purchasers and providers. SMPPs should consider working with an intermediary that can support them to participate in health financing programs. Providers should stay abreast of quality initiatives and other requirements linked to the health financing programs they participate in (or wish to in the future) and plan accordingly.

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